



STATEMENT OF THE CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, Inc. (the Center) submits this testimony to be included in the record of the hearing on Medicare Advantage, held before the Health Subcommittee of the Committee on Ways and Means on Wednesday, March 21, 2007.

Founded in 1986, the Center is a national, non-partisan educational and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The Center's national office is in Connecticut, with offices throughout the country, including Washington, D.C. The Center represents thousands of individuals in Medicare appeals each year, responds to calls and e-mails from individuals in Connecticut as well as from all across the United States, and provides support to CHOICES, the Connecticut State Health Insurance and Assistance Program (SHIP).

Originally, the logic for including private insurance plans in Medicare was that risk Health Maintenance Organizations (HMOs) could, by coordinating care and other means, provide the same services as the traditional Medicare program at reduced costs. Furthermore, allowing private plans to compete against one another would encourage efficiencies and spur the plans to offer services and benefits beyond the comprehensive coverage offered by Medicare. However, at each iteration of private Medicare options, private plans have shown that they are unable to accomplish these goals without drastic subsidies from the federal government.

Overpayments to Private Plans

The current iteration of the private Medicare options, Medicare Advantage (MA), is no exception to the rule. An analysis by the Medicare Payment Advisory Commission (MedPAC) indicates that county benchmarks are 116% and payments to plans are 112% of the average per capita expenditures in the traditional Medicare program ["Report to the Congress: Medicare Payment Policy," MedPAC (March 2007)]. Another independent analysis found that payments to MA plans averaged 12.4% more than costs in traditional Medicare during 2005 ["The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised," The Commonwealth Fund (November 2006)]. If Congress were to eliminate these overpayments by setting the benchmarks in each county equal to per capita spending in traditional Medicare, the Congressional Budget Office (CBO) estimates that Medicare would save \$8.1 billion in 2008 and \$159.8 billion through 2017 ["Budget Options," CBO (February 2007)].

MedPAC has argued consistently for years that private plans could serve an important role within Medicare, but payments to plans must be financially neutral when compared to those in the traditional Medicare program. The Center agrees that financial neutrality would be a more appropriate position than the current scheme, nevertheless the Center urges Congress to consider adjusting payments to MA plans to less than traditional Medicare expenditures as a means to stimulate competition and efficiency among the private plans. Risk-based and coordinated care is important but not if it comes at the expense of a social insurance program that has been consistently successful for over 40 years.

Private Fee-For-Service

HMO's are not the only private plan options participating in Medicare. Other plan types include Local and Regional Preferred Provider Organizations (PPOs), Private Fee-for-Service plans (PFFS), and Special Needs Plans (SNPs). Insurance companies have continued to offer private plans in more areas and now at least one private plan alternative is available to every Medicare beneficiary.

PFFS is the fastest-growing plan type, accounting for 46% of total enrollment growth from December 2005 to July 2006. PFFS was available to 45% of beneficiaries in 2005 and is now available to almost 100% of beneficiaries. With payments to PFFS plans averaging 119% of the per capita traditional Medicare expenditures, it is no wonder that PFFS plans are growing at such a rapid rate.

Arguments from the Plans

Chairman Stark and other members of Congress have begun to seize on these overpayments to private plans as a significant source of potential savings for Medicare. Not surprisingly, the private insurance companies are very concerned that they might lose billions of dollars.

The plans have argued that cutting funding to the MA plans would disproportionately hurt low-income beneficiaries. We agree that low-income beneficiaries need extra help the most. For those who are most needy, the majority rely on Medicaid or Medigap policies, not MA plans, to cover what Medicare does not. Extra help is also available to low-income beneficiaries in the form of Medicare Savings Programs (MSPs). These programs reduce out-of-pocket expenses for individuals with incomes below 135% of the Federal Poverty Level (\$18,482 for a couple and \$27,878 for a family of four), but these programs could serve even more beneficiaries. The savings from eliminating the overpayment to MA plans could be used to provide more benefits to more low-income beneficiaries, not just those who choose to enroll in an MA plan.

Private plans have also pointed out that people who enroll in an MA plan receive more benefits than are offered by traditional Medicare. It is obvious that beneficiaries should receive as many benefits as possible, but those benefits should be distributed equitably. In the current system, the vast majority of beneficiaries—who choose traditional Medicare

in the face of a marketing barrage from the private plans—pay premiums that are inflated by the overpayments made to MA plans. Why limit extra benefits to just the beneficiaries who enroll in MA plans at the expense of those who choose not to? How significant are these additional benefits, actually? The private plans cannot answer these questions. These additional services should, and could with efficient spending, be available to all Medicare beneficiaries.

The Reality of Medicare Advantage for Beneficiaries

Because Medicare Advantage plans, and in particular PFFS plans, are paid so well, they are engaged in an extensive marketing campaign to encourage, and sometimes coerce beneficiaries to join their plans. Indeed, 8.3 million beneficiaries, or 19% of the total number of beneficiaries, are currently enrolled in a Medicare Advantage plan, as compared to 7.6 million beneficiaries in 2006 [Medicare Advantage Fact Sheet, Kaiser Family Foundation (March 2007)]. In the Center's experience, not all Medicare beneficiaries understand the benefit structure of Medicare Advantage plans, know that they are enrolling in Medicare Advantage plans, or even reap "benefits" from the additional services these plans provide with the extra money they receive.

Marketing Practices

The Centers for Medicare & Medicaid Services (CMS) is supposed to monitor and approve all marketing materials. Nevertheless, these marketing materials often do not present Medicare Advantage plan structures in the most accurate light or provide all of the information a beneficiary needs to make an informed choice. A glossy, two-page advertisement inserted into the Montgomery County, Maryland, "Washington Post" in March 2007 provides an excellent example. The ad advised that someone who had chosen a Medicare plan with drug coverage still had time until March 31, 2007 to switch to an Aetna Medicare Advantage plan with drug coverage. A comparison chart showed that Medicare Parts A and B, Medicare Supplemental Plan, and Aetna Medicare Advantage Plan all have a "wide choice of local doctors/specialists," but only the Aetna Medicare Advantage Plan has preventive care with a \$0 co-pay and an allowance for eyewear and hearing aids.

Despite being approved by CMS, the advertisement is not accurate. The "network" of doctors and specialists for Medicare Parts A and B and most Medicare Supplemental (Medigap) plans is widest because there actually is no network; beneficiaries can go to any doctor in the country who accepts Medicare, this includes almost all physicians, indeed almost all health care providers nationwide. Aetna Plans, on the other hand, restrict access. According to www.medicare.gov, Aetna offers four HMOs in Montgomery County, all of which require an enrollee to use plan doctors. Aetna also offers four PPOs (two local and two regional), that allow an enrollee to use any doctor, but the enrollee must pay higher cost sharing to go out of network. It is also inaccurate to say that only Aetna Medicare Advantage Plans have a \$0 co-pay for preventive care. Beneficiaries with Medicare Parts A and B and a supplemental plan may also have a \$0 co-pay if the Medigap plan covers Part B cost-sharing. Aetna Medicare Advantage Plans

may indeed provide an “allowance” for eyewear and hearing aids that is not available under traditional Medicare, *but the allowance for eyewear under at least one of the Aetna plans is \$100 every two years*. That allowance does not justify the premium for the Medicare Advantage Plan or the additional Medicare payments the plan receives from the Medicare program.

The advertisement, and most other educational information about Medicare Advantage plans, also does not adequately explain how Medicare Advantage plan cost-sharing may differ from the traditional Medicare cost-sharing structure, particularly for more costly services. For example, one of the Aetna plans available for beneficiaries who received the “Washington Post” ad, the Aetna Golden Choice Regional PPO plan, imposes a \$150 yearly deductible for all out-of-network services. A beneficiary who is induced to enroll in this plan after seeing the ad and who believes she may use any provider will face a higher deductible than the current Part B deductible of \$131. This out-of-network deductible applies to home health services, even though Medicare Parts A and B imposes no such cost-sharing. Beneficiaries who use an out-of-network hospital or skilled nursing facility must pay 20% of the entire hospital or skilled nursing facility stay; far in excess of the cost-sharing under traditional Medicare. Beneficiaries who use an in-network SNF start paying cost-sharing after day 7, rather than after day 20 in traditional Medicare. The plan imposes a \$20 co-pay for each in-network home health visit and 20% cost-sharing for out-of-network care; traditional Medicare imposes no cost-sharing for home health services.

Individual Testimonials

Beneficiaries often do not learn about or understand these cost-sharing differences until after they have enrolled in a plan. For example, a Connecticut beneficiary required hospitalization each month to receive a blood transfusion. She paid the Part A deductible in January, but because she required monthly hospitalization she never entered a new benefit period and so paid no other cost-sharing for the rest of the year. The HMO she chose, like the Aetna PPO described above, imposed a co-pay for a Medicare-covered hospital stay that was substantially less than the Part A deductible. What the Connecticut woman did not understand until her second hospitalization was that the co-pay is required for each hospital stay, even if it falls within what would be the same benefit period under traditional Medicare. Thus, instead of saving money, she was required to pay substantially more for her hospital care than she would have paid if she was in traditional Medicare.

A beneficiary from Jasper, Florida enrolled in a PFFS plan at the beginning of 2007 because of his frustration with his prescription drug plan. Neither he nor the insurance agent understood the differences between traditional Medicare and a PFFS plan. The beneficiary expected only the prescription drug coverage to change. In February, three hours before a scheduled biopsy of a lump in his pectoral muscle, his doctor called to cancel the biopsy because the doctor would not accept the plan’s terms and conditions. He was told by his primary care physician that the doctor would not accept the plan because the plan had not paid on time in the past. In early March the beneficiary finally

received a welcome packet from the plan and saw for the first time the fine print explaining that coverage is contingent on his doctors' acceptance of the plan. He also found that the drug coverage was much more restrictive than under his previous Prescription Drug Plan (PDP). The beneficiary was able to get an "emergency" transfer back to his old PDP and original Medicare, effective April 1, 2007. However, he will have gone more than a month without the needed biopsy and other medical services.

Special Needs Plans

In addition to marketing problems and cost-sharing issues, some Medicare Advantage plans may not be providing meaningful additional benefits to their enrollees. For example, beneficiary advocates have alerted the Center about SNPs for people with Medicare and Medicaid (dual eligibles) that do not contract with the largest Medicaid mental health provider in the community, that include in their networks doctors who do not accept Medicaid, that assess cost-sharing that should otherwise be covered by the state Medicaid program, or that do not inform their enrollees that the state Medicaid program will pay for some drugs such as benzodiazepines that are excluded from Medicare drug coverage. Some SNPs provide, as extra benefits, transportation and dental services that are already covered by Medicaid and thus provide their enrollees with no extra services for the extra payments the plans receive.

Conclusion

Private Medicare plans may offer some beneficiaries a useful Medicare coverage choice, but many beneficiaries find out that the coverage is not what they expected when they enrolled. The Medicare Trustees will soon issue their annual report, and will inevitably raise alarms that Medicare is in financial peril. The payments to these plans must be at least financially neutral when compared to those made for people in the traditional Medicare program. Eliminating overpayments to private plans is a clear way to save Medicare hundreds of billions of dollars while also making the program more equitable and cost-effective. Congress should prohibit overpayments and subsidies to private Medicare plans in order to ensure fair, affordable access to health care for older people and people with disabilities — now and in the future.