



Summary of Testimony by Joe Baker, Medicare Rights Center

The Medicare Rights Center is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

People with Medicare Advantage: Medicare Rights counsels thousands of people with Medicare Advantage (MA) each year. Today, 15 million Medicare beneficiaries (29%) are enrolled in MA. The most common call to our national helpline comes from a beneficiary who is having difficulty affording a health care service or a prescription medicine. Other calls concern:

- **Denied claims and appeals:** Of all calls received on Medicare Rights' helpline in 2012, 33% concerned appeals, and the majority of these related to MA denials of coverage. Research shows that MA enrollees are more likely to report access problems than those with Original Medicare.
- **Enrollment and disenrollment:** Older adults and people with disabilities find choosing among multiple MA plans a dizzying experience. Despite regular plan changes, research suggests that inertia is widespread and most people with Medicare fail to reevaluate their coverage options on an annual basis. There are *too many* MA plans, *too many* plan variables to compare, and not enough meaningful variation among options.

Medicare Advantage Strengthened Since the Affordable Care Act: The ACA included a set of policies designed to make the MA system more efficient and to enhance plan quality. Some claimed that MA enrollees would experience increased cost sharing, tightened provider networks, and fewer plan choices as a result of changes to MA payments, but this has not proven true.

While there appears to be some slimming of MA provider networks this year, these adjustments are an *inherent risk* of any managed care system, have happened in the past, and will happen in the future. Our advice to beneficiaries remains the same: people can change their coverage during the Fall Open Enrollment Period (November 15 – December 7) if an MA plan no longer meets their health and financial needs.

ACA savings secured largely from MA payment adjustments are producing positive returns for the Medicare program overall, benefiting both current and future beneficiaries. The ACA made many other critical improvements to MA, benefiting people with Medicare and their families, including:

- Enhancing coverage and reducing costs for select preventive services
- Prohibiting higher cost sharing for renal dialysis, chemotherapy, and skilled nursing stays
- Mandating a medical loss ratio requiring that 85% of premiums and MA payments are spent on care

Recommendations to Improve Medicare Advantage:

- Improve beneficiary notices regarding annual plan changes
- Further streamline and standardize plans
- Strengthen the MA appeals system
- Adequately fund independent counseling resources, namely State Health Insurance Programs (SHIPs)
- Expand access to supplemental coverage options for people with Original Medicare
- Approach with caution V-BID models to increase cost sharing for some beneficiaries



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Introduction:

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Thank you for the opportunity to testify on the future of Medicare Part C, also known as Medicare Advantage (MA or MA-PD).¹ Our testimony will describe common beneficiary experiences with MA, explain the benefits of recent MA changes for current and future Medicare beneficiaries, offer policy options to further strengthen MA, and explain some concerns we have about increasing beneficiary cost sharing through value-based insurance design.

Medicare Rights counsels thousands of people with MA about topics ranging from enrolling in a plan to appealing a denied claim. Our experience serving MA enrollees informs our support for changes made to MA plans by the Affordable Care Act (ACA) as well as other improvements advanced by the Centers for Medicare & Medicaid Services (CMS). MA enhancements made possible by the ACA include equalizing MA and Original Medicare payments, limiting cost sharing for select services, establishing quality measurement initiatives, and more.

We believe that the ACA begins to advance a value-driven agenda for transforming our health care system. Medicare is the testing ground for many critical payment reforms, and we believe that MA plans, alongside Medicare physicians, hospitals, and other health care providers, are contributing to and should play a role in this broader transformation.

While many predicted that ACA changes to the MA landscape would lead to widespread disruption of the MA market, we have not seen that among the clients we serve or generally, as

¹ MA plans cover Medicare Part A and Part B; MA-PD plans cover Medicare Part A, Part B and Part D

described below. The premium costs, benefit levels, and availability of MA plans remains relatively stable. In fact, the MA landscape is now better and more robust for consumers. In the current open enrollment period, we received a trickle, not a torrent, of calls to our helpline from MA members who recently discovered that their physician or other provider is no longer in their plan network in 2014. While there appears to be an increased incidence of slimming MA provider networks this year, it is important to note that we see some version of this every year. Put simply, changing provider networks are an *inherent risk* of any managed care system. Plans are free to alter networks, and providers are free to leave or join networks throughout the year.

In short, MA adjustments to provider networks are business as usual. Our advice to beneficiaries remains the same, people with Medicare can switch to another MA plan or to Original Medicare during the Fall Open Enrollment Period (November 15 – December 7) if an MA plan no longer meets their health and financial needs. As always, we strongly encourage CMS to thoroughly investigate the network adequacy of MA plans as well as a given plan’s reasoning behind any sizable changes to provider networks, particularly in cases where CMS is hearing concerns directly from beneficiaries.

Drawing on our experience serving people with Medicare, we find that MA plans are a good option for some beneficiaries, but not for all. It is critical that Original Medicare is preserved as a strong, viable coverage option, and we urge Congress to improve access to supplemental Medigap coverage options. All in all, we find that the MA market has vastly improved in recent years as a result of policies advanced by the ACA and CMS to stabilize beneficiary cost sharing, streamline plan choices, and enhance the quality of MA plans.

People with Medicare Advantage

Medicare Rights knows firsthand the economic and health challenges facing people with Medicare. Medicare Rights answers 15,000 questions on our national helpline each year, serving older adults, people with disabilities, and those that help them—family caregivers, social workers, attorneys and other service providers. Through our educational initiatives, including peer-to-peer learning networks, we touch the lives of another 140,000 people with Medicare and

their families. In addition, our online learning tool, Medicare Interactive, receives approximately 1.1 million visits annually.

Today 15 million Medicare beneficiaries (29%) are enrolled in an MA plan.² The top four questions from MA callers to the Medicare Rights helpline involve the following topics: (1) billing for services or products provided; (2) coverage of health services or prescription drugs; (3) denied claims; and (4) enrollment and disenrollment. Many of our callers are satisfied with their MA coverage, and their inquiries are easily resolved. Others find navigating their MA plan challenging. These callers may struggle to resolve billing disputes, cope with coverage denials, compare plan details during open enrollment, and more.

Mr. Johnson is one such caller, who recently called our helpline for assistance resolving a billing dispute with his MA-PD plan for an expensive medication. Mr. Johnson and his wife live in Tennessee on \$1,600 per month from Social Security. Before filling his prescription, Mr. Johnson called his MA plan to double check on the copayment and was informed his epilepsy medicine would cost \$544 for a three-month supply. However, when Mr. Johnson paid for the medication he was charged a higher amount, \$805.

Alarmed by this, Mr. Johnson called the MA plan and was told that the \$544 cost described on a prior call was merely an estimate. Since then, he has spoken with several plan representatives and cannot obtain a clear answer on the exact amount of the medication copayment. A Medicare Rights counselor helped Mr. Johnson file a written grievance and assisted him with Plan Finder, the online search tool made available by CMS, to assess other MA plan options during this year's open enrollment period.

The most common call to our helpline comes from a Medicare beneficiary, like Mr. Johnson, who is having difficulty affording a health care service or a prescription medicine. We receive these calls from both people with Original Medicare and from those with MA. In 2012, half of

² Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/>

all Medicare beneficiaries lived on annual incomes at or below \$22,500—just under 200% of the federal poverty level. One in four had incomes of less than \$14,000. The Baby Boomers, many of whom will retire within the next two decades, are not expected to fare much better. In 2030, half of all people with Medicare are expected to have annual incomes at or below \$28,600.³ In 2012, one third of our helpline calls concerned coverage denials and appeals, most commonly from MA enrollees. Additionally, a core helpline service involves counseling beneficiaries about their options during Medicare’s annual enrollment period (November 15 – December 7). In 2012, Medicare Rights fielded more than 2,500 Plan Finder related calls during open enrollment.

In general, we find that older adults and people with disabilities find choosing among multiple MA plans a dizzying experience. We urge people with MA to revisit their plan’s coverage each year, as annual changes to plan benefits, cost sharing, provider networks, utilization management tools, and other coverage rules are commonplace. Despite regular plan changes, research suggests that inertia is widespread and most people with Medicare fail to reevaluate their coverage options on an annual basis.⁴ Mr. Johnson, for instance, had not revisited his MA plan selection for several years because he found Plan Finder “too confusing.” Like Mr. Johnson, many beneficiaries are overwhelmed by the number of plans available and the process of comparing multiple complex variables to select among these plans.

A recent *Health Affairs* study attributes some degree of beneficiary inertia with having too many plans to choose from. The authors write, “Our study suggests that the Medicare Advantage program presents an overabundance of choices for elderly beneficiaries, posing a level of complexity far beyond that experienced by the nonelderly.” Additionally, the findings show that

³ J. Cubanski, “Testimony: An Overview of the Medicare Program and Medicare Beneficiaries’ Costs and Service Use” (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf>; Jacobson, G., Huang, J., Neuman, T. and K. Smith, “Widespread Disparities in the Income and Assets of People with Medicare by Race and Ethnicity: Now and in the Future,” (Kaiser Family Foundation: September 2013), available at: <http://kff.org/medicare/report/wide-disparities-in-the-income-and-assets-of-people-on-medicare-by-race-and-ethnicity-now-and-in-the-future/>

⁴ Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, “To Switch or Not to Switch: Are Medicare Beneficiaries Switch Drug Plans to Save Money?” (Kaiser Family Foundation: October 2013), available at: <http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/?special=footnotes-footnote-87213-9>

difficulty selecting among MA plans and Original Medicare is more pronounced among older adults with low cognitive function, such those in the early stages of dementia.⁵

While some had predicted that the advent of the ACA would mean that the number of MA plans available to people with Medicare would decrease dramatically, that has not proven true.

Medicare beneficiaries continue to have a range of possible plans and plan types, with some positive consolidation in the numbers of plan choices. Some of this reduction in the number of plans is the result of efforts on the part of CMS to eliminate nearly identical plans offered by the same insurer in the same market, which added confusion, but no real choice, to the MA landscape.

In 2014, the average Medicare beneficiary will have a choice among 18 MA plans, compared to an average of 20 in 2013.⁶ Nearly all beneficiaries (99%) will have one or more plans to choose from in 2014, and nearly all will have a range of plan types to select from, 89% will have access to a Health Maintenance Organization (HMO) and 83% to a local Preferred Provider Organization (PPO). Consistent with past years, beneficiaries in urban areas will have more plan choices than those in suburban and rural areas.⁷

Looking beyond enrollment challenges, our experience demonstrates and available research confirms that there is no one size fits all choice for people with Medicare. Studies suggest that it is particularly difficult for people with MA to estimate expected costs apart from plan premiums, for example for copayments and coinsurance.⁸ One analysis of MA plan cost sharing estimated that average annual spending by a Medicare beneficiary in poor health (using a specified set of health care services) ranged from \$1,360 to \$7,520 across 88 MA plans.⁹ Additional research

⁵ McWilliams, J.M., Afendulus, C.C., McGuire, T.G., and B.E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs* 30:9 (September 2011)

⁶ Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2013 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: December 2012), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8388.pdf>

⁷ Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/>

⁸ O'Brian, E. and J. Hoadley, "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice," (Commonwealth Fund: April 2008), available at: http://www.commonwealthfund.org/~media/Files/Publications/Issue_Brief/2008/Apr/Medicare_Advantage_Options_for_Standardizing_Benefits_and_Information_to_Improve_Consumer_Choice/OBrien_Medicare_Advantage_options_1117_ib.pdf.pdf

⁹ Ibid

suggests that disenrollment from MA plans to Original Medicare occurs disproportionately among higher-cost, sicker beneficiaries.¹⁰

According to another study, MA enrollees were less likely than people with Original Medicare to have health care expenditures exceed 10% of their income. At the same time, however, MA beneficiaries were more likely to report access problems and to give their insurance a fair or poor rating overall. Over one third (32%) of people with MA in the study reported access problems, compared to 23% among people with Original Medicare.¹¹ Indeed, of all calls received to the Medicare Rights helpline in 2012, 33% concerned questions about appeals, and the majority of these related to MA and MA Part D denials of coverage.

Based on our experience serving people with MA, we believe that Congress should consider policy options to improve the MA landscape. In particular, federal policymakers should prioritize solutions that simplify the annual process of comparing and contrasting plan options, and ensure that unbiased counseling resources, most notably the State Health Insurance Assistance Programs (SHIPs), are adequately resourced to meet beneficiary needs. Additionally, Congress should expand and strengthen supplemental coverage options for beneficiaries whose health and financial needs are not best served by an MA plan.

Medicare Advantage: Strengthened Since the Affordable Care Act

Delivery system and payment reforms are now being implemented in the private sector, in Medicare, and in other public programs, through a variety of initiatives, many of which were made possible by the ACA. The ACA offers a blue print for constructing a high value health care system, where insurance plans, physicians, hospitals, and other providers are paid according to the quality of care delivered.

¹⁰ Riley, D., "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service," (CMS Center for Strategic Planning: 2012), available at: http://www.cms.gov/mmrr/Downloads/MMRR2012_002_04_A08.pdf

¹¹ Davis, K., Stremikis, K., Doty, M.M., Zezza, M.A., "Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems Than Adults with Private Coverage," *Health Affairs* 31:8 (August 2012); Davis, K. "The Future of Medicare: Converting to Premium Support or Continuing as a Guaranteed Benefit Program," (Invited Testimony to the House of Representatives Democratic Steering and Outreach Committee: October 2012), available at:

http://www.commonwealthfund.org/~media/Files/Publications/Testimony/2012/Oct/Davis_HouseDems_Medicare_testimony_10022012_FINAL.pdf

Medicare is the incubator for many of these reforms.¹² As such, the ACA included a set of policies designed to make the MA system more efficient and to enhance the quality of MA plans. Transforming our health system from one that rewards high-volume care to one that rewards high-value care is a goal shared by members of Congress on both sides of the aisle. Alongside physicians, hospitals, and other health care providers, MA plans have been, and should be, playing an important role in this transformation. The MA provisions included in the ACA are ultimately intended to secure high value care—in other words, better quality at a lower price.

Among the most notable ACA changes to MA were adjustments to plan payments. In 2010 and 2011, maximum MA plan payments were frozen. Beginning in 2012, gradual reductions in plan payments were phased in according to county-specific per beneficiary spending rates in Original Medicare.¹³ These adjustments are intended to scale back payments to MA plans to better approximate payments and costs in Original Medicare.

In 2009, before passage of the ACA, Medicare paid MA plans \$14 billion more for care than if the same care had been provided under Original Medicare, about \$1,000 more per beneficiary. According to MedPAC, on average MA plans were paid 114% of costs under Original Medicare. These payments varied by plan type, for instance the average HMO was paid 113% whereas the average local PPO was paid 118%.¹⁴ From 2004 to 2009 these payments cost the Medicare program nearly \$44 billion, and despite being paid more, there was little evidence to suggest that MA plans provided consistently higher quality care.¹⁵

As noted above, some claimed that people with MA would experience increased premiums and cost sharing, tightened provider networks, and fewer plan choices as a result of these payment adjustments. The Congressional Budget Office (CBO), American Health Insurance Plans (AHIP)

¹² Blum, J., “Delivery System Reform: Progress Report from CMS” (Invited Testimony to the Senate Finance Committee: February 2013), available at:

[http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20\(J.%20Blum\).pdf](http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20(J.%20Blum).pdf)

¹³ Gold, M. “Making Sense of the Change in How Medicare Advantage Plans are Paid,” (Commonwealth Fund: May 2013), available at:

<http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/May/Making-Sense-of-Changes-in-Medicare-Advantage-Plans.aspx>

¹⁴ MedPAC, Report to the Congress: Medicare Payment Policy,” (March 2009), available at:

http://www.medpac.gov/documents/mar09_entirereport.pdf

¹⁵ Angles, J. “Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries,” (Center on Budget and Policy Priorities: July 2010), available at: <http://www.cbpp.org/cms/?fa=view&id=3243>

and others even predicted that enrollment in MA plans would decline after implementation of the ACA. Yet, the opposite has proven true.

MA enrollment is on the rise, increasing 30% from 2010 to 2013.¹⁶ According to the most recent CBO projections, MA enrollment will continue to increase, with an expected 21 million enrollees in 2023.¹⁷ In short, ACA payment adjustments to MA are not expected to weaken enrollment, and predictions that the MA market will falter have not held up. As implementation of the ACA is carried out, we will continue to advocate for vigilant monitoring of the MA plan landscape to ensure plans are optimally serving people with Medicare under the new payment system.

Critically, ACA savings secured largely from MA payment adjustments are producing positive returns for the Medicare program overall, benefiting both current and future beneficiaries. First and foremost, improved cost efficiency in Medicare translates into tangible savings for older adults and people with disabilities, both for those with Original Medicare and for MA enrollees. In 2014, the Part B premium (paid by both people with Original Medicare and MA enrollees) will remain at 2013 levels, amounting to \$104.90 per month.¹⁸ This news is particularly notable given that MA overpayments historically drove up premiums for Medicare beneficiaries. For instance, in 2009, a couple with Original Medicare paid \$86 more in premiums as a result of MA overpayments.¹⁹

Importantly, the ACA put the Medicare program on sound financial footing, reducing projected Medicare spending by \$716 billion from 2013 to 2022.²⁰ According to the 2013 Medicare Trustees Report, the Medicare Hospital Insurance (HI) trust fund is solvent through 2026,

¹⁶ Jacobson, G., “Projecting Medicare Advantage Enrollment: Expect the Unexpected?” (Kaiser Family Foundation: July 2013), available at: <http://kff.org/medicare/perspective/projecting-medicare-advantage-enrollment-expect-the-unexpected/>

¹⁷ CBO, “CBO’s May 2013 Medicare Baseline,” (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf

¹⁸ CMS, “Press Release: CMS announces major savings for Medicare beneficiaries,” (October 2013), available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-10-28.html>

¹⁹ Angles, J. “Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries,” (Center on Budget and Policy Priorities: July 2010), available at: <http://www.cbpp.org/cms/?fa=view&id=3243>

²⁰ CBO, Letter to the Honorable John Boehner re: cost/revenue from ACA repeal (July 2012), available at: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf>

extended by ten years since passage of the ACA.²¹ This represents one of the longer periods of projected solvency throughout the program's history.²²

In addition to reining in payments to MA plans, the ACA made many other critical improvements to MA for people with Medicare. For instance, an added benefit for people with Original Medicare and MA is increased coverage and lower cost sharing for select preventive services, like mammograms, colonoscopies, prostate cancer screenings, depression screenings, obesity screenings and counseling, and more. In 2012, an estimated 34.1 million people with Medicare utilized a preventive service with limited cost sharing.²³ MA-PD enrollees are also benefiting from ACA provisions to close the prescription drug coverage gap, known as the doughnut hole.²⁴

The ACA also limited the ability of MA plans to charge higher cost sharing than Original Medicare for certain services, particularly those used disproportionately by sicker beneficiaries.²⁵ Specifically, as of 2011, MA plans are prohibited from charging higher cost sharing for renal dialysis, chemotherapy, and skilled nursing facility stays. In addition, starting in 2014 plans must adhere to a Medical Loss Ratio (MLR). The MLR requires that plans spend 85% of beneficiary premiums and federal payments on patient care, limiting plan spending on marketing, CEO salaries, profits, and other administrative costs.²⁶

Finally, the ACA established critical initiatives designed to improve MA plan quality. Specifically, the ACA ties payment bonuses to star ratings for MA plans. Ratings range from 1 to 5 stars, starting with 1 star for poor performance, 3 stars for average performance, and 5 stars for excellent performance. Ratings are determined through a wide array of performance measures.

²¹ The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medical Insurance Trust Fund," (May 2013), available at: <http://downloads.cms.gov/files/TR2013.pdf>

²² P.A. Davis, "Medicare: History of Insolvency Projections" (Congressional Research Service: June 2012), available at: <http://www.fas.org/sgp/crs/misc/RS20946.pdf>

²³ CMS, "The Affordable Care Act: A Stronger Medicare Program," (February 2013), available at: <http://www.cms.gov/apps/files/Medicarereport2012.pdf>

²⁴ Kaiser Family Foundation, "Explaining Health Reform: Key Changes to the Medicare Advantage Program," (May 2010), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8071.pdf>

²⁵ Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: <http://www.cbpp.org/cms/?fa=view&id=3243>;

²⁶ Ibid

Starting in 2012, MA plans with 4 or 5 stars began receiving bonus payments. At the same time, CMS launched a demonstration program providing more modest bonuses to 3 and 3.5 star MA plans and increasing bonuses across the board in an effort to more rapidly enhance plan performance through 2015.²⁷ In addition to rewarding and incentivizing high quality plans, the star rating system allows CMS to track poor performing plans and to encourage beneficiaries remaining in an MA plan ranked 3 stars or less for three consecutive years to switch to a better performing plan. CMS also has the option to terminate these plans altogether.²⁸

Data available to date suggests that these pay-for-performance initiatives are improving MA plan quality. Over one quarter of MA plans improved their star ratings since 2013, with 11 plans now boasting 5 stars as opposed to a mere three plans in 2011. These increased ratings reflect improvement across several measures including: adult BMI assessment, colorectal cancer screening, controlling high blood pressure, use of high-risk medications among older adults, persistent beta blockers after health attack, and smoking cessation.²⁹ According to the Department of Health and Human Services (DHHS), more than half of people with MA are now enrolled in a 4 or 5 star plan, up from 37% in 2012.³⁰

While the ACA served as a platform for several notable improvements to MA, CMS recently implemented key regulatory changes that further strengthened MA plans. In 2011, CMS required that MA plans include an out-of-pocket maximum on beneficiary cost sharing no higher than \$6,700 annually and strongly encouraged plans to adopt a limit of \$3,400 or less. In 2014, the average out-of-pocket maximum among MA plans will amount to \$4,797.³¹

Additionally, as previously mentioned, CMS undertook efforts to consolidate duplicative and low-enrollment plans.³² Reducing the number of nearly identical offerings addresses some of the

²⁷ Kaiser Family Foundation, "Medicare Advantage Plan Star Ratings and Bonus Payments in 2012," (November 2011), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf>

²⁸ Cotton, P., "Medicare Advantage Pay for Performance Results," (NCQA presentation to 9th Annual Medicare World Congress: July 2013)

²⁹ Ibid

³⁰ DHHS, "Pres Release: More, Higher Quality Options for Seniors in Medicare Advantage," (September 2012), available at: <http://www.hhs.gov/news/press/2013pres/09/20130919b.html>

³¹ Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/>

³² Ibid

problems, highlighted above, that beneficiaries face when choosing a plan. People are better able to make good decisions when there are a reasonable number of options, with meaningful differences among them.

In sum, recent changes to MA advanced by the ACA and CMS have strengthened MA plans for current and future enrollees. In addition to improving the overall financial outlook for the Medicare program, the ACA enhanced MA on several fronts, including through added benefits, fairer cost sharing, and improved plan quality. We expect the effects of these changes will only become more pronounced for people with Medicare over time.

Recommendations to Improve Medicare Advantage

ACA provisions to improve MA and recent actions by CMS provide a starting point for considering options to further strengthen MA plans. First and foremost, we believe that it is critically important to preserve the MA payment and cost sharing improvements advanced by the ACA. Additionally, we urge Congress to consider the following recommendations:

Provide improved notice to people with Medicare about plan changes: Congress and CMS should look for opportunities to provide more detailed and advanced notice to MA enrollees about changing plan networks, cost sharing, and other coverage rules. In light of recent MA network changes, federal policymakers should investigate the efficacy of current notices and the timeliness of those notices, such as by revisiting standardized language included in the Annual Notice of Change (ANOC). CMS should be vigilant in its oversight of plan behavior, ensuring that notice is properly delivered, transition planning is provided as appropriate, and unbiased counseling sources are prominently advertised.

Encourage meaningful variation among plans: As reflected in numerous studies as well as our experience serving helpline callers, many people struggle to select among several MA plans and multiple, complex plan variables. To encourage efficient plan selection, distinctions among plans must be made more meaningful, furthering recent efforts by CMS to eliminate plans too alike to other plans offered by the same insurer. At the same time, members of Congress should consider

standardizing MA benefit packages, similar to the rubric required for supplemental Medigap plans (i.e., Plan A, Plan B, Plan C), to encourage “apples-to-apples” comparisons.³³

Enhance star ratings: As discussed above, the MA and Part D star rating system shows considerable promise as a vehicle to improve both plan quality and access to information about the merits of a given health plan. In the short term, efforts to improve the star rating system should ensure that beneficiaries are informed and engaged, as many people with Medicare are still unfamiliar with the system. Clear, regular explanations of the rationale, meaning and importance of the star rating system are needed. In addition, stars should reflect timely quality measures so beneficiaries can make choices based on the most recent data available.³⁴

In the long term, the star rating system should be enhanced to provide consumer-directed information relevant to individual choices. As the program evolves, people with Medicare should be able to “self-weight” various factors to create individualized quality ratings, sorting plans by the metrics most relevant to their individual needs.

Support consumer counseling services: As a consumer service organization, Medicare Rights knows firsthand the importance of personalized counseling as a resource to assist people with Medicare and their families about MA plan choices. As part of New York’s Health Insurance Information Counseling and Assistance Program, which is part of the SHIP network, we know the value of this federal resource administered by the states for older adults and people with disabilities. Adequate funding for SHIPs nationwide is absolutely vital to ensuring that people with Medicare are supported in making plan decisions. Supported by federal, state and local funding, SHIPs are the go-to resource for people with Medicare and their families who have questions about Medicare and related programs.

³³ O’Brian, E. and J. Hoadley, “Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice,” (Commonwealth Fund: April 2008), available at: http://www.commonwealthfund.org/~media/Files/Publications/Issue_Brief/2008/Apr/Medicare_Advantage_Options_for_Standardizing_Benefits_and_Information_to_Improve_Consumer_Choice/OBrien_Medicare_Advantage_options_1117_ib.pdf.pdf; Precht, P., Lipschutz, D. and Burns, B., “Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans,” (California Health Advocates and Medicare Rights Center: September 2007), available at: <http://cahealthadvocates.org/pdf/advocacy/2007/InformedChoice.pdf>

³⁴ Goggin-Callahan, D. “New York’s Medicare Marketplace: Examining New York’s Medicare Advantage Plan Landscape in Light of Payment Reform,” (Medicare Rights Center: June 2012), available at: <http://www.medicarerights.org/pdf/New-York's-Medicare-Marketplace.pdf>

In addition to the above, federal policy makers should ensure that MA marketing materials, notices, and websites are additionally simplified and standardized with plain-language information. As a requirement, these plan resources should include a prominent referral to unbiased counseling resources for beneficiaries, including SHIPs and 1-800-MEDICARE. At the same time, Plan Finder should be improved, specifically through enhanced information and comparison tools related to plan provider networks.

In particular, plans should be prohibited from asserting or implying that standard benefits, like an out-of-pocket cap or free preventive services, are unique to the plan. Similarly, plans should not be permitted to suggest that income-based benefits, like the Medicare Savings Programs (MSPs) or the Low-Income Subsidy of Medicare Part D (also known as Extra Help), are dependent on enrolling in a particular MA plan. Rather, these benefits are available to all Medicare beneficiaries, whether enrolled in Original Medicare or an MA plan.

Deliver better information on appeals: We believe that beneficiaries should receive clearer, timelier information about appeal rights. In addition, federal policy makers should demand that data concerning plan denial rates and decision reversals—meaning that a plan denial is subsequently overturned by an independent review—be made public. Increased transparency concerning plan-level denials and appeals would arm CMS, members of Congress, consumer stakeholders, and others with information to investigate possible plan practices, such as blanket denials, rubber-stamped redeterminations, or overly restrictive medical review practices.

Allow continuous open enrollment for Medigap plans: The ACA modified Medicare open enrollment periods, for instance, through the creation of a 45-day Medicare Advantage Disenrollment Period (MADP) (January 1 – February 15) to allow people with MA to switch back to Original Medicare and a Part D plan should they decide that an MA plan is not meeting their needs. Special Enrollment Periods (SEPs) are also allowed for those enrolled in an MA plan that is leaving their area, those moving away from their plan’s area, those enrolled in low-income assistance programs and those who desire to enroll in a 5 star MA plan.³⁵

³⁵ Medicare Interactive, “Changing Your Medicare Advantage (private health) plan,” (2013), available at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=1064

Despite this flexibility, some beneficiaries find that their options are limited when MA no longer meets their needs because federal law does not usually give these individuals the right to purchase a Medigap supplemental plan to wrap around Original Medicare. Under federal law, people with Medicare have Medigap guaranteed issue and open enrollment rights—the ability to buy a Medigap without pre-existing condition exclusions, medical underwriting, or plan refusals—only when first becoming eligible for Medicare at age 65 or in other very limited circumstances, although some states have more generous laws.³⁶

Allowing Medicare beneficiaries to continuously enroll in Medigap would facilitate broader access to needed coverage in the event an MA plan ceases to be an appropriate choice for a given person’s health and financial needs. Anecdotally, we see that in states like New York with continuous open enrollment for Medigap some individuals are more likely to try an MA plan, knowing they can return to Original Medicare and a Medigap if they find that the MA is not the best choice for them.

Require sale of Medigap plans to people with disabilities: Federal law does not require insurers to issue Medigap plans to Medicare-eligible individuals under the age of 65, limiting affordable coverage options for people who qualify for Medicare due to a disability in many states.³⁷ Congress should establish nationwide guaranteed issue and open enrollment periods for Medigap plans for this population to facilitate broader access to coverage options when an MA plan is not well-suited to a beneficiary’s health and financial needs.

Introduce Medicare Part E: Members of Congress should consider adding or pilot-testing a voluntary, publicly-administered supplement (referred to by some as Medicare Part E) to Original Medicare that includes a combined Medicare Part A and B deductible, a catastrophic cap, reduced coinsurances for Medicare Part B, and a drug benefit with limited copayments or coinsurance. Paid for through beneficiary premiums, this public supplement would achieve

³⁶ Medicare Interactive, “Protected Times to Buy a Medigap,” (2013), available at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=816; Huang, J.T., Jacobson, G., Neuman, T., “Medigap: Spotlight on Enrollment, Premiums and Recent Trends,” (Kaiser Family Foundation: April 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf>

³⁷ Ibid

savings by building on the efficiencies of Original Medicare, reducing administrative costs, and diminishing the need for coordination among multiple sources of coverage. A Medicare Part E plan would exist alongside the private MA and Medigap supplemental market, allowing beneficiaries a baseline plan from which to compare insurance choices.³⁸

Cautionary Notes on Adopting V-BID in Medicare Advantage

Some academics, health plans, and others suggest that MA plans should be allowed to alter plan cost sharing on the basis of value or clinical nuance, known as value-based insurance design (V-BID). Under V-BID principles, health plans alter cost sharing for specific services, prescription medicines, or health care providers to encourage beneficiaries to seek out the highest value or most clinically effective care. Now being tested in the private insurance market, V-BID incorporates lower cost sharing for high-value care and higher cost sharing for low-value care.³⁹

Medicare Rights strongly supports eliminating or lowering cost sharing to facilitate access to needed, high-value health care services, such as the policies advanced through the ACA that eliminated Medicare cost sharing for select preventive care. Medicare Rights remains concerned, however, by proposals to increase cost sharing as a deterrent to certain types of care, or as a vehicle for securing savings. Before adopting V-BID in MA plans, we urge Congress to consider the following points:

- Decades of empirical research that demonstrates increased cost sharing disproportionately limits access to care for the poorest, the sickest and diverse populations.⁴⁰ V-BID models

³⁸ Davis, K., Moon, M., Cooper, B., C. Schoen, “Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries” *Health Affairs* Web Exclusive (October 2005); Davis, K., Schoen, C., S. Guterman, “Medicare Essential: An Option to Promote Better Care and Curb Spending Growth” *Health Affairs* v 32 no. 5 (May 2013)

³⁹ University of Michigan Center for Value-Based Insurance Design, “Implementing Value-Based Insurance Design in Medicare Advantage,” (June 2013), available at: <http://www.sph.umich.edu/vbidcenter/publications/pdfs/V-BID%20Brief%20Medicare%20Advantage%20June%202013.pdf>; Partnership for Sustainable Health Care, “Strengthening Affordability and Quality in America’s Health Care System,” (April 2013), available at: <http://rwjf.org/content/dam/farm/reports/reports/2013/rwjf405432>

⁴⁰ National Association of Insurance Commissioners, “Medigap PPACA (B) Subgroup” (as of June 2011) available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See literature under: “Cost-sharing Research and Literature”; Swartz, K. “Cost-Sharing: Effects on Spending and Outcomes” (Robert Wood Johnson Foundation: December 2010), available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1

that incorporate increased cost sharing should be evaluated with the utmost caution, so as not to limit access to needed care for the most vulnerable.

- According to a 2006 RAND study, added cost sharing has little utility in controlling service use once a patient enters the health care system.⁴¹ This finding confirms what we know to be true through our experience serving people with Medicare: health care providers—not beneficiaries—order services and ultimately drive utilization trends.

In other words, Medicare beneficiaries are not positioned to evaluate high-value versus low-value services. Cost sharing incentives demand a high level of sophistication and knowledge on the part of beneficiaries to evaluate care options that are ultimately recommended by their doctors. V-BID models that increase cost sharing should not be pursued in the absence of complementary efforts to better inform and educate consumers.

- V-BID models may erode “anti-discrimination” provisions included in the Social Security Act. Current rules exist to protect people from discriminatory cost sharing that might limit access to care or make a particular plan less attractive to beneficiaries in need of higher-cost services, effectively skewing a plan risk pool away from people with particular conditions.
- V-BID models now in the private market, related to the selection of prescription medicines, specialists, and hospital systems, are primarily being tested in the private, employer market where the consumers are generally younger, healthier, and have higher incomes than the Medicare population. While promising, V-BID gains seen in the private market may not be transferable to MA plans and may not account for the full scope of risks posed to older adults and people with disabilities.

In sum, based on the points raised above as well as our experience serving vulnerable people with Medicare, we urge members of Congress to proceed with caution before endorsing V-BID models in the MA market.

⁴¹ RAND, “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate” (January 2006), available at: http://www.rand.org/pubs/research_briefs/RB9174.html

Conclusion

In conclusion, the Medicare Rights Center's experience demonstrates that there is no one-size-fits-all insurance option for people with Medicare. For some older adults and people with disabilities, MA plans are a good option. For others, Original Medicare is a better choice. Thanks to recent advancements made possible by the ACA and additional efforts by CMS, the MA market has improved significantly in recent years. ACA improvements to MA plans are producing tangible results for current and future Medicare beneficiaries through stabilized, fairer cost sharing and improved coverage. These changes to MA plans must be preserved.

MA plans play an important role in the value-driven agenda advanced by the ACA. While some may be inclined to sensationalize annual plan changes, like altered cost sharing and trimmed provider networks, and link them to the ACA, it is important to recall that these practices are the norm within the MA landscape. As always, people with MA retain the option of switching their coverage during the Medicare open enrollment period if their plan no longer meets their health and financial needs.

Our experience further shows and empirical research demonstrates that Congress and CMS should do more to simplify plan selection and coverage rules for people with MA. To achieve this goal, we recommend improving beneficiary notice regarding annual plan changes, further streamlining and standardizing plans, improving the MA appeals system, and adequately funding independent counseling resources, such as SHIPs. Importantly, we also urge federal policymakers to expand the range of coverage options available to people with Original Medicare for those cases where an MA plan is not the best fit for a beneficiary's needs.

Thank you for the opportunity to testify.