
**Testimony of Judith A. Stein**
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**United States House of Representatives**
**Energy & Commerce, Subcommittee on Health**

"Keeping the Promise:
Allowing Seniors to Keep Their Medicare Advantage Plans
If They Like Them"

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## I. Introduction

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee on Health, thank you for inviting me to testify at this hearing. I am Judith Stein, founder and executive director of the Center for Medicare Advocacy (the Center). The Center is a private, non-profit organization based in Mansfield, Connecticut with offices in Washington, DC and throughout the country.

The Center provides education and legal assistance to advance fair access to Medicare and quality healthcare for Medicare beneficiaries throughout Connecticut and the United States. We represent Medicare beneficiaries throughout the state, respond to over 7,000 calls and emails annually, host websites, webinars, and publish a weekly electronic and a quarterly print newsletter. The Center also provides materials, education, and expert support for Connecticut's State Health Insurance Assistance Program (SHIP), known as CHOICES.

## II. Our Experience Assisting MA Plan Enrollees

Medicare beneficiaries have had the option to enroll in private health plans since the 1970s. The Medicare private plan option, now called Medicare Advantage (MA), was supposed to provide equal or better coverage for beneficiaries at a lower cost than traditional Medicare. Unfortunately this has not been the case. In fact, on average, private MA plans are paid significantly more than it would cost to provide similar coverage in traditional Medicare. And, in our experience, while MA plans work for some individuals, we regularly hear from MA plan enrollees who have difficulty accessing coverage that their plans are required to provide.

We recognize that MA plans can be a viable option for some enrollees. As a beneficiary advocacy organization, however, we are rarely contacted by individuals who are happy with their

plans. Instead, we regularly hear from individuals and their families who are having trouble accessing services through their MA plans. For many of these individuals, their MA plans worked fine while they were relatively healthy, but once they required more intensive medical services, or needed to see a particular provider, their MA plan became a barrier to care.

The following are some examples of the concerns about Medicare Advantage my organization hears from MA enrollees and their families.

Accessing Medicare-Covered Services

One of the most frequent issues we encounter concerning MA coverage relates to post-acute care. In the skilled-nursing facility setting, beneficiaries are denied coverage, even when they are receiving daily services that are defined as "per se skilled care" in federal regulations – and thus should trigger Medicare coverage.[1] For example, over the last year, the Center has received complaints from across the country about one large MA plan that has been denying coverage for skilled nursing facility (SNF) care, including for individuals receiving their nutrition through a feeding tube. For example:

- In November 2013 we assisted the son of an MA enrollee in Ohio who had been in a skilled nursing facility for a little over a month. She had been receiving daily therapy (speech/physical/occupational) and getting at least 80% of her daily calories through a feeding tube. During that time, her MA plan twice moved to deny coverage of skilled care, and the beneficiary appealed twice and won two reconsiderations;
- In October 2013, staff from a SNF in Pennsylvania contacted us concerning a resident, an MA enrollee, who in their view clearly met Medicare coverage guidelines for skilled

[1] See, e.g., 42 CFR §409.33(b).

care, including the requisite level of tube feeding, but her MA plan issued a coverage denial, in part, stating that the resident could get the same care at home.

Our experience is echoed elsewhere. For example, in late 2013, Minnesota's Attorney General (AG) asked CMS to investigate plans offered by one MA carrier and presented numerous affidavits of beneficiary complaints, including allegations that the insurer "denied reimbursement for services that it is required to cover for all Medicare beneficiaries—including diagnostic ultrasounds, mammograms and care in a skilled-nursing facility for a stroke patient"; in addition, the AG alleged that the plan "created confusion by not adequately disclosing which providers were in-network and does not comply with required appeals processes." [2]

These issues are not new, and occurred even at the height of MA overpayments, when plans were paid at an average of 114% of the amount traditional Medicare would spend on an individual. In 2009, for example, the Center had to take one appeal all the way to federal court in order to obtain coverage for an individual receiving daily enteral feeding – a service that is a per se skilled service, and therefore covered, under federal Medicare regulations. In this case, the Center won coverage at the highest level of the Medicare administrative appeal system, but the MA plan was so determined to deny coverage, it appealed to federal court.[3]

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[2] Quote from Kutscher, Beth, "Minnesota Wants CMS to Investigate Humana's Medicare Advantage Plans" (October 18, 2013), *Modern Healthcare*; also see Press Release, Minnesota Attorney General's Office (October 18, 2013), available at: https://www.ag.state.mn.us/Consumer/PressRelease/20131018HumanaMedicare.asp.

[3] United Healthcare Insurance Co. d/b/a Evercare v. Sebelius & Starkowski, April 5, 2011 No. 09-cv-1927-MJD-JSM (D.Minn.), filed July 23, 2009. The Center represented the Connecticut Commissioner of the Dept. of Social Services. On January 7, 2011, the district court granted the defendants' motions for summary judgment and denied the plaintiff Part C plan's cross-motion, thereby affirming the decisions in favor of the beneficiary by the ALJ and the Medicare Appeals Council. — F.Supp.2d —, 2011 WL 70626 (D.Minn. 2011). The court determined that, on the facts presented, the enteral feedings were skilled services and thereby covered by Medicare. The plan did not appeal.

In 2013, the Center conducted Medicare training for over 100 home health agency representatives in Connecticut. There was general agreement among those present that it is more difficult to obtain Medicare coverage for necessary home health care from MA plans than from traditional Medicare.

Choice of Provider

One of the most important health care considerations for an individual is the ability to choose one's doctor(s) and other health care providers. This is the choice that people really care about. By design, however, MA plans contract with a limited network of providers to care for their enrollees. Networks are supposedly designed to coordinate care and control costs; whether they do so or not, they do limit the choice of doctors and health care providers. MA networks can also cause problems for enrollees who seek health care outside their geographic area – and even for some close to home.

When plan enrollees are out of their plan's service area and require urgent or emergency services, their MA plan is required to provide coverage. But problems still arise. For example:

- A Connecticut resident was referred to the Center by his Congressman because he had almost $100,000 in outstanding medical bills for his recently deceased wife. He and his wife were enrolled in an MA plan. When they traveled to see their daughter in Florida, his wife fell and broke her hip. Emergency care for the broken hip was covered by their MA plan but other necessary care was not. As it turned out, his wife fell because she had a brain tumor, which they did not know about. She required a great deal of care, far away from home, including for myriad complications from cancer treatment. This all resulted in $100,000 in unpaid bills – which would have been covered by traditional Medicare.

Sometimes Medicare Advantage enrollees face barriers to care even within the plan's service area, including due to provider network changes and limitations. When MA plans change their provider networks, as they often do each year, it can be highly disruptive to plan enrollees. For example, for 2014, Medicare beneficiaries enrolled in the largest MA plan in my home state of Connecticut experienced major disruptions in access to care. In late 2013 United Healthcare jettisoned approximately 2,250 providers and healthcare facilities from its Connecticut Medicare Advantage network, including Yale New Haven Hospital. In a small state like Connecticut, that's a very large number – about one physician or hospital or nursing home, or other healthcare provider lost, for every 260 Connecticut Medicare beneficiaries. Neither physicians nor Medicare patients were given adequate notice of this extraordinary decision by United. In fact, it was only as the 2013 Medicare enrollment period came to a close, that people enrolled in the United Healthcare MA plan learned that their doctors and/or hospital would not be available to them in United's reduced Medicare Advantage network in 2014. Many others did not learn until after the new year, others will not learn until they seek medical care during 2014, only to find their doctor or other healthcare provider is no longer in their Medicare plan.

- As I testified at a Senate Aging Committee hearing recently,[4] clients of the Center are an example of individuals who learned about the United Healthcare network cut only when health care was urgently needed. Susan W. called us on behalf of her parents, who are both in their 80s. Mr. W. had a stroke in 2013 with bleeding in his brain. He was helicoptered from his local hospital to Yale New Haven due to the complexity of his condition. Now he is finding his medical and rehabilitation needs severely limited and

[4] Senate Aging Committee hearing "Medicare Advantage: Changing Networks and Effects on Consumers "(Hartford, CT, 1/22/14), see: http://www.aging.senate.gov/hearings/medicare-advantage-changing-networks-and-effects-on-consumers.

further complicated by United's Medicare Advantage network cuts. His long-time primary care doctor and his local hospital are no longer in United's Medicare Advantage network. He must travel farther to another, unknown hospital and find a new doctor.

Most importantly, he cannot obtain the nursing care or rehabilitation he needs at the nursing home closest to his wife and community since it too has been cut from United's Medicare Advantage plan. As with many Medicare beneficiaries, Mr. W. had long been in traditional Medicare with supplemental Medigap coverage, but switched to the United Medicare Advantage plan in 2011 because it was less expensive. This worked until he became ill and United exercised its business prerogative to severely reduce providers from its Medicare Advantage network. We know we will hear from many other people like Mr. W. as the year proceeds and they need health care but find their providers are no longer in the United Medicare Advantage network.

Access to Quality Care for All Enrollees

In addition to concerns raised for Medicare beneficiaries by MA networks, too many plans fail to provide adequate coverage and access to care when enrollees are seriously ill or injured. While beneficiaries who are relatively healthy may fare well in MA plans, that is often not true for sicker enrollees. For example, in 2012, the Centers for Medicare & Medicaid Services released a report concluding that disenrollment by individuals from MA plans back to traditional Medicare "continues to occur disproportionately among high cost beneficiaries, raising concerns about care experiences among sicker enrollees and increased costs to Medicare."[5]

[5] Gerald F. Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Services", CMS, Medicare & Medicaid Research Review (MMRR) Vol. 2 No. 4 (2012), available at: http://www.cms.gov/mmrr/Downloads/MMRR2012_002_04_A08.pdf.

## III. The Affordable Care Act Has Improved Consumer Protections and Reins in Medicare Advantage Overpayments

Improvements in Consumer Protection

The Affordable Care Act of 2010 (ACA) has strengthened both the Medicare program in general, and the Medicare Advantage program in particular. While moving the Medicare program towards providing high value care and rewarding quality, ACA implemented a number of provisions improving the MA program for beneficiaries, including:

- Limiting the ability of MA plans to charge higher cost-sharing than traditional Medicare for certain services;
- Instituting a medical loss ratio (MLR) which requires plans to ensure that they spend at least 85% of their income from premiums and Medicare payments on patient care, instead of profits, marketing, executive salaries and other administrative costs; and
- Adding quality improvement initiatives, including tying payment bonuses to quality star ratings.

CMS has also strengthened consumer protections by instituting annual maximum out-of-pocket (MOOP) requirements and improving beneficiary choice by consolidating plans with duplicative benefits and low-enrollment.

Reining in MA Overpayments

Perhaps most significantly, the Affordable Care Act has put the Medicare program on a more sound fiscal footing by reining in overpayments to MA plans over a period of years. The Balanced Budget Act of 1997 (BBA), authorized private plan options in a new Medicare Part C program known as "Medicare+Choice." These private plans were paid 95% of average

traditional Medicare costs in each county.[6] The Medicare Modernization Act of 2003 (MMA) revised the Part C program, changing the program name to Medicare Advantage, and developing a new payment system.[7]

The MA payment system passed in 2003 led to Medicare paying private MA plans in virtually every county across the country *more* than the costs for the same beneficiary in traditional Medicare between 2006 through 2010.[8] According to research at George Washington University,[9] in 2009 per-enrollee payments were, on average, 13% higher for MA plans than for traditional Medicare; a total of $12.7 billion in overpayments in 2009 alone. Further, in 2009 the costs of extra Medicare payments to MA plans over the costs in traditional Medicare were projected by the Congressional Budget Office (CBO) at more than $150 billion over 10 years.[10]

In an effort to rein in overpayments to MA plans, ACA has begun the process of bringing MA payments closer to what traditional Medicare spends on a given beneficiary. By 2017, extra payments to MA plans will be reduced to a national average of 101% of the costs of traditional Medicare.[11] So, even when the ACA payment adjustments to MA plans are fully implemented, MA plans will, on average, *still* be paid more than traditional Medicare costs.

Both Medicare costs and national health expenditures have grown at historically low rates over the last several years.[12] Slower cost growth in Medicare is factored into payment rates for

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[6] See, e.g., Kaiser Family Foundation, Medicare Advantage Fact Sheet (November 2013), available at: http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/.
[7] Id.
[8] See, e.g., Senate Aging Committee, 1/22/14 hearing "Medicare Advantage: Changing Networks and Effects on Consumers", testimony of Prof. Brian Biles, available at: www.aging.senate.gov/imo/media/doc/Biles_1_22_14.pdf.
[9] Id.
[10] Id.
[11] Id. For more information about MA payment, see, e.g., MedPAC "Medicare Advantage Payment Basics" October 2013 http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.
[12] See, e.g., CMS Press Release 1/6/14: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-06.html.

Medicare Advantage, including the estimated per-beneficiary cost of providing Medicare services in traditional Medicare. Thus, as cost growth in Medicare slows, payment increases to MA plans also slow, to reflect actual costs. This slower growth in Medicare costs is good news for Medicare financing and the federal budget.

Despite calls by some to keep MA payments "flat" by maintaining current funding levels, private insurers that choose to offer Medicare plans should not be insulated from market forces that are reducing the rate of growth of Medicare and health care costs. To do otherwise would give preferential treatment to private plans by continuing to overpay them – creating extra costs that must be subsidized by taxpayers and the majority of Medicare beneficiaries who choose *not* to enroll in MA plans.

ACA Does Not Put the Future of MA Program in Doubt

Reducing overpayments to MA plans does not threaten the security of the Medicare Advantage option. The MA program continues to be an option for beneficiaries who want it. In fact, MA enrollment is on the rise, increasing 30% from 2010 to 2013 to 15 million enrollees.[13] According to Congressional Budget Office projections, enrollment in MA plans will continue to increase despite more payment parity with traditional Medicare, with an expected 21 million enrollees in 2023.[14]

## IV. Recommendations for Further Improvement to the MA Program

To improve Medicare and Medicare Advantage for beneficiaries we recommend the following:

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[13] 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/.

[14] Congressional Budget Office (CBO), "CBO's May 2013 Medicare Baseline," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf .

- Provide better notice and consumer protections regarding MA plan benefits and network changes.
    - Require Medicare Advantage plans to provide notice at least 60 days before the Annual Enrollment Period when more than a certain percentage of their provider network is to be cut. And, regardless of the overall percentage, provide notice to each enrollee whose physicians or closest hospitals and nursing homes will no longer be in the network.
- Ensure network adequacy.
    - Review the definition of an adequate Medicare Advantage network to ensure all necessary services are available within a reasonable geographic area.
- Ensure clear, meaningful differences between plans offered by each Medicare Advantage Sponsor.
- Standardize benefits within plans – as exists for Medicare Supplement Insurance policies.
- Further limit out-of-pocket cost-sharing for enrollees in MA plans.
- Strengthen Traditional Medicare.
    - Level the reimbursement and coverage field in the two Medicare models. For example, include prescription drug coverage in traditional Medicare and ensure that other benefits available in MA are available in traditional Medicare.
- Improve Access to Medicare Supplement Insurance (Medigap).
    - Retain reasonably priced, first-dollar Medigap coverage.
    - As is the case in Connecticut and some other states, make it a federal requirement that Medigap insurance offer continuous open enrollment. Wider access to Medigap will give Medicare Advantage enrollees more flexibility to return to

traditional Medicare if their Advantage plan no longer meets their healthcare needs. Further, Medigap open enrollment rights should be extended to all Medicare beneficiaries, including those under age 65.

## V. Conclusion

The Affordable Care Act has been characterized by some as gutting the Medicare program and hastening the death of the Medicare Advantage program. This could not be further from the truth. Many of the protests and concerns we hear now about ACA were lobbed at Medicare when it was enacted in 1965. Before long, most Americans came to see Medicare as a grand success, indeed a "sacred promise" to older and disabled people and their families. As a thirty year advocate for Medicare and Medicare beneficiaries, I can tell you that the Affordable Care Act is good for Medicare and those who rely on it for health coverage. As the Affordable Care Act is fully implemented, including the MA overpayment reductions, it will help ensure the continued stability of a full and fair Medicare program.

Instead of focusing on how much Medicare Advantage payments are being "cut," Congress should focus on making sure MA plans provide what we're paying for. It's unfair to ask beneficiaries and taxpayers to shoulder extra payments to private Medicare plans. This is especially true since Medicare Advantage does not uniformly provide greater value. Enrollees in poor health often receive less coverage and all enrollees have fewer provider options than beneficiaries in traditional Medicare.

Thank you for the opportunity to testify regarding this important matter.

Respectfully submitted,

Judith A. Stein, Esq.
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