MEDICARE RIGHTS CENTER

Medicare Rights Center Comments to the Senate Finance Committee on Health Care Coverage

Submitted May 22, 2009

The Medicare Rights Center appreciates the hard work and thoughtful care that are evident in the Senate Finance Committee's three policy options papers covering delivery system reform, affordable coverage and the financing of health care reform. We thank you for your efforts to ensure all Americans have access to affordable health care. We are grateful for the opportunity to comment on the policy options for improving access to health care coverage that are outlined in your May 14 and May 18 options papers.

The Medicare Rights Center works to ensure access to affordable health care for older adults and people with disabilities through counseling, educational programs and public policy initiatives. Through our national telephone hotlines, through our in-person counseling in New York City and Westchester County and through our work with Medicare consumer advocates and counselors throughout the country, we come into direct contact with Americans who cannot obtain health care or medicine because they are uninsured or because the insurance they have does not provide coverage that enables them to afford the care they need. Based on this experience, we have identified key priorities that we believe are essential components to providing affordable coverage for all Americans. These priorities are:

- End the two-year waiting period for Medicare for people with disabilities;
- Ensure that coverage for low-income Americans, including low-income people with Medicare, is affordable and adequately limits out-of-pocket spending on health care;
- Provide the option to obtain affordable, comprehensive coverage through a public plan, including for people with Medicare;
- Prohibit discriminatory treatment based on age or disability;
- Protect consumers from deceptive and abusive marketing and standardize benefits to facilitate consumer comparison and ensure adequate protection against high out-of-pocket spending for the treatment of chronic and acute conditions.

1. End the two-year waiting period for Medicare for people with disabilities

The two-year wait for Medicare puts effective treatment and care for people with severe disabilities at risk. Many forgo medical treatment and stop taking medications, compromising their already fragile health and resulting ultimately in conditions that are often more costly to treat when Medicare coverage finally begins. According to recent research, there is a marked decline in the health status of individuals after entering the waiting period. About 12 percent of individuals report being in poor health two years before eligibility for Social Security Disability Insurance (SSDI), that percentage more than doubles in the first year of the waiting period. Thirteen percent of people die during the 24 months before Medicare coverage begins.[i]

The Medicare Rights Center favors Approach 3, which would reduce the waiting period in six-month increments, with complete elimination after one-and-a-half years. Approach 2, which would phase out the waiting period by 2015, is the next best option. We urge the Finance Committee to set its sights on complete elimination of the

waiting period and to use the duration of the phase-out period as the chief mechanism to accommodate budgetary pressures.

We have concerns about Approach 4, which would maintain the waiting period for people with access to private insurance that meets or exceeds an actuarial standard. An actuarial standard does not guarantee that coverage is affordable. An actuarial standard does not ensure that out-of-pocket costs for health care are limited, particularly for the majority of people with disabilities with low incomes. We are concerned that private coverage that meets an actuarial standard could still have benefit caps or restrictions on services vital to people with disabilities, such as prosthetics or durable medical equipment. Additionally, while the actuarial standard is being defined in regulation and a mechanism is established to screen out people with access to private coverage, there will be an inevitable delay in beginning the phase-out of the waiting period. The Medicare Rights Center has concerns about the impact of such a delay on the remainder of the people with disabilities without any access to insurance.

The Medicare Rights Center believes that Approach 1, which would reduce the waiting period to 12 months, represents the least beneficial option. While we recognize the fiscal pressures facing the committee, we believe adopting this option squanders the opportunity to eliminate the waiting period represented by health reform. There is no policy justification for maintaining a waiting period.

No one with a disability severe enough to qualify for SSDI should be without health coverage. We thank you for including these approaches in the coverage options, and look forward to working with you to ensure passage of legislation that provides affordable health care coverage for all Americans, including people with disabilities.

2. Ensure that coverage for low-income Americans, including low-income people with Medicare, is affordable and adequately limits out-of-pocket spending on healthcare.

A great achievement of Massachusetts' health reform efforts has been the provision of low- or zero-premium comprehensive health coverage with affordable cost-sharing to residents below 300 percent of the federal poverty level (FPL). For individuals between 200 percent FPL and 300 percent FPL, cost-sharing for prescription drugs is capped at $800 for prescription drugs and at $1,500 for medical services. Individuals between 100 percent and 200 percent FPL have more modest copays for medical services and prescription drugs and cannot pay more than $1,250 per year for medical services and prescription drugs combined. Individuals below the poverty line only pay copayments for prescription drugs (medical services are free) and cannot pay more than $200 out-of-pocket in one year.[ii]

The coverage options outlined in Section II have the potential to provide coverage comparable to what is provided under Commonwealth Care if:

- The tax credits and other premium subsidies make coverage affordable;

- The deductibles, copayments and capped out-of-pocket spending are limited such that access to preventive services, treatment of chronic conditions and acute care are affordable.

We recommend that the premium subsidy be structured to ensure access to a comprehensive health plan with standard cost-sharing suitable to the enrollee's income level, rather than seeking to supplement plans with cost-sharing assistance. In our experience with Part D and with Medicare Advantage, two programs that supplement standard plan benefits with cost-sharing assistance for low-income beneficiaries, there are substantial data exchange and coordination of benefit issues that result in low-income beneficiaries paying excessive cost-sharing for prescription drugs and medical care or forgoing treatment because of these inappropriate copayments. In addition, providing supplemental cost-sharing assistance creates incentives for plans to minimize the cost-sharing they cover in plans that are marketed to beneficiaries eligible for such assistance. This structure also complicates consumers' plan selection process, since the cost-sharing they will actually pay is based not on plan benefits, but on their eligibility for additional assistance. Similarly, plans' communications with beneficiaries becomes more complicated, as they must differentiate between beneficiaries who receive cost-sharing assistance and those who pay standard cost-sharing.

The cost-sharing for prescription drugs and medical care under Medicare greatly exceeds the limits established by Commonwealth Care for Massachusetts residents under 300 percent of FPL. Nearly 70 percent of people with Medicare earn incomes below this threshold,[iii] but assistance with deductibles and coinsurance under Medicare Savings Programs is provided only to people with Medicare living below the poverty line and cost-sharing assistance for prescription drugs (including coverage through the Part D doughnut hole) is unavailable to individuals earning more than 150 percent of poverty. Access to these benefits is further restricted by an asset test that excludes low-income individuals with even modest savings ($11,990 maximum for an individual) for their retirement.

Because of these eligibility restrictions, an individual earning just $16,245 per year (150 percent FPL) would face under Medicare a $1,068 charge for a hospital stay and 20 percent coinsurance for physician services, costs that can easily surpass 10 percent of her annual income *for one hospital admission*. This level of income also disqualifies an individual from assistance paying the Part B premium.

An individual earning just $21,660 per year (200 percent FPL) could face in excess of $6,154 in out-of-pocket spending for prescription drug costs, well over one quarter of annual income. Research, as well as the stories we hear from consumers, confirms that the gap in coverage causes people with Medicare to stop taking medicine or skip doses.[iv]

Health reform presents a unique opportunity to update the income and asset eligibility criteria for Medicare Savings Programs and Extra Help to make cost-sharing for low-income people affordable and provide limits on out-of-pocket spending in line with the protections health reform affords to the under-65 population.

The Finance Committee is also considering eliminating the asset test for Medicaid to streamline the application and screening processes. The same consideration should be given to eliminating the asset test for Medicare Savings Programs and Extra Help. The asset test serves as a barrier to identifying individuals who are likely eligible based on income, complicates the application and screening processes and discourages application by individuals who do qualify. The asset test also penalizes individuals for doing the right thing by saving for their retirement.

The income limits for both Medicare Savings Programs and Extra Help should also be raised to improve the affordability of Medicare to older adults and people with disabilities of limited means. The income level for the Qualified Medicare Beneficiary program (pays premiums and cost-sharing for Parts A and B) should be raised to 150 percent FPL, ensuring that Medicare's deductible and coinsurance do not serve as barriers to care. Similarly, the full subsidy under Extra Help should be available to individuals up to 150 percent FPL, ensuring modest copayments that can enable people living near poverty to take advantage of effective drug treatment. From 150 FPL to 200 percent FPL, individuals should have access to a subsidy for the Part B premium, ensuring access to outpatient care and helping with the purchase of supplemental coverage. This income bracket should qualify for the partial subsidy under Extra Help—sliding scale premiums, reduced deductibles and copayments and coverage through the doughnut hole.

3. Provide the option to obtain affordable, comprehensive coverage through a public plan, including for people with Medicare.

Medicare is seen by many as the model for a public plan option under health reform. Medicare's administrative costs are much lower than those of private insurers and there are no marketing expenses or profit margins. Medicare has the leverage to restrain costs, even with providers or drug manufacturers that have substantial market power. Medicare policy can drive reforms for the health care system as a whole, moving toward a system that rewards high-quality care.

For beneficiaries, Medicare provides better access to doctors, hospitals or other providers than commercial insurance and coverage is largely unfettered by prior authorization requirements and other bureaucratic obstacles common in commercial plans.[v]

Medicare's benefit design, however, is not a feature anyone wants to replicate in a universal coverage proposal. The Medicare benefit does not include an out-of-pocket limit for medical services, a common feature in many employer-sponsored plans. The absence of such a limit, coupled with high cost-sharing for hospital stays and other services, and the unpredictability inherent in the 20 percent coinsurance for Part B services, force many beneficiaries to seek supplemental Medigap coverage or to turn to Medicare Advantage plans, which promise (but do not necessarily deliver) lower cost-sharing.

People with Medicare, like all Americans, should have the choice to receive ALL their health coverage through a publicly administered plan. For people with Medicare, that means the option to obtain affordable health coverage directly from Medicare, including an out-of-pocket limit covering all Part A and Part B services, predictable copays for primary care and specialist consultations and affordable copays for inpatient hospital care.

We are encouraged that the Finance Committee's paper on financing options for health reform includes a discussion of restructuring the Medicare A and B benefit to include an out-of-pocket limit. We urge caution, however, in imposing additional cost-sharing on medical services, or in restricting coverage by Medigap plans, in order to pay for this important benefit.

In particular, a combined deductible for A and B services could serve as a barrier to primary care and other outpatient care that are essential to treatment of chronic conditions, particularly for individuals on limited incomes. Recent research conducted for the Medicare Payment Advisory Commission shows that the current deductibles and coinsurance for Part B services function to discourage utilization of elective services when compared to first-dollar Medigap coverage.[vi] A higher deductible for outpatient services is therefore unnecessary to make beneficiaries cost-sensitive to their use of medical services. Moreover, raising the deductible for Part B services would impose new costs on beneficiaries with retiree coverage that already caps out-of-pocket spending and already imposes copayments and deductibles designed to discourage over-utilization. At the very least, any move toward a combined deductible should ensure that preventive services and primary care are covered before the deductible, as the committee has suggested in its options paper on delivery system reform.

We also urge the committee NOT to impose new cost-sharing on home health services or new first-day copays for skilled nursing facilities in any restructuring of the Medicare benefit. Beneficiaries who need these services are the most frail and vulnerable; their access to treatment should not be impaired by new cost-sharing requirements.

Instead of paying for an out-of-pocket limit by increasing cost-sharing, the committee should consider providing beneficiaries with the option, for an additional, *unsubsidized* premium, to purchase an enhanced A/B benefit that includes an annual out-of-pocket limit and affordable cost-sharing that encourages appropriate use of primary care and other high-value services. Such a benefit would be available only to beneficiaries who forgo purchase of Medigap supplemental insurance and who are ineligible for Medicaid or Qualified Medicare Beneficiary programs that pay A/B cost-sharing. This would require that the enhanced A/B benefit have cost-sharing that was low enough so that individuals earning below 200 percent of FPL—46 percent of Medicare beneficiaries—could afford the care they need.

A voluntary enhanced benefit does not impose new costs on beneficiaries who already have adequate coverage through Medigap or a former employer. It also does not supplant

the contributions that former employers currently make toward the health care costs of retirees. A voluntary enhanced benefit avoids disruption of the coverage of current Medigap enrollees, obviates the need to revise the standard Medigap plans and makes consumers, rather than the federal government, the decision maker on whether to forgo first-dollar coverage.

Finally, an enhanced, voluntary benefit fits with beneficiaries' demonstrated preference in the Medigap market to pay an additional premium to ensure health security. Moreover, there is an existing mechanism in the Medicare Savings Programs to subsidize Medicare premiums for low-income beneficiaries. These programs could be altered if the premium for comprehensive A/B coverage were out of reach for low-income people with Medicare.

A comprehensive, integrated health insurance benefit under a public plan would also include prescription drug coverage from the same source. That option is currently unavailable to individuals enrolled in Original Medicare, who must enroll in a privately run Part D drug plan to obtain prescription drug coverage. Each drug plan has a different formulary and imposes different cost-sharing and utilization management restrictions on covered drugs. This fragmented structure makes it more difficult for prescribing physicians to comply with formulary requirements and heightens the risk of disruption in drug regimens during transitions in care setting, such as upon discharge from the hospital. Drug plans have incentives only to lower drug costs, even if the cost-sharing or coverage restrictions imposed on medicines increase the risk that beneficiaries will stop taking their drugs, skip doses or switch to a medicine that is less effective or has harmful side effects. The result can be a worsening of chronic conditions, avoidable hospitalizations and increased costs to Medicare and to plan enrollees, with drug plans held harmless from these increased costs.

By fragmenting and privatizing the delivery of Part D drug coverage, taxpayers and people with Medicare have lost the ability to force discounts from manufacturers that exist in other public programs. The Congressional Budget Office estimates that applying mandatory Medicaid-level rebates to Part D drugs on par with the discounts received by Medicaid would save $110 billion over ten years. It is worth noting that these savings are equivalent to over 80 percent of the cost to taxpayers of providing coverage through the Part D doughnut hole to all enrollees. **People with Medicare should have the option to receive Part D drug coverage through Original Medicare so that they can benefit from the stability, simplicity and cost savings that a Medicare-run drug benefit would provide.**

4. Prohibit discriminatory treatment based on age or disability.

We welcome the proposed reforms of the insurance market that prohibit companies from discriminating on the basis of pre-existing conditions. We urge the committee not to allow insurers to use age as a proxy to discriminate on the basis of health status. Allowing insurers to charge older Americans premiums up to five times the rate charged younger consumers for the same policy is unacceptable. A 2:1 ratio for age-related

premiums, the ratio that prevails in Massachusetts, has not provided sufficient protection to ensure that unsubsidized coverage is affordable to moderate-income older adults. Legislation should also require that premiums vary on the basis of the generosity of the benefits, not on the basis of the risk profile of enrollees in specific plans. This protection, which exists already in Massachusetts, prevents insurers from designing plan benefits to segment the risk pool and then use enrollment in a particular benefit plan as a means of adjusting premiums on the basis of health status.

People with Medicare are deserving of the same protections against discriminatory treatment by private insurers in the "Medigap" supplemental market. People entitled to Medicare because of a disability should have the same guaranteed issue rights to Medigap plans as Medicare beneficiaries over the age of 65 and should not be forced to pay higher premiums because of their disability status.

5. Protect consumers from deceptive and abusive marketing and standardize benefits to facilitate consumer comparison and ensure adequate protection against high out-of-pocket spending for the treatment of chronic and acute conditions.

We support the committee's proposals to establish minimum federal standards for marketing conduct of health insurance companies, including prohibitions on door-to-door marketing and cold calling, and establishing commission structures for brokers/agents. Establishing commission rates is important to minimize the diversion of premium and/or government revenue away from coverage of medical costs and to minimize incentives for aggressive, deceptive and inappropriate marketing. The commission rates established for Medicare Advantage plans have contributed to a decrease in marketing abuses in this market, as has vigorous enforcement of marketing rules (including prohibition on door-to-door marketing). The Medicare Advantage experience also supports the Finance Committee's proposal to retain the authority of state insurance commissioners to enforce appropriate marketing conduct by insurance plans. The pre-emption of such authority in the Medicare Advantage market has contributed to the proliferation of marketing abuses by divorcing the agency with authority to regulate Medicare Advantage plans (CMS) from the state insurance departments that hear the majority of consumer complaints and have the experience necessary to investigate and curtail market misconduct.

We also urge the committee to move beyond an actuarial standard in assessing the adequacy of insurance under an exchange. The actuarial standard for Medicare Advantage has allowed a marketplace that is confusing for consumers and that puts beneficiaries at risk of enrolling into plans that provide inadequate protections against high out-of-pocket costs. The committee has recognized this problem in its proposal to require Medicare Advantage plans to establish a comprehensive out-of-pocket limit in all benefit packages. A requirement for an out-of-pocket limit (no carveouts for specific services or for copayments below a dollar threshold) will also be important for plans that are sold on an exchange. The level of the mandatory out-of-pocket limit should be

pegged to the median level of beneficiary income to ensure that beneficiaries are not subject to cost-sharing for a serious illness that threatens the affordability of care.

We appreciate the opportunity to comment on the options the Finance Committee is considering for improving health care coverage for all Americans, including older adults and people with disabilities. If you have any questions, or seek clarification on these comments, please contact Paul Precht, Medicare Rights Center Director of Policy and Communications, pprecht@medicarerights.org or 202-637-0961.

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[i] See http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/May/Health-Insurance-and-Health-Care-Access-Before-and-After.aspx

[ii] See http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Connector%2520Programs/Additional%2520Resources/HealthBenefitsAndCopays.pdf

[iii] See http://assets.aarp.org/rgcenter/health/fs149_medicare.pdf

[iv] See http://www.kff.org/medicare/medicare082108nr.cfm

[v] See http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2009/May/Meeting-Enrollees-Needs.aspx

[vi] See http://www.medpac.gov/transcripts/0312-0313MedPAC.pdf