MEDICARE RIGHTS CENTER
520 Eighth Avenue, North Wing, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

Testimony of Joe Baker
President, Medicare Rights Center

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Washington, DC Office:
1825 K Street NW, Suite 400
Washington, DC 20006
202.637.0961

Introduction

Chairman Brady, Ranking Member McDermott, 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, nonprofit 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 Advantage plans (also known as Part C, MA, or MA-PD).[1] Our testimony will explain the benefits of recent changes to MA under the Affordable Care Act (ACA), describe the current MA landscape based upon our client work and our analysis of the MA market in New York (NY) State, and offer recommendations to further strengthen MA, with an emphasis on beneficiary choice.

Medicare Rights answers 15,000 questions on our national helpline each year from 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 over 1.2 million visits annually.

We counsel thousands of people with MA about topics ranging from enrolling in a plan to appealing a denied claim. This experience informs our support for changes made to MA plans by the ACA as well as other policies advanced by the Centers for Medicare & Medicaid Services (CMS). MA enhancements initiated by the ACA include equalizing MA and Original Medicare payments, limiting cost-sharing for select services, and improving quality measurement, among other initiatives.

The ACA advances a value-driven agenda for transforming our health care system, and Medicare is the testing ground for many critical payment and delivery system reforms. We believe that MA plans, alongside Medicare physicians, hospitals, and other health care providers, are contributing to and should continue to play a role in this broader transformation. Thus far, we find that the ACA's emphasis on value is producing positive returns in the MA marketplace. Specifically, the ACA sought to enhance MA plan quality, while also providing incentives for plans to compete for enrollee business. The available evidence illustrates that the quality of MA plans continues to increase.[2]

Many predicted that ACA changes to MA payment methods would lead to widespread disruption of the MA market. However, there is little evidence that this has occurred. In fact, it is important to note that MA enrollment is at an all-time high, with nearly 16 million beneficiaries now enrolled in an MA plan,

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

[2] O'Kane, M., "Testimony for the Senate Commerce, Science and Transportation Committee on Increasing Transparency on Health Care Costs, Coverage and Quality," (February 2013), available at: http://www.ncqa.org/Portals/0/Newsroom/2013/NCQA_POK_Senate_Commerce_Testimony.pdf

representing a steadily growing percentage of beneficiaries.[3] In addition, premium costs, benefit levels, and the availability of MA plans remain relatively stable across the country.[4]

MA remains a viable choice for Medicare beneficiaries, even after the ACA's payment reforms. Still, there is no one size fits all for Medicare beneficiaries. MA remains a good option for some, but not for all. As such, Congress must preserve and strengthen the Original Medicare program while also ensuring the availability of MA options through a strong, well-regulated marketplace. ACA provisions to enhance MA and recent actions by CMS provide a starting point to further strengthen MA plans, such as through additional funding for independent counseling resources, improved consumer protections when provider networks change, increased transparency on plan performance, and more.

Medicare Advantage: Strengthened by 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 initiated by the ACA. The ACA offers a blueprint for constructing a high-value health care system in which insurance plans, physicians, hospitals, and other providers are paid according to the quality of care delivered. Medicare is the incubator for many of these reforms.[5]

As such, the ACA included a set of policies designed to make the MA marketplace 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 all. 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 better quality care at the right price.

Among the most notable ACA changes to the MA market 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.[6] These adjustments are intended to scale back payments to MA plans to better approximate payments and costs in Original Medicare.

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[3] Kaiser Family Foundation, "Medicare Advantage," (May 2014), available at: http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/; Schwarz, C. "New York's Medicare Marketplace: Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act," (Medicare Rights Center and United Hospital Fund: July 2014), available at: http://www.medicarerights.org/pdf/new-yorks-medicare-marketplace-july-2014.pdf

[4] Ibid.

[5] 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

[6] 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

In 2009, before passage of the ACA, Medicare paid MA plans $14 billion more for care they provided to their members than if the same care had been provided under Original Medicare—or about $1,000 more per enrollee. Put another way, 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 Health Maintenance Organization (HMO) was paid 113% whereas the average local Preferred Provider Organization (PPO) was paid 118%.[7] From 2004 to 2009, these payments cost the Medicare program nearly $44 billion. Critically, despite being paid more, there was little evidence to suggest that MA plans consistently provided higher quality care than Original Medicare.[8]

Now, thanks to the ACA, reimbursement changes to plans are being phased in over nearly a decade to minimize disruptions in the MA market and to give plans time to adopt needed efficiencies. To date, payment adjustments are fully implemented in more than half of all counties, with another quarter of counties being fully phased-in by the end of 2015. Notably, MA enrollment increased in all counties since 2010.[9]

Furthermore, 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. This year, the Part B premium (paid by both people with Original Medicare and MA enrollees) remains at 2013 levels, costing $104.90 per month.[10]

This news is particularly notable given that MA overpayments historically drove up premiums for all Medicare beneficiaries, including those who remained in Original Medicare. For instance, in 2009, a couple with Original Medicare paid $86 more in premiums as a result of MA overpayments.[11] Facts like this are troubling given that so many people with Medicare live on low and modest incomes. In 2013, half of all Medicare beneficiaries lived on annual incomes at or below $23,500—hovering at 200% of the federal poverty level. One in four had annual incomes of $14,400 or less. [12] Furthermore, for those with the lowest incomes who are enrolled in a Medicare Savings Program (MSP), MA overpayments increased costs to states as well.

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[7] MedPAC, Report to the Congress: Medicare Payment Policy," (March 2009), available at: http://www.medpac.gov/documents/mar09_entirereport.pdf

[8] 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

[9] Neuman, T. and G. Jacobson, "Medicare Advantage: Take Another Look," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

[10] 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

[11] 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

[12] Jacobson, G., Huang, J. and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2013 – 2030," (Kaiser Family Foundation: January 2014), available at: http://kff.org/report-section/income-and-assets-of-medicare-beneficiaries-2013-2030-issue-brief-income-of-medicare-beneficiaries/

Importantly, the ACA put the Medicare program on sound financial footing while improving benefits. By reforming MA payments and enacting additional delivery and payment system reforms for fee-for-service providers, the ACA brought Medicare per capita growth to record lows and added years of solvency to the Medicare Hospital Insurance (HI) Trust Fund.

According to the 2013 Medicare Trustees Report, the Medicare HI trust fund is solvent through 2026, extended by 10 years since passage of the ACA. This represents one of the longer periods of projected solvency throughout the program's history. [13] According to the Congressional Budget Office's (CBO) most recent estimates, the HI trust fund will be solvent through 2030.[14] And many predict that the forthcoming 2014 Medicare Trustees Report will, like the CBO, project additional years of solvency.[15]

In addition to reining in overpayments, the ACA has made many other critical improvements for people with Medicare. For instance, people with either Original Medicare or MA now benefit from increased coverage with no cost-sharing for select preventive services, like mammograms, colonoscopies, prostate cancer screenings, depression screenings, obesity screenings and counseling, and more. Medicare patients also now receive an annual wellness visit, largely to identify needed preventive care and risk factors.

In 2013, an estimated 37.2 million people with Medicare utilized a preventive service with low to no cost-sharing—nearly a 10 percent increase over 2012.[16] MA-PD and other Part D enrollees are also benefiting from ACA provisions to close the prescription drug coverage gap, known as the doughnut hole.[17] Interestingly, these benefit improvements, which apply to all Medicare beneficiaries, translate into *higher payments* for MA plans. Specifically, MA plans are now paid for services that some offered as supplemental benefits prior to the ACA. This gives plans the opportunity to redirect those extra funds to supporting other benefits or lowering premiums.

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.[18] 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 this year, plans must adhere to a Medical Loss Ratio (MLR). The MLR improves value for the beneficiaries and taxpayers by requiring that plans spend 85%

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

[14] CBO, "The 2014 Long-Term Budget Outlook," (July 2014), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/45471-Long-TermBudgetOutlook.pdf

[15] Adams, R., "Medicare, Social Security Trustees' Report Missing from Budget Debates," *CQ Healthbeat News*, July 16, 2014

[16] CMS, "Press Release: 7.9 million people with Medicare have saved over $9.9 billion on prescription drugs," (March 2014), available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-03-21.html

[17] 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

[18] 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

of beneficiary premiums and federal payments on patient care, which in turn limits spending on marketing, CEO salaries, profits, and other administrative costs.[19]

Finally, the ACA established critical initiatives designed to improve MA plan quality. Specifically, the ACA ties payment bonuses to star ratings for MA plans. These ratings are determined through a wide array of performance measures and range from 1 to 5 stars, with plans receiving 1 star for poor performance, 3 stars for average performance, and 5 stars for excellent performance. 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 increased bonuses across the board in an effort to more rapidly enhance plan performance.[20] This demonstration will end in 2015.[21] In addition, 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 poor-performing plans altogether.[22]

Data suggest that these pay-for-performance initiatives are improving MA plan quality. Consider that in 2014, 38% of MA plans scored 4 stars or higher, and 14 MA and MA-PD plans scored 5 stars—all increases from ratings in 2013. According to CMS, more than half (52%) of MA beneficiaries are now enrolled in a plan with 4 stars or higher, up from 37% in 2013.[23] These improved scores reflect advancement across several measures, including adult BMI assessment, colorectal cancer screening, beta-blocker treatment after a heart attack, and the detection of potentially harmful drug interactions.[24]

While the ACA serves as a platform for several notable improvements to MA, CMS has implemented key regulatory changes that further strengthen MA plans. Specifically, in 2011, CMS required that MA plans set 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. Today, the average out-of-pocket maximum among MA plans is $4,797.[25]

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[19] Ibid

[20] 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

[21] CMS, "Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," (April 2014), available at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

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

[23] CMS, "Fact Sheet – 2014 Star Ratings," (September 2013), available at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

[24] National Committee for Quality Assurance (NCQA), "Improving Quality and Patient Experience: the State of Health Care Quality Report," (October 2013), available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf

[25] 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/

Additionally, CMS undertook efforts to consolidate duplicative and low-enrolling plans.[26] Reducing the number of nearly identical offerings addresses some of the problems that beneficiaries face when choosing a plan. In general, we find that older adults and people with disabilities find selecting among multiple MA plans a dizzying experience. We encourage 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 annually reevaluate their coverage options.[27] A recent series of focus groups conducted by the Kaiser Family Foundation validates much of what we hear on our helpline. According to the findings, "Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive…and their inability to organize the information to determine which plan is best for them."[28]

A recent *Health Affairs* study attributes some degree of beneficiary inertia with having too many plans from which to choose. 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 difficulty selecting among MA plans and Original Medicare is more pronounced among older adults with low cognitive function, such as those in the early stages of dementia.[29]

On this topic, a Consumers Union literature review concludes, "…the evidence is clear. While a few choices are good, too much choice undermines consumer decision making, particularly high stakes decisions involving health insurance."[30] In other words, people are better able to make good decisions when there are a reasonable number of meaningfully distinct options to choose from. To that end, steps taken by CMS to consolidate and/or eliminate duplicative and low-enrolling plans have been welcome.

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. Importantly, policies advanced by CMS also improved MA plans, namely by introducing out-of-pocket spending caps and constructively consolidating plan choices. We expect the effects of these changes will only become more pronounced for people with Medicare over time.

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[26] Ibid

[27] 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

[28] Jacobson, G., Swoope, C., Perry, M., and M. Slosar, "How are Seniors Choosing and Changing Health Insurance Plans?," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/

[29] 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)

[30] Consumers Union, "The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making," (November 2012), available at: http://consumersunion.org/pdf/Too_Much_Choice_Nov_2012.pdf

After the Affordable Care Act, the Medicare Advantage Market Remains Stable

Reductions to MA plan reimbursement mandated by the ACA raised concerns that the MA market—and people with MA—would suffer. Opponents claimed that MA enrollees would see increased premiums and cost-sharing, tightened provider networks, and fewer plan choices. Some predicted that enrollment in MA plans would decline after implementation of the ACA.[31] Yet, the opposite has proven true.

Today, MA enrollment is higher than ever before—with nearly 16 million enrollees, 6.3 million more than projected by CBO in 2010.[32] CBO now projects that MA enrollment will continue to rise, with 25 million enrollees expected in 2024.[33] In short, ACA payment adjustments to MA have not, and are not, expected to weaken enrollment, and predictions that the MA market will falter have not held up.

Nor has the ACA reduced the availability of ample plan options. Medicare beneficiaries continue to have a range of possible plans and plan types from which to choose, with some positive consolidation in the number of options. As noted above, some of the 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 for consumers.

In 2014, the average Medicare beneficiary has a choice among 18 MA plans, compared to 20 in 2013.[34] Nearly all beneficiaries have one or more plans (99%) and a range of plan types to choose from—89% have access to an HMO and 83% have access to a local PPO. Consistent with past years, beneficiaries in urban areas have more plan choices than those in suburban and rural areas.

Not only do beneficiaries retain a sufficient number of plan choices, plan availability remains relatively stable from year to year. Specifically, analyses suggest little change in the availability of plans from 2011 to 2014.[35] From 2013 to 2014, for example, the national MA landscape experienced a net change of only 60 products, with a total of 2,014 MA plans available this year.[36]

Enrollment is on the rise, plan availability is strong, and other fluctuations in plan offerings—namely in premiums, covered benefits, and cost-sharing—are relatively unchanged after passage of the ACA. Most notably, MA premiums actually declined, from an average $44 per month in 2010 to $35 per month in

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[31] Neuman, T. and G. Jacobson, "Medicare Advantage: Take Another Look," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

[32] Ibid

[33] CBO, "CBO's April 2014 Medicare Baseline," (April 2014), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf

[34] 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

[35] Schwarz, C. "New York's Medicare Marketplace: Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act," (Medicare Rights Center and United Hospital Fund: July 2014), available at: http://www.medicarerights.org/pdf/new-yorks-medicare-marketplace-july-2014.pdf

[36] 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/

2014.[37] At the same time, as evidenced by our recent review of the NY State MA marketplace, changes to benefits and cost-sharing remain largely unaffected, apart from expected year-to-year modifications.[38]

Through this analysis, conducted by Medicare Rights with funding from the United Hospital Fund (UHF), we compared the Evidence of Coverage (EOC) for a representative sample of NY MA plans and conducted qualitative interviews with plan administrators. Overall, we found that plan benefits have not changed substantially from 2011 to 2014. To the extent that beneficiary costs changed, there were no stark trends in cost increases or decreases. Instead, we saw both increases and decreases in costs over different years and across different plans. As with costs, we saw fluctuating adjustments within plan benefits on a year-to-year basis, as opposed to a steady, multi-year trend toward less generous plan packages.

Our qualitative interviews confirmed that reimbursement reductions to MA plans have mostly been shouldered by plans, rather than being passed on to consumers—though some voiced concern as to whether this practice can continue. That said, plan administrators expressed reluctance at increasing premiums or changing benefits, which may adversely impact their star ratings. Those interviewed suggested that plans were more likely to adopt other efficiencies to accommodate changes in reimbursement—like information sharing among network doctors, soliciting feedback on services and treatments, and investing in technologies that facilitate communication among health care providers.[39]

Critically, while MA plans continue to adapt to changing reimbursement rates, additional analyses reveal that they continue to profit. A companion report released by UHF on the NY State MA marketplace reveals that the average underwriting income among MA plans declined only slightly after the ACA, totaling $56.70 per member per month in 2010 versus $49.53 per member per month in 2012. Further, according to the report, "Even with this decline…HMOs still topped $401 million in underwriting income for MA in New York in 2012, which represented 60 percent of total HMO underwriting (or operating) income reported for 2012, compared to 48 percent in 2010."[40] On a nationwide basis, United Health Care—one of the largest MA issuers—recently reported second quarter gains in the MA market, with an increase in 65,000 MA enrollees year-over-year and a 7% increase in revenues year-over-year.[41]

And there is no evidence that changes to MA reimbursement have or will disproportionately harm low-income Medicare beneficiaries, most notably those dually eligible for Medicare and Medicaid, and diverse communities. The overwhelming majority of dually eligible beneficiaries receive their coverage through Original Medicare, not MA plans. Specifically, according to MedPAC, in December 2012, 23%

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[37] Neuman, T. and G. Jacobson, "Medicare Advantage: Take Another Look," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

[38] Schwarz, C. "New York's Medicare Marketplace: Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act," (Medicare Rights Center and United Hospital Fund: July 2014), available at: http://www.medicarerights.org/pdf/new-yorks-medicare-marketplace-july-2014.pdf

[39] Ibid

[40] Newell, P. and A. Baumgarten, "New York's Medicare Advantage Market, 2010–2012," (United Hospital Fund, July 2014), available at: http://www.uhfnyc.org/assets/1218

[41] United Health Group, "News Release: UnitedHealthGroup Reports Second Quarter Results," (July 2014), avialable at: http://insidehealthpolicy.com/sites/insidehealthpolicy.com/files/documents/jul2014/he2014_0584.pdf

of dually eligible beneficiaries were enrolled in MA while 27% of non-dually eligible beneficiaries opted for MA.[42]

While MA plans may be a good option for some dually eligible beneficiaries, we equally find that dually eligible beneficiaries avoid enrolling in MA due to more restrictive plan networks and increased use of utilization management controls. Dually eligible beneficiaries are low-income by definition, and they also tend to be sicker than the general Medicare population and require more intensive, ongoing health care services.[43] In addition, depending on household income, Medicaid and MSPs help low-income beneficiaries with cost-sharing they would otherwise face in Original Medicare.

Given this, it is important to note that nothing in the ACA restricts the core Medicare benefit package for dually eligible beneficiaries—or anyone else—enrolled in MA. To the contrary, core Medicare benefits were enhanced in the ACA. While supplemental benefits may be altered in MA plans, adjustments to these benefits were also commonplace *prior to* the ACA. Further, provisions in the ACA to restrict MA plans from charging higher cost-sharing were intended to help sicker populations—like dually eligible beneficiaries—by limiting discriminatory practices intended to keep those with high health care needs from enrolling in MA plans.

Further, it is worth noting that a part of the MA program seems poised for growth. Many MA plans, as well as new plans that have not been part of the MA program, are engaged in developing new products intended solely for dually eligible beneficiaries through a demonstration program initiated by the ACA to improve care coordination and health care quality for this population, known as the Financial Alignment Initiative.[44]

For example, 23 private health care plans are participating in the New York State demonstration. A consumer advocacy coalition, led by Medicare Rights, is weighing in on the development and implementation of this demonstration. To date, the coalition is pursuing several reforms and protections to ensure that plans are optimally serving the dually eligible population, including setting appropriate plan reimbursement rates, integrating appeals processes, building an adequate interdisciplinary care team, and establishing a statewide ombudsman.[45] Plans themselves are participating in the coalition's work through a related advisory workgroup.

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[42] MedPAC, "The Data Book: Health Care Spending and the Medicare Program," (June 2014, pg. 143), available at: http://medpac.gov/documents/Jun14DataBookEntireReport.pdf

[43] Jacobsen, G., Neuman, T., and A. Damico, "Medicare's Role for Dual Eligible Beneficiaries," (April 2012), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8138-02.pdf

[44] CMS, "Financial Alignment Initiative," (last updated July 2014), available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[45] See the following examples that include policy priorities of the Coalition to Protect the Rights of New York's Dually Eligible (CPRYNDE): Letter to CMS and NY State Dept. of Health on three-way contract (July 2013), available at: http://www.medicarerights.org/pdf/CPRNYDE-letter-to-MMCO-and-NYSDOH-re-Contract-Priorities-FINAL-11-27-13.pdf; Letter to CMS and NY State Dept. of Health on enrollment (July 2014), available at: http://www.medicarerights.org/pdf/FIDA-enrollment-letter-to-CMS-and-NYSDOH-07-14-14.pdf

In sum, the news on the MA landscape post-ACA remains overwhelmingly positive: enrollment is on the rise, premiums are down, and plan availability and benefits remain stable. However, it is critical to examine MA plan offerings and performance on an ongoing basis. As implementation of the ACA moves forward, we will continue to advocate for vigilant monitoring of the MA plan landscape and individual offerings to help ensure that plans are optimally serving beneficiaries under the new payment system.

Recommendations to Improve Medicare Advantage

While many argued that ACA changes to MA reimbursement would unduly restrict beneficiary choice, this has not proven true. To the contrary, independent, empirical research soundly supports our experience in counseling Medicare beneficiaries: by and large, beneficiaries and their caregivers are hampered by *too many* choices.

Given this, steps must be taken to further improve the MA market for people with Medicare. 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:

Support consumer counseling services: 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.

As a technical assistance provider to NY State's Health Insurance Information Counseling and Assistance Program (HIICAP) network—NY State's SHIP—we understand the value of this federal resource administered by the states for older adults and people with disabilities. Additional resources are needed to enhance the capacity of SHIPs and to increase outreach to ensure that people with Medicare are aware of free SHIP resources. In a nationally representative survey of more than 2,200 seniors conducted by KRC Research, only 37% were aware of the availability of free Medicare counseling through the SHIPs, and only 11% had used these services.[46]

In addition to the above, federal policymakers 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, most notably through the addition of content on plan provider networks.[47]

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[46] KRC Research, "Seniors' Opinions about Medicare Prescription Drug Coverage: 8th Year Update," (Medicare Today: September 2013), available at: http://www.medicaretoday.org/MT2013/KRC Survey of Seniors for Medicare Today FINAL.pdf

[47] Medicare Rights Center, "Memo: Plan Finder Observations During Fall Open Enrollment: October 15 – December 7, 2013," (Addressed to CMS' Arrah Tabe-Bedward and Amy Larrick, from Stacy Sanders and Casey Schwarz; Sent May 2014), available at: http://medicarerights.org/pdf/2013-plan-finder-memo.pdf

Further, plans should be prohibited from asserting or implying that standard benefits, like an out-of-pocket cap or free preventive services, are unique to a given MA plan. Similarly, MA plans should not be permitted to suggest that income-based benefits, like the 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.

Lessen the impact of mid-year changes to MA provider networks: Changes to provider networks are one tool available to MA plans to control costs. When these changes occur in the middle of the plan year, it can be particularly disruptive to beneficiaries, risking the continuity of needed care. Our helpline counselors work with many beneficiaries who face hardship as a result of mid-year MA network changes, including increased financial burdens, impeded access to physicians with whom they have longstanding relationships, and confusion. We observe that the sudden loss of a provider can be particularly damaging to someone undergoing active treatment for a condition or illness.

As such, we strongly support efforts by CMS to ease these burdens, namely by encouraging MA plans to provide sufficient notice prior to network changes, committing to investigating significant network changes, and granting a Special Enrollment Period (SEP) to beneficiaries where significant changes occur. To date, CMS relies on MA plans to define what constitutes a significant network change.

While we understand the need to permit some plan-level interpretation, beneficiaries need a consistent policy to ensure equal protection regardless of plan choice. As such, we continue to advocate that CMS engage in rulemaking to more clearly delineate the requirements of MA plans with respect to network issues.[48] In addition, CMS should be vigilant in its oversight of plan behavior, ensuring that notice is properly delivered, transition planning is provided as appropriate for people in active treatment, and unbiased counseling sources are prominently publicized.

Beyond rulemaking, we believe that more can and should be done to help ensure the continuity and stability of MA provider networks through the plan year. Toward this end, we urge Congress to pass the Medicare Advantage Participant Bill of Rights Act (H.R. 4998 and S. 2552).[49] This legislation ensures that MA enrollees obtain transparent, reliable, and accurate information about their plans' networks during the annual open enrollment period. Additionally, the bill provides assurance to MA enrollees that they will retain the ability to see the providers who were part of the plan's network when they made the choice to enroll in the plan. This helps to protect beneficiaries against the loss of trusted providers while the beneficiary is locked into the plan.

[48] CMS, "Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," (April 2014), available at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

[49] Senator Sherrod Brown, "Press Release: Sens. Brown, Blumenthal, and Rep. Delauro Introduce Legislation to Protect Seniors by Preventing Them From Losing Their Doctors," (June 2014), available at: http://www.brown.senate.gov/newsroom/press/release/sens-brown-blumenthal-and-rep-delauro-introduce-legislation-to-protect-seniors-by-preventing-them-from-losing-their-doctors

Enhance transparency through data and notification: A recent report by the Office of the Inspector General (OIG) found that CMS regularly reviews plan-reported data, but rarely follows up on this information. Furthermore, none of this plan-level data is yet made available to the public.[50]

Toward this end, we support CMS' April 2014 proposal to release the first public-use file on Part C and Part D plan-reported data.[51] And we ask members of Congress to urge for the release of this data. Maximizing transparency would ultimately better inform consumers, while also facilitating greater accountability among MA plans—particularly in areas like grievances and appeals, where we believe significant improvements are warranted.

Encourage meaningful variation among plans: As reflected in numerous studies as well as our experience serving helpline callers, many people struggle to make choices when presented with 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, described earlier, 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 (e.g., Plan A, Plan B, Plan C) to encourage "apples-to-apples" comparisons.[52] This would make it easier for beneficiaries to make an informed choice, while creating an environment in which plans compete based on price and quality.

Some argue that the ACA's increased emphasis on quality and efficiency must be coupled with increased flexibility for MA plans, specifically to alter cost-sharing and benefits. These suggestions concern us not only because they would further complicate the marketplace for consumers but might also lead to discriminatory practices. Given our experience, having helped tens of thousands of beneficiaries through the years, this market needs to be more standardized and well-regulated with clear rules that protect benefits, beneficiaries, and taxpayers. Increased flexibility for MA plans could encourage development of discriminatory plan designs intended to deter sicker, more vulnerable beneficiaries and skew risk unfavorably among products.

Enhance star ratings: As discussed above, the MA and Part D star rating system shows promise as a vehicle for improving both plan quality and simplifying consumer choice. In the short term, efforts to improve the star rating system should ensure that beneficiaries are educated and engaged, as many people

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[50] OIG, "CMS regularly reviews Part C reporting requirements data, but its followup and use of the data are limited," (March 2014), available at: http://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf

[51] CMS, "CMS First Public Use File (PUF) of Plan-Reported Data," (HPMS Memo from Tracy McCutcheon and Danielle Moon to all Part C and D Sponsors; Sent April 28, 2014); Medicare Rights Center, "Re: CMS First Public Use File (PUF) of Plan-Reported Data," (Comments submitted May 12, 2014)

[52] 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

with Medicare are still unfamiliar with the system. According to KRC Research, only 23% of seniors interviewed through a national survey were aware of the star rating system.[53] 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.[54]

In the long term, the star rating system should be enhanced to provide consumer-specific 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.

Conclusion

In conclusion, the experience of our clients at Medicare Rights demonstrates that for some older adults and people with disabilities, MA plans are a good option, but for many others Original Medicare is a better choice. Thanks to recent advancements made possible by the ACA and additional efforts by CMS, the market for MA plans has significantly improved. These changes to MA plans must be preserved.

MA plans can play an important role in the value-driven agenda advanced by the ACA—and are already doing so. MA plan quality continues to increase, a trend attributable to quality improvement initiatives embedded in the ACA. While some may be inclined to link any annual plan changes to the ACA, like altered cost-sharing and changes to provider networks, it is important to recall that these practices have been the norm within the MA landscape since its inception. As always, people with MA have the option to switch their coverage during the annual Medicare open enrollment period if their plan no longer meets their health and financial needs.

Despite all of these improvements, our experience and empirical research indicate that Congress and CMS should do more to simplify plan selection and coverage rules for people with MA. To achieve this goal, we recommend adequately funding unbiased counseling resources, such as SHIPs; improving beneficiary notice regarding annual plan changes; appropriately limiting the ability of MA plans to make mid-year changes to provider networks; further streamlining and standardizing plans; and making available public data on the performance of MA plans, particularly with respect to appeals and grievances.

Thank you for the opportunity to testify.

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[53] KRC Research, "Seniors' Opinions about Medicare Prescription Drug Coverage: 8th Year Update," (Medicare Today: September 2013), available at: http://www.medicaretoday.org/MT2013/KRC Survey of Seniors for Medicare Today FINAL.pdf

[54] 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

Summary of Testimony by Joe Baker, Medicare Rights Center

The Medicare Rights Center is a national, nonprofit 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.

Medicare Advantage Strengthened Since the Affordable Care Act: Today, MA plan enrollment is at an all-time high, with nearly 16 million enrollees. The ACA included a set of policies designed to make the MA system more efficient and to enhance plan quality. This emphasis on value is producing positive returns in the MA marketplace, and MA plan quality continues to improve. Importantly, the ACA put the Medicare program on sound financial footing while improving benefits. The ACA made many critical improvements to MA, benefitting current and future beneficiaries, including:

- Equalizing MA payments with the costs of providing the same care under Original Medicare
- 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

After the Affordable Care Act, the Medicare Advantage Market Remains Stable: Many predicted that ACA changes to MA payment methods would lead to widespread disruption of the MA market. Some claimed that MA enrollees would see increased premiums and cost-sharing and fewer plan choices. Yet, the opposite has proven true. Since passage of the ACA:

- Estimates suggest that MA enrollment will continue to rise, with 25 million enrollees by 2024
- Plan choice remains strong: in 2014, the average beneficiary has a choice among 18 MA plans
- MA premiums declined from an average of $44 per month in 2010 to $35 per month in 2014
- Changes to benefits and cost-sharing remain unaffected, apart from expected year-to-year modifications

Recommendations to Improve Medicare Advantage: Today, MA remains a good option for some, but not for all. Congress must preserve and strengthen the Original Medicare program, while also ensuring the availability of MA options through a well-regulated marketplace. While many argued that ACA changes to MA reimbursement would unduly restrict beneficiary choice, this has not happened.

To the contrary, our experience and independent research confirm that consumers are by and large hampered by *too many* choices. Given this, steps must be taken to further improve the MA market for people with Medicare. We urge Congress to consider the following:

- Support counseling services and adequately fund State Health Insurance and Assistance Programs (SHIPs)
- Lessen the impact of mid-year changes to MA provider networks
- Pass the *Medicare Advantage Participant Bill of Rights* Act (H.R. 4998 and S. 2552)
- Enhance transparency through publicly available data and notification, particularly on appeals
- Encourage meaningful variation among plans, specifically through standardization and consolidation
- Enhance the quality star ratings program to help consumers make better choices