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TESTIMONY

on the Medicare Payment Advisory Commission's (MedPAC) June Report to the Congress

to the
United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
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SUBMITTED BY:

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Introduction

The Medicare Rights Center is a national, nonprofit beneficiary service 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. Through our direct work with Medicare beneficiaries, their caregivers, providers and families, we have specific insights into the impact on beneficiaries of changes to the Medicare program. In this testimony, we will address the recommendations in the June 2012 Medicare Payment Advisory Commission (MedPAC) report to Congress regarding reforms to the Medicare benefit design and proposals to provide better care for individuals with both Medicare and Medicaid, also referred to as dual eligibles.

Each year, through our consumer helpline, we are able to speak with nearly 15,000 people with Medicare as they navigate their health insurance, appeal coverage denials and try to determine which coverage best suits their health needs. We are also an appointed consumer group member of the National Association of Insurance Commissioner's (NAIC) Senior Issues Task Force statutory Patient Protection and Affordable Care Act Subgroup.

The Proposed Benefit Redesign

In its report, MedPAC suggests reforming the current Medicare benefit design to create a combined deductible for Part A and Part B services, replace coinsurances with standardized copayments, institute a limit on beneficiaries' out-of-pocket spending, and add a surcharge to insurance that supplements Medicare benefits, including both individually purchased Medigap plans and retiree plans.

Many of the proposed changes are promising, and we agree that Medicare could be improved by a simplified plan design, more predictable cost sharing, and the institution of a cap on beneficiaries' out-of-pocket liabilities. The current fee-for-service (FFS) plan structure, including different deductibles for Part A and Part B services, a coinsurance for most Part B services and copay for most Part A services, and no limit on out-of-pocket costs, can be cumbersome to navigate, difficult to effectively financially plan for and costly to beneficiaries. Several of the MedPAC recommendations address these concerns, and we are encouraged to see them; however, we are concerned that some of these recommendations achieve savings by shifting costs to beneficiaries and risk deterring utilization of medically necessary services.

We strongly support the implementation of a catastrophic cap that does not change beneficiaries' aggregate cost-sharing liability. However, we do not support a surcharge on supplemental policies, which would increase costs to Medicare beneficiaries, who are already burdened with some of the highest expenditures of any insured population. While some beneficiaries will decide that they do not desire to purchase supplementary insurance if there is an out-of-pocket cap, others will continue to purchase Medigaps or continue enrollment in retiree plans to reduce the unpredictable nature of cost-sharing, because the supplemental insurance provides other benefits the individual values, or because the beneficiary is comfortable in a plan they have been enrolled in for a long time. We do not support a surcharge on these supplementary insurance products, which would increase beneficiaries' costs.

We are also concerned by MedPAC's rationale for recommending the surcharge on supplementary coverage. MedPAC argues that supplemental insurance leads to increased utilization of Medicare services and that a surcharge on supplemental insurance recoups some of the costs associated with increased utilization. As MedPAC acknowledges, increased cost-sharing is a blunt instrument for reducing utilization and is likely to reduce utilization of necessary care as much as unnecessary care.

Furthermore, MedPAC states that “as currently structured, many supplemental plans cover all or nearly all of Medicare’s cost-sharing requirements, regardless of whether there is evidence that the service is ineffective” and that comprehensive supplementary coverage “reduces incentives to weigh . . . decisions about the use of care.” These statements mischaracterize current supplemental insurance policies and the people who have them. First, Medicare does not cover services that are not medically reasonable and necessary; Medigaps rely on Medicare’s determination that the care meets the criteria for coverage. Many retiree plans also defer to Medicare’s medical necessity determination, though some make an independent assessment. Second, MedPAC acknowledges that the “selection effect” of individuals with predictably high health care costs, those who are sicker and therefore more likely to purchase supplemental coverage, “is also partly responsible for the higher spending observed among those with supplemental coverage.” (Page 17.) Rather than a license to overuse unnecessary services, supplementary insurance provides Medicare beneficiaries, half of whom live on fixed annual incomes under \$25,000, with needed protection from irregular and unpredictable high out-of-pocket costs.

We support the recommendation against increasing beneficiaries’ aggregate cost sharing liability. Changing the cost sharing design, as proposed, to combine the Part A and Part B deductibles, replace coinsurance with copays that vary by type of service and provider, and authorize the Secretary to alter or eliminate cost sharing based on the value of services, has the potential to increase predictability for beneficiaries and incentivize utilization of high value care. However, we have three concerns related to these changes. First, a combination of Part A and Part B deductibles will, as noted in the report, result in “the majority of beneficiaries in a given year—[seeing] an increase in their deductible amount.” (Page 12.) Therefore, the combined deductible is unacceptable because it shifts costs to beneficiaries and reduces utilization of both necessary and unnecessary services. Second, the categorization of high value and low value services, and setting variable copays in relation to this categorization, must be transparent, evidence-based, and clear to consumers so they can make informed decisions. Because Medicare does not cover treatment that is not medically necessary, even “low value” services should not have prohibitively high cost sharing. Third, if the Secretary is given authority to adjust copayments based on value information, the authority should be limited to reducing copays for services during the plan year. Any changes that would increase cost sharing for particular services, should be implemented only at specified intervals (e.g., annually) with adequate notice to beneficiaries so they may protect against the increase or change their behavior appropriately. Indeed, adequate education and notice to beneficiaries will be crucial to avoid costly surprises and beneficiary confusion. Notice and comment rulemaking, as suggested, is not sufficient to adequately inform affected beneficiaries.

Care Coordination in Fee-For-Service Medicare

The MedPAC report concludes that the Medicare demonstration projects related to care coordination in FFS Medicare “demonstrate the limitation of taking a specific care coordination intervention and inserting it into the Medicare FFS system when the delivery system has not been reorganized to accommodate and wrap around the intervention” and that “payment reforms that fundamentally change the incentives to provide more care offer the most promise for care coordination.” However, MedPAC notes that as comprehensive reforms may be years away, “policies to encourage care coordination within the FFS system may be an interim step.” We support the Center for Medicare and Medicaid Innovation (CMMI) initiatives to implement and evaluate care coordination models in FFS Medicare, including the development of health homes and accountable care organizations.

Care Coordination Programs for Dual Eligible Beneficiaries

The MedPAC report evaluates two models of care coordination for dual eligible and currently enrolling beneficiaries, and the report comments on the CMS demonstrations on integrated care

programs. The Medicare Rights Center supports efforts to improve health care access and quality for dual eligible beneficiaries.

We believe that CMS's demonstration projects offer a unique opportunity to address the numerous and complex problems faced by dual eligible beneficiaries. In their analysis of the CMS demonstration projects, MedPAC raises important concerns, but we support the goals of the project and believe it contains substantial promise to evaluate different models of care coordination for some of the most vulnerable and costly beneficiaries. We agree that the demonstrations provide "opportunities to test how to encourage care coordination, improve quality of care and reduce spending by reducing some of the conflicting incentives between Medicare and Medicaid." (Page 86.)

MedPAC's concerns—the scope of some of the demonstration projects, plan experience and implementation expertise, passive enrollment, and oversight—are legitimate and require careful consideration. Several of these concerns have been addressed in the notice and comment periods the States are required to engage in prior to submission to CMS, or in the CMS approval process. For example, New York's initial proposal involved the majority of dual eligible individuals in the state but has since been reduced in size. Similarly, several proposals exclude, or carve out, individuals who are enrolled in other coordinated-care models, like PACE programs, health homes or accountable care organizations. Others focus on a sub-population of dual eligible beneficiaries, for example, Massachusetts's proposal focuses only on individuals with Medicare under age 65. A balance must be struck between ensuring that these projects are true demonstrations and ensuring that large enough populations participate in order to create efficient systems and perform adequate evaluations.

The report points out that large scale demonstration projects also make dismantling failed projects difficult. For this reason, we urge CMS to require that the "opt-out" option in all of these plans continue to be a robust and realistic option for individuals who choose to remain in FFS Medicare and Medicaid. This concern also underscores the need for careful monitoring of these demonstration projects and flexibility from the states when failures are identified within the demonstration.

Demonstration projects that seek to move beneficiaries into fully capitated managed care plans raise concerns regarding programmatic experience and network adequacy. MedPAC points out that only about 20 plans are currently capitated and at risk for beneficiaries' full Medicare and Medicaid costs. Though they lack this fully capitated experience, most Medicare Advantage plans and Medicaid Managed Care plan providers do have experience serving dual eligible; however, they have not done so in a coordinated and comprehensive fashion. Indeed, no entity has experience serving large dual eligible populations in a seamless and coordinated manner, because it has never been successfully done. Dual Eligible-Special Needs Plans, even Fully Integrated Dual Eligible-Special Needs Plans continue to have in-network doctors who do not accept Medicaid, and there has been no explicit standard to which these plans are held with regard to minimum standards of care coordination. If these demonstration projects move forward, CMS must work closely with states to ensure that these fully capitated plans have adequate provider networks for Medicare, Medicaid, long term care services and prescription medications. Moreover, robust state and Federal oversight is needed to guarantee that the coordination promised in these demonstrations is realized. We agree that plan participation standards must be transparent, and plans with insufficient quality assurance, provider networks and capacity should not be permitted to participate.

The opportunity to create contracts between plans, CMS and the respective States, which protect beneficiaries, are cost effective and include evidence supported practices from various programs, will allow for innovation. Furthermore, beneficiary and other stakeholder involvement will help to ensure that proposed systems can meet the diverse needs of dual eligible individuals. This effort will require

states to work with the Federal government and stakeholders with experience in both the Medicare and Medicaid programs. While it is a praiseworthy goal for these demonstrations to include beneficiary protections from the Medicare and Medicaid program, it also requires an exhaustive knowledge of both programs, not only legally but also practically.

Enrollment practices, including proposed passive enrollment, marketing and education, and potential lock-in periods are vitally important. If states and CMS use passive enrollment systems, finding that the systems do not violate Medicare law that promises freedom of choice, they must be, as MedPAC states “intelligent.” This means that States must enroll beneficiaries into plans which meet their specific needs based on the specific services the beneficiary uses. For example an “intelligent” assignment system that only looks at long term care providers, but does not consider the beneficiary’s prescription medication needs, may result in an enrollment that leaves the beneficiary worse off. Moreover, random assignment into a plan, regardless of whether it is fully capitated, defeats the broader goals of coordination and better care for dual eligible beneficiaries. We support models which use passive enrollment, if at all, only as a last resort for individuals who do not select a plan after education and guidance with a trained neutral advisor. We agree that it “may be difficult for some dual eligible beneficiaries to be informed about their choices,” and are hopeful that thoughtful consideration from CMS, the states, beneficiaries, advocates and plan sponsors can devise strategies for effective communication during enrollment and after.

We are encouraged by CMS’s indication that beneficiaries will be able to change plans throughout the year, and we urge CMS to reject or require adjustment to proposals that include “lock-in” provisions. We further urge CMS to reject proposals with elements similar to lock-in, where leaving private insurance plans is permitted only after a certain number of months or a limited number of times. We urge CMS and MedPAC to continue to carefully review these proposals to ensure that the demonstrations have the best chance of bringing about cost-effective improvements to the access and quality of care to which dual eligible beneficiaries are entitled.