

**\*\*\*TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON FRIDAY,  
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**Testimony of John Tallent**

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**On behalf of the Medicare Cost Contractors Alliance**

**Before the Subcommittee on Health**

**House Committee on Ways and Means**

**on**

**The Medicare Advantage Program**

**September 21, 2012**

**I. INTRODUCTION**

Chairman Herger, Ranking Member Stark and distinguished members of the Subcommittee, my name is John Tallent. I am the Chief Executive Officer of Medical Associates Health Plans, headquartered in Dubuque, Iowa. I am here today testifying on behalf of the Medicare Cost Contractors Alliance, a coalition of 15 Medicare cost plans that currently serve over 400,000 Medicare beneficiaries enrolled in plans in 14 states and the District of Columbia.

Congress authorized Medicare cost plans in 1972 under section 1876 of the Social Security Act. Since then, they have proven to be a stable, cost-effective alternative to Medicare fee-for-service, particularly for beneficiaries living in rural areas and areas in which risk-based plans have encountered challenges. As a result, Congress has worked on a bipartisan basis to maintain this important program.

We appreciate this opportunity to testify on Medicare cost plans. We firmly believe that cost plans should remain available as a coverage option for beneficiaries and are grateful for the bipartisan support that the program has enjoyed. The Alliance also appreciates the efforts of two members of this Committee—Representative Paulsen (R-MN) and Representative Kind (D-WI)— who have introduced H.R. 2770, the Medicare Cost

Contract Extension Act of 2011. I also want to recognize the work of Senator Klobuchar (D-MN) and Senator Grassley (R-IA), who have introduced a companion bill in the United States Senate.

My testimony today will focus on three main areas: first, I'll provide some background information on cost plans in general and discuss Medical Associates Health Plans as an example of the types of organizations that have Medicare cost contracts; second, I'll explain the status of cost plans under current law and the need for changes to current law that will ensure that beneficiaries—many of whom have been members for more than a decade—can continue to receive care through their plans. Finally, I will present some policy options to achieve that objective.

## **II. BACKGROUND**

### **A. Medicare Cost Plans**

Like Medicare Advantage plans, Medicare cost plans cover Part A and Part B services, as well as any optional supplemental benefits. In addition, they can choose to offer Part D coverage. The principal difference between Medicare cost plans and Medicare Advantage plans is that the Centers for Medicare and Medicaid Services (CMS) reimburses cost plans based on their reasonable costs, rather than through a risk-based capitated payment.

There are 19 Section 1876 Medicare cost plans across the U.S., located principally in rural areas or areas of comparatively low Medicare Advantage rates. Ninety percent of cost plans are nonprofit organizations. A large portion of Medicare cost plans are either owned or affiliated with well-regarded medical groups. The average Medicare cost plan has been providing high quality, cost-effective services to Medicare beneficiaries for over 20 years.

In fact, although Section 1876 cost plans only represent 19 of the 569 Medicare health plan contracts, in 2012, 25 percent of all five star Medicare health plans are cost plans. All cost plans have a star rating of 3.5 or higher; however, only half of Medicare Advantage plans have a star rating 3.5 or higher.

## **B. Medical Associates Health Plans**

Medical Associates Health Plans is a provider-owned health plan located in Dubuque, Iowa. Established in 1982, the Plan operates within a 60-mile radius of Dubuque in Iowa, Wisconsin and Illinois. The organization operates two health plans—Medical Associates Health Plan, Inc. operating in Iowa and Illinois, and Medical Associates Health Plan operating in Wisconsin—collectively doing business as Medical Associates Health Plans. Their overall membership, including both commercial and Medicare members, is just over 30,000 members with an additional 12,000 members managed by the organization under a related company.

Medical Associates Clinic, the owner of Medical Associates Health Plans, was established in 1924, and is the oldest multispecialty group practice clinic in Iowa. With over 170 providers serving Dubuque and the Tri-State area, Medical Associates Clinic and Health Plans have a staff of over 1,000 health care professionals and support personnel. The clinic has two campuses in Dubuque and nine satellite clinics throughout the Plans' service area. They have been designated a Better Performing Practice by the Medical Group Management Association for over ten consecutive years. Medical Associates Clinic was awarded the Physician Practice Connections®-Patient Centered Medical Home™ by NCQA, and is ranked among the top recognized practices in the nation by scoring a Level 3, the highest recognition status obtainable.

The clinic has made a significant investment in quality, technology and service. In the area of quality, this includes NCQA recognition for Diabetes Education as well as Heart/Stroke care. The Clinic implemented use of an Electronic Medical Record in 1993, the first in the region to adopt this technology.

Medical Associates Health Plan has had a Medicare cost-based contract since 1984—converting from a Health Care Prepayment Plan, another form of cost contract, to a Section 1876 Cost Contract in 1996. We operate our Medicare cost contracts in five counties in Iowa—Dubuque, Jones, Jackson, Delaware and Clayton; four counties in Wisconsin—Grant, Iowa, Crawford & La Fayette; and one county in Illinois—Jo Daviess.

Our current Medicare cost plan enrollment is 12,290 and our Medicare members like our plan – our voluntary disenrollment rate is 1 percent or less. Our members are elderly. Their average age is almost 76 and one third of our members are 80 years of age or older.

Medical Associates Health Plans is proud of the quality of services it offers to its cost plan members. In 2012, Medical Associates Health Plan was one of twelve CMS contracts out of 569 (2.11%) that received a five star rating. Our Wisconsin plan received a 4.5 star rating. In addition, Medical Associates Health Plans have had an NCQA “Excellent” accreditation since 2002.

### **III. THE WITHDRAWAL REQUIREMENT**

The Balanced Budget Act of 1997 amended the Social Security Act to provide for a sunset of all Medicare cost plans in 1999. This provision was subsequently amended and in 2003 under the Medicare Modernization Act, the so-called “two plan test” was created. The test has been subsequently refined in an effort to ensure that beneficiaries will continue to have health plan choices.

Under current law, after January 1, 2013, Medicare cost plans must withdraw from any portion of their service area if there are two local or two regional Medicare Advantage (MA) plans that overlap that portion of the cost plan’s service area and that have met minimum enrollment requirements for the previous year. If the test is met, the affected cost plan will have to withdraw effective on January 1, 2014. The enrollment thresholds are determined by segments of the Medicare Advantage plans’ service areas. For Metropolitan Statistical Areas (MSAs) with a population of 250,000 or more, the test is met if the two Medicare Advantage plans have 5,000 enrollees in the MSA and its contiguous counties. For all other areas, the test is met if the two Medicare Advantage plans have 1,500 enrollees in areas outside of MSAs and their contiguous counties.

If current law is not changed, about 230,000 beneficiaries will lose their cost plan coverage in 10 states on January 1, 2014. Medical Associates Health Plan would be forced to withdraw from four of the five counties in its Iowa service area, affecting almost 1,400 members.

In states like Texas and South Dakota, cost plans will have to withdraw from rural areas despite very low Medicare Advantage penetration in the affected counties because the area over which the “all other area” test is measured is so large. In Minnesota, cost plans would be required to withdraw from their entire Minnesota service areas with the exception of the Duluth MSA and its contiguous counties. Additionally, cost plans will be required to withdraw from counties in Colorado, Wisconsin and Ohio.

#### **IV. MEDICARE COST PLANS SHOULD REMAIN A COVERAGE OPTION FOR BENEFICIARIES**

##### **A. Effect of Withdrawals; Cost Plan Enrollees Will Face Higher-Out of Pocket Costs**

The withdrawals required under current law will become effective on January 1, 2014. Thus, beneficiaries would have to pay the deductibles and coinsurance amounts under Original Medicare, move to a Medigap plan or choose a Medicare Advantage plan during the 2013 open enrollment season. Medigap plans will be particularly expensive for older cost plan members because they are age rated. Moreover, a 2009 study by the General Accounting Office found that cost plan benefit packages tend to attract less healthy beneficiaries.<sup>1</sup> The GAO report found that beneficiaries 80 to 84 years old who reported poor health had lower average out-of-pocket costs than competing Medicare Advantage plans or Medicare fee-for-service. Thus, these vulnerable beneficiaries will have higher out of pocket costs because of the cost plan withdrawals. They also could face disruptions in long-standing provider relationships, since many of them have been Medicare cost members for many years.

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<sup>1</sup> United States General Accounting Office, Report to Congressional Committees, MEDICARE MANAGED CARE: Observations about Medicare Cost Plans, GAO-10-185 (December 2009).

The elderly and less healthy beneficiaries who tend to be enrolled in Medicare cost plans will not receive the care management and coordination offered by Medicare cost plans if they go to Medicare fee-for-service. Moreover, studies have shown that Medicare cost plans offer higher quality of care than fee-for-service Medicare.<sup>2</sup>

One purpose of moving from a defined sunset date to the two plan test was to ensure that beneficiaries affected by cost plan withdrawals would continue to have Medicare managed care choices. However, because the effective date of withdrawals (beginning 2014) takes place during a period of decreasing Medicare Advantage rates, this will not be ensured. The Medicare Advantage payment changes authorized by the Affordable Care Act will be fully implemented over a six year period beginning in 2012. Full implementation will occur at the end of 2017. In the past, when payments to Medicare risk-based plans have decreased or have been uncertain, plans have been forced to make the difficult decision of withdrawing from the program or reducing their service areas, resulting in many beneficiaries losing their Medicare health plan choices. For example, in the period from 1999-2002 severe payment reductions went into effect and the regulatory environment presented additional challenges to plans. As a result, 374 Medicare+Choice organizations either ended their contracts or reduced a portion of their service areas, resulting in 2,205,000 beneficiaries losing their plans. A GAO analysis of the withdrawals and service area reductions noted that by 2001 almost 75 percent of counties that had a Medicare+Choice plan in 1999 were affected by service area reductions or withdrawals.<sup>3</sup>

The same GAO analysis explained that Medicare+Choice plans tended to withdraw from more difficult to serve rural counties or large urban areas that they had entered more recently or where

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<sup>2</sup> This conclusion is supported by two separate research findings: (1) that Medicare Advantage plans scored higher than Medicare FFS on the vast majority of HEDIS measures (*See Niall Brennan and Mark Shepard, Comparing Quality of Care in the Medicare Program, VOL. 16, NO. 11, THE AMERICAN JOURNAL OF MANAGED CARE, 841 (November 2010)*) and (2) that correspondingly, Medicare cost plans scored higher than Medicare Advantage plans on HEDIS measures (*See MedPAC, Report to the Congress, Medicare Payment Policy (March 2011) and United States Government Accountability Office, Report to Congressional Committees, MEDICARE MANAGED CARE: Observations about Medicare Cost Plans, GAO-10-185 (December 2009)*).

<sup>3</sup> United States General Accounting Office, Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings, GAO/HEHS-00-183 (September 2000).

they failed to attract sufficient enrollment. Many Medicare cost plans serve predominately rural areas.

### **B. Policy Options To Preserve Beneficiary Access to Cost Plans**

In order to prevent 230,000 Medicare beneficiaries from losing their Medicare cost plan choice in 2014 and to ensure that beneficiaries have a choice of quality Medicare Managed care plans, it is imperative that Congress pass legislation. Such legislation could take the form of a straight extension, under which the date the withdrawal obligation becomes effective is pushed back for three years. In the alternative, Congress could modify the current two plan test to require, as a condition of a cost plan needing to exit a market, that the two competing MA plans must both have minimum enrollment levels (as currently required) and also have a star rating equal to or greater than the star rating of the Medicare cost plan that would be required to withdraw.

Such changes could be enacted in conjunction with policy changes that would more closely align the Medicare cost plan requirements with those under the Medicare Advantage program and promote value-based purchasing, for example, by:

- Augmenting cost plans' current quality assurance program requirements by adding the Medicare Advantage requirements to have a chronic care improvement program and to conduct quality improvement projects;
- Allowing cost plans to be accredited by private accreditation agencies for certain quality requirements, as currently permitted for Medicare Advantage plans;
- Allowing cost plans to offer mandatory supplemental health care benefits in the same manner as Medicare Advantage plans;
- Applying the Medicare Advantage preemption of state law provisions (except licensure and solvency requirements) to cost plans;
- Applying the restrictions on imposing premium taxes on cost plans in the same manner that they apply to Medicare Advantage plans; and
- Permitting CMS to promote the offering of employer group health plans by approving waivers of requirements that would hinder the design of, offering of, or enrollment in cost plans.

## **V. CONCLUSION**

In closing, we once again appreciate the opportunity to testify before the Subcommittee. As we discussed, cost plans have a long history of providing high quality, affordable care to Medicare beneficiaries. In addition, cost plans have been an extremely stable plan offering for beneficiaries. It is imperative that Congress enact legislation this year necessary to prevent 230,000 beneficiaries from losing their Medicare cost plans on January 1, 2014 when there is no assurance that those beneficiaries will have ongoing access to high quality plan choices. We look forward to continuing to work with members of this Committee in meeting that important objective.