

Getting Our Money's Worth

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The surge in enrollment in Medicare private health plans over the last three years, and the negative impact this growth has on Medicare's financial outlook, has prompted a debate in Congress over how much these plans should be paid.

The House of Representatives passed the Children's Health and Medicare Protection (CHAMP) Act, which over time would have put payment to Medicare private plans, officially called Medicare Advantage plans, on par with costs under Original Medicare. In conference with the Senate, the CHAMP Act fell by the wayside, but House leaders insist that they will continue to fight for payment parity.

The Senate has yet to weigh in on Medicare Advantage payments, but discussions have begun among members of the Senate Finance Committee on next steps. The question for the Senate is how much to pay Medicare Advantage plans, as well as which types of plans and which areas of the country should receive the most generous subsidies.

There is another question looming, however: What should taxpayers and people with Medicare expect from the Medicare Advantage plans in exchange for the subsidies they receive?

Here is the short list:

Medicare Advantage plans should provide benefits at least as good as Original Medicare. Plans should not charge more than Original Medicare for hospital admissions, nursing home stays, chemotherapy or wheelchairs. Also, plans should be barred from designing benefit packages that look like they provide full coverage, but contain loopholes that punish people who need expensive care. For example, Congress should prohibit plans from carving out chemotherapy and other doctor-administered drugs from the limits they provide on annual out-of-pocket spending by plan enrollees.

Medicare Advantage plans should not engage in fraudulent, deceptive or overly aggressive marketing tactics. The Centers for Medicare & Medicaid Services (CMS) has shown over the last year that it is unable to prevent such marketing misconduct by the plans and unwilling to enforce marketing guidelines with stiff sanctions. State insurance departments, which have decades of experience in regulating the marketing of insurance, need to be allowed to hold Medicare Advantage plans to account for the abusive marketing practices of their sales agents. We need one set of marketing rules and an additional 50 cops on the beat policing the plans.

Medicare Advantage plans should not be allowed to erect bureaucratic hurdles that prevent older adults and people with disabilities from getting the care they need. There is widespread failure by the plans to abide by the timelines and follow the procedures when their plan members appeal denials of coverage of medical care and prescription drugs, according to a review of corrective action plans imposed by CMS. Those corrective action plans, however, amount to little more than admonitions by CMS that plans must abide by the rules. Congress needs to instruct CMS that Medicare Advantage plans must have in place basic consumer safeguards as a precondition for payment.

It is time for Congress to stand up and tell the insurance industry: "We will pay plans what they are worth—what it would cost Original Medicare to care for a plan enrollee—and we expect plans to deliver high-quality benefits and that means smart, humane and cost-effective coordination of care."

Companies that use deception to market their plans and prevent enrollees from receiving the care they need can take a hike.”

Medical Record

“Mrs. B lives in Suffolk County, New York. She has ovarian cancer and receives chemotherapy. When she became eligible for Medicare in June 2006, she chose a Medicare Advantage plan because she had contacted the plan and been told it would cover all costs associated with the chemotherapy. However, for her last two treatments, she was charged copays totaling about \$3,000. When Mrs. B’s daughter-in-law contacted the plan, she was told that the charge represented copays for medications supplied under Part B” (Statement by Paul Precht, Policy Coordinator, Medicare Rights Center, before the House of Representatives Committee on Ways and Means Subcommittees on Health and Oversight, [“Statutorily Required Audits of Medicare Advantage Plan Bids,”](#) October 16, 2007).

“Many plans charge more for chemotherapy and other physician-administered drugs than the 20 percent coinsurance charged under Original Medicare. Even more commonly, plans carve-out chemotherapy and other Part B drugs from the annual caps they place on enrollees’ out-of-pocket spending on medical services—if they have a cap. Some plans do both—charge more for chemotherapy and carve this service out of their out-of-pocket cap. These practices are unacceptable. They discriminate against people with cancer and other illnesses that require treatment with high-cost drugs administered by their doctor” (Statement by Paul Precht, Policy Coordinator, Medicare Rights Center, before the House of Representatives Committee on Ways and Means Subcommittees on Health and Oversight, [“Statutorily Required Audits of Medicare Advantage Plan Bids,”](#) October 16, 2007).

“In 2007, CBO estimates, the average payment to such [MA] plans is 12 percent above traditional FFS costs. The differential is larger for private fee-for-service plans: According to estimates by the Medicare Payment Advisory Commission (MedPAC), the payments to those plans in 2006 averaged 19 percent above FFS costs. Of that difference, 10 percentage points’ worth went to beneficiaries in the form of extra benefits or rebates. In contrast, payments to HMOs averaged 10 percent above FFS costs, MedPAC estimates. On average, HMOs offered extra benefits and rebates equal to 13 percent of FFS costs; those additional benefits and rebates reflected the difference between the benchmark (which averaged 10 percent above FFS costs) and the plans’ bids (which averaged 3 percent below FFS costs)” (Congressional Budget Office, [Medicare Advantage: Private Health Plans in Medicare, Economic and Budget Issue Brief,](#) June 28, 2007).