



Medicare Rights Center

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**Joint Hearing on
“Statutorily Required Audits of
Medicare Advantage Plan Bids”**

**Before the United States House of Representatives
Committee on Ways and Means
Subcommittees on Health and Oversight**

October 16, 2007

Chairman Stark, Chairman Lewis, Ranking Members Camp and Ramstad, Members of Congress, thank you for this opportunity to testify at this joint hearing by the Health and Oversight Subcommittees of the House Committee on Ways and Means. I am Paul Precht, Deputy Policy Director for the Medicare Rights Center and director of our Washington office.

Founded in 1989, the Medicare Rights Center is the largest independent source of information and assistance to people with Medicare. For the past two years, our staff and volunteer counselors have been preoccupied with two interrelated types of cases—helping victims of deceptive, fraudulent and abusive marketing by private Medicare plans, and helping people enrolled in those plans obtain coverage for the medical care, including prescription drugs—that they need.

The subject of today's hearing—the oversight of private Medicare Advantage plans by the Centers for Medicare & Medicaid Services (CMS)—goes to the heart of this work. The laxer CMS' oversight of these private Medicare plans is, the more problems with Medicare Advantage plans we see. The looser the rules CMS sets for private plans, the harder it is for our clients to get the medical care they need.

In its report presented today, the Government Accountability Office (GAO) describes how CMS failed to conduct the audits of Medicare Advantage plans mandated by law, and, when it did audit plans, failed to recoup subsidies that the audits showed had been misused by the plans. These audits are tests by CMS to see if the plans' benefit packages were actuarially equivalent to the amount of money the plans were being paid. A failure to meet this test means that plan enrollees are not getting the benefits they deserve and taxpayers are not getting their money's worth.

Let me be clear. The Medicare Rights Center does not believe that this test of actuarial equivalence is sufficient to guarantee that Medicare Advantage plans provide the benefits people need. It does not ensure that for specific services—in particular for services like home health care, inpatient hospital care, skilled nursing facilities and chemotherapy that are used by very sick people—the benefits provided by many Medicare Advantage plans are as good as the coverage provided under Original Medicare. It is a test that the coinsurance and copayments across all Medicare-covered services is, on average, on par with what Original Medicare charges.

The inadequacy of this test, and the failure of plans to meet even this extremely low bar, means that an individual with a chronic or acute condition—someone recovering from a stroke in a skilled nursing facility, someone admitted to the hospital after a heart attack—can pay more out-of-pocket under a Medicare Advantage plan than he or she would under Original Medicare, even though taxpayers are paying the plan more than they would under Original Medicare.

Individuals who enroll in Medicare Advantage plans cannot purchase supplemental coverage to cover the gaps in the benefit like they can under Original Medicare. Medicare Advantage plans, and private fee-for-service plans in particular, are being marketed as low-cost alternatives to supplemental insurance, yet they often fail to provide the protection against catastrophic medical expenses that people receive under any of the standard supplemental “Medigap” plans. Health insurance that works when you are healthy, but cuts out when you are sick, is not what Medicare has offered for over 40 years.

True Story

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. Her daughter told the counselor that if they had been told this in the beginning, they would have stayed with Original Medicare. Fortunately, Mrs. B was still in the Open Enrollment Period and could change back to Original Medicare by March 31. If she had learned of her chemotherapy copayments in April, she would have been locked in to the plan for the rest of the year.

Unfortunately, the poor coverage that Ms. B received for chemotherapy under her Medicare Advantage plan is not unusual. In researching a recent report on the benefits of standardizing Medicare Advantage benefit packages, the Medicare Rights Center found that 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. There are two profit-maximizing motives for these policies: force very sick patients to pay for their health care out-of-pocket and drive sick patients out of these plans and, typically, back into the safe haven of Original Medicare.

CMS has the authority to prohibit such plan designs as discriminatory. Such plans continue to be approved by CMS, however, because the agency takes an overly restrictive view of its legal authority to prohibit discriminatory benefit packages. In 2004, the Medicare Payment Advisory Commission (MedPAC) recommended that CMS exercise its full authority to reject

plans that have benefit designs and cost-sharing structures that discriminate on the basis of health status. Still, CMS has not acted. We look to this Committee to find out why.

It is time for Congress to mandate that CMS protect Medicare Advantage enrollees against such practices. One way to do that is to enact legislation, such as that included in the House-passed CHAMP Act, which would bar plans from charging more for specific medical services, such as chemotherapy, home health care or hospital admissions, than is charged under Original Medicare.

CMS does encourage plans to set a comprehensive cap on annual out-of-pocket spending on medical services. Plans that set such a cap at a low enough level—for 2008 it is the minimum amount spent by the 25 percent of people with Medicare with the highest out-of-pocket costs—are given greater flexibility by CMS in setting cost-sharing for individual services. In practice, this standard is so vague as to be meaningless.

In our review of plan benefit packages, we found that most plans had no out-of-pocket caps, or set caps well above the threshold recommended by CMS, yet many of these plans charged higher copayments and coinsurance than Original Medicare for chemotherapy, hospital and skilled nursing admissions and home health care. Another option for Congress would be to put teeth in this standard. No plan could charge more than Original Medicare for any specific service unless it set a low enough limit on annual out-of-pocket spending that applied to all Medicare-covered services.

There are some policymakers who will oppose stricter regulation of Medicare Advantage plans, preferring to let the marketplace cure abuses over time. These policymakers look to the Federal Employee Health Benefits Plan as a model worth of emulation. Under this system, Members of Congress and other federal employees choose from a private plan approved by the

Office of Personnel Management (OPM). Although Congress gave CMS authority similar to the power OPM has to approve health benefit plans for federal employees, the results are quite different. The Medicare Rights Center recently reviewed the benefit packages available to federal employees living in Northern Virginia. Each of these plans set a cap on enrollees' out-of-pocket spending on medical care. Not one of these plans excluded chemotherapy or other vital medical services from these caps. People with Medicare deserve the same protections from profit maximizing insurers that Members of Congress and other federal employees enjoy.

Congress should also remove the special exemptions that apply to private fee-for-service plans, the fastest growing and, for taxpayers, the most expensive type of private Medicare plan. In particular, private fee-for-service plans are exempt from the same review of their bids and benefit packages that HMOs and other Medicare Advantage plans undergo. That means that neither you nor the Administration has any idea if taxpayers are getting their money's worth from these plans—even the lax and inconsistent reviews by CMS that the General Accountability Office exposed in its recent report do not apply to these plans. There is also no review of whether the premiums that people with Medicare pay for these plans actually fund improved benefits or simply line the pockets of shareholders. The Administration has told this Committee it supported subjecting private fee-for-service plans to the same review as other Medicare Advantage plans. It is time for Congress to heed this advice.

There is another reason the market alone cannot sort out the good plans from the bad. The sheer number of plans—in many localities there are over 50 to choose from—and the dizzying variety of plan designs makes it impossible for even the savviest consumer to choose the right plan. Even MedPAC researchers, an astute bunch, could not determine with any certainty which plans provided comprehensive caps on out-of-pocket spending, and which plans exempted

certain services. Most people will not discover the loopholes in their coverage until they fall ill and find the drug they need is not covered or the coinsurance for a specific service is exorbitant. Enrollees who were happy at the low premium they paid quickly become angry that the coverage they were promised did not pan out.

Research has consistently shown the gamble that people with Medicare take when they enroll in a private Medicare plan. MedPAC researchers found that the coinsurance for a chemotherapy regimen for colon cancer ranged from under \$2,000 to over \$7,000 in the plans they studied. The Commonwealth Fund modeled costs for individuals in poor health under 88 Medicare Advantage plans. In 19 of those plans, including plans with substantial shares of their local markets, sick individuals would pay between \$285 and \$2,195 more than they would under Original Medicare with a Medigap Plan F, the most popular supplemental plan.

Congress needs to look to the reforms enacted for supplemental Medigap plans as the model for how to help people with Medicare make an informed and appropriate selection of a private Medicare plan, if that is what they want. Medigap insurers can only market plans from a defined menu of benefit packages, each of which provides protection against catastrophic medical expenses. These plans compete on the basis of premium. They are prohibited from designing benefit packages that appear attractive at first blush, but prove to be riddled with loopholes and traps. The standardization of Medigap plans has substantially reduced the consumer confusion that once surrounded these plans and that made people with Medicare so vulnerable to aggressive and deceptive marketing. With standard benefit packages it would be easier for consumers to know what they are buying and for CMS, through the audit process under discussion today, to figure out if taxpayers were getting their money's worth.

The audits and other reviews of Medicare Advantage plans that we have been discussing concern the benefits these plans provide on paper. For those benefits to become real for people with Medicare, plan enrollees must actually be allowed to use the service. A low copayment for hospital admission does no good if the plan will not cover the surgery. Drug coverage is useless if your plan will not authorize coverage of the medicine you need.

This is another area where plan performance, and CMS oversight, is lacking. A review of the recently released corrective action plans imposed on private Medicare plans by CMS shows that 94 percent of plans audited failed to meet CMS requirements on handling appeals and grievances. Plans commonly fail to issue timely notices of denial when they refuse to cover prescription drugs or medical services. Those denial notices often fail to explain the reason for the denial and at least one company failed to have medical doctors conduct the reviews of denials, as required by CMS. Without a prompt denial notice that explains the reason why the service is denied, plan enrollees cannot effectively pursue their appeal rights. In fact, they may not even know that they have appeal rights. The failure of plans to implement these fundamental safeguards means that the access to benefits promised to plan enrollees may never be realized. Despite the seriousness of these offenses, the corrective action plans imposed by CMS do little more than admonish the plans to ‘do a better job’ and follow the guidance they have already flouted.

We began this testimony by recounting the experience of Mrs. B and the high copayments she was charged for chemotherapy by her private Medicare plan. The other aspect of Mrs. B's story—the false promises she received from plan representatives that her chemotherapy would be fully covered—illustrates the deception that is too often used in the marketing of Medicare Advantage plans. A CMS official recently told a conference of health plans that the

reports of deceptive and fraudulent were not abating, but were “growing in intensity and volume.” We know now from the corrective action plans released by CMS that such marketing misconduct was widespread in large part because the Medicare Advantage plans do not have systems in place to prevent it. Agents are inadequately trained and supervised and not properly licensed. Plans do not consistently track rapid disenrollments, which should call attention to agents who misrepresent plans and sell plans that are ill-suited for the individual enrolled. Plans did not properly conduct calls to verify that new enrollees understood their new plan, either failing to make such calls or calling when the selling agent was present and able to coach the new enrollee on how to answer questions. Faced with the absence of these basic safeguards, CMS’ response is to insist, at some future date listed in the corrective action plan, that the company actually do what is already required of it.

Admonitions by CMS to do better are inadequate. Companies need to face consequences—substantial monetary sanctions or freezes on enrollment-- for failing to abide by marketing rules. Implementation of basic consumer safeguards should be a precondition to participation, not a goal that companies will get around to eventually. The contrast between the detailed and thorough market conduct examination conducted on Humana by the Oklahoma Insurance Commissioner and the cursory summary of Humana’s marketing violations in CMS’ corrective action plan illustrates two divergent approaches to oversight. The difference in fines imposed on a company with over \$20 billion in annual revenue is also indicative: \$500,000 by Oklahoma, \$75,000 by CMS.

The pattern is clear. Whether it concerns marketing violations, denial of appeal rights or the inflated bids discovered upon audit, the response by CMS is not to punish the plans for misbehavior, not to recover for taxpayers the money we have paid for services not delivered, but

to wag their finger at the plans. When oversight is lax and enforcement is absent, enrollees in Medicare Advantage plans are shortchanged on their benefits and their access to care is compromised. We applaud this Committee for holding this hearing and urge you to do what you can to ensure that CMS makes all private Medicare plans play by the rules.

The report referred to in this testimony authored jointly by the Medicare Rights Center and California Health Advocates is called “Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans.” It is available at http://www.medicarerights.org/MRC-CHA_MAsstandardization.pdf.



Medicare Rights Center



CALIFORNIA HEALTH ADVOCATES

Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans

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www.medicarerights.org

This Issue Brief is the sixth and last in a series on Medicare drug benefit issues for consumers drafted by California Health Advocates (CHA) and the Medicare Rights Center (MRC), with support from the California HealthCare Foundation.

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Executive Summary

This report posits that people with Medicare would be better able to make informed decisions about their coverage options and be more likely to receive protection against high out-of-pocket spending on health care if Medicare private health plans—so-called Medicare Advantage plans—were only allowed to offer a finite number of standardized benefit packages.

There is a marked difference between choosing among competing private Medicare health plans and selecting a supplemental “Medigap” policy. (Medigap policies are sold by private insurers and receive no government subsidy. They cover gaps, such as deductibles and coinsurance, in the standard Medicare benefit.) There are a limited number of Medigap benefit packages, all of which provide financial protection against catastrophic illness. By contrast, there is no limit on the variety of benefit designs employed by Medicare private health plans and no guarantee of protection against exorbitant medical bills.

Combining a review of recent research with an examination of the benefit packages offered to people with Medicare in 2007, the report demonstrates that there are serious deficiencies in the benefit packages of Medicare private health plans. Among the shortcomings detailed in the report

- consumers suffering from chronic illness can incur widely varying levels of cost-sharing under different plans;
- many plans do not provide a limit on enrollees’ annual out-of-pocket spending for medical services or exempt certain services, such as chemotherapy, from such limits;
- many plans charge more than Original Medicare for specific services, such as inpatient hospital care, nursing home stays or home health care.

The report finds that the current marketplace for Medicare private health plans, which is characterized by an increasing number of plans with widely varying benefit designs, makes it nearly impossible for consumers to discover the shortcomings in plans’ benefit design. Informed choice is made more difficult by the aggressive marketing of Medicare private health plans and an over reliance by consumers on the information supplied by agents and brokers with a financial interest in pushing specific plans. Only a fraction of consumers utilize web-based plan comparison tools or advice from trained counselors in the State Health Insurance Assistance Program in selecting plans.

Today’s marketplace for Medicare private health plans bears marked similarities to the marketplace for Medigap plans before Congressional action mandated the standardization of these plans, a reform that successfully enhanced consumers’ understanding of their plan options and decreased the incidence of deceptive and abusive marketing. The regulatory structure for Medicare private health plans fails to prohibit benefit designs that disadvantage individuals with serious illnesses and does not provide consumers with the means for making an informed choice of plans. Drawing from its prior experience regulating Medigap plans, Congress should create a process to develop a limited number of benefit packages for Medicare private health plans that meet minimum standards of consumer protection.

Introduction

Enrollment in Medicare private health plans has risen by over three million since 2003, with the fastest increase concentrated among private fee-for-service (PFFS) plans that are marketed as low or zero-premium alternatives to supplemental Medigap plans.¹ This enrollment surge has been accompanied by a sharp rise in reports of aggressive and deceptive marketing of Medicare private health plans (also referred to as Medicare Advantage plans).² Besides the more lurid stories of marketing abuse—individuals who were enrolled in plans without their knowledge or tricked into signing enrollment forms—counselors, advocates and insurance brokers have also fielded complaints from new Medicare private health plan enrollees who do not understand that they no longer receive the same protection against out-of-pocket spending for medical care that they had under their Medigap policies, are surprised that they cannot see their regular doctors and are devastated when they are hit with high medical bills under their new plans.

To many observers, the current Medicare private health plan marketplace is reminiscent of the Medigap marketplace of the late 1980s. At that time, people with Medicare faced a dizzying array of Medicare supplemental insurance policy choices that were difficult to understand and impossible to compare. The confusion made older adults vulnerable to sale of duplicative policies and to “churning”—being switched from one Medigap policy to another by overly aggressive brokers seeking to maximize commissions.³ Congress responded to this situation with a series of reforms in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The centerpiece of these reforms was a mandate to the National Association of Insurance Commissioners to develop a limited number of standardized Medigap benefit packages that all insurers could sell.

The OBRA 90 reforms were a success.⁴ Following OBRA 90, it was easier for consumers to compare supplemental insurance products and prices and to choose the health benefits they needed at a known cost.⁵ In addition, complaints about plans and agents were reduced.⁶ There are no hidden out-of-pocket costs in these products and no changes to their benefits once enrolled. Standardization has focused competition on premium pricing.⁷ Over the years, choosing a Medicare supplement policy has become one of the easier insurance decisions older Americans are required to make. It allows this population, the majority of whom are on a fixed income, to budget for their annual health care expenses, although the premium is often unaffordable for people with Medicare who have low incomes.

This report looks at the difficulties consumers face in selecting a Medicare private health plan and the deficiencies in the benefit structures of these plans. It makes recommendations for how Congress can remedy these twin problems by creating a process to standardize benefit packages.

Decisions Facing Consumers

The selection of a Medicare private stand-alone drug plan or private health plan can have serious and irreversible consequences for the coverage a person with Medicare can receive. Mistaken individual enrollment in a Medicare stand-alone drug plan or a private health plan can cause a former employer to drop a retiree from a group plan offering comprehensive drug and

supplemental medical coverage, sometimes without the possibility of reinstatement. People who disenroll from a Medicare private health plan and return to Original Medicare typically have no right to a Medigap policy.⁸ Most people enrolled in a Medicare private stand-alone drug or health plan will find themselves locked into their plan—and locked out of a more appropriate coverage choice—for the calendar year. Aggressive and deceptive marketing tactics, underfunding for counseling services and a confusing marketplace of coverage options increase the likelihood that consumers will make the wrong choice and suffer a reduction in coverage and access to health care services as a result.

A common choice facing consumers—choosing between coverage under Original Medicare with a Medigap plan and a stand-alone drug plan or enrollment under a Medicare private health plan with drug coverage—provides a revealing illustration.

For people with Medicare who have incomes too high to qualify for assistance through the Medicaid program or who do not have supplemental insurance from their union or former employer, a supplemental Medigap policy is the most popular option to fill gaps in the Original Medicare benefit.⁹ A Medigap plan provides coverage for specific gaps in the Original Medicare benefit package and preserves access to the full range of Medicare providers whether an individual seeks care in his or her own home town or while traveling within the United States.

In the 17 years since Medigap plans were standardized and insurance companies limited to the sale of standardized plans, 65 percent of consumers have purchased just two plans that provide the most comprehensive first-dollar coverage.¹⁰ People with Medicare have indicated a strong preference to pay the premiums these plans require to have protection against unanticipated medical expenses of unknown amounts.

With the subsidies Medicare private health plans receive for providing standard Medicare benefits, they have begun marketing themselves as low-premium, or no-premium, alternatives to Medigap policies. But Medicare private health plans are subject to much less stringent regulation of the benefit packages they provide than Medigap supplemental policies. As a result, people with Medicare have a much more difficult time comparing the benefits offered by these plans to competing Medicare private health plans, to Original Medicare or to the benefits provided by a Medigap supplemental policy. More seriously, enrollees in these Medicare private health plans who fall ill can find themselves hit with high bills for medical expenses and with no protection against catastrophic expenses for medical care.

The choice between Original Medicare with a Medigap supplement and coverage under a Medicare private health plan requires consumers to weigh restrictions on access to providers, utilization management restrictions on access to medical care and exposure to out-of-pocket spending, including premiums, copayments and coinsurance for specific medical services (information that is not easily accessible). Consumers must also compare the drug coverage available under a Medicare private health plan and a stand-alone drug plan.

Drug Coverage

Since 2006, insurers have been barred from selling Medigap plans that include prescription drug coverage. The new Medicare Part D prescription drug benefit is available only through private plans, either stand-alone drug plans or Medicare private health plans with drug coverage; there is no option to receive drug coverage directly through Medicare. Selecting the most suitable drug coverage presents a similar comparison exercise whether the plan is offered as part of a Medicare private health plan or as stand-alone coverage.

Consumers must determine whether a plan covers their drugs, whether the restrictions it imposes (prior authorization, step therapy, quantity limits) impedes coverage and whether the plan's combination of premiums, copayments and other out-of-pocket costs and drug pricing make it the "best buy." Consumers must also determine whether the pharmacies of their choice participate in the plan, particularly mail-order pharmacies. Prices on individual drugs can change at any point during the year as can formulary coverage (although plans are currently required to grandfather coverage for the remainder of the year for members already taking a drug). Given the impossibility of predicting future diagnoses, and the drugs that will be prescribed as treatment, there is little ability to assess the value of coverage under a different drug regimen from the current one.

Provider Access

Nearly all hospitals, skilled nursing and other post-acute care facilities, and over 90 percent of doctors, accept assignment by Medicare (meaning they agree to accept the Medicare-approved amount as payment in full).¹¹ Nearly all these providers accept supplemental coverage from any Medigap plan.¹²

Provider access under a Medicare private health plan is more difficult to determine. Potential enrollees in HMOs, which only cover services provided by network providers except in emergencies, can check to see if their current doctors and local hospitals are in the plans' network. But HMOs can drop providers from their networks or providers can decide they no longer accept a plan at any point during the calendar year, when plan members are locked into the HMO. Since plan members cannot predict what conditions they may get and if the specialist they need will be in the plan's network, they are left having to plan for an unknown future based solely on their needs today. Potential enrollees in preferred provider organizations (PPOs) face the same risk and must also determine whether out-of-pocket costs for out-of-network services are prohibitive or provide affordable access as an alternative to a network provider. The risk is greatest to potential enrollees in private fee-for-service (PFFS) plans. Although enrollees can seek care from any provider willing to accept the plan's rates and rules, providers who do not have written contracts with the plan—the overwhelming majority of PFFS providers—decide whether to accept the plan with each visit or treatment. A provider that accepts the plan one day may decline it the next time.¹³

Utilization Management

An assessment of the medical benefits provided by Medigap and Medicare private health plans involves a comparison of the utilization restrictions imposed on medical services and the premiums and other out-of-pocket costs the plans impose. Medigap plans do not restrict utilization; they must rely on Medicare's payment determinations and cover services paid for by Original Medicare. Medicare private health plans also provide coverage for all procedures that Original Medicare covers, but can impose conditions on coverage that restrict or improve access to services and they can set their own out-of-pocket costs for different covered services. For example, Medicare private health plans can eliminate the requirement imposed in Original Medicare that a stay in a skilled nursing facility is preceded by a hospital stay of at least three days. At the same time, Medicare private health plans can impose a range of additional restrictions, from requiring referral from a primary doctor for specialist care to requiring members to get permission from the plan (prior authorization) before a hospital stay, surgery or durable medical equipment purchase.

Out-of-Pocket Costs

The most important factor for most consumers when trying to make a choice is cost. The cost information presented to consumers to entice them to join a Medicare private health plan can be misleading. When choosing a Medigap plan, however, consumers can be sure of what they are getting.

Consumers can choose from 12 standard Medigap plans, two with high deductibles. All plans cover Medicare out-of-pocket costs for lengthy hospital stays and provide protection against high out-of-pocket expenses for Part B services (such as for chemotherapy or radiation treatment), either through full coverage of all Part B out-of-pocket costs or, in plans K and L, after annual cost-sharing has been met.

Consumers make the choice of paying a higher premium for coverage of the deductibles for Parts A and B¹⁴ or whether to pay a lower premium and pay a portion or all of Part B out-of-pocket costs below a cost-sharing limit (plans K and L and high-deductible plans F and J). In addition, consumers choose whether they want coverage of excess Part B charges when providers do not accept assignment (plans F, G, I and J) and whether to forgo coverage for Medicare cost-sharing (\$124 for days 21 through 100) for a lengthy stay in a skilled nursing facility (plans A and B). All companies offering Medigap plans offer at least one of the standard plans and compete on the basis of premiums, which are regulated at the state level.¹⁵

On the other hand, there are no standard benefit packages for Medicare private health plans. Every one of the dozens of plans available in a consumer's area may be structured differently. Plans may, or may not, limit annual out-of-pocket spending. Those that do can set the limit at any level and can exempt specific services, such as chemotherapy and other Part B drugs, from the limit. Hospital coverage may, or may not, include out-of-pocket expenses for lengthy stays in hospitals or skilled nursing facilities. Instead of the standard Part A deductible, plans often substitute per-day payments, but the wide range of chargeable days and daily rates makes comparison difficult and disguises out-of-pocket costs that can exceed the Part A deductible.

Similarly, plans can impose out-of-pocket costs on home health services that Original Medicare provides at no cost or shorten the number of days in a skilled nursing facility that are provided without copayment under Original Medicare. Medicare private health plans typically charge flat copayments for doctor visits but charge more for additional services, such as diagnostic tests, or procedures, such as chemotherapy.

Benefit designs that have higher out-of-pocket costs for certain types of care generally favor the healthy, so relatively healthy people may think a private health plan will be a good deal until they are diagnosed with cancer or another health condition that requires extensive medical care. Then they may face high out-of-pocket costs they never counted on and realize they would have been better off under Original Medicare with a Medigap supplement. At that point, they are locked into their health plan choice for the rest of the year and may not be able to buy a Medigap supplement when they can change plans.

Medicare Private Health Plan Benefit Packages: Unhealthy for Consumers

Recent research shows how Medicare private health plans' benefit packages can disadvantage certain plan enrollees, particularly those with severe or chronic illnesses.

Under a mandate from Congress, the nonpartisan Medicare Payment Advisory Commission (MedPAC) issued a report in December 2004 looking at the extent Medicare private health plans' benefit designs affected access to Medicare-covered services and discouraged enrollment of sicker individuals.¹⁶ In part, because of limitations on the data available, the MedPAC report drew no conclusion on whether benefit designs skewed enrollment toward healthier individuals. But the report did find numerous examples of plan designs that imposed disproportionately high out-of-pocket costs on medical services needed by seriously ill individuals and plans that left enrollees exposed to high out-of-pocket expenses for specific services. Surveying 505 plans accounting for 90 percent of Medicare private health plan enrollment, MedPAC found the following:

- Fifty-four percent of plans charged 20 percent or more for Part B drugs (which include chemotherapy drugs). Two-thirds of those plans had no limit on annual out-of-pocket spending. The remaining third had some form of cap on member spending, although researchers could not determine if the cap applied to some or all Part B drugs.
- Nineteen percent of plans charged 20 percent or higher for radiation therapy services, with only one-third capping out-of-pocket spending.
- Twenty-two percent of plans charged comparable or higher amounts for inpatient hospital care. One-third of those plans had no catastrophic protections.
- Fifty percent of enrollees were in plans with no cap on out-of-pocket spending. Twenty percent were in plans with a cap that applied only to inpatient hospital care. Thirty percent were in plans with caps that applied to inpatient hospital care and at least some other Medicare services.

The MedPAC report also compared the cost of treatment for colon cancer in the three Medicare private health plans with the largest enrollment in the country. Looking only at the costs of the chemotherapy regimen, and excluding related costs such as for anti-nausea medications, researchers found annual out-of-pocket spending that ranged from \$1,990 on the low end to \$6,550 and \$7,100 on the high end. The two high-cost plans had greater-than-average rates of plan members who left the plans because of the cost of premiums, copayments or coverage issues. (Those disenrollment rates occurred before the imposition of lock-in; Medicare private health plan members are now generally barred from leaving their plan until the next year.)

A November 2006 report by the AARP Public Policy Institute shows how Medicare private health plans have used the flexibility they have in benefit design to lower out-of-pocket spending for individuals in good health while raising out-of-pocket costs for those with serious or chronic illness. Between 1999 and 2005, average annual out-of-pocket expense in the lowest-premium Medicare private health plans for medical and hospital services for individuals in good health rose from \$117 to \$166, but then dropped to \$73 in 2006. During the same time period, out-of-pocket costs for individuals in poor health rose from \$258 in 1999 to \$1,219 in 2005, remaining essential flat in 2006.¹⁷ It is worth noting that this disproportionate rise in out-of-pocket expenses for individuals in poor health was maintained during the 2003-2006 period when Medicare private health plan overpayments were rising and full-risk adjustment of payments was being phased in.

The same period also saw a dramatic rise in out-of-pocket costs imposed for inpatient hospital services. In 1999, just 4 percent of the lowest premium Medicare private health plans charged any copayments for hospital admission. In 2006, 89 percent of Medicare private health plans impose such copayments. Between 2002 and 2006, the average out-of-pocket cost for a three-day hospital stay rose from \$271 to \$371, while the average annual cost for two six-day stays and a three-day stay rose from \$900 to \$1,429. These rates of increase, 37 percent and 59 percent, respectively, substantially outstripped the 17 percent rise in the inpatient deductible (\$952 in 2006) under Original Medicare over the same period.¹⁸

Researchers found that 56 percent of the lowest premium Medicare private health plans offering drug coverage had no out-of-pocket limit on medical expenses. More than half of the plans with limits set caps at more than \$2,500. The authors concluded that the structure of most Medicare private health plans does not protect individuals with extensive health care needs from substantial out-of-pocket spending.¹⁹

A May 2006 Commonwealth Fund report also shows how the benefit designs employed by some Medicare private health plans can impose disproportionately high cost-sharing burdens on individuals in poor health. The paper compares the out-of-pocket spending for individuals in good, fair or poor health under Medicare private health plans to what similar individuals would spend under Original Medicare with a Medigap Plan F offered at a community-rate premium (premium does not take into account age or health status).²⁰

Looking at 88 plans marketed in 44 localities around the country with substantial penetration by Medicare private health plans, researchers found that 19 of the 88 plans imposed greater cost-sharing for inpatient hospital stays, doctor visits and other medical care than a person would pay

under Original Medicare with a Medigap Plan F supplement. This array of services cost plan enrollees between \$285 and \$2,195 more per year under these nineteen plans than under Original Medicare with a Plan F Medigap.

Yet the plans with high out-of-pocket costs did well in the market. The 19 plans accounted for over 340,000 Medicare private health plan enrollees; 5 of the 13 plans with more than 20 percent of the local Medicare private health plan market imposed these higher costs on their unhealthy enrollees. One of the worst plans, with a benefit design that resulted in nearly \$2,000 in additional expenses for the sampled services, had garnered nearly a quarter of the local Medicare private health plan market.

The wide variation in potential liability for out-of-pocket spending prompted the report's authors to recommend increased standardization of Medicare private health plan benefit packages, including a requirement that plans set reasonable caps on annual out-of-pocket spending.

These reports illustrate the potential pitfalls for consumers as they seek to enroll in a plan that provides financial protections against unforeseen illness. The disturbing trend toward ever-higher copayments for hospital admissions also shows how plans' ability to alter benefit designs on an annual basis presents plan enrollees with an annual dilemma—whether to stick with the plan they have or shop around, assuming enrollees know that plan benefits have changed. The Centers for Medicare & Medicaid Services' (CMS) review of plan benefit designs seems unable to prevent substantial numbers of plans from shifting costs onto their sickest, most vulnerable enrollees. Medigap plans, on the other hand, cannot alter the plan benefits offered, and those plans are guaranteed renewable as long as premiums continue to be paid.

But the case for standardizing Medicare private health plan benefits rests as much on the irregular benefit design as it does on more widespread deficiencies, such as the absence of caps on out-of-pocket spending. These types of loopholes in plan benefits are the least likely to be noticed by consumers and the most likely to come as a surprise when illness strikes. Some of these coverage gaps—high out-of-pocket costs for home health services, for example—may be relatively rare, but the fact that relatively few plans adopt these features shows that it is feasible to mandate that plans forgo them. Major deficiencies—the absence of caps on out-of-pocket spending—are more common. Without minimum standards to ensure their adoption, Medicare private health plans that provide such comprehensive protection may be more likely to see enrollment by less healthy, higher-cost consumers, making it more difficult financially for plans to provide such coverage.

Overpayment to Medicare Private Health Plans Have Not Eliminated the Problems

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sharply increased payments to Medicare private health plans and changed how the Centers for Medicare & Medicaid Services (CMS) reviews plan benefit packages. Yet all of the problems in Medicare private health plan benefit design presented in the reports mentioned above remain in the 2007 plan offerings. Our own review of two categories of plans—the private fee-for-service (PFFS)

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plans with a national presence and the health maintenance organizations (HMOs) marketed in a fully developed Medicare private health plan market, Los Angeles—shows that deficiencies in plan design are present in both types of plans.²¹

PFFS plans are the fastest growing type of Medicare private health plan, with nearly 1.5 million new members in just the last three years.²² They are also marketed as lower-cost alternatives to Medigap coverage under the promise—often false—that enrollees will have the same choice of providers that they have under Original Medicare. Given this marketing strategy, it is worth exploring how these plans stack up both against Original Medicare and against coverage with a supplemental plan.

To use one example, there are 20 PFFS plans available in Benton County, Arkansas, where CMS estimates between 15 and 25 percent of people with Medicare are enrolled in Medicare private health plans. Residents can obtain a Medigap Plan F, covering all Medicare cost-sharing for the monthly premium of \$118.83. High-deductible Medigap plans that initially retain Medicare out-of-pocket costs but begin covering all cost-sharing at \$1,860 are available at \$49.08, and a Medigap Plan L (Medicare out-of-pocket costs reduced by 50 percent, out-of-pocket spending capped at \$2,070) is sold for \$66.48.²³ None of these Medigap premiums are subsidized by Medicare.

Despite receiving subsidies from Medicare—the maximum payment rate in Benton County is \$195, or 34 percent higher than the monthly average cost of providing care under Original Medicare alone—not one PFFS plan provides equivalent protection against out-of-pocket spending under a low-premium plan. Just three plans provide lower comprehensive caps on out-of-pocket spending below the levels for Medigap Plan L, but premiums for enrollees range from \$98 to \$121. Between the premiums charged for these plans, and the excess payments from Medicare, the combined cost to consumers and taxpayers is likely over \$200 per month.²⁴

Premiums for PFFS plans in Benton County range from \$0 to \$121, and the benefits enrollees receive is subject to even wider variation and bear no clear relationship with the premiums charged.

WellCare markets three PFFS plans in Benton. Its most expensive option, the Summit plan, at \$121 per month, charges no copayments for doctor visits, hospital stays and numerous other outpatient services. The charge for Part B drugs, however, is the standard 20 percent; there is no cap on out-of-pocket spending. WellCare also offers a zero-premium plan, Concert, which includes a \$3,650 cap on out-of-pocket spending. That cap, however, does not cover Part B drugs, and the coinsurance rate for those drugs is set higher, at 30 percent.

WellCare is not the only PFFS plan in Benton County that charges more for Part B drugs than Original Medicare. SecureHorizons MedicareDirect Rx Plan 52 also charges 30 percent for Part B drugs, carving them out of the \$3,900 cap on out-of-pocket spending. This plan has several other unique features. It charges \$375 per day for the first 11 days of a hospital stay, which comes to \$4,125. The same 11-day stay in a hospital under Original Medicare would only cost \$992 (the standard Part A deductible). Even only factoring in the national average hospital stay

of six days, a person enrolled in the plan would pay \$2,250 while someone enrolled in Original Medicare (with no supplemental insurance) would pay \$992.













SecureHorizons also reverses the copayment structure for skilled nursing facilities from the way Medicare pays for this service. Under SecureHorizons, a stay in a skilled nursing facility costs \$160 per day for the first 25 days and is free for the next 75 days. Original Medicare assesses no copayment for the first 20 days and \$124 per day for the next 80 days. For the average length of stay—26 days—Original Medicare would cost \$744, while the SecureHorizons plan would cost \$4,000.

Post-acute care—skilled nursing facilities and home health care—is an area where enrollees in Medicare private health plans can find higher out-of-pocket costs. Two Medicare private health plans in Benton County charge their members for home health care, a service Original Medicare provides without charge. The two Sterling PFFS plans charge between 10 percent and 15 percent for home health care; neither limits out-of-pocket spending. Universal American's Today's Options plans also charge 15 percent for home health care, although these plans have caps on out-of-pocket spending that cover all medical services set at either \$2,500 or \$3,000. Humana's PFFS plans (\$5,000 comprehensive out-of-pocket cap) also begin charging earlier for stays in a skilled nursing facility, imposing \$90-per-day fees starting on the fourth day.

These are just a sampling of the problematic benefit features that consumers must be careful of as they compare benefit packages among the 20 competing PFFS plans in Benton County. Premium levels provide little guidance on the richness of the benefit. The most expensive plan, WellCare's Summit, provides no protection against high out-of-pocket spending on Part B drugs. For a \$10 premium, consumers can join Universal American's Today's Options Value plan, which caps charges for chemotherapy at \$150 per visit and includes all Part B drugs under a \$3,000 cap.

One zero-premium plan, SecureHorizons, charges substantially more than Original Medicare for an average stay in a hospital, while the Humana zero-premium plan charges \$550 per stay, a little more than half as much as Original Medicare. Neither plan offers coverage as good as Original Medicare for the average skilled nursing facility stay. UniCare's Secure Choice Classic charges nothing for the first 20 days in a skilled nursing facility and just \$25 per day for the next 80. There are, however, two catches: it does not come with drug coverage, and home health care comes with a 15 percent coinsurance—a service that Original Medicare provides for free.

Problems with PFFS Plan Benefit Packages: Benton County, Arkansas

Unexpected Cost-Sharing	WellCare Summit	WellCare Concert	Secure Horizons PFFS	Sterling	Today's Options	Humana	UniCare Secure Choice
No Cap on Annual Out-of-Pocket Spending							
Cap Excludes Part B Drugs							
Higher Coinsurance for Part B Drugs							
Higher Hospital Costs*							
Higher SNF Costs*							
Higher Home Health Costs*							

* Higher than Original Medicare

In Los Angeles County, out of the 10 Medicare HMO contracts with the highest enrollment, only one plan, offered by Kaiser Permanente, provides a comprehensive cap on out-of-pocket spending for medical expenses (set at \$4,000, higher than the limit of \$3,100 recommended by CMS) and sets limited copayments for Part B drugs. The Kaiser plan has a serious limitation, however, charging \$300 per day for an inpatient hospital stay. A hospital stay of 10 days, the point at which out-of-pocket costs end for hospital stays under the Kaiser plan, could amount to more than three times the inpatient deductible under Original Medicare.

Two HMOs, SecureHorizons and Citizens, cap annual out-of-pocket spending on some medical services but specifically exclude Part B drugs. Both companies, along with California Physicians' Service, offer plans that involve a trade-off: a tight network of doctors in exchange for brand and formulary coverage in the doughnut hole, no copayments for doctor visits and free or greatly reduced costs for hospital admissions, all for no premium. Enrollees in these plans may reasonably expect full financial protection for medical expenses, including drugs. However, their coverage for Part B drugs leaves them exposed to unlimited out-of-pocket spending.

Unfortunately, at least one plan shifts even more costs onto cancer patients in Los Angeles. Central Health Plan, the choice of nearly 2,000 Los Angeles residents, charges 30 percent for Part B drugs—10 percent higher than the rate under Original Medicare—with no cap on out-of-pocket spending. The plan charges no premium and no copayments for doctor visits or hospital admission and reduces the Part B premium by \$23.

Consumer Decision Making

This report, like prior reports by other researchers, shows that it is possible, with sufficient staff, time and expertise, to compare the benefit structures of a limited number of Medicare private health plans and discern where specific plans leave enrollees vulnerable to high out-of-pocket spending. It is not realistic, however, to expect most people with Medicare to make the same informed assessments of their coverage options, given what is known about how people with Medicare currently make choices about their medical and drug coverage. In addition, even if people with Medicare were able to find all the information on benefit structures, they do not have a crystal ball that can tell them whether they should choose the plan that offers better chemotherapy benefits or better skilled nursing facility benefits.

With no standardized options for Medicare private health benefit packages, the difficulty in making an appropriate choice of plan becomes a function of the number and complexity of plans available in the community. In Los Angeles, for example, there are 51 Medicare private health plans (including 15 special-needs plans for populations that meet specific criteria). A market this complicated can paralyze consumer decision making. As noted by a 2006 AARP Policy Institute survey of people with Medicare, “when older adults are faced with too much information to process and/or information that is complex and difficult to understand . . . it is likely to raise their level of anxiety and worry. In such situations, individuals often avoid the burden of decision making by simply making no decision and staying with the status quo.”²⁵

According to the Medicare Payment Advisory Committee (MedPAC), roughly half of people with Medicare relied on family and friends in selecting a Part D plan.²⁶ Family and friends are undoubtedly a great help, particularly to the 29 percent of people with Medicare who suffer from cognitive or mental impairments.²⁷ But informal advisers face the same obstacles in understanding plan coverage options. They have limited time to devote to plan selection and may have similarly low levels of health literacy.

The second-most used source of advice about Medicare options comes from insurance agents and the Medicare private health plans themselves, according to the same MedPAC report.²⁸ Given the financial incentives motivating insurance agents and the inadequacy of agent training provided by the plans, this source of advice is also problematic. Consumers cannot rely on a simplified comparison between plans as they can with a Medigap policy, making it more risky to rely on the representations of agents and brokers.

Few people with Medicare used the plan comparison tools developed by Medicare or obtained advice from a trained counselor, relying instead on information from the plans themselves. According to a report by MedPAC that included an analysis of how people obtained information about Part D coverage, “[i]n general, few focus group participants said they had used web-based tools or counselors to help them make decisions. They were more likely to mention company plan descriptions they received in the mail, phone calls to plans, and conversations with plan representatives at special events.”²⁹

In its assessment of Part D decision making, the AARP Policy Institute concludes that people with Medicare “do not adequately understand the differences among health plan design options.”

Therefore, the policy goal of improving quality and lowering costs through consumer choice is potentially compromised by the “multiple choices and complicated options.” As a remedy, the AARP paper suggests integrating the drug benefit into Original Medicare and standardizing “the options in a manner similar to the way Medigap plans are standardized to make them more comprehensible to beneficiaries.”³⁰

The Current Medicare Private Health Plan Regulatory Structure

Medicare private health plans play a dual role for consumers. They serve as an alternative means of delivering Medicare coverage, and consumers view the plans as a means for lowering cost-sharing under Medicare and for providing services not covered by Original Medicare.³¹ The current statutory and regulatory structure, however, fails to guarantee either that members of Medicare private health plans will receive the standard Medicare benefit or that the most glaring gap in the standard benefit—the lack of protection against catastrophic medical expenses—is filled. Individuals who enroll in a Medicare private health plan, unlike Original Medicare, cannot use supplemental insurance to fill the gaps or cover excessive cost-sharing in their Medicare private health plan.

All Medicare private health plans submit bids to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program, which estimates plans’ cost of providing Medicare coverage to each enrollee in the counties in which they operate. These bids, however, do not have to replicate the out-of-pocket costs under Original Medicare. This means plans can charge flat copayments for doctor visits instead of the 20 percent charged under Original Medicare. Instead of the \$992 deductible for a hospital stay, they can charge a per-day copayment. In its review of plan bids, CMS actuaries determine if the benefit package contained in the plan bid is actuarially equivalent **as a whole** to the standard Medicare benefit. Of course, that means that for any individual member, depending on what services are needed throughout the year, a member’s out-of-pocket costs could be higher or lower than if the member had been in Original Medicare alone.

Out-of-pocket costs for specific services—home health care, hospital stays, Part B drugs—do not have to be actuarially equivalent to what people have to pay for these services under Original Medicare. This means that a Medicare private health plan can charge people for home health care—which Original Medicare provides at no charge—if, in the judgment of CMS actuaries, out-of-pocket costs for other services are sufficiently reduced. CMS actuaries base their judgment on the utilization patterns for particular services. If utilization of home health services is low, the extent that plans must compensate by charging less for other medical services is minimized. If utilization of home health services is high, plans must make steeper or broader reductions in out-of-pocket costs for other services.

While this may benefit a wide swath of plan members by lowering the out-of-pocket costs of widely used services—such as visits to a primary doctor—the impact on specific individuals, such as those who need home health services, can be harmful. To the extent that out-of-pocket costs is raised on services (such as home health services or Part B drugs) used predominantly by individuals with serious illnesses or disabilities and lowered on services (such as visits to

primary doctors) used by both healthy and sick enrollees, costs are shifted from the healthy onto the sick. This not only raises questions of equity, it also raises the prospect of a benefit design that caters to and attracts to the plan the healthiest, least costly enrollees while discriminating against those who become ill and discouraging enrollment by those with high health costs.

CMS does have the authority to reject plan bids that are discriminatory. In practice, however, CMS does not use this authority to reject benefit structures that have the effect of raising the out-of-pocket costs on specific services, even if those services are largely used by individuals with specific illnesses. Nearly half of Part B drugs are billed to Medicare by oncologists,³² for example, yet plans can and do impose higher out-of-pocket rates for Part B drugs than Original Medicare. Some plans exempt Part B drugs from out-of-pocket limits, discriminating against those who need chemotherapy by imposing higher out-of-pocket costs.

For non-PFFS plans, the bid review process does provide CMS with broad authority to shape the benefit packages offered by Medicare private health plans. Plans are given additional flexibility under the bid review process to raise out-of-pocket costs for individual services, such as home health care, if they provide an annual limit on out-of-pocket spending at, or below, a level set by CMS. For 2007, CMS recommended that plans set maximum out-of-pocket spending at \$3,100, the minimum amount spent by the 25 percent of people with Medicare with the highest medical bills.³³ What this additional flexibility entails is not clear. What is clear is that the presence of an out-of-pocket limit is not a strict prerequisite for CMS to allow plans to charge higher out-of-pocket costs than Original Medicare for specific services most often used by sick people.

Supplemental benefits under Medicare private health plans are funded by premiums paid by plan enrollees and by rebates plans receive if they are able to provide basic Medicare coverage for less than the payment rate in their area. Under its bid review authority, CMS can negotiate with plans over the supplemental benefits they provide. The agency can ensure that these supplemental benefits “fairly and equitably” reflect the income from rebates and enrollee premiums that plans receive. But plans are generally free to devise the supplemental benefits as they see fit. They can provide free gym memberships or travel coverage—benefits that are more likely to be valued by relatively health enrollees—rather than a limit on annual out-of-pocket spending.³⁴

CMS’ test for actuarial equivalence of the basic Medicare benefit and its authority to reject discriminatory benefit structures apply to all Medicare private health plans, including private fee-for-service (PFFS) plans. But CMS is barred by law from reviewing bids from PFFS plans to determine if the basic Medicare benefit “fairly and equitably” reflects the premium charged to enrollees. Similarly, CMS is barred from negotiating with PFFS plans to ensure that supplemental benefits “fairly and equitably” reflect the combination of Medicare subsidies and enrollee premiums that plans receive for providing such benefits.³⁵ This loophole for PFFS plans means that CMS is, in effect, barred from assessing whether taxpayers and consumers are getting their money’s worth from the PFFS plan.

The Solution

Previous investigations of Medicare private health plan benefit packages and consumer decision making have pointed to standardization of plan benefits as a means of enabling informed consumer choice and minimizing the risk of inappropriate plan selection. In their 2001 Commonwealth Fund paper, Geraldine Dallek and Claire Edwards say that the market for private Medicare plans “may have reached a point similar to that of the Medigap market prior to the 1990s reforms, where the confusion caused by differing benefit packages outweighed any advantages associated with these differences.”³⁶ Since that report, the number and variety of Medicare private health plan choices have increased dramatically, underscoring the authors’ point that the market for these plans is “undermined if beneficiaries are unable to make an informed choice among their health care options.”³⁷

Similarly, a MedPAC report recognizes that standardized Medicare private health plan benefit packages would permit comparisons of alternative plans and relieve some of the administrative burden on providers to sort out differing copayment and coinsurance rates for a patient population enrolled in multiple plans. The report also acknowledges how the standardization of Medigap policies promoted greater competition on the basis of premiums.³⁸

However, MedPAC stops short of recommending standardized Medicare private health plan benefit packages, citing a number of concerns with standardization, including

1. widely varying payment rates may make standard packages unattractive in some parts of the country;
2. standard benefit packages may stifle creativity in the development of novel benefit designs;
3. standardized packages could cause adverse selection.

Below we address each of these concerns and provide evidence that they do not prevent adoption of standardized benefits for Medicare private health plans.

1. Widely varying payment rates may make standard packages unattractive in some parts of the country. In some ways, this is almost a nonissue because Medicare private health plans already have widely varying payment rates across the country, and that has not put a dent into the plans’ membership enrollment. Medicare private health plans respond to the wide variation in payment rates across different counties by using one of three strategies: varying premiums, altering benefit packages or opting out of certain counties.

For example, Universal American offers the same benefit packages across the country: Today’s Options Premier Plus and Value Plus PFFS plans. The benefit packages (\$2,500 and \$3,000 out-of-pocket maximums respectively; drug coverage at no additional premium) are consistent, but the premium charged ranges from \$10 to \$40 to \$80 for the Value Plus plans and \$45 to \$80 to \$117 for the Premier Plus plans, depending on the amount the payment rates exceed local costs under Original Medicare. The excess monthly payment in effect acts as a premium subsidy for plan members.

Similarly, Humana has two standard Humana Gold Choice PFFS plans offered in most states. Both plans provide a \$5,000 out-of-pocket maximum, but differ in the amount of out-of-pocket costs charged for both inpatient and outpatient hospital services. Premiums for the lower-cost plans are set at either \$0 or \$69 and at \$20 or \$89 for the higher-cost plan, depending on the spread between Medicare private health plan payment rates and average per-person costs under Original Medicare in the county.

The practices employed by these two plans demonstrate the feasibility of marketing standard benefit packages across the country despite widely varying payment rates. If Medicare private health plan payment rates were put on par with Original Medicare costs in all counties, it would facilitate even broader and more consistent marketing of Medicare private health plan benefit packages that comport with mandatory standards.

The alternative strategy used by some plans—adjusting benefit packages to reflect the degree of overpayment in a particular county—makes it more difficult for marketing agents to adequately explain the benefits under the plethora of plans offered by one company. Plans that adopt this strategy under the overriding goal of offering zero-premium plans subject plan members to egregiously high out-of-pocket costs for essential services.

UnitedHealthcare, for example, has 13 different SecureHorizons PFFS products available in different parts of the country. In Utah’s Morgan and San Juan counties, the differing spread between private plan payment rates and Original Medicare costs results in widely different out-of-pocket maximums and cost-sharing imposed for stays in hospitals and skilled nursing facilities that exceed rates under Original Medicare.³⁹

2. Standard benefit packages may stifle creativity in the development of novel benefit design. On the contrary, properly structured, standardized benefit packages should allow for **innovation** that adds value for plan enrollees while prohibiting the imposition of cost-sharing that places at a disadvantage enrollees needing specific services. The goal should be to provide some uniformity in protection across a range of nondiscretionary, medically necessary services and prevent the marketing of plans that presents the illusion of protection against high out-of-pocket spending but have gaping loopholes in these protections.

Plan “creativity” in benefit design should be focused on adding improvements to basic benefit packages. Creativity in benefit design that creates loopholes in coverage should be squelched. Plans could market standardized benefit packages with additional features—on-call nurses, dental benefits, gym membership—providing consumers with both a reasonable assurance of protection against high out-of-pocket costs, a better understanding of how their benefit package compares to others as well as the features that plans find useful in marketing. Such a structure forces plans to prioritize allocation of resources to protect enrollees against high out-of-pocket spending and reduce cost-sharing for core medical services before enticements like gym membership are added to packages.

The strongest case for standardized benefit packages are plans that carve out specific services, such as Part B drugs, from their caps on catastrophic spending. These carve-outs are unjustifiable, and it is unrealistic to expect consumers to discover which services are or are not

included under the cap or anticipate their need for specific services in the future. Even MedPAC researchers were not always able to determine when caps on enrollee spending excluded certain services. Caps on out-of-pocket spending should be comprehensive, providing blanket insurance that plan enrollees will not be bankrupted by catastrophic illnesses.

Protection against catastrophic spending should be the centerpiece of all standardized benefit packages that provide a richer benefit than Original Medicare. Descriptions of standard benefit packages should clearly articulate the maximum annual amount of out-of-pocket spending.

At a minimum, standard benefit packages should charge no more than Original Medicare for individual services, such as inpatient hospital stays, home health care or Part B drugs, although equivalent copayments (set dollar amounts) could be employed instead of coinsurance (percentage of cost) or deductibles.

Standardized packages should also ensure that out-of-pocket costs are commensurate across a range of services, preventing plans from highlighting specific features that hide or obscure gaps in protections. Consumers presented with plans advertising zero copayments for doctor visits and hospital stays may reasonably expect to have no cost-sharing, or, at most, minimal cost-sharing for other nondiscretionary medical services. Standardized packages could prevent plans from offering such packages that leave plan enrollees completely exposed to unlimited out-of-pocket costs for chemotherapy or other nondiscretionary treatments.

Standard benefit packages do not necessarily have to dictate the specific copayment or coinsurance amount for individual services. For example, a per-day hospital copayment that caps out at the same level as the Original Medicare hospital deductible would form an element of one standardized benefit package; a copayment structure that never imposes costs more than half the standard deductible would be an element of a distinct benefit package. Similarly, copayments for primary care and specialist visits can be grouped according to how they compare with the standard 20 percent charge under Original Medicare. Differential copayments designed to encourage utilization of cost-effective services or high-quality providers can also work in this framework. What should be excluded is differential cost-sharing that penalizes utilization of any nondiscretionary medical services, such as chemotherapy or radiation therapy.

3. Standardized packages could cause adverse selection. The experience under Part D shows how inadequate minimum standards for benefits create adverse selection for plans that seek to improve on the standard benefit package. Consumers with high drug costs flocked to the few plans that offered coverage of both brand-name and generic drugs in the gap, or “doughnut hole,” in the standard benefit, forcing companies to discontinue these products.

Similarly, not having a mandate to protect enrollees against catastrophic expenses—for chemotherapy, for example—creates a disincentive for plans to add this crucial feature to their benefit package.⁴⁰ Standardized benefit packages should be designed such that all of them provide some level of protection against high out-of-pocket spending. Competition will then focus on premiums, added benefits or other “creative” features in benefit design, such as care coordination services.

Conclusion

The current market for Medicare private health plans and stand-alone drug plans mimics a similar situation corrected by federal legislation in which Congress acted to standardize policies that supplemented Medicare benefits.⁴¹ Prior to the enactment of OBRA 90 these policies had proliferated in number, each with different riders, benefit variation, deductibles and out-of-pocket cost requirements that made it impossible for consumers to compare one policy with another. Congress acted in response to numerous complaints that consumers were unable to make informed decisions about their health care coverage in a market with too many confusing choices.

The Medicare private health plan marketplace today is also characterized by consumer confusion and aggressive and deceptive marketing practices. Consumers are forced to sort through a seemingly infinite variety of benefit packages, many of them with specially designed loopholes in coverage, with no assurance that they will be protected against high out-of-pocket spending.

The development of specific standardized Medicare private health plan benefit packages should follow a similar process as that used to establish the current Medigap products. The National Association of Insurance Commissioners should establish an expert panel including state insurance regulators, consumer representatives and representatives from both the plans and the Centers for Medicare & Medicaid Services (CMS) to develop model regulations. The development of standard benefit packages should seek to accomplish the following goals:

- Make it easier for consumers to compare a limited number of alternative plans;
- Protect consumers against catastrophic medical expenses, regardless of the type of illness, site or type of medical service;
- Ensure that out-of-pocket costs for individual medical services, such as home health services or inpatient services, are equivalent to or less than the out-of-pocket costs imposed by Original Medicare.

Researchers, state regulators and consumer groups have each drawn the parallel between the Medigap market before 1990 and the Medicare private health plan market as it exists today. Congressional action to reform the Medigap market succeeded in eliminating unlimited benefit designs, giving consumers the ability to evaluate and make their own choices, thus drastically reducing marketing abuses. Congressional reform to standardize and simplify Medicare private health plans is long overdue. The time for Congressional action is now.

- ¹ “Medicare Advantage Overview (Chartpack),” Kaiser Family Foundation, May 4, 2007. (<http://www.kff.org/medicare/upload/7646.pdf>).
- ² *After the Goldrush: The Marketing of Medicare Advantage and Part D Plans*, California Health Advocates and Medicare Rights Center, January 2007 (<http://www.cahealthadvocates.org/pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf>); *The Reluctant Regulator: Centers for Medicare and Medicaid Services’ Response to Marketing Misconduct by Medicare Advantage Plans*, California Health Advocates and Medicare Rights Center, July 2007 (http://www.medicarerights.org/CHA-MRC-brief_reluctant_regulator.pdf); and *Testimony to Congress and NAIC Medicare Marketing Survey* (http://www.naic.org/committees_b_senior_issues_medicare_private_plans.htm).
- ³ “Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance,” Yaniv Hanoch and Thomas Rice, *Milbank Quarterly*, 2006.
- ⁴ “Medigap Reform Legislation of 1990: Have the Objectives Been Met? Consumer Information in a Changing Health Care System,” Lauren A. McCormack, *Health Care Financing Review*, Fall 1996.
- ⁵ “Medigap Reform Legislation of 1990: Have the Objectives Been Met?”
- ⁶ “Medigap Reform Legislation of 1990: Have the Objectives Been Met?”
- ⁷ “Medigap Reform Legislation of 1990: Have the Objectives Been Met?”
- ⁸ In specific circumstances, such as the termination of a Medicare Advantage plan or a substantial contract violation by the plan that affects the individual, Medicare Advantage enrollees qualify for guaranteed issue of a Medigap plan. Guaranteed Issue, the Federal Balanced Budget Act of 1997,” Public Law 105-33, *Federal Register* 70, no. 57 (March 25, 2005):¹⁵⁴⁰⁷. (http://www.cms.hhs.gov/Medigap/Downloads/FRN_NAIC_03_25_05.pdf)
- ⁹ “Low Income & Rural Beneficiaries with Medigap Coverage,” America’s Health Insurance Plans Center for Policy and Research, February 2007. (<http://www.ahipresearch.org/PDFs/FullReportLowIncomeRuralReportFeb2007.pdf>).
- ¹⁰ *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs*, Government Accountability Office, July 2001, page 7 (http://www.gao.gov/new_items/d01941.pdf).
- ¹¹ “Report to the Congress: Medicare Payment Policy,” MedPAC, March 2005, Figure 2B-1.
- ¹² “Things to Know About Medigap Insurance,” New York State Office for the Aging, Health Insurance Information, Counseling and Assistance Program (HIICAP) (<http://hiicap.state.ny.us/mgap/mgap02.htm>).
- ¹³ *Medicare Advantage Private Fee-for-Service (PFFS) Plans: A Primer for Advocates*, Center for Medicare Advocacy, May 2007 (http://www.medicareadvocacy.org/MA_PFFSPrimerForAdvocates.pdf).
- ¹⁴ Medigap policies that cover this cost are required to adjust the benefit each year to reflect any annual increase in the Parts A and B deductibles.
- ¹⁵ Guaranteed Issue, the Federal Balanced Budget Act of 1997,” Public Law 105-33, *Federal Register* 70, no. 57 (March 25, 2005):¹⁵⁴⁰⁷. (http://www.cms.hhs.gov/Medigap/Downloads/FRN_NAIC_03_25_05.pdf)
- ¹⁶ “Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans,” MedPAC, December 2004, Table 3 (http://www.medpac.gov/publications/congressional_reports/Dec04_CostSharing.pdf).
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- ¹⁸ *2006 Medicare Advantage Benefits and Premiums*
- ¹⁹ *2006 Medicare Advantage Benefits and Premiums*
- ²⁰ *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?* Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, Commonwealth Fund, May 2006. (http://www.commonwealthfund.org/usr_doc/927_Biles_MedicarebeneOOPcosts_MA_ib.pdf?section=4039)
- ²¹ Benefit information is drawn from www.Medicare.gov and plan benefit summaries.
- ²² “Medicare Advantage Overview (Chartpack),” Kaiser Family Foundation, May 4, 2007 (<http://www.kff.org/medicare/upload/7646.pdf>).
- ²³ “Bridging the Gaps: A Medicare Supplement Comparison Guide,” State Insurance Department of Arkansas and Arkansas Seniors Health Insurance Information Program, 2007. (<http://www.insurance.arkansas.gov/seniors/BG2007.pdf>)

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- ²⁴ Plans that receive the average payment for PFFS plans, 19 percent above the average per-capita costs under Original Medicare, would receive \$108 above the average cost of care in Benton County under Original Medicare (\$569.98 per month) for a total monthly payment of \$678. For rates, see CMS' *MA Ratebook 2008* (<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1198057&intNumPerPage=10>). For average PFFS payment, see Statement of Mark Miller, Executive Director, Medicare Payment Advisory Commission, *The Medicare Advantage Program and MedPAC Recommendations*, before the Senate Committee on Finance, April 11, 2007, p. 5. (http://www.medpac.gov/documents/032107_W_M_testimony_MA_CZ.pdf)
- ²⁵ *An Assessment of Beneficiary Knowledge of Medicare Coverage Options and the Prescription Drug Benefit*, Judith Hibbard, Jessica Greene and Martin Tusler, AARP Public Policy Institute, May 2006, p. 2.
- ²⁶ "Report to the Congress: Increasing the Value of Medicare," MedPAC, June 2006. (http://www.medpac.gov/publications/congressional_reports/Jun06_EntireReport.pdf)
- ²⁷ "Medicare Advantage Overview (Chartpack)," Kaiser Family Foundation, May 4, 2007. (<http://www.kff.org/medicare/upload/7646.pdf>).
- ²⁸ "Report to the Congress: Increasing the Value of Medicare."
- ²⁹ "Report to the Congress: Increasing the Value of Medicare."
- ³⁰ *An Assessment of Beneficiary Knowledge of Medicare Coverage Options and the Prescription Drug Benefit*, Judith Hibbard, Jessica Greene and Martin Tusler, AARP Public Policy Institute, May 2006, p. 32.
- ³¹ *Low Income and Minority Beneficiaries in Medicare Advantage Plans*, America's Health Insurance Plans Center for Policy and Research, February 2007. Thirty-four percent of people opting for Medicare Advantage plans did so to decrease costs, 21 percent for better benefits and 10 percent for the convenience of the local network.
- ³² "Medicare Part B Drugs and Oncology," MedPAC, July 13, 2006. (http://www.medpac.gov/publications/congressional_testimony/071306_Testimony_Part%20B_oncology.pdf)
- ³³ "Medicare Advantage, Medicare Advantage-Prescription Drug Plans CY 2007 Instructions," Memorandum, Centers for Medicare & Medicaid Services, April 4, 2006. (<http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/REV%20MA-MAPD%20Call%20Letter%20Final.pdf>)
- ³⁴ "Medicare Advantage: Required Audits of Limited Value," Government Accountability Office, July 2007 (<http://www.gao.gov/new.items/d07945.pdf>). The GAO found that the Centers for Medicare & Medicaid Services did not meet the requirement to audit one-third of Medicare Advantage plan benefit packages. A CMS contractor in 2003 identified errors in plan proposals that would have resulted in \$59 million that "beneficiaries could have received in additional benefits, lower copayments or lower premiums." CMS administrators believed that they did not have the authority to legally recover these funds for plan beneficiaries.
- ³⁵ *Medicare Advantage Private Fee-for-Service (PFFS) Plans: A Primer for Advocates*, Center for Medicare Advocacy, May 2007. (http://www.medicareadvocacy.org/MA_PFFSPrimerForAdvocates.pdf)
- ³⁶ *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages*, Geraldine Dallek and Claire Edwards, Commonwealth Fund, October 2001, p. vi. (http://www.commonwealthfund.org/usr_doc/dallek_m+cchoice_490.pdf?section=4039)
- ³⁷ *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages*, Geraldine Dallek and Claire Edwards, Commonwealth Fund, October 2001, p. vi. (http://www.commonwealthfund.org/usr_doc/dallek_m+cchoice_490.pdf?section=4039)
- ³⁸ "Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans," MedPAC, December 2004, Table 3 (http://www.medpac.gov/publications/congressional_reports/Dec04_CostSharing.pdf)
- ³⁹ *Medicare Private Health Plans vs. Medicare Savings Programs: Which Is the Better Way to Help People with Low Incomes Afford Health Care?* Medicare Rights Center, September 2007. (http://www.medicarerights.org/MA_vs_MSP.pdf)
- ⁴⁰ "Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans," MedPAC, December 2004, Table 3 (http://www.medpac.gov/publications/congressional_reports/Dec04_CostSharing.pdf)
- ⁴¹ Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, OBRA 90) and the Social Security Act Amendments of 1994 (P.L. 103-432, SSAA 94).