Statement

of the

American Medical Association

to the

Budget Committee
United States House of Representatives

RE: Medicare Advantage and the Federal Budget

Presented by: Ardis D. Hoven, MD

June 28, 2007

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The American Medical Association (AMA) appreciates the opportunity to provide our views regarding Medicare Advantage (MA) plans and their impact on the Federal Budget. We commend Chairman Spratt and the Members of the Budget Committee for your leadership in recognizing the need to examine the impact of the MA plans on Medicare patients and the long-term financial viability of the Medicare program.

The AMA supports providing Medicare beneficiaries with coverage options so that they are able to select the health insurance plan that is tailored to meet their specific needs. The MA option was originally conceived as a strategy to promote efficiency, provide enhanced patient care through care coordination, and promote private competition. MA plans were also devised to increase diverse plan offerings that would dovetail with the varied needs of beneficiaries. The AMA has been and continues to be a strong proponent of greater competition in the Medicare program to help strengthen patient choice and the program's long-term financial sustainability. However, seniors' choices should be based on their health care needs and not influenced by preferential government subsidies to highly profitable insurance companies. The average reimbursement to MA plans—112 percent of regular Medicare expenditures—has created significant market distortions and undermined competition by providing large subsidies to the MA plans at the expense of regular Medicare.

Substantial Subsidies to MA Plans

The Congressional Budget Office (CBO) estimates that Medicare spending would be reduced by $65 billion from 2008-2012 if the MA benchmarks were decreased to the Medicare fee-for-service level. CBO estimates that 21 percent of MA spending goes to private plans that receive between 120 percent and more than 150 percent of regular Medicare rates. The large disparity in payment between MA plans and regular Medicare is a particularly troubling

development because it is difficult to detect enough additional meaningful benefits to patients to justify these enormous government subsidies. In fact, there is mounting evidence that a significant number of MA plans are luring their enrollees with false promises, skimping on benefits and reimbursement, and using their government subsidies primarily to increase profits for their shareholders.

There are real tradeoffs involved in the public policy choices that Congress currently faces. An average 12 percent add-on payment is being provided to plans in which only 19 percent of Medicare beneficiaries are enrolled, while the physicians who care for all Medicare beneficiaries face a 10 percent cut next year. The Medicare Payment Advisory Commission (MedPAC) estimates that all seniors, not just those in MA plans, are paying two dollars a month in higher premiums to help fund the subsidies being paid to managed care companies. The CBO and the Medicare Actuary have noted that Medicare cost growth, which was already a cause of major concern, is now projected to rise even more rapidly due to its projections of increasing enrollment in MA plans. The Medicare Actuary also has stated that overpayments to MA plans shorten the solvency of the Part A Trust Fund and concluded that setting the benchmarks for MA plans at the regular Medicare fee-for-service level would extend the insolvency date by about two years. In other words, instead of making Medicare more sustainable as the baby-boom generation reaches the age of Medicare eligibility, the MA subsidies are having the opposite effect. The additional payment to MA plans averages about $1,000 per beneficiary and the CBO reports that the MA overpayment per beneficiary is only expected to climb.

In addition to subsidizing MA plans by paying more per enrollee in MA than for beneficiaries in regular Medicare, Congress established a further MA subsidy through the creation of the MA preferred provider organization (PPO) stabilization fund (the fund). The fund was designed to provide additional financial incentives to insurance companies that offer regional PPO plans in areas where regional PPOs would not have otherwise been established. (This additional subsidy was not necessary to encourage regional PPO participation given that there were such plans in 21 of the 26 regions in 2006.) Originally, $10 billion was placed in the fund, but Congress has already reduced the fund by $6.5 billion. If this fund were completely eliminated, the CBO estimates that it would save $3.5 billion over a ten year period. Furthermore, the CBO Budget options provided to Congress show that MA plans receive an additional financial subsidy through a duplicate payment to MA plans for Indirect Medical Education (IME). (The MA benchmarks include an IME payment even though these payments are already made directly to teaching hospitals that treat MA beneficiaries.) The CBO estimates that if the IME payments were removed from MA payments, approximately $12.9 billion would be saved over ten years.

The AMA joins other health care stakeholders, including the AARP and the Medicare Rights Center, as staunch supporters of financial neutrality between the regular Medicare program and the MA program. The AMA urges Congress to adopt the MedPAC recommendation that "the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses." We concur with MedPAC's goal of "having Medicare payments cover the costs that efficient providers incur

in furnishing care to beneficiaries, while ensuring that providers are paid fairly and beneficiaries have access to the care they need."

Medicare FFS Remains the Primary Medicare Option and It Must be Solidified and Improved

Although many physicians provide health care to MA patients, they have many more patients—81 percent—who are in regular Medicare. Huge subsidies are being paid to MA plans that serve 19 percent of Medicare beneficiaries, while physicians who take care of all senior and disabled patients face cuts of 10 percent in 2008 and about 40 percent over the next decade.

If Congress does not take action to provide Medicare physician payment updates that keep up with practice cost increases, then physicians will not be able to sustain their practices, resulting in significant access problems for all Medicare patients, not just those in regular Medicare. In a recent AMA survey of 8,955 physicians, 60 percent reported that they plan to limit the number of new Medicare patients they treat if payment rates are cut 10 percent in 2008. Only 17 percent of the surveyed physicians said that the MA subsidy should continue, while most of the remaining respondents said the subsidy would be better spent on preventing physician pay cuts and/or helping all low-income patients with their out-of-pocket costs, not just those in MA plans. These survey results demonstrate that there is a tradeoff in a tight budget environment between adequate payment updates for physicians and government subsidies for health insurance plans.

AMA Surveyed Physicians and Patients Report Problems with MA Plans

Adding to these concerns, there is mounting evidence that calls into serious question whether the extra billions of dollars being poured into MA are buying better health care coverage for seniors. An April 2007 report from the Medicare Rights Center grouped problems with MA plans coverage into nine different categories:

- Care can cost more than it would under original Medicare;
- Private plans are not stable;
- Getting emergency or urgent care is difficult;
- Continuity of care is broken;
- Members have to follow plan rules to get covered care;
- Choice of doctor, hospital and other providers is restricted;
- Getting care away from home is difficult;
- Promised extra benefits can be very limited; and,
- People with both Medicare and Medicaid can encounter higher costs.

A recurring theme throughout this report and its major conclusion is that, "[e]ven with enhanced payments, private health plans often fail to deliver coverage that a patient could obtain from Original Medicare."

In March 2007, AMA surveyed 2,202 physicians about their experience with MA plans. The findings corroborated that patients and their physicians are being shortchanged by MA plans. About half of the physicians who had patients in MA reported that they have experienced

denial of services that are typically covered in the regular Medicare program. In addition, about half responded that they have received payments from the MA plans that were below the regular Medicare rate. Contrary to industry claims that MA plans provide more benefits to patients, physicians are telling us that their patients who have enrolled in MA plans may be getting even fewer benefits than they receive in regular Medicare.

The AMA survey results also lend credence to the reports from beneficiary advocates that marketing by MA plan representatives is often confusing to beneficiaries or misleading. An overwhelming number of physicians—eight out of ten—who treated MA plan patients stated that their patients have difficulty understanding how the MA plan works. Choice is an important element of a market-driven health care system, but patients must have accurate information if they are to make decisions that best meet their health care needs. MA plans have failed in their obligation to provide patients accurate information in an accessible and comprehensible fashion. This failure has real consequences for seniors who may have their health care services interrupted or incur significant unanticipated costs when they are least able to afford it.

Good information about MA plans is also inaccessible to physicians. Six out of ten physicians reported that they have had difficulty understanding how the MA plans work. This problem is particularly pronounced for PFFS plans. In the AMA survey, over half of the physicians treating PFFS patients stated that they did not have access to or knowledge of the PFFS plans' Terms and Conditions, even though ready access to plans' Terms and Conditions is a cornerstone of the PFFS plan design. It should be no surprise that patients have had difficulty finding physicians who will accept PFFS plans, despite the promises made by sales representatives that patients would be able to go to any doctor. The recent action by CMS and several health plans to suspend marketing of PFFS plans underscores the validity of these complaints. Before the suspension can be lifted, plans will need to have a provider outreach and education program in place to ensure that physicians have reasonable access to the plan Terms and Conditions of payment, and that provider relations staff are readily accessible to assist physicians with questions concerning the plan.

Physicians report a number of additional problems with MA plans, including having to overcome additional financial and administrative burdens when accepting MA beneficiaries. Nearly six out of ten physicians indicated that they had experienced excessive hold times when attempting to contact MA plans. The same number reported that MA plans have requested excessive or additional documentation for payment of claims. Finally, about a third report that MA plans have used proprietary claims editing software to down code or bundle claims—administrative billing practices that Medicare has not approved for use in regular Medicare. These responses demonstrate that MA plans have not enhanced, but instead have hampered operational efficiency on the front lines of health care delivery in physician offices, to the detriment of physicians and their patients.

Surveyed physicians also reported that they have had experience with their patients being switched to a MA plan from regular Medicare without the beneficiary's knowledge, very restrictive formularies with MA prescription drug plans, and customer service outsourced to a foreign country.

Minority and Rural Patients

Although the insurance industry has issued reports touting the benefits of the MA program to minority and rural beneficiaries, an even-handed look at the data and related analysis paints a different picture. The Center for Budget and Policy Priorities (CBPP) pointed out that Medicaid, not MA, is the main form of supplemental coverage for low-income and minority Medicare beneficiaries. It noted that 58 percent of Asian Americans, 30 percent of African Americans, and 34 percent of Hispanics receive supplemental coverage through Medicaid. In addition, the CBPP analyzed the data offered by America's Health Insurance Plans (AHIP) in a report outlining the benefits of MA. The CBPP concluded based on the AHIP data that low-income and minority beneficiaries participate in MA plans less than other Medicare beneficiaries. In 2004, the Center for Policy Analysis and Research of the Congressional Black Caucus Foundation reported that the "unprecedented amount of financial assistance" to MA plans will divert "precious resources away" from regular Medicare. Even then the CBC Foundation argued that "unfair subsidies and other advantages" provided to MA plans should be eliminated "so that traditional Medicare can compete on a level basis."

Another AHIP report concluded that the supplemental coverage offered by Medigap plans is "particularly important to low- and moderate-income beneficiaries, especially those living in rural areas." As PFFS plans are the most common MA plan for patients in rural areas–the patients who are most reliant on Medigap for their supplemental coverage according to AHIP–it is important to note that Medigap plans are not allowed to provide coverage for MA services. In some cases, therefore, MA plans may actually put patients at higher risk for out-of-pocket costs than they would face if they had remained in the regular Medicare program and kept their Medigap policy.

Some of the services where these extra costs are especially problematic are cancer care, home health care, and other services provided to patients with potentially terminal diseases. For example, for a low-income cancer patient with Medicare coverage and a Medigap supplemental policy, Medicare would pay 80 percent of their chemotherapy costs and Medigap would pay the remaining 20 percent. However, many MA plans do not provide more than the 80 percent coverage of chemotherapy drug costs that is provided in the regular Medicare program and, because these patients are not allowed to purchase Medigap policies, cancer patients in these plans must pay the 20 percent coinsurance out of their own pockets.

The National Rural Health Association (NHRA) testified to the House Ways and Means Health Subcommittee that while currently only 5.6 percent of rural Medicare beneficiaries have joined a MA plan, left on its current course MA has the "potential to destabilize the existing rural safety net." For example, NHRA stated that there was an open question as to whether MA plans will honor existing rural add-on payments that safety net providers receive under regular Medicare. Related to the foregoing, a Texas nurse wrote to the AMA about her experience as the practice manager of a rural health clinic (RHC). She stated that the RHC received a per visit rate from regular Medicare of $68.13—this amount covers everything provided by the RHC and all codes. However, an administrative and financial nightmare has ensued because while MA plans have informed patients that they can see any physician in the clinic, some of the plans have been unwilling to pay the RHC at the higher rates that it is entitled to receive because it serves a rural community. In fact, the nurse manager wrote that

one MA plan is paying a rate that is less than half the clinic's RHC rate under regular Medicare. Far from increasing access to rural beneficiaries, MA plans could well result in fewer rural physicians being able to accept Medicare patients.

MA Plans Have Increased Costs to All Beneficiaries

MA has resulted in higher premiums across the board for all beneficiaries. MedPAC has estimated that on average every Medicare beneficiary pays approximately two dollars per month extra to finance the higher MA payments that only benefit 19 percent of beneficiaries. For example, only 8 percent of Medicare beneficiaries in South Carolina are enrolled in Medicare Advantage plans, but all seniors in South Carolina are paying higher Medicare premiums every month so that the government can provide subsidies to health plans that serve only 8 percent of the state's Medicare beneficiaries. This is true across the country—a majority of Medicare beneficiaries in all states are forced to pay higher premiums to fund overpayments to plans that enroll a select subset of beneficiaries.

MA Marketing Abuses

There have been rampant MA plan marketing abuses reported by physicians and other health care stakeholders. In testimony to the Senate's Special Committee on Aging, Wisconsin Insurance Commissioner Sean Dilweg reported that, in a survey by the National Association of Insurance Commissioners, 37 out of 43 states reported receiving complaints about inappropriate or confusing marketing practices leading Medicare beneficiaries to enroll in a Medicare Advantage plan without adequately understanding their choice to remain in regular Medicare or without adequate understanding of the consequences of their decision.

Many reports of marketing abuses focus on PFFS plans, including a common practice of signing up patients for plans that end up costing the beneficiary more in out-of-pocket expenses and misleading patients regarding which physicians accept the PFFS plans. Reportedly, many PFFS plans market themselves as providing patients the ''freedom'' to choose any provider that accepts Medicare. As a result, regular Medicare patients sign-up for PFFS with the expectation that they will be able to continue receiving their health care from the same physician they have always had. Although CMS allows patients who have been misled to drop the PFFS plan and re-enroll in regular Medicare and supplemental Medigap plans, this is a difficult, time-consuming process and can impact the delivery of health care services. In addition, once patients willingly drop supplemental Medigap, they are not able to obtain that supplemental coverage if they elect to re-enroll in regular Medicare until and unless they demonstrate that they meet a host of criteria. Even after meeting these requirements the Medigap plan may have less favorable terms. Previously, neither Congress nor CMS have addressed these patient burdens. These abuses have both short-term and long-term consequences to patients. We hope that the recently announced voluntary effort to suspend PFFS plan marketing will lead to more responsible behavior in the future.

MA Plans Have Generated Large Profits for Private Insurance Companies

When Congress set up the payment system for MA plans, it may have intended for the extra payments to support health care services. In the AMA physician survey and reports by patient advocates, MA plans are not delivering on this promise. The subsidies to MA plans are substantial, create market distortions by creating a preferred government Medicare option, and

are inefficient. Who then benefits from the subsidies? As of November 2006, the MA market was dominated by four firms that accounted for 58 percent of all MA enrollment. There have been reports that private insurance companies have reaped substantial profits from the Medicare program. For example, in February 2007 the Associated Press reported that one of the companies "fourth-quarter profit more than doubled on the strength of its burgeoning Medicare business" and the company had "a record year in revenue and profit." Recently, Goldman Sachs reported that the same company "will earn 66 percent of its net income from Medicare Advantage this year . . . which comes to between $670 million and $705 million."

Until MA plans are placed on equal footing with regular Medicare, the market distortions will continue to encourage inefficient behavior by MA plans, patients and physicians will face added financial risks, delivery of health care will be compromised, and taxpayers will pay more (seemingly for less). Clearly, the *status quo* does not advantage patients and physicians.

The AMA appreciates the opportunity to provide our views to the Budget Committee concerning MA and the Budget. We look forward to working with the Committee and Congress to preserve patient access to high quality, cost-effective health care and to find solutions to address the long-term financial sustainability of the Medicare program.