Beneficiary Issues and Medicare + Choice

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Thank you for the opportunity to be here today to testify about the lessons learned from the Medicare+Choice plans and their implications for relying on private plans to serve the Medicare population. My testimony today emphasizes beneficiary issues, and attempts to contrast them with interests of the federal government and private plans when appropriate. My concern about beneficiaries is a long standing one and has been influenced over the years by writing a column on coverage issues in the 1990s, maintaining contact with groups that counsel Medicare beneficiaries, and conducting research on Medicare. The opinions expressed here are my own and I am not representing any other group.

The Promise of Private Plans

Using private plans as an optional alternative to traditional Medicare fee for service holds considerable promise for offering services to beneficiaries. And expanding the role of private plans is often touted as the solution to Medicare's financing challenges. In theory, plans can play a pivotal role by:

- Providing coordinated care to beneficiaries with multiple health care needs;
- Experimenting with new and innovative ways of delivering care;
- Having the flexibility to offer additional services—like transportation services and home modifications—that may facilitate traditional care; and
- Competing for enrollment by offering lower prices, more services, or higher quality care.

Health care analysts have long sought to encourage coordination and flexibility of care in a capitated setting, giving plans incentives to find the least expensive ways to deliver care within a budget. This should avoid the overuse of services associated with fee-for-service medicine and offers opportunities to try out new approaches. And, if there is price competition, economic theory would suggest that this will keep the pressure on plans to be attractive to potential enrollees, increasing their market share and delivering care efficiently.

Medicare+Choice in Practice

Experience with private plans in Medicare suggests a less-than-ideal reality, however. Good quality plans seeking to serve patients well certainly exist, but a number of problems abound. Medicare has, since the 1980s, formally allowed beneficiaries to choose to be served by private plans (paid on a capitated basis) instead of remaining in the traditional fee-for-service part of the program. In 1997, this option was modified to allow plans other than health maintenance organizations (HMOs) to participate and to reform the payment system which, studies have shown, costs Medicare more for each enrollee than if they remained in the traditional program. Even with those changes, however, the Medicare program has not saved money for the federal government.

Although payments for most plans should be high enough to cover costs of required benefits, private plans have pulled out of markets or reduced the extra benefits offered. Further, there is little evidence to suggest that most private managed care plans do much to coordinate care either in Medicare or for the younger managed care population. Thus far, savings have mainly come from obtaining deep discounts from doctors, hospitals and other suppliers. And since Medicare had made inroads into discounting before most managed care plans came into the program, this avenue of savings has not reaped the same differentials in costs as were sometimes seen in the employer-based insurance market. Thus, the promise of substantially lower costs may be difficult to achieve.

In addition, beneficiaries have not been treated well by some of the private plans. Private plans have sometimes sought to save costs by limiting access to new technology, to exclude from their plans sub-specialists with considerable experience in treating certain types of illnesses, and to put in place other

barriers to getting care. If done carefully and with appropriate medical practice in mind, these methods may be a successful way of holding down costs. But, many researchers have concluded that these are sometimes arbitrary or problematic barriers. A recent study by Berk and Monheit, for example, concluded that HMOs work best for the 90 percent of the population which is healthy. The problem is that the remaining 10 percent of health care users account for 70 to 75 percent of all health care costs (regardless of age).

The organizations that contract with Medicare to provide counseling and information or who run specific hotlines for Medicare beneficiaries often find a disturbing pattern of denials of care. Those on the frontline at the Medicare Rights Center, for instance, cite numerous examples of inappropriate denials. Plans are supposed to cover all Medicare-covered services, but their clients have included people denied a type of cancer treatment specifically approved via a national Medicare coverage determination. Patients are often denied access to care from specialists outside the network who have particular expertise in a given procedure. In one case, the HMO argued that since they had an in-network physician who had performed a particular type of brain surgery twice, they had no obligation to approve care outside the network by a more experienced physician. In another case, a patient needing chemotherapy had a transportation problem that prevented him from going to the in-network site. His only recourse was to disenroll from the HMO and get the chemotherapy in another location. In that situation, the delay was only for one month, but when the lock in goes into place (in which beneficiaries will have fewer opportunities to disenroll), such a patient could be severely disadvantaged. Although these are examples and it is not known how many people have such difficulties, it suggests that the "flexibility" available to plans can be problematic and that at least in some cases, patients do not have access to all Medicare-covered services. Ironically, these examples illustrate denial of "choice" in a form that is likely to be of more importance to beneficiaries than what is often touted as an advantage of private plans offering "choice."

A number of marketing abuses have also been found by those who work with Medicare beneficiaries. The family of a beneficiary with Alzheimers disease sought help when the beneficiary was suddenly denied coverage for various services; they discovered that the beneficiary had been enrolled in a managed care plan without the family's knowledge. One of the more egregious examples occurred when a group of Spanish-speaking elderly beneficiaries were taken to Atlantic City and on the bus were asked to sign a piece of paper (in English) that they were told was to get information about the health plan. In fact, they had "enrolled."

While complaints about excessive regulation are often made by the industry, there are a substantial number of examples of problems that require careful protections for beneficiaries. The denials and confusion cited above can be cleared up by case workers but regulations are needed to protect patients' rights. If beneficiaries are going to be asked to take greater responsibility for care, it is important to have in place appropriate protections and controls for those who are cognitively impaired, frail, non-English speaking, or face other barriers to their getting care. This is a substantially larger group than found in other populations served by managed care. In that way, Medicare is different and regulatory needs are also different.

The main attractiveness of plans to beneficiaries is that plans have been able to offer additional services. In fact, the ads that many plans run suggest the importance of vision, dental and drug coverage and mention only in small type that care must be received in network. Since plans have received payments higher than necessary for Medicare-covered services and because they may be providing those services at lower costs, they have been able to subsidize their offerings of additional benefits. But, over the last three years, these extra benefits have been substantially reduced in many plans. For example drug coverage has declined from 84.3 percent in 1999 to 70 percent having such coverage in 2001. Withdrawals have left a number of beneficiaries scrambling to enroll elsewhere or to get Medigap coverage if they return to traditional Medicare. And when drug coverage has been retained, stringent caps have been applied or substantial premiums levied on the beneficiary. The cross-subsidy for these extra services has been reduced.

Ways to Improve Medicare+Choice

Many ideas have been suggested about ways to improve the Medicare+Choice option. Two areas for reform have been emphasized both by plans and policy makers who wish to have Medicare rely more on the private market for managing care. These are reforms in federal premium payments to plans and reductions in the bureaucratic complexity that restricts what plans can do. A beneficiary's perspective raises caveats about these first two issues and suggests additional issues including help in understanding the complexities of private plans and offering stability to those enrolled.

Payments to Plans. Although there is substantial criticism regarding the way in which the federal government pays plans, there is not a solid common ground between the goals of private plans and policy makers. Policy advocates of changing the way in which plans are paid usually focus on moving away from administered prices and toward a system of price competition in which plans bid against each other to attract patients. But plans are less enthusiastic about price competition. Under the current system, plans use extra benefits to attract patients. For beneficiaries, one of the main attractions to managed care—that is, extra benefits—would be eliminated. And because plans use extra benefits both as a drawing card and for offering better coordinated care by providing a full range of services rather than just those available from Medicare, they are also less interested in competitive bidding. The goal of most plans in the last few years has been to assure that payments are as high as possible, not to engage in competitive bidding.

Thus, it is not clear where payment reforms are likely to go. If the goal is to provide savings to the federal government, then lower prices will be necessary. The experience with the competitive bidding demonstrations suggests that this will be difficult to achieve because of opposition both from plans and beneficiaries who value the extra benefits that high payments allow. Further, two key problems need to be resolved before any

change in payment policy will work well.

First, without good adjustments for health status, plans face no incentives to enroll sicker Medicare beneficiaries. In fact, the lack of a risk adjustment mechanism means that the easiest way for plans to be "successful" in the Medicare program is by attracting and keeping healthier beneficiaries and by encouraging those with health problems to disenroll. To the healthy beneficiary enrolled in such a plan, everything appears to be working well. They get extra benefits and are treated well by the plan. The problem is that other plans, traditional Medicare and sicker beneficiaries are made worse off by such a situation. Until this incentive is changed and plans embrace all types of beneficiaries, they will continue to seek a healthier population and will have little reason to make inroads in the treatment of the very sick. They are simply doing what is best for their business.

Second, the elephant at the table that no one can figure out how to deal with effectively is the geographic variation that exists across the United States in use and costs of health care. This is not just a problem of administered prices, it will arise under any system as long as people are sensitive about differing levels of costs by area. In areas where costs traditionally have been high, Medicare+Choice payments are also high. If a plan comes into that area and is successful at bringing costs of care down closer to the national average, they can offer extra benefits and do well in the market. This is not because they are more efficient or effective than plans in other parts of the country, but because they are working in an environment where there is likely excess use of services which make it easier to hold down costs.

The major adjustments tried to help with this problem have been unsuccessful. Raising the floor for rural counties does not work well since most private plans find it difficult to operate in such areas. Moreover, it potentially puts in place a system in which private fee-for-service plans may come in and provide the same types of services to beneficiaries at a rate that is much higher for the federal government than care under traditional Medicare. That essentially trades one problem for another. Further, the blended rate has not done much as yet to ease the situation for areas where costs have traditionally been low, largely because low costs in traditional Medicare have slowed that implementation. The new urban floors put in place this year are likely to have an effect, but again raise costs for the federal government. If enough money is thrown at the problem, then it is possible to bring all areas up to the level of inefficiency and high cost as now exist in only a few areas. That does not seem to be a prudent tact to take.

A better approach to improving levels of payment would be to add crucial benefits such as prescription drugs to the basic Medicare package. This would achieve several goals that would help both the viability of private plans and those in traditional Medicare who also have trouble getting prescription drugs. Adding drugs to the package would raise the contributions made to plans naturally, and although geographic variation would still be an issue, there would be less variation in benefit packages offered by plans. Further, if all plans offered a standard drug package, risk selection would be less of an issue and competition would work better. And, plans would be better able to coordinate care when the benefit package is more comprehensive. Finally, this change could reduce inequities in which traditional fee-for-service beneficiaries receive no subsidies for extra benefits while those in HMOs do. Expanding this effort to other benefits such as preventive services could also help.

When the benefit package is comprehensive, it becomes more feasible to require plans to compete on price, either through competitive bidding or by offering a price discount for the Part B premium. Certainly the goal should be to find ways to move to a better pricing system, but a number of other changes in Medicare+Choice are needed as well, including adopting better risk adjusters, doing more work on geographic differences, and conducting demonstrations on alternative price setting approaches.

Complexity and Regulations. It is very difficult to determine how much plans are disadvantaged by the bureaucratic nature of the Medicare+Choice program. How many regulations are enough? What areas require the most oversight? While it is tempting to throw the current system out and start over again, many regulations continue to be needed. Two types of regulation and oversight are essential: assurances that quality care is being delivered and that beneficiaries have adequate protections from the types of problems chronicled above. The federal government as a prudent payer should not simply pay a capitated amount to private plans without safeguards and reporting requirements.

One of the major areas of complaint mentioned by plans are requirements to produce data on services provided. But without such information, it is difficult to track quality and to determine whether payments are appropriate. Is the problem that the federal government is requiring any information or does it have to do with formatting and other technical issues? It is hard to imagine that a well run business does not itself want to know what services are being used by what types of clients, so there should be grounds for agreement on providing data.

Most plans have a large commercial operation in addition to serving Medicare clients. Do they want to use the same screens for Medicare as they use for the working age populations? That would simplify requirements that they face, for example, but may not serve Medicare patients well who have different needs than working age families? The high rates of morbidity and special needs among the Medicare population are likely to require some special adjustments if they are to be served well by Medicare+Choice.

A reasonable goal of reforms in Medicare+Choice should be a careful review of existing regulations and requirements. But such a review should also closely examine whether there are *enough* protections for beneficiaries. For example, should plans be required to notify patients when they are hospitalized that all normal inpatient costs are covered by the plan and thus to ignore bills they receive directly from in-network providers? This common problem can be resolved, but how many beneficiaries just pay the bill and don't follow up? Should plans be required to get a card to an enrollee within a particular period of time so that the

patient can access health care services, or be subject to a penalty? Again, this is an issue that seems to arise frequently. These should be easily resolvable issues, but need to be backed up with strong requirements from the federal government. The problems with plan oversight do not flow only in one direction, and the needs of Medicare beneficiaries should be included in discussions regarding regulation.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, understanding the bills when they come due months later, and the need to appeal denials of care to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. The goal should be to reduce these burdens throughout health care, but to lay the issue at the doorstep of only Medicare is misleading.

Better Information and Support for Beneficiaries. One of the key lessons of Medicare+Choice is that beneficiaries do not have a good understanding of what it means to join a managed care plan, what their rights are, or how to choose wisely. Many problems have arisen because people do not understand even the basic requirements of being in a managed care plan. After an initial start at federal funding for such information, today, less, not more, is being proposed for this crucial task. The small amount available per beneficiary is insufficient to provide the information needed for beneficiaries to be knowledgeable health care consumers. When private insurers spend 10 percent or more of their per capita allocation on marketing (which translates into $600 per Medicare beneficiary), they are implicitly acknowledging how expensive it is to reach this audience.

Medicare also needs to offer its beneficiaries more than just information. It needs to provide resources to help beneficiaries follow up with problems and to fund independent sources of information that will help consumers make good choices. Independent rankings of plans and centralized enrollment for private plans through Social Security offices or elsewhere are two examples of ways in which the federal government could help empower consumers. Independent analysis comparing effectiveness of prescription drugs should be an essential piece of any prescription drug coverage. Special provisions to allow beneficiaries to disenroll to prevent abuses when the lock-in provision goes into effect may be needed as well.

Stability. Another issue that has come to the forefront is the disruption caused by plan withdrawals. In a market system, withdrawals should be expected; indeed, they are a natural part of the process by which uncompetitive plans that cannot attract enough enrollees leave particular markets. If HMOs have a hard time working with doctors, hospitals and other providers in an area, they may decide that this is not a good market. And if they cannot attract enough enrollees to justify their overhead and administrative expenses, they will also leave an area. The whole idea of competition is that some plans will do well—and in the process drive others out of those areas. In fact, if no plans ever left, that would likely be a sign that competition was not working well and/or that payments were too high. But this also means that beneficiaries have legitimate concerns about disruptions that will occur under any private plan option. Reforms in Medicare+Choice need to take into account the need for special protections and procedures for beneficiaries caught in these disruptive situations.

Is Medicare Ready for Greater Private Plan Participation?

In many ways, the Medicare + Choice benefit has been one of the less successful changes that have occurred in Medicare. Despite payments that should be sufficient to compensate plans for the costs of Medicare-covered services, the number of withdrawals of plans and cutbacks in services for those who remain reached a peak at the end of 2000. The resulting disruptions for beneficiaries have been problematic. At present, the program is neither saving money for the federal government nor achieving good, stable care for many of its enrollees. Private plans certainly have a role to play in Medicare, but many of the issues described above need to be resolved and the current program working well for beneficiaries before greater reliance is put on private plans under Medicare.

Other Publications by the Authors

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