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May 20, 2008

MAJORITY STAFF REPORT ON MEDICARE ADVANTAGE

We don't get rid of [traditional Medicare] in round one because we don't think that would be politically smart and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine because we think people are going to voluntarily leave it - voluntarily.

Former House Speaker Newt Gingrich in speech to Blue Cross/Blue Shield on Oct. 24, 1995.[1]

In 2006, the last year for which data is available, taxpayers spent about $59 billion on Medicare Advantage programs, under which private insurance plans administer Medicare benefits, rather than the traditional "fee-for-service" Medicare approach of direct payments to providers. The original rationale behind allowing private plans to participate in the Medicare program was to contain growth in Medicare spending. Policymakers expected insurance plans to drive down the cost of caring for Medicare beneficiaries through competition and the creation of plan networks under which healthcare providers agree to accept lower rates in return for a reliable stream of patients. In addition, managed care offered more opportunities for coordination of patient care than fee-for-service Medicare system.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was designed to give private plans a significant competitive advantage over traditional Medicare. As a result, in abandonment of the original cost-containment rationale, the Government now pays private plans substantially more on average than it pays under traditional Medicare to treat similarly situated beneficiaries. The Medicare Payment Advisory Commission (MedPAC), Congress's expert advisory panel on Medicare payment policy, and the Congressional Budget Office (CBO) have determined that, on average, the Federal Government is now paying private plans *12 percent more* than it costs to treat comparable beneficiaries through traditional Medicare.[2] Payments to Private Fee-for-Service (PFFS) plans, a private plan option under Medicare created by the Balanced Budget Act of 1997 that is exempt from care coordination and provider network requirements,[3] are estimated at *19 percent* above traditional Medicare.

[1]Edwin Chen, *Gingrich: Today's Medicare Will 'Wither,'* Los Angeles Times, Oct. 26, 1995
[2]Medicare Payment Advisory Commission, "Report to the Congress: Promoting Greater Efficiency in Medicare," June 2007 (MedPAC Report); and "The Medicare Advantage Program: Enrollment Trends and Budgetary Effects," Testimony by Peter Orszag, Director of the Congressional Budget Office, before the Senate Finance Committee, April 11, 2007.
[3] PFFS plans are not required to establish provider networks or coordinate care, and are exempt from quality

MedPAC and CBO have urged Congress to "level the playing field" between traditional Medicare and the insurance companies by paying plans the same amount, adjusting for the risk status of beneficiaries. MedPAC and CBO have warned that continuing taxpayer overpayments to the insurance industry is accelerating the date when the Medicare Hospital Insurance Trust Fund is expected to become insolvent. H.R. 3162, the "Children's Health and Medicare Protection Act of 2007," (CHAMP Act) would implement MedPAC's recommendations by, among other things, phasing out overpayments to Medicare Advantage (MA) plans over 4 years to bring them down to 100 percent of traditional Medicare. MedPAC estimates that reducing overpayments to private plans alone will save taxpayers $54 billion over 5 years and $149.1 billion over 10 years.[4]

The overpayments to the insurance industry not only burden taxpayers as a whole, but also increase the premiums that Medicare beneficiaries pay. Medicare's actuary has testified that beneficiaries in traditional Medicare pay an additional $48 per couple per year for monthly Part B premiums[5], nearly $700 million in total, to finance overpayments to MA private plans.

The toll taken by private plan subsidies on the financial stability of Medicare is apparent in the President's fiscal year 2009 budget proposal. While the Administration proposes that beneficiaries bear the brunt of deep cuts in provider payments under Parts A and B of Medicare and premium increases, the proposed budget would continue overpayments to the insurance industry, estimated at approximately $7.1 billion in 2006.[6] In the meantime, fueled by generous taxpayer subsidies, private plans continue to proliferate. As of January 2008, 8.8 million Medicare beneficiaries had enrolled in a Medicare Advantage plan, *a 63 percent increase* since 2005.[7] Not surprisingly, enrollment in private plans is growing fastest in regions with the highest payment levels.[8] PFFS plans, which enjoy the largest overpayments, are the fastest growing segment of the MA market.[9]

The Subcommittee on Oversight and Investigations held a hearing on June 26, 2007, entitled, "Predatory Sales Practices in Medicare Advantage." While this hearing focused on abusive sales tactics used by MA plans, predatory marketing is only one aspect of a broader array of concerns with the current design, oversight, and cost of the Medicare Advantage program, some of which are described below.

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improvement and data reporting requirements concerning health outcomes and other indices of quality applicable to other types of MA plans. 42 U.S.C. § 1395w–22(e)(1); 42 C.F.R. § 422.152(a). PFFS enrollees may obtain care from any provider who agrees to furnish care under the particular plan's terms. Providers must decide each time they see a patient whether to accept a PFFS plan's terms of participation and thus agree to its payment rates, which are supposed to be equivalent to the rates CMS establishes for providers under traditional Medicare. 42 U.S.C.A. § 1395w–22(d)(4).

[4] Congressional Budget Office Budget Options, February 2007.

[5] Testimony of Richard Foster, Chief Medicare Actuary, before the Subcommittee on Health of the House Committee on Ways and Means, April 25, 2007.

[6] Testimony of James Cosgrove, Acting Director of Health Care Issues, Government Accountability Office (GAO), before the Subcommittee on Health of the Committee on Ways and Means, "Hearing on Medicare Advantage," February 28, 2008 (GAO Testimony).

[7] "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006," brief prepared for the Kaiser Family Foundation by Mark Merlis, January 2008.

[8] Issue Brief, "An Examination of Medicare Private Fee-for-Service Plans," prepared by Jonathan Blum, Ruth Brown, and Miryam Frieder, Avalere Health LLC, for The Henry J. Kaiser Family Foundation, March 2007 (PFFS Brief).

[9] *Id.*

The purpose of this Staff Report is two-fold. First, it is intended to provide Members and staff of the Subcommittee with an overview of the various issues surrounding the Medicare Advantage program with a special emphasis on new developments subsequent to our June 2007 hearing. Second, it is intended to provide options for additional hearings and investigations to resolve outstanding problems with the program.

BACKGROUND—MEDICARE ADVANTAGE

Original Medicare

Under traditional "fee-for-service" Medicare, the Government pays healthcare providers directly for services they provide to Medicare beneficiaries according to established fee schedules. Beneficiaries are free to choose any provider who participates in the Medicare program.[10] At present, approximately 80 percent of Medicare beneficiaries participate in traditional Medicare.

Medicare Advantage

Congress has allowed managed care organizations to contract with the Medicare program since 1972. Plans participating in the early risk-based programs under Medicare were paid at a 5 percent discount per beneficiary based on the assumption that managed care was more efficient than traditional Medicare. As enrollment grew, however, policymakers became concerned about geographic disparities in plan availability and benefits, and that plans were tending to favor younger and healthier, and therefore less costly, Medicare beneficiaries.

The Balanced Budget Act of 1997 (BBA) replaced the risk program with "Medicare+Choice" (M+C) under Medicare Part C. M+C attempted to expand the managed care program both geographically and to sicker and older beneficiaries. The BBA set payment floors, required payments to factor in enrollee health status and risk, established rules for broader marketing, and created opportunities for new types of plans such as preferred provider organizations. Notwithstanding the BBA and subsequent legislation in 1999 and 2000 that raised payments and created various other incentives, between 1999 and 2001, a large number of plans withdrew from Medicare or reduced their service areas, leading to disruption in coverage for many plan enrollees.

In 2003, the MMA included more favorable payment structures for private plans,[11] changed the name from Medicare+Choice to Medicare Advantage and added two new delivery systems: Special Needs Plans (SNPs), and Regional Preferred Provider Organizations. Since the passage of MMA, enrollment in private plans has grown dramatically. In 2003 and 2004, 11

[10] Some Medicare beneficiaries also purchase "MediGap" or "Medicare Supplement" insurance to cover gaps in Medicare coverage, such as deductibles and coinsurance amounts for doctor and hospital care, and to limit their exposure to catastrophic out-of-pocket expenses. Concerns about marketing and sales abuses with respect to MediGap policies—similar to some of the abuses seen in connection with MA—led Congress to standardize MediGap benefit packages and minimize the potential for sales abuses as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).

[11] The dramatic subsidy increases in the MMA were not accidental. While most of the public's and Congress's attention was focused on the new prescription drug benefit in MMA, the insurance industry, represented by the trade association America's Health Insurance Plans (AHIP), was drafting language for the final version of the Medicare Advantage provisions in Title II of the bill. *See* Michael T. Heaney, "Brokering Health Policy: Coalitions, Parties, and Interest Group Influence," *Journal of Health Politics, Policy and Law*, Vol. 31, No. 5, October 2006, at 921; and H.R. Conf. Rep. 108–391, MMA, November 21, 2003.

percent of Medicare beneficiaries were in MA plans. In 2007, MA enrollment accounted for nearly 20 percent and is projected to be 27 percent by 2016. More than half (53 percent) of MA enrollment is concentrated in 4 organizations: UnitedHealth Group, Inc. (UNH); Blue Cross/Blue Shield affiliates; Humana Inc.; and Kaiser Permanente.[12]

PFFS plans, which are subject to less regulation and lower expenses (such as the cost of negotiating network provider agreements and fee schedules), have experienced the highest growth rate since passage of MMA. MA sponsors have targeted PFFS plans at counties with the highest benchmark rates (which are, in many cases, higher income areas).[13] While enrollment in MA Health Maintenance Organizations and Preferred Provider Organizations increased 18 percent between December 2005 and February 2007, enrollment in PFFS plans during the same time period grew *535 percent*.[14] Some analysts suggest that much of the recent growth of PFFS plans is because of their higher profit margins, and the opportunity to "arbitrage" the overpayments.[15] PFFS plans pay providers at Medicare fee-for-service rates. The wide spread between the overpayments and PFFS plans' medical expenses allows them to generate higher profit margins than those enjoyed by other MA plans, and to increase enrollment by marketing the lower premiums or additional benefits they can provide because of the Federal subsidy.

MA Marketing Abuses

Hearings held on MA marketing abuses over the past 10 months by this Committee, the Committee on Ways and Means, the Senate Select Committee on Aging, and the Senate Committee on Finance have identified a number of causes of the abuses, including:

- the opportunity for substantial profit margins in MA;
- the lack of standardized benefit packages;
- extravagant sales commissions;
- a short enrollment period and lengthy lock-in period for enrollees; and
- limiting the consumer protection role of States.

The steering of beneficiaries into inappropriate plans appears most acute in connection with sales of PFFS plans. Testimony at Congressional hearings established that insurance agents can make several times more in commissions selling PFFS plans than for other MA products.[16]

[12] Issue Brief, "Medicare Advantage: A Windfall for Insurers; Downfall for Beneficiaries," Alliance for Retired Americans Educational Fund, August 2007. *See also* "Medicare *Dis*advantage – Privatized Health Care For Seniors Can Leave Them In The Dark As Insurance Companies Reap A Windfall," CBS Evening News Report, July 16, 2007, available at http://www.cbsnews.com/stories/2007/07/16/cbsnews_investigates/main3062725.shtml.
[13] *Id.*
[14] PFFS Brief.
[15] "Medicare Private Health Plans vs. Medicare Savings Programs: Which Is the Better Way to Help People with Low Incomes Afford Health Care?" www.medicarerights.org, September 2007 (MRC Brief), at 5.
[16] It also appears that plans generally pay agents higher commissions for sales of MA plans, as opposed to stand-alone Prescription Drug Plans (PDPs). This practice provides further incentives for agents to steer beneficiaries into MA plans, rather than simply selling them PDPs. Some of the marketing abuses frequently identified involve agents signing beneficiaries up for MA plans when beneficiaries are only seeking information about a PDP or a MediGap policy. In many instances, beneficiaries do not even realize they have been enrolled in an MA plan until they need health care and discover that their provider does not accept the plan.

State Insurance Commissioners, whose traditional regulatory authority over insurance sales of most Medicare products was preempted by MMA,[17] consistently described an overheated sales environment involving, for instance:

- enrollment of dead or mentally incompetent Medicare beneficiaries and beneficiaries with limited English language skills;
- sales agents falsely claiming to be Medicare representatives;
- sales agents forging beneficiaries' signatures to enroll them in MA plans;
- sales agents "churning" beneficiaries (enrolling them in a different plan every year) in order to generate higher annual commissions;
- sales agents using beneficiaries' inquiries about prescription drug benefits to cross-sell MA products to the beneficiary;
- sales agents conducting door-to-door sales and using fraudulent mechanisms to gain access to beneficiaries' homes, nursing homes, and senior or low-income housing; and
- companies rewarding agents for high volume sales with trips to Las Vegas and cash prizes.

At the Predatory Practices hearing, several residents of a low-income apartment building testified that they were misled by a Coventry Health Care sales agent visiting their building who enrolled them in an inappropriate PFFS plan. One of the witnesses had lost her prescription drug coverage because of the fraudulent enrollment and could not afford needed medication when she became ill. Agents selling a Coventry PFFS plan had led residents, many of whom had recently enrolled in the Part D drug benefit, to believe that Medicare Part C provided benefits *in addition to* – not in place of – Medicare Parts A and B.

Congressional investigators witnessed firsthand the inappropriate targeting of "dual eligibles" (individuals who are eligible for Medicare and Medicaid) by agents selling inappropriate PFFS plans. The Committee's bipartisan team of investigators interviewed beneficiaries at the building in preparation for the Predatory Practices hearing. As the investigators were talking with a Resident Council member in the building's lobby about the traumas experienced by the residents, a sales agent from Wellcare Health Plans approached the Resident Council member. He introduced himself as "being with Medicare," and asked if he could arrange luncheons for building residents so they could hear the "good news" about the additional benefits now available under Medicare Part C.

Kim Holland, the elected Insurance Commissioner for the State of Oklahoma, described the situation in her State as "virtual lawlessness."[18] She testified that "[u]nlicensed agents are setting up shop in pharmacies, Wal-Marts, and nursing home lobbies to prey upon seniors'

[17] 42 U.S.C. §§ 1395w–26(b)(3), 1395w–112(g) (preempting State laws related to MA plans).
[18] Testimony of Oklahoma Insurance Commissioner Kim Holland, Hearing of the Senate Select Committee on Aging held on May 15, 2007, entitled "Medicare Advantage Marketing & Sales: Who Has The Advantage?" *See also*, Testimony of Mississippi Deputy Insurance Commissioner Lee Harrell, Predatory Practices Hearing available at http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.MedicareAdvantage.shtml (consumer complaints about MA plans far outnumbered complaints concerning Katrina-related insurance issues).

confusion and concern over their medical care coverage. Certain insurers are exploiting their exemption from regulatory oversight with aggressive and frequently misleading advertising; agent financial incentives that encourage high pressure sales tactics; and a lack of responsiveness, if not outright neglect, of a vulnerable population caught in the middle of an unbridled free market."

Staff at the Centers for Medicare and Medicaid Services (CMS) have described some of the fraudulent claims overheard from sales agents as follows:

- *"If you don't like our Plan, you can switch back to your original plan at any time";*
- *"The Government wants you to join our plan because it helps them and is cheaper for them";*
- *"Medicare wants you off their product and in our product";*
- *"It's really better to choose another vendor if you are sick"; and*
- *"If your doctor accepts Medicare, they accept this plan."*[19]

Insurance Commissioners and patient advocacy groups have placed some of the blame on the lack of adequate Federal oversight and enforcement. The current structure of MA, however, makes it vulnerable to sales abuses.[20] The limited enrollment window provides little incentive for MA plans to maintain a salaried, full-time sales workforce. In order to maximize sales during the limited enrollment window, plans generally turn to field marketing organizations and brokers, paid on commission, with minimal ability for direct company oversight. Moreover, the use of agents and brokers working on tiered commission systems have created financial incentives for swift and uninformed enrollments. Finally, MMA's prohibition on the exercise of State regulatory authority over companies, MA products, and insurance marketing practices means that CMS must act as the exclusive, nationwide insurance commissioner, when it lacks the resources, institutional infrastructure, familiarity with insurance regulation, or political motivation to step into such a role.[21]

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[19] CMS Conference, Private Fee-for-Service 360 Degrees. "Current PFFS Challenges: Selected Results from PFFS Monitoring & Oversight Activities" available at http://www.cms.hhs.gov/MedicareAdvPartDTrain/03_MeetingsConferences.asp#TopOfPage, PowerPoint presentation by Michael S. Adelberg Director, Division of Qualifications and Plan Management.

[20] *See also* Elizabeth C. Borer, Note, *Modernizing Medicare: Protecting America's Most Vulnerable Patients from Predatory Health Care Marketing Through Accessible Legal Remedies*, 92 Minn. L. Rev. (forthcoming 2008), *available at* http://ssrn.com/abstract=1092688 (advocating creation of a private right of action, stricter Federal protections, and repeal of MMA's preemption provisions to allow States to enforce consumer protection and patients' rights laws to give greater protection to beneficiaries).

[21] Although last year CMS began offering States the opportunity to sign a Memorandum of Understanding (MOU) to facilitate the exchange of information between CMS and State insurance departments regarding broker or agent misconduct, the National Association of Insurance Commissioners advises that at least some States participating in the MOU report they have received no information from CMS and that communications with CMS on these issues have not improved.

THE PFFS MARKETING MORATORIUM

Eleven days before the Subcommittee's June 26, 2007, hearing, CMS announced, in coordination with the trade association America's Health Insurance Plans (AHIP), that seven MA plans representing 90 percent of the market had voluntarily agreed to stop marketing their PFFS plans until they could implement basic consumer protections.[22] CMS's response came after numerous negative press reports about abusive MA marketing practices, mounting pressure from Congress, consumer advocacy groups, and State insurance regulators, along with pending legislative proposals to reduce MA overpayments. Many of the PFFS plans were already under corrective action plans (CAPs) imposed by CMS for various reasons, including, in some instances, marketing misconduct.

Notwithstanding evidence of significant beneficiary abuses, rather than exercise its regulatory authority to suspend marketing or otherwise sanction non-compliant plans, CMS allowed the plans to "volunteer" to suspend marketing, thereby giving the companies an opportunity to minimize the negative press that might ensue from regulatory sanctions, as well as avoid triggering reportable event disclosure requirements under Federal securities laws. Moreover, CMS worked closely with AHIP and the plans to orchestrate the timing and even the characterization of the moratorium in disclosing it to the press. AHIP's press call announcing the moratorium occurred immediately on the heels of the agency's press call, late on a Friday afternoon. At the time of the suspension, none of the participating plans appeared to experience any discernible decline in stock price or other adverse financial effect as a result of the freeze. Less than four months later, CMS agreed that all plans could resume marketing, in ample time for the next enrollment period.[23]

MEASURING THE EXTENT OF MA MARKETING ABUSE

The actual extent of MA marketing abuse and inappropriate enrollments is difficult to gauge for a number of reasons. CMS initially claimed that it had received only 2,700 complaints regarding MA marketing abuses from 2006 until the time of the Committee's hearing. Mississippi alone, however, received 1,000 complaints regarding MA sales in the last 2 years. Moreover, according to the National Association of Insurance Commissioners (NAIC), Florida is one of the few States that closely tracks complaints and has received more than 4,000 since enrollment began.

Shortly before the Predatory Practices hearing, it became apparent that CMS had not, in fact, been tracking beneficiary complaints specifically about MA sales. Although the agency had been tracking complaints about the prescription drug benefit reflected in calls to its 1-800-Medicare line, it had not established a separate complaint tracking module for customer service representatives answering the 1-800-Medicare number to use to identify complaints about MA plans. As a result, calls to 1-800-Medicare regarding MA sales abuses (which may or may not include a prescription drug component) were, at best, captured in an addendum or note in the context of a complaint about the prescription drug benefit, or may not have been tracked at all.[24]

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[22] *See* Bloomberg News, "Insurers Suspend the Marketing of Some Medicare Plans," *New York Times,* June 16, 2007.

[23] "Four Health Insurers To Resume Marketing Of Medicare Advantage Plans After Suspension," Medical News Today, September 27, 2007.

[24] CMS's 1-800-Medicare contract raises additional Congressional oversight concerns. Patient advocates and Congressional investigators continue to report excessive wait times and, more importantly, multiple instances of erroneous information given to beneficiaries, and inability to resolve problems.

Because the database lacked a separate category, or "module," to identify MA complaints, in order to respond to this Committee's request for information about such complaints, CMS had to perform a manual review of drug benefit complaints. This manual search may, in fact, be how CMS arrived at the low number of 2,700.

Although CMS added a separate MA complaint tracking module to the 1-800-Medicare database shortly before the hearing, any totals now identified in the system are still likely to understate the problem because 1-800-Medicare may not adequately capture complaints made to CMS's regional offices, State Health Insurance Program counselors,[25] or patient advocacy groups, let alone State insurance departments. Further, CMS has not tracked how many beneficiaries in inappropriate MA plans simply wait out the year long lock-in period and "vote with their feet" the following year by returning to traditional Medicare or enrolling in a different type of MA plan. Senior and/or disabled beneficiaries do not necessarily know who to call, and it is not unusual for elderly fraud victims to feel embarrassed to ask for help, even if they are able to do so or know who to call. In some cases, beneficiaries are afraid to complain out of fear that an offending agent will return uninvited to their home. In such cases, the victims may wait until the next enrollment period begins. Some beneficiaries may attempt to take advantage of the special disenrollment period option that CMS recently created in response to Congressional pressure about MA marketing abuses, but CMS has done little to publicize this option or to ensure that 1-800-Medicare representatives or plans are facilitating disenrollment requests.

POST-HEARING REGULATORY ACTIONS

At the time of the Predatory Practices hearing, the Center for Beneficiary Choices (CBC), which administers the MA and prescription programs, appeared reluctant to exercise its oversight authority over plan conduct in any meaningful way.[26] Abby Block, the Director of CBC, acknowledged that CBC had not exercised its exclusive authority to fine any plan for marketing misconduct, despite widespread evidence of significant problems resulting in, at a minimum, potential for beneficiary harm if not actual harm, and indicated no willingness to impose such fines in the future.[27]

Agents for one of the plans appearing at the hearing had deceived low-income and disabled Medicare beneficiaries into signing up for a PFFS plan. Victims testifying at the hearing described how one beneficiary only discovered she had lost her drug coverage when she became ill and could not pay for needed medicine. Ms. Block told the Subcommittee that it was sufficient corrective action for the plan to terminate its contract with the independent agent, and that CMS needed to take no further action such as sanctioning the plan. Moreover, despite the Subcommittee's request, Ms. Block declined to agree to make public or post, on the CMS Web site, the corrective action plans it had imposed on MA plans for violations of various agency rules governing marketing, drug coverage, appeals, and other aspects of plan operations.

[25] State Health Insurance Programs are programs provided in each State that offer one-on-one counseling and assistance to Medicare beneficiaries and their families. http://www.medicare.gov/contacts/static/allStateContacts.asp.

[26] For an in-depth analysis of this issue, see Issue Brief for California Health Advocates and the Medicare Rights Center, "The Reluctant Regulator: Centers for Medicare and Medicaid Services' Response to Marketing Misconduct by Medicare Advantage Plans," David Lipschutz, Paul Precht, and Bonnie Burns, July 2007, available at http://www.cahealthadvocates.org/advocacy/2007/07.html.

[27] Although CMS had imposed more than $400,000 in fines against plans during the year preceding the Predatory Practices hearing, Ms. Block acknowledged at the hearing that these monetary penalties had been based upon failure of plans to provide enrollees with timely notices concerning changes in costs and benefits, not marketing abuses.

It was not until July 2007, more than 18 months since the MMA amendments became effective, that CMS issued its first termination of an MA plan based on findings of imminent and serious risk to the health of beneficiaries. Finally, in September, CMS issued its first monetary penalties against two plans for MA marketing abuses.

The appointment of Mr. Kerry Weems as new Acting Administrator of CMS on September 5, 2007, appears to have brought an increase in focus and energy to the agency's oversight of MA plans. Mr. Weems made public commitments to increase transparency at the agency, specifically including the posting of MA corrective action plans on the CMS Web site. On October 1, 2007, CMS posted the 91 audits of MA plans and corrective action plans CMS had imposed for violations of various agency rules governing marketing, drug coverage, appeals, and other aspects of plan operations. The audit reports revealed, for instance, "the improper termination of coverage for people with H.I.V. and AIDS, huge backlogs of claims and complaints, and a failure to answer telephone calls from consumers, doctors and drugstores."[28]

At a Senate Committee on Finance hearing on February 20, 2008, Mr. Weems described the "secret shopper" program CMS began last fall to ensure that plans were complying with CMS marketing guidelines, and his personal participation as a secret shopper in several marketing reviews. Although Weems acknowledged that the program had uncovered 696 marketing violations, CMS's response to these findings has been limited to date. CMS has suspended marketing and enrollment with respect to *only one PFFS* plan (offered by Chesapeake Life), and has imposed a total of only $771,150 in civil money penalties against 14 different MA and prescription drug plans.[29] The penalties imposed range from $2,100 to, in one case, $264,000.[30]

In the meantime, the NAIC has been conducting a survey of State insurance regulators (NAIC survey). Preliminary results suggest that marketing abuses continue unabated. Since the survey began in January 2008, 34 States, along with the District of Columbia and Puerto Rico, have responded. While each State tracks consumer complaints differently, initial results show:

- 34 States reporting complaints about misrepresentations in marketing;
- 32 States have received complaints about inappropriate or confusing marketing practices, such as switching traditional Medicare beneficiaries to Medicare private plans without explaining the consequences;
- 25 States have reported complaints involving door-to-door sales;
- 19 States have received complaints about fraud; and
- 10 States have received complaints involving unlicensed agents.[31]

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[28] "Medicare Audits Show Problems in Private Plans," by Robert Pear, *New York Times*, October 7, 2007.
[29] CMS suspended marketing and enrollment for an MA/prescription drug plan offered by SDM HealthCare on December 7, 2007, and imposed a marketing and enrollment freeze on several drug plans offered by HealthNet, one of the largest publicly traded health insurers in the Nation, on February 19, 2008. CMS has also terminated several plans because of solvency concerns.
http://www.cms.hhs.gov/MCRAdvPArtDEnrolData/Downloads/Enforcement_Actions_Web.pdf
[30] The $264,000 penalty was levied in September 2007 against Coventry in connection with one of its PFFS plans.
[31] Final survey results will be available from the NAIC.

On May 8, 2008, CMS finally announced that it is proposing new regulations for MA plan providers, including a prohibition on door-to-door marketing and "cold calling" beneficiaries, as well as on limitations on promotional gifts for potential enrollees, sales in places such as physician waiting rooms or health fairs. In addition, the proposed rules would require insurers to pay level commissions across all MA plan product types to discourage "churning," use State-licensed agents, and comply with State laws regarding the use of appointed agents.

HIGHER ADMINISTRATIVE COSTS

Current estimates are that Government spending on the MA program will reach $100 billion annually by 2009. Hidden in this cost is the extraordinary administrative cost for managing the MA program. The cost of administering traditional Medicare is generally estimated at 2 percent or less,[32] with 98 percent of revenues spent on medical care; *i.e.*, a 0.98 "medical loss ratio." By contrast, the cost to taxpayers of having insurance companies administer Medicare benefits is far higher.

According to a report released on February 28, 2008, by the Government Accountability Office (GAO) entitled, "*Medicare Advantage – Increased Spending Relative to Medicare Fee-for Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*" (GAO Report), total revenues in 2007 for MA plans were $783 per member per month (PMPM), of which plans projected they would allocate approximately 87 percent ($683 PMPM) to medical expenses, a medical loss ratio of 0.87. Plans projected that they would spend an average of approximately 9 percent of their total revenue on non-medical expenses such as administration, marketing, and sales, and that they would retain 4 percent of revenue beyond that as a profit margin.[33] Some plans, however, projected they would allocate *even less than 85 percent* of their revenues to medical expenses. The proposed CHAMP Act would require plans to uniformly report medical loss data and dedicate at least 85 percent of their revenue to medical care.

Private plans also benefit from the Government's investment in the traditional Medicare program in several ways not reflected in the bids that plans submit to CMS, in addition to the subsidy that provides a competitive advantage over traditional Medicare. For instance, the plans receive regular capitated payments without having to expend efforts at collecting the taxes from which those payments derive. Moreover, plans generally need not incur the debt collection expenses they can otherwise incur in the private insurance context, since beneficiaries' premiums are typically deducted from their Social Security checks. In addition, CMS and the Office of Inspector General of the Department of Health and Human Services invest substantial efforts on program integrity measures that plans are able to adopt (or adapt) with respect to provider payments.[34] Moreover, as discussed below, MA plans can limit their exposure to substantial medical expenses for sick, chronically-ill, or lower-income beneficiaries by imposing higher cost-sharing in certain benefit categories, or through utilization mechanisms such as prior authorization, incentive-based provider payments, and claim denials.

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[32] GAO Testimony.

[33] GAO Report, p. 4.

[34] Medicare beneficiaries enrolled in MA plans are far more limited in their ability to participate in efforts to protect the Medicare program from fraud and abuse by providers—let alone plans—because the capitated system of payments to providers and to plans is far more opaque. Indeed, the need for regulatory oversight is arguably greater in connection with the MA program because of the far greater market power of the large insurance companies that contract with CMS under MA and the lack of transparency to beneficiaries and taxpayers in the program.

POOR HEALTH OUTCOMES

One question that has not been adequately measured is whether MA plans are helping beneficiaries and providers achieve better health outcomes, or the extent to which plans "cherry pick" healthier beneficiaries and restrict care for sicker and costlier beneficiaries. A recent report by a researcher for MedPAC indicates that health outcomes for MA enrollees are at their lowest levels since quality reporting began in 1998.[35]

Data presented at a November 9, 2007, MedPAC meeting on the health status of plan enrollees from the most recent 2-year period available, 2004 through 2006, showed that MA plans performed more poorly than commercial or Medicaid private plans on performance measures and health outcomes. According to data collected by the National Committee for Quality Assurance, from 2005 to 2006, Medicare private plans improved in only 7 of 38 reporting measures. During the same period, commercial plans improved in 30 of 44 measures, and Medicaid private plans improved in 34 of 43 measures. Moreover, 13 MA plans reported enrollees' physical health as worse than expected, as compared to the 2 prior reporting periods (2002 through 2004 and 2003 through 2005) for which no plans reported beneficiaries' physical health status as worse than national plan averages. Seven plans reported mental health outcomes as significantly poorer than the national average, the highest since plan performance data was first gathered in 1998, when 15 plans reported substandard mental health outcomes.

Several MedPAC Commissioners expressed concern over MA plan performance, particularly in light of the substantial overpayments they receive. The Commission is expected to make formal recommendations to Congress to address some of these shortcomings in the near future.

HIDDEN COSTS FOR BENEFICIARIES IN MA PLANS

CMS's implementation of MMA's "actuarially equivalent" and nondiscrimination requirements is another issue in need of further scrutiny and reform. MA plans may structure their cost-sharing in any manner they wish, so long as the total package is at least actuarially equivalent to traditional Medicare in terms of benefits provided and out-of-pocket costs to plan enrollees, and differences in benefit design are not "discriminatory" with respect to a beneficiary's health status. One of the ways in which plans can "cherry pick" and retain healthier, lower-cost enrollees is by offering benefit packages that impose significantly higher cost-sharing requirements for services typically needed by sick or chronically-ill beneficiaries such as hospital care, skilled nursing, home health, Part B covered drugs (such as those used in chemotherapy), radiation therapy, oxygen, dialysis, and durable medical equipment. GAO reports that in 2007, for example, 16 percent of MA beneficiaries were enrolled in plans that projected higher cost-sharing for inpatient services, and could have incurred double the cost-sharing they would incur in traditional Medicare for such services.[36]

MA plans also can discourage enrollment by low or moderate income beneficiaries, who may be willing to pay higher monthly premiums in exchange for predictable maximum out-of-pocket exposure in some benefit categories. GAO noted that some MA plans exclude certain services from their out-of-pocket maximums, such as Part B drugs or mental health benefits.[37]

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[35] Transcript available at http://www.medpac.gov/transcripts/1108-09Medpac%20final.pdf.
[36] GAO Report, p. 7.
[37] GAO Report, Table 5, p. 26.

Perhaps the most telling measure of problems with plan adequacy for less healthy beneficiaries has come from the insurance industry itself. Despite the contention of MA plans and CMS that private plans provide comprehensive, high quality, and affordable coverage with benefits beyond what is covered by traditional Medicare,[38] insurers have developed and are now selling a new "wraparound" package of benefits as a sort of "Medicare Advantage Medigap" to fill in gaps in MA coverage. Patient advocacy groups report that these additional plans are being sold either as non-duplicating specified benefit packages or through defined benefits sold separately, such as individual hospital indemnity plans that pay beneficiaries a cash benefit to cover the out-of-pocket costs or other expenses not covered by their MA plan.[39] In its 2008 Call Letter to plans outlining bid requirements, CMS implicitly acknowledges problems with MA benefit packages, and has promised to scrutinize plan bids for the coming year for discriminatory cost-sharing packages.

BENEFICIARY VERTIGO—THE EXPLOSION OF PLAN CHOICE

The Administration recently acknowledged its abandonment of any pretext of cost containment as a goal of the MA program. At a hearing held on February 28, 2008, by the Subcommittee on Health of the House Committee on Ways and Means, CMS Acting Director Weems testified "At its heart, Medicare Advantage is about choice." Beyond a doubt, to the extent that choice of plan variables is itself a worthwhile goal for a program intended for seniors and disabled persons, that goal has been achieved. In some localities, beneficiaries can be faced with literally a hundred different plans among which to choose.[40]

Each plan offers multiple variations in benefits and cost-sharing, which makes it difficult for anyone, particularly an elderly person with cognitive or physical impairments, to make a rational, informed decision. Under optimal circumstances, in order to make a cost/benefit comparison of all available plans, beneficiaries or their families should weigh the beneficiary's current health status and medical costs, predict the likelihood of changes in the beneficiary's health status over the next plan year, compare multiple variations in benefits and cost-sharing requirements under different health care scenarios (*e.g.*, the need for hospitalization and rehabilitation), and determine the availability of desired, qualified, and geographically convenient providers. Beneficiaries comparing PFFS plans are faced with the same dizzying array of variables. In addition, beneficiaries selecting a PFFS plan cannot assume that the providers they regularly use will agree to the plan's terms, since PFFS plans do not use provider networks and providers can accept or reject the plan each time the beneficiary seeks a medical service.

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[38] Problems of measurement persist in the context of plans' actual cost of benefit delivery, as in other areas. Only plans that operate health maintenance organizations must provide performance data to CMS. Even then, the data reported are standardized and not beneficiary-specific. Since MA payments are based on plan bids, not the plan's costs, CMS has no way to determine the costs MA plans *actually incur* for benefits they promise to provide beneficiaries. CMS Acting Director Weems recently promised at the on February 28, 2008, hearing of the Health Subcommittee of the House Committee on Ways and Means on Medicare Advantage, however, that he would take steps to collect utilization and cost data from plans.

[39] *See* Testimony of David Lipschutz, Interim President and CEO, California Health Advocates, Los Angeles, California, at a hearing of the Health Subcommittee of the House Committee on Ways and Means on Medicare Advantage, February 28, 2008.

[40] By comparison, the average Federal employee participating in the Federal Employee Health Benefits Plan may be able to choose from a maximum of only 20 or so different plans.

ADDITIONAL CONCERNS

In addition to the issues highlighted above, a number of other areas warrant Congressional oversight. Some examples include:

- Problems faced by dual eligibles when enrolling in an MA plan, including barriers to access to care and providers, lack of coordination of Medicaid benefits, and inappropriate billing of cost-sharing.
- Skewed PFFS plan availability in or targeting of higher-income individuals and communities.[41]
- Problems with PFFS payments to providers and disincentives to provider participation such as denials of payment for services covered by Medicare, payment delays, down-coding or bundling of claims that would be prohibited in traditional Medicare,[42] inconsistent claims edits and payment errors, excessive and burdensome claims documentation requirements, and inappropriate shifting by PFFS plans of administrative burdens to providers.[43]

CONCLUSION

Insurance industry abuses abound in Medicare Advantage. The Federal Government overpays $7 billion per year for a program that, in too many cases, falls far short of the high expectations Americans have for the Medicare program. MA plans' abuse of the trust seniors and the disabled place in the Medicare program, through marketing fraud and abuse and unfair treatment denials, is indefensible. It is imperative that CMS place the protection of vulnerable beneficiaries ahead of powerful insurance companies at every juncture and work with, not against, State regulators who have substantial experience with protecting patients and consumers.

Some of the recent steps CMS has taken are encouraging, but much more should be done, even within the imbalanced legal structure of MMA. Passage of the CHAMP Act will help correct some of the imbalances by reducing overpayments to MA, as well as instituting other urgently needed reforms. Even so, Congressional vigilance in the oversight process of the MA program will be vital to ensure that the program delivers health care to those who need it most.

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[41]The Medicare Rights Center of Medicare analysis of PFFS plans reveals that often people with low incomes and minority communities pay *more* compared to their wealthier neighbors and yet receive fewer benefits when they join PFFS plans. "*Medicare Private Health Plans vs. Medicare Savings Programs: Which Is the Better Way to Help People with Low Incomes Afford Health Care?*" www.medicarerights.org, September 2007, at 5.

[42]Although PFFS plans must pay providers at least as much as the rates established for providers under Parts A and B of Medicare (*see* 42 U.S.C.A. §§1395w–22(d)(4)(A) & (B); and 42 C.F.R. §422.114), these practices appear to be methods used to evade those requirements.

[43]*See, e.g.*, Testimony of Jim Mattes, President and CEO of Grand Rhodes Hospital, a Critical Access Hospital in rural Oregon, before the Subcommittee on Health of the House Committee on Ways and Means held February 28, 2008, available at http://waysandmeans.house.gov/hearings.asp?formmode=view&id=6815.

The Committee on Energy and Commerce Oversight and Investigations Majority staff recommend that this Subcommittee or other committees of competent jurisdiction continue to focus on the following issues critical to the integrity of not only MA, but the entire Medicare program, in addition to those identified in Section 9:

- standardization of plan benefit packages similar to that established for Medigap plans;
- strengthening of broker/agent training;
- publicizing of the special disenrollment period for victims of MA marketing fraud and abuse;
- comprehensive tracking of beneficiary complaints concerning MA plans and improved training of 1-800-Medicare customer service representatives to assist beneficiaries with MA questions, complaints, disenrollments, and re-enrollments;
- lengthening of MA enrollment periods and adjustment of MA enrollment periods to coincide with PDP enrollment periods;
- restoring the oversight role of States in regulation of MA sales and fostering coordination between CMS and the States;
- imposition of minimum medical loss ratios and uniform reporting requirements;
- repeal of exemptions for PFFS plans with regard to quality improvement and data reporting requirements; and
- strict enforcement of nondiscrimination requirements with respect to cost-sharing and plan benefits and protections against plan "cherry picking."