The New River Valley Agency on Aging in Virginia's Experience with Private Fee for Service Medicare Advantage Plans

Statement by Elyse Politi
SHIP Coordinator
New River Valley Agency on Aging in Virginia

Before the United States Senate
Committee on Finance

Private Fee for Service Plans in Medicare Advantage:
A Closer Look

January 30, 2008

Chairman Baucus, Senator Grassley, and members of the Committee, thank you for the opportunity to testify regarding Private Fee for Service plans in the Medicare Advantage program. My name is Elyse Politi, the current State Health Insurance Program Coordinator (SHIP) for the New River Valley Agency on Aging, which provides services to seniors in the counties of Montgomery, Pulaski, Giles, and Floyd, and the City of Radford, Virginia.

The SHIP program was established in 1993 in Virginia and I am one of the original coordinators, having spent 13 years in the Northern Virginia area until last fall, when I transferred to the Southwest part of Virginia. In Virginia, the SHIP program is called VICAP – Virginia Insurance Counseling and Assistance Program.

The SHIP program was established to help Medicare beneficiaries and their families, whether over or under 65, understand and navigate through the Medicare, Medicaid, Medigap maze, as well as provide counseling on the impact of other forms of health insurance on their Medicare status. During the past three years, as a result of the MMA of 2003, the burden on the SHIPs to constantly re-educate themselves on the Medicare Advantage (MA) plan offerings and the stand alone prescription drug plans has increased exponentially, and our efforts at outreach and education with the Medicare population, regardless of where they live has grown at the same rapid rate. Added to this burden is the imperative to find low-income beneficiaries who qualify for the extra help to pay for prescriptions. The increased number of beneficiaries reached, the amount of effort to keep ourselves and the beneficiaries educated has been shown in the numbers from across the country for the total SHIP program.

My testimony today will focus on 4 points:

Private Fee for Service promises of reduced costs to rural residents.
Marketing problems which continue to plague beneficiaries
Medicare beneficiaries need for qualified, knowledgeable counselors
Frustration of providers in dealing with PFFS plans.
Concerns about the use of the additional funds appropriated for SHIP programs.

PFFS promised reduced costs to residents in rural areas.

Many people were very encouraged and excited in 2006 to find out that there were some plans that were claiming no premiums for either health insurance other than the Part B premium, and no premium for their medications. Since there was little oversight at the time, rampant poor sales techniques were used to enroll the rural folk into several PFFS plans this area. People were told that there were extra benefits such as hearing, dental and vision coverage in addition to exercise programs that they could join. They were not told, however, that there was an out-of-pocket maximum of $4000 - $5000 per year beyond their prescription costs, (much greater than with a Medigap policy), or that their hospital co-pay for one plan would be $525 and the other $185/day for the 1st five days. In addition, there would be daily co-pays for Skilled Nursing stays after 5 days instead of after 20 days as in Original Medicare, and the durable medical equipment and Medicare part B drugs would have the same 20% co-pay that would have been payable under Original Medicare. Most of the PFFS plans are also charging high ambulance co-pays and are requiring substantial co-pays for people receiving dialysis and diabetic supplies regardless of whether the plans charge a premium for the health costs

People who gave up their Medigap policies suddenly had to pay these large, unexpected costs out of their own pocket. When one woman I spoke with found out that she had to pay the $525

hospital bill, and then received a bill for her 100 day Skilled Nursing Facility stay in the amount of $8000, she thought the end of the world had come and realized what a bad decision she made. I helped her first by contacting the plan to advise them that they needed to work out the billing issue since she obviously had gone over her $4000 out-of-pocket maximum. I then dis-enrolled her from the plan, got her back into Original Medicare and a Part D plan, and also helped her fill out a Medicaid application since she had spent enough to meet the requirements for a spend down. Had she stayed with her Medicare and Medigap, her out-of-pocket costs would have been equal to her original Medigap premium, or $1,800 and she would not have had to apply for Medicaid.

Other people find out that a health care provider will not accept their PFFS plan just as they are scheduled to receive a needed health care service. On Friday afternoon, December 28, I was contacted by a frantic son whose mother was scheduled to enter Skilled Nursing Facility the following week. The Nursing home advised him that they would not accept the PFFS she was enrolled in, and even if they did, she would be responsible for co-pays after the first 5 days she was there. This Nursing Home was the closest facility to her home and family, and the son was worried that other facilities further away might not take the PFFS plan either. After talking with his mother they decided that she needed to be dis-enrolled from the PFFS before December 31 so that when she entered the Nursing Home, she would at least be covered under Original Medicare 100% for the first 20 days.

Marketing problems continue to be rampant with PFFS plans in rural Virginia.

A beneficiary was approached by a salesperson in a local Wal-Mart. When she told him that she had TRICARE, and the Federal Blue Cross/Blue Shield Standard option, he advised her that she needed to also sign up for the PFFS plan since neither of those plans offered her full protection. He did not indicate that she could suspend her FEHBP plan. I counseled her on the benefits of both TRICARE and BC/BS, advised her that she did not need the PFFS, and possibly could suspend her BC/BS since the TRICARE was fairly inclusive. She said she would investigate further and make her decision. I reported this salesperson, who has been "working this area for the past 3 years" to both CMS and our Virginia Bureau of Insurance. The Bureau of Insurance has received several complaints about this particular salesperson on other occasions.

Another person was told by a marketing contact that the plan wanted to meet with the enrollee since the benefits of the person's PDP were changing and that the Enhanced PFFS would not only reduce his drug costs but give him added benefits. Since he had talked with a SHIP counselor last year, he knew that further investigation was needed. When I compared plans for him, and advised him of all the co-pays and liabilities he would incur by cancelling his Medigap and enrolling in this PFFS, he chose to change his PDP to a lower cost plan, and keep his Medigap. He told the salesperson that since this new plan would actually cost him more potentially he did not feel he could gamble his savings against his health.

The mother in law of the Director of the New River Valley Agency on Aging called to say that a very polite gentleman called her in response to her inquiry into joining a PFFS he represented. Since she had not talked to anyone about changing plans, she asked her daughter-in-law, the Director, to talk with the salesperson. When asked about how in fact he had gotten her mother-in-law's telephone number, he replied that the plan had given him several names of people who said they were interested... This salesperson became concerned after talking with my Director, that indeed the people on this "list" given him by the PFFS contained people who in fact had not been interested, but rather a list of "cold contacts" to call.

Medicare beneficiaries need knowledgeable counselors.

These situations require many hours of counseling, and I was grateful that I knew what the PFFS plans covered so that my help was valuable. Before the detailed benefits for each plan were uploaded to the Medicare website, I made a spreadsheet of all MA and MAPDs available to each one of the five counties I cover. Not all plans are offered in all 5 counties. I called each plan, went down the list of benefits and had this spreadsheet to show to people so that they could understand the costs. Most found it difficult to understand, especially when they realized that the co-pays, other than the $10-15 for their primary care doctor could be as much as the costs of original Medicare without a Medigap plan.

Counseling sessions can be difficult and time consuming because they need to be individualized. They require more than knowledge about the PFFS plan and other Medicare Advantage options. They require knowledge of Original Medicare, Medigap, Medicare Saving programs, and Medicaid.

Two doctors in small towns called me and asked to have counseling sessions for their patients to advise them of all the Medicare options available to their patients. In one town, the doctor's staff asked the local library to open before hours so that I could counsel 40 patients. Most had had Medigap before joining the PFFS and were swayed by the no premium, small co-pays that seemed to sound great. Some of the patients were younger people with disabilities who were not eligible to get a Medigap policy because it would have cost $500-$700 per month. Some of the people could get help paying for their drugs through "extra help". Since some people were just above the level for QMB, (Qualified Medicare Beneficiary) and received help to pay for the Medicare Part B and reduced drug costs, there was still no way to pay for the large co-payments and deductibles incurred with PFFS plans. The seemingly low-cost PFFS plan was of no help to the patients who needed the most costly services. For example, one person who was on oxygen full time still had to pay 20% of the cost of that service in the PFFS plan.

The counseling session for the person who used oxygen, which included various financial scenarios, was 5 hours over the course of several days, with an additional 2 hours spent analyzing all the possibilities. I am not sure I found them all, but I guarantee that the salesperson that sold him the PFFS plan did not do anything of the type of counseling I did.

Another emerging situation is that doctors are feeling extremely pressured to accept payment from PFFS plans because their long-time patients have signed up unknowing what they got themselves into. The two doctors that asked me to do counseling sessions for their patients felt close to being family friends – at the very least, very close to the community. They both expressed increasing difficulties in getting timely payments from PFFS plans, and were irritated by constantly having to provide more and more paper to prove that what they were doing was correct and to justify their standard procedures. These same doctors also expressed frustration with stand alone drug plans as well, when asked to furnish detailed patient notes on why certain drugs were prescribed. Additionally, this year several PFFS plans have announced that they will charge additional money if they are not notified prior to a patient is admitted to a hospital, or a Skilled Nursing Facility. This puts an additional burden on physicians, facilities, Medicare beneficiaries and their families to understand the complexities of PFFS plans. Providers need to understand all the subtle difference between 46 possible choices.

PFFS plans promise to save people money, promise to provide extra benefits, and promise to provide the same Medicare coverage as original Medicare. The plans don't tell beneficiaries that the beneficiaries may end up paying more and getting less. They don't discuss the burdens of having to find out whether providers accept the plan or of giving the plan notice before getting some services. PFFS plans increase the workload of already busy SHIP counselors who have to re-counsel beneficiaries who get less than they were promised by the sales agents and the plans on how to make future changes.

The saddest part about Medicare Advantage is that there is less control over how the Private Fee for Service plans operate, put operating budgets together, and how they choose to charge for services and how they sell their products. With the additional money they receive, they are held to lower standards than Original Medicare. Since there are no provider networks, like with an HMO, there is no way to count on any provider being there if you needed them twice in a row. Unless there is a specific dollar amount to dispute, filing an appeal is nebulous.

In addition, the manpower cost to keep educated on all a person needs to know inadvertently undermines the SHIP program. Since it takes a long time to train new paid coordinators and additional time to train volunteers on how to diagnose and analyze all issues faced by beneficiaries and their care givers, what should be easy turns out to be complex counseling, many times looking at different financial scenarios to determine what is best. If a counselor does not work with Medicare consistently, it is impossible to know all differences between Original Medicare and all the different flavors of Medicare Advantage. It is easy to see this when all the training, teleconference and counseling hours are added up during the year and how many more are added as Annual Enrollment Plan gets closer and then all the additional training of volunteers, it does become apparent that enough time and money is not being spent on the people who do the most objective and intensive counseling.

I have heard from my SHIP colleagues across the country and they report the same concerns about questionable marketing and sales tactics from insurance agents selling PFFS plans and the coverage these plans provide. Like me, they are seeing most clients after the damage is done, rather than having the time to spend on outreach and education. We can only spread ourselves just so thin and it is disappointing to see so many fall into large debt as a consequence of enrolling in PFFS plans.

I would ask that this Committee review the entire Medicare Advantage structure, because the primary thing that is happening is our seniors and people with disabilities are being taken advantage of rather than given positive advantages for their health care.

Some immediate fixes could include:

1. Much tighter control over marketing and sales materials and approaches by insurance agents.
2. Requiring PFFS plans to have a minimum network of providers that people could see and rely on during the course of a year. This should not be the enrollee's responsibility on an ongoing basis.
3. A set of benefits and requirements so that it would be easier to compare products. To see 46 different plans, with even primary physician co-pay as varied as $10 to as much as 40% of the charge is too hard to compare.

I want to express to this Committee how deeply we (SHIP Coordinators) appreciate the allocation of additional funds for 2008 through the Omnibus Appropriations Act and the

Medicare, Medicaid, and SCHIP Extension Act of 2007. I have heard though, that CMS is possibly considering keeping these funds and not distributing them to the SHIP program. I currently can spend 24 hours a week focused on SHIP activities, which is little more than a half time position. If I spend 2 – 7 hours per client, it does not allow me to see many people. With additional funds, I could either work full time, or pay for additional staff that I could train so that they could learn and take forward the valuable information from year to year.

Thank you for opportunity to testify on this important subject. I hope that my sharing of experience is helpful to you as you formulate important policy. The New River Valley Agency on Aging in Virginia stands willing to serve as a resource to the Senate Finance Committee in the future. Please do not hesitate to contact us if we can be of assistance.