National Committee to Preserve Social Security & Medicare™
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United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on the Medicare Payment Advisory Commission's (MedPAC)
June Report to the Congress
Tuesday, June 19, 2012

Mr. Chairman and Members of the Committee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare (NCPSSM), and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving and promoting Social Security, Medicare, and Medicaid. As you know, these programs are the foundation of financial and health security for older Americans. Today, I will address our views about the recommendations in the June 2012 Medicare Payment Advisory Commission (MedPAC) report to Congress regarding reforming Medicare's benefit design and Medicare/Medicaid dual eligibles.

Medicare could be improved for beneficiaries by simplifying its cost-sharing requirements and adding a catastrophic cap. The current Medicare fee-for-service (FFS) program is complicated because there are different deductibles, copayments, and coinsurance for different types of services. In many cases the cost-sharing is quite high, and Medicare does not have a limit – a so-called "catastrophic cap" – on annual out-of-pocket spending, which is found in most large employer plans. Many Medicare beneficiaries are paying premiums for Medigap insurance or retiree health coverage to help with Medicare's costs-sharing requirements. They are also paying a large share of their incomes for health care services not covered by Medicare such as vision, dental and eye care as well as long-term care.

In the past, the National Committee has urged consideration of a proposal that would provide a comprehensive benefit in FFS Medicare that would include a catastrophic out-of-pocket limit on spending and a combined Part A and Part B deductible with the goal of bringing Medicare more in line with private plans and reducing the need for beneficiaries to purchase expensive supplemental coverage. More recently, we have raised concerns about proposals to restructure Medicare's benefits that have been considered in the context of deficit reduction. These proposals, such as one included in the Bowles-Simpson report, *The Moment of Truth*, would raise costs for most beneficiaries by combining the Part A and B deductible, establishing a catastrophic cap that would only benefit a small percentage of beneficiaries each year, requiring coinsurance on all services, and restricting Medigap first-dollar coverage.

We appreciate having the information provided in the June 2012 MedPAC report about reforming Medicare's benefit design and agree with the goals of reducing out-of-pocket costs for Medicare beneficiaries and increasing their use of high-value care. We certainly support the inclusion of a catastrophic cap on Medicare's cost sharing, which would give beneficiaries some

certainty about their health spending. However, many people would likely retain their Medicare supplemental policies to make their out-of-pocket costs before reaching the cap more predictable. Therefore, we have concerns about implementing a surcharge on both Medigap and employer-provided supplemental policies that would increase costs for beneficiaries, including those with policies they have had for many years. We are also troubled that raising costs for beneficiaries in the hopes of their seeking more high-value services could cause many - and especially lower-income beneficiaries – to forego necessary care which could lead to more serious health conditions and higher costs down the road. We believe beneficiaries are already paying a great deal for their health care, and many cannot afford to pay more.

Comments on Integrated Care Demonstrations. NCPSSM supports the Centers for Medicare and Medicaid Services' (CMS) demonstrations to develop and implement programs that will improve health care for dual eligible individuals (those receiving both Medicare and Medicaid benefits) while lowering costs. These demonstrations are managed through the Medicare-Medicaid Coordination Office in partnership with the Center for Medicare and Medicaid Innovation. States have an opportunity to test two financing models, capitated or managed fee-for-service, to coordinate dual eligibles' health care. Twenty-six states are pursuing one of these models, with enrollment in the demonstrations scheduled to begin in 2013 or 2014. The quick turnaround time for demonstration implementation is concerning because states and health plans may not be ready to deliver high-quality care to large numbers of new dual eligibles, especially those starting in 2013. If states and plans are not adequately prepared, the health of millions of vulnerable individuals could decline, potentially placing their lives at risk.

As an organization representing millions of seniors, including many of whom are low-income and/or have multiple chronic conditions, the National Committee applauds the MedPAC commissioners and staff for outlining several demonstration issues that require further attention. We agree with MedPAC's observations regarding the demonstrations and have similar concerns, including the large scope of the demonstrations, plan expertise, enrollment practices, and oversight and evaluation.

Large scope of the demonstrations. Of the approximately nine million dual eligibles nationwide, CMS plans to enroll between one to three million in the demonstrations, primarily through managed care. Many of the states plan to use a capitated financing model and enroll most or all of their dual eligibles into a health plan. This rapid expansion raises the question of whether the large scope of the demonstrations is instituting a major health care delivery change rather than testing a new model. Demonstrations are generally smaller in scope and assess the effectiveness of a particular intervention before expanding it to a larger population. Placing all dual eligibles into one or a few plans could be problematic because they are a diverse group and include several subpopulations, such as individuals under and over age 65 with different health conditions, cognitive, mental, physical or development disabilities. As a result, dual eligible individuals require different approaches and levels of health care.

Another concern is that once a large demonstration is established, it may be difficult to dismantle, even if the program is not providing high-quality care, because stakeholders will have an interest in maintaining the program. In brief, quickly expanding a demonstration model that is untested to a large population in a state could lead to poor health outcomes, failure of the

program, and a waste of beneficiary and taxpayer dollars**.** The National Committee recommends that demonstrations should be smaller (not statewide) and focus on subpopulations of dual eligibles to assess the program's effectiveness before further expansion.

Plan expertise serving dual eligibles. The majority of state demonstrations intend to use managed care organizations (MCOs) for health care coordination and delivery to their dual eligible populations. However, most MCOs have little experience serving both Medicare and Medicaid beneficiaries, especially those requiring long-term services and supports (LTSS) who are the most frail and expensive dual eligibles to treat. As noted in the MedPAC report, there are only 20 health plans with experience using capitated payment and with full financial risk for Medicare and Medicaid benefits. While it is important to expand good models of care as quickly as possible, it takes time to build high-quality, patient-centered programs and provider networks that can meet the needs of dual eligibles. The National Committee recommends that health plans demonstrate to CMS their experience in serving dual eligibles and proposed systems to evaluate outcomes and make adjustments when needed, prior to enrollment.

Enrollment practices. Many of the state demonstrations propose using passive enrollment with an opt-out option under the capitated model. This would involve states assigning enrollees through intelligent assignment to plans that meet their specific needs. While passive enrollment may encourage greater enrollment and expansion of integrated care, we concur with MedPAC that some states may not have the resources for intelligent assignment, which is important for a vulnerable population. It is also critical that dual eligibles are educated and understand their enrollment options and receive continuous care that is appropriate for their health conditions. The National Committee's preference is that the enrollment be voluntary, allowing enrollees to opt-out at any time with no lock-in period.

Oversight and evaluation. For accurate analysis and evaluation, there must be sufficient data collection. States enrolling most or all of their dual eligibles into a demonstration must have a comparable control group to determine if the intervention is successful. Oversight should occur at the federal, state, and plan levels and involve consumers and their caregivers to ensure that enrollees are receiving high-quality care. In addition, evaluations should take into consideration that some dual eligibles may be involved with other demonstrations in their states such as Accountable Care Organizations or medical homes. Therefore, there needs to be a way to account for overlap in order to accurately assess which programs are effective. The National Committee recommends that demonstrations include a control group and that all components of the demonstrations including the plan and or model design, payment, operations, and coverage are transparent to enrollees and the public.

The National Committee urges MedPAC to consider these issues as well as continuity of care, transitions, quality measurement, network and plan quality, and consumer protections as the demonstrations move forward. We hope the demonstrations succeed in providing new ways to improve care to dual eligibles while lowering overall health care costs.

Thank you again for this opportunity to submit our views on the MedPAC report.