Testimony of David R. Fillman, Executive Director, Council 13 of the American Federation of State, County and Municipal Employees (AFSCME) before the Committee on Finance, United States Senate on "Private Fee For Service Plans in Medicare Advantage: A Closer Look" January 30, 2008

Chairman Baucus and members of the Senate Finance Committee, I want to thank you for the opportunity to testify today. My name is David Fillman, and I am an International Vice President of the American Federation of State, County and Municipal Employees (AFSCME), which includes 1.4 million working members, the majority current and former employees of state and local governments, and 230,000 retirees. I am also the Executive Director of AFSCME Council 13 in Pennsylvania, representing more than 65,000 public employees. Our Retiree Chapter 13 counts over 12,000 members statewide.

As requested, my testimony today focuses on our union's perspective on Medicare Advantage private fee-for-service, including our experience in Pennsylvania and in other states experimenting with Medicare Advantage private fee-for-service (PFFS) plans.

The root of many of the problems with private fee-for-service Medicare Advantage plans stem from a 2003 change in Medicare law which gave insurance companies significant profit incentives to offer Medicare Advantage plans as a replacement for traditional Medicare. In the past, Medicare Advantage (MA) plans, which went by other names, were products that competed on a level payment playing field with traditional Medicare. We are concerned that the current enhanced incentives for private products as a replacement – not a supplement – to Medicare come at a great cost to beneficiaries, taxpayers and the integrity of the Medicare program.

Current estimates are that for every dollar spent for benefits under traditional Medicare it costs $1.17 when a private fee-for-service plan provides the benefits. Not surprisingly, with that enhanced profit, incentives enrollment in MA private fee-for-service has grown at an alarmingly rapid rate over the past year. There are now more than 1.9 million beneficiaries enrolled in MA private-fee-for service plans.

These significant incentives have led to predatory and often unscrupulous marketing practices by insurance companies on the individual market but they have also distorted the group retiree health care market. This overpayment windfall is luring more public employers to consider ill-advised changes to their coverage plans. Insurance companies have targeted our employers for the hard sell, including offers to pass through some of the federal subsidies to state and local governments. Using the overpayment windfall and with a blessing from the Centers for Medicare and Medicaid Services (CMS), insurance companies can develop a replacement for Medicare with an MA private-fee-for-service plan designed exclusively for an employer's retirees.

The new accounting rules issued by the Governmental Accounting Standards Board (GASB) place a tremendous strain on public retiree health benefits and add to the lure of these private Medicare plans. The GASB rules require public employers to estimate future costs of their retiree health benefits – 35 years into the future – and publish them on their annual financial statements. To reduce this paper liability, more public employers are proposing a switch from

their own solid retiree health plans, which include traditional Medicare, to these private Medicare plans. This is a major factor in public employers' decisions to switch to Medicare Advantage private fee-for-service plans.

In my state, Governor Rendell plans to replace our Retired Employees Health Program (REHP) for state government retirees with a Medicare Advantage private-fee-for-service plan and proposes to cut our prescription drug benefits. *He is removing retirees who are aged 65 and older from the secure state plan and forcing them out of the traditional Medicare program* By removing retirees from the secure state public plan (REHP), the Governor is denying them their right to access the secure Medicare program they have paid into all their lives.

Our retirees are moving from the Medicare defined benefit plan with a solid wrap-around supplemental, to an unknown plan. Although these private Medicare replacement plans must be the actuarial equivalent of Medicare they have a broad hand in shaping the details and setting co-payments, premiums and the real value of benefits from year to year. Experts have joked that if you have seen one Medicare Advantage fee-for-service plan then you've seen one MA plan – <u>for that year</u>. Aside from the confusion and added complexity, the forced shift to a Medicare replacement product can obscure a reduction in benefits and a shift of costs onto beneficiaries who have limited incomes and may be in fragile health.

We oppose this forced switch both from our understanding of its impact on Medicare generally as well as our fellow AFSCME members' experiences in West Virginia. Those retirees were forced out of Medicare and into an MA private fee-for-service plan last July. We also are beginning to hear from AFSCME retirees in Ohio who were just switched over this month to a Medicare Advantage private fee-for-service plan.

In West Virginia, 37,000 retired state employees and teachers covered by the Public Employees Insurance Agency (PEIA) were forced out of traditional Medicare and stripped of their supplemental plan. They were enrolled in Advantra Freedom, an MA plan administered by the for-profit giant, Coventry Health Care. In November, in PEIA hearings, hundreds of angry West Virginian retirees testified against Advantra Freedom.

One senior at the Charleston hearing, Peggy Beavers, complained that Coventry is "known throughout the country to cut costs any way they can", and said she did not understand why she would be forced out of Medicare into a replacement product offered by "a company that's all about making a profit for itself."

Specifically, AFSCME is concerned about the following complaints we have received from West Virginia and other states regarding PFFS plans. These concerns are typical of the problems inherent to MA private-fee-for service plans.

- Even though these plans are marketed as nationwide and have no networks – this is false. They limit access to care and choice because significant numbers of doctors and hospitals have refused to accept the card, especially out-of-state. For example, many West Virginia retirees who moved out of state could get no doctor to accept the private MA plan.

- MA private fee-for-service plans may offer additional benefits, such as gym memberships (the only major additional benefit in West Virginia), or hearing aids and eyeglass coverage, but they modify their benefits to cut corners in more important areas, such as limiting hospital days or charging higher co-pays for nursing homes than Medicare. Indeed, officials in West Virginia actually told a state legislative committee in November that "we know that … retirees who use more medical care will be worse off under this plan".

- PFFS plans more frequently deny claims in order to hold down costs.

- The appeals processes are more difficult under the private plans. Retirees are no longer enrolled in traditional Medicare and must go through the company rather than Medicare's transparent appeals process. Further, beneficiaries are often bounced between CMS and the insurance company seeking redress.

- The subsidy to the private plans causes government employers, many of whom have secure, self-insured medical plans, to switch control of their medical decisions to these private companies, break up their efficient risk pools, and allow private companies to profit off our retirees.

- The plans are not stable. They can and do pull out of markets, disrupting health care services and causing much anxiety among beneficiaries.

- There is a lack of quality and accountability. These private replacements for Medicare are exempt from basic quality reporting requirements. It is unclear how CMS overseers will be able to determine if these private fee-for-service plans deliver health care services more efficiently or increase consumer health outcomes.

In addition, we are concerned that Medicare Advantage plans are a drain on our state and its retirees. The more than one million Pennsylvania seniors who are enrolled in traditional Medicare are paying about $25 million in extra premiums to subsidize the 32 percent of beneficiaries who are enrolled in Medicare Advantage plans. The State is also paying for these subsidies. The Medicaid program in Pennsylvania pays Part B premiums for low-income beneficiaries and this cost was an extra $6.3 million in FY 2007.

When Congress opened up Medicare to private plans, it was based on the claim that the health insurance industry would be more efficient, provide more care coordination, and do so at less cost to taxpayers. PFFS plans do none of the above, and enrollees who are forced into them are no longer enrolled in Medicare.

State and local governments see money on the table, and they are, in economist-speak, "acting rationally" and grabbing the cash, at the expense, particularly, of the federal government. It has nothing to do with the superiority of these plans.

Again, the root of these problems is the enhanced profit incentives paid to these plans, by taxpayers and beneficiaries. Congress should know that cost shifting to the federal government was the top reason for West Virginia's switch, and frankly, for every other public employer that

considers a PFFS plan. West Virginia's PEIA said its decision was influenced by the higher reimbursements given to MA plans and that "these are federal dollars that will help pay the medical costs of Medicare retirees." Moreover, PEIA additionally offloaded major costs to the federal government by switching to a Medicare Advantage prescription drug plan.

With all this cost-shifting, the irony is that in West Virginia, Pennsylvania, and elsewhere, we as a nation are paying more to these private plans, for less. States easily use the switch as an opportunity to cut benefits, which is a serious additional risk of shifting retirees into these private replacements for Medicare.

Again, the root of these problems is the excessive financial incentives to develop and market these products which are designed to replace the tried and true Medicare program. These problems, the trend towards private plans, and the devastating privatization of our traditional Medicare program must be addressed. We concur with the recommendations made by MedPAC that MA private plans should compete on a level payment playing field. AFSCME urges you to act quickly, this year, and pass legislation to stop corporate greed from ruining our retirees' health.

Thank you again for the opportunity to appear here today.