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ACCOUNTABILITY AND OVERSIGHT IN THE MEDICARE ADVANTAGE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
JOINT WITH SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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ACCOUNTABILITY AND OVERSIGHT IN THE MEDICARE ADVANTAGE PROGRAM

TUESDAY, OCTOBER 16, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:07 p.m., in Room 1100, Longworth House Office Building, the Honorable Fortney Pete Stark (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
October 04, 2007
HL–17

Contact: (202) 225–3943

Stark and Lewis announced today that the Subcommittees will hold a joint hearing on statutorily required audits of Medicare Advantage plan bids, specifically focusing on the report by the Government Accountability Office entitled "Medicare Advantage: Required Audits of Limited Value"

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) and Oversight Subcommittee Chairman John Lewis (D–GA) announced today that the Subcommittees will hold a joint hearing on statutorily required audits of Medicare Advantage plan bids, specifically focusing on the report by the Government Accountability Office entitled "Medicare Advantage: Required Audits of Limited Value" (GAO–07–945). **The hearing will take place at 10:00 a.m. on Thursday, October 11, 2007, in room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

In 2006, the Centers for Medicare and Medicaid Services (CMS) spent nearly $56 billion on Medicare parts A and B benefits in the Medicare Advantage program, which covered approximately 6.7 million (nearly 16 percent) of the 43 million Medicare enrollees.

Under the program, CMS approves private companies to offer health plan options to Medicare enrollees. These companies are required to submit yearly bids of the costs and benefits package of each Medicare Advantage plan they intend to offer. CMS compares these bids to geographic-specific benchmarks. If higher, a plan must require enrollees to pay the difference as a premium. If lower, 75% of the difference must be provided to enrollees as additional services or cost savings, while 25% is retained by the Treasury. CMS pays plans based on this formula, per enrollee, on a monthly basis, before services are rendered.

The 1997 Balanced Budget Act (BBA) (P.L. 105–33) requires CMS to annually audit the supporting financial records of at least one-third of participating organizations. The BBA also requires the Government Accountability Office (GAO) to monitor this audit activity.

In July 2007, GAO released a report on audits of the Medicare Advantage program and found that CMS did not meet the statutory audit requirement for the years 2001–2006. CMS selects organizations to meet the statutory audit requirement based on the number of organizations and not the total number of plans. GAO reported that, in 2006, CMS audited only 13.9 percent of the participating organizations (down from a high of 22.3 percent in 2003). GAO also found that, in 2006, only 159 (or 3.2 percent) of the total 4,920 Medicare Advantage plans were examined.

Some audits revealed errors in the bids. CMS does not sanction or seek to recover funds from providers that audits reveal are in violation of the bid requirements. A CMS contractor estimated that, for 2003, bid errors cost beneficiaries a net loss of $59 million in additional benefits, lower co-payments, or lower premiums.

"The GAO report raises serious questions about the management and oversight of the Medicare Advantage program. Mandated audits are not performed, and those that are performed are not used to make needed changes, costing beneficiaries and taxpayers millions in overpayments and lost benefits," said Health Subcommittee Chairman Stark. **"The report again shows that Medicare Advantage does not live up to the service and cost savings promises that were made at its inception. Lack of oversight makes this bad idea even worse."**

"The integrity of the Medicare Advantage program is important to everyone," said Oversight Subcommittee Chairman, John Lewis. **"GAO reported that, based on 2003 audits, beneficiaries could have received at least $34 million and possibly up to $59 million in additional benefits, lower co-payments, and lower premiums. Enrollees place their trust in their Medicare Advantage plans and I am committed to ensuring that the Medicare Advantage program gives enrollees what they deserve."**

FOCUS OF THE HEARING:

The hearing will examine the value and accuracy of payments to Medicare Advantage plans, specifically focusing on the report by the Government Accountability Office entitled "Medicare Advantage: Required Audits of Limited Value" (GAO–07–945).

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "110th Congress" from the menu entitled, "Committee Hearings" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You MUST REPLY to the email and ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **THURSDAY, OCTOBER 25, 2007**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. I want to thank Chairman Lewis and Mr. Camp for joining us to discuss the lack of oversight on Medicare Advantage plans. It is the third Ways and Means hearing this year to discuss the Medicare Advantage industry.

The focus of our hearing is the issue of private government contractors receiving billions of dollars to administer a government program with no oversight or control by the administration.

The Government Accountability Office will review for us their first oversight in six years on private Medicare plans, whether they have been known as: Medicare Part C; Medicare Plus Choice; Medicare Advantage. During that time, the administration has never—or we, Congress, have never asked the administration to report or review these programs. We spent $56 billion on these plans in 2006, and we will spend north of $75 billion this year. We have got 8 million beneficiaries enrolled. And yet, for 6 years, nobody has thought that the plans require any oversight.

When the plans formally asked to join Medicare in 1982, we heard the tired refrain that private industry does everything better and cheaper than government. So the payment was set at 95 percent of fee for service. Then, the plans came back a few years later, and said they could do it better, but only if they got paid as much as Medicare. Then, in 2003, they said, well, they could provide choice, or an advantage, but only if they got paid more than Medicare.

The Medicare Payment Advisory Commission, CMS's own actuary, and the Congressional Budget Office, each estimate that Medicare Advantage plans are overpaid. MedPAC estimates that the average overpayment is 112 percent of Medicare's cost, with plans in some areas exceeding 150 percent of Medicare's rates.

It is no secret that many of us find this wrong, as do many of America's taxpayers. These overpayments increase premiums for all Medicare beneficiaries. And the so-called additional benefits to Medicare enrollees are elusive, often designed to weed out the less healthy, more expensive beneficiaries.

CMS's actuary estimates that the overpayments to Medicare Advantage reduce the viability of the Medicare trust fund by 3 years. Those who wish to see Medicare Advantage continue must accept that we demand transparency. We will hear claims today that Medicare Advantage provides increases in benefits to enrollees. And, at a 12 to 20 percent premium over traditional Medicare, they ought to. But even these claims aren't substantiated by any factual reporting or detail. Those who sing the praises of Medicare Advantage must accept responsible oversight.

If you think this program is helping beneficiaries and the integrity of the Medicare system, you should be able to provide detailed accounting of what is promised and delivered, and explain how much is paid for these services. GAO reports that CMS audits only a small percentage of the bids that plans submit, even though the law requires them to audit one-third of the plans.

What is even more disturbing is that, while they have failed to meet the terms of the law, even the small percentage reveals large discrepancies with millions of dollars in lost benefits and incorrect accounting. The few audits that are actually performed only show us what plans offer, not the benefits that they actually deliver. In a $73 billion program, we have no idea what benefits are being delivered. That's not good government; it is dereliction of duty.

I hope today we can dispense with the sales pitches, and get some facts and figures that will help us determine the value of Medicare Advantage to anyone other than the stockholders and the providers.

Mr. Camp could go next, then Mr. Lewis. Is that all right?

Mr. LEWIS. Yes, that is fine.

Mr. CAMP. Well, thank you, Mr. Chairman. I don't think anyone sitting up here will argue that the Medicare program is perfect. For example, we have learned that some Medicare Advantage plans have engaged in misleading marketing practices, overly aggressive sales tactics, and questionable denials. But then I have seen that in more than a few campaigns, as well.

But, however, this is a serious issue, and we simply cannot turn a blind eye to it. And I commend the chairman for using our oversight authority to improve this program.

I am concerned that the GAO found that CMS is not auditing Medicare Advantage plans, consistent with the law. Congress enacted the audit requirements because we recognized how important it is to review and verify the data that these plans submit. CMS's failure to meet this requirement is unacceptable, and I expect to hear what steps they are going to take to address this problem.

It is also unacceptable that some plans are being paid, and not providing the benefits they promised to Medicare beneficiaries. I look forward to learning what CMS is doing to ensure that Medicare Advantage plans are providing these benefits, and whether they need any additional authority to recoup these inappropriate payments to Medicare Advantage plans. I am sure this congress will be more than happy to grant them such authority, if it is needed.

However, this is far from the only area we need to be pursuing. We are seemingly focused on the Medicare Advantage program, which deserves our scrutiny. But it is clear that there are bad apples sprinkled throughout Medicare. Recent press reports have detailed shocking examples of fraud within the fee-for-service Medicare program that have cost the Medicare program and its beneficiaries billions of dollars.

Just one recent case involving durable medical equipment providers in south Florida saw the Medicare fee-for-service program bilked out of hundreds of millions of dollars for services and equipment that were never provided. Similarly, the GAO reported that

thousands of physicians who received federal Medicare payments failed to pay their federal taxes.

Despite the committee's clear jurisdiction in this area, we have yet to explore ways to ensure that these abuses do not continue, and I hope we do so. I say this to provide suggestions for future hearings, as well as to put the issues surrounding Medicare Advantage into perspective.

While we have heard witnesses question the Medicare Advantage program, one such witness also agreed that the problems he found within the Medicare Advantage program affected only .3 percent of the Medicare Advantage enrollees in his state. Again, putting these issues in context is important.

There is no question that Medicare Advantage payment rates should be re-examined. The challenge is finding the balance between trimming the fat and cutting the bone. We don't want seniors in rural areas to lose their health coverage, nor do we want benefits slashed.

Also, we don't want plans to reap such excessive profits that they are unable to invest in and add supporting a massive expansion of government-run health care—they are able to invest and supporting a massive expansion of government-run health care.

I look forward to working with the chairman, and I hope he will take me up on my offer and engage in a constructive debate to craft a reasonable Medicare package that could be signed into law. And with that, I yield back the balance of my time.

Chairman STARK. The co-chairman.

Mr. LEWIS. Thank you, Mr. Chairman. This morning, the oversight and health subcommittees will hold a joint hearing to review the Medicare Advantage program. It is a pleasure to co-chair this hearing with my good friend from California, Chairman Stark.

Over eight million Americans rely on Medicare Advantage. They enroll in this program because they believed that the premiums they were paying would be fair for the benefits they receive. But this is not always the case. Private insurance companies make huge profits by offering these plans. The Federal Government pays, on average, 12 to 19 percent more for each senior in a Medicare Advantage plan than for a senior in traditional Medicare.

This overpayment does not buy any additional benefits, or reduce copayments. It is going directly into the pockets of the insurance companies. The waste in the Medicare Advantage program is shameful. The lack of CMS oversight is a disgrace. And the treatment of beneficiaries is just unacceptable.

Current law requires CMS to audit at least one-third of the organization participating in Medicare Advantage each year. The GAO found that CMS has not met this goal. The audits that were performed reveal large overpayments to Medicare Advantage plans. For 2003, the audits showed overpayments of up to $96 million—$96 million. That is unbelievable.

What is more amazing is that CMS did nothing, absolutely nothing, to get this money back, or to sanction these private plans. Large overpayments, huge profits and commissions have led to scandals in MA plans. Eleven states have reported seniors, who thought they were signing an information form, were suddenly en-

rolled in an MA plan. Fifteen states reported mass enrollment at senior centers, nursing homes, and senior housing.

In Georgia, insurance agents asked to visit patients alone in their rooms, and not in the common areas. One agent switched a mentally disabled patient to an MA plan without anyone's knowledge.

We must protect the beneficiaries. Senior must have a voice. If CMS will not properly oversee this program, and provide seniors with a voice, then the Congress will. Mr. Chairman, I yield back.

Chairman STARK. Thank you. And I think the staff is going to pass out—unless your eyes are a lot better than mine, the chart that we are looking at over there, the blue chart, we are going to hand out a reprint of it, if it will help those of us who are sight-challenged.

This morning our first panel consists of: Mr. Jeff Steinhoff, who is the managing director of Financial Management and Assistance at the U.S. Government Accountability Office—GAO, as I like to call it; Mr. James Cosgrove, who is the acting director of health care at the GAO; and Mr. Timothy B. Hill, the chief financial officer for the Centers for Medicare and Medicaid Services—once HCFA and now CMS.

I would like to welcome all of you here. We sort of run a clock, but if you really get us fascinated, we may let you scoot over a few minutes. We have your prepared testimony. Without objection, all of it will appear in the record in its entirety. And I would welcome you to enlighten the committee in any manner you choose.

Mr. Steinhoff, would you like to lead off?

Mr. STEINHOFF. By all means.

STATEMENT OF JEFFERY STEINHOFF, MANAGING DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. STEINHOFF. Mr. Chairman, Members of the Subcommittees, we are pleased to be here today to discuss our July 2007 report on Medicare Advantage audits. Our work covered audits for 2001 to 2006. For 2001 to 2005, the audits covered the adjusted community rate submissions. And beginning in 2006, shifted to bid submissions under MMA.

The Balanced Budget Act of 1997 requires that CMS annually audit the financial records supporting the submissions of at least one-third of the Medicare Advantage organizations. The law requires that GAO monitor these audits.

Now, what did we find when we most recently reviewed CMS's audit process? The bottom line: the audit process was of limited value. We identified three fundamental problems.

First, as shown on page four of my statement today, as well as the sheets that were just passed out to you all, and on the blue chart over here on the side, CMS did not come close to meeting the one-third requirement in any of the 5 years of the ACR audits. The highest rate was 23.6 percent for 2001.

For the 2006 bid audits, the audit rate dropped to 13.9 percent. CMS told us that it plans to perform additional procedures for 2006. The nature of this work had not been finalized at the time

of our review. But the stated time frame for completion was 3 years, which will limit the use of any results.

Second, the audits were not designed to provide information on the impact of audit findings on beneficiaries. The ACR auditors reported findings ranging from the lack of supporting documentation to overstating and understating certain costs, but were not required by CMS to determine the impact on benefits, copayments, or premiums. So you knew something was wrong, but you didn't know really what it meant in dollar terms, or in benefits delivered.

CMS subsequently hired a contractor to do so for the 2003 ACR audits, and ultimately, quantified the impact as $35 million. Chairman Lewis mentioned an earlier figure. the contractor found that there were overstatements of $96 million, as Chairman Lewis said, and understatements in other areas. And then, CMS reviewed this, and reduced the total to a net $35 million.

Reviews of the impact of errors identified by the 2004 and 2005 audits were not completed when we finished our review. And the work for 2005 was somewhat suspended because of the bid audits for 2006. Similarly, the bid audits did not require a determination of the impact of findings on beneficiaries. The type of finding was laid out. The fact it would be material in some way was stated. But the dollar effects were not quantified.

Third, although information on the impact on beneficiaries eventually became available for 2003, you had the $59 million and the $35 million net numbers, CMS plans to close out the 2003 audits without pursuing financial recoveries, or taking other remedial actions, and does not plan to take actions for the other years.

CMS's position is that it has neither the legal authority nor the contractual right to pursue recoveries based on audit results. We view this problem as being self-imposed. Our reading of the law is that CMS has the authority to amend its regulations to provide that all Medicare Advantage contracts give CMS the ability to address audit findings, including pursuing financial recoveries and other remedial actions.

We agree that CMS's regulations and contracts did not include such provisions for 2001 to 2006, which is why we recommended CMS remedy the situation going forward, either administratively, by changing its regulations—which we believe it has the authority to do—or by seeking legislation.

In closing, when CMS falls short in meeting the statutory audit requirement, opportunities to determine if participant organizations have reasonably estimated the cost to provide benefits to Medicare Advantage enrollees are lost. Inaction or untimely audit resolution undermines the presumed effective audit efforts.

Finally, the oversight that Congress called for when it mandated the audit requirement 10 years ago is not being achieved. Today's hearing provides a good starting point for re-evaluating what the congress expects out of the audit process, and determining how audits can be turned into a tool that provide value and accountability—trust, but verify through the audit process—for a program that is $60 billion today and growing rapidly, and touches the lives of millions of Americans each and every day.

Mr. Chairman, this completes my summary remarks. We would be pleased to respond to any questions that you or Members of the Subcommittees may have at this time.

[The prepared statement of Mr. Steinhoff follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittees on Health and Oversight, Committee on Ways and Means, House of Representatives

For Release on Delivery Expected at 10:00 a.m. EST Tuesday, October 16, 2007

MEDICARE ADVANTAGE

Required Audits of Limited Value

Statement of:

Jeffrey C. Steinhoff, Managing Director, Financial Management and Assurance

and

James Cosgrove, Acting Director, Health Care

Accompanied by:

Kimberly Brooks, Assistant Director, Financial Management and Assurance

GAO

Accountability * Integrity * Reliability

GAO-08-154T

GAO

Highlights

Highlights of GAO-08-1547, a testimony before the Subcommittees on Health and Oversight, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

In fiscal year 2006, the Centers for Medicare & Medicaid Services (CMS) estimated it spent over $51 billion on the Medicare Advantage program, which serves as an alternative to the traditional fee-for-service program. Under the Medicare Advantage program, CMS approves private companies to offer health plan options to Medicare enrollees that include all Medicare-covered services. Many plans also provide supplemental benefits. The Balanced Budget Act (BBA) of 1997 requires CMS to annually audit the financial records supporting the submissions (i.e., adjusted community rate proposals (ACRP) or bids) of at least one-third of participating organizations. BBA also requires that GAO monitor the audits. This testimony provides information on (1) the ACRP and bid process and related audit requirement, (2) CMS' efforts related to complying with the audit requirement, and (3) factors that cause CMS' audit process to be of limited value.

What GAO Recommends

In past work, GAO made five recommendations to CMS for meeting the one-third audit requirement, enhancing its audit follow-up, and improving the bid audit process. CMS concurred with our recommendations.

To view the full product, including the scope and methodology, click on GAO-08-1547. For more information, contact Jeanette Franzel at 202-512-9471 or franzelj@gao.gov.

October 16, 2007

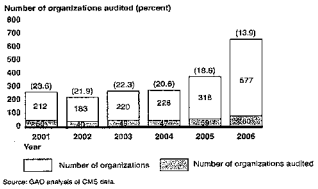
MEDICARE ADVANTAGE

Required Audits of Limited Value

What GAO Found

Before 2006, companies choosing to participate in the Medicare Advantage program were annually required to submit an ACRP to CMS for review and approval. In 2006, a bid submission process replaced the ACRP process. The ACRPs and bids identify the health services the company will provide to Medicare members and the estimated cost for providing those services. CMS contracted with accounting and actuarial firms to perform the required audits.

According to our analysis, CMS did not meet the requirement for auditing the financial records of at least one-third of the participating Medicare Advantage organizations for contract years 2001-2005. CMS is planning to conduct other financial reviews of organizations to meet the audit requirement for contract year 2006. However, CMS does not plan to complete the financial reviews until almost 3 years after the bid submission date each contract year, which will affect its ability to address any identified deficiencies in a timely manner.



Source: GAO analysis of CMS data.

CMS did not consistently ensure that the audit process for contract years 2001-2005 provided information to assess the impact on beneficiaries. After contract year 2003 audits were completed, CMS took steps to determine such impact and identified an impact on beneficiaries of about $35 million. CMS audited contract year 2006 bids for 80 organizations, and 18 had a material finding that affected amounts in approved bids. CMS officials took limited action to follow up on contract year 2006 findings. CMS officials told us they do not plan to sanction or pursue financial recoveries based on these audits because the agency does not have the legal authority to do so. According to our assessment of the statutes, CMS had the authority to pursue financial recoveries, but its rights under contracts for 2001–2005 were limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies. Further, our assessment of the statute is that CMS has the authority to include terms in bid contracts that would allow it to pursue financial recoveries. Without changes in its procedures, CMS will continue to invest resources in audits that will likely provide limited value.

Mr. Chairmen and Members of the Subcommittees:

We are pleased to be here today to testify on the results of our review of the Centers for Medicare & Medicaid Services' (CMS) audit activities related to Medicare Advantage (MA) organizations that was mandated by the Balanced Budget Act (BBA) of 1997.[1] Our results are documented in our July report, *Medicare Advantage: Required Audits of Limited Value*.[2] BBA requires CMS to annually audit the financial records (including data relating to Medicare utilization and costs) of at least one-third of the organizations participating in the Medicare Advantage program. BBA also requires us to monitor CMS' audit activities.

In fiscal year 2006, CMS estimated it spent over $51 billion on the Medicare Advantage program,[3] which serves as an alternative to Medicare's traditional fee-for-service program. Under Medicare Advantage, CMS approves private companies to offer health plan options that include all Medicare-covered services. In addition, many plans provide supplemental benefits, such as a reduction in the enrollee's required cost sharing (e.g., beneficiaries' Part B premiums)[4] or coverage for items and services not included under the traditional fee-for-service program, such as dental care. According to CMS, in fiscal year 2006, over 16 percent of Medicare beneficiaries—or about 7 million of the approximately 43 million—were enrolled in a Medicare Advantage plan.

Our review covered CMS audits for contract years 2001 through 2006. In summary, we found that the required audits were of limited value, which is similar to what we reported on audits for contract year 2000 in October 2001, when we last reviewed CMS' audit activities under BBA.[5] The findings in our latest review cause us continuing concern about the audit process. CMS did not document its process to determine whether it met the requirement to audit the financial records of at least one-third of the participating organizations for

[1]Pub. L. No. 105-33, tit. IV, § 4001, 111 Stat. 251, 320 (Aug. 5, 1997) (codified at 42 U.S.C. § 1395w-27(d)(1)).

[2]GAO, *Medicare Advantage: Required Audits of Limited Value*, GAO-07-945 (Washington, D.C.: July 30, 2007).

[3]Total Medicare outlays in fiscal year 2006 were $381.9 billion.

[4]Medicare Part B provides coverage for certain physician, outpatient hospital, laboratory, and other services to beneficiaries who pay monthly premiums.

[5]GAO, *Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness*, GAO-02-33 (Washington, D.C.: October 9, 2001).

contract years 2001 through 2006, and based on our analysis of available CMS data, CMS did not meet that requirement. For those audits that CMS completed, it did not consistently ensure that the audit process provided information needed for assessing the potential impact on beneficiaries, and CMS took limited action to follow-up on the audit findings.

Today, we will discuss the findings in our recent report. Specifically, we will tell you about:

- the adjusted community rate proposal (ACRP) and bid process and the related audit requirement for organizations that participate in the Medicare Advantage program,
- CMS' efforts to comply with the audit requirement for organizations' ACRP and bid submissions, and
- factors that cause CMS' audit process to be of limited value.

Our prior work on which this testimony is based was performed in accordance with generally accepted government auditing standards.

Medicare Advantage ACRP and Bid Process and Related Audit Requirements

Before 2006, companies choosing to participate in the Medicare Advantage program were required to annually submit an ACRP to CMS for review and approval for each plan they intended to offer.[6] The ACRP consisted of two parts—a plan benefit package and the adjusted community rate (ACR). The plan benefit package contained a detailed description of the benefits offered, and the ACR contained a detailed description of the estimated costs to provide the package of benefits to an enrolled Medicare beneficiary. These costs were to be calculated based on how much a plan would charge a commercial customer to provide the same benefit package if its members had the same expected use of services as Medicare beneficiaries. CMS made payments to the companies monthly in advance of rendering services.

In 2003, Congress enacted the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).[7] MMA included provisions that established a bid submission process to replace the ACRP submission process, as well as a new prescription drug benefit, both effective for 2006. Under the bid process, an organization choosing to participate in Medicare Advantage is required to

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[7]Pub. L. No. 108-173, 117 Stat. 2066 (Dec. 8, 2003).

annually submit a bid for review and approval for each plan they intend to offer. The bid submission includes the organization's estimate of the cost of delivering services (submitted on a bid form) to an enrolled Medicare beneficiary and a plan benefit package that provides a detailed description of the benefits offered. In addition, each MA organization and prescription drug plan that offers prescription drug benefits under Part D[8] is required to submit a separate prescription drug bid form, a formulary,[9] and a plan benefit package to CMS for its review and approval. On the bid forms, MA organizations include an estimate of the per-person cost of providing Medicare-covered services.

BBA requires CMS to annually audit the submissions of one-third of MA organizations. In defining what constituted an organization for the purpose of selecting one-third for audit, CMS officials explained that they determined the number of participating organizations based on the number of contracts they awarded. Under each contract, an organization can offer multiple plans. Further, an organization like Humana Inc. can have multiple contracts.

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GAO Analysis Shows CMS Did Not Meet the Audit Requirement

According to our analysis of available CMS data, CMS did not meet the statutory requirement to audit the financial records of at least one-third of the participating MA organizations for contract years 2001 through 2005, nor has it done so yet for the 2006 bid submissions. We performed an analysis to determine whether CMS had met the requirement because CMS could not provide documentation to support the method it used to select the ACRs and bids for audit, nor did CMS document whether or how it met the one-third requirement for contract years 2001 through 2006. Our analysis shows that between 18.6 and 23.6 percent, or fewer than one-third, of the MA organizations (as defined by the number of contracts each year) for contract years 2001 through 2005 were audited each year. Similarly, we determined that only 13.9 percent of the MA organizations

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and prescription drug plans with approved bids for 2006 were audited, as of the end of our review.[10] Table 1 summarizes our results.

Table 1: Summary of MA Organizations Audited as a Percentage of Total MA Organizations and Audit Costs

Contract year	Type of audit	Number of organizations audited[a]	Number of organizations	Percentage of organizations audited	Audit costs[b] (dollars in millions)
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[a]In determining what constituted an organization for audit purposes, CMS determined the number of organizations based on the contract level. Several plans may be offered under one contract.

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As stated earlier, CMS selects organizations to meet the one-third audit requirement based on the number of contracts awarded and not the total number of plans offered under each contract. However, to present additional perspective, we also analyzed the percentage of plans audited of the total number of plans offered by each audited organization. Our analysis shows that with the exception of contract year 2002, the level of audit coverage achieved by CMS audits has progressively decreased in terms of the percentage of plans audited for those organizations that were audited. Audit coverage has also decreased in terms of the percentage of plans audited of all plans offered by participating organizations each contract year. In contract year 2006, a large increase in the number of bid submissions meant that the 159 plans audited reflected only 3.2 percent of all the plans offered. Table 2 summarizes our analysis.

[10]The 80 organizations audited for contract year 2006 included 60 MA organizations with prescription drug plans and 20 prescription drug plans.

Table 2: Summary of Audited Plans as a Percentage of Those Offered by Audited Organizations and All Participating Organizations

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Regarding contract years 2001 through 2004, CMS officials told us that they did not know how the MA organizations were selected for audit, and the documentation supporting the selections was either not created or not retained. For contract year 2005 audits, CMS officials told us that the selection criteria included several factors. They said that the criteria considered included whether the MA organization had been audited previously and whether it had significant issues.

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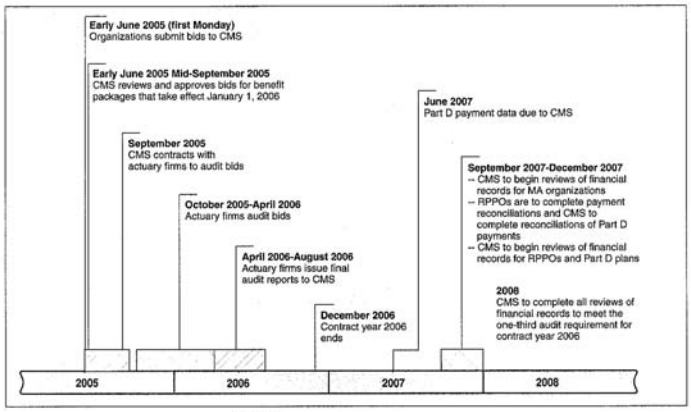
complete these other financial reviews until almost 3 years after the bid submission date (see figure 1) for each contract year, in part because it must first reconcile payment data that prescription drug plans are not required to submit to CMS until 6 months after the contract year is over. Such an extended cycle for conducting these reviews greatly limits their usefulness to CMS and hinders CMS' ability to recommend and implement timely actions to address identified deficiencies in the MA organizations' and prescription drug plans' bid processes.

Figure 1: Time Elapsed from Contract Year 2006 Bid Submissions to Reviews to Meet Audit Requirement



Source: GAO.

CMS' Audit Process Was of Limited Value

In its audits for contract years 2001-2005, CMS did not consistently ensure that the audit process provided information needed for assessing the potential impact of errors on beneficiaries' benefits or payments to the MA organizations. The auditors reported findings ranging from lack of supporting documentation to overstating or understating certain costs, but did not identify how the errors affected beneficiary benefits, copayments, or premiums. In addition, although the auditors categorized their results as findings and observations, with findings being more significant, depending on their materiality to the average payment rate reported in the ACR, the distinction between findings and observations, was based on judgment,

and therefore varied among the different auditors. In our 2001 report, we reported that CMS planned to require auditors, where applicable, to quantify in their audit reports the overall impact of errors.[12] Further, during the work for the 2001 report, CMS officials stated that they were in the process of determining the impact on beneficiaries and crafting a strategy for audit follow-up and resolution. CMS did not initiate any actions to attempt to determine such impact until after the contract year 2003 audits were completed. CMS took steps to determine such impact and identified a net of about $35 million from the contract year 2003 audits that beneficiaries could have received in additional benefits.[13] The only audit follow-up action that CMS has taken regarding the ACR audits was to provide copies of the audit reports to the MA organizations and instruct them to take action in subsequent ACR filings.

In CMS' audits of the 2006 bid submissions, 18 (or about 23 percent) of the 80 organizations audited had material findings that have an impact on beneficiaries or plan payments approved in bids. CMS defined material findings as those that would result in changes in the total bid amount of 1 percent or more or in the estimate for the costs per member per month of 10 percent or more for any bid element.[14] CMS officials told us that they will use the results of the bid audits to help organizations improve their methods in preparing bids in subsequent years and to help improve the overall bid process. Specifically, they told us they could improve the bid forms, bid instructions, training, and bid review process.

CMS' audit follow-up process has not involved pursuing financial recoveries from Medicare Advantage organizations based on audit results even when information was available on deficiencies or errors that could impact beneficiaries. CMS officials told us they do not plan to pursue financial recoveries from MA organizations based on the results of ACR or bid audits because the agency does not have the legal authority to do so. According to our assessment of the statutes, CMS has the authority to pursue financial recoveries, but its rights under contracts for 2001 through 2005 are limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies, including pursuit of financial recoveries.

[12]GAO-02-33, p. 20.

[13]Information on the impact of errors identified in contract year 2004 and contract year 2005 audits was not completed or not available at the time we completed our recent review.

[14]Findings also include any serious failure to follow applicable Actuarial Standards of Practice. Materiality for identifying observations included all other errors or deviations from the instructions or best actuarial practices that did not meet the criteria for being classified as findings.

Regarding the bid process that began in 2006, our assessment of the statutes is that CMS has the authority to include terms in bid contracts that would allow it to pursue financial recoveries based on bid audit results.[15] CMS also has the authority to sanction organizations, but it has not.

CMS officials believe the bid audits provide a "sentinel or deterrent effect" for organizations to properly prepare their bids because they do not know when the bids may be selected for a detailed audit. Given the current audit coverage, CMS is unlikely to achieve significant deterrent effect, however, because only 13.9 percent of participating organizations for contract 2006 have been audited.

Concluding Remarks

Appropriate oversight and accountability mechanisms are key to protecting the federal government's interests in using taxpayer resources prudently. When CMS falls short in meeting the statutory audit requirements and in a timely manner resolving the findings arising from those audits, the intended oversight is not achieved and opportunities are lost to determine whether organizations have reasonably estimated the costs to provide benefits to Medicare enrollees. Inaction or untimely audit resolution also undermines the presumed deterrent effect of audit efforts.

While the statutory audit requirement does not expressly state the objective of the audits or how CMS should address the results of the audits, the statute does not preclude CMS from including terms in its contracts that allow it to pursue financial recoveries based on audit results. If CMS maintains the view that statute does not allow it to take certain actions, the utility of CMS' efforts is of limited value.

In our recent report, we made several recommendations to the CMS Administrator to improve processes and procedures related to its meeting the one-third audit requirement and audit follow-up. We also recommended that CMS amend its implementing regulations for the Medicare Advantage Program and Prescription Drug Program to provide that all contracts CMS enters into with MA organizations and prescription drug plan sponsors include terms that inform these organizations of the audits and give CMS authority to address identified deficiencies, including pursuit of financial recoveries. We further recommended that if CMS does not believe it has the authority to amend its implementing regulations for these purposes, it should ask Congress for express authority to do

[15] 42 U.S.C. § 1395w-27(e)(1); 42 C.F.R. § 422.504(j). This provision also applies to prescription drug plans under Part D. 42 U.S.C. § 1395w-112(b)(3)(D).

so. In response to our report, CMS concurred with our recommendations and stated it is in the process of implementing some of our recommendations.

Contacts and Acknowledgments

For information about this statement, please contact Jeanette Franzel, Director, Financial Management and Assurance, at (202) 512-9471 or franzelj@gao.gov or James Cosgrove, Acting Director, Health Care, at (202) 512-7029 or cosgrovej@gao.gov. Individuals who made key contributions to this testimony include Kimberly Brooks (Assistant Director), Christine Brudevold, Paul Caban, Abe Dymond, Jason Kirwan, and Diane Morris.

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Chairman STARK. Thank you. Mr. Cosgrove.

Mr. COSGROVE. Mr. Chairman, I don't have any prepared remarks. I am available to answer any questions that you may have.

Chairman STARK. Okay. Mr. Hill.

[The prepared statement of Mr. Cosgrove follows:]

Prepared Statement of James Cosgrove, Acting Director, Health Care, U.S. Government Accountability Office

United States Government Accountability Office

GAO

Testimony

Before the Subcommittees on Health and Oversight, Committee on Ways and Means, House of Representatives

For Release on Delivery Expected at 10:00 a.m. EST Tuesday, October 16, 2007

MEDICARE ADVANTAGE

Required Audits of Limited Value

Statement of:

Jeffrey C. Steinhoff, Managing Director, Financial Management and Assurance

and

James Cosgrove, Acting Director, Health Care

Accompanied by:

Kimberly Brooks, Assistant Director, Financial Management and Assurance

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Accountability * Integrity * Reliability

GAO-08-154T

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Highlights

Highlights of GAO-08-164T, a testimony before the Subcommittees on Health and Oversight, Committee on Ways and Means, House of Representatives

October 16, 2007

MEDICARE ADVANTAGE

Required Audits of Limited Value

Why GAO Did This Study

In fiscal year 2006, the Centers for Medicare & Medicaid Services (CMS) estimated it spent over $51 billion on the Medicare Advantage program, which serves as an alternative to the traditional fee-for-service program. Under the Medicare Advantage program, CMS approves private companies to offer health plan options to Medicare enrollees that include all Medicare-covered services. Many plans also provide supplemental benefits. The Balanced Budget Act (BBA) of 1997 requires CMS to annually audit the financial records supporting the submissions (i.e., adjusted community rate proposals (ACRP) or bids) of at least one-third of participating organizations. BBA also requires that GAO monitor the audits. This testimony provides information on (1) the ACRP and bid process and related audit requirement; (2) CMS' efforts related to complying with the audit requirement; and (3) factors that cause CMS' audit process to be of limited value.

What GAO Recommends

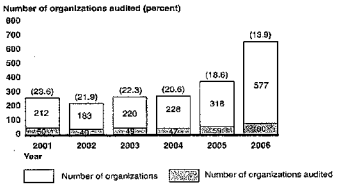
In past work, GAO made five recommendations to CMS for meeting the one-third audit requirement, enhancing its audit follow-up, and improving the bid audit process. CMS concurred with our recommendations.

To view the full product, including the scope and methodology, click on GAO-08-164T. For more information, contact Jeanette Franzel at 202-512-9471 or franzelj@gao.gov.

What GAO Found

Before 2006, companies choosing to participate in the Medicare Advantage program were annually required to submit an ACRP to CMS for review and approval. In 2006, a bid submission process replaced the ACRP process. The ACRPs and bids identify the health services the company will provide to Medicare members and the estimated cost for providing those services. CMS contracted with accounting and actuarial firms to perform the required audits.

According to our analysis, CMS did not meet the requirement for auditing the financial records of at least one-third of the participating Medicare Advantage organizations for contract years 2001-2005. CMS is planning to conduct other financial reviews of organizations to meet the audit requirement for contract year 2006. However, CMS does not plan to complete the financial reviews until almost 3 years after the bid submission date each contract year, which will affect its ability to address any identified deficiencies in a timely manner.



Source: GAO analysis of CMS data.

CMS did not consistently ensure that the audit process for contract years 2001-2005 provided information to assess the impact on beneficiaries. After contract year 2003 audits were completed, CMS took steps to determine such impact and identified an impact on beneficiaries of about $35 million. CMS audited contract year 2006 bids for 80 organizations, and 18 had a material finding that affected amounts in approved bids. CMS officials took limited action to follow up on contract year 2006 findings. CMS officials told us they do not plan to sanction or pursue financial recoveries based on these audits because the agency does not have the legal authority to do so. According to our assessment of the statutes, CMS had the authority to pursue financial recoveries, but its rights under contracts for 2001–2005 were limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies. Further, our assessment of the statute is that CMS has the authority to include terms in bid contracts that would allow it to pursue financial recoveries. Without changes in its procedures, CMS will continue to invest resources in audits that will likely provide limited value.

Mr. Chairmen and Members of the Subcommittees:

We are pleased to be here today to testify on the results of our review of the Centers for Medicare & Medicaid Services' (CMS) audit activities related to Medicare Advantage (MA) organizations that was mandated by the Balanced Budget Act (BBA) of 1997.[1] Our results are documented in our July report, *Medicare Advantage: Required Audits of Limited Value*.[2] BBA requires CMS to annually audit the financial records (including data relating to Medicare utilization and costs) of at least one-third of the organizations participating in the Medicare Advantage program. BBA also requires us to monitor CMS' audit activities.

In fiscal year 2006, CMS estimated it spent over $51 billion on the Medicare Advantage program,[3] which serves as an alternative to Medicare's traditional fee-for-service program. Under Medicare Advantage, CMS approves private companies to offer health plan options that include all Medicare-covered services. In addition, many plans provide supplemental benefits, such as a reduction in the enrollee's required cost sharing (e.g., beneficiaries' Part B premiums)[4] or coverage for items and services not included under the traditional fee-for-service program, such as dental care. According to CMS, in fiscal year 2006, over 16 percent of Medicare beneficiaries—or about 7 million of the approximately 43 million—were enrolled in a Medicare Advantage plan.

Our review covered CMS audits for contract years 2001 through 2006. In summary, we found that the required audits were of limited value, which is similar to what we reported on audits for contract year 2000 in October 2001, when we last reviewed CMS' audit activities under BBA.[5] The findings in our latest review cause us continuing concern about the audit process. CMS did not document its process to determine whether it met the requirement to audit the financial records of at least one-third of the participating organizations for

[1]Pub. L. No. 105-33, tit. IV, § 4001, 111 Stat. 251, 320 (Aug. 5, 1997) (codified at 42 U.S.C. § 1395w-27(d)(1)).

[2]GAO, *Medicare Advantage: Required Audits of Limited Value*, GAO-07-945 (Washington, D.C.: July 30, 2007).

[3]Total Medicare outlays in fiscal year 2006 were $381.9 billion.

[4]Medicare Part B provides coverage for certain physician, outpatient hospital, laboratory, and other services to beneficiaries who pay monthly premiums.

[5]GAO, *Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness*, GAO-02-33 (Washington, D.C.: October 9, 2001).

contract years 2001 through 2006, and based on our analysis of available CMS data, CMS did not meet that requirement. For those audits that CMS completed, it did not consistently ensure that the audit process provided information needed for assessing the potential impact on beneficiaries, and CMS took limited action to follow-up on the audit findings.

Today, we will discuss the findings in our recent report. Specifically, we will tell you about:

- the adjusted community rate proposal (ACRP) and bid process and the related audit requirement for organizations that participate in the Medicare Advantage program,
- CMS' efforts to comply with the audit requirement for organizations' ACRP and bid submissions, and
- factors that cause CMS' audit process to be of limited value.

Our prior work on which this testimony is based was performed in accordance with generally accepted government auditing standards.

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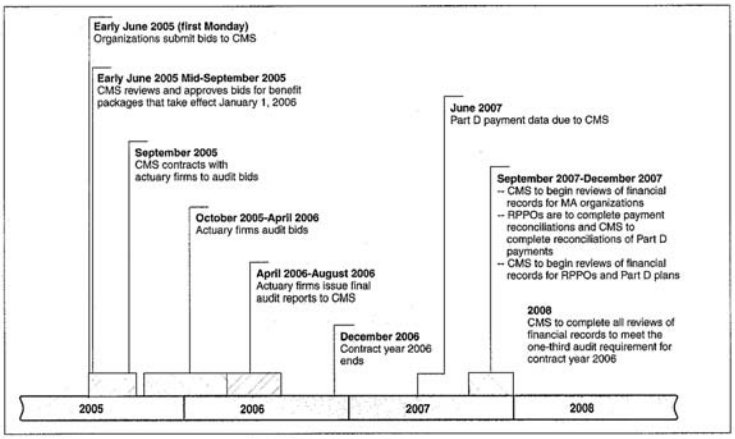
With respect to contract year 2006, CMS officials acknowledged the one-third requirement, but they stated that they did not intend for the audits of the 2006 bid submissions to meet the one-third audit requirement. They explained that they plan to conduct other reviews of the financial records of MA organizations and prescription drug plans to meet the requirement for 2006. In September 2006, CMS hired a contractor to develop the agency's overall approach to conducting reviews to meet the one-third requirement. Draft audit procedures prepared by the contractor in May 2007, indicate that CMS plans to review solvency, risk scores, related parties, direct medical and administrative costs, and, where relevant, regional preferred provider organizations' (RPPO) cost reconciliation reports for MA bids. For Part D bids, CMS indicated it also plans to review other areas, including beneficiaries' true out-of-pocket costs.[11] However, when our review ended, CMS had not yet clearly laid out how these reviews will be conducted to meet the one-third requirement. Further, CMS is not likely to

[11]True out-of-pocket costs are amounts paid by the enrollee or on behalf of the enrollee for covered Part D drugs that count toward the out-of-pocket limit that must be reached before the catastrophic benefit becomes available.

complete these other financial reviews until almost 3 years after the bid submission date (see figure 1) for each contract year, in part because it must first reconcile payment data that prescription drug plans are not required to submit to CMS until 6 months after the contract year is over. Such an extended cycle for conducting these reviews greatly limits their usefulness to CMS and hinders CMS' ability to recommend and implement timely actions to address identified deficiencies in the MA organizations' and prescription drug plans' bid processes.

Figure 1: Time Elapsed from Contract Year 2006 Bid Submissions to Reviews to Meet Audit Requirement



Source: GAO.

CMS' Audit Process Was of Limited Value

In its audits for contract years 2001-2005, CMS did not consistently ensure that the audit process provided information needed for assessing the potential impact of errors on beneficiaries' benefits or payments to the MA organizations. The auditors reported findings ranging from lack of supporting documentation to overstating or understating certain costs, but did not identify how the errors affected beneficiary benefits, copayments, or premiums. In addition, although the auditors categorized their results as findings and observations, with findings being more significant, depending on their materiality to the average payment rate reported in the ACR, the distinction between findings and observations, was based on judgment,

and therefore varied among the different auditors. In our 2001 report, we reported that CMS planned to require auditors, where applicable, to quantify in their audit reports the overall impact of errors.[12] Further, during the work for the 2001 report, CMS officials stated that they were in the process of determining the impact on beneficiaries and crafting a strategy for audit follow-up and resolution. CMS did not initiate any actions to attempt to determine such impact until after the contract year 2003 audits were completed. CMS took steps to determine such impact and identified a net of about $35 million from the contract year 2003 audits that beneficiaries could have received in additional benefits.[13] The only audit follow-up action that CMS has taken regarding the ACR audits was to provide copies of the audit reports to the MA organizations and instruct them to take action in subsequent ACR filings.

In CMS' audits of the 2006 bid submissions, 18 (or about 23 percent) of the 80 organizations audited had material findings that have an impact on beneficiaries or plan payments approved in bids. CMS defined material findings as those that would result in changes in the total bid amount of 1 percent or more or in the estimate for the costs per member per month of 10 percent or more for any bid element.[14] CMS officials told us that they will use the results of the bid audits to help organizations improve their methods in preparing bids in subsequent years and to help improve the overall bid process. Specifically, they told us they could improve the bid forms, bid instructions, training, and bid review process.

CMS' audit follow-up process has not involved pursuing financial recoveries from Medicare Advantage organizations based on audit results even when information was available on deficiencies or errors that could impact beneficiaries. CMS officials told us they do not plan to pursue financial recoveries from MA organizations based on the results of ACR or bid audits because the agency does not have the legal authority to do so. According to our assessment of the statutes, CMS has the authority to pursue financial recoveries, but its rights under contracts for 2001 through 2005 are limited because its implementing regulations did not require that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address identified deficiencies, including pursuit of financial recoveries.

[12]GAO-02-33, p. 20.

[13]Information on the impact of errors identified in contract year 2004 and contract year 2005 audits was not completed or not available at the time we completed our recent review.

[14]Findings also include any serious failure to follow applicable Actuarial Standards of Practice. Materiality for identifying observations included all other errors or deviations from the instructions or best actuarial practices that did not meet the criteria for being classified as findings.

Regarding the bid process that began in 2006, our assessment of the statutes is that CMS has the authority to include terms in bid contracts that would allow it to pursue financial recoveries based on bid audit results.[15] CMS also has the authority to sanction organizations, but it has not.

CMS officials believe the bid audits provide a "sentinel or deterrent effect" for organizations to properly prepare their bids because they do not know when the bids may be selected for a detailed audit. Given the current audit coverage, CMS is unlikely to achieve significant deterrent effect, however, because only 13.9 percent of participating organizations for contract 2006 have been audited.

Concluding Remarks

Appropriate oversight and accountability mechanisms are key to protecting the federal government's interests in using taxpayer resources prudently. When CMS falls short in meeting the statutory audit requirements and in a timely manner resolving the findings arising from those audits, the intended oversight is not achieved and opportunities are lost to determine whether organizations have reasonably estimated the costs to provide benefits to Medicare enrollees. Inaction or untimely audit resolution also undermines the presumed deterrent effect of audit efforts.

While the statutory audit requirement does not expressly state the objective of the audits or how CMS should address the results of the audits, the statute does not preclude CMS from including terms in its contracts that allow it to pursue financial recoveries based on audit results. If CMS maintains the view that statute does not allow it to take certain actions, the utility of CMS' efforts is of limited value.

In our recent report, we made several recommendations to the CMS Administrator to improve processes and procedures related to its meeting the one-third audit requirement and audit follow-up. We also recommended that CMS amend its implementing regulations for the Medicare Advantage Program and Prescription Drug Program to provide that all contracts CMS enters into with MA organizations and prescription drug plan sponsors include terms that inform these organizations of the audits and give CMS authority to address identified deficiencies, including pursuit of financial recoveries. We further recommended that if CMS does not believe it has the authority to amend its implementing regulations for these purposes, it should ask Congress for express authority to do

[15] 42 U.S.C. § 1395w-27(e)(1); 42 C.F.R. § 422.504(j). This provision also applies to prescription drug plans under Part D. 42 U.S.C. § 1395w-112(b)(3)(D).

so. In response to our report, CMS concurred with our recommendations and stated it is in the process of implementing some of our recommendations.

Contacts and Acknowledgments

For information about this statement, please contact Jeanette Franzel, Director, Financial Management and Assurance, at (202) 512-9471 or franzelj@gao.gov or James Cosgrove, Acting Director, Health Care, at (202) 512-7029 or cosgrovej@gao.gov. Individuals who made key contributions to this testimony include Kimberly Brooks (Assistant Director), Christine Brudevold, Paul Caban, Abe Dymond, Jason Kirwan, and Diane Morris.

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STATEMENT OF TIMOTHY B. HILL, CHIEF FINANCIAL OFFICER, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. HILL. Good morning, Chairmen Stark, Lewis, Ranking Member Camp, and distinguished Members of the Committee, thank you for inviting me here to discuss our audit efforts for the Medicare private health care plans.

This is the second appearance I have made before this committee to discuss how CMS meets our fiduciary obligations to beneficiaries and to taxpayers. I remain steadfast in my commitment to maintaining the highest level of accountability for the agency's financial

resources, and reiterate the commitment that our acting administrator has made to you for a transparent and robust compliance effort for all the programs we administer, including Medicare Advantage.

I would like to use my time this morning to briefly summarize our response to the GAO report, and discuss the steps that we are taking to ensure the accuracy and the integrity of the payments we make to Medicare Advantage plans, including how we are complying with the one-third financial audit requirement of the MMA.

As you know, the GAO study focused on ACR and bid audits of Medicare Advantage organizations, and made five specific recommendations. I am pleased to inform you that, as noted in our response to the GAO, we have already begun implementing the five recommendations.

GAO also describes our bid audit process as insufficient to comply with the statutory requirement to conduct a financial audit of one-third of plans each year. We agree. It is important to note, however, that the scope of the GAO review was limited to CMS's bid audits. In other words, the reviews we conduct are after we sign contracts with plans, but before the plan year is complete. The reviews are conducted to gather information on, and assess needed changes to, the bidding process for future years, which would lead to more complete and accurate bids from plans.

I want to clarify for the committee that we have never intended the bid audits to be the mechanism by which we would comply with this important statutory requirement. Rather, they are one piece of a larger strategy to ensure the accuracy and integrity of payments and protect beneficiaries.

The components of our strategy include: ensuring that bids are accurate up front, before the plan year begins, and before we sign contracts with plans; ongoing compliance monitoring throughout the plan year; and, a full-scale financial audit of one-third of the plans, once the plan year ends.

The first element of our strategy begins with reviews we conduct of bids before we sign contracts with plans. Using contracted actuaries and accounting firms, we thoroughly review each bid and its data and underlying assumptions before we sign contracts with plans. This process ensures that, to the maximum extent practicable, each contract we sign results in the maximum benefit to beneficiaries, and accurate payments from Medicare. To fall back on a fee-for-service concept, we focus our efforts on paying correctly up front, rather than relying solely on a pay-and-chase scenario.

The second element of our strategy includes ongoing compliance audits. These audits, while not financial in nature, occur throughout the plan year, and are designed to ensure that plans are complying with the various beneficiary protection requirements in our regulations. The audits are conducted largely by CMS staff on an ongoing basis, and are supplemented by ongoing data collection, ad hoc reporting, and complaint tracking mechanisms, to ensure that we identify and mitigate any compliance issues before they have an impact on our beneficiaries.

The final element of our strategy is a full-scale financial audit of one-third of the plans, once the plan year ends, per the requirements of the MMA. CMS has a specific plan in place to meet this

requirement, the elements of which have been in place since last year. We will be contracting with CPA firms to review plan information and data regarding all elements of payments, including validating risk scores, claim submissions, and beneficiary out-of-pocket costs.

We are currently reviewing the results of a small audit pilot, and will be refining our audit criteria in the coming weeks, so that auditing firms can build on these findings as they begin their work. We have selected, and have begun notifying, the first 81 plans from contact year 2006 that will be audited.

These comprehensive first-round audits will examine, in detail, the approved components of the plan bids, as well as data supporting payments made during the year, to ensure that Medicare beneficiaries in the Federal Government received what the contract specified and the plan promised. And, to the extent that we identify overpayments or underpayments as part of those audits, we will be recouping money from the plans.

We are on schedule to audit the first 81 plans this fall. But, we have a way to go to reach the 165 audits that would be required to meet the statutory one-third requirement. We have identified funds to begin the audits from within our ongoing operations, but do not believe we can meet the full statutory requirement, absent enactment of the President's budget request for 2008.

I want to emphasize that this administrative funding is a critical component of the Medicare program, and very much appreciate Congress support of the President's budget levels for these important oversight activities.

In conclusion, CMS takes our auditing responsibilities seriously, and has plans in place and in effect to meet our statutory and fiduciary responsibilities to beneficiaries and taxpayers. I appreciate the committee's ongoing interest in monitoring CMS's efforts on this front, and believe that, by working together, we can support Medicare beneficiaries, and ensure that they can maintain access to the Medicare plans that meet their individualized health care needs.

This concludes my opening remarks, and I would be happy to answer any questions that you may have. Thank you.

[The prepared statement of Mr. Hill follows:]

Testimony of Timothy B. Hill
Chief Financial Officer and Director of the Office of Financial Management
Centers for Medicare & Medicaid Services
On
CMS Audits of Medicare Advantage Plans
Before the
House Ways and Means Subcommittees on Health and Oversight
October 16, 2007

Good Morning Chairmen Stark and Lewis, Ranking Members Camp and Ramstad, and distinguished members of the Committee. Thank you for inviting me here today to discuss the audit processes for Medicare private health care plans, which provide an important source of supplemental Medicare benefits for individuals with Medicare. I am honored to have the opportunity to describe to you how the Centers for Medicare & Medicaid Services (CMS) uses these important financial tools to ensure the financial integrity of our programs and protect our beneficiaries.

I would like to begin my testimony this morning with a general discussion of the recent Government Accountability Office (GAO) report, including the steps we are taking to implement the GAO recommendations. The Agency's full response to the final GAO report is attached to the end of my testimony. Then, I would like to turn to a more detailed discussion of the steps that CMS takes to ensure the accuracy and integrity of the payments we make to Medicare Advantage (MA) plans, including how we are complying with the "one-third financial audit" requirement of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173). Finally, I will briefly touch upon other CMS compliance activities that compliment the audit process, which includes bid reviews, post-contract bid audits, and post-contract financial audits.

GAO Report to Congress

The GAO issued a Report to Congress in July of 2007 regarding the auditing procedures

in place at CMS for MA and the former Medicare+Choice (M+C) programs. The GAO's study focused on annual "Adjusted Community Rate (ACR)" audits and "bid" audits of Medicare Advantage Organizations (MAOs) for the contract years 2001 - 2006 and provided CMS with five specific recommendations to improve our financial auditing processes.

CMS welcomes these constructive suggestions and as reflected in our comments to GAO on both the draft and final reports, CMS has already begun implementing some of the report recommendations. For example, we have modified and documented our procedures for selecting MAOs and Medicare prescription drug plans (PDPs) for financial audits. In addition, we have begun to better document the standard operating procedures to clearly describe the financial audit process CMS uses in reviewing MA contracts at the conclusion of a contract year. CMS appreciates the time and resources that GAO invested in this study, and we want to be unequivocally clear today that the Agency is committed to continuing steadfast oversight of the MA program in the years ahead.

Bid Audits

It is important to note that the scope of the GAO review was limited to our oversight of the MA bid process (or in the case of the M+C program, the ACR process). The initial CMS review process has two parts: bid reviews and any post-contract bid audits. CMS believes that both serve an important purpose in enabling CMS to provide prompt feedback to update and refine bid processes for the subsequent year of bid submissions. During the bid reviews, significant errors and corrections are made to bids in advance of the contracting process. In contrast, the bid audits afford CMS the opportunity to evaluate the details of the bid development against the bid instructions and the actuarial standards of practice. The resulting observations and findings from the bid audits are used to hold MA plan sponsors specifically accountable in subsequent bid submissions and more generally, to determine new and clarifying guidance and training for all plans.

Bid audits are not financial audits, are not intended to catch significant contract mistakes (which are often corrected prior to bid approval during the bid review process), and are not intended to validate information in the contract which cannot accurately be determined until the conclusion of the contract year. Rather, their purpose is to provide prompt feedback to update and refine bid processes for the subsequent year. As we have seen over the past two years, the bidding process has become more refined and structured, particularly with regard to costs.

While we concur with GAO that CMS does not have current authority to adjust payments to plans for the years under review based on the bid audit findings set forth in GAO's report, we disagree with GAO that we would be able to establish such authority for future years through rulemaking. CMS does not believe that we could change the basic statutory design of the bid and payment process through a regulation, as suggested by GAO. According to the procedures established by Congress in the MMA, plans present CMS with a bid for Medicare benefits and other health care services, which serves as the basis of a fixed price contract for services the plans commit to provide to Medicare enrollees in the upcoming year. In submitting annual bids that will determined payment for a full year, participating MAOs and PDPs must assume risk in committing the services they will offer enrollees during the contract year; CMS reviews the bids and pays the plans based on a payment formula in accordance with the statutory guidelines for the services contained within the plan's bid. If a plan underestimates the costs of providing promised care to Medicare beneficiaries, it nevertheless is tied to the terms in the bid contract for the remainder of the program year. Conversely, plans that overestimate their bids run the risk of losing enrolled beneficiaries or potential enrollees to another, more competitively priced Medicare plan. That is, the competitive framework established by Congress is designed to ameliorate gaming by plans without subjecting MA plans and beneficiaries to mid-year corrections in payments and benefits. Of course, if a review were to highlight potential fraud, that plan would be referred immediately to the U.S. Department of Health & Human Services (HHS) Office of the Inspector General (OIG).

The "One-Third" Financial Auditing Requirement

I will now discuss implementation of the one-third audit requirement of the MMA and how that requirement becomes the true fiduciary control for health plans.

The statutory requirement for financial audits for one-third of the plans every year is established in Section 1857(d)(1) of the Social Security Act (the Act). Prior to the MMA, this section required the Secretary of HHS to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the ACR) of at least one-third of the MAOs offering M+C plans. The MMA dropped the reference to the ACR and retained the requirement for annual auditing of financial records of one-third of MAOs. In addition, Section 1860D-12(b)(3)(c) of the Act requires the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, including allowable reinsurance and risk corridor costs, as well as low-income subsidies and other costs) of at least one-third of PDPs.

In its Report to Congress, GAO suggests that CMS' post-contract bid audits are the only action that CMS has taken to satisfy the statutory audit requirement. CMS concurs that bid audits occurring after contracts are awarded to MAOs do not fully satisfy the Agency's audit responsibilities. However, CMS never intended for post-contract bid audits to serve as the only audit action to fulfill the auditing requirement. The financial audits for contract year 2006 described above had not yet been completed at the time of GAO's investigation since they can only occur after the close of the contract year and final payment reconciliation, but clearly such audits are a critical component of CMS' plan for complying with its statutory audit responsibilities.

Financial Audit Process

As noted in my opening comments, CMS has a specific plan in place to meet our one-third audit goals for contract year 2006 and we have always intended to fulfill the audit requirements with more substantive reviews than our bid review and post-contract audit process. The elements of this strategy have been in place since last year.

CMS first launched a smaller pilot audit to test and refine the criteria established for the financial audits for contract year 2006 MAOs. This pilot is currently under review, and refinements to the criteria will be forthcoming so that auditing firms can build on the findings as they begin their work. In September, we selected three accounting firms to conduct these reviews on our behalf. In the meantime, CMS is sending notification letters to inform MAOs from contract year 2006 that they have been selected for a financial audit which will commence in late 2007. (It should be noted that within each MAO contract there may be multiple plans that could be audited.) These comprehensive first-round audits are intended to examine in detail the approved components of the MAO bids to ensure that Medicare beneficiaries and the Federal government received what the contract specified and the MAOs promised. As noted earlier in my remarks, a comprehensive financial audit of plan actions cannot occur until the conclusion of a contract year and the completion of data reconciliation that plans are entitled to after that point. As such, our actions now are the first opportunity that CMS has to review and verify the results of contract year 2006 plans.

As part of our documented standard operating procedures, CMS has developed specific criteria used in selecting plans for our end of the contract year financial audits. The criteria vary in accordance with the scope of MA and Part D benefits provided by the MAO and PDP. Examples of CMS' MAO audit criteria include the amount of Medicare payments and beneficiary enrollment, prior significant findings, and recommendations from other CMS components.

Beyond procedures for MAO audit selections, CMS also has initiated standards and measures for the key elements that will govern the audit itself and enable CMS to meet its objectives in conducting the financial audits. The elements that will be evaluated in the post-contract year financial audits include:

- **Solvency:** CMS plans to evaluate a MA or PDP organization's ability to bear the risk of potential financial losses for services performed or determinations of amounts payable under the contract.

- **Risk Score Review:** CMS financial audits will verify that the accuracy of a MAO's self-reported diagnosis data by reviewing medical records and cross-referencing these records with the reported diagnostic code (e.g., ICD-9 code).
- **Related Party Transactions:** CMS audits will review a MAO's significant business transactions to identify related party transactions and determine if the transactions were reported appropriately. In addition, the audits will verify that claimed costs associated with related organizations (parties) of the MAO are accounted for on a cost basis, do not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere, and are allocated to the MAO on an equitable basis.
- **Part D Costs and Payments:** CMS will review the three prospective payment mechanisms for Part D: direct subsidy, low income subsidy, and reinsurance subsidy, as well as any applicable risk sharing adjustments by obtaining the prescription drug event (PDE) data and tracing the information to the MAO's supporting documentation to ensure that reported costs were appropriate.
- **Direct/Indirect Renumeration (DIR)**: CMS will obtain discounts, rebates, and other price concessions reported by plans (i.e., Direct/Indirect Renumerations) and trace the information to the MAO's supporting documentation to ensure that amounts from the contract year were reported accurately with a reasonable allocation methodology.
- **True Out of Pocket Cost (TROOP):** Audit procedures will verify whether PDPs and MAOs are calculating TROOP accurately.

Medicare Integrity Program Funding

The CMS post-contract financial audit process is funded through the Medicare Integrity Program. We are currently on schedule to begin audits of 81 MAOs from contract year 2006, which clearly does not meet the one-third audit requirement (meeting that requirement requires audits of 165 plans). The enactment of the President's Budget Request will help us meet that goal. As you know, CMS has requested funding in fiscal year (FY) 2008 to meet the one-third audit requirement. I want to thank you and your colleagues in Congress for supporting this request in the current House and Senate

appropriations for CMS, and emphasize that this administrative funding is a critical component of the Medicare program.

Other Compliance Activities

In addition to the financial audit process, CMS protocols for oversight of MAOs include a rigorous application and bid review process, which helps ensure that enrollees have adequate access to health care services, and that beneficiaries are not discriminated against in any way. CMS conducts routine and targeted audits of plans to verify compliance with established performance measures and tracks complaints systematically throughout the benefit year. When MAOs are found out of compliance with program requirements, CMS can employ a range of enforcement tools such as required corrective action, suspension of enrollment, suspension of payment for new enrollees, civil-monetary penalties, and termination of the plan's involvement in the Medicare program

To further support compliance efforts, on May 21, 2007 CMS issued a proposed rule to strengthen current oversight requirements and penalties for MAOs as well as Part D PDPs. In the proposed rule, CMS proposes changes to existing regulatory protocols, including:

- New steps to help expose potential fraud or misconduct through mandatory self-reporting of compliance violations; and
- Modifications to streamline the process relating to intermediate sanctions and contract determinations (including terminations and non-renewals) and to better clarify the process for imposing civil monetary penalties.

These revisions will help strengthen the existing range of compliance actions available to CMS when plans violate program requirements and contract provisions.

Conclusion

CMS takes its auditing responsibilities seriously and has plans in place and in effect to meet its statutory and fiduciary responsibilities to beneficiaries and taxpayers. We believe our complete auditing procedures, which include bid reviews, post-contract bid audits, and post-contract financial audits, will support Medicare beneficiaries by ensuring

that they can maintain access to Medicare plans that meet their individualized health care needs.

I appreciate this Committee's ongoing interest in monitoring CMS' efforts to uphold the integrity of all Medicare programs. CMS remains steadfast in its commitment to maintaining the highest level of accountability for the Agency's financial resources and will work to improve our financial management performance in all areas. Through the work of our partnerships with MAOs and PDPs and the audits of their plans, we can ensure that seniors and disabled persons get the necessary support and care they need to stay healthy, so as to enjoy enhanced wellbeing and quality of life.

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Chairman STARK. Well, I want to thank the witnesses. I am just going to ask, Mr. Steinhoff, if—I guess all my colleagues have a copy, or can see the chart. Can you just briefly explain to us what——

Mr. STEINHOFF. Okay. By all means.

Chairman STARK.—what the chart was designed to——

Mr. STEINHOFF. It is really to show the degree of audit coverage here. And we have gone through, for each of the 6 years, 5 years of ACR audits, 1 year of bid audits, and determined the percentage of the organizations—and by organizations, we mean contracts—that were audited.

As you can see, the percentage of audits has declined. We will caveat that 2006 was not, in fact, complete. These were the bid audits. And Mr. Hill mentioned the other component, which was not really in place when we were performing our work.

As you can see, the percentage of contracts audited has stayed around 20 percent for several years, then dropped down to 18.6 percent for 2005. And, as of today, for 2006, it rests at 13.9 percent. I will say that, in contract year 2000, which we covered in our 2001 report, CMS did meet the 33 percent requirement. But the bulk of those audits were done by the inspector general. The inspector general did 53 of 80 audits. So CMS did, in fact, meet the requirements then, and it has gone down since.

If you go to the second chart, it gives you an idea of what this means, in terms of plans. Maybe I have jumped ahead here on this, if you all haven't got that chart. But when we're speaking about auditing, and we're speaking about auditing contracts typically, contracts have multiple plans, ranging from 1 plan to 170 plans on 1 contract. The average is about eight plans per contract.

So, for the 2006 bid audits, which are at the bottom of that chart, there were 4,920 plans. If you look at the previous chart, there were 80 organizations audited. Of those 80 organizations, they had almost 1,200 plans, and CMS audited 159 of those plans, giving you an audit rate of 3.2 percent of the plans.

Now, CMS is measured based on organizations. But just to be clear what the magnitude of the auditing is, CMS audited roughly 3.2 percent of the plans, so far, for 2006. And you will see for the other years, it declined each year, from 22 percent of the plans in 2001, down to 5.3 percent of the plans in 2005.

Mr. Hill mentioned the resource issue. If you go back to the first chart—hope I am not going too fast on this—you will see that audit resources are not high, and that, in fact, they went down for 2006. So you've got a program that was dramatically growing, more beneficiaries, more cost, less being spent on the audits, and you're talking about audit costs in the range of $3 million per year for a program that is now $60 billion to $70 billion.

So, that is, in a nutshell, what we found. CMS didn't meet the audit requirement in any year. And, depending on how you slice and dice it, the audit rate for plans was about 3.2 percent, to date, for 2006.

Chairman STARK. Thank you. You mentioned—and I'm just going to run through a couple of items here, Mr. Steinhoff—you mentioned that you performed audits, or that—I am sorry, that the inspector general has performed audits, the HHS inspector general has performed some audits, of additional MA payments.

And the—you might, in response, let us know what the inspector general found, and whether or not the inspector general should be involved in this auditing process, and whether, if they found money owing, there was any effort to recover it. That is one issue.

There has been some difference of opinion between you and CMS as to whether there is legal authority to seek financial recoveries. You believe it does. You might want to comment on whatever——

Mr. STEINHOFF. Okay——

Chairman STARK. Well, let me finish. Any statutory changes that you think might be made that will clarify this matter, if it is

needed, I think we would all be interested in your opinion as to not only what might be wrong, but what we might do to correct this in the future.

And you might also—for those of us for whom audit is something that ends up at the end of a corporate annual report, or what we have to do for the IRS if we don't do our tax returns right—I think these audits are somewhat different than the financial audit that many of us—you might enlighten the committee a little bit as to what is in the audit.

So, that is a broad range of topics. If you could briefly address those, I think it would be helpful to the members.

Mr. STEINHOFF. Okay. Let me start, Mr. Chairman, with your first question. And I think you are referring to the Benefit Improvement Protection Act audits. There were 6 such audits done of the 2001 payments. This is where the organizations were entitled to receive additional funds.

The IG covered six different plans, amounting to $88 million in additional payments, and questioned $29 million of the $88 million. Basically, their findings zeroed in on what they thought was a lack of documentation that the capitation payment increase was justified, or that additional direct medical care had been provided. No action was taken to recover any amounts. The IG did recommend that amounts be paid back to CMS by the carriers. One of the companies audited is here today, Humana. They were one of the six. Humana of Texas was audited.

The audited $14.4 million of additional payments to Humana under that Act, and the IG questioned $10.5 million of those amounts. But as we found for any audit where a number was tied back to the audit, CMS did not act to recover or require anything to be done.

Getting to your second question on statutory changes, I believe that we and CMS are at a stalemate here. We believe that there is nothing in the law that precludes them——

Chairman STARK. We have been in a stalemate with them for years.

Mr. STEINHOFF. Well, we believe there is nothing in the law that precludes CMS from placing in their regulations, and then in their contracts, provisions that would say, "This is what we are going to do if we find something wrong."

They believe they don't have the authority to do it. So, when you get in that position, I think it is probably best for it to be resolved by the congress through a specific provision that would say yes or no. I have noted that the IG, when does the work to identify the impact of a problem, it does call on either the plan to return the money, or CMS to collect something. And that's the same position that GAO is taking. You're doing an audit, you're finding something. This isn't just an academic exercise to help the company prepare a better bid later on. There has to be more to it.

But I think it would be very important to really resolve this and I think, this hearing is perhaps a good starting point for beginning a dialogue on exactly what the congress wishes to get out of this.

With regard to your third question, for the ACR audits—those were the ones for 2001 to 2005—CMS had CPA firms apply agreed-upon procedures. This is a complex academic—American Institute

of CPA's jargon and Government Auditing Standards terminology, but these audits were done under what are called the attestation standards. They are not a financial audit, but they are a professional audit under professional standards.

What the auditor is doing is auditing what you have asked them to audit, and nothing more. So the auditors were asked to find whether there were any problems in the preparation of the bids. They were not asked to make a determination for 2001 through 2004 or 2006, as to what is the dollar impact of what they found. So, they are agreed-upon procedures.

For 2006, CMS shifted to the bid audits. And Mr. Hill makes the point that CMS has plans for additional at some time in the future. But, to date, what CMS has done what they call bid audits. And those bid audits are actually actuarial reviews. There is a lot of in-depth requirements that are placed on the organizations in preparing bids. It looks like there is quite a bit of rigor.

I am not an actuary myself, but Medicare Advantage Organizations have got to really provide a lot of information to CMS. CMS makes a bid review, which is a desk-type review, and for 13.9 percent of the contracts, and they made an actuarial review. These are not audits in the same sense as you know audits, and everyone knows audits from financial auditing. But there was some rigor to them, and they are an actuarial study. I hope that answers all your points.

Chairman STARK. Thank you. And I would just briefly ask Mr. Hill—and I apologize to my colleagues, but perhaps this will set the stage for future questions—do you agree, Mr. Hill, that, in whatever manner we do it, either you all do it at CMS by regulation, or we write into the legislation that you do it, that it would be a good thing for CMS to recover funds that somebody determines were paid in error?

Mr. HILL. It is more than a good thing, sir. It is the thing that we need to do to fulfill our fiduciary obligations.

And I would just note for a moment, just to—I am not quite sure we are at stalemate, I am not sure that is the word I would use.

Chairman STARK. Okay.

Mr. HILL. I think the issue here is where do we begin to take that money back. And the issue is, do you take it back on a bid review during the middle of a plan year, or do you do it once—a full-scale financial audit at the end of the year, when all the records are settled, and you could do a full review, as you said, of the benefits that have been delivered, and the records that we have gotten from the plans, do you take it back then?

I think it is our contention that it is best to take it at the end of the audit, than in the midst of the plan year, when there would probably be an impact on beneficiaries.

Chairman STARK. The other question that I would direct you—and at least my interest, I do not know about my colleagues—but in all of the—if we cut through a good bit of the plans' sales pitches and the audit actuarial language, we are supposed to believe that paying some amount in excess of fee-for-service rates to these plans results in additional benefits to the members of the plans, to the beneficiaries.

Many cases, there are lower premiums. That is easy to figure. I mean, if I am paying $30 a month for Part B, or 40 or 90, and somebody offers to give it to me for 10, I have saved some money. I think I can understand that. The problem is, we find that many of the plans, they kick up the copays subsequently, so that the first cost may not be the last.

But we have been unable, whether you know or not, to determine with any accuracy how much—first of all, what benefits are actually provided by these plans. They tell us what benefits are offered, but they don't tell us whether any of the beneficiaries actually take up their offer. I mean, you know, they may be offering Viagra to every member, but if people don't line up to get the pills, it doesn't cost the plan anything.

So, it would seem to me that it would help us—and perhaps even you—to know what each plan actually spends, relative to the amount over 100 percent we are paying, and whether these benefits were used or not used.

That all seems to be hidden, or buried under the idea that it is proprietary and secret. And—but basically, we have not been able to find out. I don't even know if you can find out. I hope so.

But do you think that it would be reasonable for us to have that information in some detail with each plan, so that we know what actual extra benefits, other than the standard Medicare health benefits, are being offered and used, and how much the plans are paying for them, so we have some idea whether we are paying the plans appropriate amounts?

Mr. HILL. I——

Chairman STARK. Does that trouble CMS in any way?

Mr. HILL. I think the issue here is not so much understanding what plans are providing to beneficiaries. The question is reasonable, sort of taken on its face.

From my perspective, not getting into a discussion of whether or not we should be paying plans what we are paying, and how are they using their benefits, the one thing I can tell you—we can say, and we will be able to say with some definitiveness—is, to the extent that a plan has told a beneficiary, "These are the services that I offer, and this is the benefit that you are getting for the premium that you pay," at the conclusion of these audits we are going to be able to say if the plan has provided those benefits, or if they have not.

Now, that, I do not believe, gets to your question of, you know, that marginal percentage above the fee-for-service payments, how does that work, and I think that is another level of sophistication to the analysis that the audits will tell you. So, an audit, yes, will be able to say, "Did they deliver what they said they would deliver?"

The other issue, just to keep in mind, is, to the extent that during the year, if there is a beneficiary who says, you know, "I have signed up for this plan, and it is offering a copay of $5, and they are charging me $10," that is an action we would take during the year. I mean, if a beneficiary were to call up, say, "They are charging me the wrong premium, they are charging the wrong copay," that is a compliance action we would take immediately.

Chairman STARK. I want to talk about getting in touch with that compliance——

Mr. HILL. I understand. There is more coming——

Chairman STARK. Well, I have overstayed my welcome here, and I would like to give Mr. Camp a chance to get into this. Thank you both.

Mr. CAMP. Well, thank you very much, Mr. Chairman. Obviously, Mr. Hill, with the GAO's report that CMS has failed to meet this one-third requirement—and your testimony confirms that—I guess what I would like to try to understand is why CMS has failed to meet the statutory requirement.

And, from what I understand of your testimony, you do not believe you have the legal authority to recoup funds once determined. Is that correct?

Mr. HILL. No. Well, sort of correct. I think the area of disagreement here between us and the GAO is when we do an audit of a bid during the middle of a plan year—so we have looked at the bid, we have already signed a contract, and we have looked at the bid, and we find that some underlying assumption there, either it accretes to the benefit of the government, or accretes to the benefit of a plan, should be somehow—make that adjustment, either pay more money to the plan, or take money back from the plan in the midst of the plan year.

Mr. CAMP. Well, I am not interested. I know the timing issue. Let us assume this is done at the end of the year.

Mr. HILL. We have no——

Mr. CAMP. What authority do you need, or resources do you need, to comply with this statutory requirement?

Mr. HILL. In terms of recouping the money, I do not believe we need additional authority. We believe that the statute is fairly clear, in terms of the requirement for the audits, and the fact that we can recoup money, to the extent that the audits show there is an issue.

With respect to actually carrying out the audits, to do—you know, to spend the money—and I respect the GAO's analysis here—the one-third financial audits that we are going to undertake as part of MA and MAPD post-MMA are quite more expensive than what we have done in the ACR side. And the President's budget has made a request for the last 2 years above our amounts, and it is quite substantial, but it is one I know that Congress is——

Mr. CAMP. So you are telling us the type of bid review required is more complex than what was required under previous law.

Mr. HILL. Oh, absolutely. The one-third financial audits are much more——

Mr. CAMP. And tell me how the resources have grown as that complexity has increased, and, in fact, as it looks as though the number of organizations offering Medicare advantage plans has increased.

Mr. HILL. Right. I mean, and I think it is a fair assessment that, to do the ACR audits that we conducted, in the limited capacity that we did them, was a $3 million to $5 million exercise.

When we are talking about auditing one-third of the MA and MAPD plans, we are talking about a $30 million exercise to get into the level of detail that we need to get into to validate risk

scores, to validate the claims data that we are getting into, to look at all the information that the plan has provided. It is a much higher level of rigor that we need to do.

Mr. CAMP. Have the number of auditors grown at your disposal, or are these bid out?

Mr. HILL. It is bid out.

Mr. CAMP. And has that ability—obviously, with the resources remaining fairly constant over the last 5 years, that ability to increase the number of auditors has not been there.

Mr. HILL. Right. I mean, we have found money within our base to be able to fund the things that we have funded to date. But we recognized, sort of on a going forward basis, we are going to need more resources.

Mr. CAMP. Now, the $34 million from 2003 has not been recouped. It is unclear to me why that has not been recouped. Because you say that there is really no problem there.

Mr. HILL. Well, again, this gets to the issue of—and this is complicated enough that it gives me headaches sometimes—prior to the MMA, when we are looking at the ACR audits——

Mr. CAMP. Yes.

Mr. HILL [continuing]. And the audits of the adjusted rates, and how the plans told us they were going to spend the money on the extra benefits, on those issues, for the ACR audits, we do not believe we have the authority to go back and recoup that money. This is why there has been no action taken on plans in the $34 million that is there. We do believe, however——

Mr. CAMP. So you feel you need statutory authority from Congress to go back and recoup the money, pre-MMA?

Mr. HILL. If it was Congress's intention for us to do that, we would need——

Mr. CAMP. Okay. But post-MMA, you feel you have the legal authority to conduct the bid reviews, if you have the resources to do it, and recoup those funds?

Mr. HILL. Correct.

Mr. CAMP. All right. Thank you. And it is your sense that, because the complexity of the audit process has increased, that you need more resources in order to adequately perform your statutory obligations?

Mr. HILL. Yes, sir.

Mr. CAMP. All right. Thank you. Thank you, Mr. Chairman.

Chairman STARK. I was not being facetious when I suggested to the ranking member that, if you collected this money, perhaps you could use it to hire additional resources, or charge the plans a fee to audit them. That would be——

Mr. CAMP. I think there are requirements as to where the recouped money goes.

Mr. HILL. The money goes back to the Medicare trust fund, sir.

Chairman STARK. Well, it comes out of there——

Mr. HILL. I understand.

Mr. CAMP. That could be a statutory change, also.

Chairman STARK. Sure. Chairman Lewis.

Mr. LEWIS. Thank you, Mr. Chairman. Mr. Cosgrove, in 2003, is it correct that CMS estimated that there were $96 million in overpayments to the organization? Is that correct?

Mr. COSGROVE. Yes it is, Mr. Chairman.

Mr. LEWIS. Could you tell Members of the Committee, is there similar data for other years?

Mr. COSGROVE. No. When we conducted this review, it was in terms of a comprehensive look at 1 year. That was what CMS had completed.

Mr. LEWIS. Well, should CMS be required to provide information, this data, for each year? What is the position of GAO? Should that information be forthcoming?

Mr. COSGROVE. Yes, it should be part of the audits. When we issued our report in 2001, we recommended that CMS require the auditors to quantify what the impact would be on beneficiaries and the program. And, at that time, CMS said that it would do so. In fact, CMS did not, for several years, amend the instructions for the auditors, to require them to do that kind of quantification. It was for 2003 that CMS hired a separate contractor to go back and look at all the individual auditing reports. And at that time, the contractor came up with that amount of money for 2003.

Mr. LEWIS. Do you think it should be the responsibility of CMS, or should there be an attempt to recover some of this $96 million?

Mr. COSGROVE. Certainly the auditors identified overstatements, that CMS should have tried to recover. So, yes.

Mr. LEWIS. Mr. Hill, how does CMS decide which law it will or will not comply with?

Mr. HILL. Sir, we make every effort to comply with every law.

Mr. LEWIS. Do you think you have complied with the law?

Mr. HILL. I mean, I do not think there is any way I can say to you that we have complied with the one-third audit requirement from 2001 to 2005.

Mr. LEWIS. Mr. Hill, let me ask you. Has CMS ever sanctioned a plan in the Medicare Advantage program?

Mr. HILL. Yes——

Mr. LEWIS [continuing]. For a payment issue or improper bid? Have you ever sanctioned one organization, just one?

Mr. HILL. For an improper bid?

Mr. LEWIS. Improper bid, or overpayment. For a payment issue.

Mr. HILL. Not for a payment issue, no.

Mr. LEWIS. What about an improper bid?

Mr. HILL. Well, the sanctions that we have imposed, whether they be some monetary penalties, or suspending enrollment, or up to termination, have been largely due to larger scale contract violations, either not delivering the services that they said they were going to deliver, or denying access to beneficiaries, or being insolvent, marketing violations such as the private fee-for-service issues that we have talked about here before.

But specifically to a payment issue, I think it would be hard to articulate just a payment issue.

Mr. LEWIS. Well, just so we are clear, just over three percent of the plans are audited. Audits are not completed until a year after they are conducted. CMS apparently does not even look at the audits that are conducted. And not one sanction action or any other penalty has ever been issued for an improper bid.

Can you honestly say that you think these audits serve as a deterrent? Or look like an invitation for big trouble, real trouble?

Mr. HILL. I understand your question, sir. And, based on the numbers that are up there from the GAO, I can appreciate your frustration.

I think the issue for me is to be able to articulate for 2006, for this plan year, post-MMA, now that the MMA is in full operation, that the audit and the oversight activities that we have ongoing encompass more than just the bid reviews that are articulated here by the GAO.

So, my answer to your question is, yes, I do think that the infrastructure that we have put in place, from the bid reviews to the one-third audits, to the ongoing compliance reviews we do with plans, do put in place a deterrent effect, if you will, for plans, to be sure that they are bidding appropriately.

Mr. LEWIS. Who is protecting the beneficiaries?

Mr. HILL. We are, sir. We are trying.

Mr. LEWIS. Do you have an agency? Do you have a person? Do you have an office within CMS that is protecting and looking out for the beneficiaries?

Mr. HILL. There are a couple of ways to answer that. I mean, there are two ways to answer that question. The first, and the most direct, is the MMA required us to have—and we do have—a Medicare beneficiary ombudsman, if you will——

Mr. LEWIS. What is the size of that office?

Mr. HILL. I have those facts, I don't have them at my fingertips——

Mr. LEWIS. What is the personnel make-up? What is the budget?

Mr. HILL. I can get you that information for the record——

Mr. LEWIS. You are telling me you don't know the staff make-up of that office?

Mr. HILL. I don't have——

Mr. LEWIS. The budget for that office? Can someone at GAO tell me?

Mr. STEINHOFF. No.

Mr. LEWIS. It is my understanding that the staff is about 34 people, and to represent 43 million disabled people, senior citizens. Only 34 people? That is nonsense. And the budget is only, what, $1.6 million? You should be able to do better, much better.

Mr. HILL. If I might, Congressman, the second part of that equation is not just the ombudsman office, but the ongoing compliance and oversight activity that is taking place by the plan managers in the regions, by the separate program integrity contractors that we have contracted with to oversee these plans, the——

Mr. LEWIS. Are you telling us that you have enough resources to look out for our seniors, to look out for the people that are taking part in this program?

Mr. HILL. I believe that we have enough resources to watch out for the seniors in this program.

Mr. LEWIS. Thank you, Mr. Chairman.

Chairman STARK. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. Thank you for your testimony today.

Mr. Hill, I am not sure if there is any other way to put it but to say that CMS should be embarrassed by what we are hearing

today. I do not know if any senior who is trying to figure out whether to make a payment for a copay, or figure out how to take care of a premium payment for his or her Medicare benefits to which he or she contributed years worth of taxpayer dollars while they were working, could sit and watch this and say, "I am struggling to figure out how to pay for that prescription drug or for that next doctor visit, and here I hear that CMS has failed to collect millions upon millions of dollars that were overpaid," for which they received nothing.

I hope that you are sufficiently impressed by the questions and the concern expressed by members on this panel, that the next time we have a chance to talk with CMS, that we will see some significant change.

You have mentioned that you need more resources. Is your 2008 budget request going to reflect that need for more resources to do the auditing oversight responsibilities that CMS has?

Mr. HILL. It absolutely does, and both the House and Senate appropriations committees have considered that request. And, to the extent they go through and get enacted, we should be okay.

Mr. BECERRA. With regard to the statutory authority that you possess, according to CMS's opinion, to collect monies for—in the particular case of pre-MMA overpayments, that is pre-2003 overpayments, are you proposing to the administration that it seek, through this Congress, the authority to go after any overpayments prior to 2003?

Mr. HILL. No, sir, we are not.

Mr. BECERRA. Are you planning to ask the Congress——

Mr. HILL. I am not aware that we are. We can go back and consider that. But from——

Mr. BECERRA. Would you support this Congress giving you the authority to go after overpayments dating before 2003?

Mr. HILL. I think it is something we would need to talk about, because, quite frankly, some of those plans are no longer in the program.

Mr. BECERRA. For those that are?

Mr. HILL. Right.

Mr. BECERRA. Do you support it?

Mr. HILL. I need to defer, sir. I would need to go back and——

Mr. BECERRA. Is there a reason why you wouldn't want to support a repayment of taxpayer dollars that went to plans that did not provide a service?

Mr. HILL. If it is true that plans have not provided services that they said they were going to provide, we would absolutely want to go back and recoup that money.

Mr. BECERRA. So, you would support having the authority given to you by Congress to go ahead and review pre-2003 plans that may have—may have—overcharged?

Mr. HILL. To the extent that they have delivered benefits—or not delivered benefits they said they were, absolutely.

Mr. BECERRA. So you would——

Mr. HILL. I don't mean to be——

Mr. BECERRA [continuing]. Support having the authority to do pre-2003 audits? Yes or no?

Mr. HILL. I would—I don't know that I can make that commitment, sir.

Mr. BECERRA. Okay. That is why I think you should be sufficiently embarrassed. Because if you can't tell the American taxpayers, American seniors, that you believe that the government should have the authority to recoup monies that were overpaid, it is——

Mr. HILL. I think that is the issue, that there is the notion of whether or not it is a strict overpayment.

Mr. BECERRA. Well, wait a minute. If you don't request the authority to audit and recoup, how can you ever get the money back? If you don't ask us to give you the authority to go after that money, you are telling the taxpayers, "It is okay," that, "We know that we overpaid using your taxpayer dollars, but we don't want to go after it."

Mr. HILL. I can appreciate what you are saying, sir. I just—there is some disagreement as to whether or not the nature of those audits, and what they found, that they represented any true overpayment.

Mr. BECERRA. And I understand that point. I don't want to be overzealous in my questions. I do understand that point. But my question is very simple. It is a very innocent question.

Mr. HILL. Well, let me answer it very simply, and sort of—you know, I am the CFO for the agency, I am not the program manager for Medicare Advantage, I don't sign those contracts.

I will tell you, as the CFO, to the extent that there is an overpayment, I want to go back and collect that overpayment.

Mr. BECERRA. That is fair. And I think many of us can interpret that as saying that we should give you the authority, then, to go after anything that was overpaid back before 2003.

Now, let me ask this. Going forward, is there any reason why we should hear you say that—CMS say—that it does not have the authority, statutory authority, to do a full audit, and any subsequent actions to recoup overpaid dollars?

Mr. HILL. No, sir. I believe we have that authority.

Mr. BECERRA. Okay. Mr. Steinhoff, at one point you seemed to have heartburn at one of Mr. Hill's responses. I think it had to do with the 2003—pre-2003—overpayments. And maybe it was on something else.

Let me ask this. Do you believe that you are—and I will end with this, Mr. Chairman, because I know my time has expired—do you believe that you are receiving the cooperation from CMS that you need in order to be able to conduct sufficient oversight of CMS, and also then to make the appropriate recommendations to CMS on how to proceed, in making sure we are preserving taxpayer dollars?

Mr. STEINHOFF. Yes. In looking at this particular issue, let me go back to our first review of this program, which covered 2000.

At that time, we were told by CMS that it planned, as part of the audit process, to quantify the effect of any audit findings. And we recommended that it do exactly that. In our view, the intent of quantifying the impact was to do something with the result.

CMS did not act, did nothing for 2001, 2002, 2003, 2004, or 2005 to ever change its regulations, to ever change its contracts. Went back for 2003, and did some work, but didn't take any action, other

than telling the organizations that were audited, "We found these problems." Didn't do anything with the six audits by the IG, and showed no intention, during our review, of ever doing anything with the results.

I would agree fully with Mr. Hill, in his earlier response to you, when he said, "If we find an overpayment, based on benefits delivered or costs not incurred, we will go back and recoup it." Well, if you look at the audits done between 2001 and 2005, none of those audits were directed at determining whether there was an over payment. They were directed at looking at a bid, or a proposal. And when they found problems with the proposal. They did not know whether or not the actual results were better or worse than the proposal.

So, you have to, one, design the audit in a proper manner to get a result, and to, in fact, hold the plans accountable to the American taxpayer. And then, two, have a very clear set of actions to go back and follow up. And that is really, I think, the differences that we and CMS have had all along.

Mr. BECERRA. Thank you. Thank you, Mr. Chairman. I yield back the time.

I do want to make the point, Mr. Chairman, that this is a—we hope to be able to do oversight over all of Medicare, not just Medicare Advantage; Medicare fee-for-service as well. This is not an attack on one type of plan or another. It is to preserve Medicare for seniors who are on Medicare. Thank you, Mr. Chairman.

Chairman STARK. My distinguished friend from Texas, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate that.

I am wondering. It is my understanding that the GAO report found that Medicare Advantage audits conducted in 2003 yielded a net overpayment of roughly $35 million. Did you find any instances where the plans were, in fact, underpaid, resulting in enrollees receiving additional benefits they wouldn't have otherwise received, if the bid were calculated correctly?

Mr. STEINHOFF. Yes. What the audits showed were that there were overstatements and understatements. The $35 million number that was computed by CMS was made up of $64 million of overstatements, and $29 million of understatements.

If you shift to the work that was done by CMS's contractor, who CMS had come in to review the audits, they found—and Mr. Lewis used this number—$96 million of overcharges, $37 million of undercharges. And this contractor was looking at, in this case, the adjusted community rate proposal. None of this is actual cost, getting back to Chairman Stark's initial questions. This is based on the rate proposal.

So, there were both overcharges and undercharges, based on the audits.

Mr. JOHNSON. So your 35 net is net out.

Mr. STEINHOFF. If a net number, yes. Correct.

Mr. JOHNSON. Okay. Do you know if those companies were ever coming back for the——

Mr. STEINHOFF. Nothing was done to collect, or to provide for or to require any additional benefits.

Mr. JOHNSON. Earlier this year, GAO reported 21,000 Part B providers, many of them physicians, are collecting federal Medicare payments while owing billions. What is CMS doing to address that issue?

Mr. HILL. We have—after the GAO report, we have been now working with the Department of the Treasury and Financial Management Service, as well as the IRS, to implement the tax levy offset program for Medicare, so that we are sharing our data on an ongoing basis with the Treasury Department, so that, before we make payment, or as we make payment, we are being sure to offset payments to the extent that physicians, owe taxes, or—physicians, or any other provider, I would say.

Also, back to the Medicare Advantage issue, those plans already are subject to the tax offset process. So, to the extent that Medicare Advantage, or a Part D plan has tax debt to the IRS, those monies are recouped before we make payments.

Mr. JOHNSON. Well, you know, following up with what Mr. Becerra was talking about, you've got from 2001 to 2005, really, overpayments that haven't been recouped. What are you all going to do about it?

Mr. HILL. Well, as we have discussed here, I think the Agency's position—or I know the Agency's position—at this point is that the audits are going to be closed out. We are going to look at each of the individual audits, and are looking at each of the individual audits, to be sure that, to the extent a plan misrepresented the information that had been provided, or was somehow trying to game us, as opposed to just an honest error in the system, we are going to make the appropriate referrals to the OIG, or to others, to the extent that we want to pursue action that way.

But we are—it is not our intent, right now, to go back and try and recoup those overpayments, because——

Mr. JOHNSON. Well, what are you going to do about this year, then?

Mr. HILL. For 2006, for the plan year beginning the first year of the MMA, if you will, the Medicare Advantage and Part D programs, we have put in place a process to be sure the bids—unlike the proposals we got in the ACRs, we are now reviewing bids as they come in, before we sign a contract, to be sure that they are appropriate.

And at the end of the plan year, as the GAO has indicated, we are going to look at actually the benefits that had been provided, the services that the plans provided, the information that they gave us to support their risk scores and other payments, do a full scale audit of those, and recoup overpayments, to the extent that we find them.

Mr. JOHNSON. So, you will take care of the people who were underpaid, and you will take care of the people who were overpaid?

Mr. HILL. Yes, sir. It is a symmetrical——

Mr. JOHNSON. Guaranteed?

Mr. HILL. Well, that is the approach now. I—hopefully——

Mr. JOHNSON. Okay, thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Thank you, sir. Mr. Doggett.

Mr. DOGGETT. Thank you. Thank you for the audit that you conducted. I think it is very helpful.

And, Mr. Hill, if I understand the answer that you just gave my colleague from Texas, what is it that you're not going to go back and recoup now, for the taxpayers?

Mr. HILL. I think that the OIG has identified an amount that we now agree, about $34 million——

Mr. DOGGETT. We can just write that off?

Mr. HILL. We don't believe that it is a debt that is owed.

Mr. DOGGETT. You don't believe it's a debt that is owed?

Mr. HILL. That is correct.

Mr. DOGGETT. Well, in addition to the tens of millions of dollars pointed out in this audit, the CMS attitude has been, "We might not have authority, but we are not going to bother asking for any authority."

I asked back at the July hearing about the $100 million that CMS paid to these Part D plans for retroactive coverage for dual-eligibles who were never told that they—in a timely way—that they had the coverage. And I have been asking for documents about that $100 million that may well have been wasted, in addition to all these tens of millions of dollars, ever since.

The CMS reply was that there was a reconciliation in August. As is usually the case, CMS isn't returning calls or e-mails. Is the reconciliation complete?

Mr. HILL. Yes, sir.

Mr. DOGGETT. Why don't we have the answers that I have asked for since July?

Mr. HILL. I don't know why you don't have those answers, but I will——

Mr. DOGGETT. Well, sir, that seems to be typical of CMS.

Let me ask you, with regard to the material that I have been provided from CMS, a big stack of materials concerning CMS's decision-making on abusive marketing practices, if, in your work, you ever have occasion to communicate with Abby Block at the Center for Beneficiary Choices that administers Medicare Advantage?

Mr. HILL. Do I? Yes, sir, I do.

Mr. DOGGETT. Do you do any of that by e-mail?

Mr. HILL. Yes.

Mr. DOGGETT. Do you have any idea why, in all of the documents that I have been provided, there is not a single e-mail back or forth with Abby Block, who runs the program?

Mr. HILL. No, sir. I do not.

Mr. DOGGETT. Well, would you go back and try to get me an answer on that? Because that is another of the——

Mr. HILL. Is there a particular——

Mr. DOGGETT [continuing]. Answer questions.

Mr. HILL. We will find out.

Mr. DOGGETT. Okay. Now, much of the focus has, of course, been with regard to marketing practices. But, as I look through this audit, it is not only—you know, as you look through all this audit, to me, I have a slightly different impression than my colleague. Because I don't see just a few bad apples, I see an entire orchard. And it is a very expensive and unproductive one.

Every time someone gets sucked into these Medicare Advantage programs, the taxpayer is out about $1,000 a year that it wouldn't have to pay unless—if they were in traditional Medicare.

But in addition to those marketing abuses, there are outlined in here a significant number of what are called chapter 13 abuses, where there have been corrective action plans. And those are when a person wants in, then has a grievance or can't get coverage, and then calls to try to get help.

My question to you about those corrective action plans is whether any Medicare Advantage plan has ever been sanctioned in any of these corrective action plans for not having a sufficient grievance and appeals process.

Mr. HILL. I can tell you that we have sanctioned plans for multiple contract violations.

Mr. DOGGETT. Well, I am just asking about grievance and appeal processes, since it appears, from my analysis of the audit, that there were more corrective action plans that were issued with regard to plans not the way they declined grievances and didn't handle the appeal process—there were more appeals process corrective action plans than there are marketing abuse action plans.

Mr. HILL. Right. And I know that a significant amount of the CMP activity, civil monetary penalty activity, we did last year was around the annual notice of change, which is a grievance process, but it is the notice that plans are required to give to beneficiaries, as we transition from one plan year to the next, outlining what the benefits are going to be or not be.

And we did issue CMPs on a number of plans last year on that issue.

Mr. DOGGETT. And does—do you require bids to include a line item in the bid, demonstrating that the plan has sufficient funds in their budget to handle appeals?

Mr. HILL. Well, their bid includes the administrative cost, which includes the administrative cost of meeting our regulations.

Mr. DOGGETT. Well, I understand it includes administrative costs. But how do you determine whether they have a sufficient amount to cover appeals?

Mr. HILL. I would need to get back to you exactly on how they make that determination.

Mr. DOGGETT. Okay. It appears to me that these plans get through deceptive marketing practices, in many cases at a cost of $1,000 to the taxpayer. Once they get in, they have great difficulty getting their grievances processed. And then I note if a care giver wanted to look at the website that CMS has to find out if they are getting in a good plan, great inflation at CMS seems to be rampant.

And in Texas, at least, when I looked at it, it looked like everybody was, you know, on the dean's list on these plans. They all got three-star, very good, ratings, except for one. I noticed that one Humana plan had 18 corrective action plans pending for appeals process violations at the same time it got a 3-star rating.

Is there ever any attempt to inform the consumer, relative to what is happening with the corrective action plans?

Mr. HILL. Well, yes, actually. The corrective action plans, as you know, are now posted on the web, and folks have access to that information.

I think, with respect to the rankings—take the Humana example for a minute—the 18 corrective actions that are on the web for Humana may relate to Humana as an organization. And it is the same violation, but it runs through all their contracts. So it is not like it is 18 separate——

Mr. DOGGETT. Have you ever taken a star off one of these all-star Medicare Advantage plans because they were doing such a sorry job with their marketing practices and their grievance processes, that they got one corrective action plan after another?

Mr. HILL. Well, this is the first year we have done the rankings the way we're doing them. But I can imagine that we are going to be removing stars from folks. Yes, sir.

Mr. DOGGETT. Okay. Thank you.

Chairman STARK. Mr. Emanuel.

Mr. EMANUEL. I will take the time. What I would—more of a statement, here. I mean, a lot of focus has been on the percentage on the reports, how many reports have actually been done, et cetera.

I know we had a hearing earlier on a lot of the state insurance commissioners, who said they would like to have the authority to do not only the investigations, but also the enforcement. And one of the—you know, CMS argues that they don't have the authority to do the proper type of—not just investigations, but then pursue those investigations. And my own sense here, Mr. Chairman, is that we can either have CMS do what they're supposed to do—they do it now on the supplemental Medicare—or give it to 50 different state commissioners, and then we can watch what they do on the oversight of these plans.

But somebody has to be a police on the beat who is overlooking these plans. And if it was up to me, I don't think the insurance companies would want to see this happen, but I would be more than willing to become a convert to the new sense of federalism here, and let 50 state insurance commissioners all of a sudden regulate and prosecute where they think there has been some violations here. But somebody has to be on the job to see, not only if—not only auditing, but then prosecuting, if there are any violations here.

And, to anyone who wants to pick up on this, I mean, which would you think would be more effective in overseeing this marketplace insurance plan? Would it be 50 different state insurance commissioners? Or would it be, in fact, CMS actually exercising what I think they have the authority to do? Mr. Hill?

Mr. HILL. Speaking for CMS, clearly, we believe that CMS has the authority, the wherewithal, and the obligation to be overseeing the plans, and their marketing practices, and how they are dealing with beneficiaries, and believe that is in the best interest of our beneficiaries, to have a single, consistent set of oversight activities and corrective actions being put in place.

Mr. EMANUEL. Well——

Mr. HILL. As opposed to having 50 different states. Now, the states have a role here, their——

Mr. EMANUEL. Well, Mr. Hill, let me just say this. As Abraham Lincoln once said to McClellan, "If you aren't going to use that army, do you mind if I borrow it for a time?"

Mr. HILL. I——

Mr. EMANUEL. And so, my question to you is, since you are woefully short on the audits, on the prosecution side, or, in fact, enforcing what is in the interest of the beneficiaries there, I don't think you have been fully exercising what we believe is in your authority and capacity.

Mr. HILL. I can appreciate the frustration that you are exhibiting, with respect to CMS in the past. I can only tell you, as I mentioned in my opening statement, that we are going to use the army. As you may have heard from Kerry Weems, the new acting administrator, that the start-up period here for Medicare Advantage is over. We are beyond the initial phase of getting plans in. And the focus now is on accountability, oversight, and access for our beneficiaries.

Mr. POMEROY. Will the gentleman yield?

Mr. EMANUEL. Yes, I yield to my colleague from North Dakota.

Mr. POMEROY. Thank you. Mr. Hill, there is no army. I believe you testified earlier your entire staffing was 34. Is that correct?

Mr. HILL. That is not correct, no.

Mr. POMEROY. Help me with the number. We have had different testimony from CMS over the time. How many people do you have all ready to go to sign with this new much-belated imperative of CMS?

Mr. HILL. A little bit over 500 staff, sir, and a budget of, right now, roughly $30 million, but that will grow to roughly 120, to the extent that the Congress enacts the President's fiscal year 2008 budget proposal.

Mr. POMEROY. You've got 500 staff people. What are they doing today, if they are not doing this today?

Mr. HILL. I believe they are doing this today, sir.

Mr. POMEROY. They are doing this today?

Mr. EMANUEL. Mr. Chairman.

Mr. POMEROY. I yield back.

Mr. EMANUEL. No, it's okay. Mr. Chairman, I would like to suggest, though, that if there is not a change—and not to—you know, beyond audits, if you are not going to oversee the marketplace correctly—and there is no numerical sense of what is hitting a certain number.

But the leverage is here, in fact, that either CMS does its job—and if the committee, as a whole, does not think it is, then in six months, nine months' worth of time, we take a look back of the performance. And if not, then we move on legislation, as it relates to the state insurance commissioners.

Mr. HILL. I think——

Mr. EMANUEL. There are many roads to take to enforcement.

Chairman STARK. The distinguished gentleman from North Dakota, when he was an insurance commissioner, made that deal with us some years back. And found that, eventually, in the case of supplemental insurance, that is just what he had to do.

Mr. EMANUEL. I mean, they have done a good job there. And so, the question is how you pursue that. And my colleague from Wisconsin, I do not know if he would like to add on this.

But I would like to thank you for both holding this hearing, and talking about it. But, Mr. Hill, we may have cut you off from——

Mr. POMEROY. May I just have a second more?

Chairman STARK. Sure.

Mr. POMEROY. I think that this 500 representation really does need some scrutiny. And if you have had 500 people waiting around to do this, they should have been doing it. If they had been doing it, we wouldn't have had the audit report that we have got.

The reality is, you have got these people, they have got all their jobs to do. We have heard testimony about them loosely dispersed through the regions, no clear business plan offered by the Agency, in terms of how they are suddenly providing new measures of consumer protection, reflecting, basically, what has been taking place in state insurance departments.

I believe the chairman's suggestions that we ought to look at—we ought to assess the failure of the Federal Government——

Mr. CAMP. Mr. Chairman, could we have regular order?

Mr. POMEROY.—and look at an expanded role for states that already have the capacity to do it. I yield back.

Chairman STARK. Thank you. The time for the gentleman from Illinois has expired.

Mr. Tiberi.

Mr. TIBERI. Thank you, Mr. Chairman and Mr. Hill. In talking to my Medicare case worker in my office, he tells me that most of the complaints that we get from seniors are seniors that are in the Medicare fee-for-service program. I know most of the focus has been on Medicare Advantage today, and the audit, and I know some of my colleagues are skeptical of the private sector's involvement in providing health care benefits to beneficiaries, Medicare beneficiaries.

From your perspective at CMS, what have you seen the benefit for those Medicare beneficiaries with this new market-oriented benefit called Medicare Advantage? What do you see today?

Mr. HILL. I think if you were to talk to the folks at the Agency, and tried to understand how Medicare Advantage and Part D has changed the landscape——

Mr. TIBERI. Right.

Mr. HILL.—you will see beneficiaries who are generally satisfied with the coverage that they have, in terms of drug coverage that they have now that they have not had in the past. You are generally seeing savings, relative to what they had had prior to BBA—prior to me, prior to the MMA.

For me, as the CFO's standpoint, the overall cost of the program is lower than we had originally projected, which is——

Mr. TIBERI. Can you say that again?

Mr. HILL. The overall cost of the program is lower than we had originally projected, both in terms of premiums and the absolute outlay for Part D and MA. So that is—from my perspective, that was a good thing, and which generally relates to lower overall Part D costs for taxpayers, generally.

Mr. TIBERI. We all acknowledge that there is a one-third audit requirement for the Medicare Advantage oversight. We have gone over that today on numerous times. Is there any comparable requirement for the regular fee-for-service program?

Mr. HILL. In terms of a requirement to look at a standard set? The only sets of requirements that exist are on the quality side for the state agencies who do survey and certification who go into nursing homes, home health agencies, other institutional settings, to be sure they are meeting our levels of care for quality.

But on the payment side, there are no statutory requirements for the level of payments that——

Mr. TIBERI. Is there anything that you have done, comparably, on the audit side, on the payment side?

Mr. HILL. On the payment side, we use a performance metric to ensure that we are paying appropriately.

As many of you know, and as I have testified before on this committee, we are measured by a fee-for-service error rate over time. And at one point that error rate was in double digits. We spent a lot of time and effort over the past 4 or 5 years to get it down, and now it is at roughly 4.5 percent, 4.4 percent, which has, I think—you know, using a risk-based approach to how we devote our resources to get that error rate down.

Mr. TIBERI. Well, let me just go over this again, and see if I am missing something that I cannot quite understand.

In the September CMS—you posted a list of current corrective action plans, CAPs, to your website.

Mr. HILL. Correct.

Mr. TIBERI. Do you believe this is a fair representation of the Agency's Medicare Advantage oversight activities, or does it represent just one aspect of a much broader, or larger picture?

Mr. HILL. Oh, I think it is one aspect of a much broader picture.

Mr. TIBERI. Can you expand on that?

Mr. HILL. It is a planned time estimate, as of that day, of the open caps that were in place. It doesn't reflect action that has taken place since before—corrective action plans that had been open and closed, subsequently closed out since prior to that date.

Nor does it represent the amount of work that is ongoing with beneficiaries and providers and plans on a day-to-day basis, both centrally, in our central office, as well as with the regions, to be sure that beneficiary complaints are being dealt with, and that plan compliance issues are being dealt with on a daily basis.

Mr. TIBERI. Anything comparable on the fee-for-service program?

Mr. HILL. In terms of reporting——

Mr. TIBERI. Yes.

Mr. HILL.—compliance issues? Other than the error rate, no sir.

Mr. TIBERI. Would that be helpful, to compare apples to apples, rather than apples to oranges, as we seem to be doing?

Mr. HILL. I—given the absolute level of providers in the Medicare fee-for-service program—you are talking about more than a million, versus the plan side—it would be very difficult, other than the aggregate, you know, sort of hospitals have these sorts of issues, physicians have these sorts of issues, to have a comparable sort of set of metrics.

Mr. TIBERI. Final question. Assuming that you have 49 organizations representative of the Medicare Advantage program that were part of this audit that has been talked about today. If you take the $35 million in overpayments, divide it by the total amount paid of the plans, you will find that the overpayment represents .4 percent, if my math is correct here.

What would be the error rate for payments under the fee-for-service Medicare plan?

Mr. HILL. 4.4 percent right now.

Mr. TIBERI. Say it again.

Mr. HILL. The error rate in Medicare fee-for-service is 4.4 percent.

Mr. TIBERI. So, the error rate for Medicare fee-for-service is 4.4 percent, versus the Medicare Advantage rate for error under your—under the GAO study, is .4 percent?

Mr. HILL. And——

Mr. TIBERI. That would be a good headline to see in tomorrow's paper. Thank you, Mr. Hill.

Chairman STARK. I am going to ask Mr. Steinhoff to comment on that. I think there is some—I think we have got some apples and oranges. If——

Mr. STEINHOFF. Yes, correct. We did not project an error rate. What our audits showed were, that CMS' audit rate for 2003 was around 22 percent. And for those audits that were done, they were done of the adjusted community rate proposal. This is the proposal, not what actually happened. This is what was actually paid.

So, you had less than 100 percent coverage, and you had a net of $35 million per CMS. You did not have, though, a review of every payment that is being made. So, I don't think it is even apples and oranges, I think it is more like apples and something else.

Chairman STARK. I would say, to CMS's credit, the 4 percent, or 4.5 percent——

Mr. STEINHOFF. Yes.

Chairman STARK.—used to be 14, I believe.

Mr. STEINHOFF. That is right.

Chairman STARK. And, in those days, it was half—and I don't know whether it still is—half was theft, fraud, and half was just mistakes, you know, processing 80 million pieces of paper a day, there are just mistakes.

But I think, if that is correct, I think that CMS is entitled to a real round of applause, because they have cut that error rate by at least two-thirds that I have known over the past 15 years, and that is—I don't mean to diminish that, that is a hell of a record. But I just wanted to add that.

I thank the gentleman. You have completed your inquiry, sir? All right. Mr. Kind?

Mr. KIND. Thank you, Mr. Chairman. I want to thank you and Mr. Lewis for offering this hearing today, and also to our witnesses for your testimony.

And as someone who reviewed the GAO report, and has been sitting here listening to the testimony so far this morning, I will guarantee you there wouldn't be a taxpayer in America that wouldn't be horrified by what is taking place with this program. And I also

guarantee that most of the seniors in MA plans today would be shocked and dismayed with the lack of oversight.

This—it really strikes you as the Blackwater of health care in this country today. You know, no oversight, no accountability, no consequences. And, just as the administration was quick to privatize our security needs in Iraq, in this experiment to try to privatize the Medicare program, this is the type of oversight that we are getting. And it is just clearly not acceptable.

Mr. Steinhoff, let me ask you. In preparing your report, and the investigation that the GAO did, is the lack of the audits being accomplished, not meeting the one-third requirement, due to a lack of will within CMS, or a lack of resources?

Mr. STEINHOFF. When one steps back and looks at the audit rate, when one looks at the fact that CMS didn't really have any program in place to even determine what the audit rate was, when one looks at the fact that CMS did not require the auditor to determine the impact, when one looks at the fact that CMS never looked at what actually happened, what benefits were delivered, what costs were incurred, it looked like CMS was going through just a minimal compliance effort. There wasn't much value to it, wasn't much coming out of it. And one could really question CMS's will to really aggressively pursue this.

Mr. KIND. Well, you hear of 35 people in CMS that's in charge of the audit department here, which just smacks as severely insufficient. And then, not only do we have a lack of the audits being conducted, but even a lack of the quality information that we need in order to make policy decisions based on the audits aren't even getting accomplished.

So, my question again, Mr. Steinhoff, to you, is what do we need to do to try to fix this? I mean, do we have to do a separate line item with specific instructions to CMS with specific resources? Because it is my understanding right now that the audit budget comes out of the overall administrative fund at CMS, and there is no specific line item from the appropriate bill that goes to CMS.

Do we need to look at that? Do we need to explore the possibility of user fees to help pay for the audits, to ramp up the army that we need here to conduct and to meet these requirements that——

Mr. STEINHOFF. Okay. I think certainly people should sit down with a clean sheet. Mr. Hill outlined some plans that CMS has, going forward, following the MMA. And—going forward, he said they CMS is going to do X, Y, and Z. I think that is, at least, a starting point.

If one looks back at the 1997 law, there was a provision requiring audits. It mentioned looking at the financial books. It mentioned one-third audits coverage annually. But there wasn't much, other than that, in the law. There was no clear legislative history, no clear committee report on it, and no real clear commitment or understanding on CMS's part as to what it was, in fact, to be.

So, I think, stepping back, taking a hard look at whether or not this new plan that Mr. Hill has mentioned today will, in fact, get us where we want to be. And, again, this plan was emerging and evolving as we were doing our work. But is this truly a post-audit? Is this truly going back and determining, did we get what we were paying for? Did our beneficiaries get a fair break? Were providers

offering services but they weren't being used? What were the profit margins, et cetera, et cetera.

Mr. KIND. Well, Mr. Steinhoff, on that point, let me ask you. Does CMS right now have the authority or the discretion to look into executive compensation with these MA providers in the course of the audit, and report back to us what is taking place?

Mr. STEINHOFF. I don't know of any limits they have, as to what they can and can't look at. And certainly that is something CMS can explore. But I know of no legal limits—I will caveat I am not a lawyer, but I know of no legal limits.

But the time is really here today to rethink Medicare Advantage oversight, as I was kind of hopeful, as Mr. Hill laid out the future, that while perhaps the last 6 or 7 years will be a very expensive lesson learned, that the lack of oversight during that period will be rectified, going forward.

But there is going to have to be a real change in culture here. And whether it is a $35 million oversight program as Mr. Hill mentioned, or much more expensive, you are talking about $60 billion, $70 billion being spent annually on the Medicare Advantage Program, a lot of money, a lot of complexity, a lot of plans, over 4,000 plans. And you are going to have to have a very good strategy, and a strategy that is enforced, a strategy with metrics, and a strategy that you can hold CMS accountable for meeting.

Mr. KIND. Mr. Hill, may I quickly ask you? Are you familiar with Humana's second quarter profit report that came out in August of this year?

Mr. HILL. I am not.

Mr. KIND. It is the second largest provider of MA, $217 million profit, doubling their profit. The analysts on Wall Street said Humana reported its strongest quarterly result in recent memory on the back of stronger-than-expected performance in the government segment. In line with the company's recently updated forecasts, and indicative of continued strong Medicare performance, how can you not look at that profit in the last—in the second quarter of this year, and not view it as a huge profit at taxpayer expense?

Mr. HILL. I——

Mr. KIND. Because it appears to be directly related with the MA compensation.

Mr. HILL. There is no evidence that Humana is making profit at the expense of taxpayers—based on what they have told us, and what they have told us in their bid, and what we are paying them. If what we are paying them is leading them to make money in the market, I think that is the purpose of the program, is for private plans to come in and deliver the program.

Mr. KIND. Thank you, Mr. Chairman.

Mr. LEWIS. [Presiding] Thank you. Mr. Pascrell is recognized.

Mr. PASCRELL. My good friend from Wisconsin, whatever the market can bear. Because it is very, very interesting that the—while reporting huge profits, the outgoing CEO of United, he had a $400 million bonus. I feel sorry for the guy. And he had a total retirement package worth a reported $1.5 billion.

You know, I am outraged. And I know you could care less, but I am still outraged. And I am outraged about these windfall profits,

because they go back to the debates of 2003, when we discussed the Medicare Modernization Act, plan D, which is now pretty famous.

And to hear what I am hearing today, hard working Americans are facing increased premiums and decreased quality of care, I am disappointed by the unwillingness to provide any accountability or oversight to ensure our tax dollars—and I know we're talking about civil situations, we're not talking about criminal. Are we? Are we, Mr. Hill? We are not talking about criminal actions, we are talking about civil actions. Some of these are pretty close, though. The difference between one and the other, many times, is very questionable.

It means that private insurance companies are free to determine a substantial portion of the services that are covered by Medicare. There is 43 million people on Medicare, 7 million of those people are in the Medicare Advantage. This is a big deal. This is pretty significant, as to what is happening.

And if you read the last issue of AARP Magazine, which I get because of obvious reasons, very clear about a couple of examples they give in that magazine. Bobby Boxer, a retired construction worker, he was very content with the regular Medicare. But—he was content, but last December a sales woman comes to his house and sells him a plan of Medicare, a Medicare HMO, when he thought he was buying a medigap policy. She lied. All MA plans are obliged to cover emergency care, as you well know. But what happened was he wound up with a bill of $16,000. Now, CMS is telling him, "Don't worry about that, we will get you back into regular Medicare."

This is baloney. This is not the way to deal with what is going on with these people, day in and day out. You confuse the senior community enough, and darn it, you better stop. You better end it right now. You confuse them. With all of these plans, how could they make sense of what is going on? How can they make sense?

I want to ask you a question, Mr. Hill, if I may. According to the GAO's assessment of the statutes, that CMS had the authority to pursue financial recoveries. But its rights under contracts for 2001 to 2005 are limited, because it is implementing regulations that are not required, that each contract include provisions to inform organizations about the audits and about the steps that CMS would take to address—identify deficiencies, including the pursuit of financial recoveries, which many have asked about.

Why would your agency write regulations for the MA contracts that did not include the recovery authority? Why would you do that?

Mr. HILL. I cannot speak to the ACR process that was in place from 2001 to 2005, and why those requirements are not in there, or why the Agency chose not to pursue that.

I can speak to the MAPD and the Part D plans that are in place now, post-MMA, and can tell you and assure you that it is very clear for the plans that, to the extent that we find overpayments on an audit, we have the authority to go back and recoup those funds.

Mr. PASCRELL. Now, the National Association of Insurance Commissioners, when they were asked what can be done, they advocate a stronger role for the states. The states play a stronger role

in the Medicaid program. In many of the states, the attorney general's office oversees it. You administer the MA program. You administer it. Am I correct in saying that? When we talk about administering the program, that means very specific things.

So, the states would have more authority and oversight of the MA marketing, especially in the regulation of agents and brokers, which is a state law issue in the first place. The language in the CHAMP bill, which the President said we should not vote on, because it would throw seniors off of Medicare—that is what he said, I know what he said—CMS had argued that state laws are preempted by this Medicare Modernization Act. That is what you said.

On September 28, 2007, an Alabama district court judge held that the state could sue for Medicare Advantage marketing abuses in state court under state insurance law. What is your reaction to that, Mr. Hill?

Mr. HILL. I am not familiar with the lawsuit, and I would like to take a look at it before I offer——

Mr. PASCRELL. Well, what do you think about the idea of states assuming a greater responsibility in going after the very abuses and deficiencies that you have heard questions about from this panel?

Mr. HILL. I don't think that we disagree that the states are our partner here. They are on the ground. The state insurance——

Mr. PASCRELL. Well, what do you mean by being a partner, Mr. Hill?

Mr. HILL. I think this is—they have their regulatory authority for brokers and——

Mr. PASCRELL. So you feel they have the ability, then, to pursue these civil complaints?

Mr. HILL. No, sir. I think they are our partners in this, and we work with them closely. We have entered——

Mr. PASCRELL. So you have no problems with this?

Mr. HILL. With?

Mr. PASCRELL. You have no problems with the states pursuing, as Alabama has?

Mr. HILL. As I said, I would need to take a look at that suit, to know exactly what it is they have pursued.

Mr. PASCRELL. Thank you, Mr. Chairman.

Chairman STARK. [Presiding] Thank you.

Mr. Nunes.

Mr. NUNES. No.

Chairman STARK. No? Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman. Let me try to put things in perspective. I do this at my own peril, Mr. Chairman. At a previous hearing in front of the full committee on income and equality, I pointed out that the 4.6 percent national unemployment rate was considered by most mainstream economists to be full employment, and my friend from California, a gentleman from Los Angeles, took me to task and chided me that every American deserves a job. I guess 0.0 percent unemployment is our goal.

But let me put things in perspective. The fact is that there are many on the majority side who have shown disdain for Medicare Advantage. I am not saying that is the genesis of this hearing, but I think that needs to be spoken.

The gentleman from Texas says that seniors have been "sucked in"—his words—to the Medicare Advantage program. I would like to quote specifically what the chairman of the oversight subcommittee has said, and I agree with him, where he says in his written statement, "Over 8 million Americans rely on Medicare Advantage, and there are 15,000 of those 9th congressional district of Missouri."

I am a small business owner. I pay Medicare taxes for the workers I hire. Every employer and every employee alike, every taxpayer in America deserves the comfort, or knowledge, or confidence that they are getting the bang for the buck, whether they are on Medicare Advantage, or whether they are helping fund the program.

So, with that in mind, at the end of Mr. Tiberi's questioning—I want to go back to that, because I think that has been glossed over to some degree. Now, I acknowledge, Mr. Steinhoff, that you take issue with the assumptions that Mr. Hill made regarding this error rate. So I take that as a given. My most famous constituent, Mark Twain, once said that there are lies, there are damn lies, and then there are statistics. So allow me, then, to talk about statistics.

Mr. Hill, let me flesh out a little further what Mr. Tiberi inquired of you. Because I think he asked, trying to put this in perspective again, there were audits of 49 organizations, which is about a 22 percent of those participating organizations, is that right, Mr. Hill?

Mr. HILL. That is correct.

Mr. HULSHOF. And as I also understand—again, I took this figure from Mr. Tiberi—in 2003, we spent—we taxpayers spent roughly $36,800,000,000 on Medicare Advantage. Is that number correct?

Mr. HILL. That is roughly correct.

Mr. HULSHOF. And we have learned, through this hearing, a net overpayment of about $35 million in overpayments?

Mr. HILL. That is correct.

Mr. HULSHOF. And that is a net, because, in addition to overpayments, there are also underpayments. Is that true?

Mr. HILL. That is correct.

Mr. HULSHOF. So, in other words, again, making sure that every taxpayer gets what they are entitled to—so, in other words, some on Medicare Advantage plans were getting benefits that they weren't paying for. Is that a fair assessment?

Mr. HILL. It would be implied, yes, sir.

Mr. HULSHOF. So, you calculated that, given all of that, the amount of money going to Medicare Advantage—and if we were to extrapolate those participating organizations, the error rate is what, for Medicare Advantage?

Mr. HILL. I think that is—I think, as Mr. Steinhoff indicated, we did not extrapolate that $35 million. I think if you did the math, the $35 million as a proportion of the total Medicare Advantage payments, it is a tiny fraction, a very tiny fraction. But it is not the extrapolated error rate for Medicare Advantage.

Mr. HULSHOF. Mr. Tiberi—and again, I know him to be a knowledgeable, reputable man—a .4 percent error rate, which again, I—every dollar should be legitimately spent or collected. So that—in my mind, again, I accept Mr. Tiberi's math—99.6 percent

correct, .4 percent incorrect, as opposed to you have calculated the fee-for-service error rate, and that is significantly higher. True?

Mr. HILL. Correct. It is 4.4 percent.

Mr. HULSHOF. So, I acknowledge this is useful, I think. You know, I know the righteous indignation by some, talking about profits and whatever, I mean, that is great political speech.

But I think, as far as making sure that the taxpayer gets the bang for their buck—and I hope, Mr. Chairman—I am not privileged to serve on the oversight subcommittee, but I hope that there is equal righteous indignation or aggressiveness looking at other areas of the Tax Code. For instance, the 25 to 30 percent error and fraud rate on the income supplement program called the earned income tax credit. I think every dollar that we allocate should be a dollar well spent. And I appreciate you having this hearing.

Mr. PASCRELL. Mr. Chairman, can I have a moment to speak out of turn for one minute? For 30 seconds?

Chairman STARK. Sure.

Mr. PASCRELL. Thank you. Chairman, I listened very carefully to my good friend, economics 101. This whole program is so efficient that is has been paid for by deficit financing. Thank you Mr. Chairman.

Chairman STARK. Okay, I——

Mr. PASCRELL. They have not paid for this program.

Chairman STARK. I was just—I suppose, as one of the two here who had asked for these hearings, I stipulate to my good friend that I happen to think that Medicare Advantage plans offer good medical care. Half of the residents—not half of the insured, but half of the people—who live in my district belong to one plan alone, Kaiser Permanente, and they are probably as good as any managed care plan in the country, and I happen to think that managed care is perhaps a better way for all of us to receive our medical care.

But the issue before us, the basic issue, is that we are overpaying by—according to MedPAC. And CBO and OMB all agree that we are overpaying these plans by about $40 billion over 5 years. That is the issue. Now, out of that $40 billion in overpayment, we can argue about what kind of inefficiencies there are, and how we collect that money.

But the basic problem is that, as compared to fee-for-service, which has no control over utilization, so you may actually find that we're actually paying more in fee-for-service than to say we are paying anywhere from 12 to 40 percent more is the issue.

Now, if we could somehow find out how to fairly pay the Medicare Advantage plans and recoup a good bit of that $40 billion, we would have a double win. We would have perhaps more efficient delivery of medical care, and we would save $40 billion for the taxpayers. And that, I think, would be an objective that we could all be proud to work toward on this committee.

So, I—the gentleman is right, we may be picking at small nits here, but let us not forget there is a big chunk of change out there that we have to distribute. Ms. Tubbs Jones is next.

Ms. JONES. Mr. Chairman, I thank you for holding the hearing. You know, today is Tuesday. And in two days, we are going to be voting to override the President's veto. And it is just hard for me to believe that we are arguing over $35 million to cover health care

for children. And I keep trying to read this correctly to figure out how many dollars we are concerned about here, with CMS.

I am interested, Mr. Hill. What did you do before you came to CMS?

Mr. HILL. I worked at the Office of Management and Budget.

Ms. JONES. And what did you do there?

Mr. HILL. I worked on the Medicare——

Ms. JONES. I am asking for your curriculum vitae, so you aren't concerned about the question. I am just wondering what your skill set is.

Mr. HILL. I was a budget examiner, working on Medicare and Medicaid issues.

Ms. JONES. And how long did you do that?

Mr. HILL. I was there for about 4 years.

Ms. JONES. Four?

Mr. HILL. Yes.

Ms. JONES. And what did you do before that?

Mr. HILL. Before that, I was a legislative analyst at the then-HCFA.

Ms. JONES. At what?

Mr. HILL. HCFA. What was then—I was a legislative analyst at the Centers for Medicare & Medicaid Services before I was at OMB.

Ms. JONES. In your responses, you said you have no idea what happened between 2001 and 2005 on the contract for Medicare Advantage, but you know what has happened since 2005, because you have been in charge. Is that a fair statement?

Mr. HILL. I think that is a fair statement, yes.

Ms. JONES. But when you looked at 2001 and 2005, did you say to anybody, "Let's look at the contract, we're having a problem here, we need to go back and reassess them"?

Mr. HILL. I can only tell you, ma'am, that there were some full and frank conversations between me and our Office of General Counsel about what we could or could not do with those overpayments from——

Ms. JONES. And the good lawyers that you have in the office of general counsel, didn't they have some idea that—I am sure, if they were great lawyers, and I am confident that they were—there had to be some provision in these contracts for them to address some of the issues that you raise.

Mr. HILL. Right. And the provisions in the contracts that allow us to address those issues are, to the extent there was misrepresentation by the plans. So, some of the plans on that $35 million disagreement——

Ms. JONES. Say that number again.

Mr. HILL. $35 million.

Ms. JONES. Okay, go ahead.

Mr. HILL. Disagreement—were misrepresenting what they told us. And that is what led to that discrepancy. Then we have authority under the statute to either pursue a civil monetary penalty, or to pursue a referral to the Office of the Inspector General.

Ms. JONES. So, now that you have received this GAO study that says something about why audit, or whatever——

Mr. HILL. Right.

Ms. JONES. What are you doing to make some changes?

Mr. HILL. I can tell you that, for 2006, we are not going to ignore the one-third audit requirement, as laid out in the MMA. We have put in place what I characterize as a sort of three-prong strategy here.

We make sure that, before we sign contracts with plans—as you know, they bid, we spend the summer looking at bids, and then we sign contracts in the fall. Before we sign those contracts, we look very clearly—in detail—at these bids, to be sure they accurately reflect the benefits and the assumptions that need to go into making a reasonable bid. To the extent that they don't, we ask plans to make changes, yes, ma'am.

Ms. JONES. So, consistent with your oath, as an employee of the U.S. government, and a representative of the people of America, you are saying that we made a commitment that we won't be in a position, on the contracts that you negotiate that we are in today?

Mr. HILL. That is correct.

Ms. JONES. Mr. Steinhoff, how are you, sir?

Mr. STEINHOFF. Real fine.

Ms. JONES. How long have you been in your job?

Mr. STEINHOFF. I have been with the Government Accountability Office since 1973, my current job probably for the last 8 or 9 years.

Ms. JONES. So, when you make or issue a report like you have issued with regard to Medicare Advantage to CMS, I mean, here we are, 2007. Your report speaks to—what years did this last report cover?

Mr. STEINHOFF. We are talking about 2001 through 2006, as of the end of the May/June 2007 time frame.

Ms. JONES. Let me ask you this. The report for 2001—okay, I am an official in the government, you are my auditor.

Mr. STEINHOFF. Yes.

Ms. JONES. Something happened bad in 2001. How soon do I know after that, that I made mistakes in my conduct?

Mr. STEINHOFF. Actually, you would have expected that CMS itself would have had the rate of audit, and the selection of audit, and the results of audit every year.

GAO——

Ms. JONES. Hold on a minute. I would have expected. They do not?

Mr. STEINHOFF. You would have expected that they would have had that information.

Ms. JONES. My question is, do they?

Mr. STEINHOFF. They did not have that kind of information.

Ms. JONES. 2001?

Mr. STEINHOFF. They didn't have—it.

Ms. JONES. 2002?

Mr. STEINHOFF. They didn't have it.

Ms. JONES. 2003?

Mr. STEINHOFF. They didn't have it.

Ms. JONES. 2004?

Mr. STEINHOFF. They didn't have it.

Ms. JONES. 2005?

Mr. STEINHOFF. They didn't have it.

Ms. JONES. 2006? Come on.

Mr. STEINHOFF. 2006 was——

Ms. JONES. You are joking me, right?

Mr. STEINHOFF. 2006 was not completed yet. But no, they didn't have it.

Ms. JONES. I am out of time.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to commend you on having this hearing. And I think, particularly when you read the article in the October 7th New York Times by Robert Pear, you realize that there are some audit problems.

But I think that one of the things that is troublesome to me is that there is a growing concern that the Medicare administration contracting, the macro form, in Section 911 of the Part D bill, is being implemented in a way that is setting up Medicare for failure.

And I think that the chairman and members should be looking to the future of what it is going to do when you take 49 contractors across the country and reduce it to 15, and put those contracts out purely on the basis of cost. Because you are going to have everybody talking about cutting offices.

Now, I had the—when you ride from Seattle on the airplane, you have a long time. And sometimes you have a seat mate who actually has something that is important to learn about. I sat next to a medical administrator for one of the national contracting organizations and talked to him about what is happening.

And right now when a doctor has billing, and you have auditing and you are doing—and you have what are called LDCs, local determinations, where you help the doctor try and figure out how to put his information in correctly, you try and pick up everything in advance. What is being set in place is a way to destroy Medicare fee-for-service because there is going to be a great reduction in the LDCs. The doctors won't get any help at the front end.

So everything will be paid, and then the contracts go out to the folks who are sitting there doing the payment safeguard, and recovery audit contractors will be going out into doctors' offices saying, ah-hah. We have got a fraud here.

Now, if you don't help people up front and then you hit them at the back end, it is going to set the place for a hearing in this room where people are going to come in and say, see all the fraud in the doctors. It will have been created by the way we set it up.

I came to Congress in 1989 when we were going through the savings & loan crisis. We said to the savings & loan, you can lend the money anywhere you want. You can lend swimming pools or golf courses or whatever. And the second thing they did was they cut down the number of auditors so that many of those savings & loans never had anybody coming in and saying, hey, let's look at your portfolio. Let's see what you are actually doing here, and stop it up front. We waited until the whole thing collapsed, and then we had hearings in the banking committee on endless days. We sat and listened to one folly after another that could have been prevented if we had decent auditing.

Now, I see us in this effort. We are going to put together North Dakota, South Dakota, Nebraska, Kansas, Arizona, New Mexico,

and Wyoming, I think are all in one. And it is going to have one office. One office for six or seven states.

Now, how is a doctor going to get any information whatsoever under that kind of system? And it is supposed to be reform. It is going from 46—each state has their own now. So we are going to cram them all together. Alaska, Washington, Idaho, and Oregon will all be one office. Right? California and Nevada will be one office. Now, you tell me how any doctor practicing is going to have any chance whatsoever to get any help up front.

And I think I would like to hear your ideas because those regulations are being written right now, and they are being put in place, and they are letting the contracts. I would like to hear you talk about what you think will happen in three or four or 5 years in this regard.

Mr. HILL. Right. I mean, I have to tell you, if I had heard sort of this laid out as the way the medical director or whoever it was you were sitting next to on the plane had described it, I too would be concerned. But I think it is safe to say that it is not quite as advertised.

So yes. For example, for the five states that you mentioned, there will be one contract and one entity that will be responsible for processing those claims. But it is also the case that contractor has to have an office and a medical director in every state. And that contract has to make its local coverage decisions based on what is going on in any individual state or geographic area to account for the variations that we see from region-to-region in the way that medicine is practiced differently.

And so the intent here isn't to sort of nationalize the way we process claims and nationalize where physicians or home health agencies or DME suppliers have to go to get the information. It is more for us to get economies of scale on the back end for the people who stuff the envelopes and the people who process the claims or answer the phones for more routine issues.

We would be shooting ourselves in the foot and being penny wise and pound foolish to not maintain that education and communication up front because, quite frankly, as we talked about the Medicare error rate earlier, the way we got that rate down was by communicating very aggressively with the providers who provide services.

Mr. MCDERMOTT. It is your testimony today that there will not be a reduction in the educational effort for physicians in this country who are in fee-for-service medicine taking care of Medicare patients?

Mr. HILL. Absolutely. That is my testimony.

Mr. MCDERMOTT. That is your testimony?

Mr. HILL. Yes, sir.

Mr. MCDERMOTT. Well, we will mark it down and we will see because I intend to be here a couple years from now when this whole thing begins to play out. Because my belief is if you are rushing through payment, you are going to ultimately wind up catching people in the net down there that are not necessarily fraudulent physicians.

Mr. HILL. Right.

Mr. MCDERMOTT. I think that is what makes doctors the most angry, is when they can't figure out the system, and then somebody comes in and treats them like they are a fraudulent doc. That isn't fair. And I think we ought to look at it up front. You say it is not going to happen. I hope you are—maybe you won't even be in the office. That will be the problem. I won't be able to find you. But we will bring up your quote.

Mr. HILL. If I can get out of this hearing, I think I may——

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Well, you will be happy to learn we are winding up. I just wanted to ask Mr. Steinhoff, finally, regarding the $29 million that wasn't returned to Medicare, was any of that—maybe you can summarize whether that came and whether any of that is owed to us from United and Humana, and maybe in the next panel I can help you collect some of that, Mr. Hill.

Mr. STEINHOFF. With respect to the $29 million that the IG found on the six audits of the supplemental payments, 10.5 million of that related to Humana. They audited 14.4 million of costs reimbursed to Humana, and questioned 10.5 of that.

Chairman STARK. And with United?

Mr. STEINHOFF. I don't believe they were one of the six, but I would have to check on that for you. But I do not believe they were one of the six.

Chairman STARK. Well, Mr. Camp, do you have any further inquiry? If not, I want to—Mr. Chairman?

Chairman LEWIS. No, sir.

Mr. CAMP. I just have one quick question.

Chairman STARK. Please.

Mr. CAMP. We heard some comments about salaries. But does CMS have the authority to review the salaries of hospital administrators, for example, with the result to Medicare payments?

Mr. HILL. No, sir.

Mr. CAMP. All right. And many of them have fairly significant salaries as well. So it is not just managers of Medicare Advantage plans.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. And I want to thank the panel, all of the staff from GAO, and Mr. Hill's staff, who have been sitting there trembling all morning for fear he would make a mistake. And see, he didn't, so your worries were in vain. Thank you all for being here. And we will proceed with our next panel.

And I will introduce them as they make their way to the witness table: Mr. Paul Precht, the Policy Coordinator of the Medicare Rights Center; Mr. Harry Hotchkiss, who is the Senior Products Actuarial Director of Humana of Louisville, Kentucky; Ms. Cindy Polich, the Senior Vice President of Secure Horizons, UnitedHealth Group of Minneapolis, Minnesota; Dr. Bart Asner, the Chief Executive Officer of Monarch Healthcare of Irvine, California.

I want to welcome the panel. My guess is in the next 15 minutes or so, they will call a series of votes. Perhaps we can get through the summation of your testimony, and then we will recess. We are not sure yet how many votes there will be, but I suspect it will be about at least a half an hour.

And so I will ask Mr. Precht to summarize, as with the previous witnesses. Your prepared testimony will appear in the record in its entirety. If you would like to summarize it any way you are comfortable. And we will start with Mr. Precht.

STATEMENT OF PAUL PRECHT, POLICY COORDINATOR, MEDICARE RIGHTS CENTER

Mr. PRECHT. Chairman Stark, Ranking Member Camp, members of the health and oversight subcommittees, thank you for this opportunity to testify. I am Paul Precht, Deputy Policy Director for the Medicare Rights Center.

For the past 2 years, the staff and volunteer counselors at the Medicare Rights Center have been preoccupied with two types of cases: helping victims of deceptive, fraudulent, and abusive marketing by private Medicare plans; and helping people enrolled in those plans obtain coverage for their medical care and prescription drugs.

The subject of today's hearings, the oversight of private Medicare Advantage plans by the Centers for Medicare and Medicaid Services, goes to the heart of this work. In short, the laxer CMS's oversight of these MA plans is, the more problems we see. The looser the rules CMS sets for MA and drug plans, the harder it is for our clients to get the medical care they need.

Earlier today, GAO reported how CMS had failed to conduct the audits of MA plans mandated by law, and when it did audit plans, failed to recoup subsidies that the audits showed should have funded additional benefits for plan members. In my testimony, I would like to touch on three different aspects of CMS's oversight of MA plans: CMS's review of plan benefit packages, CMS's review of the plan appeals and grievance procedures, and CMS oversight and enforcement of marketing guidelines.

MA plans and private fee-for-service plans in particular are being marketed as low cost alternatives to supplemental insurance, yet they often fail to provide the protection against catastrophic medical expenses that people receive under any of the standard supplemental Medigap plans. Individuals who enroll in Medicare Advantage plans cannot purchase supplemental coverage to cover the gaps in the benefits like they can under original Medicare.

Health insurance that works when you are healthy but cuts out when you are sick is not what Medicare has offered for over 40 years. In my written testimony, I describe how a client of ours from Long Island was hit with $3,000 in copays from her Medicare Advantage plan for the treatment of ovarian cancer after she had been told before enrolling that all of the costs associated with her chemotherapy would be covered.

Unfortunately, our review of the benefit packages offered by MA plans shows that coverage of chemotherapy is one of a number of areas where plan coverage is often inadequate. Plans charge more for chemotherapy and other Part B drugs than the 20 percent coinsurance charged under original Medicare.

More commonly, plans carve out chemotherapy and the other Part B drugs from the annual caps they place on enrollees' out-of-pocket spending, if they have a cap at all. Some plans do both, charge more for chemotherapy and carve this service out of their

out-of-pocket cap. In our view, these practices are unacceptable. They discriminate against people with cancer and other illnesses that require treatment with high cost drugs administered by their doctor.

CMS has the authority to prohibit such plan designs as discriminatory. Such plans continue to be approved by CMS, however, because the agency takes an overly restrictive view of its legal authority to prohibit discriminatory benefit packages. In 2004, MedPAC recommended that CMS exercise its full authority to reject plans that have benefit designs and cost-sharing structures that discriminate on the basis of health status. Still, CMS has not acted.

The Medicare Rights Center has a small team of lawyers and counselors who help people appeal when their private Medicare plan denies coverage for a drug or medical procedure they need. Often people come to us after they were stonewalled by their plan.

We know now, from a review of CMS audits of plan appeals and grievance procedures, that a failure to abide by the timelines, notice requirements, and procedures for appeals seems to be the rule, not the exception, among MA and drug plans. A full 94 percent of the plans audited failed to meet CMS requirements on handling appeals and grievances, requirements that are fundamental to ensuring that plan members know their appeal rights and can pursue them effectively.

For the benefits offered by MA plans to become real for people with Medicare, plan enrollees must actually be allowed to fill the prescriptions and obtain the medical services that they need. I began this testimony by recounting how one of our clients was charged high copayments for chemotherapy. The other aspect of the story, the false promise she received from plan representatives that her chemo would be covered, illustrates the deception that is too often used in the marketing of MA plans.

There are many much more egregious examples. Agents go door to door, pretending they are from Medicare. Agents threaten people under that pretense that they will lose their Medicare or Medicaid coverage if they do not sign up. Agents fraudulently obtain signatures for plan enrollment by having people sign up to receive more information, or for a raffle.

A CMS official recently told a conference of health plans that the reports of deceptive and fraudulent marketing were not abating, but were growing in intensity and volume. We know from the corrective action plans released by CMS that such marketing misconduct is widespread in large part because the Medicare advantage plans do not have the systems in place to prevent it. For example, audits consistently find that agents are inadequately trained and supervised and are not properly licensed.

Faced with the absence of these basic safeguards, CMS's response is to insist, at some future date listed in the corrective action plan, that the company actually do what is already required of it. The pattern is clear, whether it concerns marketing violations, denial of appeal rights, or the inflated bids discovered upon audit: The response by CMS is not to punish the plans for misbehavior, not to recover for taxpayers the money we have paid for services not delivered, but to wag their finger at the plans.

When oversight is lax and enforcement is absent, enrollees in Medicare Advantage plans are shortchanged on their benefits and their access to care is compromised. We applaud this committee for holding this hearing and urge you to do what you can to ensure that CMS makes all Medicare private plans play by the rules.

Thank you again for this opportunity.

[The prepared statement of Mr. Precht follows:]

Medicare Rights Center

Testimony of Paul Precht
Deputy Policy Director, Medicare Rights Center

Joint Hearing on
"Statutorily Required Audits of
Medicare Advantage Plan Bids"

Before the United States House of Representatives
Committee on Ways and Means
Subcommittees on Health and Oversight

October 16, 2007

Chairman Stark, Chairman Lewis, Ranking Members Camp and Ramstad, Members of Congress, thank you for this opportunity to testify at this joint hearing by the Health and Oversight Subcommittees of the House Committee on Ways and Means. I am Paul Precht, Deputy Policy Director for the Medicare Rights Center and director of our Washington office.

Founded in 1989, the Medicare Rights Center is the largest independent source of information and assistance to people with Medicare. For the past two years, our staff and volunteer counselors have been preoccupied with two interrelated types of cases—helping victims of deceptive, fraudulent and abusive marketing by private Medicare plans, and helping people enrolled in those plans obtain coverage for the medical care, including prescription drugs—that they need.

The subject of today's hearing—the oversight of private Medicare Advantage plans by the Centers for Medicare & Medicaid Services (CMS)—goes to the heart of this work. The laxer CMS' oversight of these private Medicare plans is, the more problems with Medicare Advantage plans we see. The looser the rules CMS sets for private plans, the harder it is for our clients to get the medical care they need.

In its report presented today, the Government Accountability Office (GAO) describes how CMS failed to conduct the audits of Medicare Advantage plans mandated by law, and, when it did audit plans, failed to recoup subsidies that the audits showed had been misused by the plans. These audits are tests by CMS to see if the plans' benefit packages were actuarially equivalent to the amount of money the plans were being paid. A failure to meet this test means that plan enrollees are not getting the benefits they deserve and taxpayers are not getting their money's worth.

Let me be clear. The Medicare Rights Center does not believe that this test of actuarial equivalence is sufficient to guarantee that Medicare Advantage plans provide the benefits people need. It does not ensure that for specific services—in particular for services like home health care, inpatient hospital care, skilled nursing facilities and chemotherapy that are used by very sick people—the benefits provided by many Medicare Advantage plans are as good as the coverage provided under Original Medicare. It is a test that the coinsurance and copayments across all Medicare-covered services is, on average, on par with what Original Medicare charges.

The inadequacy of this test, and the failure of plans to meet even this extremely low bar, means that an individual with a chronic or acute condition—someone recovering from a stroke in a skilled nursing facility, someone admitted to the hospital after a heart attack—can pay more out-of-pocket under a Medicare Advantage plan than he or she would under Original Medicare, even though taxpayers are paying the plan more than they would under Original Medicare.

Individuals who enroll in Medicare Advantage plans cannot purchase supplemental coverage to cover the gaps in the benefit like they can under Original Medicare. Medicare Advantage plans, and private fee-for-service plans in particular, are being marketed as low-cost alternatives to supplemental insurance, yet they often fail to provide the protection against catastrophic medical expenses that people receive under any of the standard supplemental "Medigap" plans. Health insurance that works when you are healthy, but cuts out when you are sick, is not what Medicare has offered for over 40 years.

True Story

Mrs. B lives in Suffolk County, New York. She has ovarian cancer and receives chemotherapy. When she became eligible for Medicare in June 2006, she chose a Medicare Advantage plan because she had contacted the plan and been told it would cover all costs associated with the chemotherapy. However, for her last two treatments,

she was charged copays totaling about $3,000. When Mrs. B's daughter-in-law contacted the plan, she was told that the charge represented copays for medications supplied under Part B. Her daughter told the counselor that if they had been told this in the beginning, they would have stayed with Original Medicare. Fortunately, Mrs. B was still in the Open Enrollment Period and could change back to Original Medicare by March 31. If she had learned of her chemotherapy copayments in April, she would have been locked in to the plan for the rest of the year.

Unfortunately, the poor coverage that Ms. B received for chemotherapy under her Medicare Advantage plan is not unusual. In researching a recent report on the benefits of standardizing Medicare Advantage benefit packages, the Medicare Rights Center found that many plans charge more for chemotherapy and other physician-administered drugs then the 20 percent coinsurance charged under Original Medicare. Even more commonly, plans carve-out chemotherapy and other Part B drugs from the annual caps they place on enrollees' out-of-pocket spending on medical services—if they have a cap. Some plans do both—charge more for chemotherapy and carve this service out of their out-of-pocket cap. These practices are unacceptable. They discriminate against people with cancer and other illnesses that require treatment with high-cost drugs administered by their doctor. There are two profit-maximizing motives for these policies: force very sick patients to pay for their health care out-of-pocket and drive sick patients out of these plans and, typically, back into the safe haven of Original Medicare.

CMS has the authority to prohibit such plan designs as discriminatory. Such plans continue to be approved by CMS, however, because the agency takes an overly restrictive view of its legal authority to prohibit discriminatory benefit packages. In 2004, the Medicare Payment Advisory Commission (MedPAC) recommended that CMS exercise its full authority to reject

plans that have benefit designs and cost-sharing structures that discriminate on the basis of health status. Still, CMS has not acted. We look to this Committee to find out why.

It is time for Congress to mandate that CMS protect Medicare Advantage enrollees against such practices. One way to do that is to enact legislation, such as that included in the House-passed CHAMP Act, which would bar plans from charging more for specific medical services, such as chemotherapy, home health care or hospital admissions, than is charged under Original Medicare.

CMS does encourage plans to set a comprehensive cap on annual out-of-pocket spending on medical services. Plans that set such a cap at a low enough level—for 2008 it is the minimum amount spent by the 25 percent of people with Medicare with the highest out-of-pocket costs—are given greater flexibility by CMS in setting cost-sharing for individual services. In practice, this standard is so vague as to be meaningless.

In our review of plan benefit packages, we found that most plans had no out-of-pocket caps, or set caps well above the threshold recommended by CMS, yet many of these plans charged higher copayments and coinsurance than Original Medicare for chemotherapy, hospital and skilled nursing admissions and home health care. Another option for Congress would be to put teeth in this standard. No plan could charge more than Original Medicare for any specific service unless it set a low enough limit on annual out-of-pocket spending that applied to all Medicare-covered services.

There are some policymakers who will oppose stricter regulation of Medicare Advantage plans, preferring to let the marketplace cure abuses over time. These policymakers look to the Federal Employee Health Benefits Plan as a model worth of emulation. Under this system, Members of Congress and other federal employees choose from a private plan approved by the

Office of Personnel Management (OPM). Although Congress gave CMS authority similar to the power OPM has to approve health benefit plans for federal employees, the results are quite different. The Medicare Rights Center recently reviewed the benefit packages available to federal employees living in Northern Virginia. Each of these plans set a cap on enrollees' out-of-pocket spending on medical care. Not one of these plans excluded chemotherapy or other vital medical services from these caps. People with Medicare deserve the same protections from profit maximizing insurers that Members of Congress and other federal employees enjoy.

Congress should also remove the special exemptions that apply to private fee-for-service plans, the fastest growing and, for taxpayers, the most expensive type of private Medicare plan. In particular, private fee-for-service plans are exempt from the same review of their bids and benefit packages that HMOs and other Medicare Advantage plans undergo. That means that neither you nor the Administration has any idea if taxpayers are getting their money's worth from these plans—even the lax and inconsistent reviews by CMS that the General Accountability Office exposed in its recent report do not apply to these plans. There is also no review of whether the premiums that people with Medicare pay for these plans actually fund improved benefits or simply line the pockets of shareholders. The Administration has told this Committee it supported subjecting private fee-for-service plans to the same review as other Medicare Advantage plans. It is time for Congress to heed this advice.

There is another reason the market alone cannot sort out the good plans from the bad. The sheer number of plans—in many localities there are over 50 to choose from—and the dizzying variety of plan designs makes it impossible for even the savviest consumer to choose the right plan. Even MedPAC researchers, an astute bunch, could not determine with any certainty which plans provided comprehensive caps on out-of-pocket spending, and which plans exempted

certain services. Most people will not discover the loopholes in their coverage until they fall ill and find the drug they need is not covered or the coinsurance for a specific service is exorbitant. Enrollees who were happy at the low premium they paid quickly become angry that the coverage they were promised did not pan out.

Research has consistently shown the gamble that people with Medicare take when they enroll in a private Medicare plan. MedPAC researchers found that the coinsurance for a chemotherapy regimen for colon cancer ranged from under $2,000 to over $7,000 in the plans they studied. The Commonwealth Fund modeled costs for individuals in poor health under 88 Medicare Advantage plans. In 19 of those plans, including plans with substantial shares of their local markets, sick individuals would pay between $285 and $2,195 more than they would under Original Medicare with a Medigap Plan F, the most popular supplemental plan.

Congress needs to look to the reforms enacted for supplemental Medigap plans as the model for how to help people with Medicare make an informed and appropriate selection of a private Medicare plan, if that is what they want. Medigap insurers can only market plans from a defined menu of benefit packages, each of which provides protection against catastrophic medical expenses. These plans compete on the basis of premium. They are prohibited from designing benefit packages that appear attractive at first blush, but prove to be riddled with loopholes and traps. The standardization of Medigap plans has substantially reduced the consumer confusion that once surrounded these plans and that made people with Medicare so vulnerable to aggressive and deceptive marketing. With standard benefit packages it would be easier for consumers to know what they are buying and for CMS, through the audit process under discussion today, to figure out if taxpayers were getting their money's worth.

The audits and other reviews of Medicare Advantage plans that we have been discussing concern the benefits these plans provide on paper. For those benefits to become real for people with Medicare, plan enrollees must actually be allowed to use the service. A low copayment for hospital admission does no good if the plan will not cover the surgery. Drug coverage is useless if your plan will not authorize coverage of the medicine you need.

This is another area where plan performance, and CMS oversight, is lacking. A review of the recently released corrective action plans imposed on private Medicare plans by CMS shows that 94 percent of plans audited failed to meet CMS requirements on handling appeals and grievances. Plans commonly fail to issue timely notices of denial when they refuse to cover prescription drugs or medical services. Those denial notices often fail to explain the reason for the denial and at least one company failed to have medical doctors conduct the reviews of denials, as required by CMS. Without a prompt denial notice that explains the reason why the service is denied, plan enrollees cannot effectively pursue their appeal rights. In fact, they may not even know that they have appeal rights. The failure of plans to implement these fundamental safeguards means that the access to benefits promised to plan enrollees may never be realized. Despite the seriousness of these offenses, the corrective action plans imposed by CMS do little more than admonish the plans to 'do a better job' and follow the guidance they have already flouted.

We began this testimony by recounting the experience of Mrs. B and the high copayments she was charged for chemotherapy by her private Medicare plan. The other aspect of Mrs. B's story—the false promises she received from plan representatives that her chemotherapy would be fully covered—illustrates the deception that is too often used in the marketing of Medicare Advantage plans. A CMS official recently told a conference of health plans that the

reports of deceptive and fraudulent were not abating, but were "growing in intensity and volume." We know now from the corrective action plans released by CMS that such marketing misconduct was widespread in large part because the Medicare Advantage plans do not have systems in place to prevent it. Agents are inadequately trained and supervised and not properly licensed. Plans do not consistently track rapid disenrollments, which should call attention to agents who misrepresent plans and sell plans that are ill-suited for the individual enrolled. Plans did not properly conduct calls to verify that new enrollees understood their new plan, either failing to make such calls or calling when the selling agent was present and able to coach the new enrollee on how to answer questions. Faced with the absence of these basic safeguards, CMS' response is to insist, at some future date listed in the corrective action plan, that the company actually do what is already required of it.

Admonitions by CMS to do better are inadequate. Companies need to face consequences—substantial monetary sanctions or freezes on enrollment-- for failing to abide by marketing rules. Implementation of basic consumer safeguards should be a precondition to participation, not a goal that companies will get around to eventually. The contrast between the detailed and thorough market conduct examination conducted on Humana by the Oklahoma Insurance Commissioner and the cursory summary of Humana's marketing violations in CMS' corrective action plan illustrates two divergent approaches to oversight. The difference in fines imposed on a company with over $20 billion in annual revenue is also indicative: $500,000 by Oklahoma, $75,000 by CMS.

The pattern is clear. Whether it concerns marketing violations, denial of appeal rights or the inflated bids discovered upon audit, the response by CMS is not to punish the plans for misbehavior, not to recover for taxpayers the money we have paid for services not delivered, but

to wag their finger at the plans. When oversight is lax and enforcement is absent, enrollees in Medicare Advantage plans are shortchanged on their benefits and their access to care is compromised. We applaud this Committee for holding this hearing and urge you to do what you can to ensure that CMS makes all private Medicare plans play by the rules.

The report referred to in this testimony authored jointly by the Medicare Rights Center and California Health Advocates is called "Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans." It is available at http://www.medicarerights.org/MRC-CHA_MAstandardization.pdf.

Medicare Rights Center

CALIFORNIA HEALTH ADVOCATES

Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans

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www.medicarerights.org

This Issue Brief is the sixth and last in a series on Medicare drug benefit issues for consumers drafted by California Health Advocates (CHA) and the Medicare Rights Center (MRC), with support from the California HealthCare Foundation.

Medicare Rights Center
520 Eighth Avenue
North Wing 3rd Floor
New York, NY 10018
212-869-3850

California Health Advocates
5380 Elvas Avenue, Suite 104
Sacramento, CA 95819
916-231-5110
www.cahealthadvocates.org

Executive Summary

This report posits that people with Medicare would be better able to make informed decisions about their coverage options and be more likely to receive protection against high out-of-pocket spending on health care if Medicare private health plans—so-called Medicare Advantage plans—were only allowed to offer a finite number of standardized benefit packages.

There is a marked difference between choosing among competing private Medicare health plans and selecting a supplemental "Medigap" policy. (Medigap policies are sold by private insurers and receive no government subsidy. They cover gaps, such as deductibles and coinsurance, in the standard Medicare benefit.) There are a limited number of Medigap benefit packages, all of which provide financial protection against catastrophic illness. By contrast, there is no limit on the variety of benefit designs employed by Medicare private health plans and no guarantee of protection against exorbitant medical bills.

Combining a review of recent research with an examination of the benefit packages offered to people with Medicare in 2007, the report demonstrates that there are serious deficiencies in the benefit packages of Medicare private health plans. Among the shortcomings detailed in the report

- consumers suffering from chronic illness can incur widely varying levels of cost-sharing under different plans;
- many plans do not provide a limit on enrollees' annual out-of-pocket spending for medical services or exempt certain services, such as chemotherapy, from such limits;
- many plans charge more than Original Medicare for specific services, such as inpatient hospital care, nursing home stays or home health care.

The report finds that the current marketplace for Medicare private health plans, which is characterized by an increasing number of plans with widely varying benefit designs, makes it nearly impossible for consumers to discover the shortcomings in plans' benefit design. Informed choice is made more difficult by the aggressive marketing of Medicare private health plans and an over reliance by consumers on the information supplied by agents and brokers with a financial interest in pushing specific plans. Only a fraction of consumers utilize web-based plan comparison tools or advice from trained counselors in the State Health Insurance Assistance Program in selecting plans.

Today's marketplace for Medicare private health plans bears marked similarities to the marketplace for Medigap plans before Congressional action mandated the standardization of these plans, a reform that successfully enhanced consumers' understanding of their plan options and decreased the incidence of deceptive and abusive marketing. The regulatory structure for Medicare private health plans fails to prohibit benefit designs that disadvantage individuals with serious illnesses and does not provide consumers with the means for making an informed choice of plans. Drawing from its prior experience regulating Medigap plans, Congress should create a process to develop a limited number of benefit packages for Medicare private health plans that meet minimum standards of consumer protection.

Introduction

Enrollment in Medicare private health plans has risen by over three million since 2003, with the fastest increase concentrated among private fee-for-service (PFFS) plans that are marketed as low or zero-premium alternatives to supplemental Medigap plans.[1] This enrollment surge has been accompanied by a sharp rise in reports of aggressive and deceptive marketing of Medicare private health plans (also referred to as Medicare Advantage plans).[2] Besides the more lurid stories of marketing abuse—individuals who were enrolled in plans without their knowledge or tricked into signing enrollment forms—counselors, advocates and insurance brokers have also fielded complaints from new Medicare private health plan enrollees who do not understand that they no longer receive the same protection against out-of-pocket spending for medical care that they had under their Medigap policies, are surprised that they cannot see their regular doctors and are devastated when they are hit with high medical bills under their new plans.

To many observers, the current Medicare private health plan marketplace is reminiscent of the Medigap marketplace of the late 1980s. At that time, people with Medicare faced a dizzying array of Medicare supplemental insurance policy choices that were difficult to understand and impossible to compare. The confusion made older adults vulnerable to sale of duplicative policies and to "churning"—being switched from one Medigap policy to another by overly aggressive brokers seeking to maximize commissions.[3] Congress responded to this situation with a series of reforms in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The centerpiece of these reforms was a mandate to the National Association of Insurance Commissioners to develop a limited number of standardized Medigap benefit packages that all insurers could sell.

The OBRA 90 reforms were a success.[4] Following OBRA 90, it was easier for consumers to compare supplemental insurance products and prices and to choose the health benefits they needed at a known cost.[5] In addition, complaints about plans and agents were reduced.[6] There are no hidden out-of-pocket costs in these products and no changes to their benefits once enrolled. Standardization has focused competition on premium pricing.[7] Over the years, choosing a Medicare supplement policy has become one of the easier insurance decisions older Americans are required to make. It allows this population, the majority of whom are on a fixed income, to budget for their annual health care expenses, although the premium is often unaffordable for people with Medicare who have low incomes.

This report looks at the difficulties consumers face in selecting a Medicare private health plan and the deficiencies in the benefit structures of these plans. It makes recommendations for how Congress can remedy these twin problems by creating a process to standardize benefit packages.

Decisions Facing Consumers

The selection of a Medicare private stand-alone drug plan or private health plan can have serious and irreversible consequences for the coverage a person with Medicare can receive. Mistaken individual enrollment in a Medicare stand-alone drug plan or a private health plan can cause a former employer to drop a retiree from a group plan offering comprehensive drug and

supplemental medical coverage, sometimes without the possibility of reinstatement. People who disenroll from a Medicare private health plan and return to Original Medicare typically have no right to a Medigap policy.[8] Most people enrolled in a Medicare private stand-alone drug or health plan will find themselves locked into their plan—and locked out of a more appropriate coverage choice—for the calendar year. Aggressive and deceptive marketing tactics, underfunding for counseling services and a confusing marketplace of coverage options increase the likelihood that consumers will make the wrong choice and suffer a reduction in coverage and access to health care services as a result.

A common choice facing consumers—choosing between coverage under Original Medicare with a Medigap plan and a stand-alone drug plan or enrollment under a Medicare private health plan with drug coverage—provides a revealing illustration.

For people with Medicare who have incomes too high to qualify for assistance through the Medicaid program or who do not have supplemental insurance from their union or former employer, a supplemental Medigap policy is the most popular option to fill gaps in the Original Medicare benefit.[9] A Medigap plan provides coverage for specific gaps in the Original Medicare benefit package and preserves access to the full range of Medicare providers whether an individual seeks care in his or her own home town or while traveling within the United States.

In the 17 years since Medigap plans were standardized and insurance companies limited to the sale of standardized plans, 65 percent of consumers have purchased just two plans that provide the most comprehensive first-dollar coverage.[10] People with Medicare have indicated a strong preference to pay the premiums these plans require to have protection against unanticipated medical expenses of unknown amounts.

With the subsidies Medicare private health plans receive for providing standard Medicare benefits, they have begun marketing themselves as low-premium, or no-premium, alternatives to Medigap policies. But Medicare private health plans are subject to much less stringent regulation of the benefit packages they provide than Medigap supplemental policies. As a result, people with Medicare have a much more difficult time comparing the benefits offered by these plans to competing Medicare private health plans, to Original Medicare or to the benefits provided by a Medigap supplemental policy. More seriously, enrollees in these Medicare private health plans who fall ill can find themselves hit with high bills for medical expenses and with no protection against catastrophic expenses for medical care.

The choice between Original Medicare with a Medigap supplement and coverage under a Medicare private health plan requires consumers to weigh restrictions on access to providers, utilization management restrictions on access to medical care and exposure to out-of-pocket spending, including premiums, copayments and coinsurance for specific medical services (information that is not easily accessible). Consumers must also compare the drug coverage available under a Medicare private health plan and a stand-alone drug plan.

Drug Coverage

Since 2006, insurers have been barred from selling Medigap plans that include prescription drug coverage. The new Medicare Part D prescription drug benefit is available only through private plans, either stand-alone drug plans or Medicare private health plans with drug coverage; there is no option to receive drug coverage directly through Medicare. Selecting the most suitable drug coverage presents a similar comparison exercise whether the plan is offered as part of a Medicare private health plan or as stand-alone coverage.

Consumers must determine whether a plan covers their drugs, whether the restrictions it imposes (prior authorization, step therapy, quantity limits) impedes coverage and whether the plan's combination of premiums, copayments and other out-of-pocket costs and drug pricing make it the "best buy." Consumers must also determine whether the pharmacies of their choice participate in the plan, particularly mail-order pharmacies. Prices on individual drugs can change at any point during the year as can formulary coverage (although plans are currently required to grandfather coverage for the remainder of the year for members already taking a drug). Given the impossibility of predicting future diagnoses, and the drugs that will be prescribed as treatment, there is little ability to assess the value of coverage under a different drug regimen from the current one.

Provider Access

Nearly all hospitals, skilled nursing and other post-acute care facilities, and over 90 percent of doctors, accept assignment by Medicare (meaning they agree to accept the Medicare-approved amount as payment in full).[11] Nearly all these providers accept supplemental coverage from any Medigap plan.[12]

Provider access under a Medicare private health plan is more difficult to determine. Potential enrollees in HMOs, which only cover services provided by network providers except in emergencies, can check to see if their current doctors and local hospitals are in the plans' network. But HMOs can drop providers from their networks or providers can decide they no longer accept a plan at any point during the calendar year, when plan members are locked into the HMO. Since plan members cannot predict what conditions they may get and if the specialist they need will be in the plan's network, they are left having to plan for an unknown future based solely on their needs today. Potential enrollees in preferred provider organizations (PPOs) face the same risk and must also determine whether out-of-pocket costs for out-of-network services are prohibitive or provide affordable access as an alternative to a network provider. The risk is greatest to potential enrollees in private fee-for-service (PFFS) plans. Although enrollees can seek care from any provider willing to accept the plan's rates and rules, providers who do not have written contracts with the plan—the overwhelming majority of PFFS providers—decide whether to accept the plan with each visit or treatment. A provider that accepts the plan one day may decline it the next time.[13]

Utilization Management

An assessment of the medical benefits provided by Medigap and Medicare private health plans involves a comparison of the utilization restrictions imposed on medical services and the premiums and other out-of-pocket costs the plans impose. Medigap plans do not restrict utilization; they must rely on Medicare's payment determinations and cover services paid for by Original Medicare. Medicare private health plans also provide coverage for all procedures that Original Medicare covers, but can impose conditions on coverage that restrict or improve access to services and they can set their own out-of-pocket costs for different covered services. For example, Medicare private health plans can eliminate the requirement imposed in Original Medicare that a stay in a skilled nursing facility is preceded by a hospital stay of at least three days. At the same time, Medicare private health plans can impose a range of additional restrictions, from requiring referral from a primary doctor for specialist care to requiring members to get permission from the plan (prior authorization) before a hospital stay, surgery or durable medical equipment purchase.

Out-of-Pocket Costs

The most important factor for most consumers when trying to make a choice is cost. The cost information presented to consumers to entice them to join a Medicare private health plan can be misleading. When choosing a Medigap plan, however, consumers can be sure of what they are getting.

Consumers can choose from 12 standard Medigap plans, two with high deductibles. All plans cover Medicare out-of-pocket costs for lengthy hospital stays and provide protection against high out-of-pocket expenses for Part B services (such as for chemotherapy or radiation treatment), either through full coverage of all Part B out-of-pocket costs or, in plans K and L, after annual cost-sharing has been met.

Consumers make the choice of paying a higher premium for coverage of the deductibles for Parts A and B[14] or whether to pay a lower premium and pay a portion or all of Part B out-of-pocket costs below a cost-sharing limit (plans K and L and high-deductible plans F and J). In addition, consumers choose whether they want coverage of excess Part B charges when providers do not accept assignment (plans F, G, I and J) and whether to forgo coverage for Medicare cost-sharing ($124 for days 21 through 100) for a lengthy stay in a skilled nursing facility (plans A and B). All companies offering Medigap plans offer at least one of the standard plans and compete on the basis of premiums, which are regulated at the state level.[15]

On the other hand, there are no standard benefit packages for Medicare private health plans. Every one of the dozens of plans available in a consumer's area may be structured differently. Plans may, or may not, limit annual out-of-pocket spending. Those that do can set the limit at any level and can exempt specific services, such as chemotherapy and other Part B drugs, from the limit. Hospital coverage may, or may not, include out-of-pocket expenses for lengthy stays in hospitals or skilled nursing facilities. Instead of the standard Part A deductible, plans often substitute per-day payments, but the wide range of chargeable days and daily rates makes comparison difficult and disguises out-of-pocket costs that can exceed the Part A deductible.

Similarly, plans can impose out-of-pocket costs on home health services that Original Medicare provides at no cost or shorten the number of days in a skilled nursing facility that are provided without copayment under Original Medicare. Medicare private health plans typically charge flat copayments for doctor visits but charge more for additional services, such as diagnostic tests, or procedures, such as chemotherapy.

Benefit designs that have higher out-of-pocket costs for certain types of care generally favor the healthy, so relatively healthy people may think a private health plan will be a good deal until they are diagnosed with cancer or another health condition that requires extensive medical care. Then they may face high out-of-pocket costs they never counted on and realize they would have been better off under Original Medicare with a Medigap supplement. At that point, they are locked into their health plan choice for the rest of the year and may not be able to buy a Medigap supplement when they can change plans.

Medicare Private Health Plan Benefit Packages: Unhealthy for Consumers

Recent research shows how Medicare private health plans' benefit packages can disadvantage certain plan enrollees, particularly those with severe or chronic illnesses.

Under a mandate from Congress, the nonpartisan Medicare Payment Advisory Commission (MedPAC) issued a report in December 2004 looking at the extent Medicare private health plans' benefit designs affected access to Medicare-covered services and discouraged enrollment of sicker individuals.[16] In part, because of limitations on the data available, the MedPAC report drew no conclusion on whether benefit designs skewed enrollment toward healthier individuals. But the report did find numerous examples of plan designs that imposed disproportionately high out-of-pocket costs on medical services needed by seriously ill individuals and plans that left enrollees exposed to high out-of-pocket expenses for specific services. Surveying 505 plans accounting for 90 percent of Medicare private health plan enrollment, MedPAC found the following:

- Fifty-four percent of plans charged 20 percent or more for Part B drugs (which include chemotherapy drugs). Two-thirds of those plans had no limit on annual out-of-pocket spending. The remaining third had some form of cap on member spending, although researchers could not determine if the cap applied to some or all Part B drugs.
- Nineteen percent of plans charged 20 percent or higher for radiation therapy services, with only one-third capping out-of-pocket spending.
- Twenty-two percent of plans charged comparable or higher amounts for inpatient hospital care. One-third of those plans had no catastrophic protections.
- Fifty percent of enrollees were in plans with no cap on out-of-pocket spending. Twenty percent were in plans with a cap that applied only to inpatient hospital care. Thirty percent were in plans with caps that applied to inpatient hospital care and at least some other Medicare services.

The MedPAC report also compared the cost of treatment for colon cancer in the three Medicare private health plans with the largest enrollment in the country. Looking only at the costs of the chemotherapy regimen, and excluding related costs such as for anti-nausea medications, researchers found annual out-of-pocket spending that ranged from $1,990 on the low end to $6,550 and $7,100 on the high end. The two high-cost plans had greater-than-average rates of plan members who left the plans because of the cost of premiums, copayments or coverage issues. (Those disenrollment rates occurred before the imposition of lock-in; Medicare private health plan members are now generally barred from leaving their plan until the next year.)

A November 2006 report by the AARP Public Policy Institute shows how Medicare private health plans have used the flexibility they have in benefit design to lower out-of-pocket spending for individuals in good health while raising out-of-pocket costs for those with serious or chronic illness. Between 1999 and 2005, average annual out-of-pocket expense in the lowest-premium Medicare private health plans for medical and hospital services for individuals in good health rose from $117 to $166, but then dropped to $73 in 2006. During the same time period, out-of-pocket costs for individuals in poor health rose from $258 in 1999 to $1,219 in 2005, remaining essential flat in 2006.[17] It is worth noting that this disproportionate rise in out-of-pocket expenses for individuals in poor health was maintained during the 2003-2006 period when Medicare private health plan overpayments were rising and full-risk adjustment of payments was being phased in.

The same period also saw a dramatic rise in out-of-pocket costs imposed for inpatient hospital services. In 1999, just 4 percent of the lowest premium Medicare private health plans charged any copayments for hospital admission. In 2006, 89 percent of Medicare private health plans impose such copayments. Between 2002 and 2006, the average out-of-pocket cost for a three-day hospital stay rose from $271 to $371, while the average annual cost for two six-day stays and a three-day stay rose from $900 to $1,429. These rates of increase, 37 percent and 59 percent, respectively, substantially outstripped the 17 percent rise in the inpatient deductible ($952 in 2006) under Original Medicare over the same period.[18]

Researchers found that 56 percent of the lowest premium Medicare private health plans offering drug coverage had no out-of-pocket limit on medical expenses. More than half of the plans with limits set caps at more than $2,500. The authors concluded that the structure of most Medicare private health plans does not protect individuals with extensive health care needs from substantial out-of-pocket spending.[19]

A May 2006 Commonwealth Fund report also shows how the benefit designs employed by some Medicare private health plans can impose disproportionately high cost-sharing burdens on individuals in poor health. The paper compares the out-of-pocket spending for individuals in good, fair or poor health under Medicare private health plans to what similar individuals would spend under Original Medicare with a Medigap Plan F offered at a community-rate premium (premium does not take into account age or health status).[20]

Looking at 88 plans marketed in 44 localities around the country with substantial penetration by Medicare private health plans, researchers found that 19 of the 88 plans imposed greater cost-sharing for inpatient hospitals stays, doctor visits and other medical care than a person would pay

under Original Medicare with a Medigap Plan F supplement. This array of services cost plan enrollees between $285 and $2,195 more per year under these nineteen plans than under Original Medicare with a Plan F Medigap.

Yet the plans with high out-of-pocket costs did well in the market. The 19 plans accounted for over 340,000 Medicare private health plan enrollees; 5 of the 13 plans with more than 20 percent of the local Medicare private health plan market imposed these higher costs on their unhealthy enrollees. One of the worst plans, with a benefit design that resulted in nearly $2,000 in additional expenses for the sampled services, had garnered nearly a quarter of the local Medicare private health plan market.

The wide variation in potential liability for out-of-pocket spending prompted the report's authors to recommend increased standardization of Medicare private health plan benefit packages, including a requirement that plans set reasonable caps on annual out-of-pocket spending.

These reports illustrate the potential pitfalls for consumers as they seek to enroll in a plan that provides financial protections against unforeseen illness. The disturbing trend toward ever-higher copayments for hospital admissions also shows how plans' ability to alter benefit designs on an annual basis presents plan enrollees with an annual dilemma—whether to stick with the plan they have or shop around, assuming enrollees know that plan benefits have changed. The Centers for Medicare & Medicaid Services' (CMS) review of plan benefit designs seems unable to prevent substantial numbers of plans from shifting costs onto their sickest, most vulnerable enrollees. Medigap plans, on the other hand, cannot alter the plan benefits offered, and those plans are guaranteed renewable as long as premiums continue to be paid.

But the case for standardizing Medicare private health plan benefits rests as much on the irregular benefit design as it does on more widespread deficiencies, such as the absence of caps on out-of-pocket spending. These types of loopholes in plan benefits are the least likely to be noticed by consumers and the most likely to come as a surprise when illness strikes. Some of these coverage gaps—high out-of-pocket costs for home health services, for example—may be relatively rare, but the fact that relatively few plans adopt these features shows that it is feasible to mandate that plans forgo them. Major deficiencies—the absence of caps on out-of-pocket spending—are more common. Without minimum standards to ensure their adoption, Medicare private health plans that provide such comprehensive protection may be more likely to see enrollment by less healthy, higher-cost consumers, making it more difficult financially for plans to provide such coverage.

Overpayment to Medicare Private Health Plans Have Not Eliminated the Problems

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sharply increased payments to Medicare private health plans and changed how the Centers for Medicare & Medicaid Services (CMS) reviews plan benefit packages. Yet all of the problems in Medicare private health plan benefit design presented in the reports mentioned above remain in the 2007 plan offerings. Our own review of two categories of plans—the private fee-for-service (PFFS)

plans with a national presence and the health maintenance organizations (HMOs) marketed in a fully developed Medicare private health plan market, Los Angeles—shows that deficiencies in plan design are present in both types of plans.[21]

PFFS plans are the fastest growing type of Medicare private health plan, with nearly 1.5 million new members in just the last three years.[22] They are also marketed as lower-cost alternatives to Medigap coverage under the promise—often false—that enrollees will have the same choice of providers that they have under Original Medicare. Given this marketing strategy, it is worth exploring how these plans stack up both against Original Medicare and against coverage with a supplemental plan.

To use one example, there are 20 PFFS plans available in Benton County, Arkansas, where CMS estimates between 15 and 25 percent of people with Medicare are enrolled in Medicare private health plans. Residents can obtain a Medigap Plan F, covering all Medicare cost-sharing for the monthly premium of $118.83. High-deductible Medigap plans that initially retain Medicare out-of-pocket costs but begin covering all cost-sharing at $1,860 are available at $49.08, and a Medigap Plan L (Medicare out-of-pocket costs reduced by 50 percent, out-of-pocket spending capped at $2,070) is sold for $66.48.[23] None of these Medigap premiums are subsidized by Medicare.

Despite receiving subsidies from Medicare—the maximum payment rate in Benton County is $195, or 34 percent higher than the monthly average cost of providing care under Original Medicare alone—not one PFFS plan provides equivalent protection against out-of-pocket spending under a low-premium plan. Just three plans provide lower comprehensive caps on out-of-pocket spending below the levels for Medigap Plan L, but premiums for enrollees range from $98 to $121. Between the premiums charged for these plans, and the excess payments from Medicare, the combined cost to consumers and taxpayers is likely over $200 per month.[24]

Premiums for PFFS plans in Benton County range from $0 to $121, and the benefits enrollees receive is subject to even wider variation and bear no clear relationship with the premiums charged.

WellCare markets three PFFS plans in Benton. Its most expensive option, the Summit plan, at $121 per month, charges no copayments for doctor visits, hospital stays and numerous other outpatient services. The charge for Part B drugs, however, is the standard 20 percent; there is no cap on out-of-pocket spending. WellCare also offers a zero-premium plan, Concert, which includes a $3,650 cap on out-of-pocket spending. That cap, however, does not cover Part B drugs, and the coinsurance rate for those drugs is set higher, at 30 percent.

WellCare is not the only PFFS plan in Benton County that charges more for Part B drugs than Original Medicare. SecureHorizons MedicareDirect Rx Plan 52 also charges 30 percent for Part B drugs, carving them out of the $3,900 cap on out-of-pocket spending. This plan has several other unique features. It charges $375 per day for the first 11 days of a hospital stay, which comes to $4,125. The same 11-day stay in a hospital under Original Medicare would only cost $992 (the standard Part A deductible). Even only factoring in the national average hospital stay

of six days, a person enrolled in the plan would pay $2,250 while someone enrolled in Original Medicare (with no supplemental insurance) would pay $992.

SecureHorizons also reverses the copayment structure for skilled nursing facilities from the way Medicare pays for this service. Under SecureHorizons, a stay in a skilled nursing facility costs $160 per day for the first 25 days and is free for the next 75 days. Original Medicare assesses no copayment for the first 20 days and $124 per day for the next 80 days. For the average length of stay—26 days—Original Medicare would cost $744, while the SecureHorizons plan would cost $4,000.

Post-acute care—skilled nursing facilities and home health care—is an area where enrollees in Medicare private health plans can find higher out-of-pocket costs. Two Medicare private health plans in Benton County charge their members for home health care, a service Original Medicare provides without charge. The two Sterling PFFS plans charge between 10 percent and 15 percent for home health care; neither limits out-of-pocket spending. Universal American's Today's Options plans also charge 15 percent for home health care, although these plans have caps on out-of-pocket spending that cover all medical services set at either $2,500 or $3,000. Humana's PFFS plans ($5,000 comprehensive out-of-pocket cap) also begin charging earlier for stays in a skilled nursing facility, imposing $90-per-day fees starting on the fourth day.

These are just a sampling of the problematic benefit features that consumers must be careful of as they compare benefit packages among the 20 competing PFFS plans in Benton County. Premium levels provide little guidance on the richness of the benefit. The most expensive plan, WellCare's Summit, provides no protection against high out-of-pocket spending on Part B drugs. For a $10 premium, consumers can join Universal American's Today's Options Value plan, which caps charges for chemotherapy at $150 per visit and includes all Part B drugs under a $3,000 cap.

One zero-premium plan, SecureHorizons, charges substantially more than Original Medicare for an average stay in a hospital, while the Humana zero-premium plan charges $550 per stay, a little more than half as much as Original Medicare. Neither plan offers coverage as good as Original Medicare for the average skilled nursing facility stay. UniCare's Secure Choice Classic charges nothing for the first 20 days in a skilled nursing facility and just $25 per day for the next 80. There are, however, two catches: it does not come with drug coverage, and home health care comes with a 15 percent coinsurance—a service that Original Medicare provides for free.

Problems with PFFS Plan Benefit Packages: Benton County, Arkansas

Unexpected Cost-Sharing	WellCare Summit	WellCare Concert	Secure Horizons PFFS	Sterling	Today's Options	Humana	UniCare Secure Choice
No Cap on Annual Out-of-Pocket Spending	⚠			⚠			
Cap Excludes Part B Drugs		⚠	⚠				
Higher Coinsurance for Part B Drugs		⚠	⚠				
Higher Hospital Costs*			⚠				
Higher SNF Costs*			⚠			⚠	
Higher Home Health Costs*				⚠	⚠		⚠

* Higher than Original Medicare

In Los Angeles County, out of the 10 Medicare HMO contracts with the highest enrollment, only one plan, offered by Kaiser Permanente, provides a comprehensive cap on out-of-pocket spending for medical expenses (set at $4,000, higher than the limit of $3,100 recommended by CMS) and sets limited copayments for Part B drugs. The Kaiser plan has a serious limitation, however, charging $300 per day for an inpatient hospital stay. A hospital stay of 10 days, the point at which out-of-pocket costs end for hospital stays under the Kaiser plan, could amount to more than three times the inpatient deductible under Original Medicare.

Two HMOs, SecureHorizons and Citizens, cap annual out-of-pocket spending on some medical services but specifically exclude Part B drugs. Both companies, along with California Physicians' Service, offer plans that involve a trade-off: a tight network of doctors in exchange for brand and formulary coverage in the doughnut hole, no copayments for doctor visits and free or greatly reduced costs for hospital admissions, all for no premium. Enrollees in these plans may reasonably expect full financial protection for medical expenses, including drugs. However, their coverage for Part B drugs leaves them exposed to unlimited out-of-pocket spending.

Unfortunately, at least one plan shifts even more costs onto cancer patients in Los Angeles. Central Health Plan, the choice of nearly 2,000 Los Angeles residents, charges 30 percent for Part B drugs—10 percent higher than the rate under Original Medicare—with no cap on out-of-pocket spending. The plan charges no premium and no copayments for doctor visits or hospital admission and reduces the Part B premium by $23.

Consumer Decision Making

This report, like prior reports by other researchers, shows that it is possible, with sufficient staff, time and expertise, to compare the benefit structures of a limited number of Medicare private health plans and discern where specific plans leave enrollees vulnerable to high out-of-pocket spending. It is not realistic, however, to expect most people with Medicare to make the same informed assessments of their coverage options, given what is known about how people with Medicare currently make choices about their medical and drug coverage. In addition, even if people with Medicare were able to find all the information on benefit structures, they do not have a crystal ball that can tell them whether they should choose the plan that offers better chemotherapy benefits or better skilled nursing facility benefits.

With no standardized options for Medicare private health benefit packages, the difficulty in making an appropriate choice of plan becomes a function of the number and complexity of plans available in the community. In Los Angeles, for example, there are 51 Medicare private health plans (including 15 special-needs plans for populations that meet specific criteria). A market this complicated can paralyze consumer decision making. As noted by a 2006 AARP Policy Institute survey of people with Medicare, "when older adults are faced with too much information to process and/or information that is complex and difficult to understand . . . it is likely to raise their level of anxiety and worry. In such situations, individuals often avoid the burden of decision making by simply making no decision and staying with the status quo."[25]

According to the Medicare Payment Advisory Committee (MedPAC), roughly half of people with Medicare relied on family and friends in selecting a Part D plan.[26] Family and friends are undoubtedly a great help, particularly to the 29 percent of people with Medicare who suffer from cognitive or mental impairments.[27] But informal advisers face the same obstacles in understanding plan coverage options. They have limited time to devote to plan selection and may have similarly low levels of health literacy.

The second-most used source of advice about Medicare options comes from insurance agents and the Medicare private health plans themselves, according to the same MedPAC report.[28] Given the financial incentives motivating insurance agents and the inadequacy of agent training provided by the plans, this source of advice is also problematic. Consumers cannot rely on a simplified comparison between plans as they can with a Medigap policy, making it more risky to rely on the representations of agents and brokers.

Few people with Medicare used the plan comparison tools developed by Medicare or obtained advice from a trained counselor, relying instead on information from the plans themselves. According to a report by MedPAC that included an analysis of how people obtained information about Part D coverage, "[i]n general, few focus group participants said they had used web-based tools or counselors to help them make decisions. They were more likely to mention company plan descriptions they received in the mail, phone calls to plans, and conversations with plan representatives at special events."[29]

In its assessment of Part D decision making, the AARP Policy Institute concludes that people with Medicare "do not adequately understand the differences among health plan design options."

Therefore, the policy goal of improving quality and lowering costs through consumer choice is potentially compromised by the "multiple choices and complicated options." As a remedy, the AARP paper suggests integrating the drug benefit into Original Medicare and standardizing "the options in a manner similar to the way Medigap plans are standardized to make them more comprehensible to beneficiaries."[30]

The Current Medicare Private Health Plan Regulatory Structure

Medicare private health plans play a dual role for consumers. They serve as an alternative means of delivering Medicare coverage, and consumers view the plans as a means for lowering cost-sharing under Medicare and for providing services not covered by Original Medicare.[31] The current statutory and regulatory structure, however, fails to guarantee either that members of Medicare private health plans will receive the standard Medicare benefit or that the most glaring gap in the standard benefit—the lack of protection against catastrophic medical expenses—is filled. Individuals who enroll in a Medicare private health plan, unlike Original Medicare, cannot use supplemental insurance to fill the gaps or cover excessive cost-sharing in their Medicare private health plan.

All Medicare private health plans submit bids to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program, which estimates plans' cost of providing Medicare coverage to each enrollee in the counties in which they operate. These bids, however, do not have to replicate the out-of-pocket costs under Original Medicare. This means plans can charge flat copayments for doctor visits instead of the 20 percent charged under Original Medicare. Instead of the $992 deductible for a hospital stay, they can charge a per-day copayment. In its review of plan bids, CMS actuaries determine if the benefit package contained in the plan bid is actuarially equivalent **as a whole** to the standard Medicare benefit. Of course, that means that for any individual member, depending on what services are needed throughout the year, a member's out-of-pocket costs could be higher or lower than if the member had been in Original Medicare alone.

Out-of-pocket costs for specific services—home health care, hospital stays, Part B drugs—do not have to be actuarially equivalent to what people have to pay for these services under Original Medicare. This means that a Medicare private health plan can charge people for home health care—which Original Medicare provides at no charge—if, in the judgment of CMS actuaries, out-of-pocket costs for other services are sufficiently reduced. CMS actuaries base their judgment on the utilization patterns for particular services. If utilization of home health services is low, the extent that plans must compensate by charging less for other medical services is minimized. If utilization of home health services is high, plans must make steeper or broader reductions in out-of-pocket costs for other services.

While this may benefit a wide swath of plan members by lowering the out-of-pocket costs of widely used services—such as visits to a primary doctor—the impact on specific individuals, such as those who need home health services, can be harmful. To the extent that out-of-pocket costs is raised on services (such as home health services or Part B drugs) used predominantly by individuals with serious illnesses or disabilities and lowered on services (such as visits to

primary doctors) used by both healthy and sick enrollees, costs are shifted from the healthy onto the sick. This not only raises questions of equity, it also raises the prospect of a benefit design that caters to and attracts to the plan the healthiest, least costly enrollees while discriminating against those who become ill and discouraging enrollment by those with high health costs.

CMS does have the authority to reject plan bids that are discriminatory. In practice, however, CMS does not use this authority to reject benefit structures that have the effect of raising the out-of-pocket costs on specific services, even if those services are largely used by individuals with specific illnesses. Nearly half of Part B drugs are billed to Medicare by oncologists,[32] for example, yet plans can and do impose higher out-of-pocket rates for Part B drugs than Original Medicare. Some plans exempt Part B drugs from out-of-pocket limits, discriminating against those who need chemotherapy by imposing higher out-of-pocket costs.

For non-PFFS plans, the bid review process does provide CMS with broad authority to shape the benefit packages offered by Medicare private health plans. Plans are given additional flexibility under the bid review process to raise out-of-pocket costs for individual services, such as home health care, if they provide an annual limit on out-of-pocket spending at, or below, a level set by CMS. For 2007, CMS recommended that plans set maximum out-of-pocket spending at $3,100, the minimum amount spent by the 25 percent of people with Medicare with the highest medical bills.[33] What this additional flexibility entails is not clear. What is clear is that the presence of an out-of-pocket limit is not a strict prerequisite for CMS to allow plans to charge higher out-of-pocket costs than Original Medicare for specific services most often used by sick people.

Supplemental benefits under Medicare private health plans are funded by premiums paid by plan enrollees and by rebates plans receive if they are able to provide basic Medicare coverage for less than the payment rate in their area. Under its bid review authority, CMS can negotiate with plans over the supplemental benefits they provide. The agency can ensure that these supplemental benefits "fairly and equitably" reflect the income from rebates and enrollee premiums that plans receive. But plans are generally free to devise the supplemental benefits as they see fit. They can provide free gym memberships or travel coverage—benefits that are more likely to be valued by relatively health enrollees—rather than a limit on annual out-of-pocket spending.[34]

CMS' test for actuarial equivalence of the basic Medicare benefit and its authority to reject discriminatory benefit structures apply to all Medicare private health plans, including private fee-for-service (PFFS) plans. But CMS is barred by law from reviewing bids from PFFS plans to determine if the basic Medicare benefit "fairly and equitably" reflects the premium charged to enrollees. Similarly, CMS is barred from negotiating with PFFS plans to ensure that supplemental benefits "fairly and equitably" reflect the combination of Medicare subsidies and enrollee premiums that plans receive for providing such benefits.[35] This loophole for PFFS plans means that CMS is, in effect, barred from assessing whether taxpayers and consumers are getting their money's worth from the PFFS plan.

The Solution

Previous investigations of Medicare private health plan benefit packages and consumer decision making have pointed to standardization of plan benefits as a means of enabling informed consumer choice and minimizing the risk of inappropriate plan selection. In their 2001 Commonwealth Fund paper, Geraldine Dallek and Claire Edwards say that the market for private Medicare plans "may have reached a point similar to that of the Medigap market prior to the 1990s reforms, where the confusion caused by differing benefit packages outweighed any advantages associated with these differences."[36] Since that report, the number and variety of Medicare private health plan choices have increased dramatically, underscoring the authors' point that the market for these plans is "undermined if beneficiaries are unable to make an informed choice among their health care options."[37]

Similarly, a MedPAC report recognizes that standardized Medicare private health plan benefit packages would permit comparisons of alternative plans and relieve some of the administrative burden on providers to sort out differing copayment and coinsurance rates for a patient population enrolled in multiple plans. The report also acknowledges how the standardization of Medigap policies promoted greater competition on the basis of premiums.[38]

However, MedPAC stops short of recommending standardized Medicare private health plan benefit packages, citing a number of concerns with standardization, including

1. widely varying payment rates may make standard packages unattractive in some parts of the country;
2. standard benefit packages may stifle creativity in the development of novel benefit designs;
3. standardized packages could cause adverse selection.

Below we address each of these concerns and provide evidence that they do not prevent adoption of standardized benefits for Medicare private health plans.

1. Widely varying payment rates may make standard packages unattractive in some parts of the country. In some ways, this is almost a nonissue because Medicare private health plans already have widely varying payment rates across the country, and that has not put a dent into the plans' membership enrollment. Medicare private health plans respond to the wide variation in payment rates across different counties by using one of three strategies: varying premiums, altering benefit packages or opting out of certain counties.

For example, Universal American offers the same benefit packages across the country: Today's Options Premier Plus and Value Plus PFFS plans. The benefit packages ($2,500 and $3,000 out-of-pocket maximums respectively; drug coverage at no additional premium) are consistent, but the premium charged ranges from $10 to $40 to $80 for the Value Plus plans and $45 to $80 to $117 for the Premier Plus plans, depending on the amount the payment rates exceed local costs under Original Medicare. The excess monthly payment in effect acts as a premium subsidy for plan members.

Similarly, Humana has two standard Humana Gold Choice PFFS plans offered in most states. Both plans provide a $5,000 out-of-pocket maximum, but differ in the amount of out-of-pocket costs charged for both inpatient and outpatient hospital services. Premiums for the lower-cost plans are set at either $0 or $69 and at $20 or $89 for the higher-cost plan, depending on the spread between Medicare private health plan payment rates and average per-person costs under Original Medicare in the county.

The practices employed by these two plans demonstrate the feasibility of marketing standard benefit packages across the country despite widely varying payment rates. If Medicare private health plan payment rates were put on par with Original Medicare costs in all counties, it would facilitate even broader and more consistent marketing of Medicare private health plan benefit packages that comport with mandatory standards.

The alternative strategy used by some plans—adjusting benefit packages to reflect the degree of overpayment in a particular county—makes it more difficult for marketing agents to adequately explain the benefits under the plethora of plans offered by one company. Plans that adopt this strategy under the overriding goal of offering zero-premium plans subject plan members to egregiously high out-of-pocket costs for essential services.

UnitedHealthcare, for example, has 13 different SecureHorizons PFFS products available in different parts of the country. In Utah's Morgan and San Juan counties, the differing spread between private plan payment rates and Original Medicare costs results in widely different out-of-pocket maximums and cost-sharing imposed for stays in hospitals and skilled nursing facilities that exceed rates under Original Medicare.[39]

2. Standard benefit packages may stifle creativity in the development of novel benefit design. On the contrary, properly structured, standardized benefit packages should allow for **innovation** that adds value for plan enrollees while prohibiting the imposition of cost-sharing that places at a disadvantage enrollees needing specific services. The goal should be to provide some uniformity in protection across a range of nondiscretionary, medically necessary services and prevent the marketing of plans that presents the illusion of protection against high out-of-pocket spending but have gaping loopholes in these protections.

Plan "creativity" in benefit design should be focused on adding improvements to basic benefit packages. Creativity in benefit design that creates loopholes in coverage should be squelched. Plans could market standardized benefit packages with additional features—on-call nurses, dental benefits, gym membership—providing consumers with both a reasonable assurance of protection against high out-of-pocket costs, a better understanding of how their benefit package compares to others as well as the features that plans find useful in marketing. Such a structure forces plans to prioritize allocation of resources to protect enrollees against high out-of-pocket spending and reduce cost-sharing for core medical services before enticements like gym membership are added to packages.

The strongest case for standardized benefit packages are plans that carve out specific services, such as Part B drugs, from their caps on catastrophic spending. These carve-outs are unjustifiable, and it is unrealistic to expect consumers to discover which services are or are not

included under the cap or anticipate their need for specific services in the future. Even MedPAC researchers were not always able to determine when caps on enrollee spending excluded certain services. Caps on out-of-pocket spending should be comprehensive, providing blanket insurance that plan enrollees will not be bankrupted by catastrophic illnesses.

Protection against catastrophic spending should be the centerpiece of all standardized benefit packages that provide a richer benefit than Original Medicare. Descriptions of standard benefit packages should clearly articulate the maximum annual amount of out-of-pocket spending.

At a minimum, standard benefit packages should charge no more than Original Medicare for individual services, such as inpatient hospital stays, home health care or Part B drugs, although equivalent copayments (set dollar amounts) could be employed instead of coinsurance (percentage of cost) or deductibles.

Standardized packages should also ensure that out-of-pocket costs are commensurate across a range of services, preventing plans from highlighting specific features that hide or obscure gaps in protections. Consumers presented with plans advertising zero copayments for doctor visits and hospital stays may reasonably expect to have no cost-sharing, or, at most, minimal cost-sharing for other nondiscretionary medical services. Standardized packages could prevent plans from offering such packages that leave plan enrollees completely exposed to unlimited out-of-pocket costs for chemotherapy or other nondiscretionary treatments.

Standard benefit packages do not necessarily have to dictate the specific copayment or coinsurance amount for individual services. For example, a per-day hospital copayment that caps out at the same level as the Original Medicare hospital deductible would form an element of one standardized benefit package; a copayment structure that never imposes costs more than half the standard deductible would be an element of a distinct benefit package. Similarly, copayments for primary care and specialist visits can be grouped according to how they compare with the standard 20 percent charge under Original Medicare. Differential copayments designed to encourage utilization of cost-effective services or high-quality providers can also work in this framework. What should be excluded is differential cost-sharing that penalizes utilization of any nondiscretionary medical services, such as chemotherapy or radiation therapy.

3. Standardized packages could cause adverse selection. The experience under Part D shows how inadequate minimum standards for benefits create adverse selection for plans that seek to improve on the standard benefit package. Consumers with high drug costs flocked to the few plans that offered coverage of both brand-name and generic drugs in the gap, or "doughnut hole," in the standard benefit, forcing companies to discontinue these products.

Similarly, not having a mandate to protect enrollees against catastrophic expenses—for chemotherapy, for example—creates a disincentive for plans to add this crucial feature to their benefit package.[40] Standardized benefit packages should be designed such that all of them provide some level of protection against high out-of-pocket spending. Competition will then focus on premiums, added benefits or other "creative" features in benefit design, such as care coordination services.

Conclusion

The current market for Medicare private health plans and stand-alone drug plans mimics a similar situation corrected by federal legislation in which Congress acted to standardize policies that supplemented Medicare benefits.[41] Prior to the enactment of OBRA 90 these policies had proliferated in number, each with different riders, benefit variation, deductibles and out-of-pocket cost requirements that made it impossible for consumers to compare one policy with another. Congress acted in response to numerous complaints that consumers were unable to make informed decisions about their health care coverage in a market with too many confusing choices.

The Medicare private health plan marketplace today is also characterized by consumer confusion and aggressive and deceptive marketing practices. Consumers are forced to sort through a seemingly infinite variety of benefit packages, many of them with specially designed loopholes in coverage, with no assurance that they will be protected against high out-of-pocket spending.

The development of specific standardized Medicare private health plan benefit packages should follow a similar process as that used to establish the current Medigap products. The National Association of Insurance Commissioners should establish an expert panel including state insurance regulators, consumer representatives and representatives from both the plans and the Centers for Medicare & Medicaid Services (CMS) to develop model regulations. The development of standard benefit packages should seek to accomplish the following goals:

- Make it easier for consumers to compare a limited number of alternative plans;
- Protect consumers against catastrophic medical expenses, regardless of the type of illness, site or type of medical service;
- Ensure that out-of-pocket costs for individual medical services, such as home health services or inpatient services, are equivalent to or less than the out-of-pocket costs imposed by Original Medicare.

Researchers, state regulators and consumer groups have each drawn the parallel between the Medigap market before 1990 and the Medicare private health plan market as it exists today. Congressional action to reform the Medigap market succeeded in eliminating unlimited benefit designs, giving consumers the ability to evaluate and make their own choices, thus drastically reducing marketing abuses. Congressional reform to standardize and simplify Medicare private health plans is long overdue. The time for Congressional action is now.

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[5] "Medigap Reform Legislation of 1990: Have the Objectives Been Met?"

[6] "Medigap Reform Legislation of 1990: Have the Objectives Been Met?"

[7] "Medigap Reform Legislation of 1990: Have the Objectives Been Met?"

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[12] "Things to Know About Medigap Insurance," New York State Office for the Aging, Health Insurance Information, Counseling and Assistance Program (HIICAP) (http://hiicap.state.ny.us/mgap/mgap02.htm).

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[15] Guaranteed Issue, the Federal Balanced Budget Act of 1997," Public Law 105-33, *Federal Register* 70, no. 57 (March 25, 2005): [15407] 'http://www.cms.hhs.gov/Medigap/Downloads/FRN_NAIC_03_25_05.pdf'

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[23] "Bridging the Gaps: A Medicare Supplement Comparison Guide," State Insurance Department of Arkansas and Arkansas Seniors Health Insurance Information Program, 2007. (http://www.insurance.arkansas.gov/seniors/BG2007.pdf)

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[26] "Report to the Congress: Increasing the Value of Medicare," MedPAC, June 2006. (http://www.medpac.gov/publications/congressional_reports/Jun06_EntireReport.pdf)

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[29] "Report to the Congress: Increasing the Value of Medicare."

[30] *An Assessment of Beneficiary Knowledge of Medicare Coverage Options and the Prescription Drug Benefit*, Judith Hibbard, Jessica Greene and Martin Tusler, AARP Public Policy Institute, May 2006, p. 32.

[31] *Low Income and Minority Beneficiaries in Medicare Advantage Plans*, America's Health Insurance Plans Center for Policy and Research, February 2007. Thirty-four percent of people opting for Medicare Advantage plans did so to decrease costs, 21 percent for better benefits and 10 percent for the convenience of the local network.

[32] "Medicare Part B Drugs and Oncology," MedPAC, July 13, 2006. (http://www.medpac.gov/publications/congressional_testimony/071306_Testimony_Part%20B_oncology.pdf)

[33] "Medicare Advantage, Medicare Advantage-Prescription Drug Plans CY 2007 Instructions," Memorandum, Centers for Medicare & Medicaid Services, April 4, 2006. (http://www.cms.hhs.gov/MedicareAdvantageApps/Downloads/REV%20MA-MAPD%20Call%20Letter%20Final.pdf)

[34] "Medicare Advantage: Required Audits of Limited Value," Government Accountability Office, July 2007 (http://www.gao.gov/new.items/d07945.pdf). The GAO found that the Centers for Medicare & Medicaid Services did not meet the requirement to audit one-third of Medicare Advantage plan benefit packages. A CMS contractor in 2003 identified errors in plan proposals that would have resulted in $59 million that "beneficiaries could have received in additional benefits, lower copayments or lower premiums." CMS administrators believed that they did not have the authority to legally recover these funds for plan beneficiaries.

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Chairman STARK. Thank you.
Mr. Hotchkiss.

STATEMENT OF HARRY HOTCHKISS, SENIOR PRODUCTS ACTUARIAL DIRECTOR, HUMANA INC., LOUISVILLE, KENTUCKY

Mr. HOTCHKISS. Chairman Stark, Chairman Lewis, Representative Camp, and distinguished Members of the Subcommittees, thank you for inviting me to testify about Humana's Medicare Advantage or MA bid process. As an actuarial director for senior products for Humana, my responsibility is limited to working on the

team that develops and submits bids and responds to CMS MA bid audits.

Humana has served Medicare beneficiaries for many years. We currently offer prescription drug and MA plans in all states. Today I will discuss Humana's compliance with the regulatory requirements for bid submission following the enactment of the Medicare Modernization Act. My written testimony also describes how this worked prior to MMA.

The MMA changed the way plans develop and submit bids and how they determine the value of the premium and benefit structure for their MA plans. Humana has detailed structures and controls in place to meet bidding, process, and audit requirements.

The MMA changed the timing and submission rules for premium and benefit filings. CMS's 45-day notice of rates comes out in mid-February, and the final rate book containing the benchmarks comes out the first Monday in April. CMS issues bid instructions soon after, and bids are due the first Monday in June.

As you can see from this chart off to my right, we begin our bid and pricing modeling in January. The bids represent Humana's expected average cost for the Medicare-covered benefits for each plan. The expected average costs for Medicare-covered benefits are then compared to the CMS MA benchmark. If the plan's bid is below the benchmark, the plan must use 75 percent of the savings to increase members' benefits, decrease members' premiums, or cost-sharing. The remaining 25 percent of savings is returned to the federal treasury.

Bids are completed by the first week of May and are peer-reviewed by a team of internal qualified actuaries. Revisions are made, and bids are then processed through an internal audit program that checks for outliers based on preestablished parameters.

CMS uses a similar process. Each outlier is reviewed, and adjustments are made where necessary. We then develop the actual documentation required by CMS, including 2-year look-back claim cost forms. We upload this information to CMS's system by the filing deadline. We then correct any discrepancies identified by CMS in their validation tests. By mid-June, we submit actuarial bid certifications.

For the next 45 days, CMS's audit firms conduct a thorough review of all bids and benefit packages. When issues arise, we generally respond within 48 hours. The auditors sign off on our bids. In mid-August, CMS releases the final PDP and RPPO benchmarks. We reconcile these final benchmarks with our earlier expected benchmarks and resubmit affected bids. In early September, CMS approves our bids.

CMS's auditors then evaluate the reasonableness and consistency of our assumptions with applicable actuarial standards of practice and CMS's instructions for completing the bid forms. Auditors conduct a desk audit, followed by a one-week onsite visit. We then respond to an initial draft of their findings and/or observations. Auditors then issue a final agree/disagree letter, to which we provide a final response.

For contract year 2006, CMS audited two contracts, resulting in no material findings. For contract year 2007, CMS audited two contracts, yielding one finding and two observations. We inadvertently

used a rate development factor for provider expenses that didn't reflect all provider reimbursement structures for the plans. This resulted in beneficiaries in the two affected plans receiving a slightly better benefit. For 2008, we improved our methodologies based on this finding.

As you evaluate improving this process, we respectfully suggest that final audit reports be issued in March of the contract year in order to impact the following year's bids. Humana has mechanisms and controls in place to internally and externally audit our processes to comply with statutory, regulatory, and contractual MA program requirements.

My written testimony also describes actions related to other areas of the MA program, including corrective action plans and site audits. I am part of the bid and audit team, and our processes are vigorous in all areas.

We take seriously the trust that the government has placed in us to offer coverage to Medicare beneficiaries and understand the vulnerability of this population. We seek to cure any issues brought to our attention, whether by external or internal sources. Thank you.

[The prepared statement of Mr. Hotchkiss follows:]

House Ways and Means Committee
Health and Oversight Subcommittees
Hearing on
"Medicare Advantage: Why Audit?"

Mr. Harry Hotchkiss, FSA, MAAA
Actuarial Director for Senior Products
Humana Inc.

October 16, 2007

Chairman Stark, Chairman Lewis, Representative Camp, Representative Ramstad and other members of the Committee, thank you for inviting me to testify about compliance with regulatory requirements of the Medicare Advantage (MA) plans' bid proposal process. I am Harry Hotchkiss, an actuary and an actuarial Director for Senior Products for Humana Inc. in Louisville, KY. My responsibilities are limited to being a member of the team responsible for the development, review and submission of premium and benefit packages or Bids to CMS and responses to audits of those Bids under the MA program.

For more than twenty years, Humana has served Medicare beneficiaries through health plans that offer affordable, comprehensive health care coverage. We currently offer stand-alone prescription drug plans (PDPs) in 50 states, the District of Columbia and Puerto Rico; private fee-for-service plans (PFFS) in 50 states and Puerto Rico; regional preferred provider plans in 23 states; local preferred provider plans in 21 states; and HMOs in 9 states and Puerto Rico. We also offer Medicare Supplement products (Medigap) in 39 states, the District of Columbia and Puerto Rico. In addition, Humana offers private health plan options through the Department of Defense's TRICARE program to military families and retirees and plans to government employees through the Federal Employees Health Benefits Program. We offer Medicaid plans in Florida and a Medicaid-type plan in Puerto Rico. Finally, we offer health insurance coverage and related services to employer groups and individuals. In total, we provide medical insurance to over 11 million members.

My testimony today will address how Humana complies with the regulatory requirements for bid submission, both before the passage of the Medicare Modernization

Act of 2003 (MMA) when such submissions were called "Adjusted Community Rate Proposals" (ACRs) and after MMA, when such submissions are called "Bids." I will conclude with some remarks about overall regulatory compliance activities. I have divided my discussion about the ACR and bidding processes into four areas:

1. ACR (Bid) Development
2. ACR (Bid) Benefit Review
3. CMS ACR Review; Bid Negotiation
4. CMS Audits

Preparation of ACRs and Bids is an actuarial process that involves coordination among Humana's product development, sales, finance, market management, corporate management and actuarial staff. This process requires a robust project management and actuarial rate development plan. Included in the process are mechanisms for reviewing the accuracy of our ACRs and Bids. We use both internal and external reviewers and/or auditors to ensure that our filings comply and are consistent with statutory and regulatory requirements and CMS guidance. The findings from our own rigorous reviews permit us to continuously improve our submissions. As you will see, we act upon and use any findings or observations made in regulatory audits to inform and continuously improve our processes going forward. We take seriously the trust that the federal government has placed in us to offer coverage to Medicare beneficiaries and understand the vulnerability of the Medicare population. As in any regulatory audit or site visit, we seek to resolve expeditiously any issues brought to our attention whether by internal or external sources.

Now, I will explain the pre-MMA or ACR process in its entirety followed by the Bid process in its entirety, including any external audits that have occurred.

ACR Development Process

Prior to implementation of the MMA, contracted MA plans submitted ACR proposals to CMS that included both a description of benefits [Plan Benefit Package ("PBP")] and a premium rate filing ("ACR") that supported the benefits being offered. The PBP listed the benefits covered, the member's cost sharing for each benefit and the member's monthly premium for the benefit plan. The ACR detailed the average cost of the benefits per member, the value of the member's cost sharing, expected premium from CMS and the member's monthly premium for the benefit plan.

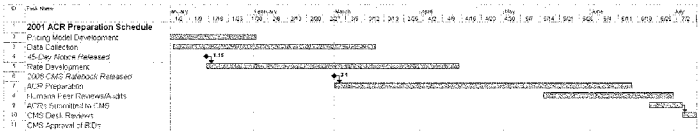

Exhibit 1 – ACR Submission Timeline

Our work on the ACR proposals began about 12-18 months prior to the actual due date for the filings. During that period of time, we developed and tested pricing models through which we would run the necessary pricing and benefit data. Six months prior to the filing date, we began to collect the data necessary to develop the proposals. During this period, CMS issued ACR instructions, modeling, and benefit software and conducted training sessions which we attended. We notified our local market offices of any new CMS requirements, provided estimates of the next year's revenue based on the ratebook published March 1 until 2004 (published late March for 2004-2005) and worked with an outside actuarial firm to review our proposals. We also used additional actuarial consulting firms on occasion for peer review. In addition to internal quality control

checks and peer-review activities throughout the process, from 2001-2005, Humana's Internal Audit Department performed company audits of the proposals.

Our ACR proposals were based on Medicare Fee-for-Service data for any new plans we offered. For existing plans, we used actual Humana claims cost experience. The value of member's cost share was based on actuarial factors. The expected premium from CMS was based on CMS-determined rates published first in a 45-day Notice (mid January of each year from 2001-2003 and the end of March for 2004-2005) outlining the methodologies it expected to use to calculate national/local rates as well as guidance for expected changes in reimbursement rates and other financial information. Secondly, CMS published its actual ratebook with per-member capitation rates by county on March 1 from 2001-2003 and the end of March from 2004-2005.

The ratebook provided the final instructions either confirming or modifying what was released in the 45-day Notice and provided any additional rate information pertaining to Medicare capitation payment rates. These capitation rates were the basis (starting point before adjustments) for the expected payment rates from CMS that were included in the ACRs. If a plan's cost of benefits was less than the CMS cost, the Plan would add benefits, lower premiums, lower cost-sharing, place extra monies in a Benefit Stabilization Fund for subsequent years or a combination of these actions. If the plan's costs were higher than the CMS cost, the plan would have to reduce benefits, increase cost sharing, add or increase a premium on the plan.

After the publication of the ratebook, we collected and summarized the claim, premium and enrollment experience for each of the existing Medicare plans as required by CMS. The actual experience became the basis for projecting the expected claims

costs in the rating period. Actuarial assumptions—such as claim cost trends, demographic or risk adjustments and benefit or cost sharing factors—were then applied to the experience period data to project expected claims costs for the rating period.

We developed actuarial assumptions in accordance with the appropriate actuarial standards. Some of the factors we used in developing our ACRs and the benefit designs included: CMS requirements, beneficiary preferences, provider contracts, CMS capitation rate increases, claim cost trends, competitors' benefits, product options, administrative feasibility (ability to administer the product design), geographic service area and affordability of member premiums. We also developed expected claim costs for prescription drug benefits. Some of the factors we considered in the development of expected costs and rates for prescription drugs included: CMS ACR instructions, expected enrollment, average number of prescriptions, cost per prescription and dispensing fees charged by pharmacies.

Based on the above data collection, our market office management staff, together with actuarial, product development, finance, sales and senior product leadership, determined what benefits, member premium and market/product expansions we would undertake as represented in our ACR submissions.

ACR Review Process

Before the filing deadline, we finalized the ACRs and benefits packages based on the most recent plan experience and any changes to provider contracting rates. We conducted internal and external audits of our ACRs the month prior to submission. First, the ACRs were peer-reviewed internally by senior actuaries for accuracy, reasonability and actuarial soundness. Necessary changes were made. They were then sent to an

outside, actuarial consulting firm for final peer review. Additional, as-needed changes were made prior to submission to CMS. Humana's Corporate Internal Audit Department also audited the proposals for 2001-2005. There were no material findings.

CMS ACR Review Process

Following ACR proposal submission, CMS reviewed the benefits using an accounting process that required the cost of benefits to be compared with the capitation rates offered by Medicare. CMS conducted desk reviews of the ACRs. We made any technical corrections or benefit adjustments required by CMS during this period. CMS then approved the ACRs. Following the approval of the ACRs, CMS approved the benefit packages.

CMS ACR Audit Process

CMS was required to audit the ACRs of at least one-third of the contracted MA organizations. CMS audited one or more of Humana's plans each year for contract years 2001, 2003 and 2004. There were no Humana plans audited in 2002 and 2005. We note that in 2001, there were two ACRs filed due to the passage of the Medicare Benefit Improvement & Protection Act (BIPA) which provided additional government payments to plans. Plans had ten days to refile ACRs following the publication of the new rates (effective March 1, 2001). CMS conducted an industry-wide training conference call on BIPA ACR instructions. It established certain rules as to how the extra monies could be spent and ultimately approved our refiled ACRs (which were based on their instructions) on February 1, 2001. The HHS Office of the Inspector General (OIG) later audited those proposals and disagreed with the allocation of extra monies. We provided all the support

documentation to substantiate our filings and maintained that we used the monies in accordance with requirements and instructions.

That noted, CMS' audit of ACRs, conducted by outside actuarial firms, generally began in November and continued for four to six weeks. These audits began with an entrance conference call and a CMS list of requested data, followed by desk review and an onsite visit. The auditors evaluated the plan's base period experience, support for two-year projections, whether the base year experience reconciled with audited financial statements, the most recent year's budget, and what was prepared the previous year. The scope of the ACR audits was an audit of the plan's ACR, tying the plan's Medicare payment to its source documents and then to the plan's audited financial statements. To the best of our recollection, the 2001, 2003, 2004 CMS ACR audits did not produce any material findings that affected members' benefits or premiums.

MMA Bidding & Audit Process

Now I will discuss how we comply with the bidding process as implemented under the MMA. This process replaced the ACR process and resulted in significant changes to pricing models, training and staff to support the process. Exhibit 2 describes the general schedule for bid submission and approval.

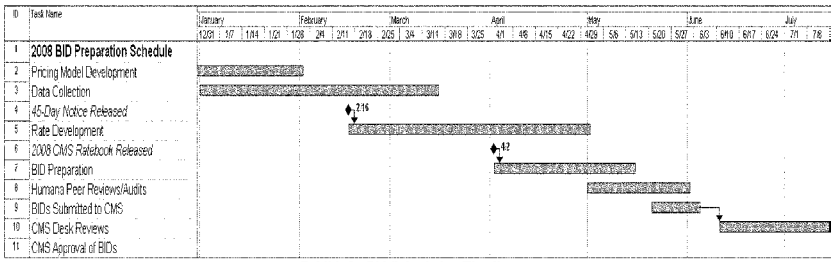

Exhibit 2 - Bid Submission Timeline

Bid Development Process

The MMA set forth a new timeline for the submission of premium and benefit filings. CMS publishes the 45-day Notice mid-February and the final ratebook (MA benchmarks), the first Monday in April. CMS generally issues instructions for completing bids 1-2 months prior to the filing date which is the first Monday in June. (We participate in CMS training sessions and technical guidance calls each year to ensure we meet statutory and regulatory provisions, as well as new CMS guidance.) The prescription drug benchmarks are generally published in August.

The Bids represent Humana's expected average cost for the Medicare covered benefits for each benefit plan. Bids can vary based on several factors—such as location (county) and risk characteristics of members. Like the ACRs, Bids are developed from actual claims cost experience for renewing plans. The expected average cost for Medicare covered benefits is then compared with the CMS MA benchmark (formerly capitation rates) found in the ratebook. If the plan's bid is below the benchmark, the plan must use 75% of the "savings" to increase member benefits, decrease member premiums or member cost-sharing. The remaining 25% of savings are returned to the federal Treasury.

Humana developed two separate bid pricing models to develop our bids: a medical benefits model and a prescription drug benefit model. These models were peer-reviewed and can be modified by our actuarial consultants. The models complete the bid forms in compliance with CMS' instructions. The average cost for Medicare-covered benefits is developed in a similar manner as the ACR process previously described.

To develop the benefits offered under our plans, our product development and actuarial staff and local market leaders develop preliminary benefit structures for each of the products we intend to offer in each geographic market and project enrollment. Actuarial pricing models are used to determine bid amounts for Medicare-covered benefits and to calculate the amount of savings for each plan. If there are savings, we calculate the cost of additional benefits to be offered. If Humana's cost is higher and/or if more benefits are offered than can be covered by 75% of the savings, the actuaries calculate the additional premium that members must be charged. Enrollment estimates are developed based on prior enrollment and the expected impact of benefit design, competition and member premiums.

The 45-day Notice and the ratebook are used to estimate CMS payments for the Bids. To estimate the expected CMS payments for the Bids, we use the same information previously described. These payments are adjusted by expected Medicare health risk adjustment factors and expected enrollment in each county in the benefit plan's geographic area. In April, we load CMS' ratebook into our pricing model and make any necessary adjustments to the bid and pricing. Our teams meet with our markets to finalize the specific benefits for each type of Medicare Advantage and Prescription Drug Plan products to be offered.

Humana Bid Review Process

MA and PDP bids are generally completed by the end of the first week in May. Those bids are then peer-reviewed by a team of qualified, internal actuaries. Any necessary changes resulting from their peer reviews are made by the Medicare pricing actuaries and then reviewed and approved again by senior actuaries. Bids are then

processed through an internal audit program that checks for consistency between the MA and PD bids where appropriate and identifies any outliers based on pre-established parameters. Consistency checks include: consistency of plan name, prescription drug premiums, membership between the two bids, acceptable administrative expenses levels, service level costs, and risk /profit margins. This process is similar to the process CMS uses after plans submit their bids. Each inconsistency or outlier is reviewed and adjustments or corrections are made where necessary. Both the rate and benefit packages are reviewed by the product development and actuarial teams to ensure the benefits are accurate and consistent.

Following the bid development, we develop the actuarial documentation required by CMS, including Two-Year Look-Back forms that summarize the claim cost experience by contract for the second prior year. This documentation is also peer-reviewed and any identified errors corrected.

Bids, Plan Benefit Packages, actuarial documentation and the Two Year Look-Back forms are then uploaded into the CMS system by the first Monday in June. Our teams work together to correct any errors identified by CMS in their validation tests. In mid-June, we submit actuarial certifications for the bids which are signed by the actuary responsible for the bid.

Bid Negotiation Process

From late June through mid-August, CMS' contracted actuaries conduct a thorough review of all bids based on instructions from the Office of the Actuary. CMS and their contract reviewers also review the benefit packages. If issues or questions arise, we generally respond within 48 hours and supply necessary documentation. For example, to

support the pricing assumption for the per-member-per-month cost of an inpatient facility benefit, Humana had to supply actuarial cost and utilization data. There are frequent conversations among the reviewers, CMS and Humana. As a result of these discussions, we may be required to resubmit bids and benefit packages to address any issues. All benefit changes after initial submission that impact bids must be re-reviewed by CMS' reviewing actuaries for bid impact. The contracted actuaries must sign-off on our bids to CMS before CMS will approve the bids.

In mid August, CMS releases the final prescription drug and Regional PPO benchmarks. Since the actual benchmarks will differ from the estimated benchmarks we included in our bids back in early June, we then adjust our benefits and/or premiums and bids based on the national benchmarks. CMS allows one week for the revised bids and benefits to be resubmitted. In early September, CMS approves our bids and attestations.

CMS Bid Audit Processes

Shortly after CMS' approval of the bids, they notify Humana of the bids that they will audit. CMS contracts with outside actuarial firms for these audits. The audits center around the reasonableness of the assumptions used for financial projections, the accuracy and reasonableness of the base period data and/or manual data supporting the bid submissions, ensuring the bids were developed consistent with the applicable Actuarial Standards of Practice as promulgated by the American Academy of Actuaries, and verifying that the bids were prepared consistent with the Instructions for Completing the Medicare Advantage or Prescription Drug Plan Bid Forms for a particular Contract Year.

The auditing firm notifies Humana and conducts an initial audit entrance conference call among the auditors, the Office of the Actuary and Humana. Humana

compiles the data requested and provides the auditors with the necessary data. The audit firm conducts a desk review of the materials followed by a one-week onsite visit to review all material and request additional information. Soon after, Humana receives and responds to an initial draft of the firm's findings or observations. The auditing firm then issues a final "Agree/Disagree" letter which contains any findings or observations made by the auditors. Humana then issues a final response to that letter.

From 2006 to present, Humana plans have been and are being audited. For the 2006 plan year, CMS audited two contracts (a Regional PPO and an HMO). There were no material findings in either audit. There were two non-material observations which had no impact on the rates and benefits we offered: 1) lack of disclosure of our outside, consulting actuarial firm's study as a source used in calculating a certain factor and 2) an inconsistency in a utilization factor. There were no findings or observations noted for our PD/PDP plans. The final CMS audit was issued on June 26, 2006.

For the 2007 plan year, CMS audited two contracts and issued one finding and two observations for one of our HMOs. In that plan, we used a rate development factor for medical expenses that was an inadvertent error with the medical cost structure for the plans. The result of this inadvertent error was that members in the two affected plans received a slightly better benefit. The finding and observation resulted in improvements to our methodologies for the 2008 bids as mentioned. The final 2007 CMS audit was issued on May 14, 2007.

Finally, we believe it would improve the bid process if the final audit reports were issued in March of the contract year to allow plans to include the impact from any findings and/or observations into the next year's bids.

Other CMS Regulatory Oversight Activities

As an organization offering MA plans (and stand-alone PDPs), Humana is subject planned and unplanned regulatory site visits and other reviews. Let me state for the record that Humana expects our policies, procedures, systems, management and operational implementation activities to be audited by CMS. Over the years, we have used internal and external resources to review, audit and maintain contract compliance. We have a 44-member regulatory compliance department; employ corporate Internal Audit resources and sometimes contract with external organizations to examine our operations. If a regulatory agency identifies an issue, Humana implements corrective actions. We have been subject to sanctions. We strive for zero tolerance in compliance with the requirements--but no one who provides services to Medicare beneficiaries is perfect. What we CAN do is have appropriate internal and external oversight and auditing mechanisms in place and work with regulatory agencies in curing any deficiencies they may identify to ensure contract compliance and improved beneficiary services.

Given that MMA inaugurated the largest entitlement program expansion in decades, government and plan challenges of the 2006 contract year were great: information system issues, changing CMS policies (including those relating to the bidding process) to meet unexpected consequences of well-intended requirements, and the unexpected volume of beneficiary needs that stretched resources. In the end, most beneficiaries have coverage, most are satisfied with their coverage and nearly all are saving money.

Learning from the 2006 experience, Humana executed the following:

1) Conducted nationwide outreach to every state Department of Insurance, most State Health Insurance Assistance Programs (SHIPs), state Medicaid agency and other consumer advocacy groups to educate them about our plans and processes, providing them with a special toll-free number to call with questions and issues and contact names for assistance;
2) Created a 20-person Performance and Process Improvement Department that developed process management systems and controls for areas of highest risk to our members;
3) Overhauled our sales management system including reducing dependence on contracted or delegated agents/brokers (we believe we have the largest employed sales force in the industry);
4) Required contracted agencies to have compliance programs in place and meet certain sales practice performance standards
5) Increased Humana sales management oversight;
6) Redesigned agency licensing management system and operations as a result of systems' flaws identified through state insurance exams and an Internal Audit; and
7) Redesigned, systematized and added resources to our process for handling sales-related complaints including strengthening agent obligations and corrective action oversight.

Our Medicare operations management meets weekly to review performance metrics.

Conclusion

Let me reiterate that we take seriously the trust that the federal government has placed in us to offer MA coverage to beneficiaries and understand the vulnerability of this population. Humana continues to strive to comply with the statutory and regulatory provisions as well as CMS guidance and instructions as they relate to our contract obligations. In any regulatory audit or site visit, we seek to correct any issues brought to our attention whether by internal or external sources. Our internal findings as well as findings from outside sources are used to inform and continuously improve our operations. The challenges we faced in the operational implementation of the provisions of the MMA have been largely overcome. Our company has reported that sales-related complaints have represented about ½ of 1 percent of all our agent-assisted sales. We take ALL complaints seriously and work hard to resolve them. We report violators. We work closely with state and federal agencies in these efforts.

Thank you for the opportunity to discuss the processes we have in place to meet the statutory, regulatory and contractual obligations in the MA Bid and audit process and issues identified in recent MA reviews.

Chairman STARK. Thank you.
Ms. Polich.

STATEMENT OF CINDY POLICH, SENIOR VICE PRESIDENT, SECURE HORIZONS, UNITEDHEALTH GROUP, MINNEAPOLIS, MINNESOTA

Ms. POLICH. Thank you, Mr. Chairman, and thank you to the committees for giving me an opportunity to testify today. I am Cindy Polich, Senior Vice President of Secure Horizons, which is a part of UnitedHealth Group, and I help lead the company's efforts in the areas of geriatric health and long-term care.

I have spent the last three decades working in the field of managed care and aging, am co-author of a book called "Managing Health Care for the Elderly," which has been used as a college textbook, and I have done extensive research and teaching in gerontology and health care.

At UnitedHealth Group, we take our role as partner with the Federal Government very seriously. We are committed to working with Congress and regulators to make sure that CMS has the information it needs to provide timely, impartial, and effective oversight.

Our participation in the Medicare program is fundamental to UnitedHealth Group's mission: to support the health and well-being of individuals, families, and communities. We are proud to serve the 1.3 million members who have chosen our Medicare Advantage plans. These plans provide integrated benefits, enhanced coverage, lower out-of-pocket costs, and coordinated care.

Medicare Advantage plans are a health care success story for millions of Americans. Fully 90 percent of Medicare Advantage beneficiaries say they are satisfied with their coverage. We also know that over the past 4 years, the pace of change in the Medicare program has created a steep learning curve for insurers, for regulators, and for beneficiaries alike. However, we believe that the new bidding and oversight provisions that recently took effect should greatly improve the ability of CMS to audit and monitor plans effectively.

The recent GAO report focused largely on CMS auditing of the old adjusted community rate process, a process that no longer exists. The new bid process that went into effect in 2006 is a significant improvement. While the old process was based on the costs and assumptions for a plan's commercial business, the new bid process is focused specifically on Medicare. It is more in line with the way the business is actually managed, which means that CMS will now have more relevant processes and data to audit. Also new in 2006 was a requirement for actuarial certification of bids before they are submitted to CMS. This provides a higher level of rigor in bid development.

CMS also has an important role in operational oversight. We take a diligent and aggressive approach to implementing any action plan that is requested by and developed with the agency. Often we find that issues raised by CMS already have been identified through our own internal audit process, and work to implement improvements is already well under way.

UnitedHealth Group is also a strong supporter of rigorous oversight of the sales and distribution of Medicare Advantage products, particularly private fee-for-service plans. That is why we backed CMS and the industry this summer in accelerating adoption of marketing guidelines that had been planned for 2008.

Medicare Advantage was created in part to give Medicare beneficiaries additional health coverage choices because all of us understand that a one-size-fits-all approach cannot possibly meet the needs, the individual needs, of every Medicare beneficiary.

Medicare Advantage plans provide benefits that do go beyond original Medicare and Medicare supplement. These benefits can include integrated prescription drug coverage at no additional cost,

preventive and wellness services, vision and hearing benefits, and caregiver support.

Moreover, Medicare Advantage plans can cover all of a person's health care needs in one integrated benefit package. This means more than just convenience. It means better health. Medicare Advantage plans encourage members to access primary and preventive care, which reduces acute episodes and hospitalization, providing better outcomes at lower costs.

An integrated benefit plan reduces fragmentation that can occur when a patient has multiple chronic conditions and multiple health care providers. This integration allows for better coordination and attention to individual needs across the continuum of care.

Medicare Advantage plan sponsors have pioneered care and disease management programs to support managers with serious chronic conditions and who are nearing end of life. Besides providing great value to the individuals who need them, these programs are also critical to the long-term financial health of Medicare, since 20 percent of beneficiaries with five or more chronic conditions consume more than two-thirds of Medicare spending.

At UnitedHealth Group, we believe that smart and effective government regulation is good for beneficiaries, and we firmly believe that what is good for beneficiaries will be good for our company as well. We are committed to continuing to work in cooperation and in a collaborative manner with CMS and all Members of Congress to further this goal.

Thank you.

[The prepared statement of Ms. Polich follows:]

Statement of Cindy Polich, Senior Vice President, Secure Horizons, UnitedHealth Group, Minneapolis, Minnesota

Good morning, Chairman Stark, Chairman Lewis, Representative Camp, Representative Ramstad, and other distinguished members of the Subcommittees on Health and Oversight. I am Cindy Polich, Senior Vice President, Secure Horizons, which is a UnitedHealth Group business unit dedicated to serving the needs of Medicare beneficiaries.

I have spent the past three decades working in the fields of gerontology and managed care. I am co-author of a book called *Managing Healthcare for the Elderly,* which has been used as a college textbook, and have done extensive research and teaching in gerontology and aging. At UnitedHealth Group, I have helped lead the company's efforts in the areas of geriatric health and long-term care, including work with PacifiCare, UnitedHealthcare, and in the 1990s with the Evercare nursing home demonstration project, which became one of the models for Special Needs Plans in the Medicare Modernization Act of 2003 (MMA).

My personal focus and commitment on improving health care for elderly Americans is one of the reasons that I came to work at UnitedHealth Group. UnitedHealth Group has long been committed to meeting the health care needs of older Americans. In fact, we serve one out of every five Medicare beneficiaries through Part D, Medicare Advantage, Special Needs and Medicare Supplement Plans. We offer such a comprehensive range of Medicare products and services because we believe fundamentally in enabling beneficiaries to make choices based on their individual healthcare needs and preferences. We are proud to serve 1.3 million Medicare Advantage members in over 1,500 counties nationwide.

For more than 20 years, private Medicare plans have been a health coverage option for beneficiaries. Today, more than eight million Americans have chosen this option through a variety of Medicare Advantage plans offered nationally.[1] When

[1] Kaiser Family Foundation, June 2007 fact sheet, http://www.kff.org/medicare/upload/2052-10.pdf.

asked why they chose Medicare Advantage, members tell us they value the integrated benefits, enhanced coverage, lower out-of-pocket costs and coordinated care.

The overwhelming majority of beneficiaries are satisfied with their Medicare Advantage plan. According to a survey conducted earlier this year for America's Health Insurance Plans, 90 percent of Medicare Advantage beneficiaries expressed satisfaction with their coverage, an increase over the 84 percent who were satisfied in a similar 2003 survey. For millions of Americans, Medicare Advantage plans are a health care success story.

Our participation in the Medicare program is fundamental to UnitedHealth Group's core mission: to support the health and well-being of individuals, families, and communities. And we know that our role in caring for seniors and the disabled brings with it heightened responsibility. With that in mind, I appreciate the opportunity to testify today and offer perspective about Medicare Advantage and the important role it plays in our health care system.

Let me state at the outset that as one of the nation's largest providers of Medicare Advantage plans, UnitedHealth Group and its Secure Horizons business unit support the need for the Centers for Medicare & Medicaid Services (CMS) to gather, through audits and other means, the information it needs to provide timely, impartial and effective oversight of these programs.

We take our role as a partner with the federal government very seriously, and want to continue to work with the Congress, CMS and other key stakeholders to address issues in a constructive way. We take very seriously the important role of Congress, and these Subcommittees, as stewards of the Medicare program.

The Real Advantages of Medicare Advantage

Medicare Advantage (as well as its predecessors, including Medicare + Choice) was created, in part, to give Medicare beneficiaries additional health coverage choices. Because health care requirements and preferences vary greatly and are very personal, a "one-size-fits-all" approach cannot possibly meet the individual needs of every Medicare beneficiary.

Medicare Advantage members expect their plans to provide them with more value than they could receive from Original Medicare and at a lower cost than they would pay for a Medicare Supplement plan. Medicare Advantage plans accomplish this by providing:

• **Integrated Benefits and Care Coordination:** Medicare Advantage plans are often the most cost-effective and convenient way for Medicare beneficiaries to cover all their healthcare needs in one integrated benefit package—rather than, for example, enrolling separately in a Part D plan, purchasing a Medicare Supplement policy, calling multiple phone numbers for service, and managing the entire process themselves.

But convenience and seamless customer experience is only a small part of the value of an integrated benefit plan. A comprehensive and integrated benefit plan reduces the fragmentation that can occur when a patient is treated by a number of physicians and other health care providers, and allows us to manage across the continuum of care. This care coordination is critically important for Medicare beneficiaries, especially those with multiple chronic conditions.

Medicare Advantage plans offer a range of programs and services to help beneficiaries navigate the fragmented health care system, and ensure they receive the care most appropriate to their health condition. Medicare Advantage plan sponsors have pioneered programs that focus on pro-active clinical support for members with serious chronic diseases, such as diabetes, congestive heart failure or chronic obstructive pulmonary disease. Offerings vary by plan, but can include care management, disease management and enhanced preventive and screening programs. These programs are particularly valuable to members with multiple chronic conditions and those nearing the end of life. These programs are critical to the future financial health of the Medicare program, since the 20 percent of Medicare beneficiaries with five or more chronic conditions consume more than two-thirds of Medicare spending.[2]

The Medicare Advantage program also includes Special Needs Plans, which provide coordinated care and benefits that are uniquely appropriate and tailored to people with complex health care needs and chronic illnesses.

• *For example, when one of our Rhode Island members was hospitalized for serious health problems including hypoglycemia, coupled with Type 2 Diabetes, her physician recommended that she move to a nursing home or assisted living facility after discharge, since she could not take care of herself. But instead she enrolled in one*

[2] "Chronic Conditions: Making the Case for Ongoing Care," Partnership for Solutions, 2004.

of our Special Needs Medicare Advantage plans. A Care Manager came to her house, did an assessment and worked with her physician, social workers and home- and community-based service providers to develop a care plan that would allow her to live at home. Today, our member—who just over a year ago could not leave the apartment without assistance—lives in an independent living apartment complex for the elderly. She is thirty pounds lighter and goes out for walks every day.

• **Enhanced Coverage and Reduced Out-of-Pocket Costs:** Medicare Advantage members tell us that what they value most from their plan are the extra benefits, lower costs and catastrophic protection provided by Medicare Advantage. Medicare Advantage plans provide benefits that go beyond Original Medicare and Medicare Supplement, including in many cases: integrated prescription drug coverage at no additional cost, which in some cases includes coverage in the gap; preventive/wellness services; vision and hearing benefits; and caregiver support, to name a few. Obtaining comparable coverage from Medicare Supplement and Part D plans could cost hundreds of dollars more per month.

Moreover, Medicare Advantage plans have designed benefit structures that not only appeal to beneficiaries, but encourage them to access primary and preventive care. This is very important when managing chronic illness, as it reduces the probability of an acute episode, lowers the incidence of hospitalizations, and improves the overall cost and quality outcome for beneficiaries.

• *Medicare Advantage makes a real difference in the lives of real people. For example, when a 78-year-old Secure Horizons member from Fort Worth suffered a heart attack and kidney failure, he had a quadruple bypass and months of rehabilitative therapy. The total bill was $1.3 million—but with his Secure Horizons Medicare Advantage plan, he paid only $2,300 in out-of-pocket costs for the year.*

Regulatory Oversight

Over the past four years, the rapid pace of change in the Medicare program has created a steep learning curve for insurers, regulators and consumers alike. After all, the Medicare Advantage program in its current form was approved in 2003—just four years ago—and implemented less than 22 months ago.

New bidding and oversight provisions implemented with contract year 2006 should greatly improve the ability of CMS to audit plans effectively going forward. Two improvements that should have a materially positive impact include replacing the Adjusted Community Rate (ACR) proposal process with a new bid process, and requiring actuarial certification.

In prior years, the rules governing the ACR proposal process required Medicare Advantage organizations to estimate the cost of providing benefits based on trend data related to how much they would charge commercial customers to provide the same benefit package. The projected Medicare costs were then adjusted to reflect expanded variations in trend or other factors. The recent GAO report focused primarily on CMS auditing of this old ACR process—which no longer exists.

The new bid process is a significant improvement, because it recognizes that the Medicare business and the commercial business are not the same. The new bid process focuses on actual costs, trends, and projections for providing coverage for the expected mix of Medicare beneficiaries served by the plan. The shift away from the commercial standard means that the rate-setting process now more accurately reflects the requirements for serving Medicare beneficiaries and is more in line with the way the business is actually managed. This means CMS will be evaluating more relevant data and information.

Also new in 2006 was the requirement that Medicare Advantage bids be actuarially certified before submission to CMS. This provides a higher level of rigor to bid development and ensures that the bids meet standards of actuarial practice.

Finally, additional oversight provisions were implemented in 2006. Bids receive multiple levels of review: from outside auditors hired by CMS and the CMS Office of the Actuary before bids are approved, through post-contract-year audits; and from the CMS two-year "look-back" process.

We support CMS in its continuing efforts to improve the Medicare program and its process of regulatory oversight. We are committed to doing our part to improve all areas of our Medicare Advantage programs. The GAO has made a number of recommendations for improving the contracting and auditing process of Medicare Advantage programs. CMS has concurred with the GAO's recommendations and UnitedHealth Group strongly supports this position.

As a further area of consideration, we recommend that as the financial audit process evolves that it focus on a company's methodology for developing Medicare Advantage bids across the range of plans the company offers. Ultimately, this might allow for a refinement of the current standard—which emphasizes the number of

audits conducted—freeing up resources to focus more on the underlying approaches a company uses to create its bids and the consistency with which these approaches are applied.

In addition to its financial oversight, CMS has an important role in the operational oversight of the Medicare Advantage program.

With respect to our action plans, we take a diligent and aggressive approach to implementation, including conducting our own internal reviews and checks to ensure that issues are resolved quickly and thoroughly. And, often, in areas that CMS highlights for further improvement, we have already engaged in activity, reflecting the work of our internal quality audits.

Beneficiaries indicate they are highly satisfied with our offerings, and we are committed to continuous improvement.

Conclusion

For millions of elderly Americans, Medicare Advantage plans provide not only needed flexibility, but also a wide range of benefits for meeting their unique health care needs. Smart and effective regulation is good for consumers, and we firmly believe that what's good for consumers will be good for our company as well. We are committed to continue working in a cooperative and collaborative manner with CMS and all members of Congress to further this goal.

Thank you, Mr. Chairman and other distinguished members of the Subcommittees on Health and Oversight, for the opportunity to speak today on behalf of UnitedHealth Group.

Chairman STARK. Thank you.

Dr. Asner.

STATEMENT OF BART ASNER, M.D., CHIEF EXECUTIVE OFFICER, MONARCH HEALTHCARE, IRVINE, CALIFORNIA

Dr. ASNER. Thank you, Mr. Stark. My name is Dr. Bart Asner, and I am privileged to testify before this committee today. I am here representing CAPG, the California Association of Physician Groups, a trade association comprised of 150 medical groups in California who provide coordinated health care services to 12 million Californians, including 1.4 million Medicare Advantage beneficiaries.

I am also the chief executive officer of Monarch Healthcare, a medical group in Orange County, California, which provides care for 175,000 patients, of whom 27,000 are Medicare Advantage beneficiaries. Monarch Healthcare physicians have real-life experience in taking care of these patients, many of whom are fragile, vulnerable seniors.

Let me first state that oversight of health plans is correct and appropriate. I am not here to defend or criticize CMS in its audit function, but rather to defend the Medicare Advantage program by providing a contrast between the episodic, disorganized care in traditional Medicare and the comprehensive, coordinated care in Medicare Advantage.

Critics of the Medicare Advantage program have used this GAO report as proof that Medicare Advantage plans are not using the money they receive to provide additional benefits to seniors. I am here today to say that this couldn't be further from the truth.

Seniors in California choose to join Medicare Advantage, such that in many areas, as Mr. Stark has alluded, 40 to 50 percent of seniors have enrolled in these programs and satisfaction is high. Enormous challenges lie ahead as the baby boomers age and enter the Medicare system, coupled with the rising rate of chronic illness

such as diabetes and heart disease. Medicare Advantage can and will address this challenge in California by having built the infrastructure to care for these patients.

Medicare Advantage provides seniors with greater value, in both economic and human terms, when compared to Medicare fee-for-service. The true value of Medicare Advantage is evident and realized in enhanced benefits, additional services, better quality care, and at a lower total cost to our senior citizens.

Medicare Advantage plans provide additional benefits to our patients, including vision, dental, podiatry, chiropractic, and, very importantly, coverage of the doughnut hole in the drug benefit. Everyone deserves these benefits. For the many low income beneficiaries in our programs, these services are vital to their health and well-being.

Much has been made of the difference in the cost to the government of Medicare Advantage versus traditional Medicare. In fairness, one should consider the cost to the beneficiary as well. When the costs to the beneficiary of coinsurance, Medigap coverage, and non-covered drugs are taken into account, the true cost of Medicare Advantage is less than traditional Medicare. In addition, this lower cost to the beneficiary promotes better access to health care services.

The value proposition for Medicare Advantage is lower total program costs coupled with superior quality, as I will explain. Medicare Advantage beneficiaries receive comprehensive care under our model in California. Many seniors are frail elderly with chronic illnesses who are confused by the complexity of the health care system. Under Medicare Advantage, California physician groups provide care coordination programs to guide these patients through the health care system and ensure that they receive the right care at the right time in the right setting.

We employ experienced nurse care managers to work with these seniors in both the inpatient and outpatient setting to be certain that they do not fall through the cracks that inevitably arise as patients move from doctor to doctor and from inpatient to outpatient settings. We employ hospitalist physicians who provide high quality, consistent care to patients in the hospital and skilled nursing facilities, as well as staff in clinics for the high-risk patients transitioning to the outpatient setting.

Monarch nurses provide case management services for our patients at high risk of complications to see that they receive the care that they need, such as specialist visits, medications, and durable medical equipment. We work with their primary physicians to offer disease management programs and other preventative services to keep people healthy.

Monarch has invested in and deploys technology unavailable to the individual physician in private practice to remind them of recommended preventative care, such as vaccinations, and of chronic illness patients who have not come to see them in their office.

Medical groups in California have made multi-million-dollar investments in disease registries, electronic health records, and technology to improve the care of our patients. Thanks to the aforementioned programs, additional resources, and investments in tech-

nology, the quality of care received by these patients is superior in Medicare Advantage.

It is difficult to be a physician today and to think beyond the immediate needs of the patient who is being seen in the examining room. Under Medicare Advantage, we manage the care of populations of patients, not merely the one-time episodic interactions of a patient and physician.

California physician groups participate in programs that measure quality and performance, and align the incentives of physicians with the goals of these programs. No comparable programs exist in traditional Medicare.

CMS has recently stated that it will no longer pay for volume, but must pay for value. Medicare Advantage programs in California provide that value. Let us together optimize health care quality at a cost our nation can afford for these deserving seniors through the Medicare Advantage program. CAPG and its members urge Congress to consider both the true economic performance of Medicare Advantage as well as the superior care this program provides to enhance the health and well-being of our nation's seniors. Thank you.

[The prepared statement of Dr. Asner follows:]

Statement of Bart Asner, MD, Chief Executive Officer, Monarch Healthcare, Irvine, California

Good morning. My name is Dr. Bart Asner, and I am the Chief Executive Officer of Monarch HealthCare, a medical group of 1,900 physicians serving 175,000 patients in Orange County, California. I am here as a board member and past Chairman of the California Association of Physician Groups (CAPG). On behalf of CAPG, its 150 member groups, the 59,000 physicians who practice in those groups, and the 12 million patients, including 1.4 million Medicare Advantage beneficiaries, they serve, I would like to thank Chairman Stark, Ranking Member Camp, Chairman Lewis and Ranking Member Ramstad for inviting us to participate in this important hearing on Statutorily Required Audits of Medicare Advantage Plan Bids.

The medical groups and physicians of CAPG are working on many of the same issues that you are grappling with here on Capitol Hill—how best to provide high quality health care, improve efficiency of the care model, ensure that the system can adjust to complex problems with innovative solutions, reduce health care costs, and improve the quality of life for our patients.

In that respect, we support requiring the Centers for Medicare and Medicaid Services (CMS) to comply with audit and financial oversight obligations for Medicare Part C organizations required by the Balanced Budget Act of 1997 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and for this audit process to be monitored by the Government Accountability Office (GAO). This practice ensures that Medicare Advantage (MA) plans are accountable to the government, to the taxpayer and to the beneficiaries they serve. To that end, we urge Congress to provide CMS with sufficient funds to carry out its oversight responsibilities. By protecting the integrity of the MA program, we are ensuring that this important program can continue to serve the millions of beneficiaries who rely on it now and in the future.

For more than 25 years, California physicians have been able to care for their senior patients through both a Medicare managed care model and through the traditional Medicare fee-for-service system. Our history and experience with both programs has given us a unique perspective of their various strengths and weakness. Earlier this year, CAPG released a report, "From the Point of Care," sharing the perspective of CAPG members—those physicians on the front lines in America's health care system—and their experience with Medicare Advantage.

In summary, CAPG physicians found that they are able to provide better health care to their patients who are in MA plans than those in traditional Medicare. Their report was the first of its kind, in that it discussed value not just in economic terms, but in human terms. CAPG's members were able to assess MA and traditional Medicare on other key characteristics, including quality, efficiency, flexibility, and

modernization. Against this backdrop, CAPG members found that MA produces significant benefits for its enrollees. Specifically, CAPG members found:

• Chronic care coordination is significantly stronger under MA. Traditional Medicare's fee-for-service reimbursement system incentivizes episodic, acute services on a hit-and-miss basis. This approach does not accommodate the need for care coordination of people with chronic illnesses that require daily attention over years or decades.

Conversely, MA allows for specialized outreach, oversight and care coordination for patients with frail and unstable conditions, patients entering complex phases of care with many providers, and patients approaching the end of life.

• The benefits of California's Pay for Performance (P4P) program are demonstrable in the MA program, resulting in better quality of care, more efficient care, and better experiences and outcomes for MA beneficiaries. There is no comparable P4P program in traditional Medicare and, given the importance of organized systems of care and population based measures, P4P in traditional Medicare faces many challenges.

• California's physician groups and their physicians, working with MA plans, are making better and more frequent use of healthcare information technologies than their traditional Medicare counterparts.

• Physician groups working with MA plans are able to scientifically direct care and avoid unjustifiable care.

Chronic Care Coordination

According to a recent study by the Commonwealth Fund, an estimated 20 percent of Medicare beneficiaries have five or more chronic conditions. These beneficiaries are treated by an average of 14 different physicians, leading to medical costs that equate to two-thirds of the federal program's spending. It is the experience of CAPG physicians that the traditional fee-for-service model is ill equipped to manage seniors with multiple chronic conditions.

For many chronic illnesses such as diabetes, arthritis, congestive heart failure, hypertension and others, there are a range of proven interventions and therapies. These therapies can minimize, delay, or entirely prevent a range of secondary complications, resulting in improved comfort, productivity and quality of life for the beneficiary while reducing the cost of avoidable crisis intervention.

Unfortunately, the current reimbursement structure cannot respond to these types of treatment needs. Multiple studies have pointed out that many patients in traditional Medicare receive chronic care oversight in a sporadic and incomplete fashion. The following example illustrates how Medicare Advantage is able to better respond to beneficiaries with multiple chronic diseases:

Mr. Q.S. is a 92 year old gentleman with multiple diagnoses, including congestive heart failure, history of pulmonary embolism, hypertension, ataxia and chronic gastrointestinal hemorrhage. Although he lives with his son, his son does not usually participate in his healthcare needs. The primary care doctor attempted to provide quality care to this gentleman, but unfortunately the patient was not proactive in contacting his doctor or follow-up with specialists. His preferred action was to call 911 to take him to the hospital for much of his primary care needs. Because of frequent emergency room visits and in-patient hospitalizations, we as the medical group evaluated his needs and identified him as a frail elderly at risk. Our case management team communicated with him on a regular basis to make sure his healthcare needs were being met. Our continuity of care case manager would see him in the hospital to assist with discharge planning and assure that continuity of care occurred post discharge. We placed him in our homecare program where a nurse practitioner was assigned to evaluate him at his apartment home. This entire management team facilitated both in-patient and outpatient care. This included facilitating and assisting in transportation to doctor's appointments. An integral part of this team approach was communication with the primary care doctor. As a result, his primary care doctor was much more involved in the overall care of the patient, his outpatient care was better coordinated and he was no longer receiving the bulk of his ambulatory services in the emergency room. The end result is that the patient became more proactive in his healthcare and had a significant decrease in his emergency room use and in the number of hospitalizations.

As demonstrated in this scenario, organized delivery systems under Medicare Advantage have embraced a chronic care model that employs a fundamental redesign of the care delivery system. This model requires computerized, centralized registries that allow providers to know which patients have certain diagnoses, when their services are due, their lab results and personal measures, and when those results

indicate the need for intervention. These care management services are only possible in the context of the Medicare Advantage program and are virtually non-existent in traditional Medicare.

Pay for Performance (P4P)

California medical groups, in collaboration with MA plans and others, have led the nation in the development of clinical performance measurement programs and economic incentives which reward high-performing providers. Under the auspices of the Integrated Healthcare Association, these efforts have set the foundation for California's annual Pay for Performance ("P4P") bonus payment system. These bonuses have created economic incentives which have resulted in health care improvement strategies being implemented across the entire state.

Our P4P program has been closely studied by the Centers for Medicare and Medicaid Services to determine which components can be exported to geographic areas where traditional Medicare payment methodologies predominate. Two characteristics seem essential to a successful P4P program: 1) medical groups need to be effectively integrated with their local provider community and 2) population-wide care improvement is the criterion for a financial reward.

The benefits of California's P4P program are demonstrable in the MA program, resulting in a new culture of measurement, public reporting, annually improving quality, an objective assessment of efficiency, and better personal experiences and clinical outcomes for MA beneficiaries. There is no comparable P4P program in traditional Medicare, and given the importance of organized systems of care and populations based measures, P4P in traditional Medicare is likely to be unsuccessful in stimulating meaningful changes in practice patterns.

The Use of Health Information Technologies To Improve and Manage Care

Monarch HealthCare has the distinction of being repeatedly recognized in the industry for our investment in Information Technology and our ability to integrate medical information in a comprehensive way that allows our physicians to make informed decisions regarding patient care.

Other groups in California's organized systems of care are also widening the application of electronic health registries, which help with the management of chronic illnesses, particularly those requiring cyclical oversight. They are also used to assure routine screening and preventive services such as mammography, cervical cancer screening, colorectal cancer and screening for other treatable illnesses.

Furthermore, California's medical groups are deploying electronic health records (EHR) well ahead of the national trend. The use of EHRs in seniors has resulted in:

- Physicians managing multiple simultaneous conditions with complete access to clinical information necessary for the best medical decision;
- Electronic prescribing and subsequent tracking to assure accuracy, continuity and safety,
- Coordination of care among multiple providers with instantaneous sharing of information to support clinical decision making to avoid redundancy, missed opportunities, and mistakes; and providing patients with portable access to critical medical records when away from home.

The structure of the MA program in California, and its reliance on physician groups and other organizes systems of care, has contributed to the development and adoption of Health IT. The use of EHRs, electronic registries, electronic prescribing and other Health IT is not nearly as prevalent in traditional Medicare.

Evidence Based Medicine

Providing evidenced based medicine is another area where MA has been able to make significant progress. In partnership with Medicare Advantage plans, California physician groups have worked to avoid inappropriate utilization by focusing on scientifically justifiable clinical decisions.

Physicians who are part of physician groups routinely submit clinical rationale and justification for procedures, especially those with "gray areas," clinical controversy, or complex choices. This exercise does not replace a physician's clinical judgment nor is it an excuse to thwart necessary care, but rather a quest to deliver the right care, at the right time, at the right place. Objective, scientific, and ethical oversight is the cornerstone of the efficient use of finite resources in a costly environment.

I think we can all agree that our health care system should promote prevention, chronic care management, and avoidance of unnecessary and unjustifiable health care. The Medicare Advantage program has made considerable progress on these, and other fronts.

Putting it in Context

Based on my perspective and experience, which is shared by the 59,000 physicians in CAPG member organizations, there is no question that MA provides superior value for its beneficiaries in both economic and human terms. But there are several other factors to consider when measuring the benefit and value of this program.

Recent reports indicate that MA members enjoy significant savings over traditional fee-for-service. According to CMS, in 2006 MA plans provided beneficiaries with an average $82 per month savings. With approximately 7 million beneficiaries enrolled in Medicare Advantage plans at that time, this translated into aggregate savings of more than $6.8 billion annually. MA enrollees are also protected from high out-of-pocket costs—more than 93% of all beneficiaries had access to an MA plan that limits out-of-pocket costs to $2,500 for Medicare-covered benefits.

Despite arguments that MA plans are overpaid when compared to traditional fee-for-service, it is important to note that in most cases MA plans are actually *less* expensive when calculating both the costs to the federal government *and* the beneficiary. Specifically, MA beneficiaries do not need to purchase Medicare supplemental insurance, which alone can cost beneficiaries $100 per month or more. Immediately, this results in cost savings to the beneficiary. Furthermore, these "overpayments" do not account for administration of the fee-for-service program, the costs of fraud and abuse—which occur almost exclusively in the traditional Medicare program due to the incentives of fee-for-service reimbursement, the hidden costs of inefficiency when medical and drug therapies are not coordinated, and more.

MA also has spillover benefits that impact the fee-for-service population as well. Adoption of Health IT, electronic medical records and quality measures provides benefits to the entire Medicare population. Similarly, many CAPG providers offer disease management services to all Medicare beneficiaries, irrespective of whether they are enrolled in MA plans or traditional fee-for-service.

Finally, little attention has been paid to the readiness of the Medicare program and America's health care delivery system to meet the tidal wave of demand that will come as the post-World War II generation becomes eligible for Medicare benefits. In our estimation, traditional Medicare, with its incentives for piecemeal disconnected approaches to care, will be incapable of coping with the demands that it will confront in less than 10 years. By comparison, CAPG views MA and its incentives for organized systems of care as the best mechanism to delivering evidence based, coordinated and efficient care to the next generation of older Americans.

For more than two decades, CAPG's members, their physicians and their patients have directly experienced the clinical and administrative successes of the MA program. If those successes are to continue and be widely shared, Congress should promote the program—not weaken it.

Chairman STARK. Thank you.

Mr. Hotchkiss, how many beneficiaries does Humana have altogether?

Mr. HOTCHKISS. We have 1.1 million MA members and 3.4 million PDP members.

Chairman STARK. 3.4 million what?

Mr. HOTCHKISS. 1.1 million MA members and 3.4 million PDP members.

Chairman STARK. PDP?

Mr. HOTCHKISS. Prescription drug plan.

Chairman STARK. For a total of 4½ million?

Mr. HOTCHKISS. 4.5 million.

Chairman STARK. And out of your $500 million in profit in 2006, how much of that profit came from managed care, Medicare Advantage?

Mr. HOTCHKISS. I don't have that information.

Chairman STARK. Why?

Mr. HOTCHKISS. I do know that when we develop our MA plans, we target a 5 percent profit margin. And for—just a moment please—for 2006, our profit was 2.9 percent, and in the first half of 2007 it was 2.4 percent.

Chairman STARK. It grew from 300 million to 500 million from 2005 to 2006. So could you get me the figures as to how much of the 500 million in 2006 came from Medicare Advantage and how much came from the—somebody behind you is shaking their head.

Mr. HOTCHKISS. I will follow up.

Chairman STARK. Will you? I would like to have it.

There was a statement made by some analyst or another that your loss ratio in the unmanaged private fee-for-service plans is 150 basis points better than it is in traditional products. That would indicate that not all of the additional reimbursement you are getting goes for additional benefits. Would you agree?

Mr. HOTCHKISS. I don't have access to that or I haven't seen that report. I would like to see it before I respond to it.

Chairman STARK. Would you see whether you could? Because if that is correct, this would indicate that you are paying for fewer additional benefits in the Medicare Advantage plans, wouldn't it?

Mr. HOTCHKISS. I still need to read the reports, Mr. Chairman.

Chairman STARK. Okay. I will see that you get it.

Mr. HOTCHKISS. Thank you.

Chairman STARK. Ms. Polich, you have got a million three Medicare Advantage beneficiaries. Correct?

Ms. POLICH. That is correct.

Chairman STARK. How many total beneficiaries in UnitedHealth? All plans?

Ms. POLICH. Actually, I am not sure what the total number is, including the commercial business. But I can get you that information.

Chairman STARK. Can you make a guess? Five million? Six million?

Ms. POLICH. Oh, more than that. We have 1.3 million Medicare Advantage members. We have over 5 million Part D prescription drug members. We also serve a large number of Medicare supplement——

Chairman STARK. How many do you have in AARP? You must have millions there. Right?

Ms. POLICH. With the Part D?

Chairman STARK. With AARP's plan.

Ms. POLICH. With the Part D, the prescription drug plan?

Chairman STARK. The supplemental——

Ms. POLICH. Oh, the Medicare supplement? Also have millions of members inform Medicare supplement. But I can get you the exact figures.

Chairman STARK. What was your total profit in the last, what, 2006? Do you know?

Ms. POLICH. I don't have that information with me. But again, I can take that question and get back to you.

Chairman STARK. Make a guess. You must have heard.

Ms. POLICH. Again, I——

Chairman STARK. They don't post it on the wall when you come into the lobby?

Ms. POLICH. No. Actually, we don't.

Chairman STARK. Gee. Well, that would be of some interest to us. Let me suggest this to you. It has been announced by AARP and you that you all are going to underwrite a Medicare Advantage plan that will be sold through AARP. You are aware of that?

Ms. POLICH. We have a partnership with AARP around Medicare Advantage starting in 2008.

Chairman STARK. Right. And AARP tells us that they are not going to sell that for more than 100 percent of fee-for-service. Now, why then, if a great company like yours, through the marketing arm of a great institution like AARP, is going to offer all of us AARP members a Medicare Advantage plan at what I would call par, at no more than 100 percent of the cost for fee-for-service, why shouldn't you do that for the rest of your Medicare advantage plans?

Ms. POLICH. Actually, I am not familiar with that comment from AARP, so I really can't——

Chairman STARK. It was made to me. I challenged them on it, and they swore to God that they weren't going to charge us more than 100 percent of fee-for-service. So if they can do it, I would suspect it is really you doing it. So we ought not to pay you—the taxpayers then ought not to pay you any more than us AARP members pay you, do you think?

Ms. POLICH. Well, Mr. Chairman, I am not familiar and can't really comment on AARP's position on that. But I would say that we continue to believe that steep and rapid cuts in Medicare Advantage funding would harm beneficiaries.

Chairman STARK. No. It would harm stockholders. Beneficiaries still get the same benefits by law. It just might cut the stockholders a little bit. But we are not in the business here of protecting your stockholders.

One other question. In the marketing of all of your plans, of the—let's guess, there are 5 or 10 million of your beneficiaries over and above the 1.3 million Medicare Advantage, in every instance the marketing of those plans is controlled or under the auspices of one or another state insurance commissioner, are they not?

Ms. POLICH. The Medicare supplement.

Chairman STARK. Every plan you sell other than Medicare Advantage is under the auspices of one of the 50 insurance commissioners in the states that you operate. Isn't that the case?

Ms. POLICH. I know they have some authority over many of our products, yes.

Chairman STARK. All of your products. Can you think of a product other than Medicare Advantage that isn't subject to the rules of state insurance commissioners?

Ms. POLICH. Yes. I don't believe the Part D plans are, either.

Chairman STARK. Stipulated. Good idea. That is one of the other problems we have.

Is there any reason that your sales people, as long as you are obeying the laws of the State of California or the State of Michigan or the State of Georgia, shouldn't obey those rules—sales people, now—in regard to marketing of Medicare Advantage plans?

Ms. POLICH. We absolutely share your concern around marketing and sales abuses and——

Chairman STARK. No. But would you be willing to have the state insurance commissioners regulate them as they do now for all your other products?

Ms. POLICH. We believe that the states have absolutely a role in overseeing the sales and marketing practices. However, I would also say——

Chairman STARK. I will take that as a tentative yes subject to your boss's approval. All right?

Ms. POLICH. I would also say that Medicare is a federal program and really needs to be overseen at a federal level. And we are also concerned about consistency of the oversight across all of our geography.

Chairman STARK. How about Humana? All your other insurance products are subject to state insurance commissioners.

Mr. HOTCHKISS. We have the same position, that we have concerns that there would be inconsistency among the states.

Chairman STARK. There is now, isn't there, for all your other——

Mr. HOTCHKISS. No. We would be concerned that—you know, it is a federal program—that there would be inconsistencies if it was——

Chairman STARK. I am just talking about the sales people, you know, things like telling the truth, that sort of thing. All of whoever sells—brokers or agents who sell your plans now, with the exception of D, as Ms. Polich has so correctly informed me, and Medicare Advantage, are subject to regulation by state insurance commissioners, are they not?

Mr. HOTCHKISS. Yes.

Chairman STARK. Why then couldn't they regulate all of it, and then we might not have these problems of rogue agents going off, which bother you, I am sure, as much as they bother me, don't they? You don't want that.

Mr. HOTCHKISS. Well, they bother Humana. But in all fairness, sir, I am an actuarial director, and that is really outside the scope of my expertise. So I would prefer to respond in writing.

Chairman STARK. Okay. But just as a guy in the insurance business in general, isn't it better for the reputation of Humana to have good agents, honest agents, representing you?

Mr. HOTCHKISS. Absolutely.

Chairman STARK. There you go. And they already do, don't they?

Mr. HOTCHKISS. Yes.

Chairman STARK. Except for Medicare Advantage and Part D. And I am just suggesting that if you can have three-quarters of your business regulated by state insurance commissioners, why not the other quarter? And then you would only have one—you wouldn't have to fuss with us. You would get all that federal regulation off your back. Sounds like, on your way to becoming executive vice president of the whole company, that it would be a good decision, wouldn't it? I will tell the board of directors——

Mr. HOTCHKISS. Again, it is outside the scope of my expertise.

Chairman STARK. I will tell the board of directors how perspicacious you are in this, and that may help.

Mr. Camp, I am going to suggest that we have another ten minutes before we have to vote.

Mr. CAMP. All right.

Chairman STARK. I am going to have to ask the witnesses, if they would mind, I will probably recess us till the end of a series of votes, which may take us as many as 45 minutes, and urge you to get some lunch or stretch, seventh inning stretch.

Mr. Camp.

Mr. CAMP. Well, thank you, Mr. Chairman. I want to thank the witnesses for coming. I appreciate your testimony very much as we try to understand these issues.

Dr. Asner, I understand in the California Association of Physicians Groups, there are about 59,000 physicians in that organization. And you outlined some of the additional—well, you treat both Medicare beneficiaries as well as those enrolled in Medicare Advantage.

Dr. ASNER. That is correct.

Mr. CAMP. And I appreciate that you outlined some of the additional benefits that are provided to seniors in Medicare Advantage. And you mentioned vision, dental, podiatry, covering the doughnut hole; also, more importantly, I think some of the disease management, prevention, as well as the coordination of care. And it is a very difficult thing to have multiple conditions and to deal with those in a hospital setting, going from physician to physician, group to group, in some cases.

Now, earlier this year the House passed a bill that would have slashed Medicare Advantage payments by $157 billion. And what sort of impact do you think that would have on the patients who rely on Medicare Advantage and the doctors who care for those patients?

Dr. ASNER. If there were cuts of that magnitude in Medicare Advantage, that would undo the entire infrastructure that we have built up in California to care for these patients.

The investments we have made and continue to make in information technology to identify these patients, to identify them for their physicians, to give the physicians the information they need to better care for them, the coordination programs we have put in place which require a number of highly skilled nurses, the hospitalist program that I described to you, which are inpatient specialists who care for these patients in a coordinated fashion—it would be devastating to our ability as physicians to take care of these patients in the coordinated fashion that they deserve.

It would, in fact, move us back to what was a traditional fee-for-service mode of care for patients, and our physicians all say that would be detrimental to their patients. Our physicians care, as you said, for both the fee-for-service patient and the coordinated care patient. These patients who are sick, frail, elderly, need that care coordination. Our physicians know that, and I think you need to understand that as well.

Mr. CAMP. You also mentioned and I commend you for the advances you have made in health IT, electronic medical records, and quality measures. Now, we have often heard that if we could just

use electronic medical records, that alone would reduce the number of medical mistakes, this new technology.

With the compilation of the quality measures that you have seen in your practice, are there advances being made as a result of the technological changes that you have been able to make?

Dr. ASNER. Absolutely. The Integrated Healthcare Association in California has been the organization that has come forth with the pay-for-performance program, which is emulated across the country. And their most recent data show that there is a clear correlation between improvement in clinical care and the use of electronic health records and technology. So there is definitely a linkage between those two.

Mr. CAMP. All right. And Ms. Polich, you mentioned in your testimony a recommendation for improving the audit process, to reflect the methodology for developing Medicare Advantage bids across the range of company plans.

Can you explain this recommendation a little bit further, please?

Ms. POLICH. Certainly. One of the things that we found in our audits, in the bid audits that we have had with CMS in the past on the ACR process, that many of the findings relate to the supporting documentation and approach that we take to making assumptions. Because of course a bid is always a forward-looking process. We have to make assumptions and forecasts based on what we think is going to happen.

And so much, I think, of how solid those bids are is a function of the methodology and approach you are taking to using past data, and the methodology that you have in creating assumptions. In my view, in our view, the extent to which CMS can work with us, which they have started doing in this new bid process, to help us get guidance and understand methodologically how plans are approaching the bids and these assumptions, would make for not only the submissions of the bids much more valuable and solid, but also make sure that there is consistency across a plan's bids and even across the industry.

Mr. CAMP. All right. Thank you very much. And again, I want to thank you all for being here. I appreciate your testimony very much.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Lewis.

Chairman LEWIS. Thank you very much, Mr. Chairman. And thank each of you for being here today.

Mr. Precht, is there an office in CMS that protects beneficiaries?

Mr. PRECHT. There is the ombudsman's office, yes.

Chairman LEWIS. Should this office be independent?

Mr. PRECHT. I believe that is the idea.

Chairman LEWIS. Well, should it be something like we have at the IRS, the taxpayer advocate, which is independent to the IRS? Shouldn't there be something within CMS?

Mr. PRECHT. Well, I can only speak to my personal and our organization's experience with the ombudsman, and that is we had a couple of meetings with the ombudsman at the outset of 2006 when a lot of the problems surfaced around the new Medicare drug benefit.

And that is it, essentially. I have not—and for whatever reason in terms of resolving particular problems, that has no longer been the channel. It has been more informal channels, going through the administrator's office. So I can't really speak to what that office does at this point in time.

Chairman LEWIS. Well, in Georgia, insurance agents are selling Medicare Advantage plans to the elderly when they are in the room alone. Have you ever heard of anything like this?

Mr. PRECHT. Oh, yes. We have heard quite a bit of that. And unsolicited door-to-door sales are prohibited, but it happens anyway. And the other way that the plans get around it or the agents get around it is to essentially get an invitation. So somebody will call a plan and say, I would like to sign up for drug coverage, and they are told, you know, it would be better if we had somebody come and visit you.

Then that person comes and visits them and sells them an HMO or another Medicare Advantage product. And, you know, when we talked to CMS about this problem, they said, well, the agents want to go in the home because they have a higher closing rate.

Chairman LEWIS. Are there laws or regs that protect a beneficiary?

Mr. PRECHT. Well, there are regulations that prohibit this door-knocking, and an agent that is found to do that can be fired from the plan. Theoretically, at least, CMS could punish the plan for the actions of its agents for conducting this.

In terms of the beneficiary themselves, the only protections they have is they—and it is a difficult process, but they can get back into original Medicare and into the plan that they—you know, after they have been fraudulently coerced into one of these plans.

Chairman LEWIS. We are running out of time here. Earlier in the hearing, the GAO reported that the Inspector General audited the 2001 payment to Humana's Medicare plan and questioned 10.5 million of this payment. These amounts were not refunded to Medicare.

Are there any plans to refund this or maybe to make it available to the beneficiary or to cover co-payments or premiums? What do you plan to do with the overpayment?

Mr. HOTCHKISS. Well, Mr. Chairman, Humana received a letter from CMS in December of 2006——

Chairman LEWIS. But you didn't refund it. Right?

Mr. HOTCHKISS. No. CMS stated that we did not have to refund any money because we filed our——

Chairman LEWIS. Oh, they told you to just keep it?

Mr. HOTCHKISS. We did not file—we filed our BIPA ACRs consistent with the instructions that we received from CMS in January of 2001.

Chairman LEWIS. Thank you.

Chairman STARK. We have about four or five minutes till the votes. They will be about 30 minutes anyway. So why don't we just say that we will come back around 1:30 or immediately after the fourth or fifth vote, however many there are. And I hope the witnesses will bear with us till that time.

The committee will be in recess.

[Recess.]

Chairman STARK. If we can find our patient and accommodating witnesses, we would ask them to come back to the table. I hope you all had a great lunch.

Mr. Hulshof, it looks like it is your turn.

Mr. HULSHOF. Thank you, Mr. Chairman. First of all, I appreciate you having us come back to continue questions. And I know this will be a bit disjointed in the sense that we had some ebb and flow of questions before. And so let me sort of resurrect a couple of those issues.

And one of the questions I think perhaps put to the panel by the chairman, or maybe someone else, regarded this idea of regulation at the federal level vis-a-vis regulation by individual states. And I think that, Mr. Chairman, the Federal Employee Health Benefit Plan, the system that Members of Congress enjoy, is a federally regulated set of plans, not at the state level.

Chairman STARK. That is right.

Mr. HULSHOF. And I think—also correct me; I will turn to the witnesses, Mr. Hotchkiss and Ms. Polich in particular. I believe that on the fee-for-service plans, that state insurers and regulators really play little to no role in those plans. Is that true, Mr. Hotchkiss, if you know? I know you are an actuary, and maybe that is beyond your expertise.

Mr. HOTCHKISS. Cindy, do you want to——

Chairman STARK. Ms. Polich?

Ms. POLICH. Sure. So the question was private fee-for-service and the regulation of sales and marketing practices?

Mr. HULSHOF. Correct.

Ms. POLICH. Actually, the states do have a role in overseeing. We work very closely with the states in terms of our—you know, understanding what brokers are appointed, and if in fact we need to terminate brokers, to notify the states.

Mr. HULSHOF. But in regards to the Federal Employee Health Benefit Plan——

Ms. POLICH. Oh, you are right. Absolutely. That is correct.

Mr. HULSHOF. Absolutely what?

Ms. POLICH. Oh, that is not regulated—that is a federally regulated program. Yes.

Mr. HULSHOF. Okay. I just wanted to make sure that we heard from someone that is an expert in the field.

Regarding that expertise, Mr. Hotchkiss, I also understand as the chief actuary, and you have been asked some questions maybe beyond that bounds of expertise, but I wanted to focus on a question that you responded to make sure I got that answer correctly.

And one question that you weren't allowed to respond: Ideally, when you are putting a package out for bid—which is in fact a binding contract once the bid is out and it is accepted by a beneficiary; correct?

Mr. HOTCHKISS. Right.

Mr. HULSHOF. That ideally your company says, we would like to have a 5 percent return on our investment, a 5 percent profit. But I thought you said that for Medicare advantage in the year 2006, that you were significantly less than that, less than 3 percent. Is that true?

Mr. HOTCHKISS. Correct. Yes. In 2006, we had a pre-tax profit of 2.9. And for the first half of 2007 it is 2.4 percent,

Mr. HULSHOF. 2.4 percent extrapolated for the entire year or for just that——

Mr. HOTCHKISS. No. Just the first half of the year.

Mr. HULSHOF. Okay. Well, let me get to—and again, I welcome all of you here, but especially Mr. Hotchkiss and Ms. Polich. You may have felt like you were being led into the lion's den, and I know that at least during the previous panel—and I know that there has been some period of time, and members have other commitments, but some of the members that were quite outspoken.

And so let me take the persona of maybe a colleague of mine who spoke earlier and pick on you, Ms. Polich.

Ms. POLICH. Okay.

Mr. HULSHOF. You are an executive, are you not, with UnitedHealth Group business?

Ms. POLICH. Yes.

Mr. HULSHOF. And even though you say that you have spent three decades working in the field of gerontology, even though you have co-authored a book, even though you have done extensive research and teaching in gerontology and aging, and even though you have helped lead your company's efforts in this area, the fact is you really just are about gouging seniors. You have executives that are over-compensated. The private sector really has no business in the Medicare field at all. And the only needs that you intend to serve are those not of your patients, but of those shareholders and the stock price, as one of my colleagues mentioned.

How dare you come here and say that you actually care about seniors?

Ms. POLICH. The reason I can say that is because I have spent three decades caring for seniors. I am a gerontologist by training. I work, and the work that I do is all geared toward trying to improve the way in which we care for seniors, and making sure that Medicare is a program that not only today serves seniors well, but is there forever to serve seniors in the future. You know, that is why I work. That is why I get up in the morning. And that is my personal mission.

Mr. HULSHOF. Thank you for that. And my facetious question, and you took it in the spirit it was given, is that, Mr. Chairman, my fear—it is entirely appropriate that we have oversight, and we should have aggressive oversight. That is our constitutional role. Every taxpayer deserves to have his or her tax dollars spent in the most positive fashion possible.

And yet I think sometimes we talk past one another, and that there are too many political speeches and ideologies. Because I take your answer, Ms. Polich and Mr. Hotchkiss—and Mr. Precht, you have done a good job in your industry, and obviously, Dr. Asner, you are on the front lines caring for patients.

And I think too often we get caught up in the rhetoric of trying to condemn the private sector or a particular company and forget the fact that our primary role for Medicare is to make sure that patients live longer, healthier lives. And if Medicare Advantage can accomplish that, Dr. Asner, as you have so eloquently stated, then

why would we be so insistent on doing harm to a program that does good?

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Do you have any further questions?

Chairman LEWIS. No. I don't want to get involved in a debate with my friend from Missouri who is such a wonderful friend. But I must tell you, there is an old saying that the road to hell is paved with good intentions. And, you know, good people sometimes go off track, and good people can do bad things. I think we have an obligation to engage in oversight.

Mr. HULSHOF. Would my friend yield?

Chairman LEWIS. Pleased to yield.

Mr. HULSHOF. I absolutely agree with you, Mr. Chairman. I do. And the oversight function—again, I appreciate the fact we have a joint hearing here because I am not privileged to serve on the oversight subcommittee, but I am with Mr. Stark's committee on health. And I think it is good that we have these joint hearings so that, in effect, the oversight and health committees can have the opportunity.

And I think tough questions are appropriate. Some good tough questions have been asked today of this panel and other panels. But I would say to my friend from Georgia, in our effort to provide that good quality care—and the chairman of the health subcommittee stated it, and I appreciate his acknowledgment that many of these plans are providing very good, beneficial services and benefits.

Now, the question then of the overpayments is a fair question. But to tar and feather or to say because you work for a particular industry, or in this case, as has been stated, and I don't want to mention the gentleman's name earlier, but to call out by name certain companies and to insinuate that those health care professionals who have come here today somehow are more interested in the almighty dollar than they are about the health care of the people that they serve, I think is not constructive.

And that was my only comment. Thank you for yielding.

Chairman STARK. It is your turn.

Chairman LEWIS. I yield back, Mr. Chairman.

Chairman STARK. I would just say to all my friends on the committee and the witnesses, the issue here before us came up basically as one governmental agency, GAO, criticizing another governmental agency—not the industry, not us—for not performing a series of audits according to a law which was written actually by the minority.

In other words, there was a requirement in the beginning of these plans that the bids be audited, and there was some suggestion—and it is pretty arcane. As they said earlier, it is not a financial audit to determine the integrity of their assets.

But there was some feeling that there were several companies that had received 5, $10 million to which the rules didn't entitle them; maybe that is the way to say it—and that there had been no effort, perhaps because there was a disagreement as to whether they were legally required to collect the money back.

And it may be that the law is confusing as to whether they owe the money. But it seemed to us that in the light of the GAO report, that we ought not to find out, one, can we clarify those rules? Will the audits find out information that will help us determine not whether there should be Medicare Advantage plans—I think that is a given—but what is a fair rate to pay them, both from their standpoint and their ability to provide the benefits, earn a profit, if that is—or a margin for expansion; if they are not for profit, give the taxpayers a fair price for their dollars.

I think to assert that there is any other agenda here would not necessarily be the case. And I would hope that we will have better cooperation between GAO and CMS. And if there is a requirement that we legislate or review the legislation, I hope that we could do that. It hardly seems partisan.

In other words, if there is something confusing in the laws now, I think we could sit down and fit out what it ought to be. What is the best way for these audits to be conducted that is efficient, that doesn't create major inconvenience on the providers. And we ought to go ahead with that.

I was going to ask that either—if I may at this time, and I would recognize others for a second round here. But Mr. Hotchkiss or Ms. Polich, I have been concerned that we are not clear or we are not informed—we aren't—and we have had some trouble getting this information as between what services are actually provided to patients or beneficiaries versus what are offered.

Now, in many cases I have heard proponents of an overpayment—by overpayment, I don't mean that as a pejorative, but over the fee-for-service rate—that that provides extra services. And the question, of course, is it access to extra services or is it actually paying for services provided?

So my question to both of you would be: Do you track internally what extra services are in fact provided to your Medicare Advantage beneficiaries? Mr. Hotchkiss, do you suppose you could come up with that information? I am not sure you have to now, but——

Mr. HOTCHKISS. Not at this time, but I would be more than happy to respond.

Chairman STARK. But you would have the records, would you not?

Mr. HOTCHKISS. I think we would be able to supply the information.

Chairman STARK. Would United have those, too, as far as you know?

Ms. POLICH. Yes. In most cases we do. We do have some supplemental services that, for example, may be part of a capitation rate to a physician group that we may not be able to track precisely. But yes. In general, yes.

Chairman STARK. I think that, from my own—it would be a lot easier for us to determine the value of the services offered and what we should pay if we had some idea of what were used and what were just offered. So that is an area which I would like more information. And we are not getting it now, routinely at least.

Mr. Camp, did you want to——

Mr. CAMP. Mr. Tiberi has not had a first round yet.

Chairman STARK. I am sorry.

Mr. TIBERI. Mr. Chairman, thank you.

Chairman STARK. Mr. Tiberi, dive in. You go right ahead.

Mr. TIBERI. Thank you. I apologize I didn't get here sooner after votes. I got stopped along the way. I apologize I didn't hear your opening testimony.

But to the panel specifically, and my question is to the two plan participants who are here today, when we were debating and eventually passing the bill earlier this year in the House on SCHIP and where we had the Medicare Advantage cuts, my office, like I am sure most offices, received a number of calls and e-mails and letters from participants, Medicare Advantage participants, in my congressional district. And some of those were generated by Medicare Advantage companies.

And so what I did is I took some of those calls and I called some of those folks who had sent letters and e-mails in. And to a person, I was shocked at the level of understanding and emotional commitment to the new Medicare Advantage plans.

Some of the people that I talked to, constituents—one lady in particular stands out. She said, I used to work for the Federal Government. I used to work for Medicare. I was on Medicare for 10 years. And now I am on a Medicare Advantage plan, and it is the best thing that has ever happened to me with respect to my health care. A pretty knowledgeable person with respect to Medicare and the way it worked.

Do you all—and really in concert to the chairman's question—do you all internally have a system in place, to the two plan participants here, that tracks either complaints or customer/client comments explaining how they feel about the program, pro or con?

Ms. POLICH. Yes. Yes, in fact, we do, both complaints that come in through our customer service as well as our physician offices, complaints that come in to us from external organizations, like state insurance commissioners or CMS. So we track all those complaints, follow up on them, track them, investigate them, and work very diligently to resolve them on behalf of our members.

Mr. TIBERI. Just to follow up, and then I will go to the next participant, do you have any positive comments that come in? And why I am—I know that people are speaking with their feet obviously by saying, I am going to choose your plan rather than these 20 other plans that may be offered to me. But do you have any other way of showing to you the quality customer assurance program or anything like that?

Ms. POLICH. Absolutely. I get letters, and actually, this is part of what really motivates me every day, is I get letters from members all the time telling me about how their membership in Secure Horizons plans have saved their life—the money that they have saved, the quality of care that they have gotten.

So yes, we do get positive feedback, which is always greatly appreciated. But also, as I say, we also have members that are having problems or concerns, and we take those very seriously as well.

Mr. TIBERI. Mr. Hotchkiss?

Mr. HOTCHKISS. I would have to agree with what she has said, that we do have policies in place that focus on customer satisfaction. Good or bad, we follow up. So I think in general, Humana does a strong job of following up with the customer.

Mr. TIBERI. Do both of you have any idea what percentage of beneficiaries that you represent were before on the fee-for-service program versus new participants to Medicare, meaning have switched? Like my mom and dad were on Medicare fee-for-service and switched to an Advantage plan, rather than maybe a person who is just qualifying for Medicare and went straight to a Medicare Advantage plan?

Mr. HOTCHKISS. I don't know the number that have switched over to an MA plan. But I know that the members that have switched over, 99 percent are still on that MA plan. So they are happy. They enjoy it. It is their choice, not ours, and they have chosen that MA plan.

Mr. TIBERI. Same question.

Ms. POLICH. Yes. I could not give you the exact numbers, but we do surveys. And so I can take that question for the record around where our members are coming from. And the last data that I saw did suggest that there was a nice mix of members that are coming in from fee-for-service that are aging into the program, as well as those are switching from Medicare supplement or possibly another Medicare Advantage plan. So we see members coming from all of those areas.

Mr. TIBERI. Thank you. Thank you, Mr. Chairman.

Mr. CAMP. Thank you, Mr. Chairman.

Dr. Asner, I appreciate the direction that your testimony took in evaluating the Medicare Advantage plans and actually comparing them to traditional fee-for-service, not just in terms of the cost to the Federal Government or the taxpayer, but the cost to the beneficiary, who often are taxpayers as well. And you mentioned a couple of factors.

Could you just sort of outline that for us again?

Dr. ASNER. Sure. I think when you look at this from the beneficiary's point of view, there are a number of factors that are savings for the beneficiary. As an example, the coinsurance that fee-for-service, traditional fee-for-service, Medicare beneficiaries have to pay is not an issue in Medicare Advantage. There are Medigap policies that they pay for as individuals. That is not an issue in Medicare Advantage as well.

And then in the drug benefit area, if you have traditional Medicare, there is an enormous doughnut hole that we all know about. And in Medicare Advantage, those drugs are covered for those beneficiaries in most cases. In addition, all of the programs that we are providing to coordinate the care of these patients don't exist in the traditional fee-for-service arena.

So they are getting enhanced benefits. We also talked earlier about the vision, the dental, the chiropractic benefits. These are benefits that don't exist for the traditional fee-for-service.

Mr. CAMP. Limits in out-of-pocket costs, for example, in Medicare Advantage programs?

Dr. ASNER. In our experience in California, the limits on out-of-pocket are lower than they are in traditional Medicare.

Mr. CAMP. The other point that you make, too, is the whole direction that medicine is taking, and that is to coordinate care, particularly as we see seniors having several chronic conditions. And you mentioned in your testimony the coordinating of medical and

drug therapies, for example, as really bringing efficiencies to the system. And we talked earlier a little bit about health IT.

Could you elaborate on those just a bit?

Dr. ASNER. Well, let me tell you a story that maybe will illustrate this very well. I will tell you the story of an 88-year-old woman who was an Orange County patient visiting in Los Angeles. And she had a mild stroke, and got admitted to one of the finest institutions in Los Angeles.

She ended up seeing a cardiologist and a neurologist. The only problem was this was out of area, so it was in the fee-for-service realm that first day. They made rounds at 12:00 midnight and 12:00 noon, so they never talked to each other. She was put on a medication that actually could have been fatal for her.

We moved her back immediately to Orange County. She came into our coordinated system. She had the nurse care manager there. She had our hospitalist there. And they discovered this problem immediately, took her off that medicine, and frankly, probably saved her life.

And these are anecdotes, I am sure. But frankly, we see this all the time. The coordination, the intensity with what we pay attention to the needs of these patients, inpatient, outpatient, preventing them falling through the cracks as they leave the hospital and go home, these are huge, huge benefits to the beneficiaries.

When our patients leave the hospital, we know that they are going to sometimes forget to get their drugs, be confused, not get their equipment that they need. We have nurses who make sure by guiding them through that system, calling them to make sure that they are following through and getting those things.

That prevents these patients from getting sicker. It prevents them from having to be readmitted to the hospital. These are all very, very important issues. So that is what we mean by coordination of care. And it takes programs. It takes IT systems to know who these patients are and know what interventions need to be accomplished.

Mr. CAMP. Particularly, I think, when you see many seniors don't have a family member or advocate who can help them through really the intense administrative side of health care as well, especially as care gets more complicated. So I certainly appreciate your comments there. And I think it is something that we certainly want to look forward to.

I guess with that, Mr. Chairman, I appreciate your time. I think—I would be happy to yield to you, or do you want your own time? I am done with my time, Mr. Chairman. I think Mr. Hulshof would like to question as well.

Chairman STARK. Go ahead, Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman. I appreciate your generosity in allowing this time. And again, I appreciate some of the statements that you have made, Mr. Chairman, about trying to focus. I mean, when you consider the number of senior citizens that now depend upon Medicare, when you look down the road not that much further, I mean, the number of senior citizens that will be dependent upon Medicare is going to be a staggering number, nearly 78 million. And we are living longer, which is a good thing.

Thank you, Dr. Asner, on behalf of all medical people for helping make that happen.

And I guess I have kind of a Pollyanna-ish point of view about Medicare, is that if we can focus on the quality of the health care provided to the beneficiary, not only is the senior citizen going to be in better personal health, but the system itself is going to be in better financial health. And so that is why, in a bipartisan way, we focus on wellness, and prevention, and early screening for colorectal cancer, and a host of other things.

Along that line, Dr. Asner, here is my question. Last year Congress passed a bill that implemented a program that actually would provide physicians with a bonus payment, if you will, if physicians reported some quality measures to CMS. Personally, I thought this was a good first step because if we are going to go—if we go in the direction of pay for performance, this was one of the ways to do that.

Now, that is my point of view, and I know there are differing points of view. But for instance, an earlier bill that we considered here on this committee repealed that provision. In your view, is repealing that bonus payment to report quality initiatives, is that good thing to repeal it? Or should we maybe rethink that in the future?

Dr. ASNER. I would strongly encourage you to continue the pay for performance program in fee-for-service Medicare.

Mr. HULSHOF. Why?

Dr. ASNER. There is no question in my mind that you need to have physicians paying attention, especially in the fee-for-service arena, to quality metrics. The initial step is to tell them what they need to be measured on and then have them report on that, which is what has begun.

And those metrics have actually taken hold. I actually sit on a committee that works with the AMA to help them understand California's expertise in this area. And as I said earlier, measurement of these metrics does improve performance. We have seen that in California. We have seen the clinical improvements.

So I do believe that we need to do that. There is much more of a challenge in fee-for-service Medicare because the individual physician doesn't have the systems in his or her office to even do the reporting. You ought to ask the question about how many physicians were reporting. The numbers are not as high as they should have been.

And it is not the fault of the physicians. It is really a problem with the system. It is difficult to report on these types of metrics off of your paper charts and your office computer. Most of the offices aren't set up for that.

In California, we have invested in the type of technology and infrastructure to report on our metrics. But again, those are the IT investments that I talk about that medical groups have made. We need to have that everywhere in this country. We need individual physicians to be measured. Physicians don't mind being measured. Physicians have been measured their entire life. Through all of their schooling, they were measured and they got good grades. They want that. We can actually influence physician behavior. If we tell them what we expect of them, they will perform.

Mr. HULSHOF. Thank you, Mr. Chairman.

Chairman STARK. Mr. Tiberi.

Mr. HULSHOF. Thank you, Mr. Chairman, for your indulgence.

One last question, Dr. Asner. I am convinced, in talking to my constituents and physicians, that there is a benefit to the Medicare Advantage program. However, the critics would say that it costs more money and it creates a higher unfunded liability in the Medicare system that, with baby boomers getting ready to retire, is going to create greater unfunded liability.

In your estimation, having dealt with both long-term, what is your sense of measuring Medicare Advantage costs long-term versus fee-for-service Medicare long-term going to do to the unfunded liabilities?

Dr. ASNER. Well, obviously I am not an economist. But I can tell you that there is no question that high quality care is cost-effective care. And as we approach the baby boomers coming in 2011, I am very concerned about what that is going to do to our Medicare system if those patients don't have the benefits of Medicare Advantage.

If we don't focus on prevention, coordination of care, and quality care, I think the system will collapse under the economics that we will face in the future. I am not yet a senior citizen, but I am a baby boomer. When the time comes for me, I want to be in that system from a quality perspective. And I do know from our experience that is the most cost-effective way to take care of patients and provide the best quality. And those two go hand in hand.

Mr. HULSHOF. But which?

Dr. ASNER. Medicare Advantage.

Mr. HULSHOF. Why?

Dr. ASNER. As I said, if you focus on prevention, then you are going to diminish the number of complications for patients with heart disease, diabetes, obesity. All of these are coming. And we focus on that. And at least 85 percent of the cost of the system is, as we heard earlier, in about 15 percent of the Medicare Advantage patients. And those are the patients with chronic disease.

We need to make sure we keep those people well, avoid complications, keep them out of the hospital. That we do in Medicare Advantage. In Medicare fee-for-service, the incentive is, frankly, pay for volume. The more you do as a physician, the more you get. That is not the incentive that we want to have in place as we have the baby boomers aging into Medicare.

Mr. HULSHOF. Thank you, sir.

Chairman STARK. Mr. Precht, isn't it your understanding that most of the Medicare Advantage drug plans do not cover pharmaceuticals in the doughnut hole except for some inexpensive drugs? Is that not correct?

Mr. PRECHT. That is correct.

Chairman STARK. Okay. I just wanted to set that record straight, that it is a rare—other than generics, there are very few plans that cover. That has been suggested several times that the case was otherwise, and set that record straight.

Dr. Asner, you refer in your testimony, and I don't know whether I think it is an error or cute, but that 90 percent of Medicare beneficiaries have access to a Medicare Advantage plan with a $2500

cap on out-of-pocket costs. And that might be a reference to regional PPOs. But fewer than one-half of one percent of Medicare Advantage beneficiaries actually are enrolled in that kind of plan.

So there is a world of difference between the 90 percent who have access to those plans and the half of one percent who are enrolled in them. And I just thought I—from the standpoint of accuracy.

But there are different plans. And while most members in Medicare plans do not now have a cap on out-of-pocket costs, would you support a cap on out-of-pocket costs for all plans?

Dr. ASNER. For Medicare Advantage programs?

Chairman STARK. Yes.

Dr. ASNER. Oh, I would support a cap on out-of-pocket expenses.

Chairman STARK. Good. I think that is—in our recent bill that we just passed, I think we had that in there, didn't we? A rule that they couldn't pay more than—charge more than the Medicare deductibles or copays. In other words, many plans, while they have a lower premium, might charge $500 a day for a hospital copay, where Medicare would charge $900 and change for the whole encounter. So if you are in the hospital three or four days, you are doubling the cost of what you would pay under fee-for-service.

We had suggested in that bill that the plans could charge no higher a copay or deductible than fee-for-service Medicare. And I presume that you would be agreeable with that as well.

Dr. ASNER. As you know, we don't design the benefits. The plans do. So I know you are referring to the plans.

Chairman STARK. Yes.

Dr. ASNER. But I have been in discussions with plans over benefits, and it seemed to me that at least in our market in Southern California, they are well aware of trying to keep the benefit cost to the beneficiary below fee-for-service Medicare.

Chairman STARK. Well, as I say, I thank the panel, reminding them that the purpose of the hearing was not to suggest that Medicare Advantage plans, perhaps with the exception—maybe, Dr. Asner, would you care to comment on the difference? Because I suspect you are—either a staff model or HMO plans that mostly you are referring to in Southern California.

What has been your experience with the private fee-for-service plans?

Dr. ASNER. That is a great question. We actually are an organization of physicians who are private practice, so our physicians are independent. We don't employ them. And in our organization, we don't have any experience with the private fee-for-service plans. In fact, when I talk about Medicare Advantage and the coordination of care, that is what I am referring to, our type of coordinated care plan.

Chairman STARK. Or a staff model like——

Dr. ASNER. My understanding is in private fee-for-service there is no coordination of care.

Chairman STARK. Or staff model plans like——

Dr. ASNER. Well, and again, staff models have the coordination of care as well. But I am not referring in any of my testimony to the private fee-for-service component.

Chairman STARK. Thank you for that clarification.

Again, I want to thank all of you for your patience and your willingness to participate. I will look forward both to Mr. Hotchkiss and Ms. Polich giving me some idea of whether there is a great difference in profits between the commercial book and the private—well, actually, private fee-for-service where you have it, and the other Medicare Advantage plans.

Because what we are really trying to determine here is not whether—I think we would all stipulate that managed care plans are beneficial as a delivery system for medical services. The question is: How do we pay for it, and how much should we pay? And that is the road we have to go down.

Thank you all for your participation. The hearing is adjourned.

[Whereupon, at 2:25 p.m., the subcommittees were adjourned.]

[Questions for the Record follow:]

CHARLES B. RANGEL, NEW YORK,
CHAIRMAN

FORTNEY PETE STARK, CALIFORNIA
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ALLYSON Y. SCHWARTZ, PENNSYLVANIA
ARTUR DAVIS, ALABAMA

JANICE MAYS,
CHIEF COUNSEL AND STAFF DIRECTOR

Congress of the United States
U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

JIM McCRERY, LOUISIANA
WALLY HERGER, CALIFORNIA
DAVE CAMP, MICHIGAN
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DEVIN NUNES, CALIFORNIA
PAT TIBERI, OHIO
JON PORTER, NEVADA

BRETT LOVER,
MINORITY STAFF DIRECTOR

November 2, 2007

Timothy B. Hill
Chief Financial Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mailstop C3-01-24
Baltimore, MD 21244-1850

Dear Mr. Hill:

Please provide answers to the following Questions for the Record from the 10/16/2007 Joint Health and Oversight Subcommittee Hearing on Oversight and Accountability in the Medicare Advantage Program:

Questions from Chairman Lewis

1. What is the personnel make-up of the CMS Office of the Ombudsman? What is the budget for the Office of the Ombudsman?

2. Has CMS contemplated any changes to the website or other information portals providing the phone number or contact information for the Office of the Ombudsman?

Questions from the Honorable Lloyd Doggett

1. CMS's Inability to Account for Millions Paid to Private Medicare Plans

In May 2007 the GAO reported that CMS paid $100 million to private Medicare Part D plans for retroactive coverage for dual eligibles, despite the fact that CMS did not inform beneficiaries of their right to seek reimbursement for drug costs incurred during these periods. The GAO reported that "CMS does not monitor its payments to PDPs for retroactive coverage or the amounts PDPs have reimbursed dual-eligible beneficiaries."

In response to my question to CMS at the June 21 hearing about whether CMS would be able to track these payments, CMS delivered a written reply on October 17, the day after the hearing, stating "CMS is currently in the process of tracking these retro-active

enrollments and will use this information to determine how many months of retroactive coverage the Agency is providing to new dual-eligible individuals." CMS testified on October 16 that the reconciliation process necessary to track how this money was used is, in fact, complete. Several questions are outstanding:

(b) Does CMS already know how many months of retroactive coverage were provided since it paid $100 million dollars to plans for that retroactive coverage?
(c) How many months of coverage were provided?
(d) How many people were retroactively enrolled?
(e) How many of the new dual eligible beneficiaries who were retroactively enrolled were already in a Part D plan before they were awarded dual eligible status?
(f) How have you verified that the plans in which people were already enrolled reimbursed those beneficiaries for the copayment amounts they paid over the limit of that owed by a dual eligible?
(g) For those who were not already enrolled in a Part D plan during the period of retroactive coverage, how many people submitted claims to their new plan for drugs purchased during the retroactive coverage period?
(h) How much did plans pay out in benefits for all retroactively enrolled dual eligibles for which Part D plans received $100 million?

2. Ensuring Consumers Have Access to a Fair and Timely Appeals Process

(a) Do you require MA, MA-PD, and PDP bids to have a line item under administrative costs demonstrating that they have dedicated enough funding to appropriately handle appeals?
(b) What specific steps does CMS take to ensure plans have an appeals process in place that complies with statutory requirements?
(c) Are plans allowed to simply attest that they have an appeals process without providing further detail to demonstrate this is the case?

3. CMS's Failure to Update Consumer Report Cards on Medicare.gov

The Corrective Action Plans (CAPs) available on CMS's website show that Humana's Regional PPO contract number R5826 has 18 pending CAPs for deficiencies in its appeals processes (Chapter 13: Grievances, Coverage Determinations, and Appeals). Though the CAPs for Humana R5826 were issued July 31, 2007, as of October 24, 2007 on Medicare.gov that same contract number in Texas shows that the plan has three out of three stars – a perfect score – on appeals. When will CMS remove stars for this and other poor-performing plans so that beneficiaries can make decisions based on accurate information?

4. CMS's Failure to Reply to Request for Comments on Prescription Coverage Now Act

Nearly six months have passed since I requested at the May 3, 2007 hearing that CMS inform me of any specific objections it had to the Prescription Coverage Now Act, legislation I have introduced with 170 cosponsors to improve Medicare Part D for low-income beneficiaries. I have still not received comments on that legislation. You said you are working with other agencies to provide technical and policy comments. When will those comments be ready?

5. Incomplete Reply on Marketing Abuses Request

As follow-up to a May 22 hearing on Private Fee-for-Service Marketing Abuses at which Abby Block testified, I submitted the following question to CMS: "1. Please provide us with specific documentation of the process by which CMS identified and acted to curb marketing abuses. Include the number of complaints, all corrective action plans against specific plans and a full detail of other intermediate sanctions levied against plans for marketing abuses. Also provide any interagency memos or reports detailing the extent of abusive marketing practices and possible solutions to the problem."

The documents provided by CMS in response to this question did not include a single e-e-mail or memo to or from Ms. Block, who runs the Center on Beneficiary Choices. This is surprising since Ms. Block testified on May 22 that it is this Center that she heads that that receives and handles complaints, and is responsible for administering both the Medicare Advantage and the Medicare prescription drug program. On October 16, CMS testified that Ms. Block does indeed communicate by e-mail. I therefore request that CMS supplement its Sept. 21 reply to include these communications, which should have already been provided.

Question from the Honorable Earl Pomeroy

At the hearing you alluded to the fact that there are approximately 500 people within CMS overseeing Medicare Advantage marketing practices. Please provide the Committee with verification of these 500 staff members and an accounting of what percent of time each is engaged in monitoring marketing practices and enforcing regulations. For example, are these 500 people working full-time or part-time to monitor Medicare Advantage marketing practices? If they are working part-time, how much of their time is devoted to Medicare Advantage oversight? Does their work on Medicare Advantage oversight detract from their routine work? If so, what is their routine work?

Moreover, at a previous Health Subcommittee hearing on May 22, 2007 on Private Fee-For-Service plans I asked, in a Question for the Record, "How many FTEs were added at CMS regional offices to review advertising and other marketing materials of PFFS plans". CMS responded by saying that "The rapid growth in PFFS plans is not something that was anticipated, which would have been required in order to add FTEs for this specific purpose", the response went on to state "Based on information available, we

cannot state that new FTEs were added to the CMS workforce specifically for the purpose of PFFS plan reviews".

Given CMS's response above and the fact that you now know that the PFFS product is growing at an exponential rate, are there any plans to hire new staff to deal with Medicare Advantage marketing and oversight?

Additional Written Questions from the
W&M Joint Health and Oversight Subcommittee Hearing
On Oversight and Accountability in the
Medicare Advantage Program
October 16, 2007

Questions from Chairman Lewis

1. **What is the personnel make-up of the CMS Office of the Ombudsman? What is the budget for the Office of the Ombudsman?**

Answer: The Office of the Ombudsman employs 34 full time equivalent employees. For fiscal year 2007, the operating budget for the office was as follows:

Travel:	$13,000
Training:	$2500
Awards:	$19,000
Supplies:	$1400
Contracts:	$1,677,600

2. **Has CMS contemplated any changes to the website or other information portals providing the phone number or contact information for the Office of the Ombudsman?**

Answer: The Medicare Beneficiary Ombudsman works within the Medicare program to identify and resolve system-wide issues impacting people with Medicare and to bring about changes that could help prevent future problems. Unlike some other Ombudsmen that people may be familiar with, the Medicare Beneficiary Ombudsman is not intended to be the initial contact for information and complaints. There are several points of contact in the Medicare program for individual questions, complaints, and grievances such as 1-800 MEDICARE and medicare.gov on the web. In addition, there is a function within the 'Frequently Asked Questions' section of medicare.gov that provides the opportunity for beneficiaries to submit their questions or complaints. People with Medicare and those acting on their behalf can also contact entities such as the State Health Insurance Assistance Programs (SHIPs) and CMS Regional Offices for assistance with their individual questions, complaints, and grievances.

Nonetheless, the Office of the Medicare Ombudsman (OMO) does respond to many of the beneficiary inquiries and complaints that are initially received by the CMS Central Office (whether through 1-800 MEDICARE, through a Regional Office, or through other channels). For example, in instances where the 1-800 MEDICARE customer service representatives cannot handle a caller's request for information or complaint, the call can be forwarded to the OMO.

Questions from the Honorable Lloyd Doggett

1. CMS's inability to Account for Millions Paid to Private Medicare Plans

In May 2007, the GAO reported that CMS paid $100 million to private Medicare Part D plans for retroactive coverage for dual eligibles, despite the fact that CMS did not inform beneficiaries of their right to seek reimbursement for drug costs incurred during these periods. The GAO reported that "CMS does not monitor its payment to PDPs for retroactive coverage or the amounts PDPs have reimbursed dual-eligible beneficiaries."

In response to my question to CMS at the June 21 hearing about whether CMS would be able to track these payments, CMS delivered a written reply on October 17, the day after the hearing, stating "CMS is currently in the process of tracking these retroactive enrollments and will use this information to determine how many months of retroactive coverage the Agency is providing to new dual—eligible individuals." CMS testified on October 16 that the reconciliation process necessary to track how this money was used is, in fact, complete. Several questions are outstanding:

(a) Does CMS already know how many months of retroactive coverage were Provided since it paid $100 million dollars to plans for that retroactive coverage?

Answer: No, but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(b) How many months of coverage were provided?

Answer: This is not a question to which we currently have an answer but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(c) How many people were retroactively enrolled?

Answer: This is not a question to which we currently have an answer but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(d) How many of the new dual eligible beneficiaries who were retroactively enrolled were already in a Part D plan before they were awarded dual eligible status?

Answer: This is not a question to which we currently have an answer but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(e) How have you verified that the plans in which people were already enrolled reimbursed those beneficiaries for the copayment amounts they paid over the limit of that owed by a dual eligible?

Answer: Medicare Part D plan sponsors have an obligation to reimburse their members (or another payer) for costs incurred retroactively. However, to fully analyze this question would require the use of prescription drug event (PDE) data. PDE data are collected pursuant to section 1860D-15(f)(1) of the Social Security Act. Section 1860D-15(f)(2) restricts the use of these data solely for CMS payment to plans. Consequently, consistent with longstanding interpretation of similar statutes by the Office of Legal Counsel within the Department of Justice, we would be unable to disclose that information.

(f) For those who were not already enrolled in a Part D plan during the period of retroactive coverage, how many people submitted claims to their new plan for drugs purchased during the retroactive coverage period?

Answer: To fully analyze this question would require the use of prescription drug event (PDE) data. PDE data are collected pursuant to section 1860D-15(f)(1) of the Social Security Act. Section 1860D-15(f)(2) restricts the use of these data solely for CMS payment to plans. Consequently, consistent with longstanding interpretation of similar statutes by the Office of Legal Counsel within the Department of Justice, we would be unable to disclose that information.

(g) How much did plans pay out in benefits for all retroactively enrolled dual eligibles for which Part D plans received $100 million?

Answer: To fully analyze this question would require the use of prescription drug event (PDE) data. PDE data are collected pursuant to section 1860D-15(f)(1) of the Social Security Act. Section 1860D-15(f)(2) restricts the use of these data solely for CMS payment to plans. Consequently, consistent with longstanding interpretation of similar statutes by the Office of Legal Counsel within the Department of Justice, we would be unable to disclose that information.

2. **Ensuring Consumers Have Access to a Fair and Timely Appeals Process**

(a) Do you require MA, MA-PD, and PDP bids to have a line item under Administrative costs demonstrating that they have dedicated enough funding to appropriately handle appeals?

(b) What specific steps does CMS take to ensure plans have an appeals process in place that complies with statutory requirements?

(c) Are plans allowed to simply attest that they have an appeals process without providing further detail to demonstrate this is the case?

Answer:

(a) No. CMS does not require MA, MA-PD, and PDP bids have a line item demonstrating they have adequate dedicated funding to appropriately handle appeals. See below for description of CMS requirements for plan appeal processes.

(b) Monitoring compliance with appeals requirements is a key feature of our MA and Part D plan audit guides, and we have implemented many compliance action plans based on appeals-related audit findings. In addition, we monitor plan appeals data (including both first level appeals at the plan and the independent second level reconsiderations done by MAXIMUS as another appeals performance measure. Based on the MAXIMUS data, we have initiated a series of performance improvement programs at plans that have unusually high rates of cases overturned at the MAXIMUS level.

In addition, our audit guide provides for audits of appeals processes. We take samples from Medicare Advantage Organizations (MAOs) to determine if they are processing appeals correctly. We do not require attestations because we actually test this area through the Targeted Appeals Monitoring Strategy (TAMS). The TAMS score has been calculated annually since 2003 for all MAO contractors using measuring adherence to statutory timeliness requirements, congruence with the independent review entity's evaluation, and member satisfaction survey information regarding access to information and processes to make appeals. Review of the TAMS score is a review element in the MA audit in addition to review of actual appeals cases.

(c) There are a number of ways in which CMS documents that plans have appeals procedures in place. As noted above, both MA and Part D audits include appeals components that document not only that appeals are being carried out but also whether or not plans are complying with key appeals-related requirements, such as the regulatory timeframes and notice requirements. We also track Part D appeals through our complaint tracking monitoring system, which includes a specific category on this topic.

3. **CMS's Failure to Update Consumer Report Cards on Medicare.gov**

The Corrective Action Plans (CAPs) available on CMS's website show that Humana's Regional PPO contract number R5826 has 18 pending CAPs for deficiencies in its appeals processes (Chapter 13: Grievances, Coverage Determinations, and Appeals). Though the CAPs for Humana R5826 were issued July 31, 2007, as of October 24, 2007 on Medicare.gov, that same contract number in Texas shows that the plan has three out of three stars – a perfect score – on appeals. When will CMS remove stars for this and other

poor-performing plans so that beneficiaries can make decisions based on accurate information?

Answer: The information that is provided for consumers to help them choose a Medicare Advantage (MA) plan, MA-PD, or Prescription Drug Plan (PDP) was updated as of November 15, 2007 for the Annual Election Period. The information on the Medicare Part C compare tool (Medicare Options Compare) and the Part D compare tool (Medicare Prescription Drug Plan Finder) was expanded to include additional quality and performance measures, to create composites to summarize the performance and quality information and make the information more accessible to users of the site. Additionally, all of the composites and individual measures have 5 star ratings where 1 is poor performance and 5 is excellent performance.

On www.cms.hhs.gov for R5826 there are 18 corrective action plans listed for Humana. Out of the 18, 17 relate to Part D. On www.medicare.gov (the consumer site), there are two Part D performance measures that relate to appeals. One measure captures delays in appeals decisions. Humana received one star for this measure. The other measure focuses on reviewing appeals decisions. Humana had insufficient data to report this measure. The current information on the consumer site is consistent with the information that is available on www.cms.hhs.gov regarding appeals.

4. **CMS's Failure to Reply to Request for Comments on Prescription Coverage Now Act**

Nearly six months have passed since I requested at the May 3, 2007 hearing that CMS inform me of any specific objections it had to the Prescription Coverage Now Act, legislation I have introduced with 170 cosponsors to improve Medicare Part D for low-income beneficiaries. I have still not received comments on that legislation. You said you are working with other agencies to provide technical and policy comments. When will those comments be ready?

Answer: CMS has worked actively on this issue since first requested, and we continue to work with other agencies to develop technical and policy comments on the legislation. Once those comments have been fully vetted and cleared, we will be in a position to provide them to your staff.

5. **Incomplete Reply on Marketing Abuses Request**

As follow-up to a May 22 hearing on Private Fee-for-Service Marketing Abuses at which Abby Block testified, I submitted the following questions to CMS: "1. Please provide us with specific documentation of the process by which CMS identified and acted to curb marketing abuses. Include the number of complaints, all corrective action plans against specific plans and a full detail of other intermediate sanctions levied against plans for marketing abuses. Also provide any interagency memos or reports detailing the extent of abuse marketing practices and possible solutions to the problem."

The documents provided by CMS in response to this question did not include a single email or memo to or from Ms. Block, who runs the Center on Beneficiary Choices. This is surprising since Ms. Block testified on May 22 that it is this Center that she heads that receives and handles complaints, and is responsible for administering both the Medicare Advantage and the Medicare prescription drug program. On October 16, CMS testified that Ms. Block does indeed communicate by e-mail. I therefore request that CMS supplement its Sept. 21 reply to include these communications, which should have already been provided.

Answer: Information responsive to this request would be provided to the Chairman and Ranking Member under separate cover, and should not be reproduced as part of the public record, or otherwise published or made public. These documents may contain information protected or prohibited from public disclosure under the Freedom of Information Act (Title 5, United States Code [U.S.C.] section 552), the Trade Secrets Act (Title 18, U.S.C. section 1905), the Privacy Act (Title 5, U.S.C. section 552a), and/or Department regulations.

Question from the Honorable Earl Pomeroy

At the hearing you alluded to the fact that there are approximately 500 people within CMS overseeing Medicare Advantage marketing practices. Please provide the Committee with verification of these 500 staff members and an accounting of what percent of time each is engaged in monitoring marketing practices and enforcing regulations. For example, are these 500 people working full-time or part-time to monitor Medicare Advantage marketing practices?

Answer: Following the enactment of Medicare Prescription Drug Benefit (Part D) with the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS initiated an aggressive strategy to implement the program and provide benefit information to our beneficiaries. A key part of our implementation strategy included the development of an integrated effort to ensure the accuracy and integrity of plan payments, to oversee plan compliance with regulations and other requirements (including marketing guidelines), and to protect beneficiaries. This comprehensive program oversight effort included bid reviews, ongoing compliance monitoring of plans, post-contract bid audits and post-contract financial audits.

The implementation of this comprehensive oversight strategy required the involvement of multiple CMS components and over 500 staff members. The Part C and Part D Actuarial Group administer the bid review process and audits. The ongoing administration and monitoring of the Medicare Advantage and Medicare Prescription Drug Plans compliance with Federal requirements is performed by central office staff in the Center for Beneficiary Choices and regional office staff across the country. The financial audits of one-third of the plans are coordinated by the Office of Financial Management.

CMS maintains a strong commitment to protecting our beneficiaries and taxpayer dollars and ensuring the sound financial management of the Medicare and Medicaid programs. We have taken significant actions to implement our programs and to strengthen our oversight efforts.

We will continue to monitor and assess our efforts to oversee the Medicare Advantage and Medicare Prescription Drug Plans and will work to deploy our CMS resources in the most efficient manner.

Moreover, at a previous Health Subcommittee hearing on May 22, 2007 on Private Fee-For-Service plans I asked, in a Question for the Record, "How many FTEs were added at CMS regional offices to review advertising and other marketing materials of PFFS plans". CMS responded by saying that "The rapid growth in PFFS plans is not something that was anticipated, which would have been required in order to add FTEs for this specific purpose", the response went on to state "Based on information available, we cannot state that new FTEs were added to the CMS workforce specifically for the purpose of PFFS plan reviews".

Given CMS's response above and the fact that you now know that the PFFS product is growing at an exponential rate, are there any plans to hire new staff to deal with Medicare Advantage marketing and oversight?

Answer: CMS hiring is bound by the budget process. CMS manages the Medicare Advantage (MA) program, including marketing and oversight activities, under its program management budget (PM) and FTE allocation. For FY 2008, the CMS PM budget was funded at $3.152 billion by the Congress, or $122.3 million less than the FY 2008 President's Budget request. The Congress did not provide the $183 million requested in FY 2008 for a discretionary Health Care Fraud and Abuse Control, a portion of which was specifically targeted for MA. MA plan oversight is a high priority.

CHARLES B. RANGEL, NEW YORK,
CHAIRMAN

FORTNEY PETE STARK, CALIFORNIA
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ARTUR DAVIS, ALABAMA

JANICE MAYS,
CHIEF COUNSEL AND STAFF DIRECTOR

Congress of the United States
U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

JIM McCRERY, LOUISIANA
WALLY HERGER, CALIFORNIA
DAVE CAMP, MICHIGAN
JIM RAMSTAD, MINNESOTA
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JON PORTER, NEVADA

BRETT LOPER,
MINORITY STAFF DIRECTOR

November 2, 2007

Harry Hotchkiss
Senior Products Actuarial Director
Humana, Inc.
500 W. Main Street
Louisville, KY 40202

Dear Mr. Hotchkiss:

Please provide answers to the following Questions For the Record from the 10/16/2007 Joint Health and Oversight Subcommittees Hearing on Oversight and Accountability in the Medicare Advantage Program:

Questions from Chairman Stark

1. Please provide information on how much of Humana's $500 million profit in 2006 was contributed by payments from Medicare Advantage plans.

2. A report by a CIBC World Markets analyst, which was provided to you at the hearing, indicates that Humana's medical loss ratio in private fee-for-service MA plans is 150 basis points better than it is in Humana's HMO plans. Could you please respond to this report?

   - Would this indicate that all of the additional reimbursement that Humana is receiving for its private fee-for-service plans is spent on additional benefits?

3. At the hearing you indicated that Humana has the ability internally to track which extra benefits are used by Medicare Advantage beneficiaries; is this correct?

   - Could you please provide the Committee with the dollar value of the extra benefits that were actually used by Medicare Advantage beneficiaries enrolled in each of your plans for each of the last 2 plan years?

Hotchkiss Questions for the Record
Questions from Chairman Stark

1. **Please provide information on how much of Humana's $500 million profit in 2006 was contributed by payments from Medicare Advantage plans.**

   For calendar year 2006, Humana's consolidated revenues totaled 21.1 billion (excluding investment income). Of that amount, earnings before net investment income and taxes totaled $533 million. Of that amount, earnings related to Medicare totaled $339 million reflecting a Medicare operating margin of 2.9%.

2. **A report by a CIBC World Markets analyst, which was provided to you at the hearing, indicates that Humana's medical loss ratio in private-fee-for-service MA plans is 150 basis points better than it is in Humana's HMO plans. Could you please respond to this report?**

   a. **Would this indicate that all of the additional reimbursement that Humana is receiving for its private fee-for-service plans is spent on additional benefits?**

      First, we note that the CIBC analyst in a follow-up report published on October 9, 2007, reminded investors that: "There is almost no public data available on SG&A *[selling, general & administrative]* ratios by product, however, so this piece of our profitability analysis admittedly relies on nothing more than conversations with industry sources and our best estimates." In fact, the calendar year 2006 medical expense ratio for Humana's Private Fee-for-Service products was only 50 basis points less than the average for our Medicare Advantage products in total. We note that this ratio is affected by the fact that the Medicare Advantage open enrollment period in 2006 extended through June 30, 2006 resulting in less than a year's claims experience on all members.

      Additional reimbursement is targeted for additional benefits, reduced premiums and reduced cost-sharing for beneficiaries. Further, administrative costs include such items as clinical management programs, utilization management, wellness and prevention programs, care coordination programs, customer care programs, provider outreach & education, where applicable—provider contracting, compliance activities, tools to guide member health decisions, etc.

3. **At the hearing you indicated that Humana has the ability internally to track which extra benefits are used by Medicare Advantage beneficiaries; is this correct?**

a. **Could you please provide the Committee with the dollar value of the extra benefits that were actually used by Medicare Advantage beneficiaries in each of your plans for each of the last 2 plan years?**

We have examined ways in which we might be able to provide this information. Extra benefits are provided in a number of ways: reduced cost-sharing, reduced premiums and additional services. Due to these various forms of benefits, we cannot provide the information in the format described above.

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JANICE MAYS,
CHIEF COUNSEL AND STAFF DIRECTOR

Congress of the United States

U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS

1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625

Washington, DC 20515-6348

http://waysandmeans.house.gov

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BRETT LOPER,
MINORITY STAFF DIRECTOR

November 2, 2007

Cindy Polich
Senior Vice President
Secure Horizons
UnitedHealth Group
P.O. Box 1459
Minneapolis, MN 55440-1459

Dear Ms. Polich:

Please provide answers to the following Questions For the Record from the 10/16/2007 Joint Health and Oversight Subcommittees Hearing on Oversight and Accountability in the Medicare Advantage Program:

Questions from Chairman Stark

1. At the hearing you indicated that UnitedHealth has the ability internally to track which extra benefits are used by Medicare Advantage beneficiaries; is this correct?

   - Could you please provide the Committee with the dollar value of the extra benefits that were actually used by Medicare Advantage beneficiaries enrolled in each of your plans for each of the last 2 plan years?

2. How many total beneficiaries are in UnitedHealth plans?

   - In the UnitedHealth AARP Prescription Drug Plan?
   - In the UnitedHealth AARP Medicare supplement plan?

SecureHorizons®
by UnitedHealthcare

Cindy Polich
Senior Vice President
3120 Lake Center Drive
Santa Ana, CA 92704
Tel 714-825-5308 Fax 714-825-5016
cindy.polich@phs.com

November 1, 2007

The Honorable Pete Stark
Chairman
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Stark:

At a joint Health and Oversight Subcommittees hearing on October 16, you stated that "AARP tells us that they are not going to sell that [Medicare Advantage plans underwritten by UnitedHealth Group] for more than 100 percent of fee-for-service". I would like to take this opportunity to correct the record, and to clear up any confusion that may have resulted from this statement.

The statement implies that AARP is offering Medicare Advantage plans. This is not accurate. UnitedHealth Group (UHG) and AARP have entered into a trademark license agreement which allows UHG to use the AARP name on its Medicare Advantage plans. The plans are provided through SecureHorizons, one of UHG's businesses, and are underwritten by various of its licensed entities. In addition, the trademark license agreement between AARP and UHG does not define or influence the Medicare payment that our plans receive. The plans using the AARP name will receive the same level of funding as any other Medicare Advantage plan.

I hope this information is useful. Please let me know if you have any questions.

Sincerely,

Cindy Polich
Cindy Polich
Senior Vice President
Secure Horizons

CP/cms

SecureHorizons®
by UnitedHealthcare

December 19, 2007

The Honorable Pete Stark
Chairman
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Stark:

I am pleased to have this opportunity to respond to your questions from the record from the October 16 hearing.

UnitedHealth Group provides products and services to more than 70 million Americans through our various operating divisions. We insure 16 million people through our UnitedHealthcare division, providing health care for employers and individuals. Uniprise, which is our division that provides health care services for Fortune 500 businesses and other large employers and health plans, serves 12 million people.

On the Medicare side 4.1 million Medicare beneficiaries receive their Medicare prescription drug benefits through a UnitedHealth Group stand-alone Part D plan that carries the AARP name. In addition, we have more than 2.6 million Medicare beneficiaries enrolled in AARP Medicare Supplement Plans.

Provided below are data on the extra benefits we provide our Medicare Advantage enrollees as included in our annual bid filings:

- 2006 - $79.14 per member per month
- 2007 - $68.46 per member per month
- 2008 - $85.98 per member per month

These benefits are provided for no additional supplemental A/B premium, and the majority of the value of these benefits is related to reducing FFS cost sharing for A/B services. Consistent with CMS bidding requirements, these values also include an allocation for administrative costs.

Sincerely,

Cindy Polich
Senior Vice President
Secure Horizons

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