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The US has one of the most technologically advanced and highest quality health care systems in the world. However, the rising costs of health care pose an ever increasing economic burden for individuals and the nation. Between 1990 and 2000 total annual national health care expenditures rose nearly $700 billion, to $1.3 trillion. Projections that take into account recent spending patterns indicate that national health care expenditures could reach $2.8 trillion in 2011. As health care costs continue to rise, many individuals and families are experiencing increases in their own costs for health insurance coverage.

At the same time, for many people, access to coverage and services is difficult. The US Census Bureau estimates that in 2001 some 41 million people of all ages had no health insurance coverage from any source. People with existing health problems frequently have difficulty obtaining coverage because insurers typically prefer to enroll only the healthy. Many small employers are still priced out of the health insurance market entirely. Although most older people have Medicare coverage, the Medicare program pays only about 50 percent of a typical beneficiary’s health care costs. The Medicaid program, the most prevalent source of health insurance for people with low incomes, covers about 40 percent of those living below the poverty level, but nearly 31 percent of the poor were uninsured in 2001.

AARP has long advocated comprehensive reform of the US health care system. For example, in response to member requests, in 1993 AARP developed a health care reform proposal called Health Care America, built on AARP’s health care reform principles. Health Care America was a comprehensive proposal incorporating acute and long-term care services, preventive care, outpatient prescription drugs and enhanced public health services. The AARP program featured health insurance coverage for all individuals in the US and reflected other features incorporated in AARP’s health care principles.

However, AARP will support incremental steps that move the system toward fully inclusive access to affordable coverage for acute and long-term care for people of all ages. One example of incremental reform is the State Children’s Health Insurance Program, which was part of the Balanced Budget Act of 1997. It provides state governments with matching funds beyond those available under Medicaid to expand coverage for uninsured children. In some states legislative activity targeted at changing the health care system has increased in the absence of comprehensive reform at the national level.
AARP’s health care principles are designed to guide the association in its efforts to reform the health care system at the national and state levels. The principles do not address every health care reform issue but establish criteria for evaluating and comparing reform proposals. They also guide AARP’s participation in the public debate over health care reform. These principles have assisted AARP in developing specific positions on comprehensive health care reform. AARP recognizes, however, that there are many paths to this goal (see Chapter 7, Long-Term Care, for AARP’s principles on reforming long-term health care).

All individuals have a right to health care services when they need them. The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures access to needed physical and mental health care services for all individuals. Particular consideration should be given to ensuring access for individuals living in rural, low-income and minority communities.

All individuals have a right to access to health care coverage that provides adequate financial protection against health care costs. The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures universal access to health care coverage for all individuals, including those with physical or mental health problems or disabilities. The health care system should be designed to ensure that all individuals have public or private health coverage. The governments should establish a minimum, adequate, defined package of benefits to which all individuals are entitled.

All individuals have a right to high-quality health care. Information about the performance of the health care system (e.g., individual practitioners, institutions and health plans) should be collected, analyzed and made publicly available. This information should address the six domains of quality: safety, effectiveness, the degree to which care is patient-centered and responsive, timeliness, equity and efficiency. Quality assurance programs, such as peer review and professional licensing, should be strengthened and coordinated. Quality improvement should be an integral component of the quality assurance process.

All individuals should have a reasonable choice of health care providers. Access to providers who are knowledgeable about and sensitive to the culture and values of individual patients and to practitioners with appropriate expertise should be assured, especially in health plans with
networks that limit choice of health care providers in order to contain costs or improve quality. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

**Financing of the health care system should be equitable, broadly based and affordable to all individuals.** Government, employers and individuals share the responsibility to participate in health care financing. However, our present method of financing health care should be made fairer and more progressive. Burdensome cost-sharing requirements (e.g., high deductibles, coinsurance or copayments) should be avoided because they disproportionately affect the poor and those with chronic and severe health problems. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. The method of administering subsidies should preserve the dignity of the individual, regardless of income level.

**Methods of provider reimbursement should promote high-quality medical care and efficient service delivery and compensate providers fairly.** All payers should work to ensure that providers are compensated through equitable, timely and fair reimbursement arrangements; provider reimbursement should not vary dramatically in a given geographic area.

**Health care spending should be more rational and support the goals of more efficient planning, budgeting and resource coordination.** The distribution and allocation of health care resources (e.g., capital, technology and personnel) should encourage innovation, efficiency and cost-effectiveness and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources. Funding sources should not be a barrier to the creation of a seamless system of coordinated care.

**Health promotion and disease prevention efforts should be strengthened.** The public health system should be strengthened to ensure the public’s health, safety and well-being. Public health efforts should increase citizen understanding and awareness of health, environmental and safety issues and improve access to primary and preventive care services. Public health efforts should encompass research on health, environmental and safety issues as well as the coordination, collection and dissemination of public health information. The public health system should protect the public’s health through surveillance of health problems and enforcement of health, environmental and safety standards.

**Individuals share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive**
measures to protect their health, safety and well-being. The government, health care providers, employers and consumer organizations should educate the public about health and health care. Individuals have a responsibility to adopt healthy behaviors. Incentives to promote healthy behavior should be encouraged as long as they do not deny access to health care.

Acute, chronic, and long-term care services should be coordinated and integrated to ensure a continuum of care throughout an individual’s lifetime.
THE HEALTH CARE SYSTEM

Background

Transformation of the Health Care System

The nation’s health care system has been undergoing massive changes over the last two decades. The driving force behind this transformation was escalating health care costs, which grew an average of 12 percent annually during the 1980s. As a result, in the 1990s many policymakers in both the private and public sectors began to embrace market competition as a way to transform the health care system.

Competition among health plans and insurers to maintain or gain market share and to offer new managed care products marked the 1990s. Health plans largely replaced traditional indemnity insurance plans with managed care plans and fee-for-service payment with fixed payments for each enrollee. The goal of these changes was to limit cost increases and to share financial risks with providers in order to discourage delivery of unnecessary services. In response to the widespread adoption of managed care, consumers are concerned that their access to necessary care and quality services not be reduced (see this chapter’s section Managed Care).

The dominance of managed care and the reliance on competitive forces to contain costs has affected all parts of the delivery system. Growing costs and declining profit margins have strained the financial stability of some health care institutions. This has led to mergers among some insurers, health plans and providers and to pulling back on expansion efforts among others. Constraints on payments from insurers and health plans have squeezed hospital budgets and the incomes of other providers. More recently, some providers have withdrawn from plan participation and some have leveraged their own growing market power to negotiate higher payments. In some instances providers and patients have had relationships disrupted.

To obtain the resources needed to compete in a rapidly changing environment, some health care providers and plans have looked beyond traditional financing sources, to such mechanisms as capital reserves and bonds and the financial markets. Use of the financial markets has led a number of providers and plans to change their organizational structure—converting from nonprofit organizations to privately held corporations. This private investment in local plans and delivery systems has generated strong and divided responses.

Cost containment aims to reduce inefficiencies and excess capacity. While this puts pressure on inefficient plans and providers, well-run plans and providers also face increasing pressure to hold down costs. In this environment, plans and health care professionals providing services and
functions that do not pay for themselves are in jeopardy. Without the financial resources to restructure or sustain money-losing services, some providers may not survive. This development raises the issue of what effect the loss of plans and providers has on the health delivery system and patients’ access to care.

Given the new wave of cost pressures, the future is likely to hold further transitions. Potential changes in the health care system cut across many areas of existing public policy and bring new areas of concern into focus. These changes are the source of anxiety and uncertainty on many levels and have raised a series of public policy concerns. Policymakers and elected officials have important roles in ensuring quality in the health care system: They can initiate changes in federal, state and local programs and facilities; they regulate various activities (e.g., mergers, securities and licensing) of private health care entities; and they have broad power to protect the public’s health and safety. In these roles government is in a position to oversee the transformations in the health care system and to monitor carefully the impact of these dramatic changes on those who use and rely upon it.

It is clear that we must gain a better understanding of the effects of these changes, particularly on consumers. Research reveals that the effects of transformation differ from community to community and vary with the interaction of forces that shape a local health care system. It can be risky, for example, to generalize that the effects of conversion of a not-for-profit hospital to for-profit status will be the same from one community to another.

FEDERAL & STATE POLICY
THE HEALTH CARE SYSTEM

Transformation of the Health Care System

Federal and state governments must monitor carefully the ongoing changes in the health care marketplace to assess their impact on consumers and the health delivery system. Market forces may not always protect communities’ or consumers’ access to health care services. Thus, governments must ensure that access to affordable, high-quality care increases, rather than decreases, as changes occur in the health care delivery and insurance systems.

STATE & LOCAL POLICY
THE HEALTH CARE SYSTEM

Transformation of the Health Care System

If not-for-profit and public health care institutions and plans propose conversion, merger, reorganization or restructuring to for-profit status, AARP supports legislative and regulatory programs requiring systematic review of
such proposals and transactions in order to safeguard community assets and access to care.

To protect the public’s interest, AARP supports strong and effective government oversight of major business transactions concerning not-for-profit and public institutions. At a minimum the oversight process must be public and require:

- evaluation of the transaction’s health care implications for the community,
- review and approval of the entity’s asset valuation,
- review and approval of the plan for distributing those assets and
- assignment of authority and responsibility for ensuring that the transacting parties fulfill the community-benefit terms of approved conversions.

State and local governments should create a public process to oversee the contracting of publicly funded or operated health care programs and services to protect beneficiary and patient interests.

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**THE HEALTH CARE SYSTEM**

**Background**

**Health Care Spending**

After several years of relatively slow growth during the 1990s, health care spending is now rising at a faster rate. While total health care spending growth averaged 5.4 percent per year between 1994 and 1999, it was 7.4 percent in 2000 and 8.7 percent in 2001. Spending growth is projected to exceed 8 percent in 2002 and then slow slightly to about 7 percent per year between 2003 and 2011. Despite this accelerated rate of growth in recent years, national health care expenditures are expected to grow at a rate that is below the 12 percent annual rate that existed between 1971 and 1988.

Several factors have contributed to the recent trend of increased growth in national health care spending. First, the shift of many health plan enrollees toward less restrictive models of managed care (e.g., preferred provider organizations) means that fewer consumers are enrolled in the kinds of plans with the greatest ability to influence the delivery of services and control costs (see the Managed Care sections of this chapter for further discussion). Other major factors contributing to the increased rate of spending growth include advances in medical technology (both in the introduction of new services and equipment and in the new applications of existing services and equipment).
and higher medical inflation. Further, there is a lag between the general economy and health care spending, so health spending continues to grow even after the economy has slowed. For this reason, the growth in real per capita income in the recent past due to a previously strong economy has contributed to the current health care spending growth. However, the presently slow economic growth is expected to dampen health spending somewhat in the near future.

Since 1995 prescription drugs have been the fastest growing component of national health care expenditures. Total national health spending on outpatient prescription drugs increased by an average of about 12.5 percent per year between 1994 and 1999, but it grew by about 16 percent per year between 1999 and 2001. It is projected to continue to grow rapidly over the next decade: more than 10 percent per year through at least 2011. Such rapid growth has been associated with an increase in drug utilization (the number of prescriptions per person), changes in the intensity of prescription drug use (the mix of prescriptions used) and higher prices of prescription drugs used.

Another factor that adds significantly to health care spending in both the private and public sector is the cost of fraud and abuse. However, the lack of solid, empirical information concerning both the extent of fraud and abuse and the effects of antifraud activities on the incidence of illegal practices is a serious deficiency in the battle against fraud and abuse. In a 2001 audit of Medicare fee-for-service payments, the inspector general of the Department of Health and Human Services estimated that $11.9 billion was improperly paid in fiscal year 2000. The audit, however, could not determine what percentage of these improper payments resulted from fraud and abuse (see this chapter’s section Health Care Fraud and Abuse for further information).

As policymakers, employers and insurers attempt to constrain costs, the pressures to reduce the growth in health care costs in some sectors could shift costs to other sectors. For example, as Medicare and Medicaid reduced reimbursement levels in previous years, providers tried to recoup losses by shifting costs to private payers. Unless systemwide changes to control all health care costs are made, more of this type of cost-shifting could occur.

Some of the proposed strategies to control health care costs have included increasing cost-sharing, offering health plans that shift costs to consumers to make them more conscious of the costs of services, controlling prices through government regulation, returning to more tightly controlled managed care plans such as HMOs, and improving effectiveness and quality. However, none of these approaches alone is expected to contain health care spending, and there are tradeoffs involved. Challenges remain in simultaneously controlling health care costs while not compromising quality or improperly denying access to care.
Health Care Spending

As part of the efforts to control health care costs, AARP supports antifraud and abuse measures at all levels of government, as well as within the private insurance sector. AARP supports consumer involvement as an integral part of these efforts. Government agencies and private insurers should take appropriate steps to ensure that these efforts do not adversely affect consumers (e.g., create barriers to receiving services).

Health Care Spending

Federal and state governments should initiate cost-containment measures that effectively constrain growth in price, volume and intensity of health care services without compromising quality of care or inappropriately denying access to care. Cost-containment efforts should not create incentives to shift costs inappropriately or widen the gap in provider payments between private and public health care plans.

Health Care Spending

The federal government should monitor trends in health care spending and quality. Special attention should be given to how different forms of managed care (e.g., health maintenance organizations, preferred provider organizations and point-of-service plans) perform relative to fee-for-service insurance with respect to access, overall costs, outcomes, quality and out-of-pocket costs to consumers.

The federal government should increase research and information dissemination on the effectiveness of medical goods and services so that resources might be directed to activities where the yield is the greatest.

Congress should review the health care systems of US territories and the adequacy of federal funding for care in those locations.
Sources of Financing for Health Insurance

Private health insurance, which is primarily employment based, constitutes the single largest means by which Americans finance their health care needs. Despite the prevalence of employment-based coverage for workers, dependents and retirees, most Americans without health insurance either work or live in families with someone who works. The federal government is a major source of public financing of other health care programs, including Medicare, Medicaid and programs for veterans, federal workers and military personnel.

The federal share of financing for public and private health insurance comes from a limited number of sources. Direct taxes, such as the income and Medicare payroll tax, are a major source. In addition, the tax code is used to encourage spending for health insurance and to recognize the high cost of medical care. Examples of tax preferences—that is, choosing not to collect certain revenues—currently include the business deduction allowed for employer-provided health care benefits, the exclusion from taxation of the value of those benefits to employees, the deduction for health care expenses in excess of 7.5 percent of adjusted gross income that individuals may claim, and the deduction of individually purchased health insurance premiums by self-employed individuals (see Chapter 2, Taxation, for an additional discussion of tax preferences).

AARP has long supported and worked toward improving our nation’s health care system. Proposals to reform the overall financing structure for health care range from incremental changes (e.g., modifying tax or regulatory policies) to comprehensive overhaul. To enact further reforms of the health care system, either incremental or comprehensive, additional revenues could be needed, depending on the nature of the proposed reform plan. It is important that any such reforms be adequately financed over both the short and long terms (see Chapter 2, Taxation, for AARP’s principles on tax policy).
Growing with enrollment, progressive and consistent with furthering public health objectives.

Consistent with AARP’s health care principles, government, employers and individuals should share the responsibility of any additional financing required to implement health care reforms. The revenue sources for incremental or comprehensive reforms should adhere to AARP’s tax principles.

HEALTH CARE COVERAGE

Introduction

Most Americans rely on health coverage to pay for some portion of the health care services and supplies they use. They obtain coverage either through private insurance or through publicly sponsored programs. The next three sections discuss private coverage, public coverage and the uninsured.

HEALTH CARE COVERAGE • Private Health Insurance

Background

Private Market Regulation

Since the majority of people under age 65 get their health coverage through the private market, access to private coverage is crucial. Improving access to private coverage has been at the heart of efforts to change practices of health insurers and private health care plans (including self-insured employer plans) in recent years. Policies relating to how the private health insurance market functions are the subject of this section. Policies that relate to private health coverage through managed care plans, retiree health plans and Medicare supplemental insurance are the subject of separate sections of this chapter. Policies related to long-term care insurance are in Chapter 7, Long-Term Care. Policies that relate to the broader insurance market are in the insurance sections of Chapter 12, Consumer Products and Financial Services.

Regulation of private health insurance has traditionally been a state responsibility. However, regulation of employers’ self-insured benefit plans (i.e., those covered by the Employee Retirement Income Security Act (ERISA)) is a federal responsibility. Since ERISA plans account for a significant share of private health coverage, this regulatory framework has frustrated some states’ managed care and health care reforms because state requirements are often preempted and do not apply to ERISA plans. The
current system for regulating private health coverage means consumers have different protections depending on the state in which they live and whether they are covered by an insured or self-insured health plan.

The federal government and many states have sought, under their respective authorities, to regulate practices in the private health market that hamper access to private coverage. In Title I of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress provided protections limiting the use of preexisting-condition exclusions for those changing group coverage (known as portability) and prohibiting discrimination in group coverage against those with health conditions. These protections apply to both ERISA plans and fully insured plans. HIPAA also guaranteed access to coverage in the individual market for those losing group coverage and for the renewal of coverage in the individual market. However, people buying coverage as individuals have fewer protections than those covered through a group.

Providing guarantees that groups and individuals can get and keep health coverage without onerous restrictions on coverage for existing health problems has been the area most widely addressed by state and federal reforms.

Finding ways to spread the cost of covering less healthy individuals more broadly, so that premiums are affordable, has proven difficult. Restrictions on insurers’ ability to use health status in setting premiums for groups and individuals have been implemented fairly widely. A few states have gone further and require some form of community rating. Under “pure community rating,” everyone covered under the same plan is charged the same premium regardless of individual characteristics. “Adjusted community rating” permits changes in the pure community rate based on allowed demographic factors, such as age and geography, but not health status or experience. The adjustments limit the rate variation for an allowed rating factor, such as age. Such variation is commonly expressed as a percentage or ratio. In some states that are implementing community rating, the amount of variation may gradually change over several years to ease the transition to community rating.

Both pure community rating and adjusted community rating aim to narrow the premium differences between those in poor health and others. Some states have set up risk-adjustment or reinsurance pools to help spread risk among insurers so that insurers providing coverage to those with poorer health do not have to bear all of the excess risk (i.e., the higher costs) on their own. And many states have created high-risk pools to provide private coverage to those who cannot find coverage in the private market or cannot find it at a price below that in the high-risk pool. This arrangement provides those considered uninsurable by the private market with access to coverage. Risk pools help subsidize premiums for those who are uninsurable with
funding from other insurers or taxes. Even with the subsidy premiums may not be affordable to many high-risk individuals.

Other reform efforts, such as purchasing cooperatives and other group purchasing arrangements, have tried to address the higher costs and lack of choice that individuals and small purchasers face by creating pooling mechanisms. In some instances private purchasers have organized these purchasing efforts; in others, states have authorized their creation. The evidence to date seems to show that these mechanisms may be effective in expanding the number of insurance options available to small purchasers. However, they have neither yielded significant gains in extending coverage to employers that previously did not offer health coverage nor led to significant reductions in premiums.

In the past few years, proposals have been offered in Congress to allow pooling through entities not subject to state insurance regulation. Proponents argue that the ability to offer coverage that is not subject to state-mandated benefits, combined with the purchasing power of the pool, will reduce the price of coverage and allow more small employers to offer it. Opponents argue that these mechanisms undermine state efforts to regulate markets and that there is potential for such entities to segment risk so that higher risks will be concentrated in the state regulated market.

Another private coverage reform that has been tried in recent years is the medical savings account (MSA). An MSA plan pairs a high-deductible health insurance policy with a personal medical savings account. The personal medical savings account provides tax-sheltered savings that can be spent on health care expenses that are below the amount of the insurance policy’s high deductible. A number of states and the federal government have enacted laws granting tax advantages to medical savings accounts. HIPAA established a national MSA demonstration in the private insurance market, which Congress has extended through 2003. The HIPAA demonstration has so far been undersubscribed.

New health insurance products and employer health benefit designs that share some features with MSAs have recently emerged. These models typically pair high-deductible health plans with an account for health expenses below the deductible; depending on how the product is made available, either employers or individuals can contribute to the accounts. They may be referred to as defined contribution and consumer-driven health care models. Employers as well as some insurers promote these models as a means of making consumers more sensitive to the cost of health care, containing premiums and health benefit costs and allowing consumers to have more responsibility for their own care. In the face of rapidly rising health costs, employers are exploring the potential of new benefit designs to restrain their health benefit costs. It is too soon to know if the new products will restrain cost growth. The Internal Revenue Service issued guidance in the summer of 2002 that clarified the circumstances under which
reimbursements from health accounts can be excluded from employee gross income and unused amounts can be carried forward and similarly excluded. These clarifications may spur wider interest in the emerging products.

For consumers, the new products pose many of the same issues as MSAs. They may be most attractive to people who are healthier, making traditional products more expensive if the people who remain enrolled in them are less healthy, i.e., if the risk pool is segmented. Likewise, people may not seek needed care if they are responsible for large out-of-pocket costs and do not have adequate resources to cover the costs in either a health account or personal savings. Lower income people may be particularly vulnerable unless they have been able to accumulate resources in a health reimbursement account.

Implementation of incremental reforms often involves tradeoffs and has unintended side effects. For instance, rating restrictions inevitably raise premiums for some while holding them down for others. Experience shows that reform components interact. Application of different rules to different segments of the private market provides opportunity for risk segmentation and adverse selection and can undercut existing reforms and coverage pools. Moreover, effects may spill over beyond the private market into public programs such as Medicaid, underscoring the importance of identifying negative interactions among reforms and other problems to prevent destabilizing effects before they reach a critical level.

**FEDERAL & STATE POLICY**

**HEALTH CARE COVERAGE & Private Health Insurance**

**Private Market Regulation**

AARP supports health care reform that achieves universal access to health care coverage and provides adequate protection against health care costs (see the Principles section at the beginning of this chapter).

In the absence of universal access to health care coverage, AARP supports incremental insurance reforms that will expand access to private health coverage for individuals seeking to obtain or retain health coverage in the private market either on their own or through a group (see the Principles and The Uninsured sections of this chapter for broader policy on incremental strategies, including tax proposals).

Reforms to make private health insurance more accessible, affordable and portable, as well as to protect consumers, should apply uniformly to all insurers (including those that insure individuals, small groups, large groups and associations) and self-insured purchasers. The reforms should:
guarantee that all individuals and groups wishing to purchase or renew health insurance can do so,

prohibit selective premium increases for individuals based on their health status or claims experience,

require insurers to use community rating in setting premiums and

limit coverage exclusions or waiting periods for preexisting health conditions and credit policyholders’ prior coverage toward satisfying limits on preexisting conditions.

Adjusted community rating may be appropriate to phase in pure community rating or to minimize observed, undesirable effects. If adjusted community rating allows age as a rating factor, the rate difference between the highest and lowest age groups must be narrow.

AARP supports federal and state enforcement of access, portability and renewability protections of Title I of the Health Insurance Portability and Accountability Act for group and individual coverage.

AARP supports the use of reinsurance pools, risk adjustment and similar mechanisms by regulators to spread the insurance risk more broadly across the industry, when appropriate to implement reforms.

AARP supports purchasing cooperatives or pools where they enhance access to health coverage and expand plan choice; do not restrict participation on the basis of demographic characteristics (e.g., age or gender), health status or source of employment; provide consumer access to fair grievance and appeals procedures and representation on governing bodies; and do not undermine existing federal and state protections.

The association believes high-risk pools for those denied health insurance should be designed to include as much of the potentially eligible population as possible and use cost-containment features such as case management and incentives for administrative effectiveness.

AARP opposes medical savings accounts (MSAs) and similar plans with high deductibles that segment risk pools or expose consumers to undue risk of unaffordable expenditures. Where such plans have been established and implemented, AARP calls for regulators and employers to carefully monitor and evaluate the plans’ effect, not only on the covered populations but also on the affordability of other insurance products.

Insurers and private sponsors of health coverage, including plans with health accounts, must be required to provide prospective and current subscribers with accurate, readily understandable information on:
benefits, limitations, exclusions and type of expenses that will and will not count toward satisfying any deductible provisions;

ownership of, carry over provisions in, and retention rights to health account funds, as well as a description of how contributions to and spending from the account are treated for tax purposes; and

provider performance to the extent it is available.

(See Chapter 2, Taxation: Income Tax Options—Tax Incentives for Health Insurance.)

FEDERAL POLICY

HEALTH CARE COVERAGE \& Private Health Insurance

Private Market Regulation

AARP supports the equal application of federal insurance reforms to Employee Retirement Income Security Act (ERISA) plans as well as state-regulated health plans.

AARP supports changes in ERISA that would provide a means for states to apply state health care initiatives to ERISA health benefit plans as well as state-regulated insurance coverage. Such reforms might include:

- consumer protections and grievance procedures,
- broadly based financing strategies to contain costs or provide funding to improve access and coverage,
- health insurance market reforms,
- financial solvency guarantees,
- uniform claims procedures and
- uniform utilization and cost data.

HEALTH CARE COVERAGE \& Private Health Insurance \& Managed Care

Background

Types of Managed Care Plans

Managed care combines health insurance with the delivery of care and provides an alternative to traditional indemnity insurance. There are many
different models of managed care organizations. Although the models differ widely, they generally share three essential characteristics: limitations on the use of some or all providers, negotiated provider reimbursement and some form of utilization review. While it is useful to describe the different types of managed care plans as discrete models for conceptual purposes, pure models are rarely found in the marketplace. Instead, as the managed care industry continues to evolve, managed care insurance products reflect a blend of features of one or more of the models described below.

In group- or staff-model **health maintenance organizations** (HMOs), physicians are paid on the basis of a fixed amount per enrollee (i.e., a capitation) or a salary. Here, the providers generally practice together in a medical center or clinic. A somewhat looser form of HMO is an **individual practice association** (IPA), in which a health plan contracts with an entity that then contracts with individual physicians or groups of physicians. Under an IPA the participating physicians are usually solo practitioners or practice together in medical groups. Until recently most HMOs required enrollees to obtain approval for most care through a primary care provider, a physician who typically acted as a gatekeeper. However, this role is gradually being eliminated, and open access plans that do not require the prior approval of a primary care physician to obtain services are becoming more common.

A key feature of the marketplace during the last several years has been broader choice, as illustrated by the **point-of-service** (POS), or open-ended, model. In this arrangement HMO enrollees are permitted to seek care outside the HMO, typically with significantly higher deductibles and/ or coinsurance and sometimes higher premiums. The majority of HMOs make POS options available, although employers may not necessarily offer the option to their employees.

Another model of a managed care plan is the **provider-sponsored organization** (PSO), also known as a **physician-hospital organization** (PHO) or **physician service network** (PSN). These types of organizations are owned and operated by providers and are composed of one or more hospitals and their attending physicians and/ or physician groups, which form integrated delivery systems.

Even more loosely structured organizations are **preferred provider organizations** (PPOs), in which physicians are generally paid on a discounted fee-for-service basis, and consumers have incentives, usually in the form of reduced cost-sharing, to obtain care from participating providers. This type of managed care plan is the fastest growing model due largely to the looser restrictions on network use, which many consumers find appealing. About 48 percent of those insured in the private sector are enrolled in PPOs. However, government agencies do not apply the same consumer protections and quality-assessment measures to PPOs (particularly with respect to access to service, patient satisfaction and customer service). Standardized information could help consumers make head-to-head
comparisons between HMO and PPO performance and help state regulators strengthen oversight of PPOs. Recently, greater attention is being paid by private accrediting bodies and government agencies to developing measures that can be used to hold PPOs accountable for various aspects of service.

Currently, there is greater diversity with respect to model type and organizational structure in the private sector than in the Medicare program. The Balanced Budget Act of 1997 expanded the types of managed care plans that may be offered to Medicare beneficiaries. With enactment of this legislation, the Centers for Medicare and Medicaid Services has the authority to contract with “coordinated care plans,” which are defined in the law as HMOs (with or without a POS option), PPOs and PSOs, as well as nonmanaged care options. However, to date, with a few exceptions the newly authorized options have not materialized in most parts of the nation, and HMOs remain the predominant form of managed care in the Medicare program (see this chapter’s section Medicare Program: Medicare+Choice for a detailed discussion of the options that may be offered to Medicare beneficiaries).

As of the new millennium the private health care sector has been transformed from one dominated by indemnity insurance to one characterized by managed care. The Kaiser Family Foundation has reported that between 1981 and 1998 for-profit HMOs grew from representing 12 percent of enrollees to 63 percent, and from 18 percent of plans to 74 percent. The rapid expansion of managed care also has brought with it a new and heretofore untested relationship between the stock market and health care. There is now clear evidence of a public backlash against the dramatic shift to managed care. This backlash can be seen on numerous fronts: in public opinion, physician attitudes, the stock market and state legislative responses. For example, public opinion polls register widespread suspicion that managed care reduces access to care and compromises health care quality. In addition, physicians are dissatisfied with their loss of autonomy and reduced income. State legislators have demonstrated their responsiveness to these concerns by enacting patient protection laws that range from ensuring easier access for managed care enrollees to emergency care to providing physicians with certain due process protections. To date, Congress has failed to enact similar legislation.

Many argue that managed care has failed to live up to its promise. Rather than coordinate care while providing a more cost-effective and efficient system, it is viewed by its critics as nothing more than an insurance mechanism that unduly restricts needed care. Not only has managed care failed to stem health care cost inflation, most consumers now face double-digit increases in health care premiums. Others argue that the recent surge in health care premiums reflects the loosening of the controls that were initially imposed by managed care plans during the 1990s and which have been relaxed in response to consumer opposition to strict oversight of health care utilization.
The current research on cost, quality, resource use and enrollee satisfaction in managed care plans continues to be inconclusive. Clear patterns are not discernible because existing studies vary in scope and methodology, data are often old and the studies differ in the number of plans analyzed. Therefore, it is very difficult to draw conclusions from these studies in the aggregate or to generalize from them. Although published studies have not reported a decrease in the quality of care for most enrollees, vulnerable populations (e.g., people who are sicker and those with disabilities) report lower satisfaction rates and more access-to-care problems than their healthier counterparts. Clearly, continued research is essential.

FEDERAL POLICY

Types of Managed Care Plans

AARP encourages ongoing research to determine whether managed care organizations achieve savings and deliver high-quality care. Such research should investigate the impact of managed care by health plan characteristics and provider organization. In addition, research should focus on population subgroups such as older people, those with chronic conditions and people with disabilities or low incomes. Research should try to assess the costs of providing care in managed care settings and the level of clinical quality and access to care, so that policymakers can determine the effect of managed care delivery systems on these groups.

Background

Enrollment in Managed Care Plans

Managed care is available in both the public and private sectors but is far more prevalent in the latter (see The Medicare Program—Medicare+Choice section for more on Medicare and managed care). In 2002 about 95 percent of workers were enrolled in some type of managed care plan; HMOs covered 26 percent; PPOs, 52 percent; and point-of-service plans, 18 percent. (The remaining 5 percent were enrolled in conventional fee-for-service plans.)

In contrast, as of September 2002, 5 million Medicare beneficiaries (about 12 percent) were enrolled in risk-based Medicare plans. In 2001, 20.8 million Medicaid beneficiaries were enrolled in managed care plans, approximately 57 percent of the total Medicaid population. (Figure 6-1).
Enrollment in Managed Care Plans

AARP supports health care reform that achieves universal coverage for comprehensive health benefits (see the section on health care principles). As a matter of policy, AARP does not favor any particular health care delivery system. Plan selection should be voluntary and at the consumer’s discretion.

Public and private sponsors should offer more than one health insurance option to those eligible for coverage. However, if an employer or public sponsor offers only one option, it should be a point-of-service plan or preferred provider organization in order to afford employees or beneficiaries maximum opportunities for choice of health care providers.
of most managed care plans do not fall under its jurisdiction. While the inherent incentives of managed care create the potential for high-quality, cost-effective care, the same incentives, if abused, could result in the withholding of necessary care. Therefore, uniform standards that apply to a full range of operational and delivery activities of managed care plans are necessary to protect those who enroll in such plans. Without the enforcement of established requirements, enrollees in managed care plans cannot be confident that they will receive an appropriate level of quality of care or that there will be suitable and sufficient protections to ensure the delivery of services within a reasonable time frame or appropriate due process protections if enrollees wish to challenge health plan decisions about their care.

The absence of uniform standards that apply across the nation results in a patchwork series of rules for managed care operations. Consumers are only protected to the extent that they live in a state with comprehensive managed care laws or are covered by a purchaser, such as Medicare, that has its own national and uniform requirements (see The Medicare Program section of this chapter). National uniform standards would provide all consumers, regardless of where they live or how they obtain coverage, with a consistent level of protection. Uniform standards would also avoid unnecessary duplication and waste of valuable resources.

Consumer protection is enhanced by public accountability through the collection and reporting of standardized measures on health plan performance, including patient satisfaction and the clinical effectiveness of care. Data from the Health Plan Data and Information Set (HEDIS)—standardized measures developed by the National Committee for Quality Assurance—demonstrate that public accountability has a positive effect on health care quality. Those plans that publicly report their HEDIS results have better performance scores.

Many states have responded to the growth of managed care within their borders by enhancing licensing and oversight activities. These legislative efforts have taken many different forms. In some cases states have adopted a broad set of regulations that address the bulk of managed care activities for all models of managed care plans. In other cases states have chosen to regulate only one type of managed care plan (e.g., HMOs but not preferred provider organizations) or have enacted laws that regulate only a particular aspect of a managed care system, such as utilization review, hospital length of stay or physician-patient communications.

**Deeming**—States are increasingly relying on private organizations’ review or accreditation as part of their health care licensing and regulatory oversight. Some states require accreditation for licensing; others allow private accrediting bodies to “deem” that a plan has satisfied all or some of the state’s requirements. These practices are a response to concerns of the managed care industry and others that the reporting requirements health
plans must meet to satisfy public and private purchasers, regulatory authorities and accrediting bodies are duplicative and burdensome. They contend that such duplication is costly and diverts scarce resources from needed health care and other activities of greater value to consumers. Approximately 21 states allow private accrediting organizations to deem that a health plan satisfies some or all of the state requirements in such areas as quality assurance, utilization management, access to care and credentialing (see the Medicare+Choice section for a discussion of deeming in that program).

**Medical loss ratios**— Some states require managed care plans to report on “medical-loss ratios.” This is a term borrowed from the indemnity insurance industry. In managed care systems the medical loss ratio generally measures the fraction of total premium revenue that health plans devote to clinical services, as distinct from administration and profit. Insurers do not report the components of the medical loss ratio in a consistent manner.

**Managed care liability**— Allowing consumers to have access to state courts to recover damages for improper medical care is an important consumer protection. All states permit lawsuits to recover damages for medical malpractice. However, when the defendant is an organization such as a managed care plan, rather than an individual medical professional, consumers may not have access to their state’s judicial system. For example, many states have laws prohibiting the “corporate practice of medicine” and interpret these statutes to bar a malpractice suit against a plan. The theory is that because the plan is forbidden to practice medicine, a plan decision about care is not a medical decision. According to this theory the plan cannot commit medical malpractice even when it improperly delays or denies medical care. Some court decisions have overruled this interpretation, but it remains an obstacle in many states.

A second obstacle to accessing the state courts is the federal Employee Retirement Income Security Act (ERISA), which has been interpreted by some courts as preventing employees in self-insured plans from suing their plans in state courts for damages that result from denied or delayed care. (ERISA permits participants in self-insured plans to sue in federal court; however, they are allowed to recover only the actual cost of the benefit denied or delayed rather than seek the punitive or compensatory damages that could be awarded by a state court.)

Those who want managed care plans to be held liable for their actions argue that plan decisions affect physician behavior and often displace a physician’s medical judgment. Therefore, to the extent that a plan determines what care is given, and the determination is not medically sound, the plan should answer in court for the injuries it causes. Proponents of state-court liability for HMOs assert that the threat of litigation would cause health plans that might otherwise be inclined to consider only the bottom line to be more careful about denying care to their enrollees. Those who argue against
managed care liability question whether lawsuits are the best way to deter health plan misconduct. They contend that increasing health plan exposure to lawsuits will encourage frivolous suits, increase defensive medical practices and increase overall costs for purchasers and consumers without actually deterring medical negligence.

As of December 2001, 12 states—Arizona, California, Georgia, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Texas, Washington and West Virginia—have enacted health plan liability laws to make it easier for managed care enrollees to sue their health plans. Many others have considered similar legislation. In addition, at the federal level HMO liability has figured prominently in the congressional debate on managed care consumer protections.

FEDERAL & STATE POLICY

Uniform national standards should apply to all forms of managed care plans (including provider-sponsored organizations and preferred provider organizations). To the extent possible these standards should be the same for all models of managed care and for fee-for-service plans. These standards should be consistent across all payers, including Medicare, Medicaid, self-insured plans regulated by the Employee Retirement Income Security Act (ERISA) and state-regulated plans offered to employer groups and individuals.

Medicare’s comprehensive system of consumer protections that applies to coordinated care plans (i.e., HMOs) should be maintained. For the rest of the system, including ERISA plans, AARP supports standards that are comprehensive. AARP does not support federal preemption of a state’s managed care laws until a federal law is established that affords consumers greater protections than they would have under their state’s managed care laws.

STATE POLICY

In the absence of national standards, states should enact a comprehensive set of rigorous standards (comparable to the standards that AARP supports in Medicare) that to the extent possible apply to all types of public and private managed care plans (including preferred provider organizations), regardless of their profit status or organizational structure. (See this chapter’s section on
Medicare+Choice, Federal Standards for Medicare Managed Care Plans, for a
detailed delineation of the standards applicable to all managed care plans
participating in Medicare.)

**Financial**— All health plans must be financially sound. Financial standards
should address solvency requirements, including requirements for capital
reserves that take into account the plan’s level of risk and service-delivery
capabilities and that are set at adequate levels to protect enrollees in the event
of a plan’s insolvency. They should also include reinsurance requirements and
hold-harmless provisions that prohibit providers from billing enrollees for
covered services (other than for allowable cost-sharing amounts). AARP
supports the use of medical-loss ratios when the components of the ratio are
defined in a uniform manner.

**Pharmacy benefits**— AARP does not oppose the use of drug formularies by
health plans, because formularies can be an effective cost-containment and
quality-enhancement tool. However, in providing drug benefits, health plans
using drug formularies should:

1. ensure participation of plan physicians in the development of
formularies,

2. publicly disclose the nature of formulary restrictions and utilization
management policies,

3. permit formulary exceptions when medical necessity dictates that a
nonformulary alternative is needed and ensure that plan members are
aware of how they can obtain such alternatives,

4. provide any prescription drugs that are exceptions to the health plan
formulary under the same terms and conditions (e.g., cost-sharing
requirements) as drugs in the formulary and

5. subject disagreements between an enrollee and a health plan about
prescription drug coverage to the plan’s internal complaint process and
external independent appeals process.

(See section on Prescription Drugs and Pharmacy Practices for additional
protections.)

**Emergency care**— In the event of an emergency, managed care enrollees
should not be required to obtain care through the plan’s network of providers.
“Emergency care” must be defined using the “prudent layperson standard,”
that is, coverage for emergency care should include coverage for services
provided where the enrollee presents to a provider outside the plan with
symptoms, including severe pain, that a prudent layperson would reasonably
believe to be an emergency medical condition. Health plans should be
contacted once managed care enrollees receiving emergency care are stabilized
to determine follow-up treatment, and the plan should be prepared to assume
the care of the patient. In any event patients should be covered for all necessary care in connection with the emergency. Health plans also should be prohibited from requiring prior authorization for emergency services, and the special needs of people with mental illness and substance abuse should be taken into account when coverage decisions are made concerning emergency services or urgently needed care.

**Marketing**—Health plans should be required to provide standardized information to prospective and new enrollees, including:

1. information on benefits, limitations, exclusions, restrictions on use of services and plan ownership;

2. a summary of physicians’ financial incentive arrangements written in terms that will be understood by the average consumer;

3. the stability and composition of the provider and practitioner network, including a list of participating physicians and hospitals, with their credentials;

4. comparative and standardized information on patients’ experience with care in the plan and the plan’s clinical performance (e.g., Health Plan Data Information Set or HEDIS and CAHPS data);

5. information on whether the plan is accredited by a national organization;

6. disenrollment experience;

7. information about grievances and appeals filed by enrollees; and

8. the plan’s current status with respect to compliance with statutory and regulatory requirements.

All marketing materials must be approved by the appropriate state agency before their use, written at a sixth-grade reading level and available in languages other than English when the plan serves or will serve substantial numbers of enrollees whose native language is not English. In addition, plans must provide these standardized data to the state or an independent body identified by the state that is charged with compiling and distributing materials to all interested parties.

To avoid the possibility of discriminating against population groups that reside in certain locations, plans should serve a complete market service area.

**Accessibility**—Health plans must be able to demonstrate that the services they offer are reasonably available and accessible 24 hours a day, seven days a week. Health plans must have sufficient numbers of practitioners and providers (including facilities) and sufficient distribution of providers by specialty and location within the plan’s service area to serve their enrolled
members. The adequacy of a network should be assessed in relation to the health plan’s model type, the prevailing patterns of provider distribution in the geographic area the plan serves and the needs of the plan’s enrollees.

Women should have direct access to obstetricians/gynecologists and be allowed to designate these physicians as their primary care providers.

Health plans should be required to provide referrals to specialists affiliated with the plan or recognized specialty-care centers affiliated with the plan pursuant to treatment plans. Referrals should include provisions for standing referrals, as determined by the referring practitioner.

Health plans should be required to provide out-of-network referrals at no additional cost to the enrollee if the health plan does not have a network physician with appropriate training and experience or affiliation with a recognized specialty-care center to meet the enrollee’s covered medical needs. Patients with mental disorders should receive appropriate referrals to mental health specialists.

**Continuity of care**—To facilitate continuity of care, health plans must notify affected enrollees at least 90 days before the termination of a provider, when such termination is not for cause. Enrollees who are undergoing an active course of treatment for a life-threatening disease or condition, or a degenerative and disabling disease or condition, or those who have entered the second trimester of pregnancy at the effective date of enrollment, should be able to receive covered medically necessary care from their physician specialists for up to 90 days (or through postpartum). This should apply to new enrollees who belong to a group that did not provide them the option of continuing with their previous physician specialist and to existing enrollees if their previous physician specialist was terminated by the health plan for reasons other than cause.

**Quality assessment/quality improvement (QA/ QI)**—Health plans must demonstrate compliance with quality indicators applicable to the entire range of services, including preventive care and care for patients with chronic illness. Wherever possible, these indicators should reflect data from ongoing medical outcome studies.

As part of its QA/ QI activities, a health plan must undergo external quality review by a designated professional review entity (see The Medicare Program section of this chapter for a description of the components of external review).

The Centers for Medicare and Medicaid Services, the Agency for Health Care Research and Quality and other appropriate agencies, working with external organizations, should build on existing efforts to develop quality measures that can be used to assess pharmacy practices in managed care plans.
Utilization review/utilization management (UR/UM)—Clinical review criteria must be developed with the involvement of health plan practitioners and be available to plan practitioners and enrollees. UR/UM plans must be designed to detect underutilization as well as overutilization, and adverse UR decisions must be made by clinically qualified personnel and reviewed by active practitioners in the same or a similar specialty. However, reviewing clinicians need not be residents of the state in which the enrollee whose claim is being reviewed resides. Reviewers may not receive financial compensation based directly or indirectly on the number, or volume, of certification denials. Certification decisions must be made at least as rapidly as the enrollee’s medical situation requires in order to protect health and permit a meaningful appeal. Denials must be accompanied by clear information on the reasons for denial as well as instructions on how to appeal the denial.

Grievances and appeals—Health plans should have a system for receiving, reviewing and reporting enrollee complaints and grievances. These should include provisions in the following areas:

- **Information**—When a requested service or payment is denied, or when needed care is reduced or terminated, enrollees must receive timely, clear information about such decisions; the specific reasons for a denial, termination or reduction of service or payment; and a description of enrollees’ right to appeal and the procedure for doing so. Information must include the medical criteria relied on and the process followed by the plan in reaching its decision. The methods of communicating information about the denial and appeal process must meet the specific needs of an older population as well as other populations with special needs, taking into account vision or reading difficulties, language and cultural differences.

- **Independent review**—Enrollees must have the right to have plan decisions reviewed by an independent entity that is not appointed or selected by the health plan, including an external review of plan decisions by medically qualified reviewers. There should be no charge to the enrollee for gaining access to such independent review or for the review itself. States should certify and monitor the independent review bodies that review appeals to ensure that the processes and procedures of these organizations are fair and objective and that their decisions are rendered in a timely manner. States should engage in active oversight of the operations of the independent review organizations.

- **Fairness**—Plans must give adequate advance notice of termination or reduction of services that an enrollee is already receiving, with specific reasons for the termination or reduction and clear instructions on how to appeal such decisions. Ongoing services, particularly hospital inpatient services and skilled nursing or rehabilitation services, should continue as covered services until the reconsideration is complete. The enrollee should not be responsible for the costs of the appeal process, including
the cost of external medical review. The appeal process must include an opportunity for the enrollee to attend the review in person, testify, submit evidence and call and question witnesses.

Timeliness—There must be specific time limits, which reflect the medical needs of enrollees who have been denied care or face the cutoff of services, for appealing a denial, termination or reduction of services. Expedited review must be available in cases where following the regular time limits could jeopardize the enrollee’s life, health or ability to regain or retain maximum function. Such cases should be resolved as rapidly as the situation requires, in no event to exceed a specified maximum amount of time. Failure by the plan to meet specified deadlines or to provide necessary information should result in automatic approval, for both expedited and regular appeals.

Health plans should collect and report grievance and appeal data specified by the state on standardized formats (see Chapter 13, Personal and Legal Rights, for policy on mandatory binding arbitration).

Managed care liability—All managed care plans should be held accountable for their actions. In cases where a health plan has been involved in a decision to delay or deny needed health care services, and the decision has medical consequences, the plan should be liable for any injuries or harm sustained by the enrollee. The right to seek meaningful judicial redress for decisions that lead to injury or death should be available to all managed care enrollees regardless of the source of their health care coverage. State laws on the corporate practice of medicine that prevent holding managed care organizations accountable for harm caused by an inappropriate treatment decision should be revised to afford the injured enrollee access to state court.

Coverage for experimental services—Health plans should have an objective process for considering experimental treatments. Plans should have an expeditious process for adopting new medical technologies that includes a process for reviewing new drugs, devices, procedures and therapies. There should be an external, independent review process for examining denials of coverage for experimental treatments. This review should be conducted by a panel of experts selected by an impartial, independent, accredited entity.

Coverage for care in clinical trials—Enrollees in managed care plans should have appropriate access to, information about and protections within clinical trials. Managed care plans should cover routine patient care costs (e.g., hospital services, physician services and diagnostic tests) associated with the participation of plan enrollees in clinical trials that are:

funded by the National Institutes of Health (NIH), Centers for Disease Control (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) and the Department of Veterans Affairs (VA);
supported by centers or cooperative groups funded by the NIH, CDC, AHRQ, CMS and DOD;

sponsored by the VA and conducted under an investigational new drug (IND) application reviewed by the Food and Drug Administration (FDA), drug trials exempt from needing an IND application under FDA regulations and any other trials deemed by CMS to meet the qualifying criteria developed by the appropriate multiagency federal panel.

These services should be covered even if the provider participating in the clinical trial is not part of the managed care organization’s network. However, the following services related to clinical trials need not be covered by the managed care organization: the investigational item or service itself, items and services provided solely to satisfy data collection needs, and items and services provided by the trial sponsor without charge.

**Credentialing**—Each practitioner must be credentialed before participating in the plan and recredentialed every two years. A representative of the health plan who is authorized to act on behalf of the plan (e.g., the medical director) must be responsible for the credentialing process. The health plan medical director need not be licensed in the state in which the plan is operating. There must be a credentialing committee, with representation of plan practitioners. Credentialing information must be subject to review and correction by the practitioner being credentialed. Information about the credentialing process and policies must be available for review to providers and enrollees upon request. Information on practitioner credentials must be made available to plan enrollees. It should also be readily available on request to prospective enrollees. For credentialing, the plan must obtain primary verification of current license, malpractice coverage, hospital privileges, board certification (if any), Drug Enforcement Agency certificate, medical degree and residency training and secondary verification of license history, malpractice history and National Practitioner Data Bank history. The plan also must conduct an on-site office visit and review of medical record-keeping practices. For recredentialing, in addition to all the procedures required for initial credentialing, the plan must review member complaints, results of quality assurance and utilization review activities, and member-reported experience with care.

**Provider and practitioner contracting**—Plans should be required to provide services through contracts with providers and practitioners. If a health plan denies a physician’s application to participate in the plan, terminates its agreement with the physician or suspends its contract with the physician, the health plan should provide the physician with a written explanation for the action and afford the physician the right to appeal.

Contracts must encourage open communication between providers and enrollees concerning all treatment options and other issues concerning patient
health care. Each contract should clearly identify the services to be provided and include provisions that:

• hold enrollees harmless for payment for covered services in the event of nonpayment by the health plan;

• require continuation of covered services to enrollees for the period for which a premium has been paid, regardless of insolvency of the health plan or other nonpayment by the health plan;

• prohibit collection of any payments from enrollees for covered services provided by the practitioner or as a result of an authorized referral by the practitioner, other than required cost-sharing;

• require the practitioner to participate in and cooperate with quality assurance and utilization review activities of the health plan and of federal external quality review entities;

• prohibit any physician incentive plan that directly or indirectly bases payment on the reduction or withholding of medically necessary services to enrollees;

• require medical records to be maintained in an appropriate manner that ensures the confidentiality of such records;

• require providers or practitioners to report specified data; and

• require the practitioner or provider’s office or facility to be subject to inspection by the plan.

Confidentiality— Managed care plans must prevent improper use or release of personally identifiable medical information and must adopt protections appropriate to the use of electronic information and nationally based payer and provider systems. Standards for confidentiality would best be established through a single federal law applicable to the entire health care system that includes civil and criminal penalties for violations.

Data collection and reporting— All health plans must comply with standardized data and reporting requirements that address the frequency and format of reports and the acceptability of aggregated data. States should require commercially licensed and public health maintenance organizations under their authority (e.g., Medicaid HMOs) to report complete Health Plan Data and Information Set (HEDIS) data, including the clinical effectiveness measures and the enrollee satisfaction information (i.e., CAHPS). Other managed care organizations (e.g., preferred provider organizations) should be required to collect and report at least enrollee satisfaction information as well as additional measures assessing access to care and customer service. (States also should survey fee-for-service enrollees to determine their satisfaction and experience with care.)
States are encouraged to publish HEDIS performance results, including the CAHPS data in a format that makes the information readily understandable to consumers.

Data collected by health plans must be independently audited for verification by an authorized entity. States also should require data on:

1. plan administration, such as medical costs or expenditures on a per capita basis by type of expenditure (physician, inpatient, outpatient, home health, skilled nursing facility, etc.);

2. complaints, grievances and appeals and their resolution;

3. physician satisfaction;

4. quality assurance and improvement;

5. credentialing;

6. utilization management and appeals regarding use of out-of-plan services;

7. accessibility, including wait times for appointments, rates of referral requests and numbers of practitioners accepting new patients;

8. rates of physician turnover; and

9. enrollment/disenrollment.

**Deeming by a private accrediting organization**—A state must not allow a private accrediting organization (PAO) to deem a health plan as meeting one or more of the state’s requirements unless the state has determined that the PAO’s standards and guidelines meet or exceed the state’s.

When a state authorizes a PAO to deem a health plan to be in compliance with one or more of the state’s requirements, the state must ensure that:

1. it retains full authority to enforce all regulatory requirements, whether or not it relies on the PAO’s information, processes or standards, and to initiate enforcement actions based on the results of a PAO’s processes and standards;

2. the use of or reliance on a PAO’s assessment is subject to full and open public comment processes;

3. a PAO’s standards and measures are readily and publicly available at no or nominal cost;
information about individuals who conduct reviews on behalf of a PAO is publicly disclosed, including the individual’s qualifications and affiliations;

- the surveys conducted by PAOs are periodically validated;

- the results of the PAO review process are public; and

- the PAO has no conflicts of interest with and is independent from those entities it accredits.

Compliance with either state or private accreditation standards should not be considered a substitute for complying with the requirement to undergo external quality review by designated professional entities.

Ombudsman programs—Consumers should have access to an independent, nonprofit ombudsman program that receives financial support from a state and/or the federal government. Such programs should assist consumers in understanding plans’ marketing materials and coverage provisions, educate enrollees about their rights within health plans, help identify and investigate enrollee complaints, assist enrollees in filing formal grievances and appeals, operate and staff a telephone hotline, and report to and advocate before appropriate regulatory bodies on issues of concern to consumers. Health plans should be required to cooperate with such programs.

Oversight—To ensure strong and effective oversight, states should allocate sufficient resources and personnel to the regulation of managed care organizations. States should ensure that the personnel assigned to regulate managed care plans are adequately trained to enforce applicable laws and regulations effectively. States should engage in ongoing oversight by reviewing and, as necessary, acting on data (e.g., by setting performance targets and issuing compliance notices) submitted by managed care plans. In addition, periodic site visits should be conducted in managed care plans every other year or more frequently as appropriate.

In those states where more than one agency has authority to regulate managed care organizations, those agencies should coordinate their activities to facilitate effective oversight.

Consumers should be represented on health plan decisionmaking and advisory bodies.

States organizing task forces to study managed care should include enrollees, prospective enrollees and other consumer representatives on such bodies.

As greater managed care enrollment occurs in rural areas, states must ensure that all standards, including but not limited to those standards that apply to the adequacy of the provider network, are met by plans operating in sparsely
populated areas, taking into account the prevailing patterns of service delivery in those areas.

HEALTH CARE COVERAGE • Private Health Insurance • Managed Care

Background

Restraints on Managed Care Operation

As managed care plans have proliferated, various laws have attempted to curtail the ability of managed care organizations to select freely their participating providers. These “any willing provider” laws require managed care plans to contract with any provider who is willing to accept the terms and conditions put forth by the managed care organization. These laws differ in the types of plans and providers to which they apply. Variations of any willing provider laws include pure freedom of choice and “contingent” freedom of choice laws. Under the former an enrollee may obtain covered services from any provider, whether or not the provider participates in the plan’s network. Under the latter the enrollee may obtain services from a nonparticipating provider as long as that provider is willing to accept the terms and conditions of the plan. Those who favor these types of laws consider them necessary to protect consumer choice, preserve continuity of care and maintain an acceptable level of quality. Those who oppose these laws argue that they are inconsistent with the way managed care plans are organized to do business and therefore undermine the ability of these plans to contain costs, inhibit their ability to have effective control over quality and increase administrative and health care costs.

FEDERAL & STATE POLICY

Restraints on Managed Care Operation

AARP supports the availability of managed care plans and opposes laws that pose barriers to their operation (such as “freedom of choice” or “any willing provider” laws). It is important that states and the federal government enforce all standards to ensure that consumers have access to managed care plans that are of the highest quality and that consumers receive the care they need.
Provider Reimbursement/Financial Incentives

The way providers are reimbursed can produce unintended effects on provider behavior. For example, in fee-for-service medicine, the fact that providers are paid a fee for each service provided could result in overuse of services and unnecessary care. In managed care the incentives are just the opposite. Because the health plan, the providers or both receive a fixed payment, regardless of the number of services rendered, there is the potential for under-service and the denial of needed care.

Managed care plans often employ financial incentive arrangements to induce participating providers to provide care cost effectively. These incentives include capitation payments, withholdings and bonuses for meeting budgetary targets. Depending on how these arrangements are implemented, financial incentives can have an adverse effect on patient care. Therefore, special protections are needed to ensure that financial incentives to induce providers to be cost conscious do not become barriers to care. It is also critical that financial incentive arrangements do not constrain providers in any way from discussing with patients the full range of treatment options (or any other issues) that may affect patient health or be available for a patient’s condition.

Some managed care plans reimburse individual providers on a full-risk capitation basis. This means a physician receives a fixed payment for providing all of the services his or her patient requires. In this approach to physician reimbursement, the relationship between the physician’s income and the amount of services provided to an individual enrollee is so direct that the physician may have an incentive to give fewer services than might be necessary.

A recent practice among large purchasers and employer coalitions is to offer health plans financial incentives to improve their performance. Pay for performance initiatives are intended to reward enhanced quality of care and a demonstrated commitment to quality and public reporting of performance. Typically, a percentage of the health plan premium is at risk, with payment contingent on achieving a specified level of performance. Performance in clinical care, member access to services and patient-reported experience with the care they receive is typically measured. In addition, many health plans are beginning to tie physician reimbursement to the delivery of care that meets high standards. A recent study reported that 24 percent of physicians were subject to performance-based incentives for patient satisfaction and 19 percent for quality. Physicians in practices that earn a higher proportion of revenues from capitation are more likely to be subject to these types of
incentives. However, in these types of practices, health plans are also more likely to use profiling, where physicians’ use of medical resources is compared with that of their peers.

FEDERAL & STATE POLICY

Provider Reimbursement/Financial Incentives

Financial incentives that foster the delivery of high-quality, cost-effective care should be encouraged. Financial incentives that create barriers to care or lead to under-service should be prohibited. Full-risk capitation should be prohibited for an individual provider.

States should require health plans to make information about the financial arrangements with their providers publicly available in standardized formats. To the extent possible this information should be consumer friendly and presented in nontechnical terms.

Laws should prohibit health plans from imposing gag rules or in any way constraining providers from discussing with patients their treatment options or other issues affecting their care. Providers should not be penalized for advocating on behalf of their patients. Laws should prohibit health plans from retaliating against providers or health care workers if they reasonably and in good faith report quality concerns to appropriate governmental agencies or bring such concerns to the attention of the most appropriate management official.

Research should be conducted to determine the impact of various incentive arrangements on access to and the quality of care in order to inform policymakers about incentive arrangements that should be prohibited.

HEALTH CARE COVERAGE • Private Health Insurance • Managed Care

Background

Retiree Health Coverage

Employer group health plans are the major source of health coverage for working adults and their families. Roughly two-thirds of all those under age 65 receive health insurance through an employer-sponsored plan. Research has shown that the availability of health benefits is a key factor in retirement decisions, especially among those who are not yet age 65, the age when Medicare coverage typically becomes available. Since the likelihood of health problems and the cost of insurance increase with age, maintaining health coverage is important to older adults facing retirement. Health insurance
plays an important role in protecting financial stability in retirement. If one lacks adequate health coverage, a major health problem can seriously erode retirement savings at a time in life when replacing lost savings is difficult.

Because of the significant role that employer-sponsored health coverage plays in retirement, the decline in the number of employers offering retiree health benefits in recent years is a matter of concern. Between 1993 and 2001 the percentage of large employers offering health benefits dropped from 46 percent to 29 percent for early retirees (those under age 65) and from 40 percent to 23 percent for Medicare-eligible retirees.

Even those retirees who continue to have employer-sponsored health benefits face higher costs, as employers increasingly pass a portion of the rise in health care cost along to retirees. In 2001, among large employers that provide coverage for early retirees, 35 percent require them to pay the full cost of their health benefits; 45 percent share premium costs with them. Among large employers that provide coverage for Medicare-eligible retirees, 31 percent require the retiree to pay the full cost of their benefits, and 47 percent share the cost. Retirees with employer-sponsored health benefits are likely to face other changes in their coverage, as employers seek ways to limit their future financial liability for these health benefits. For example, retirees may face incentives to move into managed care plans and caps on the employer contributions. These trends mean that retirees are likely to confront increasing out-of-pocket costs, which may price retiree health benefits beyond the reach of many retirees and leave them vulnerable to the risk of major financial difficulties if they become seriously ill.

An August 2000 decision of the US Court of Appeals for the Third Circuit (Erie County Retiree Assoc. v. County of Erie, 220 F.3d 193 (3d Cir. 2000)) highlights many of the evolving legal and economic issues surrounding employer-provided retiree health benefits. The court held that the Age Discrimination in Employment Act (ADEA) prohibition against discrimination in benefits prohibits employers from implementing benefit plans that treat retirees differently based on their Medicare eligibility. Thus, for example, an employer may not reduce or eliminate retiree health benefits at age 65. This decision has raised concerns among employers that their retiree health plans may be in violation of the ADEA. The case may have ramifications for retiree health benefits today and in the future if, in order to comply with the ADEA, employers decide to change, reduce or stop offering these benefits rather than incur higher costs.

Policies relating to tax treatment of employer benefits, regulation of employer health plans, age discrimination in employment, Medicare cost-sharing and coverage requirements, managed care and subsidies for individuals all affect employers and their decisions about retiree health benefits.
Retiree Health Coverage

AARP supports incentives to employers to maintain and safeguard retirement health benefits.

AARP opposes policies that will increase the number of uninsured early retirees or Medicare-eligible retirees without adequate coverage. Policies affecting retirement health benefits should incorporate features that prevent deterioration of health benefits.

For additional policy on retiree health coverage see:

1. Chapter 2, Taxation: Taxing Employer-Provided Benefits (policy on medical expense deduction);
2. Chapter 3, Retirement Income: Postretirement Health Benefits;
3. Chapter 4, Employment: Age Discrimination in Employment—Discrimination in Older Workers’ Benefits (policies related to ADEA’s “equal benefit” rule and exceptions);
4. Chapter 4, Employment: Employee Compensation and Benefits—Employee Health Benefits (policy on continuing coverage); and
5. Chapter 6, Enrollment in Managed Care Plans (policy on choice of plans), Strengthening Medicare for Current and Future Beneficiaries (policy on age of eligibility) and The Uninsured (policy on Medicare expansion).

HEALTH CARE COVERAGE • Private Health Insurance • Managed Care

Background

Medicare Supplement (Medigap) Insurance

Medicare beneficiaries who have private insurance to supplement their Medicare benefits generally have coverage either under an employer’s health benefit plan or under a Medicare Supplement policy, commonly called Medigap. Medigap coverage is predominantly sold to individuals rather than employer groups; this coverage, not employer-sponsored retiree coverage, is the subject of this section.
The Medicare supplemental (Medigap) insurance market was simplified by the Medigap reforms mandated as part of the Omnibus Budget Reconciliation Act of 1990. This federal law provided for standardized Medigap policies that insurance companies can offer. In addition, it included a variety of important consumer protections, such as guaranteed renewal of all policies, a uniform outline of coverage, guaranteed issuance of coverage at age 65 or older regardless of health status for the first six months of Medicare Part B enrollment, a six-month limit on coverage restrictions for preexisting conditions, and prohibition of the sale of duplicative policies (see also Chapter 12, Consumer Products and Financial Services: Insurance).

The Balanced Budget Act of 1997 expanded guaranteed access to Medigap to people under certain circumstances, including the loss of other coverage due to the termination of a Medicare+Choice plan’s Medicare contract, termination of employer-sponsored coverage and beneficiaries’ voluntary disenrollment within 12 months from their initial enrollment in a Medicare+Choice option. The act also improved portability protections by providing that prior, continuous insurance coverage be credited against the allowed six-month restriction on benefits related to preexisting conditions.

Although these federal Medigap reforms have strengthened consumer protections in the Medicare supplement market, there is room for more improvement.

Federal law does not guarantee that disabled Medicare beneficiaries under age 65 are offered Medicare supplemental health insurance without preexisting-condition exclusions upon initial enrollment in Medicare Part B. Among this group of beneficiaries, only about 6 percent have any form of individually purchased private insurance, compared with 27 percent of older beneficiaries.

Rising premiums may push Medicare supplemental insurance beyond the reach of many people on fixed incomes. Among those remaining in the Medicare fee-for-service program, private supplemental coverage (under an employer-sponsored plan or Medigap) declined from 24.2 million in 1992 to 22.5 million in 1999. Over the same time frame, the number of beneficiaries enrolled in fee-for-service Medicare who had no supplemental coverage dropped from 3.9 million to 3.3 million. These Medicare beneficiaries risk incurring substantial out-of-pocket health costs if they have a serious health problem. Since the majority of individuals with Medigap pay the full premium cost out of their own pockets, they are affected by premium increases. Hence, there is growing concern about containing premium increases. Rating practices that permit rate increases on the basis of age can contribute to the expense of Medigap coverage over time. While many people have the option of enrolling in a Medicare+Choice plan that may have a lower premium, many others do not.
Changes in Medicare itself raise issues that call for reexamining the rules governing Medicare supplemental policies. Rules on initial, annual and special election periods for Medicare coverage options protect access to fee-for-service Medicare. Rules governing open enrollment and special enrollment for Medicare supplemental insurance protect a beneficiary’s access to supplemental coverage at the point of initial Medicare enrollment and for special enrollment periods. However, Medicare supplemental rules do not protect beneficiary access to coverage outside current special enrollment periods, and they guarantee access to only certain plans, none of which covers drug benefits. Ideally, rules governing access to Medicare supplemental insurance should parallel those for Medicare+Choice options. Under current law Medicare beneficiaries may disenroll from a Medicare+Choice plan at any time. However, they may not be able to buy Medigap coverage if they change to original Medicare.

**FEDERAL & STATE POLICY**

**HEALTH CARE COVERAGE**  
- Private Health Insurance  
- Managed Care

**Medicare Supplement (Medigap) Insurance**

AARP supports efforts to ensure that Medicare supplemental health insurance (Medigap) is affordable and available to those who need it by:

1. requiring pure community rating and prohibiting insurers from varying premium levels and premium rate increases for different individuals on the basis of age;

2. applying similar regulatory rules on medical underwriting to all Medigap insurers in an effort to improve coverage affordability and availability;

3. requiring Medicare supplemental insurers to provide disabled Medicare beneficiaries under age 65 who are not in Medicare’s end-stage renal disease (ESRD) program with the same guaranteed access to supplemental coverage given to beneficiaries age 65 and over; and

4. providing a means to protect ESRD beneficiaries against high out-of-pocket costs by creating a managed care option; a federally supported Medicare supplemental policy, Medigap risk-pool program or reinsurance program for guaranteed access to private supplemental coverage; or some variation on, or combination of, these options.
HEALTH CARE COVERAGE

**FEDERAL POLICY**

**Private Health Insurance**

**Managed Care**

**Medicare Supplement (Medigap) Insurance**

AARP supports Medigap standardization.

To put access to all Medicare coverage options (fee-for-service and Medicare+Choice) on a level playing field, AARP supports a uniform, annual, open enrollment period that makes all Medigap products available to Medicare beneficiaries without regard to their health status.

**STATE POLICY**

**Private Health Insurance**

**Managed Care**

**Medicare Supplement (Medigap) Insurance**

States should monitor changes in Medigap premiums and be particularly attentive when reviewing and approving them to ensure that rates appropriately reflect major shifts in claims exposure (with particular attention to pharmacy claims in plans with drug benefits).

**HEALTH CARE COVERAGE • Publicly Administered Health Insurance**

**Background**

**The Medicare Program**

Medicare was enacted in 1965 to help the elderly obtain and pay for necessary medical care. Before Medicare only about half of older Americans had any health insurance. Employer-provided retiree health coverage was the exception, not the rule, and those seeking to purchase coverage privately were frequently denied it on the basis of age or preexisting conditions, or they found coverage unaffordable. Today, Medicare is a popular federal health insurance program that serves 39 million beneficiaries, including most Americans age 65 and over and younger people who have been receiving federal disability benefits for at least two years. The program benefits not only elderly and disabled people but also their families by providing a financial safety net.

Medicare has two parts: Part A and Part B. Part A (Hospital Insurance) includes inpatient hospital care (including inpatient drugs), home health services linked to a prior hospitalization, limited skilled nursing home care and hospice care. Part B (Supplemental Medical Insurance) includes
physician services, some home health services (those not linked to a prior hospitalization) and outpatient services. Medicare does not cover prescription drugs needed outside the hospital; long-term care; routine physical examinations; or most vision, hearing or dental services. Beneficiaries pay a monthly premium for doctor services and significant coinsurance and deductibles for covered services. Medicare pays approximately 50 percent of the cost of beneficiaries’ health care services.

Medicare Part A is financed primarily by payroll taxes—employers and employees each pay 1.45 percent of wages to the Part A trust fund. Medicare Part B is financed by a combination of beneficiary premiums and general federal revenues. Beneficiary premiums are intended to cover about 25 percent of Part B program costs, while general federal revenues finance the remainder through the Part B trust fund.

Some Medicare beneficiaries can receive Medicare benefits through a Medicare+Choice option. Medicare+Choice is designed to give beneficiaries a wider range of private health plan options beyond the original Medicare program. Medicare+Choice plans must provide all the benefits covered by Parts A and B in original Medicare. In addition, many Medicare+Choice plans may offer beneficiaries lower cost-sharing and more benefits than original Medicare. Beneficiaries who choose a Medicare+Choice plan are still responsible for paying the Part B premium, as well as any additional premiums and cost-sharing that may be charged by the Medicare+Choice plan they choose.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
- The Medicare Program

Background

**Medicare as Social Insurance**

Since its inception, Medicare has been a social insurance program: It provides a set of health benefits defined in law to all eligible Americans and individuals with disabilities, and all beneficiaries are entitled to the same level of benefits, regardless of age, income or health status. Individuals become entitled to Medicare benefits by paying into the system through payroll taxes. Requiring an income or asset test to demonstrate need for Medicare coverage, or conditioning eligibility or cost-sharing on income or assets would change the entitlement. It would be administratively complex and costly, erode popular support for the program and undermine the principle of social obligation and interdependence among generations that is the hallmark of social insurance.
Medicare as Social Insurance

AARP is strongly committed to Medicare as a social insurance program. The association opposes efforts to convert Medicare from a defined benefit to a defined contribution program (see this chapter’s section Publicly Administered Health Insurance—The Medicare Program—Strengthening Medicare for Current and Future Beneficiaries). AARP opposes efforts to condition Medicare eligibility on income or assets and/or vary program deductibles and coinsurance by income or assets.

Background

Strengthening Medicare for Current and Future Beneficiaries

For nearly 40 years Medicare has enabled millions of Americans who could not otherwise afford health care to get the care they require. Americans of all ages link the availability of Medicare to financial security and independence in retirement. There is a need to ensure that Medicare remains strong so that it can continue to protect not only current but future generations.

Continued increases in medical costs, rapid changes in medical technology and the aging of the baby-boom population will require consideration of reforms to Medicare in future years. This effort will require extensive discussion among current Medicare beneficiaries, future beneficiaries (particularly members of the baby-boom generation), health care providers, health plans and government officials.

The following are some of the longer-term reform issues that are part of the debate over Medicare’s future:

Who should be eligible to receive Medicare benefits? One of the fundamental issues for the future of Medicare is whether the program’s current eligibility requirements should remain the same. Some have suggested that Medicare be changed to a means-tested program, in which eligibility would be based on income, in addition to the program’s current age or disability status requirements. In a means-tested program individuals with income and assets above a predetermined threshold who are otherwise entitled to receive benefits would not be eligible for Medicare coverage.
Supporters of this approach contend that it would allow the government to focus its resources on those Americans least able to afford health insurance. Critics argue that there are at least three problems with this approach: a program that is not broadly based tends to decay over time because of a loss of public support; there is currently no private insurance market for older Americans and individuals with disabilities, nor do we know the extent to which the private sector is willing or able to provide health insurance to this population; and even if such a market develops, the private market’s ability to segment the risk pool could lead to less expensive health insurance premiums for younger and healthier beneficiaries but unaffordably high premiums for people who are older, less healthy or disabled.

**How should Medicare be coordinated with other programs for Americans who become disabled before age 65?** Under current law people who are under age 65 and become disabled and then qualify for federal disability programs generally have to wait 24 additional months before they can receive Medicare benefits. This waiting period is waived only for individuals diagnosed with amyotrophic lateral sclerosis. The waiting period established for Medicare took into consideration the various public and private programs that can provide health care coverage to individuals during this period, including state temporary disability programs, Veterans’ benefits, workers’ compensation plans and employment- and union-based health insurance. However, not all people who become disabled are protected by these programs as they wait for Medicare eligibility. Extending Medicare coverage to more people who become disabled would involve both issues of coordination among payers and additional costs to Medicare.

**At what age should people become eligible for Medicare benefits?** Currently, Americans age 65 and over (as well as many Americans with disabilities) are eligible to receive Medicare benefits. Some recommend reducing Medicare costs by raising the age of eligibility for nondisabled beneficiaries to 67, while others advocate expanding eligibility by offering a buy-in to early retirees and other people under age 65 who do not have health insurance. Those who advocate raising the age of eligibility contend that doing so would reduce program costs, bring Medicare in line with changes already made in the Social Security eligibility age and discourage early retirement. However, critics assert that raising the age of eligibility would do little to reduce Medicare’s costs, because 65- and 66-year-olds, in general, use relatively few Medicare services. In addition, caring for the 65- and 66-year-olds most in need of services would increase costs to those employers who provide retiree coverage (because Medicare would no longer cover these individuals) and could lead employers to reduce or eliminate retiree coverage. Also, those most in need of Medicare services likely would have difficulty qualifying for affordable health insurance elsewhere. By contrast, those who advocate expanding eligibility through an early Medicare buy-in, assert that, if the option is affordably priced, it could expand access for individuals near the age of Medicare eligibility. However, critics of an early buy-in contend that it could substantially increase Medicare costs.
What benefits should Medicare cover? Compared to private health insurance policies, original Medicare has significant gaps in coverage (particularly for prescription drugs) and lacks limits on out-of-pocket spending. Filling those gaps would not only enhance the quality of care for beneficiaries, but also allow original Medicare to compete more effectively with managed care options, since many managed care plans offer some or all of these benefits. However, filling these gaps also could result in large increases in Medicare costs.

What should the nature of Medicare’s guarantee be? Medicare currently offers a guarantee of a defined package of benefits, regardless of the level of federal government contribution required to provide those benefits. Some critics assert that this defined benefit system gives neither beneficiaries nor providers an incentive to adopt cost-efficient ways of providing and delivering medical services. Alternatively, supporters of the defined benefit system contend that it provides the foundation of Medicare’s guarantee of access to affordable health care.

Some Medicare reform advocates have proposed alternatives to the current Medicare guarantee of defined benefits. Among the most commonly discussed options are defined contribution models. Under this framework Medicare would guarantee payment of a defined financial contribution that is used toward the purchase of Medicare coverage, rather than provide a guarantee of a specified package of benefits.

One option for setting the defined financial contribution is to allow it to grow at the same rate as an externally determined measure, such as the general rate of inflation. This approach has the advantage of providing budgetary predictability. However, over time, it would likely mean a decrease in the value of benefits because health care costs typically rise faster than measures such as the general price level. Another option for setting the payment level is to link it to a measure of health care cost inflation. Since different types of health care, such as prescription drugs or hospital care, might increase at different rates, establishing a fair payment level could be difficult under any formula tied to a single external measure. Inadequate payment rates could lead some providers to avoid participating in Medicare.

An alternative defined contribution option, commonly known as a premium support model, would link changes in Medicare’s financial contribution to changes in health plan costs rather than to an externally determined measure. This option is intended to guarantee access to a standardized benefit package while giving beneficiaries a financial incentive to choose the least costly plan that fits their needs. Proponents assert that this option offers beneficiaries greater protection against increasing Medicare costs than do other defined contribution approaches. Some also propose a model that encompasses a defined contribution and a defined benefit, that is, a formula in which the public contribution to Medicare premiums is set at the level necessary to provide a basic benefit package defined in law. Critics contend that
beneficiaries could still be at risk of greater out-of-pocket health costs if Medicare's premium contribution were reduced in order to achieve budgetary savings, or if the benefit package were not sufficiently comprehensive, forcing beneficiaries to buy additional insurance.

**How should Medicare be financed?** Another issue in the reform debate is whether and how to provide additional financing to Medicare. Currently, income to the Part A trust fund comes primarily from the payroll tax. (Additional sources include a portion of federal income taxes on Social Security benefits that is dedicated to the Part A trust fund; see Chapter 3, Retirement Income, for further discussion.) However, these revenue sources are projected to fall behind future enrollment growth. During times of federal budget surpluses, one proposal was to dedicate a share of any projected federal budget surplus to extending Part A solvency. (Medicare Part B, which is funded through beneficiary premiums and federal general revenues, does not face the same solvency issues as Part A.) Supporters of this approach have suggested that it would strengthen Medicare without imposing additional taxes. However, critics assert that proposals to provide additional funds to Part A would fundamentally change Part A's financing structure by making it more reliant on general revenues and surpluses that might never materialize.

An additional proposal being debated is whether to income-relate Medicare Part B premiums— that is, ask higher-income beneficiaries to pay a greater share of Part B costs. Currently, all Medicare beneficiaries pay the same premium, which covers only about 25 percent of Part B costs; the federal government covers the remaining Part B costs. Although income-relating the Medicare Part B premium would do little to reduce Medicare costs over the long term, some people believe that the federal government should reduce its Medicare Part B payment for higher-income beneficiaries in order to reduce the budgetary cost of the program. However, others contend that requiring higher-income beneficiaries to pay higher premiums might undermine support for the program. People who are now paying the most in payroll taxes for Medicare Hospital Insurance during their work lives could resent having to pay more to enjoy the benefits to which they are entitled after they retire.

**How much should beneficiaries pay for health care?** Although Medicare provides valuable financial protection to its beneficiaries, it currently covers only about half of beneficiaries' total health care costs. Medicare reform discussions need to address the amount that beneficiaries should be asked to pay for Medicare (both premiums and cost-sharing) and for health care in general, whether and how to restructure beneficiary cost-sharing and what costs all taxpayers would be required to share.

**What kind of consumer and quality protections should Medicare provide?** Consumer advocates assert that all Medicare contractors, regardless of plan structure or model type, should comply with strong and
comprehensive consumer protection and quality standards. There are those who believe that in order to ensure access to high-quality care, such requirements should be embedded in a system of strong regulatory oversight. Others believe that this result is better achieved through free-market competition.

**How could quality be improved in the Medicare program?** There are serious and widespread problems in the quality of care provided to Americans, including Medicare beneficiaries. These problems include overuse, or exposing individuals to the risks of health services from which they cannot benefit; underuse, or failing to receive necessary and appropriate services; and misuse, resulting in injury caused by preventable complications (see also this chapter’s section The Medicare Program—Medicare Payments to Managed Care Plans—Quality Oversight).

**How could original Medicare be improved?** In recent years the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services (CMS), had begun adopting a number of management changes designed to improve the administration and management of the traditional fee-for-service Medicare program. There is significant evidence demonstrating that, even without taking on new responsibilities, the current administrative infrastructure at CMS is inadequate. A number of experts have proposed reforms, including changes in CMS’s statutory and regulatory authorities and responsibilities, an increase in resources to permit the recruitment of needed staff and technical expertise and to upgrade antiquated information systems, and higher levels and more secure funding to support education and technical assistance to both beneficiaries and providers.

Some experts contend that administrative and management reforms are not enough, and that Medicare should move away from its traditional orientation as a payer of health insurance claims and take on a more proactive role as a “value purchaser.” This would mean using its leverage to improve the health care options available to beneficiaries and to foster the prevention of illness and more effective management of health problems across the continuum of care. It could include adopting private-sector practices such as competitive contracting for specialty services; establishing contracts with preferred providers through special payments or allowing payment for otherwise noncovered services as part of specialized case management, disease management or care coordination programs; or partnerships with community-based organizations to promote beneficiary health. Proponents of this role believe that more emphasis on these practices would improve beneficiary care and could in some circumstances lead to cost savings. However, critics are concerned that some practices borrowed from the private sector, such as some forms of provider contracting, could undermine fundamental aspects of original Medicare that guarantee to beneficiaries the ability to choose their own provider and could result in some new or enhanced services and benefits being available only to beneficiaries in particular regions or metropolitan areas.
FEDERAL POLICY

HEALTH CARE COVERAGE  groupId  Publicly Administered Health Insurance  groupId  The Medicare Program

Strengthening Medicare for Current and Future Beneficiaries

AARP is committed to maintaining and strengthening the Medicare program so that it will continue to provide high-quality, affordable health care coverage for current and future beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) must monitor the impacts of Medicare payment reforms. In particular, CMS must:

1. monitor provider payments and alert Congress if they are inadequate and discouraging providers from offering services to Medicare beneficiaries, especially in rural areas;

2. monitor the impact of increases in Part B premiums on lower-income beneficiaries, particularly those without Medicaid, and determine whether premium affordability is a barrier to access to Part B services; and

3. ensure that the phase-down of beneficiary coinsurance for outpatient hospital care continues as rapidly as possible.

In times of federal on-budget surpluses, AARP supports dedicating an appropriate portion of such surpluses to extending Medicare’s solvency and improving Medicare, for example, by adding prescription drug coverage in Medicare.

Over the longer term Medicare must address demographic shifts and delivery system changes in the rest of the health care marketplace. Any Medicare reforms should be made deliberately, with extensive input from current and future beneficiaries. Medicare reforms should reflect the following principles:

1. Medicare should guarantee coverage for all older Americans and people with disabilities, regardless of income or health status.

2. Medicare should guarantee specified benefits defined in law, that is, remain a defined benefit program that meets beneficiaries’ health care needs. The government’s share of the costs of Medicare benefits must keep pace with the growth in the costs of those benefits and not be tied to artificial budgetary targets.

3. Medicare’s benefit package should provide access to the most effective medical treatments and therefore should include prescription drug coverage available to all beneficiaries, without regard to their income,
geographic location, health status or choice of Medicare plan. While AARP recognizes that the Medicare program requires some additional reforms, it supports the provision of prescription drug coverage that meets the association's Medicare principles, even in the absence of such reforms (for additional policy on Medicare coverage for prescription drugs, see the section Publicly Administered Health Insurance—Original Medicare—Medicare's Coverage of Prescription Drugs).

Original fee-for-service Medicare should be strengthened so that it remains a viable option for all beneficiaries. AARP supports changes that improve operating efficiencies and enhance Medicare's ability to function as a large purchaser of health care. Specific proposals to expand Medicare's contracting and procurement authorities must contain protections necessary to preserve access to and ensure the delivery of high-quality care for beneficiaries in the original fee-for-service program.

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs.

Medicare reforms should explicitly recognize the special health care and economic needs of low-income beneficiaries, the vast majority of whom are women, and protect them from bearing undue out-of-pocket health costs.

Medicare reforms should neither reduce access to health care nor shift burdensome financial risk to Medicare beneficiaries. Thus, AARP opposes raising the age of eligibility for Medicare or means testing Medicare, that is, basing eligibility on income or assets (for policy on means testing, see Publicly Administered Health Insurance—The Medicare Program—Medicare as Social Insurance).

Medicare payment rates should be fair, reflect geographic variations in costs and encourage efficiency among providers while maintaining beneficiaries' access to affordable health care.

Criteria for evaluating Medicare's financing sources should include the extent to which such sources are broadly based, stable, progressive and consistent with furthering public health objectives, and grow with enrollment.

Medicare should improve the quality of care for beneficiaries and maximize the value of its expenditures by implementing ways to prevent the overuse, underuse and misuse of health care services.

Medicare beneficiaries should continue to have access to a choice of providers and health plan options, including a strong and viable original Medicare program. To enhance these choices all beneficiaries should have access to coverage that supplements original Medicare.
All health options offered to Medicare beneficiaries must meet rigorous standards for consumer protection and quality of care. (See the Medicare+Choice section of this chapter).

Medicare must rigorously attack waste, fraud and abuse in order to ensure value for the program and for beneficiaries.

Policymakers should eliminate the existing 24-month Medicare waiting period for Social Security Disability Insurance (SSDI) recipients.

Policymakers should investigate and evaluate options for extending health insurance to the near-elderly. Among possible options to be studied are a Medicare buy-in, Comprehensive Omnibus Budget Reconciliation Act (COBRA) extensions or expansions and private-market reforms (for federal policy on this issue, see The Uninsured and the Need for a Safety Net—The Uninsured in this chapter).

Congress should expand Medicare to offer coverage for long-term care.

Major changes in the Medicare program should first be evaluated in demonstration projects that assess the effects of proposed changes on Medicare costs, access to health care services, continuity of care, quality of care, beneficiary satisfaction, stability of the Medicare risk pools and beneficiaries' out-of-pocket costs.

Ultimately, comprehensive health care reform offers the best opportunity to ensure all Americans, including Medicare beneficiaries, access to needed health services while effectively controlling health care costs.

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HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program

Background

Improving Care for Beneficiaries with Chronic Conditions

New developments in medicine, technological advances and greater knowledge about healthy lifestyles promise continued improvements in longevity for Americans. Longer lifespans also mean increased survival of those with serious, persistent illnesses. Due in part to the aging of the population, the number of older Americans with chronic diseases is already large and growing. In 1996, 51 million Americans age 50 and older—more than three out of every four older people—had at least one chronic condition. About 40 percent of these individuals also had a mental or physical impairment that limited their activities.
The number and type of chronic conditions vary across individuals, particularly with age among the population. While roughly two-thirds of Medicare beneficiaries have more than one chronic condition, multiple chronic conditions are also relatively common, especially among older or less healthy beneficiaries, e.g., nursing home residents, beneficiaries dually eligible for Medicaid, those age 85 and older and non-Hispanic blacks. Medicare beneficiaries under age 65 are more likely to be among beneficiaries with mental retardation and severe mental illness; these disabled people present special challenges for parents who are aging and dealing with the impact of their own chronic conditions. Common chronic conditions limiting daily activities among all beneficiaries include circulatory disorders, such as hypertension and heart disease, arthritis and diabetes; among those age 70 and over, visual impairments and osteoporosis also become increasingly prevalent. Overall, 8 percent to 15 percent of people over age 65 have Alzheimer's disease, the most common form of dementia, and the risk of developing the disease goes up dramatically with age. Older people also are at increased risk of suffering incontinence, malnutrition, falls and medication misuse.

Not surprisingly, the health and long-term care needs of people with chronic conditions are both complex and diverse. With the rise of these chronic conditions has come a shift in needs away from care that is predominantly acute and episodic. Instead, the need for long-term care (i.e., personal care and other supportive services that a person might need because of a disability or functional limitation) is often intertwined with the need for medical care. Nevertheless, at times people with ongoing chronic conditions need treatment for acute, short-term episodes of their illness. Furthermore, in many cases, the patient is receiving care from more than one health care provider and from providers in different settings, introducing further information and communication challenges into a situation where care is already fragmented. For beneficiaries with certain chronic conditions, preventing further complications or minimizing disability is the primary goal. Individuals with chronic conditions may also have mental health or substance abuse needs that require a different type of attention.

In addition, due to their greater use of services and limited coverage for certain services (especially custodial care not covered by Medicare), chronically ill people are at greater risk for facing large out-of-pocket costs. Individuals with chronic conditions also are more sensitive to cost-sharing features since their incomes are likely to be more limited. Affordable supplemental coverage to protect against burdensome cost-sharing often is not accessible to younger disabled Medicare beneficiaries and those with end-stage renal disease. The impact of chronic conditions on out-of-pocket spending is particularly apparent with prescription drugs. Medicare beneficiaries in poor health or with chronic conditions fill more prescriptions than healthier beneficiaries; yet in 1998 beneficiaries with three or more chronic conditions who did not have drug coverage purchased roughly 25 percent fewer prescriptions and paid nearly $375 more out of pocket than did their counterparts with coverage.
Treatment of chronic illnesses accounts for the majority of health care expenditures, including those of the Medicare program. While much progress has been made in the management and control of chronic conditions, including the prevention of complications, examples of where chronic care practices continue to fall short of delivering proven interventions abound: approximately three out of four people with high blood pressure or depression do not receive adequate treatment, 71 percent of diabetics have uncontrolled lipid levels and 50 percent of patients previously hospitalized with congestive heart failure are readmitted within three months. In its second major report on the quality of health care in America, the Institute of Medicine recently concluded that the health care delivery system needs fundamental change in order to improve care substantially, including care for people with chronic illnesses. Key systemwide shortcomings include failures to share knowledge about best practices and implement processes for optimal care, apply advances in information technology to facilitate multiple providers’ access to patient information, support clinical decisionmaking and align payment and accountability incentives with quality goals.

A number of factors affecting Medicare’s ability to meet the needs of chronically ill beneficiaries have been identified, including:

1. Lack of limits on out-of-pocket expenses incurred by sicker beneficiaries who use more services;
2. Lack of coverage for prescription drugs, which play an important role in controlling chronic conditions;
3. Limited or no coverage for products and services provided to slow further deterioration or maximize beneficiary functioning rather than achieving a cure—Examples of services generally not covered are dental care, as well as aids that partially or fully restore hearing and vision in people with impairments. Examples of services where coverage is limited to specific circumstances include mental health care, podiatric services and some rehabilitation therapies; and
4. Lack of a structure or incentives for providers outside of Medicare health maintenance organizations to assess the needs of chronically ill beneficiaries, deliver chronic condition management services (e.g., case management and disease management) or develop innovative programs for meeting these needs.

In recent years several initiatives have begun to explore ways of improving care generally for chronically ill people covered under Medicare without increasing program costs. Such efforts include a demonstration of coordinated care services—case management and disease management—for fee-for-service beneficiaries with complex chronic conditions and a demonstration of disease management services for specific chronic conditions. Several of the
demonstration projects are modeled on lessons learned from chronic care delivery in managed care plans.

FEDERAL POLICY

HEALTH CARE COVERAGEatham Administered Health Insurance

Improving Care for Beneficiaries with Chronic Conditions

The federal government should focus more attention on optimizing the health of Medicare beneficiaries. This means ensuring that providers and health plans have information about the state of the art in managing chronic conditions. It also involves helping individuals of all ages cope with changes as chronic diseases progress, to prevent further disability and maximize function and well-being. In addition, geriatric conditions that are common among older people need to be better addressed, especially through tertiary prevention.

Government efforts should emphasize:

1. encouraging providers for Medicare beneficiaries and other populations to intervene early to prevent the progression of disease;

2. providing appropriate educational and self-care programs that help maintain or improve the health status of those with chronic diseases;

3. tracking the continuity of care across multiple institutional, home and community settings; and

4. improving the interpersonal aspects of care, such as patient-physician communication.

In particular, the Centers for Medicare and Medicaid Services (CMS) should collaborate with other agencies to identify and distribute information to help Medicare beneficiaries and providers learn more about how to manage problems of chronic illness and their role in this process.

Medicare policies should support the efficient delivery of the optimal care for meeting the health care needs of those with chronic illness and disabling conditions. Specific features of such a delivery system include the appropriate use of proven medical protocols (guidelines) and interdisciplinary care teams that may be composed of health professionals such as physicians, nurses, social workers, therapists and pharmacists (see Chapter 7, Long-Term Care, for policy on long-term care). Medicare should cover the most appropriate level of health care services. In addition, in order to ensure that people with chronic conditions are not disadvantaged in the receipt of services or access to health plans, program payments to providers and health plans should more accurately reflect the effort involved in providing health care services to these individuals.
CMS should be responsible for determining the conditions under which, and the target populations for whom, Medicare coverage for comprehensive geriatric assessment is warranted. CMS should also identify opportunities and mechanisms for introducing chronic care management activities to all parts of the Medicare program.

AARP supports developing comprehensive, coordinated approaches to financing and delivering a wide range of needed care to chronically ill people. Under specific circumstances, existing Medicare and Medicaid waiver authority should be used to join funding streams and facilitate the integration of health and long-term care for beneficiaries enrolled in both programs (see this chapter’s section Health Care Coverage—Publicly Administered Health Insurance—When Medicare and Medicaid Meet—Federal-State Flexibility).

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program

Background

Medicare+Choice

The Balanced Budget Act of 1997 established the Medicare+Choice program (M+C), which included a wide array of health care coverage options for Medicare beneficiaries in addition to the original Medicare Plan. These are described below.

In original Medicare, beneficiaries choose their own physicians and hospitals, which are paid on a fee-for-service basis. In addition to the Part B premium, beneficiaries pay cost-sharing in the form of deductibles and coinsurance. Most beneficiaries supplement their Medicare benefits either through privately purchased Medigap policies or retiree benefits provided through a previous employer. A small proportion of Medicare beneficiaries do not have supplemental coverage.

M+C Options— To be eligible for an M+C option, a Medicare beneficiary must be eligible for Parts A and B of Medicare and pay the Medicare Part B premium. M+C consists of the following types of plans:

Coordinated care plans— There are three types of coordinated plans:

1. Health maintenance organizations (HMOs) have been available to Medicare beneficiaries for many years. They offer all Medicare benefits and sometimes additional benefits not covered by the original Medicare plan. Enrollees must receive all their health care services from the HMO, except for emergency care or urgently needed care provided outside the HMO’s service area. HMOs also may offer an option that allows a beneficiary to obtain services
outside its network for higher out-of-pocket costs. This is called a point-of-service option.

1. Provider-sponsored organizations (PSOs) are similar to HMOs and offer networks of health professionals who provide comprehensive services. However, PSOs are organized and operated by the physicians and hospitals that provide most of the services.

1. Preferred provider organizations (PPOs) have networks of physicians and hospitals that have agreed to discount their rates for plan members. Enrollees are free to consult non-network health professionals whenever they want but must pay higher out-of-pocket costs to do so.

1. **Private fee-for-service (PFFS) plans**—These allow private insurance companies to offer Medicare beneficiaries an indemnity health insurance policy. PFFS plans are required to cover at least the basic benefits covered by the original Medicare program. They also may offer supplemental benefits. Unlike in other M+C options physicians in private fee-for-service plans may balance-bill 15 percent above the plan’s fee schedule. As of January 2003 two private fee for service plans were offered. One insurance company began marketing a PFFS plan in July 2000; it is now available in parts or all of 25 states. (By region these states are: in the West: Alaska, Arizona, Idaho, New Mexico, Nevada, Oregon, Washington and Utah; in the Midwest: Illinois, Iowa, Minnesota, Nebraska, Ohio and South Dakota; in the Northeast: Pennsylvania and Delaware; and in the South: Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, Texas and West Virginia.) A second plan entered the Medicare market in 2003 and will be available in Iowa, Minnesota, Wisconsin, and parts of North and South Dakota. In 2003 PFFS plans will be available to 34 percent of Medicare beneficiaries.

1. **Medical savings accounts (MSAs)**—MSAs may be offered on a trial basis to up to 390,000 beneficiaries. Beneficiaries who select the MSA option must remain enrolled for an entire year. In an MSA doctors, hospitals and other providers may charge the beneficiary whatever fee level they choose; MSAs are not subject to Medicare’s own fee schedules or balance-billing protections. Beneficiaries who choose the MSA option may not buy or keep Medicare supplemental (Medigap) insurance to help pay for services not covered in the MSA plan. Finally, beneficiaries who choose the MSA option may face financial incentives to forgo necessary preventive and routine care. To date no MSAs have been offered in the Medicare program (for a description of MSAs, see Private Health Insurance—Private Market Regulation).

The Medicare+Choice program poses both opportunities and risks for Medicare beneficiaries and the Medicare program. On the one hand having a wider array of health plan options gives beneficiaries greater opportunities to
find health plans that meet their needs and preferences (e.g., additional benefits and a range of cost-sharing arrangements). On the other hand by giving beneficiaries broader choices in addition to original Medicare, the Medicare risk pool is inevitably segmented. There is already evidence that the healthiest beneficiaries are likely to enroll in an M+C option, leaving the sicker (hence, most expensive) beneficiaries in original Medicare. In addition, two of the M+C options, PFFS plans and MSAs, could cause adverse selection within the Medicare+Choice program. If these options attract the healthiest beneficiaries, the other options with sicker enrollees could become more expensive over time.

Favorable selection in the M+C program underscores the importance of risk-adjusting Medicare payments to contracting plans. An accurate risk-adjustment mechanism may mitigate the effects of risk segmentation by increasing payments to health plans for high-cost or high-risk beneficiaries and reducing payments to plans with healthier enrollees. Without these kinds of corrections, Medicare will continue to overpay providers for healthier enrollees while underpaying them for those who are sicker.

Among its original objectives in establishing the M+C program, Congress sought to contain the growth in Medicare spending, improve the payment method for certain providers and provide beneficiaries with more choices and enhanced benefits to make Medicare look more like a private-sector program. It is now evident that the M+C program has not met these objectives. There is evidence that M+C plans—like their predecessor, managed care programs—have not been successful in achieving Medicare savings. M+C plans attract, on average, healthier enrollees than those in the original Medicare plan. The General Accounting Office estimated that in 1998 Medicare spent 13.2 percent more ($3.2 billion) on health plan enrollees than it would have if they had received services under the original Medicare plan. In addition, the wide range of additional choices authorized by Congress has not materialized. With few exceptions HMOs (with or without a point-of-service option) remain the sole alternative to original Medicare. Many experts point out that the policy objectives Congress initially established for the M+C program are contradictory and unattainable. For example, it is difficult to expect health plans to save the Medicare program money if they are also expected to provide beneficiaries additional benefits, such as prescription drugs. These experts agree that the inclusion of a prescription drug benefit in the Medicare program would greatly relieve some of the pressure on the M+C plans and would help stabilize this program. In addition, they advise Congress to clarify its objectives for the program.

To stimulate participation of PPOs in the M+C program, CMS has initiated a demonstration program to test PPOs that would operate under different conditions from those mandated for other M+C plans, including different risk-sharing arrangements. Starting in January 2003 these demonstration plans will operate in parts of 23 states (Alabama, Arizona, California, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, Nevada,
New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Virginia, Washington and West Virginia. CMS estimates that 150,000 Medicare beneficiaries may enroll in these health plans.

Since the inception of the M+C program, more than 2.4 million beneficiaries have been affected by plan withdrawals from Medicare markets. For 2003, 217,000 will be affected by plan terminations and service-area reductions. Of these, 32,000 will have no other M+C option. The majority of affected beneficiaries (187,000) will have access to at least one coordinated care plan; about 15,200 beneficiaries will have access to a private fee-for-service plan. Beneficiaries in rural areas particularly lack access to Medicare HMOs. Many experts assert that rural areas are unlikely to attract HMOs due to the inability of these plans to develop adequate provider networks and the low level of Medicare payments, both of which discourage market entry. In rural areas in 2002 availability of Medicare managed care plans dropped to 13 percent of beneficiaries, although 57 percent of beneficiaries had access to some type of M+C plan (i.e., either a managed care plan or a private fee-for-service plan; Figure 6-2).

There are multiple reasons for the plan terminations, including the cumulative effect of several years of a 2 percent cap on payment increases; provider resistance to negotiated payments; diminished private-sector commitment to Medicare business; and strategic business decisions based on factors unique to each plan, such as market share. The result of several years of M+C terminations has been an instability that has undermined beneficiaries’ expectations that their Medicare plans will be available from year to year. In addition, while some Medicare HMOs have been a good value for beneficiaries, many are now facing rising premiums and a reduction in the extra benefits they received in the past. Zero-premium plans were available to 30 percent of beneficiaries in 2002, compared with 32 percent in 2003. Nationally, enrollment in M+C HMOs, which grew almost threefold between 1993 and 1997 and continued increasing in 1998 and 1999, has been steadily declining (Figure 6-3).
Nevertheless, Medicare HMOs remain an important alternative for many beneficiaries, especially members of ethnic minorities and those with lower incomes. For example, 40 percent of African-American beneficiaries are in M+C plans compared with 13 percent who have Medicare with a Medigap policy. Likewise, among Hispanics, 52 percent are in an M+C plan, and 11 percent have Medicare with a Medigap policy. In the past the majority of those disenrolled from their Medicare HMOs choose to reenroll in other HMOs if they were available. Fifty-five percent of beneficiaries whose enrollment in an M+C plan was terminated in 1999 enrolled in another Medicare HMO. Beneficiaries in terminated plans were disproportionately more vulnerable than other M+C enrollees; they had lower incomes and were less educated (73 percent had incomes of less than $20,000 annually, and 38 percent had less than a high school education.)

The instability in the Medicare+Choice market calls attention to the importance of preserving and strengthening the original Medicare program and adding a prescription drug benefit.

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**Medicare+Choice**

AARP supports a genuine choice of health plan options for Medicare beneficiaries. The original Medicare plan should remain a viable and affordable option. In addition, a range of managed care options should be available and include health maintenance organizations, preferred provider organizations, provider sponsored organizations and point-of-service plans.
AARP strongly urges Congress and the Centers for Medicare and Medicaid Services (CMS) to monitor carefully the effects of Medicare+Choice (M+C) options and health plan payment rules on beneficiary access, the stability of Medicare beneficiaries' health coverage and their out-of-pocket health spending.

AARP does not support medical savings accounts (MSAs) or private fee-for-service plans as Medicare coverage options. Congress should carefully consider whether private fee-for-service plans and MSAs provide added value in the Medicare program, including whether these models are likely to attract healthier enrollees than those who select other Medicare coverage options. The value of multiple plan types should be reassessed.

AARP encourages Congress to take constructive steps to protect beneficiaries in M+C plans that terminate their contract with the Medicare program, including facilitating the transition from one Medicare health plan to another.

AARP urges CMS to continue implementing risk-adjusted payments to M+C plans (see this chapter's section The Medicare Program—Medicare Payments to Managed Care Plans).

Within each managed care option offered, the choice of providers should be as broad as is reasonably practical and consistent with the operational constraints of the particular option. In managed care models that contract with multiple medical groups, enrollees should be allowed to select providers from among all participating medical groups. Plan enrollees should be permitted to change providers whenever they choose.

To ensure that Medicare beneficiaries understand the implications of enrolling in any of the options offered, AARP urges Congress to provide CMS with adequate funding and other necessary resources to conduct public education and outreach programs. These programs should include information about the right of a contracting health plan to terminate annually its relationship with Medicare and change either the benefits (including drug coverage) it offers and/or the premiums it charges. (For further policy on Medigap policies, see Private Health Insurance—Medicare Supplemental (Medigap) Insurance.)
(i.e., national and local) capitation rate, a minimum percentage increase from the previous year or a guaranteed floor payment.

One expected effect of the blended and floor payments was a reduction in the variation in reimbursements among plans in high- and low-cost areas, thus increasing enrollment in rural areas. However, since the inception of the BBA payment methodology, payments based on the blended formula were made only in 2000, when 63 percent of counties were eligible. For 2003 virtually all of the county rates reflect the minimum percentage increase of 2 percent. Payments attributed to the indirect costs of medical education and direct graduate medical education (formerly part of the M+C payment) have been removed from the capitation rate. The capitation payment is still primarily adjusted for age, disability status, gender, institutional status and other risk factors that the Centers for Medicare and Medicaid Services (CMS) deems appropriate. Currently, only 10 percent of the federal payment to M+C plans is adjusted for beneficiary health status. Recently, CMS implemented a simplified system that varies payment for M+C enrollees based on whether they had one or more of 61 medical conditions during the previous year. Data for risk adjustment will be derived from either inpatient or ambulatory care settings. M+C payments are scheduled to fully reflect health risk adjustment factors by 2007.

Demonstration projects, such as the competitive-pricing and Medicare Choices programs, could provide an opportunity for CMS to test the viability of an alternative method of providing and paying for services to Medicare beneficiaries.

FEDERAL POLICY

**HEALTH CARE COVERAGE** ▶ Publicly Administered Health Insurance ▶ The Medicare Program ▶ Medicare+Choice

**Medicare Payments to Managed Care Plans**

AARP urges Congress to evaluate the impact of the Medicare+Choice (M+C) reimbursement methodology to ensure reasonable participation levels in the Medicare program on the part of M+C plans and Medicare payments to participating plans that are set at appropriate levels.

To ensure that payments to M+C plans are set at appropriate levels, the Centers for Medicare and Medicaid Services (CMS) should continue to phase in risk-adjusted payments with the eventual objective of basing payments on data from inpatient and outpatient settings as soon as it is feasible to do so. CMS should monitor the phase-in and make necessary adjustments to avoid any significant unintended consequences.

AARP supports payment methodologies, such as competitive bidding, on a demonstration basis in order to evaluate the impact of new payment methodologies on beneficiaries’ and overall program costs.
CMS should monitor beneficiaries’ experiences in current and new demonstration projects with regard to accessibility and quality of services, giving adequate consideration to consumer privacy rights. Data should be collected and evaluated to assess beneficiary satisfaction, cost of services and quality of care. Provider-specific data and aggregate results of the evaluation should be made available to the public.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
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Background

Federal Standards for Medicare Managed Care Plans

Unlike traditional health insurers, managed care plans not only assume risk by insuring specified covered benefits, they also assume the responsibility for providing or arranging for the delivery of covered services. When administered properly managed care plans can oversee total patient care effectively and discourage unnecessary use of services. However, because managed care plans receive the same level of reimbursement regardless of the number of services they provide, providers may be tempted to skimp on care. Therefore, it is particularly important for safeguards to be in place to ensure that financial incentives to control costs do not adversely affect access to or the quality of care. For example, the right to disenroll monthly is an important safety valve for beneficiaries. In 2002 Congress enacted legislation to preserve beneficiaries’ right to month-to-month enrollment until 2005.

Unless quality-of-care standards and other consumer protections are enforced, the 5 million Medicare beneficiaries whose choice of care and providers is restricted by their enrollment in a managed care plan cannot be confident that they are receiving high-quality care or be assured that when a problem is identified, corrective action will be taken. While the other Medicare+Choice (M+C) options are organized differently from managed care plans, they too are risk-based plans (i.e., plans are reimbursed on a fixed-payment basis). Therefore, other M+C options may also create incentives to skimp on care, necessitating safeguards similar to those needed for managed care enrollees.

One important safeguard is regulatory authority to terminate Medicare contracts or exercise other intermediate sanctions. Currently, the Centers for Medicare and Medicaid Services (CMS) may terminate a contract with a Medicare+Choice organization for several reasons, including the organization’s failure to substantially carry out the contract’s terms. Before terminating a contract CMS may give the contracting organization the opportunity to develop a plan to correct the deficiencies, unless the reason for termination is financial difficulty.
CMS also may impose intermediate sanctions on an organization for contract violations when, for example, it fails to provide medically necessary services required by Medicare+Choice organizations, imposes premiums in excess of the allowable amounts, expels or refuses to enroll a beneficiary in violation of Medicare requirements, engages in any practice that could have the effect of denying or discouraging higher-risk individuals from enrolling, or misrepresents or falsifies information that it furnishes to CMS, enrollees or others.

Intermediate sanctions include civil money penalties from $10,000 to $100,000 depending on the violation, suspension of enrollment of Medicare beneficiaries, suspension of the payment by CMS on behalf of the beneficiaries enrolled and cessation of the right to market to Medicare beneficiaries.

**FEDERAL POLICY**

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**Federal Standards for Medicare Managed Care Plans**

All managed care plans that serve Medicare beneficiaries should be required to meet federal standards. All plans participating in the Medicare program must be initially certified as having met the federal standards designated by the Centers for Medicare and Medicaid Services (CMS) and must be subject to federal oversight to ensure ongoing compliance with the standards. These standards must apply to the following health plan functions in the following areas:

**Finance**—All participating health plans must be financially sound. Financial standards should address solvency requirements, including requirements for capital reserves that take into account the plan’s level of risk and service-delivery capabilities and that are set at adequate levels to protect beneficiaries in the event of a plan’s insolvency. Financial standards should also address reinsurance requirements and hold-harmless provisions that protect beneficiaries from being billed by providers for prepaid services (other than allowable cost-sharing amounts).

**Benefits**—CMS should establish standard definitions for all services. In addition, participating health plans must be required to provide at least the current Medicare benefits covered by Parts A and B. (Providing benefits of equivalent monetary value, i.e., actuarial value, would not meet this standard.)

**Pharmacy benefits**—AARP does not oppose the use of drug formularies and preferred drug lists by health plans, because formularies and preferred drug lists can be an effective cost-containment and quality-enhancement tool. However, in providing drug benefits, health plans using drug formularies and preferred drug lists should:
ensure participation of plan physicians and clinical pharmacists in the
development of formularies and preferred drug lists,

publicly disclose the nature of formulary and preferred drug lists
restrictions and utilization management policies,

permit formulary exceptions to drug formularies and preferred drug lists
or unlisted drugs when medical necessity dictates that a nonformulary
alternative is needed and ensure that plan members are aware of how
such alternatives can be obtained,

provide any prescription drugs that are exceptions to the health plan
formulary and preferred drug list under the same terms and conditions
(e.g., cost-sharing requirements) as drugs that are in the formulary and

subject disagreements between an enrollee and a health plan about
prescription drug coverage to the plan’s internal complaint process and
external appeals process

(See this chapter’s section Prescription Drugs and Pharmacy Practices for
additional protections.)

**Emergency care**—In the event of an emergency, managed care enrollees
should not be required to obtain care through the plan’s network of providers.
“Emergency care” must be defined using the “prudent layperson standard,”
that is, coverage for emergency care should include coverage for services
provided where the enrollee presents to a provider outside the health plan with
symptoms, including severe pain, that a prudent layperson would reasonably
believe to be an emergency medical condition. Health plans should be
contacted once managed care enrollees who present to emergency
departments are stabilized to determine follow-up treatment, and the plan
should be prepared to assume the care of the patient. In any event patients
should be covered for all necessary care in connection with the emergency.
Health plans should be prohibited from requiring prior authorization for
emergency services, and the special needs of people with mental illness and
substance abuse should be taken into account when coverage decisions are
made concerning emergency services or urgently needed care.

Supplemental benefits should be offered and priced separately from the basic
benefit package.

The present Medicare balance-billing limitations should apply to all Medicare-
covered services provided to Medicare beneficiaries for in- and out-of-network
care.

**Marketing**—Health plans should be required to provide standardized
information to prospective and new enrollees, including:
information on benefits, limitations, exclusions, restrictions on use of services and plan ownership;

- a summary of physicians’ financial incentive arrangements, written in terms that will be understood by the average beneficiary;

- the stability and composition of the provider and practitioner network, including a list of the participating physicians and hospitals with their credentials and licensing data;

- comparative and standardized information on patients’ experience with care in the plan and the plan’s clinical performance (e.g., Health Plan Data Information Set, HEDIS and CAHPS data);

- information on whether the plan is accredited by a national organization;

- disenrollment experience;

- information about grievances and appeals filed by beneficiaries; and

- the plan’s current status with respect to compliance with statutory and regulatory requirements.

All marketing materials must be approved before their use by federal authorities, written at a sixth-grade reading level and available in languages other than English when the plan serves or will serve substantial numbers of enrollees whose native language is not English. In addition, plans must cooperate in providing data to CMS or any other independent body charged by CMS with compiling and distributing the materials to all interested parties.

Marketing presentations that imply that a beneficiary’s failure to enroll will result in loss of entitlement to Medicare must be prohibited. Other prohibited marketing activities should include door-to-door solicitation, offering beneficiaries inducements to enroll and discriminatory activities designed to recruit healthier-than-average enrollees.

To avoid discriminating against population groups that reside in certain locations, plans should serve a complete market service area.

**Enrollment practices and procedures**— All enrollment in Medicare managed care plans should be conducted by a CMS third-party contractor. No health plan should be permitted to enroll beneficiaries directly. All health plans, including fee-for-service, managed care and Medigap insurers, should be required to participate in an annual, coordinated open enrollment period when plans must accept all eligible applicants without regard to their health status, previous claims experience, medical history or lack of evidence of insurability to the extent plan capacity will allow as determined by CMS.
**Disenrollment**—Medicare beneficiaries enrolled in managed care plans should have the opportunity to disenroll at any time, effective the first day of the following month, for cause or not for cause, and change their enrollment to the Medicare fee-for-service program or any other health plan offered by CMS. To the extent it is feasible, Medigap carriers should be required to sell insurance coverage to any beneficiary who applies for supplemental coverage after disenrolling from a managed care plan and returning to the fee-for-service program (see this chapter’s section Medicare Supplemental/ Medigap Insurance).

**Rates and payments**—Premiums charged by health plans participating in the Medicare program must be community rated for the Medicare population. Payments to plans should be set using an appropriate risk-adjustment factor so that payment reflects the actual risk undertaken by the plan on behalf of the beneficiaries enrolled (see Medicare Payments to Managed Care Plans in this section).

**Accessibility**—Health plans must be able to demonstrate that the services they offer are reasonably available and accessible 24 hours a day, seven days a week. Health plans must have sufficient numbers of practitioners and providers (including facilities) and sufficient distribution of providers by specialty and location within the plan’s service area to serve their enrolled members. The adequacy of a network should be assessed in relation to the health plan’s model type, the prevailing patterns of provider distribution in the plan’s geographic service area and the needs of the plan’s enrollees.

Women should have direct access to obstetricians/gynecologists and should be allowed to designate these physicians as their primary care providers.

Health plans should be required to provide referrals to specialists affiliated with the plan or recognized specialty-care centers affiliated with the plan pursuant to treatment plans. Referrals should include provisions for standing referrals, as determined by the referring practitioner.

Health plans should be required to provide out-of-network referrals at no additional cost to the enrollee if the health plan does not have a network physician with appropriate training and experience or affiliation with a recognized specialty-care center to meet an enrollee’s covered medical needs. Patients with mental disorders should receive appropriate referrals to mental health specialists.

**Continuity of care**—To facilitate continuity of care, health plans must notify affected enrollees at least 90 days before the termination of a provider, as long as such termination is not for cause. Enrollees who are undergoing an active course of treatment for a life-threatening disease or condition, or a degenerative and disabling disease or condition, or those who have entered the second trimester of pregnancy at the effective date of enrollment, should be able to receive covered medically necessary care from their physician specialists.
for up to 90 days (or through postpartum). This should apply to enrollees if they belong to a group that did not provide the option of continuing with their previous physician specialist and to existing enrollees when their previous physician specialist was terminated by the health plan for reasons other than cause.

**Quality assessment and improvement**—Health plans must demonstrate compliance with standard federal quality indicators developed specifically for the Medicare population. These quality indicators must be applicable to the entire range of services, including preventive care and care for chronic illness. Wherever possible these indicators should reflect data from ongoing medical outcomes studies (see the section The Medicare Program—Medicare+Choice—Quality Oversight).

**Utilization review/ utilization management (UR/ UM)**—Clinical review criteria must be developed with the involvement of health plan practitioners and be available to plan practitioners and enrollees. Utilization review/ utilization management plans must be designed to detect underutilization as well as overutilization. Adverse UR decisions must be made by clinically qualified personnel and reviewed by active practitioners in the same or a similar specialty. Reviewing clinicians need not be residents of the state in which the enrollee whose claim is being reviewed resides; reviewers may not receive financial compensation based directly or indirectly on the number, or volume, of certification denials. Certification decisions must be made at least as rapidly as the beneficiary’s medical situation requires in order to protect health and permit a meaningful appeal. Denials must be accompanied by clear information on the reasons for denial as well as instructions on how to appeal the denial.

**Grievances and appeals**—Health plans should have a system for receiving beneficiaries’ grievances (i.e., disagreements that relate to furnished services for which the beneficiary has no further liability for payment, such as physician behavior, waiting times and quality of care). Health plans also should have an appeals process to address disputes that involve the denial, termination or reduction of services or payment. Grievance and appeals procedures should include provisions in the following areas:

- **Information**—When a requested service or payment is denied, or when needed care is reduced or terminated, beneficiaries must receive timely, clear information about such decisions; the specific reasons for a denial, termination or reduction of service or payment; and a description of the right to appeal and the procedure for doing so. Information must include the medical criteria relied on and the process followed by the plan in reaching its decision. The methods of communicating information about the denial and appeal process must meet the specific needs of an older population, taking into account vision or reading difficulties, language and cultural differences.
Independent review—Beneficiaries must have the right to have their claims reviewed by independent entities that are not appointed or selected by the health plan, including an external review by medically qualified reviewers of plan decisions about medical necessity, followed by a hearing before an administrative law judge and access to the federal courts. There should be no charge to the enrollee for gaining access to such independent review or for the review itself.

Fairness—Plans must give adequate advance notice of termination or reduction in any services that a beneficiary is already receiving, with specific reasons for the termination or reduction and clear instructions on how to appeal such decisions. Ongoing services, particularly hospital inpatient services and skilled nursing or rehabilitation services, should continue as covered services until the reconsideration is complete. The beneficiary should not be responsible for the costs of the appeal process, including the cost of external medical review. The appeal process must include an opportunity for the beneficiary to attend the review in person, testify, submit evidence and call and question witnesses.

Timeliness—There must be specific time limits, which reflect the medical needs of beneficiaries who have been denied care or face a cutoff in services, for appeals of a denial, termination or reduction in services. Expedited review must be available in cases where following the regular time limits would jeopardize the beneficiary’s life or health or ability to regain or retain maximum function. Such cases should be resolved as rapidly as the situation requires, in no event to exceed a specified maximum amount of time. The plan’s failure to meet specified deadlines or provide necessary information should result in automatic approval of both expedited and regular appeals.

Health plans should collect and report data on grievances and appeals in standardized formats (see Chapter 13, Personal and Legal Rights, for policy on binding arbitration).

Managed care liability—All managed care plans should be held accountable for their actions. In cases where a health plan has been involved in a decision to delay or deny needed health care services and the decision has had medical consequences, the plan should be liable for any injuries or harm an enrollee sustains. The right to seek meaningful judicial redress for decisions that contributed to injury or death should be available to all managed care enrollees regardless of the source of their health care coverage. State laws on the corporate practice of medicine that prevent holding managed care organizations accountable for harm caused by inappropriate treatment decisions should be revised to afford the injured enrollee access to state court.

Coverage for experimental services—Health plans should have an objective and expeditious process for considering experimental treatments, including new drugs, devices, procedures and therapies. In addition, health plans should
be required to participate in an external, independent review process to examine denials of coverage for experimental treatments. This external review should be conducted by a panel of experts selected by an impartial, independent and accredited entity.

**Coverage for care in clinical trials**—Enrollees in managed care plans should have appropriate access to, information about and protections within clinical trials. Managed care plans should cover routine patient care costs (e.g., hospital services, physician services and diagnostic tests) associated with the participation of plan enrollees in clinical trials that are:

1. funded by the National Institutes of Health (NIH), Centers for Disease Control (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD), and the Department of Veterans Affairs (VA);

2. supported by centers or cooperative groups funded by the NIH, CDC, AHRQ, CMS and DOD; and

3. sponsored by the VA and conducted under an investigational new drug (IND) application reviewed by the Food and Drug Administration (FDA), drug trials exempt from needing an IND application under FDA regulations and any other trials deemed by CMS to meet the qualifying criteria developed by the appropriate multiagency federal panel.

These services should be covered even if the provider participating in the clinical trial is not part of the managed care organization’s network. However, the following services related to clinical trials need not be covered by the managed care organization: the investigational item or service itself, items and services provided solely to satisfy data collection needs, and items and services provided by the trial sponsor without charge.

**Credentialing**—Each practitioner must be credentialed before participating in the plan and recredentialed every two years. A representative of the health plan who is authorized to act on behalf of the plan (e.g., the medical director) must be responsible for the credentialing process. There must be a credentialing committee, with representation of plan practitioners. Credentialing information must be subject to review and correction by the practitioner being credentialed. Information about the credentialing process and policies must be available for review by providers and enrollees upon request. Information on practitioner credentials must be available to plan enrollees. The plan also must obtain primary verification of current license, malpractice coverage, hospital privileges, board certification (if any), Drug Enforcement Agency certificate, medical degree and residency training, and secondary verification of license history, malpractice history and National Practitioner Data Bank history. The plan also must conduct an on-site office visit and review of medical record-keeping practices. For recredentialing, in addition to all the procedures required for initial credentialing, the plan must review member complaints,
results of quality assurance and utilization review activities and member-reported experience with care.

**Provider and practitioner contracting**— Plans should be required to provide services through contracts with providers and practitioners. If a health plan denies a physician’s application to participate in the plan, terminates its agreement with the physician or suspends its contract with the physician, the health plan should provide the physician with a written explanation for the action and afford the physician the right to appeal the action.

Contracts must encourage open communication between providers and enrollees concerning all treatment options and other issues concerning patients’ health care. Each contract should clearly identify the services to be provided and include provisions that:

1. hold enrollees harmless for payment for covered services in the event of nonpayment by the health plan;
2. require continuation of covered services to enrollees for the period for which a premium has been paid, regardless of the insolvency of the health plan or other nonpayment by the health plan;
3. prohibit collection of any payments, other than required cost-sharing, from enrollees for covered services provided by the practitioner or as a result of the practitioner’s authorized referral;
4. prohibit balance-billing;
5. require the practitioner to participate in and cooperate with quality assurance and utilization review activities of the health plan and of federal external quality review entities;
6. prohibit any physician incentive plan that directly or indirectly bases payment on the reduction or withholding of medically necessary services to enrollees;
7. require medical records to be maintained in an appropriate manner;
8. require providers or practitioners to report specified data; and
9. require the practitioner or provider’s office or facility to be subject to inspection by the plan.

**Confidentiality**— Managed care must prevent improper use or release of personally identifiable medical information and must adopt protections appropriate to the use of electronic information and nationally based payer and provider systems. Standards for confidentiality would best be established through a single federal law that applies to the entire health care system and includes civil and criminal penalties for violations.
Data collection and reporting—After the development of national standards for data collection and reporting that address the frequency and format of reports and the acceptability of aggregated data, all health plans serving Medicare beneficiaries must comply with such standards. Data collected by the plan must be independently audited for verification by an authorized entity.

Health plans must provide standardized data on:

1. encounters between beneficiaries and clinical personnel;
2. medical costs or expenditures on a per capita basis by type of expenditure (physician, inpatient, outpatient, home health, skilled nursing facility, etc.);
3. plan administration;
4. beneficiary satisfaction;
5. complaints and grievances and their resolution;
6. physician satisfaction;
7. quality assurance or improvement;
8. credentialing;
9. utilization management or appeals regarding use of out-of-plan services;
10. accessibility, including wait times for appointments, rates of referral requests and numbers of practitioners accepting new patients;
11. rates of physician turnover; and
12. enrollment/disenrollment.

Ombudsman programs—Consumers should have access to an independent, nonprofit ombudsman program that receives financial support from a state and/or the federal government. Such programs will assist consumers in understanding plans’ marketing materials and coverage provisions, educate members about their rights within health plans, help identify and investigate enrollee complaints, assist enrollees in filing formal grievances and appeals, operate and staff a telephone hotline, and report to and advocate before appropriate regulatory bodies on issues of concern to consumers. Health plans should be required to cooperate with such programs.

Current insurance counseling programs should have sufficient funding to provide adequate staff training and meet the demand for assistance among beneficiaries.
AARP urges CMS to monitor the activities of Medicare+Choice organizations to ensure compliance with all requirements. In the event CMS detects violations, AARP urges CMS to enforce the requirements through use of intermediate sanctions or contract termination.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance  
• The Medicare Program • Medicare+Choice

Background

Quality Oversight and Improvement

Through the Centers for Medicare and Medicaid Services (CMS), the Medicare program currently employs the following approaches to ensure that high-quality care is provided by the managed care plans with which it contracts:

- certifying contracting health plans to ensure that they meet specified conditions, such as having an internal quality assurance program and demonstrating appropriate health care utilization controls and access to services;
- requiring that plans have grievance and appeals systems;
- conducting on-site monitoring;
- imposing penalties on plans that fail to comply with specified requirements; and
- requiring external review by peer review organizations.

In addition, CMS has published the Quality Improvement System for Managed Care (QISMC) standards that require Medicare health maintenance organization contractors to conduct quality improvement projects that over time demonstrate sustained improvement in clinical and nonclinical areas. In addition, these plans must collect specified quality performance measures, including measures from the Health Plan Employer Data and Information Set (HEDIS) and CAHPS. These measurement sets are intended to help CMS monitor plan performance and help consumers assess health plan performance.

In the Balanced Budget Act of 1997 and Balanced Budget Refinement Act of 1999, Congress authorized CMS to establish and oversee a program that allows private, national accrediting organizations to “deem” that a Medicare+Choice program complies with certain Medicare requirements. Medicare+Choice programs may be deemed to meet requirements in quality assurance, access to services, information on advance directives, provider
participation rules, antidiscrimination, confidentiality and accuracy of enrollee records. Accordingly, CMS has designed an oversight process that consists of the following components: equivalency reviews to determine that the standards of the accrediting body are equivalent to CMS's; validation reviews to ensure that the accrediting body's standards remain equivalent to CMS's; on-site observations to ensure that the accrediting body implements its own processes appropriately; and investigations of serious complaints, including a requirement that the accrediting body has a system for investigating complaints it receives.

FEDERAL POLICY

HEALTH CARE COVERAGE Publicly Administered Health Insurance The Medicare Program Medicare+Choice

Quality Oversight and Improvement

Given the financial incentives integral to the operation of managed care plans, AARP supports the need for strict monitoring of compliance with Medicare program requirements, including the quality of care provided. AARP supports the direction of the Quality Improvement System for Managed Care standards and urges the Centers for Medicare and Medicaid Services (CMS) to hold plans accountable for sustained quality improvement.

Plans must have internal quality assessment and quality improvement (QA/QI) systems that include QA/QI plans. These plans should be in writing, developed with provider input and carried out under the direction of an individual authorized to make definitive clinical decisions on behalf of the plan (e.g., the medical director). The QA/QI system should have the capacity to identify exemplary and problematic patterns of health care in the aggregate and for individual practitioners and must direct action, including referrals to enforcement agencies, in the event of serious or persistent poor-quality care.

A health plan must collect and analyze relevant data, including encounter data, and report results to regulatory agencies, providers and beneficiaries. The data and analyses must be consistent with national protocols designed to promote comparisons between and among plans.

As part of its QA/QI activities, a health plan must undergo external quality review by designated professional review entities that have no conflicts of interest. Effective external oversight of managed care plans should ensure that regulators and policymakers can evaluate the quality of care in the Medicare+Choice program and assess the impact of system changes on the quality of care provided to Medicare beneficiaries. External review should enable providers to improve the quality of care they offer.

The components of external review should include:
providing feedback of performance comparisons among plans ("benchmarking") to identify opportunities for improvement—Plans should then provide information to individual practitioners regarding their performance as it relates to the benchmarks;

educating practitioners about new practice guidelines and outcomes research;

combining state-of-the art technical expertise with a thorough knowledge of local medical practice to help each plan achieve the highest quality care;

advocating on behalf of Medicare beneficiaries in matters concerning quality of care by investigating and responding to beneficiary complaints about the quality of care and making data available to beneficiaries to promote informed health care choices;

referring cases evidencing seriously poor quality-of-care issues to state licensing and regulatory authorities and/ or federal authorities, as appropriate; and

proposing systems to prevent medical error.

The quality improvement organization (QIO) performance measurement system for managed care plans should include measures of access to and timeliness of care, including referrals, appropriateness of the setting, treatment and premature discharge. The measures should encompass the entire range of care delivered and a wide range of clinical conditions. Particular attention must be paid to home health and other postacute services, because evidence suggests that health outcomes for these services in managed care are not as favorable as they are in the fee-for-service sector.

CMS must be aggressive in its efforts to provide the public with provider-specific information about QIO findings concerning performance of the Medicare+Choice contractors (for further discussion of QIOs, see the section Publicly Administered Health Insurance—The Medicare Program—Original Medicare—Consumer Protections and Quality Oversight).

AARP supports efforts to evaluate and improve oversight procedures to ensure appropriate external reviews of managed care plans’ quality assurance programs. In this connection, the effectiveness of the QIO review system with regard to these organizations must be evaluated as well.

**Deeming by a private accrediting organization**—AARP recognizes the important contribution private accrediting bodies have made in fostering standard setting, continuous quality improvement, comparative analysis and public disclosure of health plan performance information. Health plans that have achieved accreditation should not be subject to redundant review by CMS as long as the agency has judged the private accrediting body’s
standards to be comparable to the required federal standards for participating health plans.

However, CMS must not allow a private accrediting organization (PAO) to deem a health plan as meeting one or more of CMS’s requirements unless CMS has determined that the organization’s standards and guidelines meet or exceed the agency’s.

When CMS authorizes a PAO to deem a health plan to be in compliance with one or more of the state’s requirements, CMS must ensure that:

1. it retains full authority to enforce all regulatory requirements whether or not it relies upon the PAO’s information, processes or standards and to initiate enforcement actions based on the results of a PAO’s processes and standards;

2. the use of or reliance on a PAO’s assessment is subject to full and open public comment processes;

3. a PAO’s standards and measures are readily and publicly available at no or nominal cost;

4. information about individuals who conduct reviews on behalf of PAOs is publicly disclosed, including the individual’s qualifications and affiliations;

5. PAO surveys are periodically validated;

6. the results of the PAO review process are public; and

7. the PAO has no conflicts of interest with and is independent from those entities it accredits.

Private accreditation should not be a condition of participation in the Medicare program.

Compliance with federal standards or deeming by a private accreditation organization should not obviate the requirement for health plans to undergo external quality review by designated professional review entities.

Congress should establish an adequate staffing level within CMS and provide adequate funding to permit effective monitoring of M+C organizations.
HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program • Medicare+Choice

Background

Consumer Information

The conceptual framework of the Medicare+Choice (M+C) program assumes that Medicare beneficiaries value choice and will be able to make informed health care decisions. If the Medicare program becomes more market driven and enrollment in the M+C program grows, the need to provide beneficiaries with accurate, concise and understandable information about the availability, quality and outcomes of Medicare services will be even more pressing.

However, there are still many questions concerning the information needs of Medicare beneficiaries: Is the consumer-choice strategy optimal for all segments of the beneficiary population? What kinds of information will be most useful to help Medicare beneficiaries make informed health plan selections? What is the best way to communicate with beneficiaries? How can information be tailored to meet the diverse needs of a diverse population? How useful is the information they currently receive? How should information be formatted and disseminated to consumers? (See the section The Medicare Program—Medicare+Choice—Federal Standards for Medicare for details concerning standards relating to data collection and reporting.)

FEDERAL POLICY

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program • Medicare+Choice

Consumer Information

Federal standards should be established for data collection and reporting, including the frequency and format of reports and the acceptability of aggregated data required from all plans. Information must be collected in a manner that will ensure comparability across plans and should include data that is salient and useful to Medicare beneficiaries, such as information on benefits, coverage restrictions, out-of-pocket liability, member and provider satisfaction, quality of care, credentialing, utilization management, grievances and appeals, and enrollment and disenrollment. Additional information that research indicates may not be of interest to a broad beneficiary audience should nonetheless be available to those who request it.

Data collected in these categories should be presumed disclosable to the public unless prohibited by federal law or by federal regulations establishing
restrictions based on the compelling needs of the Medicare quality improvement and quality oversight effort.

Consumer satisfaction data should be standardized and collected by an external entity. Centers for Medicare and Medicaid Services (CMS) should continue to expand the use of CAHPS as new instruments to measure medical group and physician performance are developed and tested. Other data may be collected by health plans themselves but, if reported to CMS or the public, must be independently audited for verification by an authorized entity.

Further research should be conducted to learn more about consumer preferences with respect to the types of information consumers prefer and how this information is communicated to them.

CMS should work with consumer organizations and experts in the field of consumer information and education to develop ways to present information on quality in formats useful to consumers.

To ensure that Medicare beneficiaries receive information to make informed health care choices, Congress must adequately fund the National Medicare Education Program.
Beneficiary Out-of-Pocket Spending

Medicare beneficiaries are financially responsible for coinsurance, deductibles and Part B premiums (Figure 6-4), as well as for the costs of services and products not covered by Medicare. It is estimated that in 2000, older beneficiaries living in the community spent an average of $2,580 out of pocket, or 19 percent of their income, on health care costs (Figures 6-5 and 6-6). Beneficiaries under age 65 spent $2,030 on average, or 17 percent of their income. These costs include Medicare cost-sharing payments, Medicare Part B and private insurance premiums, and payments for goods and services not covered by Medicare (including most outpatient prescription drugs), but exclude the costs of home health care and long-term nursing facility services. Other than health care premiums, prescription drugs represent the largest component of beneficiaries’ out-of-pocket spending on health care, on average.

<table>
<thead>
<tr>
<th>Part A (Hospital Insurance)</th>
<th>Part B (Medical Insurance)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>Deductible</strong></td>
</tr>
<tr>
<td>$840 per benefit period</td>
<td>$100 per year</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td><strong>Coinsurance</strong></td>
</tr>
<tr>
<td>$210 per day for the 61st to 90th day of each benefit period</td>
<td>20 percent of Medicare allowable charges</td>
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<tr>
<td>$420 per day for the 91st to 150th day of each benefit period</td>
<td></td>
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<tr>
<td><strong>Skilled nursing facility</strong></td>
<td><strong>Part B monthly premium</strong></td>
</tr>
<tr>
<td>$105 per day for the 21st to 100th day of each benefit period</td>
<td>$58.70</td>
</tr>
</tbody>
</table>

Prepared by AARP Public Policy Institute.
About 91 percent of beneficiaries age 65 and older have supplemental insurance to help pay for Medicare’s cost-sharing requirements, through Medicaid, private insurance (i.e., employer-sponsored insurance or individually purchased Medigap) or a Medicare+Choice plan. However, having such coverage does not guarantee low out-of-pocket expenses. Those
with private insurance may face high premiums and/or diminishing coverage. Those with partial protection from Medicaid through the Qualified Medicare Beneficiary program or the Specified Low-Income Beneficiary program can face substantial expenses for their health care goods and services, compared with beneficiaries who have full Medicaid benefits. The 8 percent of older beneficiaries with only original Medicare are fully responsible for all their health care bills, unless they are able to obtain some type of assistance through charitable organizations or other public programs.

Being eligible for full Medicaid benefits does protect some of the poorest beneficiaries from the high costs of health care. However, about half of older beneficiaries with incomes below the poverty level did not receive Medicaid assistance in 2000. Out-of-pocket health expenses for these beneficiaries can consume a considerable share of annual income. Indeed, beneficiaries age 65 and older with incomes below the federal poverty level who were not enrolled in Medicaid were estimated to have spent about half of their income, on average, on out-of-pocket health costs in 2000. Those with employersponsored or Medigap coverage spent the greatest share—over half their income, on average—while those with Medicare+Choice coverage or only Medicare coverage spent about 38 percent of their income (Figure 6-7). Poor beneficiaries may not receive Medicaid because they do not meet the federal categorical requirements or the state income and asset requirements; others who meet those eligibility requirements may decline to participate or not realize they are eligible for benefits.

Long-term care costs may pose another significant out-of-pocket burden. Although the average annual cost of nursing home care was $54,900 in 2001,
few beneficiaries purchase private long-term care coverage, primarily because of the high cost and medical underwriting. (Medicaid helps pay for low-income beneficiaries’ long-term care costs.) The average annual premium for a 65-year-old for a basic long-term care policy (without inflation protection and nonforfeiture benefits) was $1,002 in 1999; for a 79-year-old, it was $4,166. The cost of this coverage increases dramatically with age and can more than double when inflation protection and nonforfeiture benefits are added.

FEDERAL POLICY

HEALTH CARE COVERAGE  Publicly Administered Health Insurance
  The Medicare Program  Original Medicare  Beneficiary Costs

Beneficiary Out-of-Pocket Spending

Congress should close gaps in Medicare coverage that lead to burdensome out-of-pocket costs.

Congress should limit increases in out-of-pocket costs, including increases in Medicare’s overall cost-sharing requirements for current benefits.

Congress should ensure that low-income beneficiaries are protected against high out-of-pocket expenses.

HEALTH CARE COVERAGE  Publicly Administered Health Insurance
  The Medicare Program  Original Medicare  Beneficiary Costs

Background

Beneficiary Coinsurance for Hospital Outpatient Services

A loophole regarding payment for hospital outpatient services often causes Medicare beneficiaries to pay more than the 20 percent of the Medicare-approved charge for services such as one-day surgery, diagnostic tests and radiology. The Centers for Medicare and Medicaid Services (CMS) estimates that Medicare beneficiaries currently are liable for an average of about 50 percent of total payments for hospital outpatient services, because beneficiaries’ coinsurance is based on 20 percent of whatever amount the hospital charges, rather than on the amount Medicare approves.

The lack of payment rules for hospital outpatient care creates incentives for hospitals to categorize patients as outpatients, even when treatment lasts for several days in the hospital. Such patients pay far more out of pocket than they would had their care been categorized as inpatient care. The Balanced Budget Act of 1997 began to correct this problem by gradually reducing beneficiary coinsurance to 20 percent of Medicare’s payment. However,
implementation of this reduction will be accomplished gradually over the next 20 years or more. The Balanced Budget Refinement Act of 1999 capped beneficiary coinsurance for outpatient services at the amount of the hospital inpatient deductible ($840 in 2003). Legislation passed in 2000 further accelerates the phase-down of beneficiary coinsurance for outpatient services.

FEDERAL POLICY

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
  • The Medicare Program • Original Medicare • Beneficiary Costs

Beneficiary Coinsurance for Hospital Outpatient Services

AARP supports restoring beneficiary coinsurance for all outpatient services to the appropriate level of 20 percent of Medicare’s approved amount as quickly as feasible.

The Centers for Medicare and Medicaid Services and/or Congress should prohibit hospitals from billing as outpatients those beneficiaries who stay longer than 24 hours.

Background

Private Contracting for Physician Services

The Balanced Budget Act of 1997 allows some physicians to contract privately with Medicare beneficiaries for services that would otherwise be covered by Medicare, as long as antifraud and antiabuse requirements are met. Under a private contract arrangement, a beneficiary agrees to pay 100 percent of the amount the physician charges for services covered by the contract. Medicare does not pay any portion of the cost of these services. Previously, providers of covered services to a Medicare beneficiary enrolled in Part B were bound by Medicare’s payment rules, and private contracting for these services was not allowed. (There are no restrictions on a consumer’s ability to purchase services the program does not cover.)

Physicians are allowed to contract privately with Medicare beneficiaries for Medicare-covered services only if the physicians agree, in writing, to forgo all reimbursement from Medicare for at least two years. This restriction serves two purposes. First, it reduces the potential for fraudulent billing of Medicare, because some physicians might otherwise try to bill Medicare for services also paid for through a private contract. Second, it protects...
beneficiaries by preventing physicians from being able to pick and choose beneficiaries on the basis of severity of illness in order to maximize revenues.

The law also protects beneficiaries by requiring the physician to sign a contract with the beneficiary in advance, disclosing that no Medicare payment will be made for privately contracted services, no balance-billing limits will apply, no Medigap coverage can be applied to payment of these services and the services to be performed would be paid for by Medicare if provided by another physician who accepted Medicare payment.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
  - The Medicare Program
  - Original Medicare
  - Beneficiary Costs
  - Patient Payments to Providers

**Private Contracting for Physician Services**

Congress should not expand private contracting for physician services. Physicians who accept Medicare reimbursement for services should not be allowed to also contract privately with beneficiaries. Such extensions would add to the potential for fraud in Medicare, would eliminate beneficiary protections against excessive physician charges and could create a two-tier system in which beneficiaries who cannot afford to contract privately for Medicare-covered services could have reduced access to medical care.

Physicians who privately contract with consumers for Medicare-covered services should continue to provide consumers with complete information on the lack of Medicare coverage for services provided under the contract, the lack of balance-billing limits on charges for those services, the cost of the service, the nonapplicability of supplemental coverage for contracted services, the availability of Medicare payment if the services were provided by a physician who accepts Medicare payment and the physician’s status as a provider who does not accept Medicare payment.

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
  - The Medicare Program
  - Original Medicare
  - Beneficiary Costs
  - Patient Payments to Providers

**Background**

**Physician Balance-Billing**

When doctors do not accept assignment on Medicare claims, the patient is responsible not only for 20 percent of Medicare’s approved rate but also for the amount that exceeds the approved rate (known as balance-billing or excess billing). Balance-billing is limited by law to 15 percent of Medicare’s...
approved fee. The Centers for Medicare and Medicaid Services (CMS) has the authority to sanction any physician who knowingly, willfully and repeatedly charges in excess of the balance-billing rate. In 2001, 2 percent of Medicare claims were subject to balance-billing, compared with 30 percent in 1986.

Although previous enforcement of balance-billing limits has been lax, it appears that most physicians are now complying with these limits. The average balance-billing rate, which had been as high as 23 percent of charges in 1993, fell to the 15 percent limit by 1995. While an average of 15 percent implies that some bills exceed the limits, analysis shows that most charges that exceed the limit do so by relatively small amounts. Furthermore, more physicians are choosing to become participating practitioners. These physicians sign a binding agreement with Medicare to accept assignment (which precludes balance-billing) for all Medicare-covered services performed during the year. In 2001, 98 percent of practitioners participated in this program, compared with 41 percent in 1989.

As of 1996 nine states protected some or all beneficiaries from physician balance-billing by “mandating assignment”—that is, requiring all physicians, by state law, to accept Medicare’s approved reimbursement as payment in full.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
- The Medicare Program
- Original Medicare
- Beneficiary Costs
- Patient Payments to Providers

**Physician Balance-Billing**

AARP remains committed to mandatory assignment.

The Centers for Medicare and Medicaid Services (CMS) should continue to closely monitor and aggressively enforce the balance-billing limit.

CMS should continue to encourage physicians to sign voluntary participation agreements.

**STATE POLICY**

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
- The Medicare Program
- Original Medicare
- Beneficiary Costs
- Patient Payments to Providers

**Physician Balance-Billing**

States should prohibit balance-billing.
State medical societies should encourage their members to accept assignment for all Medicare patients.

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**HEALTH CARE COVERAGE • Publicly Administered Health Insurance**
- The Medicare Program
- Original Medicare
- Beneficiary Costs
- Patient Payments to Providers

**Background**

**Advanced Beneficiary Notices**

An advanced beneficiary notice (ABN) is an agreement between a beneficiary and his or her physician or other provider used when there is a question about whether Medicare will pay for a particular service the physician recommends. By signing an ABN, a beneficiary agrees to pay if Medicare denies the physician’s claim for payment. The ABN is intended to facilitate an informed discussion between the doctor and the beneficiary. Use of an ABN is not considered private contracting.

Unfortunately, ABNs have been misused. Some beneficiaries have been asked to sign blanket notices, in which the beneficiary accepts complete financial liability if Medicare denies coverage for any services. A blanket notice does not fulfill the purpose of the ABN or enable a beneficiary to make an informed choice.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE • Publicly Administered Health Insurance**
- The Medicare Program
- Original Medicare
- Beneficiary Costs
- Patient Payments to Providers

**Advanced Beneficiary Notices**

The Centers for Medicare and Medicaid Services (CMS) should ensure that providers and beneficiaries are informed about the appropriate use of advanced beneficiary notices (ABNs).

ABNs should clearly indicate the item or service for which Medicare payment is in question, the reason why Medicare payment is in question and why the provider believes the service is necessary. ABNs also should require the signatures of both the provider and the patient.

The routine use of ABNs by providers should be prohibited.

CMS should conduct a demonstration project to test alternatives to ABNs, including a system of prior determination, that would be less prone to misuse.
Background

Medicare’s Use of Program Information

Medicare beneficiaries can be confused by the complexities of Medicare’s benefits and payment rules. Accurate yet understandable program information is essential if Medicare is to be user-friendly and help beneficiaries receive appropriate services.

Medicare has made significant investments in the development of consumer-oriented information on the program’s website, and its hard-copy publications are widely available. Medicare’s effective management of the information it provides will help control both program and beneficiary costs. Work on Medicare’s new internal state-of-the-art electronic data management system is continuing.

FEDERAL POLICY

Medicare’s Use of Program Information

AARP urges the Centers for Medicare and Medicaid Services (CMS) to continually work to modernize all of its data systems. Congress should ensure adequate funding in CMS’s program budgets to support this work.

Concurrently, CMS should reinforce methods of evaluating the performance of Medicare carriers and intermediaries. CMS should ensure that Medicare beneficiaries are provided with:

- clear, accurate and easily accessible information;
- prompt and accurate claims processing;
- an explanation of Medicare benefits form for all claims for payment;
- effective follow-through on beneficiary fraud and abuse complaints;
- claim-by-claim enforcement of the limiting charge law; and
- timely processing of appeals.

To further support beneficiaries’ information needs, CMS should:
maintain, at an adequate level, the toll-free line for beneficiaries with questions about benefits or claims;

courage federal and state agencies with jurisdiction over programs for beneficiaries to intensify their outreach and beneficiary assistance programs—Congress should increase program budgets supporting this work;

simplify the billing process for beneficiaries and providers, including coordination of Medicare and Medicare supplemental insurance; and

implement a process that ensures quick remedies for Medicare denials that result from incorrect primary-payer information.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program • Original Medicare • Beneficiary Costs

Background

Preventive Health Care

Medicare’s traditionally limited Part B coverage for preventive services has expanded in recent years to include vaccinations for pneumonia, hepatitis B and flu; pap smears and pelvic examinations once every two years (or more frequently for those at high risk); annual mammography screening for women over age 40; and annual glaucoma screenings for people at high-risk. Other covered preventive services include annual prostate screenings for men over age 50, colorectal screening, outpatient diabetes self-management training, glucose monitoring equipment, bone-density measurement for those at high-risk, and nutrition therapy for beneficiaries with certain medical conditions. Deductibles and/or coinsurance have been waived on some of these services to ensure that financial considerations are not a barrier to their use.

The US Preventive Services Task Force (USPSTF) was convened by the US Public Health Service to evaluate clinical research that assesses the merits of preventive measures such as screening tests, counseling, immunization, and chemoprevention. Their review has implications for the potential expansion or modification of preventive services covered by Medicare. Recent recommendations include routine osteoporosis screening for women age 65 and older, and beginning at age 60 for women at risk for osteoporotic fractures.
Preventive Health Care

Where there is evidence of clinical effectiveness, Congress should consider covering preventive care and screening services with nominal or no cost-sharing to encourage beneficiaries to pursue prevention and early detection of new conditions and to avoid or delay further complications from existing conditions.

In order to expedite Medicare coverage for preventive services with proven effectiveness, Congress should consider delegating authority for approval of such services to a qualified governmental entity, such as the Institute of Medicine or the US Preventive Service Task Force.

To realize the value of covered preventive and screening services, Congress and the Centers for Medicare and Medicaid Services should fund community-based outreach, education and promotion, including targeted initiatives, for at-risk beneficiary groups.

Congress should adequately fund research to identify and evaluate appropriate preventive and screening services not currently covered by Medicare.

Background

Durable Medical Equipment

Durable medical equipment (DME), which includes medical supplies and equipment such as wheelchairs, walkers, oxygen and prosthetics, is reimbursed under Part B of Medicare. The Medicare program is estimated to have spent $5.4 billion on DME in 1999. Fraud and abuse associated with DME have been identified as a particularly serious problem. Recognizing this, Congress included a number of antifraud provisions specific to DME in the Balanced Budget Act of 1997. The act requires DME suppliers to provide the Centers for Medicare and Medicaid Services with their Social Security numbers and requires new suppliers who wish to do business with Medicare to post surety bonds (for further discussion see the section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Health Care Fraud and Abuse).
The Balanced Budget Act also established several competitive bidding demonstration projects for DME. Reports on these projects indicate that they have saved the program money without creating problems in access or quality of services.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
  - The Medicare Program
  - Original Medicare
  - Beneficiary Costs

**Durable Medical Equipment**

AARP supports the reforms implemented to reduce fraud and abuse associated with durable medical equipment (DME).

AARP supports the use of competitive bidding in all types of DME where it has been demonstrated that quality is not compromised by the competitive bidding process.

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
  - The Medicare Program
  - Original Medicare

**Background**

**Access Issues**

In Medicare, access to care refers to the ease with which beneficiaries may approach or use Medicare-covered medical services. These services may be provided through hospitals, physicians, postacute or subacute care providers, or mental health agencies and may be accessed through the fee-for-service system or through Medicare+Choice plans. Each of these areas may raise specific access issues for beneficiaries.

In 2001 the Medicare Payment Advisory Commission (MedPAC) issued a report to Congress on Medicare in rural America, where about one-quarter of the program’s beneficiaries live. While MedPAC found that, overall, rural beneficiaries do not seem to be measurably disadvantaged compared with urban beneficiaries, they do face a variety of barriers to obtaining care, particularly specialty care. MedPAC also reported that rural beneficiaries’ greatest barrier to care appears to be cost. In addition, MedPAC found a number of problems related to payment incentives in both fee-for-service and Medicare+Choice payment policies in rural areas, and weaknesses in Medicare’s systems for monitoring quality of care in rural areas.
Hospitals

In fiscal year 1984 Medicare reformed its payment system for inpatient services by using predetermined per-case payment rates under the prospective payment system (PPS) for hospitals. In the years following the implementation of PPS, many hospitals began to see decreases in their Medicare inpatient margins (the measure of a hospital’s profitability from its Medicare operations) and their total margins (the measure of a hospital’s overall profitability) as Medicare tightened its control over inpatient payment rate increases. However, this trend reversed after 1991 and, in the mid-1990s, most hospitals’ Medicare inpatient margins and total margins steeply increased.

These rising profit margins occurred to a large extent because of the much slower growth in hospital costs associated with treating Medicare beneficiaries. The decline in hospital cost growth resulted from shorter lengths of inpatient stays by beneficiaries due to earlier discharges to home or to less costly facilities, less invasive surgical techniques and the use of more effective prescription drugs. In general, hospitals performed better in response to pressure from private payers, which have limited their payments to hospitals. Competition has increased, placing greater pressure on hospitals to reduce costs.

The Balanced Budget Act (BBA) of 1997 included a number of provisions that reduced spending for hospital services. For example, the act decreased the rate of growth in hospital payments by reducing the annual payment updates to PPS hospitals and established a PPS for outpatient department services. Moreover, the BBA expanded the range of managed care options that could be offered to beneficiaries under Medicare; these types of plans typically achieve savings by reducing the number and length of hospital stays.

Some data indicate that many hospitals’ profit margins decreased from their pre-BBA levels in the period immediately following the implementation of the act. Congress then modified some of the BBA limits affecting hospitals in legislation passed in 1999 and 2000.

In addition to paying for beneficiary services, Medicare also provides special subsidies to teaching hospitals and other facilities that serve a disproportionate share of low-income people. Medicare both directly and indirectly subsidizes teaching hospitals: directly, by paying these hospitals a dollar amount for each medical resident trained, and indirectly, by paying them higher PPS rates. The graduate medical education (GME) subsidy was
designed to increase the number and specialties of medical residents, create incentives for teaching hospitals to treat Medicare beneficiaries and augment the overall financial resources of teaching hospitals.

In fiscal year 2002 Medicare provided approximately $8 billion through the GME subsidy to teaching hospitals, with most of this money coming from the Hospital Insurance trust fund. Some observers argue that the GME subsidy should not come from Medicare, since teaching hospitals perform important functions that benefit the entire health system. One such function is training physicians in the latest practice techniques. A second function is caring for patients with complicated illnesses that require services other hospitals often cannot provide. Another function of teaching hospitals is engaging in medical research and developing technological innovations that benefit modern medicine.

There has been no evidence to date of a growing problem in beneficiaries’ access to hospital services. In fact, in its March 2002 report to Congress, the Medicare Payment Advisory Commission (MedPAC) reported that aggregate Medicare payments for hospital services were adequate as of fiscal year 2002, even after taking into account changes legislated for fiscal year 2003 that will reduce payments. Large enough reductions in the growth of Medicare payments to hospitals could, however, result in some hospitals reducing staffing levels (which could reduce quality of care for hospital patients, e.g., sending patients home in an unstable condition) and might result in closures of some hospitals with low operating margins, particularly rural hospitals, inner-city teaching hospitals and public hospitals. These changes could affect all who use hospital services, including Medicare beneficiaries.

FEDERAL POLICY

HEALTH CARE COVERAGE  ¤ Publicly Administered Health Insurance  ¤ The Medicare Program  ¤ Original Medicare  ¤ Access Issues

Hospitals

AARP calls for continuing research by the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) on the impact of Medicare payments to hospitals on access to care and quality of care, especially in rural areas. For example, CMS should monitor whether hospital closings and the reductions in the number of beds due to Medicare’s fiscal policies adversely affect access to care.

Because changing patterns of hospital reimbursement have led to increased levels of outpatient services, CMS and/or MedPAC should also continue to monitor whether access to and the quality of these services have been maintained or improved.

MedPAC and/or CMS should study the adequacy of Medicare subsidies to hospitals that treat a disproportionate share of low-income patients.
Graduate medical education subsidies should be removed from Medicare and adequately financed through a separate and broader mechanism.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program • Original Medicare • Access Issues

Background

Physicians

Since 1992 Medicare has set physician payment rates according to a fee schedule that reimburses physicians based on such factors as the time, skill and intensity required for medical care. This system has reduced much of the unjustified variation in physician fees.

As an unintended result of the fee schedule’s annual payment-update formula, physicians saw reductions in their Medicare reimbursements in 2002. As was the case with the initial implementation of the fee schedule, there has been concern that lower reimbursement rates might cause some physicians to stop treating Medicare patients. In addition, some specialties of physicians in certain geographic areas are reporting financial pressure from recent increases in malpractice insurance premiums. Access problems for Medicare beneficiaries could result, particularly if a large number of physicians or certain types of physicians refuse to treat Medicare patients or serve certain communities. Although anecdotal evidence of access problems has been reported in certain geographic areas, data show that this has not been a nationwide trend.

In June 2002 the Medicare Payment Advisory Commission released its findings regarding Medicare beneficiary access to care based on its analysis of the 1999 Medicare Current Beneficiary Survey. The commission found that while access for most beneficiaries appears to remain good, access problems continue for beneficiaries who lack supplemental insurance, are under age 65, report poor health and have incomes below 200 percent of the federal poverty standard. In general, these beneficiaries were more likely than other beneficiaries to report having trouble receiving health care services, having delayed care because of cost or not having a usual source of care.

The Centers for Medicare and Medicaid Services (CMS) is required to monitor annually the impact of payment reform on beneficiaries’ access to care. That information is necessary to identify any midcourse corrections in policy that may be needed to ensure that beneficiaries have access to care. However, CMS historically has been slow to develop and implement the monitoring program.
Physicians

The Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) should regularly and in a timely manner evaluate and monitor Medicare beneficiaries’ access to quality care in all Medicare settings and develop a clear plan to address any access problems, particularly those related to the adequacy of Medicare payments to physicians. CMS also should continue to release to the public the data on access and health care utilization and all relevant information from the Medicare Current Beneficiary Survey. CMS should pay particular attention to access problems of special populations, including beneficiaries in rural areas and in US territories and commonwealths, people with disabilities, low-income individuals, minorities, beneficiaries with end-stage renal disease, people living in institutions and in communities where access problems are common because of a shortage of health care personnel.

Both CMS and MedPAC should increase research into the causes of access problems, especially those the commission identified in its analyses.

Congress should correct any errors or miscalculations in the formula used to update payments annually.

Background

Postacute and Subacute Care

In Medicare postacute care generally refers to services, such as skilled nursing and therapy services, that beneficiaries need following inpatient hospitalization. The most common postacute providers are home health agencies and skilled nursing facilities (SNFs), although hospital outpatient departments, rehabilitation facilities and long-term care hospitals also provide postacute care. Many beneficiaries require care in multiple postacute settings after an acute illness and may be discharged from the hospital to a SNF and later from the SNF to the care of a home health agency.

For postacute institutional care such as SNF care, the Medicare benefit is conditioned upon prior hospitalization of at least three days. Beneficiaries in SNFs must begin paying daily coinsurance amounts after 20 days in a facility.
To receive home health care, there is no requirement of prior hospitalization, and not all home health users are postacute in the sense of having been recently hospitalized. These home health users are sometimes referred to as subacute patients. They receive Medicare home health care because of a severe chronic condition, disability or a combination of severe health conditions. Home health visits are not subject to deductibles or coinsurance. Postacute and subacute care must be ordered by a physician.

Between the mid-1980s and mid-1990s, the rate of growth in payments for SNF and home health benefits exceeded that for the rest of Medicare program benefits. This growth has been attributed to improvements in SNF program administration since the late 1980s; increased home health utilization (number of users and number of visits); uncontrolled growth in the costs of nonroutine items and services, such as therapies, medical equipment and supplies; and the effects of fraud and abuse. To contain costs the Balanced Budget Act of 1997 (BBA) mandated a prospective payment system for SNFs and home health. Further, a prospective payment system has recently been implemented for rehabilitation facilities and one will soon be implemented for long-term care hospitals.

Under the SNF prospective payment system implemented in 1998, facilities are paid a per diem amount, determined by the beneficiary's classification in one of 44 resource utilization groups, known as RUG-IIIIs. The home health prospective payment system was implemented in October 2000. Other BBA reforms include an annual cap of $1,500 for outpatient therapy services (not applicable to services provided in hospital outpatient departments). This provision remains under a moratorium, as a result of legislative refinements enacted in 1999.

Prospective payment and other reforms hold promise for controlling the costs of postacute and subacute care, while making the program more cost effective. However, balancing concerns about costs against patient and family needs is a delicate task, especially when discontinuing benefits leaves care needs that the patient and/ or family must try to meet through other public or private sources. For instance, Medicare home health users tend to be older, more limited in activities of daily living, more likely to use Medicaid and more burdened by out-of-pocket health expenses than Medicare beneficiaries generally. The recent and continuing changes in the payment systems are likely to be felt by some of these patients. Policymakers and analysts are closely studying the effects of the BBA on access and quality. Some early reports suggest that the payment reforms currently in place could eventually lead to access problems for the sickest beneficiaries.

In addition to implementing payment reforms, CMS is developing methods to oversee the quality of care provided in postacute care settings. For instance, through collection of patient-level outcome data, CMS proposes to identify and target problem providers as well as develop strategies for improving postacute outcomes systemwide.
The Omnibus Budget Reconciliation Act of 1987 mandated that Medicare monitor the quality of home health care and services with a "standardized, reproducible" assessment instrument. To fulfill this mandate, CMS in 1999 began requiring home health agencies to use the Outcome and Assessment Information Set (OASIS) to evaluate patient differences in health status and care needs. OASIS has great potential for measuring the outcomes of care and fostering quality improvements. It also is being used to calculate Medicare prospective payments for home health care. OASIS initially collected a fairly extensive amount of data that now is being reduced. Still, stakeholders generally agree that there is room for further streamlining so that providers can spend less time on paperwork and more time with patients. In addition, some parties have advocated that OASIS be required only for Medicare (or Medicaid) beneficiaries in order to reduce documentation and reporting burdens. Opponents of such a change argue that it would eliminate an essential tool for ensuring adequate assessment and quality improvement for other patients.

So far, however, CMS has not implemented regulations to safeguard the safety and quality of various types of medical equipment used in the home. Medicare beneficiaries are not protected from serious risk resulting from the improper installation and maintenance of life-sustaining equipment such as ventilators and oxygen tanks. In addition, there are no explicit Medicare provisions governing the quality of drug infusion therapies, which carry a high risk of major medical complications if not properly monitored and are increasingly being delivered in the home.

In a number of respects, current Medicare coverage policy is inadequate to provide reasonable access to postacute or subacute care in SNFs or in the home:

1. The SNF coinsurance amount is substantial, $105 per day for the 21st–100th day in each spell of illness in 2003. Because the coinsurance amount is computed on the basis of the Medicare hospital deductible, it is much higher than the 20 percent coinsurance required for most Medicare services. In fact, for many beneficiaries, $105 actually exceeds the daily cost of SNF care.

2. Medicare does not pay for SNF services beyond 100 days.

3. The requirement of prior hospitalization for SNF eligibility means that some people in the community with legitimate skilled-care needs, such as a person whose condition deteriorates while receiving home health care, will not be covered by the SNF benefit. In addition, the requirement creates a perverse incentive to hospitalize patients so that they can qualify for the benefit.

4. In order to qualify for Medicare home health benefits, including the services of a home health aide, a beneficiary must be homebound, that is,
able to leave home only with great difficulty and for short, infrequent absences (e.g., a doctor’s visit)—and need skilled nursing care, physical or speech therapy, or continuing occupational therapy. The definition of “homebound” has recently been clarified to allow the home health user to leave the home to receive treatment at adult day care and to attend religious services.

Although there is no statutory limit on the total number of home health visits for those who meet eligibility criteria, Medicare’s coverage of home health care is limited to part-time and intermittent care.

Original Medicare does not cover care management or care coordination across various providers, other than requiring limited physician oversight of home health care.

FEDERAL POLICY

Postacute and Subacute Care

Provider payments—The incentives of postacute payment methods must safeguard access to necessary, high-quality covered services for all beneficiaries, without regard to the intensity or duration of care required.

Beneficiaries must have the right, and be advised of the right, to appeal decisions such as denials, cutbacks and discontinuation of postacute care.

AARP urges the Centers for Medicare and Medicaid Services (CMS) to educate the postacute provider community about the rights of beneficiaries and join with state and federal enforcement officials to take strong action against postacute providers that inappropriately deny, reduce or restrict services.

Program monitoring and research—Congress, CMS and other government agencies should closely monitor the impact of Medicare payment policies on the quality of and access to postacute care (home health, skilled nursing facilities (SNF) and outpatient therapy services) and the appropriateness of care in various settings.

Future postacute policy proposals should be informed by careful research on access to care and delivery of care, including design options for Medicare-covered care management or care coordination for postacute and subacute beneficiaries.

Improving postacute benefits and access to care—Congress should mandate improvements in postacute benefits, safeguard beneficiary access to the benefits and avoid shifting the costs of postacute care to beneficiaries. AARP places particular priority on enacting proposals to:
protect beneficiaries from exposure to high out-of-pocket costs by reducing the SNF coinsurance obligation

- increase the number of SNF-covered days,

- remove the prior-hospitalization requirement for new SNF admissions and

- maintain home health benefits free of copayments.

CMS should take strong steps to ensure the quality of postacute care and promote quality improvements where necessary. AARP places particular priority on:

- pursuing initiatives to improve the quality of care in nursing homes (see Chapter 7, Long-Term Care);

- enforcing the home health conditions of participation, and strengthening protections for beneficiaries using medical equipment in the home;

- using data sets such as the Outcome and Assessment Information Set (OASIS) and others to measure and improve home health outcomes and, in working to streamline OASIS, ensuring that its role in outcome measurement and quality improvement be maintained and that it not be diluted into a tool used only for determining payment amounts—Further, OASIS should be used and reported for all patients, not just those in Medicare or Medicaid;

- working with quality improvement organizations to improve quality of care provided in postacute settings; and

- improving methods of coordinating care among multiple providers, while maintaining or enhancing beneficiaries’ choice of providers and access to needed care.

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**HEALTH CARE COVERAGE**  •  Publicly Administered Health Insurance
  •  The Medicare Program  •  Original Medicare  •  Access Issues

**Background**

**Mental Health**

The need for mental health services for older Americans has not adequately been met. Estimates place the percentage of older people with unmet mental health needs in the community at a minimum of approximately 40 percent (see Chapter 7, Long-Term Care, for discussion of the mental health needs of nursing home residents).
Normal aging is not characterized by mental or cognitive disorders, and there are effective interventions for most mental disorders experienced by older people (e.g., depression, anxiety and disorders associated with the inability to adjust to life changes). The failure of many primary care physicians to diagnose mental health and substance abuse disorders, and the stigma often associated with these disorders, serve as obstacles to appropriate mental health and substance abuse care for older adults. For example, physicians are less likely to make mental health referrals for older patients than for younger patients or to diagnose accurately alcohol and substance abuse disorders among older adults. A complicating factor is the reluctance of many older people to seek counseling to help cope with the challenges of later life, such as bereavement, disability, loneliness and isolation.

Access to care in the community is further limited by the institutional bias in Medicare mental health policy. In 1996 the most recent year for which data are available, an estimated 68 percent of Medicare’s mental health payments were for Part A payments to hospitals and skilled nursing facilities.

While Medicare’s coverage of mental health services has gradually improved (e.g., by eliminating the payment limit on Part B mental health services), the coverage continues to reflect restrictions and coinsurance differentials that do not apply to other health services. For example, beneficiaries pay an effective coinsurance rate of 50 percent for most outpatient mental health services, and there is a 190-day lifetime limit on psychiatric care in freestanding psychiatric hospitals.

A partial hospitalization benefit was added to the list of covered services in 1987. Partial hospitalization services, covered only for those who would otherwise require inpatient psychiatric care, may be provided in community mental health centers as well as hospital outpatient departments. In 1998 the federal Department of Health and Human Services’ Office of Inspector General found evidence of widespread abuses in billing under the partial hospitalization benefit by community mental health centers in a number of states; the Centers for Medicare and Medicaid Services has implemented an action plan to curb abuse and protect beneficiaries (see Chapter 9, Housing, for policy on homelessness and supportive housing, and Chapter 13, Personal and Legal Rights, on the need to expand a variety of adult protective services).
FEDERAL POLICY

HEALTH CARE COVERAGE  Publicly Administered Health Insurance
                       The Medicare Program  Original Medicare  Access Issues

Mental Health

The Medicare law and regulations should be amended to reimburse mental health services more adequately and to eliminate the 190-day lifetime limit on inpatient psychiatric care in freestanding psychiatric hospitals under Part A.

The 50-percent coinsurance for Medicare outpatient mental health therapy services should be set at 20 percent to make such services more affordable to beneficiaries and eliminate the disparity in coinsurance for mental health services and other health care.

The Centers for Medicare and Medicaid Services (CMS) should improve access to Medicare mental health and substance abuse benefits, particularly Part B outpatient services.

CMS also needs to monitor more closely partial hospitalization services provided in community mental health centers in order to prevent abuse, while also protecting beneficiaries’ access to high-quality services.

CMS should ensure that Medicare beneficiaries with mental or addictive disorders, particularly those residing in nursing homes or enrolled in managed care plans, have access to appropriate services. Data collection and other oversight activities must be conducted in a way that preserves beneficiaries’ privacy and confidentiality.

Both primary care physicians and mental health professionals should be trained in recognizing, diagnosing and treating the mental health problems of the elderly. They should also be trained to refer patients with complex needs for interdisciplinary geriatric assessment when appropriate. Special training in cultural and ethnic sensitivity should be emphasized in professional and paraprofessional education, and mental health services should be accompanied by culturally relevant outreach efforts.

CMS, through research and demonstration projects, and the Substance Abuse and Mental Health Services Administration should encourage innovative service-delivery models for mental health services, such as bringing mental health services into homes, senior centers, residential care facilities (including board and care homes) and federally assisted housing sites.

Community mental health centers should be encouraged to reach out to older adults, who typically will not self-refer, by providing services at other sites and establishing affiliations with area agencies on aging.
Finally, additional funding must be made available for research on the complex epidemiology of mental health problems of older Americans and on preventing and reducing mental and alcohol/substance abuse disorders among older adults. Mental health research should evaluate the impact of specific therapies on outcomes for older patients.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance
• The Medicare Program • Original Medicare

Background

Medicare’s Coverage of New Technologies

The Centers for Medicare and Medicaid Services (CMS) makes national coverage decisions regarding whether and when Medicare will include a new medical technology as a covered benefit. Medicare payment contractors will continue to make the majority of local coverage decisions.

Those making decisions to cover current and new technologies must carefully weigh the added program costs of such coverage against the benefits in health and longevity such technologies can bring to beneficiaries (for information regarding coverage of experimental services by managed care plans, see the section Publicly Administered Health Insurance—Medicare+Choice—Federal Standards for Medicare Managed Care Plans).

FEDERAL POLICY

Medicare’s Coverage of New Technologies

The Centers for Medicare and Medicaid Services (CMS) should provide timely public notice and an opportunity for public input before a Medicare program decision is made on coverage for a new technology.

CMS should develop, publish and enforce standard payment procedures for contractors to follow when they make local coverage decisions. These procedures should include an opportunity for public comment on the proposed decisions.

AARP opposes the use of cost as a principal criterion in decisions regarding coverage of new medical technology, believing such decisions should be based predominately on quality-of-care considerations.
Background

**Medicare’s Coverage of Prescription Drugs and Other Uncovered Services**

Medicare does not typically pay for prescription drugs dispensed in an outpatient setting. As a result Medicare beneficiaries spend more out of pocket for prescription drugs, on average, than they do for hospital care, physician services or other health care goods and services. According to the Congressional Budget Office, Medicare beneficiaries incurred an estimated average of $860 in out-of-pocket costs for prescription drugs in 2002. High out-of-pocket prescription drug spending is less a function of income than it is a function of insurance status (i.e., whether a beneficiary has prescription drug coverage and the generosity of that coverage), health status and number of chronic conditions.

About two-thirds of Medicare beneficiaries have some form of supplemental coverage for prescription drugs, but 40 percent or more lack coverage at some point during the year. While the lack of drug coverage affects beneficiaries regardless of geographic area, age or income, it disproportionately affects beneficiaries who live in rural areas, are age 85 and older or who have annual incomes between $10,000 and $20,000. Furthermore, supplemental coverage does not always protect beneficiaries from high out-of-pocket drug costs. For example, average out-of-pocket drug spending in 1998 among beneficiaries with individually purchased supplemental drug coverage was nearly twice that of beneficiaries who had drug coverage in Medicare+Choice plans, and 75 percent more than beneficiaries with employer-sponsored prescription drug coverage. In addition, current prescription drug coverage may not be stable or dependable. Medicare+Choice plans can change their benefits or even withdraw from the program on an annual basis. Employer-sponsored prescription drug coverage is becoming less generous and less common. And annual increases in Medigap premium costs are making those policies less and less affordable.

The lack of a Medicare prescription drug benefit can have adverse effects on both quality of care and costs of treatment. Some beneficiaries forgo prescription drug treatment or use less than the fully prescribed dosage because they are unable to afford the price of their drugs. To the extent that the lack of treatment or incorrect dosage worsens beneficiaries’ medical condition and requires further care, higher Medicare costs for some treatments could result. Evidence from the Medicaid program suggests that lack of access to prescription drugs can increase other health care costs of chronically ill elderly people. Although the magnitude of the impacts for
Medicare is uncertain, health care analysts are increasingly able to show how certain prescription drug treatments improve health outcomes and, in some cases, reduce other non-drug health care costs.

Leaders of both major political parties have introduced proposals to add a prescription drug benefit to Medicare. Most policymakers have also concluded that the prescription drug benefit should be voluntary, part of Medicare and defined in law; that a low-income benefit alone is not adequate; that all beneficiaries should receive some subsidy from Medicare to help pay part of the cost of medications; that low-income individuals should receive substantial financial assistance with their premium and cost-sharing; and that the benefit should be available in all plans.

However, several other important issues remain unresolved, including:

1. the amount of federal funds available to subsidize a prescription drug benefit;
2. the generosity of the benefit, particularly how much coverage (if any) would be provided at each spending level;
3. the degree to which Medicare would subsidize the premium;
4. which special populations would be eligible for additional subsidies;
5. the degree to which the benefit would be administered by Medicare, versus the private sector; and
6. how to allow beneficiaries to maintain coverage they currently receive from other sources.

One of the most important issues that Congress still must settle is how to design a Medicare drug benefit that falls within designated budget targets yet has an affordable premium and offers a benefit that people will want to purchase. In 2002 Congress considered a number of drug benefit designs that had ten-year costs to the federal government as high as $500 billion, but typically in the range of $300 billion to $375 billion. However, these plans, which would have had premiums of between $25 and $35 per month in their first year, would have required high cost-sharing relative to many employer-provided plans (i.e., as much as 50 percent of drug costs) and—under some proposals—substantial gaps where no coverage would be provided at all. Most plans would have provided substantial additional subsidies to lower-income beneficiaries.

Congress did not pass legislation in 2002 establishing a Medicare prescription drug benefit. Among the many points of debate was whether the proposals would have provided a meaningful benefit—that is, whether they provided sufficient coverage for needed prescriptions and, therefore, would attract broad participation. Without broad participation, a benefit that lacks
mandatory enrollment would overwhelmingly attract beneficiaries with high drug costs, and the long-term affordability and viability of the benefit would be threatened. While this concern could have been allayed by enhancing the benefit package, such a solution would have required either substantially increasing costs to the federal government, substantially increasing beneficiaries' premiums (which itself would decrease participation), reducing subsidies to lower-income beneficiaries, or a combination of these changes.

A second key issue facing Congress is whether the program should be administered like Medicare—where private insurers administer the benefit but the federal government bears the financial risk of program costs—or should be administered by private plans that bear some or all of the financial risk and operate more independently from Medicare. Proponents of a Medicare-run drug benefit contend it is simpler to administer; that private plans may be reluctant to offer a stand-alone drug benefit, particularly in rural areas; and that private plans may adopt cost-control policies that could threaten beneficiary access to the most medically appropriate drugs. By contrast supporters of private administration of a Medicare drug benefit contend that this mechanism would be the best approach for promoting competition and efficient mechanisms for controlling rapidly rising prescription drug costs.

A related element of these proposals is how to manage the benefit on a daily basis and contain its cost. Many of the proposals rely on health plans and/or pharmacy benefit managers (PBMs) to administer the Medicare drug benefit. These approaches reflect both a reluctance to regulate prices paid by Medicare and a belief that PBMs and managed care plans can apply approaches they have used in the private sector to reduce prescription drug costs. However, some analysts question the extent to which health plans and PBMs can reduce drug spending and, for PBMs in particular, the extent to which the price discounts they obtain are passed on to consumers. Critics are also concerned about whether patients' prescriptions are inappropriately switched to lower-priced medications that could harm patient health (see the discussion on unitary pricing in the section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Prescription Drugs and Pharmacy Practices).

An additional administrative feature to be addressed is whether to limit enrollment periods rather than allow beneficiaries to opt in and out of the program as their needs change. If beneficiaries were permitted to buy coverage only when they expected to have high drug costs, the cost of the benefit would increase substantially because the insurance risk would be spread over a smaller, "sicker" pool. To minimize the costs associated with adverse risk selection, access to a voluntary drug benefit could be restricted to specified enrollment periods. Medicare Part B's enrollment rules are an example of a voluntary plan with specified enrollment periods.
Other administrative features that can help to reduce costs include the use of formularies or other drug utilization management approaches designed to provide enrollees with the most effective drug at the lowest cost. These approaches, which frequently are used by private-sector benefit plans, can reduce benefit costs by limiting which drugs enrollees can obtain or by requiring enrollees to pay higher cost-sharing for more costly or less effective drugs. These types of administrative features can have a significant impact on the benefit’s affordability. Ultimately, policymakers and beneficiaries alike will have to make decisions about the trade-offs they are willing to accept to have an affordable benefit.

In addition, some proposals would extend any Medicare price discounts to beneficiaries’ out-of-pocket drug purchases (such as for a deductible or for spending beyond the benefit cap). Currently, drug manufacturers and pharmacies are likely to charge higher prices for sales to Medicare beneficiaries who pay out of pocket for their prescription drugs than they do for sales to beneficiaries who have prescription drug benefits through private insurance or Medicare managed care plans that offer a prescription drug benefit. By extending a Medicare discount to beneficiaries’ out-of-pocket drug payments, Medicare would be able to use its buying leverage to lower prices for all beneficiaries, regardless of whether Medicare is the ultimate payer.

In 2001 the president proposed a discount program to give Medicare beneficiaries access to such discounts even in the absence of a Medicare prescription drug benefit. Under this proposal private PBMs would use the purchasing power of Medicare beneficiaries to negotiate lower prices with pharmacies and drug manufacturers and would offer discount cards to Medicare beneficiaries, who would then be able to purchase prescription drugs at a reduced price. Proponents of this proposal contend that beneficiaries could obtain discounts of 15 percent to 25 percent off a drug’s retail prices.

Other proposals would use mechanisms outside of Medicare to provide prescription drug coverage to some beneficiaries. For example, one approach would provide block grants to the states for developing state-based pharmaceutical assistance programs (for a discussion of existing state-based programs, see Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Prescription Drugs and Pharmacy Practices). While these approaches can address particular components of inadequate drug coverage, they nonetheless operate outside Medicare and therefore would not address the broad need for drug coverage among the Medicare population.

In addition to prescription drugs, Medicare also does not cover other valuable health services and screenings often included in many private insurance benefit packages. These include vision care, eyeglasses, dental care, hearing examinations and hearing aids. As with prescription drugs,
beneficiaries in need of these health care services and screenings must either have supplemental coverage to help pay for them, pay out of pocket or go without care.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE**  
Ɣ Publicly Administered Health Insurance  
Ɣ The Medicare Program  
Ɣ Original Medicare

**Medicare’s Coverage of Prescription Drugs and Other Uncovered Services**

Medicare should provide a prescription drug benefit to all beneficiaries that:

1. is available to all beneficiaries, without regard to income, geographic location or health status;

2. is available without regard to a beneficiary’s choice of Medicare plan, including original Medicare;

3. is voluntary, so that beneficiaries can choose between keeping their existing drug coverage or enrolling in the Medicare drug benefit;

4. minimizes incentives for employers to drop prescription drug coverage for their insured retirees;

5. is part of a defined benefit package, so that prescription drug benefits are guaranteed over time and beneficiaries understand what is included in their benefit;

6. includes a government contribution that minimizes risk selection through an affordable beneficiary premium and a benefit design attractive to all beneficiaries;

7. ensures that each beneficiary has access to drug therapies that his or her physician determines to be medically appropriate and necessary;

8. provides additional subsidies for low-income beneficiaries to protect them from unaffordable costs and ensure that they have access to the benefit;

9. uses Medicare’s aggregate purchasing power to obtain discounts and/or rebates from drug manufacturers and pharmacies;

10. relies on stable, broadly based and equitable financing; and

11. protects Medicare beneficiaries from exorbitant costs.
Medicare's prescription drug benefit should not be subject to an arbitrary budget target.

If private risk-bearing entities are used to deliver a Medicare prescription drug benefit, they should be an option alongside non-risk-bearing, government entities in order to assure that all Medicare beneficiaries will have access to some form of prescription drug coverage.

Medicare should use its purchasing power to obtain price discounts that beneficiaries can apply to their out-of-pocket drug purchases. A Medicare prescription drug benefit should include quality improvement components to reduce medical error and encourage appropriate prescribing, monitoring and use of medications.

To ensure affordability of a voluntary Medicare prescription drug benefit, it will be essential to minimize risk selection to the greatest extent possible. To that end, Congress should establish enrollment periods for the Medicare drug benefit similar to the process for enrollment in Medicare Part B, so that beneficiaries would have a specified period to enroll after initially becoming eligible for Medicare. Any restrictions on when beneficiaries can enroll in a Medicare prescription drug benefit must be coupled with an aggressive education and marketing program to help beneficiaries understand their options and the limitations on their choices. Those beneficiaries who involuntarily lose drug coverage provided by another source must have a period during which they could enroll in a Medicare drug benefit without penalty.

Congress should assess the impact of allowing late enrollment in the Medicare drug benefit. In particular, Congress should assess whether penalties similar to those associated with late enrollment in Medicare Part B would be sufficient to reduce the potential adverse effects of late enrollment in the risk pool.

AARP does not oppose the use of pharmacy benefits management or other managed care approaches to providing prescription drug benefits to Medicare beneficiaries. However, Medicare should oversee and monitor private entities’ management of a Medicare prescription drug benefit to ensure that beneficiaries have access to appropriate drug therapies and pharmacies and that their prescriptions are not inappropriately switched to lower-priced drugs that could endanger beneficiaries’ health (for a discussion of how these safeguards should be structured, see Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Prescription Drugs and Pharmacy Practices). In addition, Medicare should monitor the management of its prescription drug benefit with respect to its impact on the overall costs and quality of health care.

Medicare should ensure that all its prescription drug plans are sufficiently accountable for the quality of services provided by any benefit managers with which they contract.
Congress should ensure coordination of Medicare prescription drug benefits for beneficiaries also enrolled in Medicaid.

While awaiting enactment of a Medicare prescription drug benefit, Congress should explicitly authorize the Centers for Medicare and Medicaid Services to develop a drug price discount program. However, such a program should not be considered a substitute for meaningful prescription drug coverage within Medicare.

Medicare should provide coverage for vision care, dental care, eyeglasses, hearing examinations and hearing aids.

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**HEALTH CARE COVERAGE • Publicly Administered Health Insurance • The Medicare Program • Original Medicare • Consumer Protections and Quality Oversight**

**Background**

**Appeals**

An appeals system is essential for correcting payment errors and erroneous determinations that a service is not covered by Medicare. In general, fee-for-service Medicare has a good appeals system. However, the fee-for-service appeals system is not without problems. It is complicated and lengthy, particularly at the later stages. Many beneficiaries find it confusing and are intimidated by formal procedures. They are often not given much useful information about either the reason for a coverage denial or their appeal rights.

**FEDERAL POLICY**

After receiving public input Medicare should adopt clear, published standards for coverage and payment. The public should have access to all manuals, transmittals and other statements of policy used in Medicare decisionmaking.

Carriers and fiscal intermediaries should have incentives to reach the correct decision on a claim at the first level of review.

Any decision that could result in a beneficiary not receiving the care in question should be made and communicated as rapidly as the beneficiary's medical situation requires.
Medicare beneficiaries and other parties directly affected by a Medicare coverage or payment decision are entitled to a timely, written explanation of the basis for the decision and of their appeal rights. This information should be understandable to a layperson and sufficiently detailed to permit a meaningful appeal.

Appeal procedures should be as simple and streamlined as possible without sacrificing beneficiary protections. They should ensure basic fairness for the beneficiary, including an opportunity for an informal in-person hearing by the carrier or fiscal intermediary.

### Quality Oversight and Improvement

Problems in the quality of care provided to Medicare beneficiaries can be considered in three categories: overuse, in which individuals are exposed to the risks of health services from which they cannot benefit; underuse, in which individuals fail to receive services that save lives or prevent disability; and misuse, in which individuals are injured when avoidable complications of health care are not prevented. These problems are found in all types of delivery systems, including original Medicare, and result in wasted resources as well as lost lives or reduced function.

The Centers for Medicare and Medicaid Services (CMS) is ultimately responsible for ensuring quality in all Medicare programs. Quality oversight and improvement encompass measures to ensure that providers meet quality standards and initiatives that promote and improve the quality of care provided to beneficiaries. CMS uses six main strategies to address quality in the Medicare program: establishing and enforcing standards; providing technical assistance through Quality Improvement Organizations (QIOs), formerly peer review organizations (PROs); promoting collaboration and partnerships; supporting or directly providing consumer assistance and information; structuring payment and coverage to improve care; and rewarding performance.

In original Medicare CMS fulfills its responsibility directly and through contracts with various organizations that monitor, survey, inspect and review the provision of Medicare services. Medicare quality contractors include state survey and certification units and independent accrediting bodies, such as the Joint Commission on the Accreditation of Healthcare Organizations and QIOs. The QIOs’ primary function is to collect and analyze data on patterns of care and outcomes in order to help physicians and other providers...
improve the quality of care provided to Medicare beneficiaries. The QIO role has been expanded under the current scope of work to include the Nursing Home Quality Initiative, a new community-based, quality improvement program offered to nursing homes, and the Home Health Care Initiative, which will implement the Outcome Based Quality Improvement (OBQI) system pilot project for home health care.

In addition, one of the three chief responsibilities of QIOs is to protect beneficiaries by expeditiously addressing individual cases in such areas as beneficiary complaints, hospital-issued notices of noncoverage, violations of the Emergency Medical Treatment and Active Labor Act (e.g., dumping) and other statutory responsibilities. In a report on the former PROs, the Department of Health and Human Services (DHHS) inspector general’s office observed that the organizations seemed to be more oriented to the provider community than to the beneficiary community and failed to provide meaningful response to complainants. DHHS advised either fixing the beneficiary complaint process or removing the function from the PROs.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE**

- Publicly Administered Health Insurance
- The Medicare Program
- Original Medicare
- Consumer Protections and Quality Oversight

**Quality Oversight and Improvement**

Congress should make a significant investment in the infrastructure and operating capacity of the Centers for Medicare and Medicaid Services (CMS) so that it can meet its responsibilities for quality oversight in original Medicare.

CMS should place a priority on coordinating its quality oversight programs across provider types, service-delivery settings, geographic regions and beneficiary populations.

CMS must have authority from Congress to exercise discretion in formulating and pursuing an overall approach to quality oversight.

Health care quality improvement programs must be regularly evaluated to determine if measurable improvements in outcomes and processes are achieved. Medicare fee-for-service providers should be required to implement patient safety programs.

CMS should develop and maintain adequate data systems so it can assess the quality of care delivered to beneficiaries in the original program.

CMS should closely manage and hold accountable the contractors it empowers to conduct quality reviews and inspections on its behalf, such as payment contractors, state survey agencies, the Joint Commission on the Accreditation of Healthcare Organizations and Quality Improvement Organizations (QIOs).
CMS's oversight activities should include addressing beneficiary complaints and pursuing national clinical projects to measure access to care, timeliness of care and appropriateness of setting, treatment and discharge.

Congress should direct the Medicare Payment Advisory Commission to study whether and how the Medicare beneficiary complaint process might be improved, including whether or not it should be the responsibility of an entity other than the QIO.

CMS should develop a process for making useful information about quality available to the public, including data that permit comparisons between the original program and Medicare+Choice plans.

AARP urges CMS to exercise its enforcement authority in all cases where actions against providers or practitioners are necessary to protect beneficiaries from substandard care and practices.

AARP supports CMS's participation in partnerships with other agencies, such as the Healthy Aging Initiative, to promote improvements in beneficiary care and well-being.

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**HEALTH CARE COVERAGE • Publicly Administered Health Insurance**

- **The Medicaid Program**

**Background**

**The Medicaid Program and Children’s Health Insurance**

Medicaid is the nation’s largest publicly financed health insurance program for low-income adults, children, the elderly and disabled people. As a means-tested entitlement program, Medicaid requires states to provide coverage for certain groups of individuals as long as they are a member of the covered group and meet financial requirements. Under a joint financing arrangement between the federal and state governments, a state receives matching payments from the federal government based on its per capita income. The Federal Medical Assistance Percentage (FMAP) varies among states and ranges from 50 percent to 83 percent of total costs. On average, the federal government pays 57 percent of Medicaid expenditures.

Medicaid is the most important source of health insurance coverage for low-income individuals of all ages. The Congressional Budget Office projects that by the end of fiscal year 2002, Medicaid will have provided coverage to about 47 million people at an approximate cost of $247 billion. Medicaid helps pay for health care for more than one in eight Americans, including one in five children, is the single largest purchaser of the nation’s maternity care and pays approximately one-half of all long-term care costs. Its significant role in financing services provided by hospitals and other health care providers
means that Medicaid also plays an important role in sustaining local economies.

Four basic groups of low-income people are eligible for Medicaid: pregnant women and children, adult family members with Medicaid-eligible dependent children, the elderly and people who are blind or disabled. For each group there are multiple pathways for becoming eligible. Some of these pathways apply in all states (e.g., all states must cover pregnant women with incomes of up to 133 percent of the poverty line). Other eligibility pathways are available only if a state chooses to offer them (e.g., raising the income threshold for the elderly to 100 percent of poverty). In addition to belonging to a specified group or category, all Medicaid-eligible individuals must have incomes and resources below specified levels. Because these levels are determined by states within federal guidelines, there are large variations in Medicaid coverage among states.

Most disabled people and a large share of elderly people who are covered by Medicaid are eligible because they receive cash assistance through the Supplemental Security Income (SSI) program. To be eligible for SSI, individuals who are aged, blind or disabled must meet certain income and asset requirements. In 2001 SSI income eligibility varied among states from 74 percent to 100 percent of the poverty level. (In 2002 the federal poverty level was $8,860 for an individual.) Asset limits are $2,000 for an individual and $3,000 for a couple. Qualifying aged, blind and disabled legal immigrants who entered the country before August 1996 are eligible for SSI-related Medicaid. All other legal immigrants, who would otherwise be eligible for the program, are barred from participation during their first five years in the US.

The remainder of elderly and disabled people covered by Medicaid generally are not eligible for SSI, but their income and resources are within state-established levels that qualify these individuals as “medically needy.” Incurred out-of-pocket medical expenses can be subtracted from income to determine whether a person qualifies as “medically needy.” Although states are not required to extend coverage to the elderly and disabled under their medically needy programs, in 2001, 33 of 34 states with medically needy programs and the District of Columbia offered the medically needy option to the elderly and disabled.

Categories of low-income women and children for which states are required to provide Medicaid coverage include pregnant women and infants up to 1 year old in households with income at or below 100 percent of the federal poverty level (FPL), children between ages 1 and 5 in households with income at or below 133 percent of the FPL and children ages 6 to 18 in households with income at or below 100 percent of the FPL. For these individuals Medicaid provides comprehensive primary preventive and acute health care services. The most important benefit children receive under Medicaid is the Early and Periodic Screening, Diagnosis and Treatment
benefit, which provides regular and periodic health screenings and access to any necessary follow-up treatment regardless of whether the treatment is otherwise covered by Medicaid.

Low-income children may also gain access to Medicaid coverage through the State Children’s Health Insurance Program (SCHIP), enacted in 1997. Under this program states have three options for extending health insurance coverage to uninsured children: expand Medicaid, establish a new program separate from Medicaid or design a program that combines Medicaid and another approach. All fifty states, the District of Columbia and the US territories operate one or more SCHIP programs. Among jurisdictions with approved SCHIP plans, 21 are Medicaid expansions, 15 combine Medicaid with a separate insurance approach and 20 are stand-alone programs. As a result of program expansions, Medicaid now provides insurance for 47 percent of all children under 18 in families with income below 200 percent of the federal poverty level (Figure 6-8). Together with the growth in Medicaid enrollment, campaigns by almost all states to market and promote enrollment in SCHIP since the late 1990s have contributed to national reductions in the number of low-income children who are uninsured.
In comparison with low-income children, the elderly and people who are blind or disabled, low-income adults have few pathways for becoming eligible for Medicaid. States are required to cover certain adults in families with dependent children, such as low-income single adults with qualifying dependent children and adults in two-parent households with qualifying children if the principle wage earner works fewer than 100 hours per month. States have the option to eliminate this so-called 100-hour rule without a waiver, making it easier for two-parent working families to access Medicaid and, in effect, treat one- and two-parent families the same. As of 2002, 42 states had eliminated the 100-hour rule. Generally, nondisabled adults without dependent children are not eligible to participate in Medicaid regardless of their income. Exceptions can only be made by state’s use of statutory waiver authority under Section 1115 of the Social Security Act (see section in this chapter on Federal-State Flexibility).

Although Medicaid was created to serve individuals with low incomes, between 1997 and 1999 less than half of all people living in poverty in the US were covered by the program. Limits on Medicaid coverage arise for a variety of reasons. A major factor is the federal requirement that individuals meet the categorical and financial eligibility criteria associated with the program. For example, the majority of uninsured people age 50 to 64 are childless adults, and about 15 percent of them have incomes below the poverty level.
However, there is no coverage category that extends Medicaid eligibility to childless adults under age 65 unless these individuals are disabled and qualify for Supplemental Security Income.

There is increasing evidence that many potentially eligible individuals are not enrolled in Medicaid. Many barriers to Medicaid enrollment have been identified. These include lack of information about availability of Medicaid benefits, complex eligibility rules and enrollment processes, shortages of bilingual informational materials and program staff, fears related to immigration status and a reluctance by some to receive publicly funded benefits.

Despite these barriers, Medicaid programs have a variety of mechanisms for providing additional services and covering a broader population. Within federal guidelines states can expand or limit coverage of certain population groups; they can expand or limit the range of services offered and the amount, duration and scope of those services; and they may seek exemption from other federal requirements. States have used federal waiver authority to expand enrollment in Medicaid managed care, restructure their Medicaid program and experiment with integrating health and long-term care (for specific policy on Medicaid waivers, see Publicly Administered Health Insurance—When Medicare and Medicaid Meet—Federal-State Flexibility; for additional policy on managed care, see Health Care Coverage—Private Health Insurance—Managed Care, and Publicly Administered Health Insurance—The Medicare Program—Medicare+Choice—Federal Standards for Medicare Managed Care Plans).

The Balanced Budget Act of 1997 (BBA) greatly expanded the discretion that states already enjoyed in administering their Medicaid programs. Now many innovative state policies can be initiated without securing a federal waiver. For example, states are permitted to offer the Program of All-Inclusive Care for the Elderly (PACE) as an optional benefit under their Medicaid programs. PACE provides integrated health and long-term care services to small numbers of frail elderly people at risk of institutionalization. BBA also established PACE organizations as Medicare-recognized providers (for additional policy on integrating health and long-term care, see Chapter 7, Long-Term Care: Coordination and Integration of Long-Term Care Services—Integrating Health and Long-Term Care).

**FEDERAL & STATE POLICY**

*HEALTH CARE COVERAGE*  
- Publicly Administered Health Insurance  
- The Medicaid Program

**The Medicaid Program and Children’s Health Insurance**

Federal and state governments should take steps to ensure that all people living at or below the federal poverty level are covered by Medicaid, to
improve Medicaid participation among eligible people of all ages and to ensure the highest level of Medicaid participation among all health care providers. Enrollment and outreach activities must be tailored to meet the needs of a culturally diverse eligible population. An annual review should be conducted to ensure that Medicaid’s provisions for paying providers and managed care plans do not threaten access to health care. Efforts to restructure Medicaid should:

- maintain the government’s guarantee so that all who qualify for Medicaid will be covered,
- maintain and improve current federal and state consumer protections,
- adopt financing policies and payment strategies that do not compromise access and quality,
- ensure that long-term care services reflect the needs and preferences of beneficiaries and their families,
- ensure that quality protections are given the same priority as costs and access issues and
- ensure that consumers have a strong voice in any attempts to restructure Medicaid.

FEDERAL POLICY

HEALTH CARE COVERAGE • Publicly Administered Health Insurance • The Medicaid Program

The Medicaid Program and Children’s Health Insurance

To improve health care access for low income people, Congress should:

- encourage continuous Medicaid coverage for vulnerable people of all ages, including the working poor;
- support Medicaid as a viable insurance option for those unable to find ongoing private health insurance coverage;
- provide enhanced federal matching funds to encourage states to exceed the minimum federal requirements wherever possible;
- evaluate the federal funding formula for Medicaid programs operating within the US and its commonwealths and territories to determine if it is adequate to provide meaningful access to primary preventive and acute care services for all eligible people; and
- require all states to have a medically needy program that provides full Medicaid benefits to people of all ages.
The Medicaid Program and Children’s Health Insurance

States should exercise available options for expanding Medicaid eligibility and services by offering:

- a medically needy program that is as generous as the federal government allows;
- coverage for pregnant women and infants where household income is between 133 percent and 185 percent of the poverty level;
- full Medicaid coverage for people with disabilities and elderly people living at or below 100 percent of the federal poverty level;
- coverage using less restrictive income and asset tests, as authorized under Sections 1902(r)(2) and 1931(b) of the Social Security Act;
- coverage to low-income working adults, to the extent allowed under federal law (e.g., by disregarding the number of hours worked for two-parent households with dependent children);
- coverage to other groups, such as individuals who receive state support payments but are ineligible for federal Supplemental Security Income benefits because of income levels; and
- Programs of All-Inclusive Care for the Elderly (PACE) for people age 55 and older.

To improve Medicaid participation among those currently eligible, states should:

- conduct outreach activities and promote Medicaid and the State Children’s Health Insurance Programs (SCHIP) as a single, coordinated program of health insurance;
- monitor Medicaid participation rates and report enrollment rates on an ongoing basis, giving particular attention to underserved areas; and
- develop action plans in areas that are underserved or have large welfare declines to ensure Medicaid and SCHIP coverage is appropriately maintained.

States should use Medicaid’s significant market power to foster the highest quality of health care for vulnerable citizens at the most reasonable price.
States should establish legal assistance programs for Medicaid beneficiaries who have trouble obtaining services or paying their medical bills or believe a Medicaid claim was incorrectly processed or inappropriately denied.

States should contract with cost-efficient, high-quality hospitals, physicians and other providers to serve Medicaid beneficiaries. Beneficiaries should be able to choose among providers who practice in an area near beneficiaries’ homes.

**HEALTH CARE COVERAGE • Publicly Administered Health Insurance**
• The Medicaid Program

**Background**

**Managed Care in the Medicaid Program**

States have looked to managed care as a means of controlling costs while improving access. The enrollment of Medicaid beneficiaries in managed care plans has grown significantly in recent years; in 2001, 57 percent of beneficiaries were enrolled in some form of Medicaid managed care program. States frequently mandate enrollment in a managed care plan as a condition for receiving Medicaid benefits. There are concerns about laws that require Medicaid beneficiaries to enroll in a managed care plan because such mandates deny Medicaid beneficiaries the freedom to select the type of health care coverage most suitable for their needs. In addition, unique problems are associated with individuals eligible for both Medicare and Medicaid—referred to as dual-eligibles.

Medicaid beneficiaries often have more complex health and social needs than the general population; they also frequently reside in medically underserved areas. Many Medicaid beneficiaries have encountered difficulty finding providers willing to accept Medicaid reimbursement. On the assumption that managed care held the opportunity to simultaneously enhance beneficiary access to health services and produce savings, states turned to managed care, not only to contain expenditures but also to help improve access to care for beneficiaries. Early evidence on Medicaid managed care implementation indicates some improvement in women’s and children’s access to providers in some states, as well as some dissatisfaction with the care provided (compared with the Medicaid fee-for-service sector).

No clear picture has emerged about whether or by how much the use of managed care programs affects Medicaid costs. Often, however, these savings have been produced through the enrollment of the least costly segment of the Medicaid population—children and families. As elderly and disabled beneficiaries are made eligible for managed care, the overall Medicaid savings from managed care are likely to fall. Medicaid managed care has operated under tight budget constraints in most states. Provider
payments in many areas are substantially below private-market rates. Managed care plans leaving the Medicaid program is a growing concern in some areas of the country.

Quality assurance and other consumer protections are essential in Medicaid managed care plans to ensure that the appropriate level of service is provided to each beneficiary (see the section Publicly Administered Health Insurance—The Medicaid Program—Medicare+Choice—Federal Standards for Medicare Managed Care Plans for a detailed discussion of such standards). The Consumer Bill of Rights proposed by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry is being applied to Medicaid and other federal insurance programs. In addition, the 1997 Balanced Budget Act provides standards to ensure managed care plan capacity and enforce consumer protections. Implementation of quality performance standards for Medicaid managed care is a promising development that can help states monitor access and quality for this vulnerable population.

FEDERAL & STATE POLICY

HEALTH CARE COVERAGE  Publicly Administered Health Insurance

The Medicaid Program

Managed Care in the Medicaid Program

Medicaid beneficiaries should have a choice of fee-for-service or managed care plans. However, in the event a state does require Medicaid beneficiaries to enroll in managed care plans, it should do so only if a choice of managed care plans is offered and these plans have adequate staff to meet enrollees’ needs. To the extent that Medicaid beneficiaries enrolled in managed care plans have a choice of fee-for-service or other managed care plans, they should have the opportunity to disenroll from managed care or change plans at any time.

To ensure that Medicaid beneficiaries make informed choices about health coverage in a stress- and pressure-free environment, AARP urges states to either conduct enrollment directly or contract with third-party enrollment brokers. States should allocate sufficient resources to ensure that the enrollment process is conducted smoothly and in a timely, efficient manner.

States must take strong steps to ensure that the plans selected to participate in their Medicaid programs meet a comprehensive set of standards that apply to health plans offered by all other payers. These standards should include a full range of consumer protections. The consumer protections that apply to health plans serving Medicaid beneficiaries should be at least as comprehensive and adequate as those applicable to health plans serving Medicare beneficiaries (see protections in the Medicare+Choice section). It is especially important that plans have a fair, rapid appeal process that allows Medicaid beneficiaries to have decisions overturned that incorrectly deny, reduce or terminate care.
In the context of mandated enrollment in Medicaid managed care programs, the Medicare rights of dual-eligibles must be preserved. For qualified Medicare Beneficiaries enrolled in Medicare+Choice plans, states should pay all appropriate cost-sharing; the Centers for Medicare and Medicaid Services must enforce the prohibition on plans billing beneficiaries for these amounts.

HEALTH CARE COVERAGE • Publicly Administered Health Insurance • When Medicare and Medicaid Meet

Background

Dual Eligibility and Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

More than one in five Americans age 65 years and older (more than 8 million individuals) live on incomes below 135 percent of the federal poverty level. (In 2002 the poverty level for a family of one was $8,860.) Poverty rates for the elderly increase with age, are higher for women than men and are higher for elderly minority populations than for whites. From a health perspective, low-income people of any age are particularly vulnerable because they are more likely to have serious and chronic health problems requiring medical attention than those who are more affluent, yet they are less able to access needed care. For low-income people with Medicare, the out-of-pocket costs of uncovered services (such as outpatient prescription drugs and annual physical exams), cost-sharing requirements and Part B premiums impose a serious financial burden.

Most Medicaid beneficiaries age 65 and older, and about one-third of Medicaid beneficiaries with disabilities, are also Medicare eligible; these individuals are referred to as dual-eligibles. There are several categories of dual eligibility. The largest group consists of Medicare beneficiaries who are also eligible for full Medicaid benefits. These individuals tend to be either users of long-term care services or acute care users who depend on Medicaid for prescription drug coverage and other services not covered by Medicare. Disabled Medicare beneficiaries under age 65 are more likely than elderly Medicare beneficiaries to have Medicaid coverage, primarily due to their higher rates of poverty but also due to the prevalence of functional limitations and cognitive impairment.

Another important category of dual-eligibles receives assistance from Medicaid only to pay a portion of Medicare expenses (Figure 6-9). Under the Qualified Medicare Beneficiary (QMB) program, Medicaid pays the Medicare premiums, deductibles and coinsurance for Medicare beneficiaries with annual incomes at or below the federal poverty level and with assets below a specified threshold. However, state Medicaid programs are not required to pay the full Medicare deductible and copayment amounts if Medicare’s actual
payment to a provider exceeds the allowable Medicaid payment for the service. Medicare beneficiaries with incomes between 100 percent and 120 percent of the federal poverty level and limited assets—known as Specified Low-Income Medicare Beneficiaries (SLMBs)—are eligible to have their Medicare Part B premiums paid through state Medicaid programs.

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**Figure 6-9**

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<th>Medicaid’s Protections for Low-Income Medicare Beneficiaries</th>
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<td><strong>Program</strong></td>
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<td>Full Medicaid benefits</td>
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<td>Qualified Medicare Beneficiary</td>
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<td>Specified Low-Income Medicare Beneficiary</td>
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<td>Qualifying Individuals 1</td>
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*Some states (209b) are permitted to set lower levels; states have the option to go up to 100% of poverty.

Note: Individuals must have limited assets (below $2,000 for an individual to receive full benefits and below $4,000 for an individual in other categories).

Prepared by AARP Public Policy Institute.

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Qualifying individuals, or QIs, are an additional category of dual-eligibles. Under the Balanced Budget Act of 1997 (BBA), Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty level (QI-1) may have their Part B premiums paid by Medicaid. The BBA also allows states to pay the extra premium cost attributed to home health care for people between 135 percent and 175 percent of the poverty level (QI-2). Because federal funding for the Q1 and Q2 programs is capped and allocated to states as grants, eligibility is extended on a first-come, first-served basis until each year’s allotment of funds is expended. Funding for the QI-1 and QI-2 programs was scheduled to terminate in 2002. However, Congress has temporarily extended the QI-1 benefit, and may eventually reauthorize the program. The QI-2 program was allowed to sunset after December 31, 2002.

Recent estimates are that fewer than two-thirds of QMB and SLMB eligibles are enrolled; however, precise federal program statistics are unavailable. Among the significant barriers faced by Medicare beneficiaries to accessing these protections are lack of awareness about the benefit and complex administrative processes. In an effort to improve participation in all of the dual-eligible programs, the Centers for Medicare and Medicaid Services launched a major outreach initiative in 1999.

Many other older people who live just above the poverty level remain unprotected from incurring high out-of-pocket health costs. Because of
assets above specified levels, they may not be eligible for the QMB and SLMB programs. Often, they cannot afford to purchase Medicare supplemental (Medigap) insurance given their low incomes. (About 38 percent of older people at or below 135 percent of the federal poverty level do have private supplemental coverage, either through a former employer or an individually purchased Medigap policy.) Low-income Medicare beneficiaries without Medicaid face substantial health care expenses. Out-of-pocket health costs averaged $2,695, or 39 percent of income, for those at or below 135 percent of the federal poverty level without Medicaid in 2000. (The importance of Medicaid to older Medicare beneficiaries is further illustrated in Figure 6-10.)

The elderly poor and near-poor need Medicaid’s protection because Medicare does not cover many services, such as prescription drugs and long-term care. These elderly people cannot afford to purchase long-term care services on their own nor can they afford coverage from private long-term care insurance. Without Medicaid, many low-income elderly would not be able to afford Medicare’s cost-sharing requirements or Part B premiums. Medicare beneficiaries without private or public supplemental coverage have fewer physician visits and are less likely to seek health services.
Dual Eligibility and Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

The asset test for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) buy-in protection should be eliminated or made less restrictive. One mechanism for accomplishing this is for Congress to change the asset test requirement that applies to all states. Another option, allowed under Section 1902(r)(2) of the Social Security Act, is for states to use less restrictive resource methodologies than those under SSI. In the absence of new federal law, states should use existing statutory flexibility to eliminate or modify the asset test. A state can introduce less restrictive resource requirements by disregarding all resources or by allowing additional exclusions from countable assets.

Federal and state governments should monitor QMB and SLMB participation rates, report enrollment levels on an ongoing basis and develop action plans in areas with low QMB and SLMB enrollment to ensure improved participation rates. Special attention should be given to problems of access in rural areas.

The Medicaid program should be required to examine the extent to which the nonpayment of the full amounts of the Medicare deductible and copayment for QMBs threatens access to care for these beneficiaries. The federal government should provide a statutory remedy requiring states to pay full cost-sharing where access is negatively impacted.

Dual Eligibility and Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

To improve protections for low-income Medicare beneficiaries, federal policy must be strengthened in the following ways:

1. Medicaid buy-in protection for Medicare premiums, deductibles and coinsurance should be extended to Medicare beneficiaries with incomes of up to 200 percent of the federal poverty level.

2. The Medicaid program should be fully funded to ensure that all people eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs, as well as those
newly protected under the Balanced Budget Act of 1997 as qualified individuals, can receive Medicaid coverage.

The Centers for Medicare and Medicaid Services (CMS) should require states to ensure that the QMB and SLMB programs are fully implemented and that Medicare beneficiaries and social services personnel are adequately informed of the programs’ eligibility requirements and benefits.

Federal agencies with jurisdiction over programs for low-income seniors, including the Social Security Administration, should ensure that individuals they serve are aware of Medicaid, especially its QMB and SLMB protections. These agencies must lead efforts to develop intensive outreach initiatives and simplified application processes. Outreach efforts that are more effectively or efficiently performed at the federal level should be implemented by the appropriate federal agencies and funded adequately.

CMS should continue providing funds to states to support QMB and SLMB outreach and enrollment efforts. State receipt of future funds should be based, in part, on standards for past performance.

Rather than extend the QI-1 and QI-2 programs, the federal government should expand the SLMB program to provide coverage of Medicare premiums for low-income Medicare beneficiaries with household income between 120 percent and 135 percent of the federal poverty level.

STATE POLICY

HEALTH CARE COVERAGE

Publicly Administered Health Insurance

When Medicare and Medicaid Meet

Dual Eligibility and Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

States should institute administrative simplification procedures that will increase the likelihood that eligible beneficiaries will become enrolled. Examples of these procedures include: the development of simplified applications, the use of consumer-friendly application sites, the institution of passive renewal processes and the elimination of burdensome documentation requirements.

States should conduct innovative grassroots outreach to educate seniors about Medicaid, particularly the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and Qualifying Individuals 1 programs. Innovations should take place in methods and sites.
Federal-State Flexibility

The successful implementation of strategies to reform health care systems at the state level relies increasingly on changes to or exemptions from certain federal laws and regulations. The statutes most often involved are those pertaining to Medicare and Medicaid. The status of waiver authority for each of these laws is different, although the issues are related. The Medicaid statute gives states broad authority to waive many federal requirements. States interested in implementing comprehensive reform initiatives or making more incremental program changes may seek expanded program flexibility through waivers.

Under Section 1115 of the Social Security Act, the secretary of the Department of Health and Human Services (DHHS) can waive Medicaid eligibility, benefit and service-delivery requirements in the context of research and demonstration projects to promote program objectives. Federal law requires Section 1115 waivers to be federally budget-neutral, meaning that the cost to the federal government over the life of the waiver cannot be more than federal expenditures would have been without the waiver. Many states have sought Section 1115 Medicaid waivers to fund expansions of coverage to low-income individuals who may be ineligible for Medicaid because of the program’s categorical or financial limitations. States also have sought these waivers to integrate health and long-term care services using both Medicare and Medicaid funding, through programs such as social health maintenance organizations. States are now permitted to offer the Program of All-Inclusive Care for the Elderly as an optional benefit under their Medicaid programs, without a federal waiver.

Section 1115 authority contains no procedural requirements or substantive standards to guide the secretary’s use of administrative discretion. In 1994 the Health Care Financing Administration, (now Centers for Medicare and Medicaid Services) published a nonbinding policy statement describing its procedures for receipt of public comment on such waivers; that statement offers little assurance that public concerns will be seriously considered.

In 2001 the DHHS secretary authorized the use of Section 1115 waivers to conduct Health Insurance Flexibility and Accountability (HIFA) demonstration initiatives. The primary goal of the HIFA initiative is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within the current levels of Medicaid and SCHIP resources. A particular emphasis is being placed on broad statewide approaches that maximize private health insurance
coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the federal poverty level. Using HIFA waivers, states may expand Medicaid and SCHIP coverage to new populations while, at the same time, reducing coverage or benefits for some existing beneficiaries. States must continue covering mandatory populations and provide mandatory benefits as specified in Medicaid law and must maintain children’s eligibility levels as of June 1997. According to analysis by the Urban Institute, optional eligibility accounted for 56 percent of elderly Medicaid beneficiaries, 43 percent of parents enrolled in Medicaid, 22 percent of disabled people with Medicaid and 20 percent of children in the program in 1998. As of November 2002, seven states - Arizona, California, Colorado, Illinois, Maine, New Mexico and Oregon had approved HIFA waivers.

Last year the DHHS secretary authorized the use of Section 1115 waiver authority for Pharmacy Plus waivers. Under Pharmacy Plus, states may extend Medicaid-funded prescription drug benefits to Medicare beneficiaries and/or people with disabilities with income up to 200 percent of the federal poverty level. People covered by the waiver must not be eligible for full Medicaid under other coverage categories.

The Balanced Budget Act of 1997 broadened states’ discretion to make changes to Medicaid without securing waivers. In the past, states had to secure a waiver under Section 1915(b) of the Social Security Act to require Medicaid beneficiaries to enroll in managed care plans. States now have the authority to enroll most Medicaid beneficiaries in managed care without going through the lengthy federal waiver process.

Current Medicare waiver authority is limited to demonstration projects involving waivers of reimbursement requirements. Waivers to test different payment methods are granted at the discretion of the DHHS secretary. Under current law, for example, states wishing to establish all-payer hospital reimbursement systems must obtain a waiver of Medicare’s prospective payment system. The DHHS secretary must grant states’ requests for these waivers, if certain statutory requirements are met.

There is currently no broad waiver authority in Medicare that would allow a state to incorporate Medicare beneficiaries or funding or both into its state health care reform plan or would limit individual beneficiaries’ choice of provider outside of the Medicare+Choice program.
Federal-State Flexibility

AARP believes that state waivers from certain aspects of Medicare and Medicaid statutes are appropriate and even desirable under specific circumstances. In order to protect existing coverage and maintain other current protections, certain criteria must be met.

Use of Section 1115 Medicaid waiver authority should meet the following criteria:

1. All people currently eligible under the state’s Medicaid standards should be automatically entitled to enroll in the waiver program. Current prohibitions against enrollment caps, preexisting condition exclusions or waiting periods should not be waived. Waivers should not include references to transfer-of-assets requirements.

2. Eligibility expansions under a waiver should be consistent with the principle of covering those more in need before covering those less in need. For example, programs should not extend coverage to some people with income at 200 percent of the poverty level while not providing coverage to those below that level.

3. New cost-sharing and premium contributions should be permitted only if the secretary of the Department of Health and Human Services (DHSS) makes a reasonable determination that they do not create barriers to receipt of services. Premium contributions should not be required of people with income at or below 100 percent of the federal poverty level. In addition, this population should be exposed to nominal cost-sharing obligations only if they do not create barriers to access to care.

4. Mandatory Medicaid services must be covered in the same amount, duration and scope for all eligible people, regardless of category of eligibility.

5. Individuals eligible for both Medicare and Medicaid must maintain their Medicare rights. There must be no mandatory enrollment in managed care.

6. Quality assurance standards, at a minimum, should include internal and external quality review, meaningful grievance and appeals procedures, strong monitoring and oversight by the state (e.g., an ombudsman) and strong sanctions for violations of quality standards.
Waivers that include Medicaid beneficiaries with disabilities, mental illness and other complex health care needs must demonstrate adequate protections for these populations, including the adequacy of provider networks.

The waiver process must provide meaningful opportunities for public involvement at both the federal and state levels. As a precondition of waiver approval, states should demonstrate that there has been a meaningful public process and the state has addressed public concerns. DHSS should provide opportunity for public comment on waiver requests as part of its approval process. Public comment and the state's response should be included in the application and made part of the administrative record.

The Centers for Medicare and Medicaid Services (CMS) should establish a waiver review panel that consists of consumers, providers and federal and nongovernmental technical experts to receive testimony and comments and to recommend approval or disapproval of the waiver or any modification to it.

States' applications should include a beneficiary impact statement, which would include an analysis of the impact of the proposal on each discrete category of beneficiary (i.e., the medically needy, children and dual-eligibles) and a detailed explanation of the state's plan for ongoing monitoring of the impact on each category. CMS would define the categories and give the states guidance on monitoring.

The research design component of the Section 1115 waiver must be adequate to support waiver evaluation. At a minimum states should be required to demonstrate that the research goals to be achieved through the waiver are measurable and that states have actual capacity to collect relevant data.

States should ensure ongoing public participation and evaluation throughout the waiver period, ideally through a waiver implementation commission that includes consumers, providers, state legislators and other interested parties. Access, cost and quality issues should be reviewed throughout the term of the waiver through ongoing evaluations and periodic public reports. The commission's responsibilities could also include:

- review and comment on the initial waiver request,
- approval of the final negotiated waiver and any modifications and
- approval of requests for modification of the waiver and other submissions to CMS.
Existing Medicare and Medicaid waiver authority should be used to integrate health and long-term care under the following conditions:

1. Beneficiaries must retain their rights to full Medicare and Medicaid benefits.

2. There must be voluntary enrollment and disenrollment at any time.

3. Cost-sharing should be permitted only if it is not a barrier to receipt of services.

4. Cost-sharing and other participation requirements must not result in coercive inducements to enroll or disenroll.

5. Strong consumer protections, including an independent ombudsman program and external grievance procedure, must be in place.

6. The state and CMS must provide strong and timely oversight.

7. Consumers must participate in the development, implementation and oversight of the waiver program.

8. There must be strong quality assurance standards, including measures of functional and medical outcomes.

9. Eligibility criteria for long-term care services should consider and appropriately measure the need for these services among those with physical impairments, mental impairments and chronic illnesses. Determination of need should be based on measures of physical and mental functioning. Individuals should not have to meet medical criteria to be eligible for long-term care services.

10. Contracting specifications should be adopted to ensure that a wide range of organizations is able to compete for the opportunity to manage the integrated systems. The organizations could include not-for-profit, public and community-based organizations; entities experienced in long-term care delivery; and managed care plans.

11. Existing Medicare waiver authority should be used to test Medicare reimbursement changes and should not be used for broader program changes. Any such broadening of the Medicare waiver authority currently requires—and should continue to require—federal legislation. In that case federal legislation should provide for adequate oversight and accountability.
HEALTH CARE COVERAGE

Background

The Uninsured and the Need for a Safety Net

A defining objective of health care policy must be to create more secure and effective access to health care for all Americans. Roughly 41 million people lacked health care coverage in 2001. The Institute of Medicine reported that the uninsured not only receive too little care too late, and worse care than insured people, but that they are also sicker and die earlier. In addition millions of those who do have health insurance also have difficulty gaining access to the health care system and securing services because of where they live or because of the nature of their medical condition. They also may have difficulty navigating the complex health care delivery system. These vulnerable individuals include low-income people of all ages; people with chronic conditions, mental illness or retardation, age-related illnesses, cultural barriers or physical disabilities; people with language barriers; and those who live in rural and urban underserved areas or far from medical services. The following sections address policy on providing coverage to the uninsured and giving them access to needed health care despite their lack of coverage.

The Uninsured

About 41 million people—15 percent of the population—were without public or private health insurance throughout 2001. Among the uninsured were about 272,000 people age 65 and older and 5.7 million people between the ages of 50 and 64. People age 65 and older, nearly all of whom are enrolled in Medicare, are less likely to be uninsured than other age groups. Among people age 50 to 64, 13 percent have no coverage. The vulnerability among near-elderly people is often related to their departure from the workforce (sometimes due to onset of disability), poorer health status and a greater use of health services. Women in this age group are more likely than men to rely on their spouses’ employers, the individual private insurance market and the Medicaid program for coverage.

There are a number of reasons why people are uninsured. Among the uninsured and underinsured age 65 and over are people who are:

1. eligible for Medicare but cannot afford the program’s Part B premiums,
eligible for assistance to pay for Medicare Part B premiums but do not receive the assistance and

ineligible for Medicare and lack the means to buy into the program.

People age 50 to 64 may be uninsured because they:

lack access to employer-sponsored health benefits,

cannot afford their share of the premium in an employer-sponsored plan,

are not eligible for a group plan and cannot afford the cost of buying coverage on their own,

do not qualify for public coverage or subsidy programs,

become disabled and do not immediately qualify for Medicare, and

cannot buy coverage in the private insurance market because of their health problems.

Young adults, minorities, people with low incomes, the self-employed, individuals working less than full time or for small employers, individuals without a high school diploma and women are all more likely than others to be uninsured. A primary factor underlying other characteristics associated with being uninsured is income. In addition:

individuals between the ages of 18 and 24 are the most likely to be uninsured;

minorities are particularly at risk of being uninsured: 33 percent of Hispanics, 19 percent of African-Americans and 18 percent of other minorities have no health insurance, compared with 10 percent of non-Hispanic whites; and

poor people under age 65 are twice as likely (34 percent) as people in the general population under age 65 (17 percent) to be uninsured.

Although the vast majority of people under age 65 who have insurance receive it through an employer, many workers and their dependents are uninsured. Workers who are self-employed, work in a business with fewer than 25 employees (Figure 6-11) or work part time or in part-year jobs are less likely to have coverage through their employer. Unemployment and other changes in job status, family status (e.g., divorce or spouse’s death), health status (including onset of disability) or insurance practices, or retirement before Medicare eligibility all contribute to people losing employment-based health insurance.
For those insured through Medicaid, changes in family status, increased income, moving off welfare or changes in eligibility requirements can all result in people losing insurance coverage.

Other trends contribute to the ranks of the uninsured. Faced with steadily increasing premiums, employers have tried to hold down their costs for employee and retiree coverage by asking workers and retirees to bear a greater share of the costs for themselves and/or their dependents. As workers' share of premiums has risen, more employees have decided they cannot afford the premiums and are not enrolling in group plans. Likewise, recent employment trends also mean that workers are less likely to have employer-sponsored insurance. More people are becoming self-employed or are working part-time or on a temporary basis. Most new jobs are being created by small employers and in the service sector, both of which tend to pay lower wages than other areas of employment.

For decades, federal, state and local governments have sought to provide protection for those without health insurance in a variety of ways: providing health care services directly, subsidizing providers serving the uninsured and establishing public insurance programs. In more recent years the Medicaid program has been expanded to cover additional vulnerable populations. Some states have made Medicaid accessible to more of the uninsured through waivers (see Publicly Administered Health Insurance—When Medicare and Medicaid Meet—Federal-State Flexibility) and by helping subsidize the purchase of private coverage for the near-poor. Through high-risk pools states have helped people previously considered uninsurable to get coverage and have subsidized part of the cost of that coverage through public money or private insurers. These programs are vulnerable to state budget pressures.
The Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA) both include provisions to help those losing employer-sponsored coverage retain access to coverage. And, a federal and state program aimed at helping uninsured children, the State Children’s Health Insurance Program, was enacted as part of the Balanced Budget Act of 1997. The program establishes block grants for states to help uninsured, low-income children obtain health coverage either through expansion of Medicaid or through other state programs. Some states extend coverage to the uninsured parents of these children. All of these efforts have helped some people get health coverage, but the size of the uninsured population remains substantial. For those who do not qualify for public coverage, the cost of health insurance is most often the root of the problem.

There are various incentives in current federal tax policy that reduce the cost of coverage for individuals with employer-sponsored health coverage, the self-employed and taxpayers whose health expenses exceed 7.5 percent of adjusted gross income. Recently, some policymakers have proposed using tax mechanisms to increase equity among those who currently do not benefit from tax policy and to help make health coverage more affordable to the uninsured. Tax proposals vary in a number of dimensions. To determine their potential for reducing the ranks of the uninsured, tax proposals need to be assessed in the context of who the uninsured are and why they are uninsured. For instance, for the uninsured who do not pay income tax, a tax deduction would be of little value. For those uninsured who pay income taxes, a year-end tax deduction does not help pay health premiums, which are incurred over the course of the year. Tax policy that does not take these issues into account will not be meaningful for a significant segment of the uninsured. Hence, a refundable tax credit may be a more effective policy option than a tax deduction.

The value of the tax subsidy is also important. To be effective the value of the subsidy must be high enough to put premiums for an adequate health insurance policy in reach of an uninsured individual or family. How affordable a premium is depends on a range of factors, including the income and age of the uninsured, whether the individual purchases coverage through an employment-related group or directly from the insurer and whether the premiums vary depending on health.

The effects of a tax incentive also have to be analyzed. For example, would everyone with a tax incentive have access to private coverage? If private insurers can deny coverage or offer it at a price that is too expensive, a tax incentive may prove to be of little value in the marketplace.

Who should be eligible for tax relief is another consideration. Some proposals are limited to those without insurance; other proposals would extend tax relief to some or all of those who have health insurance. Tax proposals that include the currently insured are more expensive because they
cover more people rather than specifically directing the tax breaks to those without health coverage. Yet, an argument can be made that it is inequitable not to help some lower-income families that stretch their budget to purchase health insurance. The interactions of new tax proposals with existing tax policy and with employer-sponsored coverage are additional considerations when evaluating new health coverage tax proposals.

In addition to the roughly 41 million uninsured Americans, many more are underinsured. The estimates of the number of people with inadequate coverage vary depending on the definition of “underinsured.” It is estimated that in 1994, among the nonelderly population with private insurance, roughly 19 percent had inadequate coverage that left them at risk for out-of-pocket expenditures of more than 10 percent of their family incomes in the event of major illness.

Two groups that have a greater-than-average risk of being underinsured in the face of a serious illness are the poor and those purchasing coverage outside a group. Their rates of underinsurance were estimated to be 62 percent and 41 percent, respectively, in 1994. Individually purchased insurance is concentrated disproportionately among retirees approaching 65.

FEDERAL & STATE POLICY
HEALTH CARE COVERAGE • The Uninsured and the Need for a Safety Net

The Uninsured

In the absence of health care reform that provides universal access to coverage, and recognizing the size and complexity of the health care system, AARP can support incremental reforms that move the system closer to achieving universal coverage or significantly improve coverage for those who are either without public or private insurance or are at risk of losing coverage.

While AARP prefers an integrated approach to move toward universal coverage (one that addresses the needs of the multiple populations that are without coverage or at risk of losing it), reforms may be stand-alone efforts to expand coverage for a particular population if they will significantly improve coverage. Strategies for improving access may include:

1. opening existing public health insurance (e.g., Medicare and Medicaid) programs to new categories of people who are uninsured;

2. developing health plans specifically for the uninsured;

3. creating high-risk pools for uninsurable people;

4. subsidizing the purchase of private coverage, e.g., through income tax relief, for those who are uninsured, underinsured or at risk of losing
health coverage, such as low-income children and adults, and people between jobs or approaching Medicare eligibility (see also Chapter 2, Taxation: Principles);

- inducing employers to offer health insurance to employees; and

- continuing group health coverage at group rates to people whose access to group coverage is ending.

In evaluating tax incentives to support the purchase of private health coverage, AARP favors policies that:

- give priority to groups currently without coverage and those not benefiting from current tax incentives,

- recognize the high cost of coverage in private markets faced by those who are older and those who have health problems or histories of poor health,

- incorporate assistance for those whose income may not require them to pay taxes and who may have insufficient resources to pay premiums out of pocket during the tax year,

- guarantee access to policies offering adequate coverage in the private market (see Health Care Coverage—Private Market Regulation) and

- conform to AARP’s taxation principles (see Chapter 2, Taxation).

For people who are close to Medicare eligibility and lose group coverage, reforms should ensure continuation of their former group coverage (under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation laws) or other affordable coverage until they attain Medicare eligibility.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE** 

**The Uninsured and the Need for a Safety Net**

**The Uninsured**

AARP supports comprehensive national reform that achieves universal access to health care coverage (see this chapter’s section Principles).

Proposals to extend Medicare to the near-elderly should:

- include sufficient subsidies to make coverage affordable to low-income individuals unable to afford the full premium,

- not affect the financial stability of the existing Medicare program and
protect against the erosion of existing employer-sponsored coverage.

(For additional policy related to taxation of medical insurance and expenses, see the following sections in Chapter 2, Taxation: Income Tax Options—Tax Expenditures; Tax Incentives for Health Insurance; and Other Revenue Options—Taxing Employer-Provided Benefits.)

STATE POLICY
HEALTH CARE COVERAGE • The Uninsured and the Need for a Safety Net

The Uninsured

States should:

• ensure full consumer participation in developing, implementing and monitoring state reform programs to improve access to health coverage and health services for all state residents;

• develop health care plans that work toward universal access to basic coverage for all residents—Any state plan for universal access to coverage should conform to AARP’s health principles (in this chapter) and long-term care principles (in Chapter 7, Long-Term Care); and

• take full advantage of federally funded programs to deliver health care services. States should pay particular attention to meeting elderly people’s health-related needs through block grant programs such as the community health services block grant, the preventive health and health services block grant and the alcohol abuse, drug abuse and mental health block grant.

HEALTH CARE COVERAGE • The Uninsured and the Need for a Safety Net

Background

Ensuring Access to Care Through the Safety Net

Americans in many urban and rural areas lack access to basic health services. These vulnerable populations tend to be disproportionately low income, uninsured and, in the case of rural areas, older. Several factors account for the disparity. Among them are lack of health insurance coverage, insufficient numbers of providers, physical barriers to reaching providers and the unavailability of providers who are proficient in the population’s spoken language.

While both rural and urban residents may experience barriers to accessing care, important differences exist between the two populations in relation to
their health care systems. One-fourth of all Americans live in rural areas. Small rural hospitals are more likely than their urban counterparts to be financially distressed and have closed at a faster pace. Rural residents often must travel long distances and migrate to urban areas for needed health care services.

The health status of urban residents is heavily influenced by communicable disease (e.g., AIDS and tuberculosis), unsafe living conditions and violence. Population-dense urban areas suffer from inadequate financial resources to attract providers to economically depressed neighborhoods, resulting in many urban dwellers relying on government-funded resources for their health care. This places heavy demands on system. Local hospitals and government-supported community clinics play a large role in the care of urban residents, although the sheer number of people involved often means excessive waits for appointments and/or treatments.

Factors such as the effects of competitive market forces, diminished subsidies for many safety-net providers, shortages of health care providers in many regions, failing economies in some rural and urban areas and government payment policies for Medicare and Medicaid help perpetuate inadequacies in access to the health care system for the medically underserved (see this chapter’s section Publicly Administered Insurance). These factors are exacerbated by a continuing erosion of the public safety net for health care in many communities. Public hospitals, for example, are more likely than others to change ownership; this may result in less delivery of uncompensated care to indigent patients or outright closure.

Traditionally, hospitals have financed health care for some uninsured people by providing charity care and writing off bad debt. In 2000 hospitals provided $21.6 billion of uncompensated care. Hospitals have offset these costs by raising fees for their paying patients and insurers. In the changing health care environment, however, purchasers of care are often unwilling to pick up the cost of care beyond what their own members use.

Other changes in the delivery system, particularly increased reliance on managed care, have major implications for the public’s health safety net. Providers that lack resources to reshape themselves in an environment dominated by managed care or that provide services and functions that do not pay for themselves may have to cut services or reorganize in other ways to stay financially viable. Yet traditional safety net providers, such as public hospitals, health centers and clinics and health departments, have unique experience and expertise in providing health care to residents of underserved rural and urban areas.

The public sector, through federal and state governments, is responsible for ensuring access to health care for the nation’s vulnerable and often underserved residents. These responsibilities may be carried out through either direct or indirect public health interventions. An example of a direct
health care. Indirect interventions might include providing access to health insurance or providing financial subsidies to local community clinics.

FEDERAL & STATE POLICY

HEALTH CARE COVERAGE \(\text{\texttt{a}}\) The Uninsured and the Need for a Safety Net

Ensuring Access to Care Through the Safety Net

Until comprehensive health care programs to cover the uninsured are established, AARP supports sufficient public funding to ensure that residents of medically underserved areas receive adequate health care.

Until health care coverage is attained for all Americans, AARP also supports efforts to create and maintain access to health care for the uninsured through innovative community-based approaches, such as the use of volunteer health care personnel and donated medical equipment. In all cases where health care is offered through voluntary efforts or donated equipment, consumer protections should be maintained by checking the adequacy of professional licenses, ensuring practice competencies, retaining a patient’s right to full and just compensation for injuries resulting from inappropriate medical care, ensuring adequate malpractice insurance coverage for volunteers, and implementing other appropriate quality control measures.

Federal and state agencies should provide incentives to encourage physicians, nurses and other health care personnel to practice in medically underserved areas. Incentives might include student loan forgiveness programs, training stipends and other financial incentives.

State and federal governments should establish programs to recruit and train health care providers to work in rural and urban underserved areas. State and federal governments should also target education subsidies to health care professions in which practitioners are in shortest supply.

Publicly funded interventions should be sensitive to communities’ special needs and preferences.

State and federal governments should provide incentives for health training programs to conduct practicums in medically underserved areas.

States should help rural communities to improve local access to health care by facilitating community-based discussions aimed at identifying potential solutions for access problems; providing relevant demographic and utilization data; providing incentives when appropriate for managed care plans to extend needed coverage to rural areas; providing assistance and incentives in the recruitment and retention of all types of health care personnel; and providing
technical assistance in developing delivery systems, analyzing alternative options such as tele-medicine systems and improving transportation resources.

Federal and state agencies should establish and support programs that either develop or provide cost-effective, creative approaches to improved delivery systems in medically underserved areas, such as infrastructure development, tele-medicine networks, transportation systems, and the use of trained community-based lay personnel to provide nonmedical services such as outreach and education.

Federal and state governments should increase financial resources dedicated to increasing access to health insurance, community clinics and outreach activities.

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**HEALTH CARE COVERAGE • The Uninsured and the Need for a Safety Net**

**Background**

**Providing Care to People with Mental Illness**

Mental health is fundamental to overall health, according to the first report by a surgeon general on mental health and mental illness, issued in 1999. Mental illness can strike people of all ages and incomes and can be as debilitating as any other major medical illness. However, insurance policies typically place restrictions on coverage for mental health services that do not apply to other services. “Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services,” observed US Surgeon General David Satcher in the report. In addition, state-of-the-art mental health treatments are not being translated into community practice, according to the report.

On the federal level, the Mental Health Parity Act (MHPA) of 1996 prohibits group insurers from placing more restrictive limits on annual or lifetime spending for mental health care than on care for other health conditions. However, it does not require health plans to cover mental health care or put patient cost-sharing and day/visit limits for mental health services on a par with those for other services, loopholes that the General Accounting Office recently found employers are using to limit coverage.

Beginning in January 2001 the Federal Employees Health Benefits Program implemented parity between benefits for mental health and other conditions. A number of states also have taken steps to expand mental health coverage. As of June 2001, 36 states had some form of parity legislation. However, state parity laws that are more comprehensive than the MHPA do not apply to enrollees in self-insured health plans due to preemption by the federal Employment Retirement Income Security Act.
State mental health delivery systems are moving toward providing treatment in the least restrictive, clinically appropriate setting. However, they often still rely too heavily on hospital services and do not provide a range of community-based services for those with mental illness. The increased cost of providing more comprehensive mental health and substance abuse services should be largely offset by savings in the economic, social and criminal justice sectors.

The delivery and financing of mental health and substance abuse services is being transformed by the use of managed care to deliver both privately and publicly funded behavioral health services. In 1999 approximately 177 million Americans were enrolled in a managed behavioral health care plan, that is, a managed care plan offering only specialized mental health/substance abuse services.

Spending for mental health care has declined as a percentage of overall health spending over the last decade. Moreover, the public sector, principally Medicaid and other state or local government sources, is paying for an increasing share of overall spending for mental health/substance abuse services.

**FEDERAL & STATE POLICY**

**HEALTH CARE COVERAGE • The Uninsured and the Need for a Safety Net**

**Providing Care to People with Mental Illness**

AARP supports proposals to require adequate and affordable mental health coverage. AARP also supports parity for mental health services, i.e., covering mental health services at levels equivalent to coverage for other health services.

The Department of Labor’s Pension and Welfare Benefits Administration should rigorously monitor and enforce the implementation of the Mental Health Parity Act (MHPA), particularly with respect to ensuring that businesses accurately estimate implementation costs. Congress should ensure that restrictions on mental health services in all types of health plans that the MHPA does not address do not exceed those for physical health services (e.g., day/visit limits and higher levels of cost-sharing for mental health care than for other services).

Federally funded programs should collect data on the use and cost of mental health services for older people, including those enrolled in managed care plans.

AARP believes that all mental health providers should be trained in state-of-the-art treatments. In addition, payment should not be denied for specific medications that are prescribed by a physician for the management of mental
Health conditions if the physician deems the insurer’s recommended substitution to be medically inappropriate.

AARP supports increased federal funding for community-based mental health services through the mental health block grant. A larger portion of funds should be targeted toward nontraditional providers of mental health services for the elderly, such as hospice programs, adult day care centers and other community-based long-term care providers.

Protections are needed for those in managed care plans with mental/substance abuse disorders in order to ensure access to necessary services, including emergency services and mental health specialist care (see the extensive list of standards that apply to all health plans in the section Publicly Administered Health Insurance—The Medicare Program).

AARP encourages the evaluation of managed behavioral health care in order to assess whether enrollees have access to appropriate, high-quality and timely care.

AARP also encourages ongoing research to evaluate the impact of specific mental health services on patient outcomes and on the use of other health services.

**STATE POLICY**

**HEALTH CARE COVERAGE: The Uninsured and the Need for a Safety Net**

**Providing Care to People with Mental Illness**

States should ensure adequate funding for mental health and substance abuse services, develop comprehensive and coordinated delivery systems for such services and emphasize special training in cultural and ethnic sensitivity for service providers. States also should ensure that both privately and publicly funded mental health services meet high standards for quality; monitor access to and satisfaction with services; protect clients’ due process rights; and involve consumers and family members in planning, implementing and evaluating mental health services.

States should ensure parity (e.g., in day/visit limits and cost-sharing levels), beyond the provisions of the Mental Health Parity Act, for all plans providing mental health services.

Medicaid law and regulations should provide for payment at adequate rates for mental health services (see the discussion of federal standards for Medicare in the section Publicly Administered Health Insurance—The Medicare Program—Medicare+Choice for a detailed delineation of the standards applicable to all managed care plan enrollees in public- or private-sector programs).
Individuals should be able to choose the same delivery system for mental health services as for physical health services. For example, if individuals select a fee-for-service plan, they should have access to mental health services as well as physical health services on a fee-for-service basis.

States should set strong licensing standards for community mental health centers.

States should evaluate the effectiveness of publicly funded managed behavioral health systems, including various types of carve-outs, with respect to access (e.g., timely service and array of appropriate services), enrollee satisfaction, outcomes of care (e.g., ability to live independently) and systems integration (e.g., tracking in other systems, such as criminal justice and education, to determine if mental health programs are working).

States are encouraged to improve mental health and substance abuse services in criminal justice settings through increased funding and better collaboration with the mental health system. For example, states should establish jail diversion programs, possibly through the use of specially trained police or onsite crisis teams, to minimize the number of seriously mentally ill individuals who are inappropriately incarcerated. Inmates with serious mental illness should receive psychiatric and substance abuse services while in jail and receive follow-up care upon release.

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

**Introduction**

While health care coverage is central to the challenge of making affordable care available, additional features of the current health care system are essential to protecting and improving access for all. Such additional features include policies and programs that seek to protect consumers in the health care marketplace, promote public health, address issues of health care quality and meet the continuing needs for qualified and trained health care personnel.
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

• Consumer Protection and Consumer Information

Background

The Need for Strong Quality Protections and Consumer Information

There is significant and substantial evidence that serious problems exist in the quality of care throughout the American health care system. These quality problems can be characterized as underuse, in which individuals fail to receive services that save lives or prevent disability; misuse, in which individuals are injured when avoidable complications of health care are not prevented; and overuse, in which individuals are exposed to the risks of health services from which they cannot benefit. They are found in all types of delivery systems, including fee-for-service and managed care, and result in wasted resources as well as lost lives and reduced function.

Consumer information on quality is critical to public accountability and informed choice. At the same time consumers will continue to need both strong protections against poor-quality care and the ability to pursue complaints about their care effectively. State oversight of licensing activities is a vital component of such protections (see the discussion of grievance and appeals protections in the section Publicly Administered Health Insurance—The Medicare Program—Medicare+Choice).

The demand by both public purchasers and large private employers for greater accountability from the health insurers with which they contract is growing, although not yet widespread. Empowering consumers with information about their health plan choices, including the quality of care that is provided, is part of the strategy to promote such accountability. The Medicare Compare website developed by the Centers for Medicare and Medicaid Services (CMS) for Medicare beneficiaries compares health plans on various standardized measures. The site and the report cards published by large employers are examples of efforts to provide consumers with information on quality. Important research is currently underway to develop measures that will provide information at the medical group and physician levels as well.

The Institute of Medicine has reported that information technology (IT) is a critical element in a safe, effective, patient-centered, timely, efficient and equitable health care system. The potential of IT applications to improve health care quality assumes the availability of automated clinical data. However, there are many barriers to the widespread automation of clinical information. These include concerns about privacy and confidentiality, the need for standards, the cost of automation and the availability of a workforce to create and use the database.
The Need for Strong Quality Protections and Consumer Information

States or the federal government (as appropriate) should provide sufficient funding for quality oversight, information and data infrastructures, and consumer protection activities, including funding for direct consumer representation for public programs.

A comprehensive quality system should encourage internal quality improvement efforts. Independent external quality oversight must also be a central component of such a system.

More resources should be devoted to developing and implementing methods to prevent medical errors and injuries.

There should be substantial representation of consumers knowledgeable about health issues on all bodies established to oversee health care quality, including licensing boards, as well as appropriate opportunities for incorporating consumer perspectives into health plan decisions that affect enrollees.

Valid, accurate and objective information should be available to consumers to assist in their health care decisions. Such information should include but not be limited to information on treatment options, plan benefits and procedures, plan and provider performance, consumer satisfaction, service utilization and cost. Ways to present such data that are informative to all consumers and fair to providers should be developed and evaluated to assess their usefulness in consumer decisionmaking.

The Need for Strong Quality Protections and Consumer Information

National quality-of-care standards are required to ensure delivery of high-quality care, regardless of the source of payment (public or private), delivery system (e.g., fee-for-service or managed care) or site of care. A system for public accountability for health care quality should be designed to measure and improve health outcomes.

A core set of quality and performance measures should be developed and collected from all providers and practitioners. In developing these measures, special attention should be paid to identifying gaps in access and quality for
vulnerable populations, including people with chronic physical and mental illnesses.

To encourage greater use of information technology (IT), Congress should direct the appropriate federal agencies (e.g., Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services and Federal Employee Health Benefits Program) to take a leadership role in fostering public and private efforts to build an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, education and research. In recognition of the large investment that is needed to make appropriate technology more widely available, Congress should also study the feasibility of developing financial incentives to encourage greater use of IT in the health care sector for quality improvement purposes.

The federal government should mandate the establishment, collection and dissemination of report cards to assist consumers in deciding among health plans.

Nationally uniform due process protections, including access to independent and timely appeal mechanisms, should be in place for all consumers in the event of quality problems or denials, reductions or terminations of needed care.

**STATE POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

*Consumer Protection and Consumer Information*

**The Need for Strong Quality Protections and Consumer Information**

States should publish report cards that enable consumers to compare the health plan options available in the state. To the extent possible such report cards should permit consumers to compare the performance of competing types of plans such as health maintenance organizations, preferred provider organizations and conventional fee-for-service plans. When feasible, comparative data on medical groups, physicians and institutions (e.g., hospitals) also should be provided.

States should set strong standards for health care plans and providers, including a requirement for independent external quality oversight.

States should require health plans of all delivery types, including traditional insurance plans, to collect and publicly disclose standardized, independently audited data on cost, medical error, outcome and consumer satisfaction or furnish the appropriate data to an independent agency for analysis and disclosure.
States should regulate private utilization review activities to protect the right of patients to receive medically necessary, appropriate services. (For the specific safeguards that should be included in state legislation, see the section The Medicare Program—Federal Standards for Medicare Managed Care Plans.)

In conducting their licensing functions, states should:

1. discipline incompetent health care professionals and providers and eliminate substandard care;

2. mandate continuing education requirements for physician and nurse licensing and other health professionals as appropriate—The requirements should include instruction in risk management (preventing patient care errors) and on the impact of patterns of practice on quality of care and health care costs and, for providers working with the elderly, instruction in gerontology and geriatrics;

3. ensure that licensing boards have adequate funding and authority to carry out their responsibilities, including vigorous investigation and disciplining of substandard providers—Licensing boards should be required to share appropriate case information with peer review organizations and query the National Practitioner Data Bank before giving a physician the right to practice;

4. mandate public disclosure of disciplinary actions taken by health regulatory boards; and

5. review and revise as necessary licensing laws for health facilities to improve the administration and operation of their provider and physician oversight responsibilities. Reforms should include a greater range of sanctions that can be taken against poorly performing providers and practitioners.

States should ensure that public regulation and private accreditation of health and long-term care facilities and services include regular, frequent, random and unannounced inspections. All inspection reports must be widely disseminated to the public.

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**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

- **Consumer Protection and Consumer Information**

**Background**

**Prescription Drugs and Pharmacy Practices**

Prescription drugs have become an increasingly important part of health care. To a large extent this trend is due to the introduction of new drugs that
prolong life, improve the quality of life or replace more intensive and expensive medical treatments. Recently introduced prescription drugs have provided enhanced treatments for conditions such as stroke, heart disease, mental illness, nausea associated with chemotherapy and asthma. Ongoing research and development, including the mapping of the human genome, may lead to the availability of improved drug treatments, particularly for serious conditions that disproportionately affect older Americans. The importance of prescription drugs within overall therapeutic regimens has led to increased efforts, both public and private, to expand access to pharmaceutical treatments.

At the same time innovations in drug treatments have been accompanied by a dramatic increase in prescription drug costs. Nationally, outpatient prescription drug spending has increased at double-digit rates and is projected to continue to do so well into the future (for a discussion of trends in prescription drug spending, see The Health Care System—Health Care Spending). Concern about prescription drug costs has led public and private purchasers to adopt cost-containment strategies.

Health insurers try to reduce prescription drug costs by negotiating price discounts or rebates with drug manufacturers, creating incentives for the use of lower-priced generic drugs, encouraging the use of mail-order pharmacies and obtaining discounts in pharmacist dispensing fees. A health insurer may contract with a pharmacy benefit manager (PBM) to administer its drug benefit, negotiate price reductions and/or implement pharmacy benefit management procedures. In particular, insurers or their PBMs may steer physicians toward prescribing drugs that are on a preferred drug list or to a formulary—a list of drugs that the plan or PBM believes to be more effective or less costly than therapeutically similar products. A preferred drug list or a formulary could try to achieve these goals through the use of a tiered copayment system that imposes lower cost-sharing for generic drugs, intermediate level cost-sharing for preferred brand-name drugs and higher cost-sharing for nonpreferred brand name drugs.

A number of legislative approaches have focused on expanding competition in the pharmaceutical market. For example, the federal Drug Price Competition and Patent Term Restoration Act of 1984 required the Food and Drug Administration (FDA) to approve generic drugs that are shown to be bioequivalent to previously approved drugs without requiring new proofs of safety or effectiveness. This measure, together with state laws that facilitate the substitution of generic drugs for brand-name equivalents, has dramatically increased access to lower-priced generic products. State regulations that require pharmacies to post prices allow consumers to comparison shop for their prescriptions.

In order to expand drug coverage, some states have established programs to pay the cost of prescription drugs for low-income Medicare beneficiaries who do not qualify for benefits under state Medicaid programs. As of
September 2002, 25 states had established or were implementing pharmacy assistance programs that offer prescription drug coverage to certain populations. These programs vary in scope according to what drugs are covered, the maximum allowable benefit, required cost-sharing and eligible populations. Generally, they are targeted toward people age 65 and older; although some states allow disabled people under age 65 to enroll as well. Nationwide, these programs are estimated to provide assistance to about 1.5 million individuals; programs in five states—Illinois, Massachusetts, New Jersey, New York and Pennsylvania—account for about 75 percent of this enrollment. Other state approaches to reducing prescription drug costs include efforts to reduce drug prices and offer tax credits (although the two states that have offered tax credits—Michigan and Missouri—have since replaced them with coverage programs).

Other public-sector measures, aimed at increasing efficiency in the pharmaceutical market, could pose both opportunities and risks for consumers. The Prescription Drug User Fee Act (PDUFA) is designed to allow FDA to dedicate more resources to shorten approval time for new drugs, but some critics have raised safety concerns about these quicker approval times. Others have called for easier approval for moving a medicine’s status from prescription to over-the-counter (i.e., not requiring a prescription). The shift to over-the-counter status could increase access to certain drugs by reducing total drug costs, but might expose consumers to greater risk if safety considerations are not adequately considered in the decisionmaking process. (It could also increase consumer out-of-pocket costs if the over-the-counter product is not covered by insurance.)

These trends—increased management of pharmacy benefits for insured populations, a desire to reduce prescription drug costs and concerns about drug safety—have raised public policy concerns that are discussed in the sections below (for a further discussion of issues relating to prescription drugs, see Chapter 12, Consumer Products and Financial Services: Drugs).

**Lack of oversight of pharmacy benefit management**—Concerns have been raised about whether the use of pharmacy benefit management to reduce pharmaceutical costs adversely affects quality of care. While there has been no systematic analysis of this issue, anecdotal evidence suggests that pharmacy benefit management techniques used by insurers and other payers could promote utilization of lower-priced products that may not be appropriate for some patients. Compounding this concern is the difficulty patients and their health care providers face in assessing whether a “preferred” medication is the most medically appropriate, since neither the FDA nor any other federal agency assesses the relative effectiveness of therapeutically similar drugs. Furthermore, patients may not be aware of whether their health plan’s drug benefit has a formulary or preferred drug list, how that formulary or drug list operates, how to obtain drugs that are not on the formulary or list or how to appeal utilization management decisions. Patients also may not be aware of whether their drug benefit is being
managed by a PBM. Because one of the largest PBMs is owned by a drug manufacturer, there have been calls for safeguards to prevent patients' prescriptions from being inappropriately switched to the parent company's drug product. There are also confidentiality concerns, particularly about whether PBMs are providing drug companies with claims data about drug usage by specific patients. To date, there is insufficient evidence to assess the validity of these concerns.

Although several accrediting bodies have begun to promote standards for drug formulary use, federal oversight officials have an important role in monitoring the impact of utilization management on quality of care. The Federal Trade Commission has been closely monitoring the relationships between PBMs and drug manufacturers, and the inspector general of the Department of Health and Human Services (DHHS) has called for greater oversight of pharmacy benefit managers. The FDA also has a role to play in examining the marketing relationships between PBMs and pharmaceutical manufacturers.

**Safety issues in therapeutic and generic drug substitution**

Efforts to restrain prescription drug costs and enhance quality in the outpatient setting may include therapeutic and generic substitution of prescribed drugs.

Therapeutic substitution is the substitution, with the prescribing physician's permission, of one prescribed drug for another that is in the same therapeutic class but has a different active ingredient (i.e., a different chemical composition).

Generic substitution refers to the substitution of a prescribed drug with a drug that contains the same active ingredient(s) and is chemically identical in strength, concentration, dosage form and route of administration to the product prescribed.

Therapeutic substitution may be used to recommend a lower-priced but therapeutically similar product to the one prescribed. It also may be applied when the insurer or pharmacist feels that a similar drug may be more appropriate or more effective than the prescribed drug (for example, if the prescribed drug could have an adverse reaction to another drug the patient is also using). By contrast, generic substitution is typically used only as a cost-saving measure, since generic drugs tend to be much less expensive than brand-name products yet have the same active ingredients.

State laws regulate physician and pharmacist roles in therapeutic and generic substitution of prescribed drugs. Every state requires physician approval before a pharmacist can make a therapeutic substitution of a prescribed medicine. By contrast, no state requires explicit prior physician approval for generic substitution (an exception to this is for so-called narrow therapeutic index (NTI) drugs, described below). In all states and the District of
Columbia, pharmacists typically can substitute a generic version of a prescribed drug without physician approval as long as the physician’s objection to a generic substitution is not designated on the prescription. No state allows pharmacists to make a generic substitution if the physician has designated on the prescription form that a generic substitution is not appropriate. The particular method by which a physician must designate that a generic drug is not appropriate (such as by checking a particular box or writing “brand medically necessary”) varies from state to state.

There have been initiatives in some states to limit pharmacists’ authority to substitute generic NTI drugs. Also referred to as narrow therapeutic ratio drugs, NTI drugs are products for which small changes in the dose and/or blood concentration could potentially result in lethal changes in drug efficacy or safety. The FDA asserts that the generic version of an NTI drug can be expected to have as equivalent a therapeutic effect as the brand. However, some physician organizations and advocacy groups have proposed that generic NTI drugs should not be substituted for brand versions without the physician’s prior approval. Indeed, some states have adopted restrictions on generic substitution of NTI drugs in the interests of patient safety. Critics, however, contend that such provisions do nothing to enhance safety and only limit the ability of payers to reduce prescription drug costs.

While therapeutic substitution requires the approval of the treating physician, consumers with third-party prescription drug coverage may incur financial penalties if their physician feels that the therapeutic substitution would have an adverse impact. Such circumstances could arise if a prescribed drug is not covered by the insurer or if the insurer has reserved the right to prior authorization before paying for a drug. If the insurer and the prescribing physician disagree about whether the prescribed drug is medically appropriate, then the insurer may require the consumer to pay for the drug out-of-pocket or may require substantially higher coinsurance for the prescribed drug. A consumer in this situation faces a choice of paying more for the drug the physician feels is appropriate or asking the treating physician to accept the insurer’s recommendation to use the drug the insurer covers.

**High drug prices, particularly for people who pay out-of-pocket for drugs**—Many consumers, particularly those who pay out-of-pocket for most or all of their prescription drugs, are burdened by high prices for prescription drugs. While health insurers and PBMs are often able to obtain price discounts from drug manufacturers and pharmacists, these discounts are not typically available to individuals who pay for their drugs out-of-pocket. These individuals often pay the highest price that manufacturers and pharmacies charge their customers. Furthermore, drug manufacturers often charge higher prices in the US than they do in other industrialized countries, placing an additional burden on consumers and third-party payers alike.

In recent years there have been some efforts to reduce the difference between prices charged to PBMs and private health plans and those charged
to the cash-paying retail market. In court challenges and state legislative proposals, advocates of “unitary” or nondiscriminatory pricing have supported measures that would require drug manufacturers to offer retail pharmacies the same terms and conditions offered to insurers, managed care buyers, mail-order pharmacies and PBMs. Supporters of such measures contend that they would increase competitive pressures on manufacturers and reduce prices charged to the cash-paying retail market. However, some third-party-payers and independent analysts contend that these measures could curtail the discounts given to managed care buyers and may have a limited impact on reducing costs for those who pay for drugs out-of-pocket. This effect would be particularly harmful to people enrolled in managed care plans and who receive prescription drug benefits through those plans.

More recently, some states have tried other innovative approaches to reducing the prices that some or all consumers pay for prescription drugs. For example, California and Florida require pharmacies to extend to Medicare beneficiaries the price discounts that they provide to their respective state Medicaid programs. Maine was the first state to implement a program currently in operation that requires both Medicaid pharmacy discounts and drug manufacturers’ Medicaid rebates to be offered to low- and moderate-income residents who do not have prescription drug coverage. Although there is a court case challenging Maine’s ability to require manufacturers rebates for drugs purchased by a population that does not receive full Medicaid benefits, several other states have implemented similar programs.

Another approach to providing discounts for out-of-pocket prescription drug purchasers is to create buying pools. These pools, which could be managed by a government agency, a PBM or a managed care plan, would negotiate price discounts with drug manufacturers and pharmacies. People would be free to join such a pool and would pay the discounted price rather than the full retail price. This approach is being implemented in Iowa and New Hampshire, and is similar to the discount card approach proposed by President Bush for Medicare (see the section Publicly Administered Health Insurance—The Medicare Program—Original Medicare—Medicare’s Coverage of Prescription Drugs and Other Uncovered Services). While this approach could provide some discounts for enrollees, experience in private discount card programs suggests that discounts are most generous for low-cost generic drugs and that discounts for widely used brand-name drugs often are only in the 5 percent to 10 percent range. Further, it is not known whether drug manufacturers and pharmacies would be able to reduce the impact of the discounts by raising prices for all customers.

An additional alternative under consideration is for the state to set—either through regulation or negotiation—maximum prices that drug manufacturers and wholesalers can charge. This might take place on behalf of an individual state or for a consortium of states. Proposals in some states would explicitly allow other purchasers within the state (such as managed care plans) to
negotiate prices below the maximum allowable price. To date, only one state—Maine—has enacted legislation to reduce drug prices statewide. Under Maine’s law, the state would establish a process to regulate prescription drug prices within three years if it is not successful at using market-based approaches to provide all consumers with the kinds of discounts that other purchasers are able to receive. While regulatory approaches, if found to be legal, have the potential of lowering drug prices for residents of the state, their impact on the broader pharmaceutical market is unknown (the provision in Maine’s law calling for negotiated discounts backed by the threat of prior authorization requirements in its Medicaid program currently is undergoing review by the US Supreme Court).

At the federal level, in 2000 Congress passed legislation that would allow wholesalers and pharmacists to import or reimport FDA-approved drugs for sale in the US. For this legislation to take effect, the DHHS secretary was required to certify to Congress that implementation of the new law would pose no additional risk to public health and safety and would result in a significant reduction in the cost of prescription drugs to American consumers.

Supporters of this legislation believed that it would have allowed pharmacists and wholesalers to buy drugs in countries where the price is lower and to pass along these lower prices to US consumers. However, critics raised several concerns about the legislation. First, they noted that there was no guarantee that pharmacists and wholesalers would pass along savings to consumers. Second, some critics cited loopholes in the legislation that would have allowed manufacturers to block imports by withholding necessary package labeling inserts required for sale in the US. Third, they noted that manufacturers would not have been prohibited from entering into contracts with distributors to prevent them from selling reimported products.

In December 2000 the DHHS secretary notified the president that she could not certify that the legislation would reduce costs and pose no increased risk to public health. The current DHHS secretary has reiterated this position. As a result, the provisions of this legislation will not be implemented, and pharmacists and wholesalers will continue to be prohibited from importing or reimporting prescription drugs for resale.

**Concerns about access to low-cost generic drugs**—Because the average retail price of generic drugs is almost one-fourth less than that of brand-name drugs, use of generic drugs can help restrain the growth of prescription drug costs. Generic drugs accounted for more than 42 percent of all prescription units dispensed in the US retail prescription market in 2001. This ratio has been stable since 1996 but is up from 32 percent in 1989 and more than double the 1984 figure of about 20 percent. While many brand-name drugs are scheduled to lose patent protection in the next several years, some recent trends are threatening the ability of consumers to reap the rewards of generic drug introductions. First, some manufacturers have asked
Congress to extend patents for certain drugs. Manufacturers contend that delays in FDA approval diminished the effective patent life of some drugs and that patent extensions are needed to provide revenues to recoup the manufacturer’s substantial investment in product development. However, critics assert that such extensions are not warranted and that any extension of such patents further delays competition by lower-cost generic products. (The patent extension debate does not apply to orphan drugs—drugs that treat rare diseases affecting fewer than 200,000 people—which receive seven years of marketing exclusivity from the date of marketing approval regardless of their patent status.)

Second, some brand-name manufacturers allegedly have paid generic drug manufacturers to delay marketing of competing generic products. In at least two cases, the Federal Trade Commission (FTC) has charged brand manufacturers with restraining market competition by paying the manufacturer of the first generic drug approved as a substitute for the brand-name product to delay marketing the generic. Because the first generic version that receives FDA approval is granted a 180-day period of market exclusivity, this practice has the effect of extending the brand manufacturer’s market exclusivity for 180 days. This allows brand manufacturers to continue charging and receiving high prices for products after the relevant patents have expired. In 2002 the FTC recommended that Congress pass legislation to require that agreements between brand-name and generic drug manufacturers that delay generic drug entry be reported to the commission. Also in 2002 the FDA proposed regulations to close some of those loopholes.

Another approach to delaying generic competition is to engage in “evergreening,” the practice of extending patent protection of a brand-name drug as the original patent nears expiration. One evergreening approach increasingly in use is to seek a “late-file patent,” a patent on an aspect such as drug formulation, new dosage regimens or tablet shape or color that is filed shortly before the expiration date of the patent on the drug’s active ingredient. Late-file patents act to extend the period of market exclusivity for the brand-name drug because the generic substitute cannot come on the market until the new patent has expired. The FTC has also recommended reducing the amount of evergreening in which a brand-name manufacturer can engage. In 2002 Congress considered—but did not pass—legislation that would have reduced some of these evergreening approaches. Subsequently, the FDA issued draft regulations in late 2002 that, while viewed by some as less strong than the proposed federal legislation, would close some of the loopholes that permit evergreening to occur.

Finally, in past years consumers have faced rapid price increases for a limited number of generic drugs. Certain manufacturers of these products were alleged to have become monopoly sellers by obtaining exclusive agreements with the suppliers of the raw materials used to make the drugs. Prices for these drugs rose several-fold over a short time. The manufacturers of these
drugs asserted that the price increases were required to prevent financial losses. In at least one of these cases, the FTC filed suit against a generic drug manufacturer, charging it with restraint of trade, monopolization and conspiracy to monopolize the market. The company paid a $100 million fine to the FTC and accepted an injunction barring it from engaging in similar conduct in the future.

**Promotional marketing to consumers and physicians**— In 2000 prescription drug manufacturers spent nearly $16 billion marketing their products to consumers, physicians and other health care providers. Of this amount, about 16 percent, or $2.5 billion, was spent on direct-to-consumer (DTC) advertising, compared with $55 million in 1991. This advertising appeared in print media, on radio and television and on the Internet. Nearly $2.8 billion was spent on DTC advertising in 2001. The FDA requires that all prescription drug advertisements, including DTC ads, be accurate and nonmisleading in their claims of safety and efficacy, and include a brief summary of the product's indications, risks and possible side effects. However, these statements are often produced in small, unreadable print.

Critics of DTC advertising contend that such practices unnecessarily increase the demand for advertised drugs. Some contend that such advertising is inappropriate because patients are not in a position to diagnose conditions or judge the relative safety, effectiveness and appropriateness of alternative treatments. Research findings have also raised questions about the adequacy of information provided in DTC advertisements and how well consumers—particularly older consumers—understand that information. However, some observers contend that DTC advertising gives consumers the information they need to discuss treatment options with their physicians. This information is particularly important in managed care environments, where physicians' prescribing decisions may be influenced by a drug formulary. There is also evidence that DTC advertising may lead consumers to ask their physicians about medical conditions that they had not previously discussed and may promote compliance with prescribed drug regimes.

In addition to DTC advertising, drug manufacturers spend substantial sums in promoting their products to physicians and other providers. In 2000 this included $7.9 billion for the retail value of drug samples left with physicians, $4.8 billion on personal visits by pharmaceutical company representatives to office and hospital-based physicians and nearly $500 million on advertising in medical journals. In addition, drug companies spent $1.9 billion in 2000 hosting or otherwise paying for educational meetings for physicians (which are often accompanied by a meal or may be held at premier hotels) and providing various gifts to physicians. A number of concerns have been raised about whether these promotional activities inappropriately influence physicians' prescribing decisions. Responding to these concerns, the American Medical Association issued guidelines on gifts to physicians from the pharmaceutical industry, and the Pharmaceutical Research and Manufacturers of America issued a voluntary code of interactions with health
care professionals. More recently, the DHHS inspector general issued draft guidance for pharmaceutical manufacturers on what types of actions might be considered fraudulent (if they would inappropriately increase use of certain prescription drugs that are paid for by federal health programs).

**Marketing of drugs over the Internet**—According to the General Accounting Office (GAO), the first Internet pharmacies began online service in early 1999. During that year almost 10 million Americans used the Internet to shop for health products, spending an estimated $160 million on prescription drugs.

Obtaining prescription drugs from unlicensed pharmacies without adequate physician supervision places consumers at risk of harmful side effects, and even death, from drugs that may be fake, unapproved, outdated, substandard or inappropriate for them. Also of concern is the confidentiality of personal health information given to the Internet pharmacy and the potential transfer of such information to third parties.

The sale of prescription drugs to US residents by foreign Internet pharmacies poses the most difficult challenge for U.S. law enforcement authorities. Many of the products sold by these pharmacies have not been approved in the US and are, therefore, illegal. While the FDA technically has jurisdiction over a resident of a foreign country who sells a prescription drug to a US resident, practically speaking it is difficult to enforce US laws against foreign sellers.

At the federal level a range of agencies (including the FDA, the FTC, the Drug Enforcement Administration and the US Customs Service) have begun investigating and prosecuting pharmacies and physicians for illegally dispensing and prescribing prescription drugs. The licensing and regulation of pharmacies and physicians traditionally has taken place at the state level, but Internet pharmacies provide a challenge to state regulators because they operate across state and national borders.

Some states have taken action against Internet pharmacies and attempted to shut down unlicensed pharmacies and pharmacies that have inadequate prescribing procedures. Difficulties in regulating Internet pharmacies include problems in identifying such companies, inadequate authority and resources, and jurisdictional and technological limitations.

**Prescription Drug User Fee Act and postmarketing surveillance**—In 2002 Congress reauthorized the Prescription Drug User Fee Act (PDUFA), which authorizes the FDA to collect fees from companies that produce human drug and biological products. The revenues from these fees, which supplement appropriated funds, are used to hire additional drug reviewers and support staff. In addition to authorizing fees, PDUFA implementation has resulted in specific performance goals for the FDA.
Since the initial passage of PDUFA in 1992, total resources for drug review activities increased from $120 million to an estimated $332 million in fiscal year 2002, about half of which came from industry fees. Median approval time from initial submission of a marketing application to the issuance of an approval letter for priority drugs (drugs the FDA expects to provide significant therapeutic benefits beyond drugs that are already marketed) dropped from 20 months in 1993 to 6 months in 2002. Median approval time for standard drugs (drugs perceived to provide no significant therapeutic improvements beyond those for available drugs) dropped from 27 months to 14 months in the same period.

Some critics of PDUFA assert that certain drugs have been put on the market without adequate time to study safety and that the FDA needs to put greater emphasis on postmarketing surveillance of drugs in order to monitor adverse drug reactions. The GAO reported that reduced federal funding for the FDA diverted agency resources away from non-PDUFA activities. While the reauthorized PDUFA provided the agency with increased resources for performing postmarketing surveillance, critics contend that more resources are needed.

**Switching drug status from prescription to over the counter**— In the US, medicines are available either through a doctor’s prescription or over the counter (OTC). A drug’s status depends on a number of factors, including issues of safety (e.g., the incidence and severity of side effects and the potential for harm if abused) and effectiveness. In recent years many prescription drugs have been converted to OTC status; the switch from prescription to OTC status can affect a drug’s availability, cost and use.

Many groups support continued and increased prescription-to-OTC conversion because it increases access to medicines and thereby gives consumers more control over their health care. However, others are concerned that too many drugs that have significant side effects and require supervision by a health care professional are being made available over the counter. Some consumer advocates have voiced concern that consumer out-of-pocket costs could rise when a drug is switched to OTC status, because nonprescription drugs typically are not covered by insurance.

**FEDERAL & STATE POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

Consumer Protection and Consumer Information

**Prescription Drugs and Pharmacy Practices**

The Department of Health and Human Services (DHHS) and state governments should study the effects of pharmacy benefit management procedures, including the use of formularies or preferred drug lists, mail-order pharmacies and other utilization management procedures, on health care costs and quality.
AARP opposes laws, regulations and practices that increase prescription drug prices without providing tangible benefits to consumers.

AARP supports guarantees of patient confidentiality in the sharing of any claims records among pharmacy benefits managers, insurers and health plans, drug manufacturers and/or pharmacies.

**FEDERAL POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

**Consumer Protection and Consumer Information**

**Prescription Drugs and Pharmacy Practices**

The Food and Drug Administration (FDA) should strengthen consumer protections and regulatory accountability by proposing guidance on the marketing of prescription drug products.

The FDA should strengthen its oversight of direct-to-consumer (DTC) drug advertising and promotion of prescription drugs and enforce the intent of existing regulations to ensure that such advertising is balanced and accurate and includes easily readable information on adverse effects. Congress should allocate sufficient new appropriations to the FDA to ensure that it has adequate resources to perform these functions (for additional policy on direct-to-consumer advertising of prescription drugs, see Chapter 12, Consumer Products and Financial Services: Drugs—Direct-to-Consumer Advertising).

Congress and/or the Department of Health and Human Services (DHHS) should assess the impact of DTC drug advertising and promotion on prescription drug prices, drug spending and physicians' prescribing decisions.

Congress should enact legislation that would more effectively regulate Internet and mail-order pharmacies. Such legislation should require these pharmacies to provide specified identifying information on their websites. Standards should be uniform and established by an independent body with representation of all affected stakeholders, including consumers. Congress should coordinate with the states in regulating these pharmacies.

The FDA should closely monitor the manufacturing of generic drugs to assure their bioavailability and chemical equivalence to brand-name drugs, especially those drugs with narrow therapeutic indices or ranges.

The FDA should continue its approach of determining the appropriateness of changing a medicine’s status from prescription to over the counter on a case-by-case basis. In so doing it should consider factors such as the ease of self-diagnosis, the nature of the condition (chronic or acute), the benefit-risk ratio and the potential for harm. It should also carefully review the long-term data from prescription use (in particular, the number of adverse reactions reported).
Congress should appropriate new funds to allow the FDA to improve its postmarketing activities to ensure that problems with approved drugs are discovered and resolved quickly.

Congress should fund independent clinical research that compares the effectiveness of therapeutically similar prescription drugs and require that research findings be made easily accessible to consumers, physicians and other providers, insurers and payers.

The Federal Trade Commission (FTC) should monitor relationships between pharmacy benefit managers (PBMs) and drug manufacturers. In particular, the FTC should ensure that PBMs do not inappropriately switch patients’ prescriptions to products manufactured by a parent company. The FTC should also monitor relationships between PBMs and the pharmacies that own them. Congress and the DHHS secretary should assess how to develop and implement legislation regarding the importation and reimportion of prescription drugs in a way that would result in a significant decrease in the costs of prescription drugs to consumers and public purchasers and would not pose a significant risk to public health and safety.

Congress should not extend patents for prescription brand-name drugs, should adopt the FTC recommendations for reducing evergreening of drug patents and should require brand-name and generic drug manufacturers to report to the FTC any agreements that delay entry of generic product. Furthermore, AARP opposes laws and practices that allow brand-name drug manufacturers to extend market exclusivity beyond the expiration of the patent for a drug’s active ingredient.

The FTC should continue monitoring restraint of trade in the generic drug industry and initiate appropriate action against any brand-name or generic drug manufacturer that is alleged to have violated federal antitrust laws.

**STATE POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

Consumer Protection and Consumer Information

**Prescription Drugs and Pharmacy Practices**

States should develop approaches to providing prescription drug coverage and/or reducing prescription drug prices that enhance access to safe, effective and appropriate drug therapies.

States should not construct barriers to the development of approaches that expand prescription drug coverage or reduce prescription drug prices, including “any willing provider” and “freedom of choice” laws that apply to pharmacies.
AARP opposes any measure that would weaken the competitive forces that allow purchasers of prescription drugs to obtain price discounts from drug manufacturers. Cost savings achieved through competition should be reflected in lower costs to consumers.

AARP supports cooperative efforts among states to ensure access to prescription drugs of good quality at reasonable costs.

AARP does not oppose the use of drug formularies or preferred drug lists because these mechanisms can be effective cost-containment and quality-enhancement tools. However, states should oversee and monitor health plans’ administration of pharmacy benefits to meet the following standards:

1. The process by which a formulary or preferred drug list is developed is administered by a pharmacy and therapeutics (P&T) committee or similar entity composed of practicing physicians, pharmacists, other health care professionals and consumers.

2. P&T committees’ clinical decisions are based on scientific evidence and standards of practice, and economic factors are considered only after safety, efficacy and therapeutic need have been assessed.

3. Insurers and PBMs ensure appropriate oversight of the P&T committee and its decisions and have policies that address potential conflicts of interest and disclosure by P&T committee members.

4. Pharmacy benefit management systems that contain any financial incentives—such as manufacturer rebates to the third-party payer or PBM, or payments to physicians or pharmacists—do not interfere with the delivery of high-quality, medically necessary care.

5. Formularies and preferred drug lists are regularly reviewed and evaluated by the P&T committee, and formulary systems reflect state-of-the-art therapeutic treatments.

6. Insurers permit exceptions to drug formularies and preferred drug lists when medical necessity dictates that a nonformulary or unlisted alternative is needed.

7. Any prescription drugs that are provided as formulary exceptions are done so under the same terms and conditions (e.g., cost-sharing requirements) as drugs on the formulary.

8. Insurers that apply different cost-sharing levels for “preferred” and “nonpreferred” brand-name prescription drugs should have an exceptions process that allows an enrollee to obtain a prescribed nonpreferred drug at the cost-sharing level for preferred drugs when the prescribing physician determines that therapeutically similar preferred drugs are medically inappropriate for the enrollee.
States should require insurers to provide clear and easily understood information to enrollees—in both paper and electronic form—about the scope of prescription drug coverage, including:

- cost-sharing requirements and benefit limits;
- whether a drug formulary or preferred drug list is used;
- a list of drugs included in the formulary or preferred drug list, upon request, and any changes made to the formulary or preferred drug list;
- the nature of formulary or preferred drug list restrictions and utilization management policies; and
- policies and procedures that must be followed to request formulary or preferred drug list exceptions and to appeal coverage denials.

People whose prescription drug coverage employs a formulary or preferred drug list, or their physicians on their behalf, should have the right to timely appeal disputed decisions made by their insurer to an independent, objective third party and to receive an immediate decision of their appeal or one as rapid as the patient’s condition requires.

Insurers should be required to show cause before denying payment for a particular drug when the prescribing physician has deemed the insurer’s recommended substitution to be medically inappropriate.

AARP supports state efforts to provide consumers, insurers, physicians and other health care providers with objective information on the relative effectiveness of prescription drugs in order to enhance the prescribing of the safest and most effective treatment at the least cost.

States should adopt guidelines to govern financial relationships between drug and medical device manufacturers and prescribing health care providers. These guidelines should restrict manufacturers from offering, and physicians and other health care providers from accepting, any items or financial payments or compensation that could interfere with the independence of a health care provider’s prescribing practices.

States should implement pharmaceutical assistance programs that help pay prescription drug costs for poor and near-poor people who do not receive Medicaid drug benefits.

States should investigate the feasibility of developing prescription drug buying pools that can offer price discounts to all residents who currently pay out of pocket for drugs.

States should prohibit pharmacists from performing therapeutic substitution—that is, they should not allow pharmacists to substitute a chemically dissimilar
drug unless a prescribing physician has indicated such substitution is medically appropriate.

States should not allow pharmacists to substitute a generic version of a prescribed drug when the prescribing physician has deemed such substitution to be medically inappropriate.

States should not impose tighter generic substitution restrictions for particular drugs, such as narrow therapeutic index drugs, unless the Food and Drug Administration shows that such restrictions are needed to ensure patient safety.

States should work with the federal government to develop and enforce an effective system for the regulation and oversight of Internet and mail-order pharmacies.

States should not adopt laws and regulations that would impose unnecessary and costly burdens on out-of-state, mail-service pharmacy operations.

States should prohibit insurers, health plans and state Medicaid agencies from requiring enrollees to purchase prescription drugs only by mail.

States should encourage price competition by requiring pharmacies to post prices.
FEDERAL POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE
  • Consumer Protection and Consumer Information

Antitrust

Because the need for health care providers to have statutory exemptions from federal antitrust laws has not been demonstrated, AARP opposes changes to the federal antitrust laws that would exempt health care providers and activities from these laws.

STATE POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE
  • Consumer Protection and Consumer Information

Antitrust

States should not change their antitrust statutes and should actively enforce them with relation to health care entities.

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE
  • Consumer Protection and Consumer Information

Background

Health Care Fraud and Abuse

Fraud and abuse can be found in all segments of the health care system and in all areas of the country. Fraudulent and abusive practices include overcharging or double-billing health insurance companies or the government for services provided, charging for services not provided and rendering inappropriate or unnecessary care.

Our current health care system, with its multitude of payers and providers, makes detection and pursuit of wrongdoers extremely difficult. The simple fact that there are more than 1,000 payers and billions of annual claims to be paid to hundreds of thousands of providers illustrates the enormity of the task. In the past, government efforts have been frustrated because detection and prosecution have been underfunded. Private-sector payers have met with even less success in combating fraud and abuse because they lack the legal and administrative tools available to the federal government.

Over the last few years, a number of legislative and regulatory actions have changed the way health care fraud and abuse is being combated. In 1995 Operation Restore Trust, a Department of Health and Human Services (DHHS) pilot program, began targeting some of the most fraud-plagued
segments of the health care industry. As of January 1997 providers were required to use a national provider identification code on all Medicare claims.

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, significantly changed the way fraud and abuse are combated by promoting the coordination of antifraud and antiabuse efforts, creating a federal criminal health care fraud and abuse statute and making other changes to facilitate the detection and prosecution of fraud. The Balanced Budget Act of 1997 also added a number of important antifraud measures.

**FEDERAL & STATE POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

- Consumer Protection and Consumer Information

**Health Care Fraud and Abuse**

Adequate resources should be provided to support antifraud and antiabuse efforts at all levels of government and support educating consumers to involve them in these efforts. In addition, steps should be taken to ensure that antifraud and antiabuse activities do not have unintended negative effects on patient health care, e.g., by adversely affecting patient access to care or resulting in the withholding of medically necessary treatment.

**FEDERAL POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

- Consumer Protection and Consumer Information

**Health Care Fraud and Abuse**

Congress and the Department of Health and Human Services (DHHS) should continue to conduct substantial research regarding the extent of health care fraud and abuse and the effects of initiatives to combat it.

Restrictions on physician self-referral and provider kickback schemes must be maintained and enforced.

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

**Background**

**Protecting and Promoting the Public’s Health**

The importance of the public health dimension of the US health care system is often overlooked, yet major improvements in the health of Americans is a direct result of public health measures initiated during the 20th century, when the health and life expectancy of people in the US improved dramatically.
Since 1900 the average lifespan of people in the US has lengthened by more than 30 years; 25 years of this gain are attributable to advances in public health. According to the Centers for Disease Prevention and Control, the ten greatest US public health achievements of the 20th century are the development of vaccines, efforts to improve motor vehicle safety, workplace safety initiatives, control of infectious diseases, efforts to reduce deaths attributable to heart disease and stroke, food safety laws, maternal and child health initiatives, family planning efforts, fluoridation of drinking water and recognition of tobacco use as a health hazard.

Recent outbreaks of communicable and environmental diseases (such as the West Nile virus, viral meningitis and anthrax contamination) remind us again of the importance of shoring up and maintaining a sustained investment in all aspects of the nation’s public health infrastructure. Policymakers have responded to the post-September 11, 2001, world with renewed interest in developing state and local capacity to handle the public health challenges facing our nation today. Populations that are especially at risk during public health crises include children, the elderly, people who live in low-income communities and the uninsured.

The public health domain is multifaceted and includes activities such as monitoring disease, preventing and containing communicable disease, promoting health, ensuring air and water quality and food safety, preventing injuries and violence, and protecting workers’ health and safety. Strategies to improve the public's health also include broadly based community interventions, such as promotion of healthy lifestyles, prevention of disease and disability, research and education, epidemiological work, water treatment and sewage disposal.

There are many issues within the public health domain that demand attention and resources. These include communicable disease prevention and control (particularly for tuberculosis and hepatitis C, HIV/AIDS and other sexually transmitted diseases), lead poisoning in children, injuries and chronic illnesses, risks posed by tampering with consumer products, and tainted food and water. Violent crime, including domestic violence, has a substantial impact on the public’s health. Because of the serious threat handguns pose to citizens of all ages, their distribution and sale has also been recognized as a serious public health hazard (see Chapter 13, Personal and Legal Rights, for more detail). Increasingly, environmental and safety issues and other by-products of a modern economy represent growing public health concerns.

The heightened threat of bioterrorism has focused attention on the importance of having in place a system capable of responding to the full range of public health issues that may arise. These and many other problems demonstrate the need to protect the nation’s health through effective, coordinated and sustained efforts by the public sector. Unfortunately, these challenges are increasing at a time when fewer public resources are being allocated for public health activities.
Funds generated through recent settlements by tobacco companies with a number of states may represent an opportunity to enhance public health programs and related health care activities (Figure 6-12).

With new demands being constantly made on federal, state and local public health systems, and the current focus on bioterrorism, the contributions of health promotion activities to the improvement of the overall health status of the U.S. population might be overlooked. However, the health benefits of sound nutritional habits have long been established (see Chapter 12, Consumer Products and Financial Services: Food and Nutrition—Nutrition Education); smoking cessation has been linked to increased mortality and lower morbidity; research has demonstrated that better diet and nutrition and physical activity yield health improvements; and seat belt use has a well-documented impact on reducing mortality associated with vehicular accidents. Recognizing the continued importance of these and other health promotion policies will help ensure ongoing benefits from public health gains achieved in the US over the last several decades.

Factors outside of the formal health system also influence participation in health promotion activities. For example, environmental amenities that encourage physical activity (e.g., bike paths and walking paths throughout a community) are an important component of public health promotion (see Chapter 10, Alternatives to Driving, Walking and Bicycling).

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**Figure 6-12**

**State Allocation of Tobacco Revenues, FY 2000-2002**

- Tobacco prevention, health services & long-term care: 41%
- Endowment & budget reserves: 26%
- Tobacco growers & communities: 3%
- Education: 6%
- Children & youth: 3%
- Research: 5%
- Other: 16%

*Excludes Massachusetts allocation for FY 2002.
Protecting and Promoting the Public’s Health

Federal, state and local governments should bring public health issues to the attention of the nation, promote the application of scientific knowledge in policymaking, support the collection and analysis of health data and strengthen state and local capacity for service delivery. Public health officials at all levels should coordinate their efforts.

Federal, state and local governments should work together to develop, fund, implement and evaluate strategies to improve and protect the public’s health. Sound public health protection, prevention and promotion strategies should be evidence based and effective. Costs and benefits should be considered but not be determinative. In addition to infrastructure development (such as laboratory capacity, provider education and surveillance capacity), strategies to improve the public’s health should focus on broadly based community interventions, such as promotion of healthy lifestyles, prevention of disease and disability, research and education, epidemiological work, water treatment and sewage disposal.

Preference for allocating government revenues from tobacco company settlements should be given to programs designed to improve the public’s health, including Medicaid and Medicare expansion, antismoking programs, smoking-cessation programs and other efforts designed to expand access to health and long-term care. Tobacco settlement funds should not replace existing federal or state funding in these areas.

Financial resources dedicated to activities that protect the public’s health should be strengthened. The federal and state governments should:

1. increase funding for surveillance activities at the national, state and local levels and for enforcement of public health, environmental and safety standards, research and public and professional health education;

2. direct sufficient resources, both financial and technological, toward solving environmental problems and work cooperatively with the private sector to address environmental concerns;

3. provide financial support for research designed to identify effective strategies to adequately protect the public from biological assaults; and

4. provide funding to ensure that key public- and private-sector health care personnel are adequately prepared to respond to public health crises relevant to their areas of practice;
Federal and state agencies should take specific and effective steps to control all forms of pollution, including biological and chemical agents that threaten health, safety and quality of life.

The federal and state governments should enact legislation banning smoking in nonresidential public buildings, on public transportation and in restaurants.

The federal and state governments should undertake a variety of activities designed to promote the health of the public. These include:

1. Identifying health-promoting behaviors, ways in which such behaviors are linked to health improvements and the costs and benefits associated with health-promoting activities;

2. Adequately funding health promotion programs (e.g., nutritional counseling and drug-, alcohol- and tobacco-addiction treatment programs), preventive health education programs for people most in need and access to preventive health services;

3. Educating individuals about risk factors for prevalent health conditions, behaviors that reduce health risks (e.g., exercise and nutrition) and the importance of preventive care (e.g., mammography, cancer screening and early immunizations for children);

4. Educating the public about the effect of guns and violence on the public’s health, as well as the widespread human costs of many other preventable injuries;

5. Supporting research that identifies the impacts of health-promoting behaviors on public health with regard to the public and private sectors (e.g., the impact of exercise on cardiovascular health);

6. Funding cost-benefit research on health-promoting behaviors with regard to both the public and private sectors (e.g., the cost to employers of workers’ inactivity);

7. Supporting the inclusion of prevention and health promotion content in curricula for health care professionals;

8. Supporting outreach and education about the value of engaging in healthy behaviors, with information targeted to policymakers, consumers and employers;

9. Supporting policies that promote healthful behaviors and provide incentives to engage in them; and

10. Strengthening the physical infrastructure that supports health-promoting behaviors (see Chapter 10, Alternatives to Driving, Walking and Bicycling).
AARP supports the position that individuals have a responsibility to safeguard their health by educating themselves and taking appropriate preventive measures to protect their health, safety and well-being.

AARP supports the position that individuals should be educated about behavioral risk factors for contracting and spreading serious communicable diseases such as tuberculosis, hepatitis and HIV/AIDS. Programs should teach all individuals who know or have reason to believe that they may be infected to protect others from infection and to inform those whom they know to be at risk to seek testing. The outcome of such tests should be confidential, consistent with public health responsibilities and subject to the requirements of confidentiality standards (see the section Protecting and Improving Health and Access to Care—Health Information, Privacy and Confidentiality).

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

• Protecting and Promoting the Public’s Health

Background

Quality of Care at the End of Life

It is widely recognized that serious problems are associated with end-of-life care. The need for quality health care does not diminish as individuals approach the end of their lives. Research has shown that a substantial gulf exists between the type of care people say they want and the type of care they actually receive in their final weeks and days.

A number of obstacles make it difficult for patients to receive the type of care they want. Among the obstacles are those that relate to physician education and medical culture, which prevent doctors from communicating effectively with their patients and propel them to use aggressive care against patient wishes. Another obstacle relates to the difficulties physicians have in making accurate prognoses in life-threatening illnesses. This leaves the patient unable to make informed decisions and may, for example, prevent or delay the use of hospice care. In addition, hospice care may be inappropriately discouraged or delayed as an unintended consequence of government attempts to discourage fraud and abuse. Finally, deficiencies in knowledge relating to palliative care result in an unnecessary degree of suffering by terminally ill patients (see Chapter 13, Personal and Legal Rights, for a further discussion of advance directives).
Quality of Care at the End of Life

To ensure that people are afforded every opportunity to make informed choices regarding their medical treatment at the end of life and to ensure that they have an appropriate range of choices available to them, their knowledge base must be substantially improved. There should be a sensitivity to cultural values and beliefs when end-of-life medical interventions are considered.

AARP supports:

1. improved training programs for health care professionals in palliative care and in other issues associated with the care of dying patients;

2. research leading to better-quality information on prognoses and outcomes of treatment options for physicians to impart to patients and their families—The best currently available information must be communicated to patients and their families in a timely manner;

3. programs to help physicians improve their communication skills, particularly in imparting complex information to seriously ill patients and their families—These programs should be made part of the standard medical school curriculum;

4. programs to assist patients in the creation of clear and comprehensive advance health care directives (see Chapter 13, Personal and Legal Rights);

5. studies of the consistency of patient wishes over time, as changes in medical conditions and life situations occur, with regard to life-sustaining treatment and of the adequacy of current policies regarding the creation, maintenance and review of advance medical directives;

6. improved palliative care, including treatment for emotional distress;

7. continued research to identify the outcomes most important to terminally ill patients and their families and to develop appropriate measures of those outcomes;

8. efforts to identify the processes of care that are linked to improved outcomes for terminally ill patients and their families, which will assist in the development of clinical practice guidelines and improve the quality of care;

9. eliminating all barriers to the medically appropriate management of pain;
eliminating all barriers to patient use of the Medicare hospice benefit; and

developing changes in the way end-of-life care is financed to facilitate appropriate care, e.g., to promote more appropriate use of hospice care.

STATE POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Protecting and Promoting the Public’s Health

Quality of Care at the End of Life

AARP supports:

- legal recognition of the duty of physicians to provide palliative care sufficient to relieve their patients’ pain, limited only by their patients’ informed wishes and the limits of medical science; and

- advance health care directives laws that are enforceable-in-fact (see Chapter 13, Personal and Legal Rights).

AARP encourages health insurance plans to provide adequate coverage for hospice care.

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Protecting and Promoting the Public’s Health

Background

National Practitioner Data Bank

The National Practitioner Data Bank, which opened in September 1990, enables the Department of Health and Human Services to collect information bearing upon the competence of physicians, dentists and other health care practitioners. The information, which is available to hospitals, health plans and state licensing boards, includes medical malpractice payments, adverse professional actions (regarding licensing, privileges and professional society membership) and exclusions from the Medicare and Medicaid programs. The data bank was intended to reduce the opportunity for incompetent providers to move their practices to another state without detection. Currently, the public does not have access to the information in the data bank.

As of September 2000 the data bank contained a total of almost 258,000 reports covering 161,000 practitioners; 73 percent of these reports were on malpractice payments, 14 percent were on adverse actions and the remainder were program exclusions and clinical actions. The “match rate” (the proportion of queries that produce a report of adverse action or malpractice
payment) continues to increase as the data bank receives more and more reports. However, concern has been expressed that reports are not being filed consistently, as required by law. It has been suggested that innovations in the way certain types of settlements (such as mediated settlements with corrective action plans) are recorded in the data bank could lead to more complete reporting.

**FEDERAL POLICY**

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

- Protecting and Promoting the Public’s Health

**National Practitioner Data Bank**

AARP supports:

- expanding the data bank’s mission, functions and resources to permit public access to practitioner performance information, including appropriate information with respect to medical malpractice payments that will assist consumers in choosing providers;

- actions to increase the compliance with legally mandated reporting requirements;

- publishing the identity of hospitals known to be out of compliance with the obligation to consult the data bank;

- requiring that monetary sanctions by peer review organizations be reported to the data bank;

- maintaining the requirement that all malpractice awards and settlements, regardless of the amount, be reported to the data bank; and

- requiring that all types of health care organizations, including managed care organizations, query the data bank before credentialing practitioners.

The secretary of the Department of Health and Human Services should investigate changing the way those settlements reached through mediation, which contain a specific corrective plan for the type of error committed, are reported to the data bank (see also the following section, Preventable Medical Injury and Medical Malpractice).
Background

Preventable Medical Injury and Medical Malpractice

Preventable medical injuries that are the result of medical errors are widespread and costly. Preventable medical injuries are those patient injuries that result from flaws in the complex interactions among several health care professionals, as well as problems at the interface between people and sophisticated technologies, products and organizational systems. They also result from individual negligence, impairment and incompetence.

In 1999 the Institute of Medicine’s (IOM) Committee on Quality of Health Care in America issued a report titled “To Err Is Human: Building a Safer Health System.” The report reviews what is known about the nature and extent of preventable medical injuries in America’s hospitals and the costs associated with those injuries. In addition, the IOM developed recommendations for actions designed to reduce the number of such injuries by one-half over a five-year period. The report estimated that between 44,000 and 98,000 people die annually as a result of preventable medical error, making it one of the leading causes of deaths. Costs associated with injuries resulting from errors were estimated to be between $17 billion and $29 billion each year. Although critics of the IOM report have, in studies that misinterpreted the IOM data, challenged the report figures as overstating the dimensions of the problem of medical injury, it should be emphasized that the IOM estimates are conservative because they are based primarily on retrospective hospital record reviews and are limited to inpatient hospital care. Other studies have estimated the figures to be much higher. For example, one 1997 study cited in the IOM report found that more than one in six hospitalized patients whose care was observed suffered a medical injury that prolonged their hospital stay. It has been suggested that total annual costs to society associated with preventable medical injury in all care settings may be as high as $200 billion.

The IOM report, consistent with other studies, attributes most preventable medical injuries to systems failures, not individual negligence or incompetence. (A systems approach focuses on learning how and why errors occur and developing and implementing systems that will avoid them.) Types of errors that may be termed preventable include diagnostic errors (e.g., incorrect or delayed diagnoses or a failure to order or use indicated tests and therapies), treatment errors (e.g., errors in the performance of operations, procedures and testing, or errors in medication management), inadequate preventive care (e.g., failure to provide prophylactic care or providing inadequate follow-up care) and other errors resulting from failures in communication and equipment and other system failures.
Older patients are particularly vulnerable to preventable medical injury. A recent AARP Public Policy Institute paper found that at least 6 percent of hospitalized patients age 65 and older suffer a treatment-caused injury serious enough to result in a measurable disability or prolong their hospital stay. This is approximately twice the rate of injury in younger patients. Iatrogenic (treatment-related) injury in other care settings, such as nursing homes, is also widespread. The risk of accidental medical injury increases with advancing age, particularly for falls and surgical complications. About two-thirds of iatrogenic injuries are potentially preventable. Older patients are particularly susceptible to adverse drug events, falls, nosocomial (hospital-acquired) infections, pressure sores, delirium and surgical complications.

In the past most discussions concerning preventable medical error and injury have focused on the medical malpractice system instead of the injury problem itself. The tort system continues to be attacked as an important source of problems in America’s health care system. It is asserted that rapid increases in some medical malpractice liability premiums, which are creating great concern within the provider community, are due to rising numbers of malpractice claims and increasingly large damage awards. Rising malpractice premiums also are being blamed for causing physicians to move from one location to another or to change the scope of their practices in certain parts of the country, potentially creating access problems for patients. Some observers consider the practice of defensive medicine to be a key factor in rising health care costs.

Currently available data do not indicate substantial increases in the number of claims or the size of damage awards. (Due to the long lag time between the occurrences of events triggering claims and the resolution of those claims, claims data for the most recent years are incomplete and cannot be considered.) The rate of medical malpractice litigation, when compared with the incidence of preventable medical injury, is actually low. A 1990 Harvard University Study found that patients brought claims in fewer than one in eight cases of negligently caused medical injury; a 1997 study found an even lower claims rate. There is anecdotal evidence that some physicians may be leaving certain areas or limiting their practices due, at least in part, to rising malpractice premiums, but widespread access problems have not been identified. Finally, the medical malpractice system does not play a major role in rising health care costs. In both 1991 and 2000, medical malpractice premiums made up less than 1 percent of total health care expenditures.

The central problem is not the tort system but preventable medical injury. Of course the legal system does suffer from serious deficiencies. Patients with relatively small claims, particularly older people and poor people, cannot gain access to compensation because it is unprofitable for attorneys to take such cases under the contingent fee system. Once claimants are in the system, it takes an excessively long time for their cases to be resolved. Finally, successful claimants receive only about 40 cents for every dollar in liability premiums paid, with the rest going to litigation costs and insurance company
overhead. It should be noted, however, that although the tort system is imperfect, it is not irrational. The one dependable study of closed medical malpractice cases that has been conducted found that nonmeritorious medical malpractice claims had not been paid. That study also found that claimants were often undercompensated, but seldom overcompensated.

A different kind of problem with the current system for addressing medical malpractice is that it discourages the reporting of medical error. The tort system and some of its stakeholders impede the flow of information to researchers attempting to learn the nature of systems deficiencies that lead to patient injuries. That information is essential before systems corrections can be devised.

**FEDERAL POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

**Protecting and Promoting the Public’s Health**

**Preventable Medical Injury and Medical Malpractice**

AARP supports efforts to eliminate all preventable medical injury and medical accidents due to procedural errors or inadequacy and endorses the recommendations of the Institute of Medicine. As steps toward that goal, AARP supports:

- the work of the Center for Patient Safety within the Agency for Healthcare Research and Quality to set national goals for patient safety, track and report progress, increase the knowledge and understanding of errors through research, fund Centers of Excellence, evaluate methods for identifying and preventing errors, and fund dissemination and communication activities to promote patient safety;

- nationwide mandatory reporting to provide for the collection of standardized data by states about adverse events that result in serious injury or death—Congress should provide funds and technical expertise to help states establish or adapt their current reporting systems to collect and analyze the data and conduct follow-up action as needed with health care organizations. The Center for Patient Safety should convene states to share information and expertise and should identify best practices for implementation, assess the impact of state programs and receive and analyze aggregate reports from the states to identify persistent safety issues that require more intensive and/ or broader-based responses;

- voluntary reporting efforts, which should be encouraged and supported by the Center for Patient Safety—Such voluntary reporting systems should receive reports of hazards that have the potential to cause patient injury, as well as cases in which injuries have actually occurred;
legislation to extend peer review protections to data on patient safety (not involving incidents subject to mandatory reporting) collected and analyzed by health care organizations for internal use or shared with others solely for the purpose of improving safety—Information about serious adverse events that must be reported under the mandatory reporting recommendation should not be protected from public disclosure;

health care organization performance standards that focus greater attention on patient safety, with regulators and accreditors requiring the implementation of meaningful patient safety programs—In addition, public and private purchasers should provide incentives to health care organizations to demonstrate continuous improvement in patient safety;

actions by licensing bodies to promote patient safety performance standards for health care professionals by implementing periodic reexaminations and relicensing of doctors, nurses and other key providers, based on both competence and knowledge of safety practices—Professional societies should make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement. This committee should develop a curriculum on patient safety and encourage its adoption into training and certification requirements; disseminate patient safety information to members by all available means of communication; recognize patient safety considerations in the development of practice guidelines and in standards related to the introduction and diffusion of new technologies, therapies and drugs; work with the Center for Patient Safety to develop community-based, collaborative initiatives for error reporting and analysis; and collaborate with other professional societies and disciplines in a national summit on the professional’s role in patient safety;

increased attention by the Food and Drug Administration (FDA) to the safe use of drugs in both the premarketing and postmarketing processes. In particular, the FDA should develop and enforce standards for the design of drug packaging and labeling, require pharmaceutical companies to use FDA-approved methods to avoid sound-alike and look-alike confusion with drug names and work with professionals and consumers to establish appropriate responses to problems as they are identified;

action by health care organizations and their affiliated professionals to make patient safety a declared and serious aim by establishing a defined executive responsibility—Among the measures they should take is developing and implementing nonpunitive systems for reporting errors within the organizations; and

institution of proven medication safety practices by health care organizations.
AARP also supports:

- a systems-approach study of medical error and patient injury, whether caused by systems deficiencies or inadequate designs;

- development of methods to facilitate the collection of data on medical errors that would be consistent with patients’ legal rights; and

- development of a vigorous and effective system to protect the public by removing from practice those health care professionals incapable of providing consistently safe and effective care.

AARP is opposed to any action that would impair the right of injured patients to full and just compensation for injuries resulting from inappropriate medical care.

With regard to the current system to address medical malpractice, AARP supports:

- reforms that would promote access to the courts for all legitimate claims, including smaller malpractice claims, and accelerate the resolution of cases;

- further exploration of alternative dispute resolution systems for medical malpractice cases that could serve injured patients better than the current system does;

- the development and evaluation of demonstration projects for other promising systems of compensation for preventable medical injuries; and

- malpractice insurance rates that fairly and accurately reflect claims experience.

**STATE POLICY**

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

- Protecting and Promoting the Public’s Health

**Preventable Medical Injury and Medical Malpractice**

States should not single out Medicaid beneficiaries or recipients of uncompensated care for reduced protection if malpractice exclusions or waivers are established for providers.

Voluntary binding arbitration should be promoted, with the constitutional right of appeal to the courts preserved for error.

States should, through demonstration projects, explore and evaluate promising systems of patient compensation, such as accelerated compensation events
systems and mediation. In so doing, states should be careful to avoid restricting patient access to fair and just compensation.

Statutes of limitation should be no shorter than two years and should not begin until the injury is discovered or should have been reasonably discovered.

All medical providers and hospitals should be required either to carry adequate levels of medical malpractice insurance or to demonstrate an ability to pay potential malpractice claims. Insurance mechanisms that make liability insurance coverage available should be supported, and states should require that malpractice insurance premium increases be approved by state regulators, ensuring that proposed rates are justified by claims loss ratios. States should also require that insurance companies report filed claims to the state insurance commissioner on an annual basis.

Hospitals should be held liable for injuries resulting from medical malpractice that occurs within their walls.

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PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE
• Protecting and Promoting the Public’s Health

Background

**General Health and Mental Health Research**

The nation’s health care research agenda must address a variety of priorities, such as biomedical research (including stem cell research), alternative delivery systems, wellness, health promotion and disease prevention.

Among the most common debilitating age-related diseases is some form of dementia. An estimated 4 million Americans are affected by Alzheimer’s disease, the most common form of dementia, and the incidence rises steeply with age. Another debilitating age-related neurological disorder, Parkinson’s disease affects approximately 1 million Americans and in its later stages can result in dementia. Age-related diseases exact a heavy toll in health care costs, disability and lost productivity of both patients and family caregivers; the noneconomic burden is incalculable.

Huge dividends can be reaped through greater understanding of the biochemistry of aging and its effects on the body, behavior and quality of life. The country’s investment in understanding the aging process and the diseases of aging is crucial to society’s ability to meet the medical and social needs of an aging population.

One of the most promising areas of investigation is stem cell research, in which scientists are working to learn how to stimulate the development of pluripotent stem cells into specialized cells. This will offer the possibility of a
renewable source of cells to replace diseased cells and of tissue to treat myriad conditions and disabilities, including Parkinson’s and Alzheimer’s diseases, stroke, heart disease, diabetes, osteoarthritis and rheumatoid arthritis. There is almost no realm of medicine that might not be touched through innovations derived from stem cell research. However, the promise of stem cell research will be realized only if adequate funds, both public and private, are made available to ensure that needed human, financial and physical resources are available, and if the supply of stem cells is adequate.

The US is the world leader in biomedical research. Stem cell research will occupy a central place in that research for many years to come. It has been suggested that if the US unduly restricts the availability of stem cells for research, it would lose its leading researchers to other countries and its long-held standing as the foremost center for medical research and learning.

Forty-two percent of Americans (83 million people) use some form of complementary and alternative medicine (CAM), such as chiropractic care, acupuncture, herbal remedies, homeopathy or naturopathy. Among the fastest growing groups of users are members of the baby-boom generation and individuals age 65 and older. The National Center for CAM, within the National Institutes of Health, works to provide the public with reliable information on the safety and efficacy of various CAM treatments. However, the current body of medical literature about CAM is limited, as is the number of studies completed on the cost-effectiveness, safety and efficacy of particular CAM treatments.

FEDERAL & STATE POLICY
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Protecting and Promoting the Public’s Health

General Health and Mental Health Research

AARP supports:

1. greater investments in research on the aging process, particularly on diseases associated with aging such as Alzheimer’s disease and Parkinson’s disease—AARP also endorses continuing research on diseases, such as HIV/AIDS and diabetes, affecting both younger and older Americans;

2. equitable allocation of funding for research on the health concerns of women and minorities;

3. adequate funding for the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality and the Center for Mental Health Services—Any targeted NIH funding for specific diseases should be allocated fairly and equitably;
making available adequate support for stem cell research, both to advance research into preventing and treating serious diseases and conditions affecting all ages and to ensure that the US remains at the forefront of biomedical research and development;

- expansion of opportunities to test the efficacy of health promotion efforts and expand disease prevention services; and

- further study of the safety and efficacy of particular complementary and alternative medicine treatments (see Chapter 12, Consumer Products and Financial Services: Food and Nutrition—Dietary Supplements).

**PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE**

**Background**

**Health Information, Privacy and Confidentiality**

The most efficient and cost-effective health information management systems, including billing, reimbursement and clinical data systems, are fully computerized. Besides saving dollars that can be better used to deliver health care to patients, widespread, integrated computerized health care information systems produce the standardized data necessary for large-scale quality assurance programs and research studies.

However, fully computerized data systems will allow instantaneous access to everyone’s private medical information. In particular, the increasing use of genetic testing is raising concerns that knowledge of an individual’s hereditary characteristics could have an adverse affect on the ability to obtain health insurance coverage. As progress toward national electronic health care information systems incorporating clinical data continues, there are justified concerns that these data systems could jeopardize the confidentiality of each individual’s health care information and imperil individuals’ personal privacy.

There is a nearly universally acknowledged right of confidentiality between patients and their physicians, a right grounded in physicians’ codes of ethics and professional guidelines. Patient-physician confidentiality is, with certain exceptions, respected at common law. Many states also have statutes providing some protection against inappropriate disclosure of personally identifiable medical information. The patchwork of state laws, however, has left many gaps in privacy protections.

Until recently, there were no comprehensive federal medical information privacy protections. The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that health care system providers and payers adopt uniform information transaction standards and use electronic health information data systems to process transactions by the end of 2002.
The HIPAA also included a mandate requiring Congress to pass comprehensive national legislation establishing patients’ privacy rights and a set of rules governing the confidential handling of personally identifiable medical information. In the absence of congressional action, the secretary of the Department of Health and Human Services (DHHS) issued the health privacy regulation in December 2000. In August 2002 DHHS significantly modified the regulation. The regulation has the force of law and, in most cases, creates a national minimum standard for privacy; with few exceptions, it does not preempt state laws that grant higher levels of protection. Further modifications to the regulations cannot be issued until August 2003.

While the regulation gives important new privacy protections to health care consumers, it is not comprehensive. As provided for by HIPAA, the regulation will only directly apply to covered entities (health plans, health care clearinghouses and those health care providers who conduct certain financial and administrative transactions electronically, for example, electronic billing and funds transfers). Only Congress has the authority to pass a comprehensive federal law that will directly cover all of the entities that collect, maintain, and disclose health information, such as life insurers and pharmaceutical companies.

The December 2000 rule required providers to obtain written patient consent before sharing their information for treatment, payment and health care operations (TPO). In addition, separate patient authorization was required for nonroutine disclosures. Further, it ensured that health information would not be used for nonhealth purposes, such as disclosures to employers to make personnel decisions or to financial institutions, without explicit authorization from the individual. Patients were given the right to request restrictions on the uses and disclosures of the information. It also provided for patient education on privacy protections, ensured patient access to their own medical records and provided for recourse should patient privacy be violated.

In general, disclosures of information were to be limited to the minimum amount necessary for the purpose of the disclosure. However, this provision did not apply to the disclosure of medical records for treatment purposes in recognition of the fact that providers need access to all patient information to safely and effectively render treatment.

The rule also established privacy safeguard standards that covered entities were required to meet, although it permitted considerable flexibility in how they were to meet the standards. They were required to provide written privacy policies to patients and to train employees in those policies. They were also required to designate a privacy officer.

The rule also established civil and criminal penalties for misuse of personal health information.
A revised final rule issued in August 2002 made substantive changes to the regulations. It eliminated the requirement to obtain written consent before sharing information for treatment, payment and health care operations and replaced the consent requirement with simple patient notification of a provider’s own privacy policies. It also eliminated the requirement that disclosures pursuant to an authorization be included in an accounting of disclosures, removed the “minimum necessary” requirement when consumers have provided written authorization and deleted a requirement for special authorization provisions in research.

FEDERAL & STATE POLICY
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Health Information, Privacy and Confidentiality

AARP believes individuals have the right to examine and copy the contents of their health care records and have the right to know the identities of other entities and people who have examined their health care records.

FEDERAL POLICY
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Health Information, Privacy and Confidentiality

AARP supports public and private efforts directed toward full computerization of health care administrative and clinical data systems and believes these efforts should continue to be aggressively promoted.

AARP believes individuals have a right to privacy with respect to their personal medical information. Further, AARP believes that genetic testing should not be performed unless an individual has provided informed consent for the testing. AARP also believes individuals have the right to determine who may have access to all personally identifiable health information and for what purpose. Guarantees of that right must be paramount.

AARP opposes use or disclosure of an individual’s medical information except as authorized by the patient for public health reporting as required by law, for enforcement of the financial integrity of publicly funded health programs (provided that personal identifiers have been removed whenever possible) and for research and quality assessment and improvement (provided that personal identifiers have been removed whenever possible). Such uses or disclosures for reporting and enforcement should be supported by public policies confirming that the need for personally identifiable information has been established and cannot be met by other means and, after careful scrutiny, has been found to justify the use or disclosure. There must be substantial civil and criminal penalties for unauthorized or inappropriate use or disclosure. A warrant must
be required of law enforcement agencies seeking access to personal health
information. The use of personal health information permitted for disclosure
must be limited to the satisfaction of the original need for disclosure.
Information thus used or disclosed must not be used for any other purpose.

AARP supports actions that make individually identifiable health information
less vulnerable to inappropriate disclosure and misuse. Although the new
standards constitute a step forward for health privacy, some provisions
concern AARP.

Written consent should be required before information is shared for
treatment, payment and health care operations (TPO). Mere notification to
patients of a provider’s own privacy policies is inadequate because it would
deny consumers the opportunity to exercise the right to privacy. Legitimate
concerns about problems resulting from a written consent requirement can
and must be addressed.

In addition, AARP believes that use of clinical information for marketing
without express written consent (or, an opt-in) should be prohibited. This
higher level of protection for clinical information is above and beyond the
standard for nonclinical information, such as name, address, age and
insurance status. The types of communication that constitute marketing must
be clearly delineated. Possible criteria include whether information is directly
related to ongoing treatment regimens, whether it concerns new products
and whether a covered entity is receiving any remuneration from another
provider, manufacturer or service provider for giving information to
consumers.

AARP strongly supports the right of consumers to have their names
removed from marketing lists.

AARP strongly believes that minimum necessary requirements are
appropriate for maintaining the confidentiality of protected health
information that is not needed for a specific purpose.

Covered entities should be required to provide, on request, an accounting of
information disclosures that were made for TPO or for which authorization
had been obtained. Patients should be able to learn who has obtained access
to their individually identifiable health information.
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Background

Carve-Outs

Many employers carve out certain services (most notably, mental health and substance abuse treatments) from managed care or other insurance benefit packages. Thus, rather than offering a complete range of health care services, the insurer or managed care plan does not cover or provide carved-out services. Proponents justify this practice on the basis that a managed care plan may lack the clinical personnel, management resources or expertise to provide the service effectively. In this case alternative approaches outside the managed care plan or by another insurance carrier would provide higher-quality care more efficiently or at lower cost.

Carve-out programs also may deter risk selection on the part of health plans. Because certain benefits, such as mental health or substance abuse services, are known to be used by higher-cost patients, health plans may have incentives to avoid enrolling such individuals to avoid members who require more resources. Carving out the service curbs the opportunity for plans to shun people who may be higher-service users.

Opponents of carving out benefits (particularly from managed care plans where service coordination is featured) argue that health care delivery ought to be comprehensive, integrated and coordinated. Carve-outs, they argue, result in fragmentation, duplication of effort and lack of accountability. (Carve-outs should not be confused with the practice of a managed care plan contracting with an external vendor for a particular service, in which case the managed care plan would still have the responsibility for delivering that service.) Therefore, when a purchaser carves out a particular benefit, it is important that it hold the entity that it selects to provide the carved-out benefit accountable for the benefit.

FEDERAL & STATE POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Carve-Outs

Public (e.g., federal and state governments) and private (e.g., employers) purchasers should closely monitor benefits that are carved out, such as mental health care and substance abuse services, to ensure that such benefits are accessible and of high quality and to maintain continuity of care and accountability.
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Background

Availability and Training of Health Care Personnel and Geriatric Training

Social, economic and demographic factors have created serious shortages and distribution inequity among various health care personnel in this country. Evidence indicates that these conditions will continue and worsen in the future and will increasingly affect the quality and delivery of health care. The shortage of some categories of health care personnel, particularly those trained to deal with the special needs of older patients, may have an especially deleterious effect on this population, whose numbers are growing rapidly. The number of geriatric specialists, already inadequate to meet the needs of older patients, is actually declining in relation to the increasing population of older people. In addition, there has been a persistent imbalance between primary care providers and specialists, despite rapid growth in the number of physicians in the US.

Our society is becoming increasingly diverse, culturally and ethnically. Patients from different cultures and ethnic groups bring with them different traditions and sensitivities that affect the way they interact with the health care system. Health care providers commonly lack knowledge about these patients’ views regarding health care, impeding physician-patient communication and rendering successful patient outcomes less likely. In addition, perceived lack of understanding and respect for their different traditions and sensitivities may discourage people from different cultures and ethnic groups from ever seeking appropriate medical care. There are few programs in health care education curricula designed to teach future health care professionals about different cultural perspectives on medical care.

Physician education is also important in the case of complementary and alternative medicine (CAM). Research indicates that a lack of communication between patients and physicians about CAM can be a problem. Dangerous and life-threatening interactions between conventional medicine and CAM can occur when a physician is not aware of a patient’s CAM usage. One reason for this communication gap is that many physicians do not ask about possible CAM use, often because they have limited knowledge of such therapies. Physicians with proper training can better advise their patients to make safe and appropriate choices about CAM.
FEDERAL POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Availability and Training of Health Care Personnel and Geriatric Training

Federally funded research into the potential impact of the aging of the health care workforce, which is occurring simultaneously with the overall aging of society, should be undertaken.

Federal funding for education and training of health care personnel should be targeted to the types of professionals in short supply.

All health care providers should have appropriate training to address the unique health care needs of older patients. Efforts should be undertaken to ensure that there will be an adequate number of qualified geriatric specialists available to meet the needs of the growing population of older Americans.

More emphasis should be placed on geriatrics and the special needs of older patients in medical and nursing school recruitment and in core curricula. To ensure such an emphasis, significant increases are needed in the number of medical and nursing faculty appropriately qualified to provide education and instruction in the care of older people.

Health professional curricula also should increase and improve understanding of and sensitivity to cultural and ethnic differences that may affect the health care of the increasingly diverse patient population.

More geriatric-specific in-service training is necessary to prepare health care workers in both institutional and noninstitutional settings to meet the physical and psychological needs of an increasing elderly population.

AARP supports continued physician education on CAM. Additionally, physicians should encourage communication with their patients regarding CAM usage.

STATE POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Availability and Training of Health Care Personnel and Geriatric Training

States should:

mandate that professional schools with health and human services curricula require education in geriatrics and gerontology;
• at time of license renewal, require proof of continuing education in geriatrics for those engaged in treating older adults;

• establish and enforce appropriate educational and training standards for providers representing themselves as having a specialty in geriatrics;

• make grants available to establish divisions or centers on geriatric medicine, support biomedical research on aging and develop geriatric curricula for use in training in chronic care institutions;

• establish and expand research and educational facilities to meet the special needs of elderly people and people with disabilities, emphasizing the needs of older minority people and older women;

• amend current medical licensing laws to allow nurses, nurse practitioners and allied health professionals to perform duties for which they have been trained—These professionals should be monitored by the appropriate state licensing board and be disciplined when they deliver inferior care or attempt to provide care that exceeds their capabilities; and

• require training in English as a second language, as appropriate.