HEALTH CARE • 6

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INTRODUCTION

The US has one of the most technologically advanced health care systems in the world. Despite this and other progress in health care, some aspects of the health care system have gotten worse and substantial improvements are still needed. The rising costs of health care pose an ever-increasing economic burden for individuals and the nation. Between 1990 and 2003 total annual national health care expenditures rose from nearly $700 billion to $1.7 trillion. Projections that take into account recent spending patterns indicate that national health care expenditures could reach $3.1 trillion in 2012. As health care costs continue to rise, surveys find many people believe that the quality of health care has gotten worse in recent years and that confidence about their future ability to get needed treatment without financial hardship is eroding. Although it is clear that all consumers will be expected to bear more responsibility for making informed health care choices, very little systematic information exists about the state of health care quality in the nation. Consumer information on quality is critical to informed choice as well as public accountability. Research indicates that there are serious and pervasive problems with the quality of care throughout the health care system and that these affect health outcomes and system costs. The Institute of Medicine estimates that medical error is a leading cause of death and that injuries resulting from medical errors cost billions each year. A recent survey by the Kaiser Family Foundation found that one in three individuals reported that a preventable medical error was made in their care or that of someone in their family.

For many people access to coverage and services is compromised by its growing cost. The US Census Bureau estimates that in 2003, 445 million people of all ages had no health insurance coverage from any source throughout the year. This means one in six people were without coverage. Compared with five years ago, an additional two million people are without coverage. 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, and large employers offering coverage are increasingly concerned about how to handle their rising health benefits costs. 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 is a major source of coverage for those living below the poverty level. However, roughly 30 percent of the poor were uninsured in 2003.

AARP has long advocated comprehensive reform of the US health care system and continues to do so. 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.

In the absence of comprehensive national reforms, AARP supports incremental steps that move the system toward one that ensures access to quality care and affordable coverage for needed acute and long-term services 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. Likewise, in the absence of comprehensive reform at the national level, some states have targeted changing their health care systems.

What progress has been made in the past ten years has indeed come in small steps. All the while, the problems of our health care system continue to multiply and have lasting consequences for the lives of a growing number of people. If we are to achieve the goals embodied in the following principles set forth by our members, we must increase the pace at which we are proceeding.
AARP PRINCIPLES

AARP’s health care principles are designed to guide the association in its efforts to reform the health care system and to guide its participation in the public debate over health care reform 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. 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 Services and Supports 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 government 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 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 of participating 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 has been escalating health care costs. As a result of cost growth many policymakers in both the private and public sectors began to embrace market competition as a way to transform the health care system. In the 1990s managed care and market competition were pursued as a solution to escalating health costs, with managed care plans ultimately replacing traditional indemnity coverage as the main type of health coverage (see this chapter’s section Health Care Coverage—Private Health Insurance—Managed Care). By the turn of the century, however, double-digit health care cost increases returned, and managed care restrictions had generated consumer backlash.

Nevertheless, economic pressures continue to reshape the health care landscape. Growing costs and declining profit margins have strained the financial stability of some health care entities. This has led to mergers among some insurers, health plans and providers. 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, 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 or public entities to privately held corporations. This private investment in local plans and delivery systems has generated strong and divided responses.

Cost-containment methods aim 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 have raised a series of public policy concerns. Policymakers and elected officials have important roles in ensuring the quality of care 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 trading and licensing) of private health care entities; they have broad power to protect the public’s health and safety; and they have the power to safeguard tax-supported assets. 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.

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 neither access to affordable care nor the quality of care is jeopardized, 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 becoming for-profit organizations, through conversion, merger, reorganization or restructuring, 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 and enforcement 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.

THE HEALTH CARE SYSTEM

Background

Health Care Spending

After several years of relatively slow growth during the 1990s, health care spending has been growing at a faster rate in recent years. While total health care spending growth averaged 5.3 percent per year from 1993 through 1997, it was 9.3 percent in 2002. Spending growth slowed somewhat to 7.7 percent in 2003. National health care expenditures are expected to grow at about 7.2 percent per year from 2003 through 2013, below the 11.5 percent average annual rate that existed for the years from 1970 through 1993.

Several factors have contributed to the recent trend 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 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 can continue to grow rapidly even after the economy has slowed and can grow slowly during periods of high economic growth.
Since 1995 prescription drugs have been one of the fastest growing components of national health care expenditures. Total national health spending on outpatient prescription drugs increased by an average of 17.4 percent per year from 1999 through 2001, 14.9 percent in 2002, and 10.7 percent in 2003. Prescription drug spending is projected to continue to grow by more than 10 percent per year through at least 2013. 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 (see also this chapter's sections on Medicare's Coverage of Prescription Drugs and Other Uncovered Services and Prescription Drugs and Pharmacy Practices).

Another factor that affects health care spending in both the private and public sectors is the cost of fraud and abuse. However, the lack of empirical evidence concerning 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 such practices (see also this chapter's section Health Care Fraud and Abuse).

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 public programs (Medicare and Medicaid) reduced reimbursement levels in previous years, providers tried to recoup losses by shifting costs to private payers; more recently, some payers have been shifting costs to consumers. 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 price of services, controlling costs through government regulation, returning to more tightly controlled managed care plans such as health maintenance organizations, and improving effectiveness and quality. However, none of these approaches alone is expected to contain health care spending, and there are tradeoffs involved in each. In addition, some of the changes needed to improve the efficiency and quality of health care delivery are likely to increase costs, at least in the short term. Clearly, challenges remain in simultaneously controlling health care costs while not compromising quality or improperly denying access to care.

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**FEDERAL, STATE & LOCAL POLICY**

**THE HEALTH CARE SYSTEM**

**Health Care Spending**

As part of the efforts to control health care costs, AARP supports antifraud and antiabuse 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).

FEDERAL & STATE POLICY

THE HEALTH CARE SYSTEM

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.

FEDERAL POLICY

THE HEALTH CARE SYSTEM

Health Care Spending

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

The federal government should increase research and dissemination of information 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.

THE HEALTH CARE SYSTEM

Background

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 for 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 one 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—or policies under which the government chooses 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 of health care range from incremental changes (e.g., modifying tax or regulatory policies) to comprehensive overhaul. To enact further reform 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).

FEDERAL POLICY

THE HEALTH CARE SYSTEM

Sources of Financing for Health Insurance

The criteria for evaluating financing sources for health care reform should include the extent to which such sources are broadly based, stable, capable of 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 through private insurance or 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 reform practices of health insurers and private health care plans (including self-insured employer plans).

(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 Services and Supports. Policies that relate to the broader insurance market are in the insurance sections of Chapter 12, Financial Services and Consumer Products.)

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; state requirements are often preempted and do not apply to ERISA plans. Because ERISA plans account for a significant share of private health coverage, this dual regulatory framework has frustrated some states’ health care and managed care reforms. 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 guarantees 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.

Finding ways to spread the risk and cost of covering less healthy individuals more broadly, so that premiums are affordable, has proven difficult. Regulation of rating practices affects how narrowly or broadly this cost, or risk, is spread. Restrictions on insurers’ ability to use health status in setting premiums have been implemented fairly widely in the group market, but such restrictions are not yet widespread in the nongroup market. A few states require “pure community rating” or “adjusted community rating” to further narrow the premium differences among covered individuals. Under “pure community rating,” everyone covered under the same plan is charged the same premium regardless of individual characteristics. Under “adjusted community rating,” changes in the pure community rate are allowed for specified demographic factors, such as age, number of dependents and geography, but not health status or experience. The adjustments also limit the rate variation for an allowed rating factor, such as age. Such variation is commonly expressed as a percentage or ratio.

To help spread risk more broadly among insurers, some states have set up risk adjustment or reinsurance pools. Thus, 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. 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. However, the premiums for high-risk populations are above the market average. Risk pools use funding from other insurers or taxes to help subsidize premiums for those who are uninsurable. Even with the subsidy, premiums may be unaffordable for many high-risk individuals with modest incomes. The Trade Act of 2002 established a short-term grant program to help support the creation of new high-risk pools and to help subsidize losses in state high-risk pools.

Other reform efforts have used pooling mechanisms to address the higher costs and lack of choice that individuals and small group purchasers face. In some instances private purchasers have organized these purchasing efforts; in others, states have authorized their creation. The evidence to date shows that these mechanisms may be effective in expanding the number of insurance options available to small purchasers. However, they have not led to expansion of coverage through employers that previously did not offer health coverage or to significant reductions in premiums.
In recent 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.

As part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Congress enacted tax-sheltered health savings accounts (HSAs), replacing an earlier, limited medical savings account (MSA) demonstration. HSAs are paired with high-deductible health plans (HDHPs); individuals with comprehensive health coverage are not eligible to open or contribute to an HSA. HSA contribution amounts are limited annually and are not permitted after age 65, but these contributions are sheltered from taxes, as are growth in the account’s balance and withdrawals for health spending. Savings in the account are intended to help individuals pay their deductible, and balances that are not used in a given year can be rolled over for future use. While theoretically these accounts can be used to help with Medicare and other health costs in retirement years, analysis indicates that at least for those close to retirement, it will be difficult to accumulate sufficient savings, because most individuals will withdraw a portion of the funds to pay for current health expenses.

The backlash against the types of restrictions typically used in managed care combined with several years of double-digit premium increases have created a context in which both insurers and employers have been looking for more affordable coverage options. New high-deductible health products (which may come in varying forms and are sometimes called consumer-driven health plans) have been gaining attention in the last few years. Some plans are not paired with a health account and allow consumers to tailor benefits and networks to their own needs.

High-deductible health plans serve different functions within the health care system. For example, in high-risk pools and nongroup markets, where the consumer usually pays the full premium, a high-deductible plan may offer the only affordable coverage option for some consumers. (These plans may or may not conform to the definition of a high-deductible plan that qualifies an individual to have an HSA.) In the small-group market where annual premium increases may prove difficult for employers to absorb, affordability and the desire to reduce benefit costs may lead some employers to offer an HDHP instead of a more comprehensive health plan. Employers offering HDHPs may or may not make a contribution to the savings account. Under HSA rules, whether or not the employer contributes, the individual may contribute to the account as long as total contributions do not exceed the limit. Some large employers, which offer a choice of plans, have added a HDHP to their coverage offerings or substituted it for another offering.
A number of public policy concerns associated with the spread of HSAs and high-deductible health plans have implications for private coverage markets. The first is risk segmentation. Enrollment in these products draws people away from more comprehensive products; if the less healthy risks remain, the more comprehensive products could become too expensive to sustain in the marketplace. A second concern is that consumers without the resources or savings to pay for care below the deductible will be underinsured and may be unable to access needed care. In the nongroup market, individuals must have the resources for premiums and account contributions. In all market segments low-income individuals and those with expensive chronic conditions are particularly vulnerable because they may delay care until their health problems are exacerbated and ultimately incur greater costs. A third concern has implications for taxpayers and employers that contribute to health savings. To the extent that those who enroll in HDHPs are healthier, but funding for the plans is not adjusted to account for this, HDHPs may add to total health spending rather than constrain it, because employers may spend more than they presently do on behalf of these people and taxpayers may forego more revenue.

Some initial research points to the potential need to assist low-income and chronically ill enrollees in these plans. It is also important to look at the impact of HSAs on a policy level, not just an individual level, since tax expenditures directed toward HSAs are public resources that are then not available for other public objectives (such as other means of reducing the number of uninsured or subsidizing those who cannot afford needed health spending). Due to the newness of HSAs and the small share of the market in HDHPs, there is still insufficient experience to reliably draw conclusions about how they will affect either risk segmentation or health spending.

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

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 may support 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 under Health Care Coverage: The Uninsured and the Need for a Safety Net 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,
- limit coverage exclusions or waiting periods for preexisting health conditions and credit policyholders’ prior coverage toward satisfying limits on preexisting conditions, and
- encourage closer coordination between private health insurance benefits and long-term services and supports, particularly for people with chronic 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 the access, portability and renewability protections in Title I of the Health Insurance Portability and Accountability Act for group and individual coverage.
AARP supports regulators’ use of reinsurance, risk adjustment and similar mechanisms to spread the insurance risk more broadly across the industry, when appropriate to implement reforms.

AARP supports purchasing cooperatives or pools that enhance access to health coverage and 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; give consumers a voice 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; use cost-containment features such as case management and incentives for administrative effectiveness; provide subsidies adequate to ensure that pool enrollment does not close; and offer subsidies that make the risk pool premiums affordable for those with modest incomes.

AARP opposes tax incentives for health savings accounts (HSAs) 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, regulators and employers should carefully monitor and evaluate the plans’ effects, 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 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 deductibles;
- 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 also 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 and state-regulated health plans.
AARP supports changes in ERISA that would provide a means for states to apply state health care initiatives to both ERISA health benefit plans and 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.

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### Types of Managed Care Plans

Managed care combines health insurance with the delivery of care and provides an alternative to traditional indemnity insurance. The vast majority of workers with health insurance are enrolled in some type of managed care plan. Traditionally, most models of managed care generally shared three 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, managed care insurance products reflect a blend of features. 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. The providers generally practice together in a medical center or clinic. A somewhat looser form of HMO is an **independent 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. While some HMOs require enrollees to obtain approval for most care from a primary care provider, more plans are offering “open access” to specialists without prior approval of a primary care physician.

A key feature of the marketplace during the last several years has been broader choice, as illustrated by the **point-of-service** (POS) 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**, also known as a **physician-hospital organization** or **physician service network**. The distinguishing feature of these types of organizations is that they are owned and operated by providers and are composed of one or more hospitals and their attending physicians and/or physician groups.

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 55 percent of insured workers are enrolled in PPOs. However, regulatory 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). 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 by adding PPOs, POS plans, and private fee-for-service plans. 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 Private Health Plans in the Medicare Program: Medicare+Choice/Medicare Advantage for a detailed discussion of the options that may be offered to Medicare beneficiaries). The Medicare Modernization Act of 2003 further expanded the types of coverage options that may be offered to Medicare beneficiaries; in addition to those models previously authorized, “regional” PPOs may be offered starting in January 2006.

There continues to be evidence of a public backlash against managed care plans, although its intensity has diminished slightly. Despite high ratings for their own managed care plans, consumers typically consider managed care’s impact to be negative in terms of decreased access to specialists, the time doctors spend with patients, and quality of care for those who are sick. Some experts attribute escalating health care costs to the abandonment of traditional managed care cost-containment approaches.
The 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 and types 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**

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

**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.

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

**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 Private Health Plans in the Medicare Program: Medicare+Choice/Medicare Advantage section for more on Medicare and managed care). In 2004 about 95 percent of workers were enrolled in some type of managed care plan: health maintenance organizations covered 25 percent; preferred provider organizations, 55 percent; and point-of-service plans, 15 percent. The remaining 5 percent were enrolled in conventional fee-for-service plans.

By contrast, as of September 2004, 4.6 million Medicare beneficiaries (about 12 percent) were enrolled in risk-based Medicare plans. In 2003, 25 million Medicaid beneficiaries were enrolled in managed care plans, approximately 59 percent of the total Medicaid population.
FEDERAL & STATE POLICY

HEALTH CARE COVERAGE • Private Health Insurance • Managed Care

Enrollment in Managed Care Plans

AARP supports health care reform that achieves universal coverage of comprehensive health benefits (see this chapter’s 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.

Background

National Standards for Managed Care Plans

Regulation and oversight of managed care plans are inconsistent across the states. 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 the full range of managed care plans’ operational and delivery activities are necessary to protect plan enrollees. Without the enforcement of established requirements, enrollees cannot be confident that they will receive necessary care or have the suitable and sufficient protections to ensure service delivery within a reasonable time frame. Moreover, enrollees may lack appropriate due process protections in challenging health plan decisions about their care.

The absence of uniform standards results in a patchwork of rules for managed care operations. Consumers are only protected to the extent that they either 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. Finally, uniform standards would eliminate duplicative requirements that waste valuable resources.

Consumer protection is enhanced by public accountability. Published reports of performance on standardized measures, including patient satisfaction and
the clinical effectiveness of care, help to advance health plan accountability. Data from the Health Plan Employer 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. Plans that publicly report HEDIS results have better performance scores.

Scope of state oversight—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., health maintenance organizations 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 come in 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 34 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/Medicare Advantage section of this chapter for a discussion of deeming in that program).

Medical-loss ratios—Some states require managed care plans to report “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 and, therefore, a 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). Some courts have ruled that the law prevents 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 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 2003, 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. However, HMO liability and the scope of these laws continues to be contentious and subject to litigation. In June 2004, in two companion cases, the US Supreme Court ruled that ERISA completely preempts state laws that are intended to supplant ERISA civil enforcement remedies. This means that HMO enrollees cannot sue their health plans for personal injury damages in state court when their employer-sponsored plan denies coverage recommended by the patient’s physician.
FEDERAL & STATE POLICY

HEALTH CARE COVERAGE • Private Health Insurance
• Managed Care

National Standards for Managed Care Plans

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 for 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 state managed care laws until a federal law is established that affords consumers greater protections than they have under state laws.

STATE POLICY

HEALTH CARE COVERAGE • Private Health Insurance
• Managed Care

National Standards for Managed Care Plans

In the absence of national standards, states should enact a comprehensive set of rigorous standards (comparable to those 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/Medicare Advantage—Federal Standards for Medicare Managed Care and Other Private Health Plans for a detailed delineation of the standards applicable to private health plans participating in Medicare).

Finances—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 are set at levels adequate 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:

- ensure participation of plan physicians in the development of formularies,

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

- 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,

- 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

- 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 this chapter’s section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—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. 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:

- information on benefits, limitations, exclusions, restrictions on use of services, and plan ownership;
a summary of physicians’ financial incentive arrangements written in terms that the average consumer will understand;

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

■ comparative, standardized information on patients’ experience with care in the plan and the plan’s clinical performance (e.g., Health Plan Employer Data and Information Set and Consumer Assessment of Health Plans Study data);

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

■ disenrollment experience;

■ information about grievances and appeals filed by enrollees; and

■ 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 or lower, 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 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 discrimination against population groups that reside in certain locations, plans should serve a complete market 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 provider.

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 is terminated by the health plan for reasons other than cause.

**Quality assurance/quality improvement (QA/QI)**—To inform consumer decisions, ensure public accountability, and improve health care quality, health plans must collect and report information on their performance using standardized measures that apply to preventive, acute and chronic care and indicate the performance of their practitioner and institutional contractors (e.g., physicians, hospitals and skilled-nursing facilities). Wherever possible, these measures should reflect outcomes of care or process measures that have a known relationship to outcomes. Health plans should also conduct ongoing quality improvement activities.

Appropriate agencies such as the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality should build on existing efforts to develop quality measures that can be used to assess health care services across all settings as well as pharmacy practices in managed care plans. These agencies should ensure that best practices in QA/QI are shared with all health plans.

**Utilization review/utilization management (UR/UM)**—Written 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 over-utilization, and 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 enrollee’s medical situation requires in order to protect the patient’s 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 their 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 appeals 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 and 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 independent review bodies to ensure that their processes and procedures 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 that 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 appeals 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 had medical consequences, the plan should be liable for any injuries or harm to 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 method 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 and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or the Department of Veterans Affairs (VA);

- supported by centers or cooperative groups funded by the NIH, CDC, AHRQ, CMS or DOD;

- sponsored by the VA and conducted under an investigational new drug (IND) application reviewed by the Food and Drug Administration (FDA), exempt from needing an IND application under FDA regulations, or 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 and items and services provided solely to satisfy data collection needs or 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 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 and 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 agencies conducting external quality reviews;

- 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 data and reporting requirements that address the frequency, content and format of reports. States should require commercially licensed and public health maintenance organizations under their authority (e.g., Medicaid HMOs) to report complete Health Plan Employer Data and Information Set (HEDIS) data, including the clinical effectiveness measures and enrollee satisfaction information (i.e., Consumer Assessment of Health Plans Study (CAHPS)). Other managed care organizations (e.g., preferred provider organizations) and other types of insurers should be required to collect and report at least enrollee satisfaction, measures that assess access to care and customer service, and, to the extent possible, clinical information. States are encouraged to publish HEDIS performance results, including the CAHPS data, in a format that consumers will readily understand.

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

- 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.);

- complaints, grievances and appeals and their resolution;
■ physician satisfaction;
■ quality improvement;
■ credentialing;
■ utilization management and appeals regarding use of out-of-plan services;
■ accessibility, including wait times for appointments, rates of referral requests, and numbers of practitioners accepting new patients;
■ rates of physician turnover; and
■ enrollment or disenrollment levels.

**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:

■ 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;

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

■ 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. As needed, these programs should receive federal and/or state funding. 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 states where more than one agency has authority to regulate managed care organizations, the agencies should coordinate their activities to facilitate effective oversight.

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

State task forces that study managed care should include enrollees, prospective enrollees and other consumer representatives on such bodies.

States must ensure that all standards, including but not limited to those 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

Provider Reimbursement and Financial Incentives

The way providers are reimbursed can produce unintended effects on their 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 cost-effective care. 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 a set of financial incentives to improve their clinical and service
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. Incentive programs typically measure performance in clinical
care, member access to services, and patient-reported experience with the
care they receive.

In addition, health plans are offering financial incentives to physicians to
improve health care quality as well. Approximately 35 health plans covering
more than 30 million enrollees have programs that tie physician payments to
performance. A recent study reported that 24 percent of physicians were
subject to performance-based incentives for patient satisfaction, and 19
percent to incentives 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 such practices, health plans are also more
likely to use profiling, where physicians’ use of medical resources is
compared with that of their peers.
Provider Reimbursement and Financial Incentives

Financial incentives (e.g., “pay-for-performance” plans) 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 their financial arrangements with providers publicly available in standardized formats. To the extent possible this information should be consumer friendly and presented in nontechnical terms.

States 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 quality of care in order to inform policymakers about incentive arrangements that should be prohibited and which would be most effective.

When pay-for-performance programs are implemented, performance should be assessed using evidence-based measures that have been tested and validated.

HEALTH CARE COVERAGE • Private Health Insurance

Retiree Health Coverage

Employers’ group health plans are the major source of health coverage for working adults and their families. Three in five individuals 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 may be difficult or impossible.

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 2003 the percentage of large employers offering health benefits dropped from 46 percent to 28 percent for early retirees (those under age 65) and from 40 percent to 21 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 rising health care costs along to retirees. Among large employers that provide retiree coverage, nearly two in five have the retiree pay the full cost of coverage, while most of the others share the cost of coverage with retirees. Retirees with employer-sponsored health benefits are also likely to face changes in coverage, as employers seek to limit their future financial liability for health benefits. For example, more retirees may face caps on employer contributions, or a fixed contribution to their health costs. Surveys indicate that employers continue to consider raising retirees’ out-of-pocket costs for premiums and care. If the price of retiree health benefits grows beyond the reach of retirees, they could be vulnerable to the risk of major out-of-pocket costs if they become seriously ill.

An August 2000 decision by 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 Equal Employment Opportunity Commission (EEOC) has proposed a rule that would allow employers to discriminate against older retirees by permitting an employer to provide retiree health benefits to retirees younger than age 65 without providing these benefits to older retirees eligible for Medicare. The court case and the proposed regulation 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 to all retirees rather than incur higher costs for retirees age 65 and over.
Because employers will make decisions about whether and how to change their retiree drug benefits in light of the drug benefit in Medicare, retirees are concerned that the establishment of the Medicare drug benefit may jeopardize more generous retiree drug coverage. In recognition of the trend toward fewer employers offering retiree health benefits, Congress included special subsidies for retiree drug benefits in the Medicare Modernization Act as an incentive for employers to retain current retiree drug benefits outside of the Medicare benefit. In relation to the subsidy for coverage that remains outside of Medicare, there is a concern among retirees that employers might get a windfall from the subsidy as they shift costs to retirees and benefit from their spending on premiums and cost-sharing. There is also concern that, if published, the EEOC rule will undercut the subsidies by permitting employers to legally eliminate these benefits for older retirees.

In addition to health care cost increases, 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, subsidies for individuals, and accounting standards affect employers and their decisions about retiree health benefits.

**FEDERAL POLICY**

**HEALTH CARE COVERAGE • Private Health Insurance**

**Retiree Health Coverage**

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

AARP opposes implementation of employer subsidies under the Medicare Modernization Act in a way that allows employer windfalls at the expense of retirees.

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:

- Chapter 2, Taxation: Taxing Employer-Provided Benefits (policy on medical expense deduction);
- Chapter 3, Retirement Income: Postretirement Health Benefits;
- Chapter 4, Employment: Age Discrimination in Employment—Age Discrimination in Employment Benefits (policies related to the Age
Discrimination in Employment Act's "equal benefit or equal cost" rule and exceptions) and Retiree Health Coverage;

- Chapter 4, Employment: Economic Security for Workers—Employee Health Benefits (policy on continuing coverage and retirement health benefits); and

- Chapter 6, Health Care: 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

Background

Medicare Supplemental (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 supplemental 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 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, Financial Services and Consumer Products: 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 underwriting 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, the share of beneficiaries enrolled in fee-for-service Medicare with individually purchased Medigap coverage dropped from 37 percent in 1992 to 33 percent in 2001, and the share with no supplemental coverage dropped from 11 percent to 9 percent. The declining share of fee-for-service enrollees with no supplemental coverage may in part reflect an increase in Medicare managed care enrollment in the same period. 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 in special circumstances. However, Medicare supplemental insurance rules do not protect beneficiary access to coverage outside these periods, and in the most common special enrollment circumstances, they do not guarantee access to plans with drug benefits.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) prohibits the sale of policies with drug benefits once there is a drug benefit in Medicare; Medicare beneficiaries who have Medigap plans with drug coverage will be given a one-time opportunity to shift to a plan without drug benefits or drop the drug benefit from their current policy. 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.
In the MMA, Congress authorized two new Medigap plans, which prohibit first-dollar coverage but cap annual out-of-pocket spending under the plan. The law also asks the National Association of Insurance Commissioners to review and revise the standards to update the plans. Trends in Medicare—such as the addition of the drug benefit, new kinds of Medicare Advantage plans, the prohibition against Medigap supplementing Medicare drug coverage—and trends within the Medicare supplemental market itself all contribute to a changing landscape that could erode some of the gains of Medigap market standardization. The importance of standardization increases as consumers face a changing array of Medicare and supplemental choices.

**FEDERAL & STATE POLICY**

**HEALTH CARE COVERAGE ● Private Health Insurance**

**Medicare Supplemental (Medigap) Insurance**

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

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

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

- 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

- 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.

AARP supports Medigap standardization and urges federal and state policymakers and the National Association of Insurance Commissioners to extend that framework to innovation in standardized plans and other add-ons sold to those with standard plans.
FEDERAL POLICY

HEALTH CARE COVERAGE • Private Health Insurance

Medicare Supplemental (Medigap) Insurance

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

HEALTH CARE COVERAGE • Private Health Insurance

Medicare Supplemental (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 a special focus on 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 more than 41 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.

Traditional fee-for-service Medicare has two parts: Part A and Part B. Part A (Hospital Insurance) covers 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) covers physician services, some home health services (those not linked to a prior hospitalization), and outpatient services. As the result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003,
Medicare will begin in 2006 to cover prescription drugs needed outside the hospital. However, Medicare does not cover long-term nursing home care; routine physical examinations (apart from an introductory physical exam for newly eligible Medicare beneficiaries, starting in 2005); 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.

Participation in Medicare Part A is mandatory and financed primarily by payroll taxes—employers and employees each pay 1.45 percent of wages to the Part A trust fund. Most individuals become automatically entitled to Medicare Part A when they turn 65. Participation is voluntary for Medicare Part B, which 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. Beginning in 2007 high-income beneficiaries will be required to pay higher Part B premiums based on their income. Approximately 95 percent of beneficiaries who participate in Part A also enroll in Part B.

Some Medicare beneficiaries elect to receive Medicare benefits through a private Medicare+Choice (M+C) option, also referred to as Medicare Part C and now renamed Medicare Advantage (MA). (Between now and December 31, 2005, the terms “M+C” and “MA” are interchangeable.) M+C is designed to give beneficiaries a range of private health plan options beyond the original Medicare fee-for-service program. M+C plans must provide all the benefits covered by Parts A and B in original Medicare. In addition, many M+C plans may offer beneficiaries lower cost-sharing and more benefits than original Medicare. Beneficiaries who choose an M+C 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 plan they choose.

Medicare prescription drug legislation establishes a new voluntary outpatient prescription drug benefit, referred to as Part D. Beginning in 2006 beneficiaries may elect to receive drug coverage by enrolling in either an integrated health plan, such as a health maintenance organization or preferred provider organization, or a stand-alone drug plan. During 2004 and 2005 beneficiaries may subscribe to Medicare prescription drug discount cards offered by private entities in accordance with Medicare standards.
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 the 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.

FEDERAL POLICY

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

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 the following section of this chapter). AARP opposes efforts to condition Medicare eligibility on income or assets and/or vary program deductibles and coinsurance by income or assets.

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

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 current and future generations.
Continued increases in medical costs, rapid changes in medical technology, and the aging of the baby-boom population will require consideration of Medicare reforms 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. First, a program that is not broadly based tends to decay over time because of a loss of public support. Second, 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. Third, 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 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. While an outpatient prescription drug benefit will become available in 2006, the benefit has a coverage gap. In addition, the catastrophic spending threshold (i.e., the level of beneficiary out-of-pocket spending that must be incurred before lower coinsurance applies) is quite high under this benefit ($3,600 in 2006), and other parts of the Medicare program entirely lack 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 the 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 enforces 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.

**What role should private plans play in Medicare?** Private plans have been available within the Medicare program for many years. More recently, particularly since enactment of the Balanced Budget Act of 1997, efforts have been made to expand the role of private plans in Medicare. Advocates of expanding the presence of private plans assert that they enhance beneficiary choice, provide additional benefits and increase efficiency. Critics will point to past instability among private plans in Medicare and the lack of evidence of cost savings to the program.

There are a number of important questions to consider regarding the role of private plans in Medicare. For example, what is the proper role of private plans compared with that of the traditional fee-for-service program? Should incentives be used to encourage private plan participation? Should private plans enjoy advantages over Medicare’s traditional fee-for-service program, to encourage beneficiaries to enroll in private plans? If so, what types of incentives are appropriate, e.g., those that produce higher payment levels which, in turn, permit plans to lower premiums or those that give beneficiary rebates for enrolling in private plans? Or, should incentives be provided even if they effectively turn Medicare into a defined contribution program (an option discussed above)? Other important considerations include whether
traditional Medicare should be expected to compete directly with private plans, and if so, what changes would be necessary to level the playing field between traditional Medicare and private plans.

Recent legislative proposals have included provisions to place Medicare’s traditional fee-for-service program in direct competition with private plans. These proposals raise serious concerns that the traditional program would be at a competitive disadvantage compared with private plans for a variety of reasons, including the inability of fee-for-service Medicare to provide additional benefits due to statutory limitations. The choice of younger and healthier beneficiaries to enroll in private plan options could lead to rapid premium increases for beneficiaries who remain in the fee-for-service program.

As enacted in the Medicare prescription drug legislation passed in 2003, direct competition between fee-for-service Medicare and private plans is restricted to a future demonstration program of limited scope and duration with protections against excessive premium increases and strict standards of accountability.

**How should Medicare be financed?** Another issue in the reform debate is whether and how to provide additional Medicare financing. 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, recently adopted proposal will 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 amount. Starting in 2007 Medicare Part B enrollees with income above $80,000 ($160,000 for couples) will pay a progressively greater share of Part B costs than enrollees with lower incomes. In 2011, when fully phased in, these new premiums will range from 35 percent to 80 percent of program costs for those at the highest income levels ($200,000 for individuals and $400,000 for couples). So, all beneficiaries will receive some level of premium subsidy. These thresholds will be indexed for inflation.
Although income-relating the Medicare Part B premium will increase Medicare revenues only modestly over the long term, some people believe that the federal government should reduce its Medicare Part B contribution 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 contribute the most to Medicare in payroll taxes during their working years may resent having to pay more to enjoy Medicare benefits.

**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 coverage (in 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+Choice—Medicare Payments to Private Health Plans, and Quality Oversight and Improvement).

**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 oversight 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 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 role as a payer of health insurance claims and become a “value purchaser.” This would mean using its leverage to improve beneficiaries’ health care options, foster illness prevention efforts, and encourage the more effective management of health problems across the continuum of care. It includes 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 setting up 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 certain practices borrowed from the private sector, such as some forms of provider contracting, could undermine fundamental aspects of original Medicare that guarantee beneficiaries the ability to choose their own provider. Critics add that these changes 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 • Publicly Administered Health Insurance
  • 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 and affordable health care coverage for current and future beneficiaries.

All competing Medicare options should have a level playing field.

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:

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

■ monitor the effect of increases in Part B premiums on both high- and low-income beneficiaries, particularly those without Medicaid, and
determine whether premium affordability is a barrier to access to Part B services; and

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

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:

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

- Medicare should guarantee specified benefits defined in law, i.e., 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 those costs and not be tied to artificial budgetary targets.

- Medicare’s benefit package should provide access to the most effective medical treatments for all beneficiaries, without regard to their income, geographic location, health status or choice of Medicare plan.

- 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 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 this chapter’s section 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 they are broadly based, stable, progressive, consistent with furthering public health objectives, and grow with enrollment.

Medicare should improve the quality of care for beneficiaries and maximize the value of the program’s 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 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 extensions, or expansions and private-market reforms (for federal policy on this issue, see this chapter’s section The Uninsured and the Need for a Safety Net—The Uninsured).

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 that all Americans, including Medicare beneficiaries, have access to needed health services while effectively controlling health care costs.
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 2001, 62 million Americans age 50 and older—78 percent of the 79 million people over age 50—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 when age is factored in. While roughly two-thirds of Medicare beneficiaries have 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, beneficiaries 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 provider and from providers in different settings. This introduces 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 in the case of 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 abound in which chronic care practices continue to fall short of delivering proven interventions. A 2003 study of the quality of health care delivered to adults in the US found that only 56 percent of recommended care for chronic conditions was actually provided. For example, people with hypertension received about 65 percent of recommended care, only 24 percent of people with diabetes had their blood sugar appropriately monitored, and 45 percent of people presenting with myocardial infarction received the proper medications known to reduce deaths among patients suffering from this condition. Other studies among Medicare beneficiaries and, in particular among frail elderly people, have drawn similar conclusions for patients suffering from depression (e.g., care for depression was provided slightly less than a third of the recommended time) and other chronic and geriatric conditions.

In its second major report on the quality of health care in America, the Institute of Medicine 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, 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:

- lack of limits on out-of-pocket expenses incurred by sicker beneficiaries who use more services;

- inadequate coverage for prescription drugs, which plays an important role in controlling chronic conditions;

- limited or no coverage for products and services provided to slow further deterioration or maximize beneficiary functioning rather than to achieve 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, durable medical equipment and supplies, and some rehabilitation therapies; and

- 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.

Recently enacted Medicare legislation has expanded the number and type of Medicare demonstration projects that are being undertaken to coordinate care for beneficiaries with chronic conditions, both in Medicare managed care plans and traditional Medicare. The purpose of these demonstrations is to explore ways of improving care generally for chronically ill people covered under Medicare without increasing program costs. They target a variety of chronic conditions, such as congestive heart failure, diabetes and emphysema, using different approaches to coordinating care, including case management and disease management. Several of the demonstration projects are modeled on lessons from chronic care delivery in managed care plans.

A common feature of Medicare demonstration projects on chronic care is that they must remain budget neutral—in other words they must improve chronic care without increasing program costs. This requirement raises questions as to whether the funding is sufficient to optimize the potential impact of these interventions on chronic conditions. Budget neutrality may prevent potential improvements in quality of care, quality of life and increased longevity from being explored.

There are also questions as to how the Medicare program will be able to capture potential savings that may be associated with various approaches to chronic care, particularly from capitated payment arrangements.

Some important features of chronic care coordination under the Medicare fee-for-service program, such as beneficiary protections from potential
marketing and operational abuses, have not yet been addressed through statute or regulation. It may be several years before the results of these demonstrations become available to inform policy decisions. In the meantime care managers may seek to aggressively market programs in a manner that could infringe on beneficiary privacy or exert undue influence to participate. In addition, care managers may offer financial or nonfinancial incentives and lock-ins to attract and retain beneficiaries in a particular type of care coordination arrangement. From a beneficiary perspective a lock-in period would restrict access to other providers. However, without a lock-in period, care managers might find it difficult to recover savings. As an alternative or addition to a lock-in, care managers may want to offer incentives to beneficiaries who enroll in chronic care coordination programs or achieve designated health objectives, such as reductions in blood pressure or cholesterol. As yet, it is unclear to what extent chronic care coordination programs might use beneficiary incentives and lock-ins.

FEDERAL POLICY

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

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:

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

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

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

■ 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 chronic illness and their roles in this process.
Medicare policies should support the efficient delivery of optimal care for meeting the 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 physicians, nurses, social workers, dietitians, therapists and pharmacists (see Chapter 7, Long-Term Services and Supports 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 determine the conditions under which, and the target populations for whom, Medicare coverage for comprehensive geriatric assessment is warranted. It also should 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).

Budget neutrality requirements should be eliminated for current and future Medicare demonstrations regarding care coordination for chronic conditions. A long-term (i.e., multiyear) time frame should be applied when determining the budget impact of these demonstrations.

Approaches to capturing Medicare savings from capitated payment arrangements, such as competitive bidding for coordinated care services, should be tested and implemented.

Chronic care demonstrations and programs, when established, should include the following beneficiary protections:

- Beneficiary and provider participation in Medicare care coordination programs should be voluntary, without additional cost to beneficiaries, and should not affect access to other Medicare benefits.

- Conditions for beneficiary participation in both demonstration projects and fully phased-in programs should include informed consent for patients and notification to the patient’s current physicians along with periodic reports of progress and changes in condition.
■ Medicare beneficiaries must be permitted to “opt out” of participation if they are automatically enrolled in chronic care demonstrations and programs.

■ Conditions for beneficiary participation should not include lock-ins, which limit beneficiary access to other providers for an extended period.

■ Beneficiary privacy must be protected.

■ Protections for patients deemed incompetent should be explicitly addressed.

Chronic care demonstrations and programs, when established, should be permitted to include the following incentives:

■ Medicare beneficiaries should be encouraged to participate in rigorous trials and evaluations of coordinated care techniques.

■ Medicare should encourage participation in chronic care demonstrations by assuming that potential participants would be willing to participate unless they opt out (i.e., the demonstrations should include automatic enrollment).

■ Conditions for beneficiary participation should permit care managers to offer various levels of incentives, including financial and nonfinancial incentives, to encourage enrollment and participation. Incentives should be permitted to vary for different target populations.

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

Background

Private Health Plans in the Medicare Program: Medicare+Choice/Medicare Advantage

Private plans are not new to Medicare. In one form or another, they have been available almost since the program’s inception. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) includes financial incentives and other mechanisms to encourage increased enrollment in private health plans. The law’s provisions affect both health plans and Medicare beneficiaries. Plans are eligible for financial incentives (e.g., shared-risk arrangements, entry bonuses and increased payments) to enter and remain in the Medicare market. Beneficiaries may save money (e.g., through lower premiums or out-of-pocket costs) if they choose lower-cost plans. (The legislation assumes that the lower-cost coverage options will be operated by private plans.) Finally, in contrast to other Medicare benefits, the
new Medicare prescription drug benefit is available only through private plans.

The Balanced Budget Act of 1997 established the Medicare+Choice/Medicare Advantage program (M+C/MA), which included a wide array of health care coverage options for Medicare beneficiaries in addition to original Medicare. MMA renames the M+C/MA program simply the Medicare Advantage (MA) program. (Until December 31, 2005, “M+C/MA” and “MA” are interchangeable.) In addition, the new legislation made several revisions to current law, including the introduction of a new type of plan (regional MA plans), a new payment option for 2004–05, a new payment methodology starting in 2006, and authorization of a premium-support demonstration starting in 2010. These changes are addressed in the following sections on private plans in the Medicare program.

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 pay an additional premium to supplement their Medicare benefits, either through privately purchased Medigap policies or retiree benefits provided through a previous employer. Those who enroll in M+C/MA plans typically do not require Medigap supplemental coverage. A small proportion of Medicare beneficiaries in the fee-for-service program do not have supplemental coverage.

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

- **Coordinated care plans**—There are four types of coordinated plans:
  - 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, most notably prescription drugs. Enrollees must receive all their health care services from the HMO, except for emergency or urgently needed care provided outside the HMO’s service area. HMOs also may offer a point-of-service option that allows a beneficiary to obtain services outside its network for higher out-of-pocket costs.
  - Preferred provider organizations (PPOs) are 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. To stimulate participation of private health plans in the M+C/MA program, the Centers for Medicare and Medicaid

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Services initiated a demonstration program to test PPOs that would operate under different conditions from those mandated for other M+C/MA plans, including different risk-sharing arrangements. In January 2003 these demonstration plans began enrolling members 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). The demonstration program attracted relatively few enrollees, most of whom (74 percent) came from other M+C/MA plans.

■ 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.

■ Regional MA plans were introduced in the MMA. They are authorized to be available beginning in January 2006. Regional MAs are similar but not identical to PPO plans already in Medicare. Regional MA plans cover a much larger service area, and they are eligible for federal subsidies to enter or remain in the Medicare market. In addition, regional MAs must have a single deductible for Part A and B services and include an out-of-pocket limit for in-network care and on expenditures for benefits under the original Medicare fee-for-service program.

■ 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/MA options, physicians in private fee-for-service plans may balance-bill 15 percent above the plan’s fee schedule. As of September 2004 five private fee-for-service plans were offered, with a total enrollment of about 42,000 people. PFFS plans tend to locate in suburban or less densely populated areas. In 2004, 32 percent of Medicare beneficiaries had access to a PFFS plan.

■ Medical savings accounts (MSAs)—The MMA included several incentives to encourage greater participation by MSAs. The demonstration program under which MSAs had been authorized to participate in Medicare was made permanent. In addition, the act lifted the previous capacity limit of 300,000 enrollees, eliminated the deadline for enrollment by January 2003, and dropped the requirement for quality reports. Finally, noncontract providers who provide services to MSA enrollees were made subject to the Medicare balance-billing limitations. Beneficiaries who choose the MSA option may not buy or keep Medicare supplemental (Medigap) insurance to help pay for services not covered in
Private health plans in the Medicare program pose both opportunities and risks for the program and its beneficiaries. On the one hand, having a wide array of private health plan options gives beneficiaries greater opportunities to find 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 more choices in addition to original Medicare, the task of selecting coverage is more complicated. In addition, the Medicare risk pool is inevitably segmented. There is already evidence that the healthiest beneficiaries are likely to enroll in an M+C/MA option, leaving the sicker (hence, most expensive) beneficiaries in original Medicare. In addition, two private health plan options, PFFS plans and MSAs, could cause adverse selection within the M+C/MA program. If these options attract the healthiest beneficiaries, the other options with sicker enrollees could become more expensive over time and eventually be priced out of the market.

Favorable selection in the M+C/MA 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 (including those residing in rural areas) with more choices and enhanced benefits, to make Medicare look more like a private-sector program. These objectives have been retained in the MMA, which contains a new method of paying private plans; subsidies for private health plans to enter and remain in Medicare; and additional choices for beneficiaries, including a new regional PPO option.

Beneficiaries in rural areas particularly have less access to private plan options than those in urban areas. In 2004, 50 percent of beneficiaries who lived in rural areas had access to an M+C/MA option; however, only 16 percent had access to a coordinated care plan. The predominant type of private plan option available in rural areas is private fee-for-service, which does not typically offer prescription drug coverage. Many experts assert that rural areas are unlikely to attract managed care plans (particularly 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. Provisions in the MMA are designed to address this issue, particularly the
authorization of regional MA plans with service areas that cover both rural and urban areas.

Since the inception of the M+C/MA program, almost 2.5 million beneficiaries have been affected by plan withdrawals from Medicare markets. 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 these 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 people have faced rising premiums and a reduction in the extra benefits they received in the past. Nationally, enrollment in M+C/MA HMOs, which grew almost threefold between 1993 and 1997 and continued increasing in 1998 and 1999, began to steadily decline. Since enactment of the MMA, enrollment in MA plans appears to have stabilized.

The MMA included M+C/MA rate increases for the MA plans. The Centers for Medicare and Medicaid Services reported that in 2004, 42 percent of the increases were used to strengthen provider networks; 31 percent, to reduce enrollee premiums; 17 percent, to enhance existing benefits (including additional support for the availability of the Medicare-sponsored drug discount card); and 5 percent, to reduce cost-sharing charges. The remaining 5 percent of funds were used for plan stabilization. (These must be depleted by the end of 2005.)

Medicare HMOs remain an important alternative for many beneficiaries, especially minorities and those with lower incomes. In the past the majority of beneficiaries who disenrolled from their Medicare HMO choose to reenroll in another HMO if one was available.

The past instability in the M+C/MA market calls attention to the importance of preserving and strengthening the original Medicare program.

FEDERAL POLICY

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

Private Health Plans in the Medicare Program: Medicare+Choice/Medicare Advantage

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 private health plan options, such as
health maintenance organizations, preferred provider organizations, provider sponsored organizations and point-of-service plans should be available.

AARP strongly urges Congress and the Centers for Medicare and Medicaid Services (CMS) to monitor carefully the effects of private health plan options by plan type 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 other coverage options. The value of multiple plan types should be assessed.

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

AARP urges CMS to implement risk-adjusted payments to private health plans (see this chapter’s section The Medicare Program—Medicare+Choice/Medicare Advantage—Medicare Payments to Private Health Plans) so that plans with sicker patients are fairly compensated for their costs, and plans with healthier enrollees are not overpaid.

Within each private health plan option, 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, such as trained personnel, to conduct public education and outreach programs. These programs should include information about the right of a private health plan to terminate annually its relationship with Medicare, to change either the benefits (including drug coverage) it offers and/or the premiums and cost-sharing it charges, and to drop providers during the contract year (for further policy on Medigap policies, see this chapter’s section Private Health Insurance—Medicare Supplemental (Medigap) Insurance).
Background

**Medicare Payments to Private Health Plans**

In general, there are payment approaches that apply to Medicare Advantage (MA) plans. The capitation rate paid to private plans contracting with Medicare is the greatest of:

- a blended (i.e., national and local) capitation rate;
- a minimum percentage increase from the previous year—an amount set at 2 percent or the Medicare national growth rate in fee-for-service expenditures, whichever is higher (for 2005, the national growth rate will be 6.6 percent);
- a guaranteed “floor” payment that differs for areas with more than 250,000 people (the urban floor) and rural areas (the rural floor); and
- a rate that is equal to 100 percent of a county’s average fee-for-service costs.

For technical reasons, in 2005 all rates paid to MA plans will be the greater of the 2004 capitation rate plus the minimum percentage increase or the 2005 fee-for-service rate. The Medicare Payment Advisory Commission (MedPAC) has recommended that Medicare payment policies should promote financial neutrality between private plans and the traditional program.

On average, MA per-county payments exceed those in the traditional Medicare program by about 8 percent. Overpayment varies considerably by county. In some locations, Medicare payments to private health plans exceed fee-for-service payments by more than 20 percent.

The capitation payment to private plans is adjusted for a combination of demographic and health factors (e.g., age, disability, gender, institutional status, and other risk factors that the Centers for Medicare and Medicaid Services (CMS) deems appropriate). In 2005, 50 percent of the federal payment to Medicare+Choice/Medicare Advantage (M+C/MA) plans is adjusted for beneficiary health status. Risk-adjusted payment varies for M+C/MA enrollees based on whether they had one or more of 61 medical conditions during the previous year. Data for risk adjustment are derived from inpatient and ambulatory care settings.

For 2005 (as in 2004) CMS implemented risk adjustment to be budget neutral across the program in order to offset the effect of risk adjustment on plans.
To prevent aggregate plan payments from decreasing as a result of the more sensitive risk adjustment methodology now in use, CMS estimated the impact of the new system on aggregate plan payments and restored the difference in plan payments. Budget neutrality had the effect of raising all 2004 rates by almost 5 percent. In 2005 CMS will again apply a budget neutrality policy to risk adjustment, which will increase MA payments by an average of 7 percent. M+C/MA payments are scheduled to fully reflect health risk adjustment factors by 2007.

In 2006 the payment approach will change, and payments to MA plans will be determined by a bidding process. Medicare will compare bids submitted by M+C/MA plans and establish a benchmark for benefits under Parts A and B. The benchmark payment will help determine the federal payment. If the beneficiary selects a plan whose bid is above the benchmark, the beneficiary will pay the difference between the plan’s bid and the benchmark. If the bid is below the benchmark, the beneficiary will receive a rebate, equal to 75 percent of the difference, in the form of additional benefits, reduced cost-sharing, or reduced Part B or Part D premiums. The remaining 25 percent will be retained by Medicare.

The demonstration of competitive pricing and other programs that pay more for better quality service (sometimes called pay-for-performance programs) could provide CMS with an opportunity to test private-sector approaches. (MedPAC has recommended that CMS conduct demonstrations to evaluate provider payment differentials and structures that reward improved quality of care.)

FEDERAL POLICY

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

Medicare Payments to Private Health Plans

AARP does not support paying more to private health plans for providing services to Medicare beneficiaries than covered benefits for the same beneficiaries would cost in the traditional Medicare program. AARP urges Congress to evaluate the impact of the Medicare+Choice/Medicare Advantage (M+C/MA) reimbursement methodology to ensure reasonable participation levels in the Medicare program on the part of private health plans and guarantee that Medicare payments to participating plans are set at appropriate levels.

To ensure that payments to M+C/MA plans are set at appropriate levels, the Centers for Medicare and Medicaid Services (CMS) should implement risk-adjusted payments. Congress should assess the practice of offsetting the effects of risk adjustment by implementing risk adjustment in a budget
neutral manner. CMS should monitor the phase-in and make necessary changes to avoid any significant unintended consequences.

AARP supports payment methodologies, such as competitive bidding, on a demonstration basis only in order to evaluate the impact of new payment methodologies on beneficiaries’ and overall program costs. In addition, CMS should fund demonstration programs to assess pay-for-performance efforts that reward better performance (i.e., higher quality) with higher payments; such demonstrations should include at least one rural site.

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 and perceptions of care, cost of services, and quality of care. The results of the evaluation should be made available to the public.

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**HEALTH CARE COVERAGE** • Publicly Administered Health Insurance
- The Medicare Program • Medicare+Choice/Medicare Advantage

**Background**

**Federal Standards for Medicare Managed Care and Other Private Health Plans**

Several of the private plan models in the Medicare program provide or arrange for the delivery of covered services; they also usually assume risk by insuring specified covered benefits. When administered properly many types of private plans (e.g., those with integrated delivery systems) can oversee total patient care effectively and discourage unnecessary use of services. However, private health plans receive the same level of reimbursement regardless of the number of services they provide, and participating providers may have incentives to skimp on care. Therefore, safeguards must be in place to ensure that financial incentives to control costs do not adversely affect access to or quality of care.

One such safeguard for people with Medicare is the right to disenroll monthly. Under current law, beneficiaries have the right to month-to-month enrollment until December 31, 2005. Other safeguards provide Medicare beneficiaries the right to an independent review of appeals, including an expedited appeal when they believe their condition requires a rapid review of a plan decision. Generally, an expedited decision must be made within 72 hours. A fast-track appeal gives beneficiaries the right to an immediate review by an independent body when a plan discharges them from a skilled-nursing facility, comprehensive outpatient rehabilitation facility, or home health agency and beneficiaries believe services should continue.
Unless quality-of-care standards and other consumer protections are enforced, Medicare beneficiaries whose choice of providers is restricted by their enrollment in a private plan option cannot be confident that they are receiving high-quality care or be assured that corrective action will be taken when a problem is identified.

An important beneficiary safeguard is the regulatory authority that the Centers for Medicare and Medicaid Services (CMS) has to terminate Medicare contracts or exercise other intermediate sanctions. Currently, CMS may terminate a contract with a Medicare+Choice/Medicare Advantage (M+C/MA) organization for several reasons, including its failure to substantially carry out the contract’s terms.

M+C/MA intermediate sanctions include civil money penalties that vary depending on the violation, suspension of enrollment of Medicare beneficiaries, suspension of payment by CMS on behalf of the beneficiaries enrolled, and cessation of the right to market to Medicare beneficiaries.

FEDERAL POLICY

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

Federal Standards for Medicare Managed Care and Other Private Health Plans

All private health plans that serve Medicare beneficiaries should be required to meet federal standards. All participating health plans 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 list 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 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 Protecting and Improving Health and Access to Care—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. 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:
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., the Health Plan Employer Data and Information Set and Consumer Assessment of Health Plans Study);

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 (more than 5 percent) 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 area.

**Enrollment practices and procedures**—All enrollment in Medicare private health 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 private health 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 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 Private Health Insurance—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 Private Health Plans in this chapter’s section).

- 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 care in and out of the network.

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 them 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 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 for 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 their employer drops a plan that includes the patient’s treating physician specialist and to existing enrollees if their previous physician specialist is terminated by the health plan for reasons other than cause. Health plans should facilitate the coordination of care and transition to new providers.

Quality assurance and improvement—Health plans must demonstrate compliance with quality indicators developed specifically for the Medicare population. These indicators must be applicable to the entire range of services, including preventive care and care for chronic illness, and should reflect performance of a plan’s practitioner and institutional contractors. Quality measures should be evidence-based and wherever possible should measure outcomes of care or processes that have a known relationship to outcomes. All private health plans participating in the Medicare program should be engaged in ongoing quality improvement programs (see this chapter’s section The Medicare Program—Medicare+Choice/Medicare Advantage—Quality Oversight and Improvement).

Utilization review/utilization management (UR/UM)—Written 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. 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 the decision; 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 appeals process must meet the specific needs of an older population, taking into account vision or reading difficulties, and 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. In addition, fast-track appeals should be available for those enrollees requesting immediate review of a plan’s discharge decision from a skilled-nursing facility, comprehensive outpatient rehabilitation facility, or home health agency. 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).
Private health plan liability—All private health 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 private health plans should have appropriate access to, information about and protections within clinical trials. Private health 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 and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD), and Department of Veterans Affairs (VA);

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

- sponsored by the VA and conducted under an investigational new drug (IND) application reviewed by the Food and Drug Administration (FDA), exempt from needing an IND application under FDA regulations, or 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 and items and services provided solely to satisfy data collection needs or 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, terminates its agreement with the physician, or suspends its contract with the physician, the 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:

- 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 the insolvency of the health plan or other nonpayment by the health plan;
- 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;
- prohibit balance-billing;
- require the practitioner to participate in and cooperate with quality assurance and utilization review activities of the health plan and of federal agencies conducting external quality reviews;
- 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;

- 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—Private health 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 that applies to the entire health care system and includes civil and criminal penalties for violations.

Data collection and reporting—All health plans serving Medicare beneficiaries must collect and report standardized data that will demonstrate compliance with national standards. Data collected by the plan must be independently audited.

Health plans must provide standardized data on:

- encounters between beneficiaries and clinical personnel;

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

- plan administration costs and personnel;

- beneficiary experience with care;

- complaints and grievances and their resolution;

- physician satisfaction;

- quality assurance or improvement;

- credentialing;

- utilization management or appeals regarding use of out-of-plan services;

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

- rates of physician turnover; and
enrollment or disenrollment.

Ombudsman programs—Consumers should have access to an independent, nonprofit ombudsman program that receives federal and/or state funding. Such programs would assist consumers in understanding a plan’s 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.

Insurance counseling programs should have sufficient funding to provide adequate staff training and meet the demand for assistance among beneficiaries.

CMS should monitor the activities of all private health plans participating in the Medicare program to ensure compliance with all requirements. In the event CMS detects violations, the agency must enforce the requirements through use of intermediate sanctions or contract termination.

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

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 and that care is assessed and improved:

■ 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, which 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 and Consumer Assessment of Health Plans Study. These measures are intended to help CMS and consumers monitor 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/Medicare Advantage (M+C/MA) program complies with certain Medicare requirements. M+C/MA 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.

The Medicare Prescription Drug, Improvement and Modernization Act modified some tools that Medicare will use to oversee quality. In 2006 all MA plans except private fee-for-service and medical savings account plans will be required to have an ongoing chronic care improvement program and a quality improvement program. The quality improvement program (QI) requirements will be altered to provide private health plans with more discretion than they currently have in designing their QI programs. CMS will establish separate rules for MA regional plans on collecting, analyzing and reporting data that permit measurements of health outcomes and other indices of quality.

FEDERAL POLICY

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

Quality Oversight and Improvement

Given the financial incentives integral to the operation of private health plans that receive a capitated payment, AARP supports the need for strict monitoring of compliance with Medicare program requirements, including the quality of care provided. AARP urges Congress to hold all plans in the Medicare program accountable for sustained quality improvement, regardless of model type. Further, Congress should establish a “level playing field” in
the Medicare program by requiring all health plans to collect and report similar information on performance to permit valid comparisons and conduct ongoing quality assurance programs. All plans must have internal quality assurance 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 take 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 private health plans should ensure that regulators and policymakers can evaluate the quality of care in the Medicare+Choice/Medicare Advantage (M+C/MA) 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:

■ provide 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;

■ educate practitioners about new practice guidelines and outcomes research;

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

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

■ refer cases that show seriously poor-quality care to state licensing and regulatory authorities and/or federal authorities, as appropriate; and

■ propose systems to prevent medical error.
The quality improvement organization (QIO) performance measurement system for private health plans should include measures of access to and timeliness of care, including referrals, appropriateness of 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.

The Centers for Medicare and Medicaid Services (CMS) must be aggressive in its efforts to provide the public with provider-specific information about QIO findings concerning performance of the M+C/MA contractors (for further discussion of QIOs, see this chapter’s 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 private health 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 the agency 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:

- 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;

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

- 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 PAOs is publicly disclosed, including the individual’s qualifications and affiliations;

PAO surveys 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.

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

Compliance with federal standards or deeming by a PAO 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/MA organizations.

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

Background

Consumer Information

The conceptual framework of the Medicare+Choice/Medicare Advantage (M+C/MA) program assumes that Medicare beneficiaries value choice and will be able to make informed health care decisions. As the Medicare program becomes more market driven and enrollment in the M+C/MA program grows, the need to provide beneficiaries with accurate, concise and understandable information about the availability, quality and outcomes of Medicare services is becoming 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, and how do beneficiaries’ literacy levels affect their ability to make informed decisions? How can information be tailored to meet the diverse needs of a diverse population? How useful is the information beneficiaries currently receive? How should information be formatted and disseminated to consumers? (See this chapter’s section The Medicare Program—Medicare+Choice/Medicare Advantage—Federal Standards for Medicare Managed Care and Other Private Health Plans for details concerning standards on data collection and reporting.)
FEDERAL POLICY

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

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. The Centers for Medicare and Medicaid Services (CMS) should continue to expand the use of the Consumer Assessment of Health Plans Study (CAHPS) as new instruments to measure hospital, 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, the data 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 want and how data are communicated to them. Literacy and health literacy levels should be taken into account in developing consumer information.

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

Introduction

Beneficiary Costs

The creation of Medicare in 1965 dramatically increased access to acute health care services for most elderly people. While only about half of older Americans had any health insurance before 1965, most people age 65 and older are now covered by Medicare Part A (Hospital Insurance). In addition, 95 percent of older Medicare beneficiaries in Part A also enroll in Part B (Supplementary Medical Insurance) coverage through payment of a monthly premium. Medicare also has become an important source of insurance for people under age 65 who receive Social Security Disability Insurance and those with end-stage renal disease. The proportion of noninstitutionalized Medicare beneficiaries under age 65 increased from 7 percent in 1972 to 15 percent in 2003. However, rising health care costs and increasing cost-sharing requirements over the years have gradually eroded Medicare's protection.

Background

Beneficiary Out-of-Pocket Spending

Medicare beneficiaries are financially responsible for coinsurance, deductibles and Part B premiums (Figure 6-1), as well as for the costs of services and products Medicare does not cover. It is estimated that in 2003, older beneficiaries living in the community spent an average of $3,455 out of pocket, or 22 percent of their income, on health care costs (Figures 6-2 and 6-3). Beneficiaries under age 65 spent $2,765 on average on health care, or 19 percent of their income. These costs include Medicare cost-sharing payments, Medicare Part B and private insurance premiums, and payments for goods and services Medicare did not cover in 2003 (including most outpatient prescription drugs). It excludes the costs of home health care and long-term nursing facility services. Other than health care premiums, prescription drugs represent on average the largest component of beneficiaries’ out-of-pocket spending on health care.
### Figure 6-1

**Medicare Deductibles, Coinsurance and Premium Amounts, 2005**

<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>Deductible $110 per year</td>
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<tr>
<td>$912 per benefit period</td>
<td>20 percent of Medicare allowable charges</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Part B monthly premium $78.20</td>
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<td>$228 per day for the 61st to 90th day of each benefit period</td>
<td></td>
</tr>
<tr>
<td>$456 per day for the 91st to 150th day of each benefit period</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled-nursing facility</strong></td>
<td><strong>Part B monthly premium $78.20</strong></td>
</tr>
<tr>
<td>$114 per day for the 21st to 100th day of each benefit period</td>
<td></td>
</tr>
</tbody>
</table>


### Figure 6-2

**Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,* by Type of Service, 2003**

- **Total = $3,455**

*Noninstitutionalized Medicare beneficiaries age 65 and older.

**Includes costs for short-term nursing facility care only.

***The Medicare Benefits Model does not separate spending on physician services or supplier and vision items. However, prior studies suggest that out-of-pocket spending for physician services accounts for about 85 percent of the combined physician-vision spending. See Gross, et al., Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections, AARP Public Policy Institute.

Note: Figures may not add up to 100 percent due to rounding.

In 2003, about nine out of ten beneficiaries age 65 and older received help paying for Medicare’s cost-sharing requirements through supplemental insurance such as Medicaid, private insurance (i.e., employer-sponsored insurance or individually purchased Medigap) or a private Medicare 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 7 percent of older beneficiaries with only original Medicare were fully responsible for all their health care bills, unless they were 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, more than half of older beneficiaries with incomes below the poverty level (about 1.8 million beneficiaries) did not receive Medicaid assistance in 2003. 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 but who were not enrolled in Medicaid were estimated to have spent an average of about half of their income on out-of-pocket health costs in 2003. Those with employer-sponsored or Medigap coverage spent the greatest share—almost 65 percent of their income, on average—while those with only Medicare coverage spent about 35 percent (Figure 6-4). Poor beneficiaries may not receive Medicaid because they do not meet the federal categorical requirements or the state income and asset limits.

Figure 6-3
Average Out-of-Pocket Spending on Health Care as a Percentage of Income by Medicare Beneficiaries,*
by Income Level, 2003

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Total</th>
<th>&lt;135%</th>
<th>135–200%</th>
<th>200–400%</th>
<th>&gt;400%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22%</td>
<td>33%</td>
<td>28%</td>
<td>21%</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Noninstitutionalized Medicare beneficiaries age 65 and older.
**In 2003 the federal poverty thresholds for people age 65 and older were $8,825 for individuals and $11,122 for couples.
requirements; others who meet those eligibility requirements may decline to participate or not realize they are eligible for benefits.

The costs of long-term care may pose another significant out-of-pocket burden. For example, the average annual cost of nursing home care was $57,700 in 2003. Few beneficiaries purchase private long-term care coverage, primarily because of its 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 $1,337 in 2002; for a 79-year-old, it was $5,330. The cost of this coverage increases dramatically with age and can more than double when inflation protection and nonforfeiture benefits are added.

Reforms to Medicare’s cost-sharing or provider payments can directly or indirectly affect beneficiaries’ out-of-pocket spending. For example, raising the Medicare Part A deductible directly increases beneficiaries’ out-of-pocket spending if they lack supplemental coverage for the deductible; it also indirectly increases spending for those who are covered (through higher private supplemental insurance premiums). Even reforms that are seemingly unrelated to beneficiaries can affect their out-of-pocket spending. For example, payment increases to physicians raise Part B spending. Since Part B premiums and coinsurance payments are a function of Part B spending, increases in spending translate into increases in out-of-pocket costs for beneficiaries. Beneficiaries face the largest Part B premium increase in the program’s history in 2005 ($11.60) due to a combination of factors, including

*In 2003 the federal poverty thresholds for people age 65 and older were $8,825 (for individuals) and $11,122 (for couples).
**Noninstitutionalized Medicare beneficiaries age 65 and older.
provider payment increases (e.g., for physicians, rural health providers and Medicare Advantage plans) and higher than previously anticipated Part B costs in general. In 2005 the Part B deductible also increases, from $100—the level at which it had been from 1991 to 2004—to $110, due to a statutory change. Starting in 2006, the Part B deductible will increase annually by the growth in Part B costs.

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 and premiums for current benefits.

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

When considering program changes (e.g., cost-sharing or provider reimbursement reforms), Congress should explicitly analyze and report on the direct and indirect effects on beneficiaries’ out-of-pocket spending.

Background

Beneficiary Coinsurance for Hospital Outpatient Services

A loophole regarding payment for hospital outpatient services often causes Medicare beneficiaries to pay more than 20 percent of the Medicare-approved charge for services such as one-day surgery, diagnostic tests and radiology. Medicare beneficiaries currently are liable for up to 45 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 (known as the “buy-down”) 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 ($912 in 2005). 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 accelerating the buy-down of 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.

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

**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. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 allows other providers—dentists, podiatrists and optometrists—to enter into private contracts. Under a private contract, a beneficiary agrees to pay 100 percent of the amount the physician charges for services under 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 that the physician sign the contract in advance of treatment. The contract must state 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 for these services, and the services 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.

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 nonparticipating physicians’ allowed charge. The average annual beneficiary liability for balance-billing is small; however, the extent of balance-billing varies by specialty and geographic location.
Although previous enforcement of balance-billing limits had been lax, it appears that most physicians are now complying with these limits. Most physicians are 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 2003, 91 percent of physicians who billed Medicare were enrolled in the program as a participating physician.

The Centers for Medicare and Medicaid Services has the authority to sanction any physician who knowingly, willfully and repeatedly charges in excess of the balance-billing rate. States also may protect 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 should continue to encourage physicians to sign voluntary participation agreements and closely monitor and aggressively enforce the balance-billing limit.

**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.

Where possible, public policies should be designed so that state medical societies encourage their members to accept assignment for all Medicare patients.
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. ABNs are not considered private contracts.

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.

Unlike in Medicare, enrollees and providers under most private insurance contracts can request and obtain assurances that a procedure or claim will be covered prior to submission of the claim. This is particularly the case for higher-cost services; in fact, the health plan may require preauthorization for certain services. As part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Congress is implementing a system of prior determination in Medicare for certain items and services.

FEDERAL POLICY

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.

Providers’ routine use of ABNs should be prohibited.
CMS should closely monitor the system of prior determination in Medicare to ensure that it is applied as fairly and broadly as feasible.

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

**Background**

**Medicare’s Use of Program Information**

Medicare beneficiaries can be confused by the complexities of the system’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**

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

**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. The agency also should ensure that Medicare beneficiaries are provided with:

- clear, accurate and easily accessible information;
- prompt and accurate claims processing;
- an explanation of the Medicare benefits form for all claims for payment;
- effective follow-through on beneficiary fraud and abuse complaints;
- claim-by-claim enforcement of the law that limits charges; 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;
- encourage 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 through 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 cancer 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. In 2005 the program will cover initial preventive physical examinations for new enrollees and for cardiovascular and diabetes screening. Medicare beneficiaries who have been diagnosed with either cardiovascular disease or diabetes are not eligible to receive these screening examinations.

In spite of efforts to ensure the use of preventive services by Medicare beneficiaries, racial and ethnic disparities in their use persist. For example, among Medicare beneficiaries, elderly African-Americans have lower rates of utilization of preventive services (e.g., influenza immunizations). The causes of these disparities, which exist not just in Medicare but throughout the health care system, are not well understood.
The US Preventive Services Task Force—an independent panel of experts in primary care and prevention—was convened by the federal Public Health Service to evaluate clinical research that assesses the merits of preventive measures such as screening tests, counseling, immunization and chemoprevention. The task force 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.

**FEDERAL POLICY**

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

**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. This would encourage beneficiaries to pursue prevention and early detection of new conditions and would avoid or delay further complications from existing conditions.

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, the US Preventive Service Task Force, or the Centers for Medicare and Medicaid Services (CMS).

To realize the value of covered preventive and screening services, Congress and CMS 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 that Medicare does not cover.

Congress should adequately fund research to identify and address the cause(s) of racial and ethnic disparities in the use of Medicare-covered preventive services.
Durable Medical Equipment

Durable medical equipment (DME) includes medical supplies and products such as wheelchairs and walkers. Together with oxygen, prosthetics, orthotics and supplies, DME is referred to collectively under Medicare as durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) and is reimbursed under Part B. The Medicare program is estimated to have spent $7.7 billion on DMEPOS in 2001. Fraud and abuse associated with DMEPOS 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 (CMS) with their Social Security numbers and requires new suppliers who wish to do business with Medicare to post surety bonds. However, the surety bond requirement has been temporarily suspended.

In response to the Medicare Prescription Drug, Improvement and Modernization Act, the Department of Health and Human Services has proposed regulations that would impose accreditation and quality assurance standards on DMEPOS suppliers. Separate provisions of the law seek to curb inappropriate utilization of DMEPOS by requiring a physician or other health care professional to visit each patient in person before prescribing and certifying the medical necessity of DMEPOS. Finally, the new Medicare law requires that competitive bidding for DMEPOS suppliers be phased in over four years, starting in 2007. In areas of the country not subject to competitive bidding, CMS will be permitted to substitute DMEPOS prices submitted by competitive bidders in place of amounts from existing fee schedules. Regulatory implementation of these provisions could affect Medicare beneficiaries’ access to DMEPOS, particularly during the early stages of these changes.

FEDERAL POLICY

Durable Medical Equipment

AARP supports the reforms implemented to reduce fraud and abuse associated with durable medical equipment (DME). The Department of Health and Human Services (HHS) should continue to monitor and control the incidence of fraud and abuse associated with DME.
AARP supports the use of competitive bidding in all types of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) where it has been demonstrated that quality and access are not compromised by the competitive bidding process.

AARP urges HHS to develop strict implementing regulations for accreditation of, and minimum quality standards for, DMEPOS suppliers. These should deter unnecessary utilization of DMEPOS supplies while assuring Medicare beneficiaries access to safe, good quality, medically necessary and appropriate DMEPOS supplies. The HHS should monitor and publicly report on whether Medicare beneficiaries and the program are receiving appropriate quality of service and value for DMEPOS supplies, as indicated by their safety, cleanliness and cost. In particular, HHS should monitor Medicare beneficiaries’ access to DMEPOS during and after implementation of forthcoming regulations.

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

Introduction

Access Issues

In Medicare, “access to care” refers to the ease with which beneficiaries seek out or use Medicare-covered 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 private Medicare 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. MedPAC found that while 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 private Medicare plan payment policies in rural areas, as well as weaknesses in Medicare’s systems for monitoring quality of care in rural areas.
Background

Hospitals

In 1984 Medicare tightened its control over payments to hospitals by implementing a new prospective payment system (PPS) for inpatient services that uses predetermined per-case payment rates. In the years following the implementation of the PPS, many hospitals’ Medicare inpatient margins (the measure of a hospital’s profitability from its Medicare inpatient operations) decreased. However, this trend reversed after 1991, and in the mid-1990s most hospitals’ Medicare inpatient margins steeply increased.

The Balanced Budget Act of 1997 (BBA) included provisions that were implemented to reduce spending growth for inpatient hospital services. The act also established new PPS systems for Medicare outpatient department services and for different postacute services (e.g., home health care and skilled-nursing facility). Between 1997 and 2002, many hospitals’ overall Medicare margins (the measure of a hospital’s profitability from its combined Medicare inpatient, outpatient, and postacute operations) decreased from their peak level in 1997. Legislation passed by Congress in 1999 and 2000 modified some of the BBA limits affecting hospitals, and some provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) benefited certain hospitals, particularly those in rural areas. However, predicting the future path of Medicare margins is difficult, given the uncertainty about hospital costs and the overall impact of the MMA and other legislative changes on Medicare payments.

In addition to paying for beneficiary services, Medicare (primarily Part A) provides special subsidies to teaching hospitals, facilities that serve a disproportionate share of low-income people, and certain rural hospitals paid under the PPS. (Other small hospitals in rural areas can qualify as critical access hospitals and receive cost-based—rather than PPS-based—reimbursement through Medicare.) One category of subsidy, the graduate medical education (GME) subsidy—about $8 billion in fiscal year 2002—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.

Some observers argue that the GME subsidy should not come from Medicare, since teaching hospitals perform important functions that benefit the entire health system. For example, such hospitals train physicians in the latest practice techniques, care for patients with complicated illnesses that require services other hospitals often cannot provide, engage in medical research, and develop technological innovations.
In its March 2004 report to Congress, the Medicare Payment Advisory Commission reported that access to hospital services was not a problem for most beneficiaries. Most hospitals have low occupancy rates, which suggests that hospitals have sufficient capacity available to treat Medicare beneficiaries. Large enough reductions in the growth of Medicare’s hospital payments, however, could result in some hospitals reducing staffing levels or closing, particularly those with low operating margins such as rural hospitals, inner-city teaching hospitals and public hospitals. These changes 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 how Medicare payments to hospitals are affecting access to and quality of care in inpatient and outpatient settings, 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.

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.

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.

Annual payment updates to the fee schedule are based on a complex formula known as the “sustainable growth rate” (SGR), which was designed to account for practice (or input) costs and to control overall spending. The SGR, which is the target rate of growth in spending for physician services, is a function of the percentage change in input costs for physician services and
other factors such as the per capita growth in real gross domestic product (GDP). Under the SGR formula, a recession (or negative GDP growth) could reduce the increase in physician payment rates from the level it would be otherwise, despite the rise in the physicians’ underlying (input) costs. Indeed, in part due to a recession in 2001, physicians saw reductions in their Medicare reimbursements in 2002, an unintended result of the SGR formula. (Calculation errors in previous years’ SGR computations also contributed to the 2002 decline.) Legislation passed in 2003 reversed scheduled payment decreases in 2003, and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) instituted payment increases of 1.5 percent in both 2004 and 2005. Physicians in rural areas also received additional payment increases.

As was the case with the fee schedule’s initial implementation, 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. Further, as a result of the MMA, reimbursement for Part B—covered drugs administered in a doctor’s office has been reduced. (The MMA also requires the Medicare Payment Advisory Commission (MedPAC) to review the impact of the payment changes and report its findings by January 2006 and January 2007.) Reductions in reimbursement rates could cause access problems for Medicare beneficiaries, 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 some locales, data show that this has not been a nationwide trend.

Recently, a small number of physicians who participate in Medicare in various geographic areas have adopted “boutique medicine” (or “concierge care”) arrangements. These arrangements require patients to pay an annual fee for services not covered by Medicare, such as certain preventive benefits (e.g., annual physicals). Patients who do not pay the additional fee are typically no longer able to see the physician. Physicians who have adopted such practices contend that they allow the physician to spend more time with and devote more attention to the patient. Critics argue that these arrangements discriminate against lower-income beneficiaries, who might have difficulty paying the annual fee. Further, some contend that paying an annual fee might violate Medicare regulations, because physicians are not permitted to collect a fee from the patient and also bill Medicare for a service. (If the annual fee under the arrangement includes payment for Medicare-covered services, such an agreement may result in duplicate payment or in a violation of Medicare’s assignment rules.)

In March 2004 MedPAC released its findings regarding Medicare beneficiary access to care based on its analysis of the 2000 and 2001 Medicare Current Beneficiary Surveys. The commission found that access for most beneficiaries appeared to remain good. The commission also examined
results from other surveys conducted between 2000 and 2003, which indicated that access to physicians was good overall. The commission did find access problems were more likely to occur for beneficiaries who are Hispanic or African-American, who lack supplemental insurance, or who have both Medicare and Medicaid coverage. In general, these beneficiaries were more likely than others to report having trouble receiving health care services, having delayed care because of cost, or not having a usual source of care or doctor.

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.

**FEDERAL POLICY**

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

**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, including physician services and Part B—covered drugs, in all Medicare settings. The agencies also should develop a clear plan to address any access problems, particularly those related to the adequacy of Medicare payments to physicians.

CMS should continue making public the data on access and health care utilization and all relevant information from the Medicare Current Beneficiary Survey. The agency also should pay particular attention to access problems of special populations, including beneficiaries in rural areas and US territories and commonwealths, people with disabilities, low-income individuals, minorities, beneficiaries with end-stage renal disease, and people living in institutions and in communities where access problems are common because of a health care personnel shortage.

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

Congress should develop a more stable formula for updating Medicare’s payments to physicians. However, Congress should also consider ways to protect beneficiaries from extraordinary premium increases in the event that physician payments rise as a result of these or other legislative changes.
CMS should monitor the impact of Medicare “concierge care” or “boutique medicine” arrangements on access to care.

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

Background

Postacute and Subacute Care

In Medicare, “postacute care” generally refers to services, such as skilled nursing and rehabilitation therapy, that beneficiaries need following inpatient hospitalization. The most common postacute care 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 an SNF and later from the SNF to the care of a home health agency.

For postacute institutional care, such as in a SNF, the Medicare benefit is conditioned upon a prior hospitalization of at least three days. Beneficiaries in SNFs must pay daily coinsurance amounts of one-eighth of the Medicare hospital deductible ($114 in 2005) from the 21st day to the 100th day. Thereafter, beneficiaries are liable for the full cost of skilled or custodial care which, in 2003, averaged about $4,750 per month for a semiprivate room, according to industry sources.

To receive home health care, including the services of a home health aide, there is no requirement of prior hospitalization. In fact, not all home health users are postacute in the sense of having been recently hospitalized. However, Medicare requires that a beneficiary must be homebound—that is, able to leave home only with great difficulty and for short, infrequent absences (e.g., to visit the doctor)—and need skilled care, including nursing, physical therapy, occupational therapy or speech therapy. Such 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 must be ordered by a physician but are not subject to deductibles or coinsurance.

Between the mid-1980s and mid-1990s, the rate of growth in payments for SNF care, home health services, rehabilitation therapy services and long-term care hospitals exceeded that for the rest of Medicare’s program benefits. This growth was attributed to increased home health utilization; uncontrolled growth in the costs of nonroutine items and services, such as therapies, medical equipment and supplies; and increased fraud and abuse. To contain costs the Balanced Budget Act of 1997 (BBA) mandated a prospective
payment system (PPS) for SNFs, home health agencies, inpatient rehabilitation facilities and long-term care hospitals.

Under the 1998 payment system, for SNF care, facilities are paid a per diem amount, determined by the beneficiary’s classification in one of 44 resource utilization groups, known as RUG-III categories. The home health PPS was implemented in October 2000. Other BBA reforms include annual payment caps for rehabilitation therapy services in outpatient settings except hospital outpatient departments. These caps, which restrict Medicare coverage for rehabilitation therapy, were in effect for one year during 1999 but were suspended under a moratorium that began in January 2000. Payment caps were reimposed in September 2003, at $1,590 for physical therapy and speech therapy combined and $1,590 for occupational therapy. The Medicare Prescription Drug, Improvement and Modernization Act again suspended these caps from December 2003 through 2005.

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 the patient and/or family to meet care needs 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 postacute payment systems are likely to adversely affect some of these patients. Policymakers and analysts are closely studying the effects of the BBA on access and quality. Reports indicate that the transition of postacute care services to prospective payment has reduced utilization of home health services and rehabilitation therapy services, particularly for the oldest and sickest patients. Reductions in utilization were most apparent for patients who were receiving outpatient rehabilitation therapy and exceeded the 1999 Medicare payment caps. The impact of declines in utilization of postacute services on access to services, quality of care and health outcomes has not been adequately evaluated.

In addition to implementing payment reforms, the Centers for Medicare and Medicaid Services (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 (see this chapter’s section Health Care Coverage—Publicly Administered Health Insurance—The Medicare Program—Medicare+Choice —Quality Oversight and Improvement—Background for discussion of Medicare quality improvement organizations and public reporting initiatives).

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. Although OASIS initially collected a fairly extensive amount of data, the range of data is now 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. Recent Medicare legislation suspended the requirement that home health agencies collect OASIS data for non-Medicare and non-Medicaid patients, in order to reduce documentation and reporting burdens. This has increased the possibility that data are not being collected and monitored to allow adequate assessment of quality and outcomes for private patients.

The National Quality Forum (NQF), a private, voluntary consensus standard-setting organization, is considering voluntary industry consensus guidelines for indicators of quality performance by home health agencies. These indicators could form the basis for modifying OASIS and expanding the data it collects. NQF expects to recommend that its quality indicators be adopted by CMS and reported for all home health users.

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:

- The SNF coinsurance amount is substantial. 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.

- Medicare does not pay for SNF services beyond 100 days, leaving Medicare beneficiaries with the potential responsibility of paying the full cost of SNF care.

- The requirement of prior hospitalization for SNF eligibility means that Medicare beneficiaries 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 Medicare SNF benefit. In addition, the requirement creates a perverse incentive to hospitalize Medicare beneficiaries so that they can qualify for the SNF benefit.

- Medicare coverage criteria for home health services still contain a "homebound" requirement, despite recent clarification by CMS that this term is intended to allow the home health user to leave the home to receive treatment at adult day care or attend religious services.
Medicare’s definition of “homebound” will be relaxed in a demonstration program that will allow severely disabled beneficiaries to receive Medicare coverage for home health services even if they leave the home for errands and social reasons. The demonstration will be limited to 15,000 beneficiaries in three states for two years.

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. The program’s PPS encourages home health agencies to avoid high-cost users.

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

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

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 services, skilled-nursing facility (SNF) care, long-term care hospitals and outpatient therapy services) and the appropriateness of care in various settings.

Congress should fund comparative research on the clinical and cost-effectiveness of rehabilitation therapy across inpatient and outpatient settings for various patient populations.

Congress should fund research to establish clinical norms for appropriate postacute care levels, particularly for home health users.
Future postacute policy proposals should be informed by careful research on access to 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 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 Medicare SNF coinsurance obligation,
- increase the number of Medicare covered SNF days,
- remove Medicare’s prior-hospitalization requirement for new SNF admissions,
- maintain home health benefits free of copayments, and
- repeal payment caps for outpatient rehabilitation therapy.

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 Services and Supports);
- using data sets, such as the Outcome and Assessment Information Set (OASIS) and others, to measure and improve home health outcomes—Efforts to streamline OASIS must ensure its role in outcome measurement and quality improvement and not dilute it into a tool used only for determining payment amounts. Further, OASIS data should be used and reported for all patients, not just those in Medicare or Medicaid;
- reestablishing the OASIS reporting requirement for all patients, not just Medicare and Medicaid beneficiaries;
- 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.
Background

Mental Health

The need for mental health services for older Americans has not been met adequately. According to estimates, a minimum of about 40 percent of older people in the community have unmet mental health needs (see Chapter 7, Long-Term Services and Supports 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 such abuse and protect beneficiaries.

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 for 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 coinsurance rate for Medicare outpatient mental health therapy services, currently set at 50 percent, should be 20 percent. This would make such services more affordable 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 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**

Traditional Medicare covers all items and services that are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” The Medicare statute specifically excludes coverage for certain items and services, such as cosmetic surgery. Health maintenance organizations that treat Medicare beneficiaries must cover all items and services covered under Parts A and B and may cover additional services.

The Centers for Medicare and Medicaid Services (CMS) has authority to make national coverage determinations regarding whether and when Medicare will include a new medical technology, such as a medical device, drug or surgical procedure, as a covered benefit. Most commonly, CMS makes such determinations in the case of items or services that are unusually expensive (e.g., implantable defibrillators), represent dramatic improvements or breakthroughs in the standard of care, or are not effective (for example, because they are outmoded or evidence suggests they are ineffective). CMS has made national coverage determinations for only a few hundred items and services. In addition to making individual claim determinations, Medicare contractors (i.e., fiscal intermediaries and carriers) will continue to make thousands of local coverage determinations for items and services that are not specifically excluded by statute or national coverage determinations.

Medicare coverage criteria are based on clinical efficacy and do not explicitly take cost into account. Although CMS has authority to change the criteria for coverage determinations, and previously has proposed to incorporate cost as a factor, the agency withdrew this proposal to make coverage decisions based on cost or cost-effectiveness.

Recently, it has been suggested that concepts such as “therapeutic equivalence” and “functional equivalence” might serve to help contain
Medicare program costs. But the use of these terms without specific definition or explanation has created some confusion regarding their policy implications for Medicare. Nevertheless, both of these terms imply that some drugs, devices, procedures and other interventions, while not identical, serve clinically comparable functions and may offer appropriate substitutes for each other. In the context of Medicare coverage policy, therapeutic or functional equivalence would probably mean that lower-cost substitutes would receive more favorable coverage terms.

Advocates of these concepts suggest that they could apply first to drugs (such as gastric antacids) that are not generic equivalents but may produce therapeutically or functionally equivalent clinical effects. Questions have been raised about the apparent similarity of functional equivalence within a drug formulary (see this chapter’s section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Prescription Drugs and Pharmacy Practices for information about pharmacy benefit management, therapeutic substitution and drug formularies).

Neither the Food and Drug Administration, nor any other federal agency, assesses the relative effectiveness of therapeutically or functionally similar drugs, devices or procedures. While independent clinical research has been performed regarding the comparative effectiveness of some drugs and technologies, the extent of this research is limited. To date, the application of therapeutic or functional equivalence to federal policy has not been well described nor have the criteria or process for determining equivalence been clearly articulated.

**FEDERAL POLICY**

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

- The Medicare Program • Original Medicare

**Medicare’s Coverage of New Technologies**

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

The Centers for Medicare and Medicaid Services (CMS) should provide timely public notice and an opportunity for public input before deciding whether Medicare will cover 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 supports efforts to provide objective information on the comparative effectiveness of technologies in order to enhance decisions on Medicare coverage for the safest and most effective treatment at the lowest cost.

Congress should fund independent clinical research that compares the effectiveness of therapeutically similar devices, procedures and other interventions.

Determinations of drugs’ therapeutic or functional equivalence should comply with AARP policy recommendations for drug formularies, such as appropriate oversight and a provision for medical exceptions (see this chapter’s section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Prescription Drugs and Pharmacy Practices—Federal & State Policy for recommendations related to prescription drugs and formularies).

CMS should continue to develop and evaluate policies and procedures for applying research into comparative effectiveness in the context of functional and therapeutic equivalence. These concepts should be considered in an open and public process for their applicability to coverage policy under fee-for-service Medicare when parameters for their implementation are better defined, the implications of such determinations have been evaluated on a case-by-case basis, and coverage for medically necessary services can be ensured.

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

**Background**

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

Until 2006 Medicare will not pay for most 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. Medicare beneficiaries incurred an estimated average of $999 in out-of-pocket costs for prescription drugs in 2003 (the last year for which data are available). High out-of-pocket prescription drug spending is less a function of income than insurance status (i.e., whether a beneficiary has prescription drug coverage and the breadth of that coverage), health status or number of chronic conditions.

About two-thirds of Medicare beneficiaries have some form of supplemental coverage for prescription drugs, but about 40 percent 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 Advantage (MA) plans can change their benefits on an annual basis or even withdraw from the program. Employer-sponsored prescription drug coverage is becoming less generous and less common. Annual increases in Medigap premium costs are making those policies less and less affordable.

The absence of Medicare prescription drug coverage 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 costs for some treatments could result. Evidence from at least one study of Medicaid beneficiaries suggests that lack of access to prescription drugs can increase other health care costs of chronically ill elderly people. Although the magnitude of the effects on 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 nondrug health care costs.

In 2003 the Medicare Prescription Drug, Improvement and Modernization Act was enacted to provide prescription drug coverage to Medicare beneficiaries. This new law created a voluntary prescription drug benefit within Medicare beginning in 2006. It also established a prescription drug discount card program starting in 2004 (with subsidies for low-income beneficiaries). Key features of the new Medicare drug benefit include the following:

- **All beneficiaries will have access to drug coverage, including those who stay in original Medicare.** All beneficiaries, including those who choose to remain in original Medicare, have the option of enrolling in a stand-alone private prescription drug plan (PDP). Alternatively, where available, beneficiaries may enroll in a MA plan that offers drug coverage.

- **Plans will be available in all geographic areas.** The new law guarantees that all beneficiaries—including those in rural areas—will have access to drug plans in their area. Medicare will be required to
negotiate reduced-risk contracts with private plans if a region has fewer than two approved plans (including at least one stand-alone PDP).

- **Plans must offer coverage that is at least actuarially equivalent to a standard benefit defined in law.** The dollar amounts shown in Figure 6-5 are for 2006 and will increase each year based on the growth in average per capita drug spending by Medicare beneficiaries.

<table>
<thead>
<tr>
<th>Annual deductible</th>
<th>$250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost-sharing</td>
<td>25% coinsurance until total drug spending reaches $2,250</td>
</tr>
<tr>
<td>Gap in coverage (also called the doughnut hole)</td>
<td>No coverage between $2,250 in total drug spending and $3,600 in out-of-pocket drug spending (i.e., $5,100 in total drug spending for beneficiaries with no other drug coverage)</td>
</tr>
<tr>
<td>Catastrophic coverage</td>
<td>5% coinsurance or copayment of $2 generic/$5 brand ( whichever is greater) once out-of-pocket drug spending reaches $3,600</td>
</tr>
<tr>
<td>Estimated average monthly premium</td>
<td>$35</td>
</tr>
</tbody>
</table>


- **Low-income beneficiaries will receive extra assistance.** The legislation provides additional subsidies to lower-income beneficiaries, including all full dual-eligibles (that is, Medicare beneficiaries who are also eligible for all Medicaid benefits). Premium and cost amounts in Figure 6-6 are for 2006 and will rise in future years based on increases in prescription drug costs. However, about 10 percent of beneficiaries who are eligible on the basis of income will not be eligible for such assistance because they will not meet the required asset test.

- **Beneficiaries will face penalties for late enrollment, as they do in Part B.** 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, less-healthy pool. To minimize the costs associated with adverse risk selection in the voluntary drug benefit, the law requires that extra premiums be charged to beneficiaries who do not enroll within six months of becoming eligible.

- **Beneficiaries will have access to their plans’ price discounts for out-of-pocket purchases.** 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 for...
sales to beneficiaries who have prescription drug benefits. By extending the plan’s price discount to beneficiaries’ out-of-pocket purchases (i.e., Medicare-covered drugs purchased when the deductible or “doughnut hole” applies) lower prices would be available to beneficiaries.

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**Figure 6-6**

**Low-Income Assistance**

**Under Medicare Prescription Drug Benefit, 2006**

<table>
<thead>
<tr>
<th>Beneficiary Characteristics</th>
<th>Income up to 135% of federal poverty level and assets below $6,000**</th>
<th>Income up to 135% of federal poverty level and assets below $10,000*</th>
<th>Income between 135% and 150% of federal poverty level and assets below $10,000*</th>
</tr>
</thead>
</table>
| Dual-eligibles with incomes below 100% of federal poverty level* | • No premium  
• No deductible  
• No coverage gap  
• $1 copay for generics  
• $3 copay for brand-names  
• No copay if in nursing home  
• No copayment over catastrophic limit | • No premium  
• No deductible  
• No coverage gap  
• $2 copay for generics  
• $5 copay for brand-names  
• No copayment over catastrophic limit | • Sliding-scale premium  
• $50 deductible  
• No coverage gap  
• 15% coinsurance  
• $2 generic or $5 brand-name copayment over the catastrophic limit |
| Income up to 135% of federal poverty level and assets below $6,000** | • No premium  
• No deductible  
• No coverage gap  
• $2 copay for generics  
• $5 copay for brand-names  
• No copayment over catastrophic limit | • No premium  
• $50 deductible  
• No coverage gap  
• 15% coinsurance  
• $2 generic or $5 brand-name copayment over the catastrophic limit | • Sliding-scale premium  
• $50 deductible  
• No coverage gap  
• 15% coinsurance  
• $2 generic or $5 brand-name copayment over the catastrophic limit |

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- **Beneficiaries have access to an interim Medicare discount card, with subsidies for lower-income beneficiaries.** Medicare-endorsed discount cards offered by private entities have been available since June 2004 and are good through 2005. These cards allow beneficiaries without Medicaid coverage to obtain discounts until the drug benefit takes effect. The cards have offered an average savings of nearly 20 percent on widely used brand-name prescription drugs and over 65 percent on widely used generic drugs. In addition, beneficiaries who have incomes up to 135 percent of the poverty level and do not have drug coverage will be able to receive a $600 annual credit on their card and will not be required to pay the card’s annual fee of up to $30. They will, however, be required to make small copayments on some of their purchases.

Despite the creation of a Medicare drug benefit, a number of aspects of the benefit will need to be improved over time and others will require continued monitoring as the law is implemented. For example, critics contend that the new benefit—particularly with its substantial gap in coverage, or “doughnut hole”—does not provide comprehensive coverage of sufficient value to attract broad participation. Without broad participation, a benefit that lacks
mandatory enrollment will overwhelmingly attract beneficiaries with higher drug costs; this threatens the long-term affordability and viability of the benefit. 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 approaches.

Another concern involves those who are dually eligible for both Medicare and Medicaid benefits. All beneficiaries eligible for full Medicaid benefits could also enroll in the Medicare drug benefit; dual-eligibles would not be able to receive Medicaid benefits for Medicare-covered drugs. Therefore, the concern is whether some beneficiaries also enrolled in Medicaid will incur higher prescription drug costs than they do currently. Some states require no cost-sharing from Medicaid beneficiaries, while others impose small cost-sharing but cannot deny coverage to beneficiaries who do not pay those amounts. While states can cover the cost-sharing required of dually eligible Medicare beneficiaries (Figure 6-6), they will not receive federal matching funds under Medicaid.

A controversial element of the new law involves ways to contain program costs. The new law relies on health plans and/or pharmacy benefit managers (PBMs) to administer and deliver the Medicare drug benefit. This approach reflects both a reluctance to regulate prices paid by Medicare and a belief that PBMs and managed care plans can effectively apply approaches they have used in the private sector—including formularies, preferred drug lists, or other drug utilization management approaches—to provide Medicare enrollees with the most effective drug at the lowest cost. Some efforts have been made to enhance private-sector plans’ ability to use these tools by providing them with independent analyses on the comparable effectiveness of therapeutically similar medications.

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 that patients’ prescriptions may be inappropriately switched to lower-priced medications that could harm patient health (see the discussion on unitary pricing in this chapter’s section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information and Prescription Drugs and Pharmacy Practices). In addition, the new law has been criticized for prohibiting Medicare from using its aggregate buying power to negotiate prescription drug prices or developing a national prescription drug formulary.

Another concern of consumer advocates is whether beneficiaries will have the information needed to adequately compare Medicare prescription drug plans. Early experience with the drug discount card showed that beneficiaries had difficulty comparing cards, determining whether a particular card would
be honored by their local pharmacy, and knowing what the drugs would cost. While lessons from the discount card’s initial implementation have effected some changes in how comparative information is provided to beneficiaries, it remains to be seen how these lessons will apply to information beneficiaries receive under the new drug benefit.

Medicare does not cover some 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. Beneficiaries who need 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 • Publicly Administered Health Insurance
  • The Medicare Program • Original Medicare

Medicare’s Coverage of Prescription Drugs and Other Uncovered Services

Medicare’s prescription drug benefit should:

■ be available to all beneficiaries, without regard to income, geographic location or health status;

■ be available without regard to a beneficiary’s choice of Medicare plan, including original Medicare;

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

■ maximize incentives for employers and state pharmacy assistance programs to retain prescription drug coverage;

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

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

■ ensure that each beneficiary has access to drug therapies that his or her physician determines to be medically appropriate and necessary;

■ provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and ensure that they have access to the benefit;
use Medicare’s aggregate purchasing power to obtain discounts and/or rebates from drug manufacturers and pharmacies;

■ rely on stable, broadly based and equitable financing; and

■ protect Medicare beneficiaries from exorbitant costs.

Congress should reduce, and ultimately eliminate, the coverage gap in the Medicare prescription drug benefit.

Pharmacies, prescription drug plans and Medicare Advantage plans should be allowed to forgive copayments in cases where they would hinder a low-income beneficiary’s ability to obtain medically necessary prescription drugs.

Medicare’s prescription drug benefit should not be subject to an arbitrary budget target.

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.

The Centers for Medicare and Medicaid Services (CMS) should ensure that the comparative information it and the drug plans provide to beneficiaries is accurate and easy for beneficiaries to understand. CMS should regularly evaluate and improve the quality of this information.

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 a non-Medicare source must have a period during which they could enroll in a Medicare drug benefit without penalty.

Congress and the Department of Health and Human Services should monitor the impact of allowing late enrollment in the Medicare drug benefit. In particular, they should assess whether penalties similar to those associated with late enrollment in Medicare Part B are sufficient to reduce the potential adverse effects of late enrollment on the risk pool.

AARP does not oppose the use of pharmacy benefits management or other managed care approaches to providing Medicare beneficiaries with prescription drug benefits. However, CMS should oversee and monitor private entities’ management of Medicare’s prescription drug benefit to ensure that health plans and administrators make decisions based on comparable drug effectiveness, when available; that beneficiaries have access to appropriate drug therapies and pharmacies; and that prescriptions are not
inappropriately switched to lower-priced drugs that could either endanger beneficiaries’ health or lead to greater use of other health care services that impose additional costs on beneficiaries or the Medicare program (for specific policies that outline how these safeguards should be structured, see this chapter’s section Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—Prescription Drugs and Pharmacy Practices).

CMS also should:

- monitor the management of its prescription drug benefit with respect to its impact on the overall costs and quality of health care;
- establish a board of medical experts, independent of health plans and the pharmaceutical industry, to oversee the process of formulary development by Medicare prescription drug plans; and
- ensure that all Medicare prescription drug plans and administrators 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.

Medicare should cover 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 and coverage errors.

Medicare affords its beneficiaries a number of protections that may be enforced through an appeals process. In most cases, an appeal requires an affirmative action by the beneficiary. For example, a person who is denied enrollment as a Medicare beneficiary may appeal this decision to the Social Security Administration. As another example, depending on the type of claim, the Medicare contractor (e.g., the Part A intermediary, Part B carrier or health maintenance organization) must inform the beneficiary whether Medicare covered the services, the amount Medicare will pay, the amount of coinsurance and deductible for which the beneficiary is liable, and his or her appeal rights.
Evidence suggests that Medicare contractors have denied claims for seemingly arbitrary reasons. This is the result of incentives created under their contracts with the Centers for Medicare and Medicaid Services (CMS) or of inadequate attention to proper procedures. Beneficiaries may appeal denied claims or the amount they’ve received to a hearing officer, an administrative law judge (ALJ), the Department of Health and Human Services (HHS) Departmental Appeals Board and ultimately, to federal court, depending on the disputed amount. The results of an appeal apply only to the individual beneficiary’s claim.

The Medicare Prescription Drug, Improvement and Modernization Act created an additional appeals process. A beneficiary may challenge local and national coverage decisions regarding items and services that the beneficiary and his or her physician believe are medically necessary but that the Medicare contractor or CMS has determined are not covered. The right to challenge a local or national coverage decision is distinct from existing appeal rights for individually denied claims. The new process involves examining the entire coverage policy and may lead to changes that affect other beneficiaries. An adverse decision may be appealed to the Medicare Appeals Council and, ultimately, to federal court.

Decisions by Medicare contractors and the Medicare Appeals Council overwhelmingly favor the government, in part, because they follow CMS statements of Medicare policy, which interpret the Medicare statute and regulations. Decisions by ALJs and federal courts, which are not bound by and may overrule CMS policy, tend to be more balanced.

A Medicare beneficiary may also file a complaint regarding service quality with a quality improvement organization (QIO). The claim may be further appealed to the HHS. If a beneficiary has been harmed by the care, he or she may file a civil suit for malpractice against the provider or physician directly in state or federal court.

Recent Medicare legislation changed the appeals process for beneficiaries and providers, both in Medicare fee-for-service and for Medicare Advantage (MA) plans. However, not all the regulations needed to implement these changes have been finalized. For instance, Medicare legislation enacted in 2000 required the creation of another level of appeal that would both expand administrative appeals and replace the hearing officer with a qualified independent contractor (QIC). While CMS has proposed a rule to implement this legislation, the regulation is not final.

MA plans must have their own internal grievance and appeals process. A plan’s adverse decisions are automatically forwarded to a QIC and, thereafter, may be appealed to an ALJ and to federal court.

Regulations implementing an appeal process under the new Medicare drug benefit also have been proposed but not finalized. As proposed, these rules
do not provide adequate beneficiary protections and would not automatically forward adverse decisions for independent review.

The appeal system in fee-for-service Medicare is complicated and lengthy, particularly at the later stages. Many beneficiaries find the process confusing and frequently do not receive information about either the reason for a coverage denial or their appeal rights.

**FEDERAL POLICY**

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

**Appeals**

After receiving public input the Centers for Medicare and Medicaid Services (CMS) 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.

All decisions that could result in a beneficiary’s not receiving the care in question should be made and communicated as rapidly as the beneficiary’s medical situation warrants.

Medicare beneficiaries and other parties directly affected by coverage or claim denials should receive 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.

The grievance and appeals process proposed for the Medicare Part D drug benefit needs to be streamlined to include faster dispute resolution and access to temporary drug supplies pending appeals.

In the case of adverse decisions, and to avoid further unnecessary delay, Medicare beneficiaries’ appeals should be forwarded automatically to the first level of independent review without further action by the beneficiary.

CMS should finalize statutory changes to the appeals process in a timely manner.

Appeals 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.
While the appeals process has been substantially simplified by recent legislative changes, it should be further streamlined by eliminating the need for Medicare Appeals Council reviews and allowing decisions by administrative law judges to be appealed in a timely manner to an impartial forum, such as the federal courts.

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

Background

Quality Oversight and Improvement

Problems in the quality of patient care can generally be divided into 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. In addition, there appears to be no relationship between spending and quality; geographic areas in which Medicare spending is greater do not necessarily manifest better outcomes of care.

The Centers for Medicare and Medicaid Services (CMS) is ultimately responsible for ensuring quality in all Medicare programs. Quality oversight and improvement encompass strategies to ensure that providers meet quality standards and take initiatives that promote and improve the quality of care for beneficiaries. CMS uses six strategies to address quality in the Medicare program, including:

- 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.

CMS accomplishes these strategies primarily by managing quality improvement initiatives through partnership with affected stakeholders,
identifying priority clinical areas, adopting or developing performance measures, and collecting and analyzing data.

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 QIOs and the Joint Commission on the Accreditation of Healthcare Organizations. The QIOs primarily collect and analyze data on patterns of care and outcomes in order to help physicians and other providers improve the quality of beneficiaries’ care. This role has been expanded 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 implements the Outcome-Based Quality Improvement (OBQI) system 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, and violations of the Emergency Medical Treatment and Active Labor Act (e.g., dumping) and other statutory responsibilities. In response to findings by the Department of Health and Human Services’ inspector general and related litigation that the beneficiary complaint process is inadequate and unresponsive to beneficiary needs, CMS recently introduced a mediation process as an alternative to the beneficiary complaint process. This is a voluntary, no-cost program (for both parties) that is facilitated by an impartial, trained mediator. Mediation sessions are confidential and no records are kept of the proceedings. By law, nothing said during a mediation session may be used in court or for other purposes.

**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.
Congress should authorize CMS to conduct demonstrations of innovative methodologies that align payments to providers and practitioners with demonstrated improvements on evidence-based performance indicators.

Health care quality improvement programs must be regularly evaluated to determine if measurable improvements in outcomes and processes are achieved. All participating providers and practitioners 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 and 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 a QIO.

CMS should continue to make useful information about quality available to the public, including data that permit comparisons between the original program and private health plans. The information should take into account the diversity of Medicare beneficiaries, including literacy levels.

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’ Healthy Aging Initiative and CMS’ partnership with other agencies to promote improvements in beneficiary care and well-being.

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. It is the
nation’s third largest domestic program; in the federal budget, only Social Security and Medicare are larger. As a means-tested entitlement program, Medicaid requires states to provide coverage for individuals as long as they are a member of a covered group and meet financial requirements. The federal government matches legitimate state Medicaid expenditures at a rate determined by the federal medical assistance percentage (FMAP).

Medicaid is the most important source of health insurance coverage for low-income individuals of all ages. Medicaid helps pay for the health care of more than one in eight Americans, including one in five children. It is the single largest purchaser of the nation’s maternity care and long-term care services, accounting for 43 percent of all long-term care spending in 2002. The program’s 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: children and pregnant women, adult family members with Medicaid-eligible dependent children, the elderly, and people who are blind or disabled. For each group there are multiple pathways to eligibility. Some of these apply in all states (e.g., all states must cover pregnant women with incomes of up to 133 percent of the poverty level). Other eligibility pathways are available only if a state chooses to offer them (e.g., states may raise the income threshold for the elderly above the minimum requirement of between 74% for an individual and 82% of the federal poverty level for a couple, to 100% of the federal poverty level). Most states also require individuals in these groups to have income and resources below specified levels. Because these levels are determined by states within federal guidelines, Medicaid coverage varies widely among states.

With one exception, federal law requires states to provide Medicaid coverage for elderly people and people with disabilities who are receiving 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 2005 the SSI income eligibility limit is $579 per month in countable income and no more than $2,000 in countable assets. The asset limits generally apply to “liquid assets” such as stocks and bonds, mutual funds and money in bank accounts; they exclude the value of assets such as homes, cars, burial plots or funds, personal effects, and the cash surrender value of life insurance.

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 Social Security Act Amendments of 1972 established an exception to the general rule that states must provide Medicaid coverage to all SSI
beneficiaries. Section 209(b) of this law allows states to use their 1972 state assistance rules for the Aid to the Aged, Blind, and Disabled program to determine Medicaid eligibility for elderly people and people with disabilities. States choosing the section 209(b) option generally use at least one income standard, resource standard, method of counting (income or resources), or definition of “blindness” or “disability” that is more restrictive than the comparable SSI criteria. In 2001, 11 states—Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia—used the section 209(b) option.

The remainder of elderly and disabled people covered by Medicaid generally are not eligible for SSI; they qualify for Medicaid because their income and resources are within state-established levels that make them “medically needy.” People can qualify under the medically needy option if they have income that meets the standard medically needy income level (MNIL) or have incurred out-of-pocket medical expenses that when subtracted from their income, places them below the MNIL. Although states are not required to extend coverage to the elderly and disabled under their medically needy programs, in 2001, 34 states and the District of Columbia provided Medicaid eligibility to low-income older people and people with disabilities through the medically needy option.

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 (EPSDT) 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 50 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 6-7). 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. Recent evidence, however, raises concerns that states’ vigorous outreach efforts to enroll children in SCHIP may be waning.

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 can eliminate this so-called 100-hour rule without a waiver—making it easier for two-parent working families to access Medicaid—and effectively 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 states’ use of statutory waiver authority under Section 1115 of the Social Security Act (see this chapter’s section Publicly Administered Health Insurance—When Medicare and Medicaid Meet—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 they are disabled and qualify for SSI.

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 materials and program staff, fears related to immigration status, and reluctance by some to receive publicly funded benefits. Recently, in light of state budget problems, some states have begun to reimpose enrollment barriers as a way to slow down program enrollment and expenditures.

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 or the range of services offered and the amount, duration and scope of those services. States also may seek exemption from other federal requirements. For example, 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 this chapter’s section 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 and Other Private Health 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. The BBA also established PACE organizations as Medicare-recognized providers (for additional policy on integrating health and long-term care, see Integrating Health and Long-Term Services and Supports in Chapter 7, Long-Term Services and Supports: Coordination and Integration of Long-Term Services and Supports).

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 FMAP varies among states and currently ranges from 50 percent to 77 percent of total costs. On average
the federal government pays 57 percent of all Medicaid expenditures. The cost of Medicaid to the federal and state governments in fiscal year 2004 was projected to be approximately $303 billion, with the federal government paying $178 billion and the states paying $125 billion.

Most states have faced severe fiscal crises in the past several years. State revenues fell due to the downturn in the national economy, a series of federal policy actions, and in several cases tax cuts at the state level. At the same time, state spending is increasing. Some of these increases are discretionary, some are in response to increased demands during economic slowdowns (especially on the Medicaid program), and some reflect unfunded federal mandates in such areas as homeland security and special education. In response to increased pressure on state Medicaid programs, the federal government increased by 2.95 percent the FMAP for the last two quarters of fiscal year (FY) 2003 and the first three quarters of FY 2004 for every state, the District of Columbia, Puerto Rico and the US territories. On July 1, 2004, states reverted back to their FY 2004 FMAP.

Medicaid remains one of the largest items in state budgets; in 2003 it accounted for an average of 16.5 percent of state-only spending and 21.4 percent of total state budgets (which include federal funds). In the face of mounting budget pressures (all states except Vermont are required to balance their budgets), states are addressing deficits by reducing spending, increasing revenues or both. According to a 2004 50-state survey conducted by the Kaiser Commission on Medicaid and the Uninsured, all states and the District of Columbia implemented at least one Medicaid cost-containment strategy in FY 2004, and all states and the District of Columbia were planning to implement such strategies in FY 2005. Measures planned for FY 2005 included freezing or reducing provider payments (47 states), implementing pharmacy cost controls (43 states), narrowing benefits (9 states), restricting eligibility (14 states) and increasing beneficiary copayments (9 states).

Another cost-containment strategy is the development of disease management programs within state Medicaid programs. These programs typically use a variety of approaches, including working directly with physicians, to help people with chronic disease(s) learn to better manage their illness(es). According to a recent Kaiser survey, 28 states had adopted measures to implement disease management programs in FY 2005. In theory, improved health management could lead to lower program costs for these individuals. While there is no conclusive evidence to support the cost-savings theory, disease management programs have been shown to improve health outcomes. However, once Medicaid beneficiaries who are also on Medicare begin receiving their prescription drugs through the Medicare program, state Medicaid agencies may no longer have access to information about the patients’ drug utilization patterns, making it more challenging to administer effective disease management programs.
From time to time some policymakers raise the idea of financing Medicaid through a block grant as a solution for rising program costs and a way to improve program integrity. In the wake of the recent state fiscal crisis, the block grant idea has been resurrected. A block grant, sometimes referred to as global financing or a lump-sum allotment, is a fixed amount of money that the federal government gives to states for a specific purpose. Under a block grant, states would have limited federal funds; if their actual costs were higher than anticipated under the block grant, states would have to make up any difference without additional federal assistance. Those who oppose making Medicaid a block grant program argue that it would undermine the fundamental nature of the program as a safety net, because states may not be able to respond to increased needs for health care during economic downturns if the federal contribution is capped. A different approach to Medicaid financing reform is to change the current funding formula so that it more adequately responds to state economic cycles.

FEDERAL & STATE POLICY

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

The Medicaid Program and Children’s Health Insurance

The 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 the culturally diverse eligible population (including legal immigrants). An annual review should be conducted to ensure that Medicaid’s rules for paying providers and managed care plans do not threaten access to health care. Efforts to restructure Medicaid should:

■ maintain the government’s benefit guarantee, so that all who qualify for Medicaid will be covered, and maintain the entitlement nature of Medicaid funding by not converting Medicaid into a block grant program;

■ maintain and improve current federal and state consumer protections;

■ adopt financing policies and payment strategies that do not compromise access and quality;

■ identify and implement strategies to address fraud, waste and fiscal abuse in ways that do not threaten access to program benefits for low-income people and that direct savings back into the program;

■ 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;

- require Medicaid and Medicare program administrators to work together to ensure that once Medicaid beneficiaries begin receiving Medicare prescription drug coverage, Medicaid disease management programs will still be able to function effectively—Both programs should be required to evaluate their impact on health outcomes and ensure that all beneficiary privacy rights are protected;

- explore the feasibility of adopting alternatives to the current Medicaid funding formula that will be more responsive to changing financial circumstances within states;

- 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 whose 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 Program (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 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 2002, 58 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 opted for this approach. Early evidence on the use of managed care in Medicaid indicates more improvement in women’s and children’s access to providers in some states, as well as more 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 (for a detailed discussion of such standards see this chapter’s section Publicly Administered Health Insurance—The Medicare Program—Medicare+Choice—Federal Standards for Medicare Managed Care and Other Private Health Plans). One mechanism for ensuring quality care is the Consumer Bill of Rights proposed by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry; it is being applied to Medicaid and other federal insurance programs. In addition, the Balanced Budget Act of 1997 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.

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 they select 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 the protections in this chapter’s section Publicly Administered Health Insurance—The Medicare Program—Private Health Plans in the Medicare Program: Medicare+Choice/Medicare
It is especially important that plans have a fair, rapid appeals process that allows Medicaid beneficiaries to have overturned any decisions 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 that bill beneficiaries for these amounts.

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

Background

Dual Eligibility and Medicare Savings Programs

More than one in five Americans age 65 years and older (more than eight million individuals) live on incomes below 135 percent of the federal poverty level. (In 2004 the poverty level for an individual was $9,310.) Poverty rates for the elderly increase with age, are higher for women than men, and are higher for elderly minority populations than for older 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 coverage, 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 because of 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 6-8). 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.

<table>
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<th>Program</th>
<th>Who’s eligible</th>
<th>What Medicaid pays</th>
<th>Entitlement?</th>
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<td>&lt; 100% of poverty</td>
<td>Medicare Part B premium &amp; cost-sharing</td>
<td>Yes</td>
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<tr>
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<td>Medicare Part B premium</td>
<td>Yes</td>
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<tr>
<td>Qualifying individuals</td>
<td>120%–135% of poverty</td>
<td>Medicare Part B premium</td>
<td>No</td>
</tr>
</tbody>
</table>

*Some states (the “209(b)” states) are permitted to set lower levels; states have the option to go up to 100% of poverty.

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

Prepared by AARP Public Policy Institute.

Qualifying individuals (QI) are an additional category of dual-eligibles created by the Balanced Budget Act of 1997 (BBA). Under the current QI program, Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty level may have their Part B premiums paid by Medicaid. Because federal funding for the QI program 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. The QI program was to have expired on September 30, 2004. However, after a series of extensions, the program is now in place until September 30, 2005.

Recent estimates are that fewer than two-thirds of people eligible for QMB or SLMB are enrolled; however, precise federal program statistics are unavailable. Among the significant barriers Medicare beneficiaries face in accessing these protections are lack of awareness about the benefits 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 $3,835, or 43 percent of income, for those at or below 135 percent of the federal poverty level without Medicaid in 2003. (The importance of Medicaid to older Medicare beneficiaries is further illustrated in Figure 6-9.)

The elderly poor and near-poor need Medicaid’s protection because Medicare does not currently 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 people would not be able to afford Medicare’s cost-sharing requirements or Part B premiums. Medicare beneficiaries without private or public supplemental coverage visit physicians less often and are less likely to seek health services.

In terms of prescription drug coverage, beginning January 1, 2006, all Medicare beneficiaries will be eligible for a prescription drug benefit through the Medicare program. At that time, state Medicaid programs will no longer receive Federal Financial Participation for providing prescription drugs to Medicare beneficiaries (for a detailed description of the Medicare prescription drug benefit, including how the benefit affects low-income

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### Figure 6-9

**Insurance Status of Medicare Beneficiaries**  
**Age 65 and Older, by Income, 2003**

<table>
<thead>
<tr>
<th></th>
<th>135% FPL*</th>
<th>135% FPL and under</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Medicaid</td>
<td>8%</td>
<td>38%</td>
</tr>
<tr>
<td>Employer paid</td>
<td>16%</td>
<td>44%</td>
</tr>
<tr>
<td>Medigap</td>
<td>22%</td>
<td>28%</td>
</tr>
<tr>
<td>Medicare+Choice</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Medicare only</td>
<td>6%</td>
<td>12%</td>
</tr>
</tbody>
</table>

*FPL = federal poverty level.  
Figures may not sum to 100 percent due to rounding.  
people, see this chapter’s section Health Care Coverage—Publicly Administered Health Insurance—The Medicare Program—Original Medicare—Medicare’s Coverage of Prescription Drugs and Other Uncovered Services). The new drug benefit is financed in part by states. The state share, known as the claw-back, is based on a formula that takes into account the number of people enrolled in both Medicaid and the drug benefit.

FEDERAL & STATE POLICY

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

Dual Eligibility and Medicare Savings Programs

The asset test for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) buy-in protections 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 for Supplemental Security Income. 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, SLMB, and qualifying individuals (QI) participation rates, report enrollment levels on an ongoing basis, and develop action plans in areas with low QMB, SLMB and QI 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 affected.

The federal government should take steps to ensure that states do not eliminate Medicaid optional eligibility categories or alter eligibility criteria as a strategy to reduce the amount of their Medicare payments (known as the claw-back) and in the process deny or withdraw needy beneficiaries’ access to important health benefits.
Dual Eligibility and Medicare Savings Programs

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

■ 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.

■ The Medicaid program should be fully funded to ensure that all people eligible for the Medicare savings programs can receive Medicaid coverage.

■ The Centers for Medicare and Medicaid Services (CMS) should require states to ensure that the Medicare savings 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 the individuals they serve are aware of Medicaid, especially its Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and qualifying individuals (QI) 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 funding state outreach and enrollment efforts for the Medicare savings programs. States’ receipt of future funds should be based in part on standards for past performance.

■ Rather than extend the QI-1 program, the federal government should expand the SLMB program to pay Medicare premiums for low-income Medicare beneficiaries with household income between 120 percent and 135 percent of the federal poverty level.
Dual Eligibility and Medicare Savings Programs

States should simplify their administrative procedures so that eligible beneficiaries will more likely enroll. States could develop simplified applications, consumer-friendly application sites, institute passive renewal processes, and eliminate burdensome documentation requirements.

States should conduct innovative grassroots outreach to educate seniors about Medicaid, particularly the Medicare savings programs. Innovations should take place in methods and sites, including by involving volunteer organizations in outreach.

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. These exemptions are collectively known as Medicaid waivers. There are a variety of types of waivers, each designed to allow states to accomplish specific policy objectives, such as covering services for some groups of people but not others, changing the delivery system, or covering more people or a different mix of people.

The Medicaid statute gives states broad authority to waive many federal requirements. The waivers allow states expanded program flexibility so they can implement comprehensive or incremental reform initiatives. The most fundamental requirement for all waivers is that they have a neutral effect on the federal budget. That is, federal Medicaid spending under the waiver cannot be more than federal spending without the waiver.

Under Section 1115 of the Social Security Act, the secretary of the Department of Health and Human Services (HHS) can waive Medicaid eligibility, benefit and service-delivery requirements in the context of research and demonstration projects to promote program objectives. Federal law requires that Section 1115 waivers have no impact on the federal budget. Many states have sought Section 1115 Medicaid waivers to expand coverage to low-income individuals who may be ineligible for Medicaid because of the program’s categorical or financial limitations. States also have sought 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 contains no procedural requirements or substantive standards to guide the secretary’s decision on granting waivers. In 1994 the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) published a nonbinding policy statement describing its procedures for receipt of public comment on such waivers; the statement offers little assurance that public concerns will be seriously considered.

In 2001 the HHS secretary authorized the use of Section 1115 waivers to conduct Health Insurance Flexibility and Accountability (HIFA) demonstration initiatives. Using HIFA waivers states may expand Medicaid and State Children’s Health Insurance Program coverage to new populations while reducing coverage or benefits for some existing beneficiaries. States must continue covering mandatory populations, provide mandatory benefits as specified under Medicaid law, and must keep children’s eligibility levels the same as they were in June 1997. According to analysis of 1998 data by the Urban Institute, optional eligibility accounted for the Medicaid enrollment of 56 percent of elderly beneficiaries, 43 percent of parents, 22 percent of disabled people, and 20 percent of children. As of February 2003, 12 states—Arizona, California, Colorado, Delaware, Illinois, Maine, Michigan, Minnesota, New Jersey, New Mexico, Oregon and Washington—had approved HIFA waivers.

One of the more recent variations on the Section 1115 waiver—the Pharmacy Plus waiver—shows how states can use waiver authority to cover people who could not be covered under normal Medicaid rules. Pharmacy Plus waivers allow states to secure federal Medicaid matching funds for the cost of operating prescription-only programs for seniors who otherwise would not be eligible for Medicaid. 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 ($18,620 for one individual in 2004). People covered by the waiver must not be eligible for full Medicaid under other coverage categories.

To secure federal approval of a Pharmacy Plus waiver, the HHS requires states to achieve federal budget neutrality by placing all of their expenditures for elderly and disabled Medicaid beneficiaries under a global funding cap. Thus, the HHS requires states to forgo their guaranteed receipt of federal Medicaid matching funds for all elderly and disabled Medicaid beneficiaries and replace it with a limited or “capped” amount of federal Medicaid funds. The fundamental theory behind Pharmacy Plus waivers is that prescription drug coverage for older people and people with disabilities will pay for itself over time by generating offsetting savings in other Medicaid services. The underlying assumption of the budget neutrality analysis for Pharmacy Plus
waivers is that enrollment in a prescription drug program will keep a substantial number of low-income seniors healthier and reduce their long-term care and other medical bills. This in turn makes it less likely that they will become poor enough to qualify for Medicaid coverage and more likely that they will require fewer services if they do end up on Medicaid. There is no empirical evidence to support this assumption. When Medicare prescription drug coverage becomes effective in January 2006, it is unclear whether states with Pharmacy Plus waivers will continue to receive federal financial assistance to provide Medicaid-covered prescription drugs to the waiver population.

The Balanced Budget Act of 1997 broadened states’ discretion to change Medicaid without securing a waiver. 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 HHS 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 HHS 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 POLICY

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

Federal-State Flexibility

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

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

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

- The waiver process should not be used to limit or erase important benefits.

- 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.

- New cost-sharing and premium contributions should be permitted only if the secretary of the Department of Health and Human Services (HHS) 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.

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

- Budget neutrality should not be achieved by threatening existing services for eligible beneficiaries.

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

- Quality assurance standards should include, at a minimum, 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, or 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 that the state has addressed public concerns. The HHS should provide an 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 waiver applications should include a beneficiary impact statement, which would include an analysis of the proposed waiver's impact 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:

- Beneficiaries must retain their rights to full Medicare and Medicaid benefits.
- There must be voluntary enrollment and disenrollment at any time.
- Cost-sharing should be permitted only if it is not a barrier to receipt of services.
- Cost-sharing and other participation requirements must not result in coercive inducements to enroll or disenroll.
Strong consumer protections, including an independent ombudsman program and external grievance procedure, must be in place.

The state and CMS must provide strong and timely oversight.

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

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

Eligibility criteria for long-term services and supports 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.

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.

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, which should provide for adequate oversight and accountability.

### HEALTH CARE COVERAGE

#### Introduction

**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. More than 45 million people lacked health care coverage throughout 2003. The Institute of Medicine reported that the uninsured not only receive too little care too late, and worse care than insured people, but also are sicker and die younger. 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, the nature of their medical condition, or difficulty navigating the 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. The following sections address policy on providing coverage to the uninsured and giving them access to needed health care despite their lack of coverage.

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

Background

The Uninsured

More than 45 million people—15.6 percent of the population—were without public or private health insurance throughout 2003. Among the uninsured were about 286,000 people age 65 and older and 6.4 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, 13.5 percent have no coverage. The vulnerability among near-elderly people is often related to their departure from the workforce (sometimes due to the 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:

- 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,
cannot buy coverage in the private insurance market because of their health problems, and

think they can do without it or it isn’t a good value.

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. The nonelderly poor are almost twice as likely (34 percent) as all people (18 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, 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 toward self-employment and part-time or temporary work mean that workers are less likely to have employer-sponsored insurance.

In addition to the more than 45 million uninsured Americans, many others are underinsured. The estimates of the number of people with inadequate coverage vary depending on the definition of “underinsured.” With growing health costs and greater shifting of some of those costs to the insured population, individuals with insurance may nonetheless have problems affording and accessing health care. For example, increased availability of health coverage with high deductibles may contribute to underinsurance if those with low incomes and/or chronic health problems do not have the resources to pay for services before they reach the deductible.

Research has shown that the poor and those purchasing coverage outside a group have a greater than average risk of being underinsured in the face of a
serious illness. Individually purchased insurance is concentrated disproportionately among retirees approaching 65.

For decades federal, state and local governments have sought to protect those without adequate health insurance by offering health care services directly, subsidizing providers serving the uninsured, and establishing public insurance programs. These latter programs generally have sought to address different subgroups of the population—the elderly, the poor and low-income children.

From time to time there have been federal and state proposals to reform the health care system to provide everyone with access to coverage. Since the national health care reform proposals of the early 1990s were not successful, most federal and state legislative proposals related to the uninsured have been incremental. Two incremental reforms enacted in the 1990s were the Health Insurance Portability and Accountability Act (HIPAA) and the State Children’s Health Insurance Program (SCHIP). State efforts have largely relied on Medicaid waivers to expand coverage for special populations. More recent federal incremental reforms have included a federal grant program to help fund state high-risk pool programs (which sell coverage to those otherwise “uninsurable” in the private market) and Health Coverage Tax Credits (HCTC). The credits are available to workers who have lost their jobs due to foreign trade and for retirees ages 55 to 64 who receive payments from the Pension Benefit Guaranty Corporation. While helpful to discrete populations, these reforms are not designed to serve the needs of the vast and growing uninsured population.

The continuing rise in the cost of health coverage, along with weakening economic conditions, creates an environment in which the number of uninsured is expected to increase. Reforms to address the problem of the uninsured confront great competition for limited public resources because federal and state budgets are under enormous pressure. Nonetheless, health care cost increases and the growing numbers of uninsured have again given rise to discussion in political, policy and business circles of the need for more comprehensive health reform.

Because there is no national consensus for undertaking health care reform, it continues to mean different things to different people. For example, it is not clear that there is broad consensus that universal coverage should be a national goal. Even among advocates for universal coverage, there is not consensus about how to achieve the goal. Some favor a single government-run health program to ensure that everyone has access to health coverage. Others continue to favor proposals that build on our existing voluntary system, which includes both private and public coverage programs. Other advocates favor employer and/or individual mandates because a voluntary coverage system can’t guarantee universal coverage. The task of enacting health care reform will continue to be a challenge unless the public and political leaders can agree on goals, approach, resources and priorities.
Meanwhile, the rise in the cost of health coverage adds to the challenge not just of funding public coverage programs but also of keeping private coverage affordable for employers and individuals. Among those favoring expansion of private coverage, the cost issue has led to various proposals to use the tax system to subsidize the cost of coverage.

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 ways. 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 or credit is of little value unless it is refundable and sufficient to cover the price of adequate private insurance. The cost of private insurance varies by age and health status. In such a situation, a one-size-fits-all credit will fall short for many uninsured. Since health premiums are incurred over the course of a year, a year-end tax deduction may not help unless it can be advanced. Policy that does not take these issues into account will not be meaningful for a significant segment of the uninsured.

Analysis of the merits of a tax proposal must take into account the context of the private insurance market. 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. HCTCs can only be applied to certain plans. Yet, not all individuals may qualify for some of these plans, and other options may not be available unless states put them in place. Roughly half of the states had taken such action by mid-2004.

Who should be eligible for tax relief is another consideration. Some proposals are limited to those without insurance; others 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 important in evaluating new health coverage tax proposals.
The Uninsured

Until universal access to coverage has been achieved, and recognizing the size and complexity of the health care system, AARP supports health care reforms that significantly improve access to coverage for those who are either without public or private insurance or are at risk of losing coverage.

These reforms might take a comprehensive approach that addresses the needs of the multiple populations without coverage or at risk of losing it, or a narrower approach that expands coverage for a particular population. Narrower approaches must significantly improve access to coverage for a particular population without undermining existing coverage. Strategies for improving access may include:

- opening existing public health insurance (e.g., Medicare and Medicaid) programs to new categories of people who are uninsured;
- developing health plans specifically for the uninsured;
- creating high-risk pools for uninsurable people;
- 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);
- encouraging employers to offer health insurance to employees; and
- continuing group health coverage at group rates for people whose access to group coverage is ending.

In evaluating the use of 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;
- adjust incentives to recognize the high cost of coverage in private markets faced by those who are older, those with health problems or histories of poor health, and those with low incomes;
- 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 this chapter’s section Health Care Coverage—Private Health Insurance and Private-Market Regulation); and

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

AARP believes that tax policies that relate to health coverage, health savings and health spending should be evaluated in the context of broad health policy objectives and priorities as well as in the context of fiscal policy.

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 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

Rather than a state-by-state approach, AARP favors comprehensive national reform that achieves universal access to health care coverage (see this chapter’s section AARP Principles).

Proposals to extend Medicare or other federal coverage 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 and Tax Incentives for Health Insurance and Other Revenue Options—Taxing Employer-Provided Benefits.)
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 Services and Supports); 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 grants such as those available for community health services; preventive health and health services; and alcohol abuse, drug abuse and mental health.

States should take necessary steps to make alternative qualified plans available to beneficiaries of the Health Coverage Tax Credit under the Trade Act of 2002.

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. Approximately one-fourth of all Americans live in rural areas. Small rural hospitals have closed at a faster pace than urban hospitals and are more likely to be financially distressed. 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 affected 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’ reliance on government-funded resources for their health care. This places heavy demands on the 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 Health 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 2002 hospitals provided $22.3 billion in 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 the 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 direct or indirect public health interventions. An example of a direct intervention is the provision of services by a local health department. Indirect interventions might include providing access to health insurance or providing financial subsidies to local community clinics.
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 innovations.

The federal and state governments should establish programs to recruit and train health care providers to work in rural and urban underserved areas. The federal and state 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.

The federal and state governments should provide incentives for health educators to conduct training in medically underserved areas.

States should help rural communities 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.

The 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 Government Accountability 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 2003, 35 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. Cost savings from providing more comprehensive mental health and substance abuse services have been demonstrated in certain circumstances, e.g., where community-based outpatient treatments are substitutes for inpatient psychiatric care and where outpatient mental health services reduce unnecessary use of general medical services.

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 2002 approximately 164 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, insurers should be required to show cause before denying payment 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 this chapter’s 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 this chapter’s 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 on-site 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 to ensure the health and safety of all those who use the health care system, it is necessary to implement policies and programs that protect consumers in the health care marketplace, promote public health, improve health care quality, and meet the continuing needs for qualified and trained health care personnel.
The Need for Strong Quality Protections and Consumer Information

There is 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.

The 1998 report of the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended that all affected stakeholders in the health care system (public and private purchasers, insurers, practitioners, providers and consumers) act jointly to measure health care quality and report the results of such measures to the public. This two-pronged framework of measurement and public reporting serves as the basis for holding the various components of the health care system publicly accountable, as well as helping them improve care delivery.

The demand by both public purchasers and large private employers for greater accountability from the health insurers with which they contract (as well as from hospitals and other facilities and providers) is growing, although not yet widespread. Empowering consumers with information about their health plan, hospital, nursing home, physician and other 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 for Medicare beneficiaries compares health plans, nursing homes, home health agencies and dialysis centers on various standardized measures. Soon there will be information about hospitals and physicians. This site and similar reports published by large employers and state agencies are examples of efforts to provide consumers with information on quality. Important research is currently underway to expand the number of evidence-based performance measures on a wider range of clinical conditions in more care settings (e.g., hospitals, nursing homes, home health agencies) and on medical groups and physicians.

The Institute of Medicine has reported that information technology (IT) is a critical element in a health care system that is safe, effective, patient-centered, timely, efficient and equitable. 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.

In April 2004, the President issued an executive order calling for the widespread adoption of interoperable electronic medical records within ten years. He also established a new position, the national coordinator of health information technology. A new report by the coordinator outlines a framework for a strategic plan that will be implemented in cooperation with the private sector and that includes four goals for a national health information infrastructure: inform clinical practice through electronic medical records adoption; interconnect clinicians through regional collaborations; personalize care through the use of personal health records (PHRs) and tele-health systems; and improve population health through improved monitoring of quality, dissemination of evidence, and unifying public health surveillance efforts.

PHRs are an important approach to increasing consumers’ engagement in their health care. The record system can take advantage of technology to facilitate patient education and self-management, permit secure messaging between patient and clinician, provide patients with preventive service reminders, allow patients to maintain diaries (e.g., of pain, symptoms and side effects), obtain prescription refills, schedule medical appointments online, and track test results. Ideally, personal health records are connected to electronic medical records.

Information is necessary but not sufficient to ensure that consumers get the care they need and avoid inappropriate care. Strong protections against poor-quality care and effective grievance and appeals procedures will always be necessary. Oversight of licensing activities is essential to ensure compliance with standards. In recognition of the skills and knowledge gaps of many practitioners and concerns about the frequency of medical errors in the health care system, many quality experts are urging continuing competency assessment of health professionals to better ensure patient safety and improve health care quality.

**FEDERAL & 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 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 system to ensure quality should encourage internal quality improvement efforts and include independent external quality oversight and public accountability through the collection of standardized data and the publication of performance information.

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.

The federal government and states should ensure that valid, accurate, objective and standardized information is available to consumers to help inform their health care decisions. Such information should include but not be limited to data on treatment options; plan benefits and procedures; plan, provider and practitioner performance; consumer experience; and cost. Information should be presented in formats that consumers understand. Processes known to reduce the cognitive difficulty of using information should be employed, and users’ literacy levels should be taken into account when information is developed. Consumer information should be evaluated to assess its usefulness and salience.

**FEDERAL POLICY**

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

- Consumer Protection and Consumer Information

**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 in the six domains of quality identified by the Institute of Medicine (i.e., that care be safe, effective, patient-centered, timely, efficient and equitable) 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., the 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. The design of the information and supportive technology systems should be able to accommodate personal health records. In addition, recognizing the large investment needed to make appropriate technology more widely available, Congress should also study the feasibility of developing financial incentives to encourage greater use of IT for improving the quality of health care.

The federal government should mandate the establishment, collection and dissemination of report cards on providers to help consumers covered by federal programs make informed choices.

Nationally, uniform protections for due process, 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. 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 costs, medical errors, outcomes 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 this chapter’s section Health Care Coverage—Publicly Administered Health Insurance—The Medicare Program—Medicare+Choice/Medicare Advantage—Federal Standards for Medicare Managed Care and Other Private Health Plans).

In conducting their licensing functions, states should:

- discipline incompetent health care professionals and providers and eliminate substandard care (e.g., by revoking or suspending licenses to practice);

- mandate continuing education (CE) requirements for physician and nurse licensing and other health professionals as appropriate—Providers working with the elderly should have CE requirements in risk management (i.e., preventing patient care errors), in understanding the impact of patterns of practice on the quality of care and costs, and in gerontology and geriatrics;

- ensure that licensing boards have adequate funding and authority to carry out their responsibilities, including through 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;

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

- 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 increase the 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.

Working with professional organizations, consumers and other interested parties, states should examine the feasibility of phasing in a mandatory continuing competency system for all health professionals that would include rules to assess the continued competence of licensees as a condition of periodic license renewal.
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

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. Manufacturers’ prices for widely used prescription drugs are increasing at several times the rate of inflation, on average. 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 this chapter’s section 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’s 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. Preferred drug lists or formularies could be tailored to help achieve these goals through 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. These approaches are used in the private sector and in state Medicaid programs. Some states are trying to increase their negotiating leverage by pooling their Medicaid populations
with other state programs (such as state employee and retiree plans) and/or with efforts in other states.

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 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 before they implement a Medicare drug benefit, some states establish 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 2004, 23 states and the District of Columbia had 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 at 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 1.6 million individuals; programs in seven states—Illinois, Maryland, Massachusetts, New Jersey, New York, Pennsylvania and Wisconsin—account for about 80 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 is designed to allow the FDA to dedicate more resources to shortening approval times for new drugs, but some critics have raised safety concerns about faster approvals. Others have called for easier approvals in 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, Financial Services and Consumer Products: Drugs).

**Lack of oversight of pharmacy benefit management**—Concerns have been raised about whether the use of a PBM 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 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. There have been assertions that some PBMs raise costs for their clients by steering utilization toward drugs manufactured by a parent company or that provide the PBM with a larger rebate. Finally, there are 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 any of these concerns.

Although several accrediting bodies have begun promoting 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 watching the relationships between PBMs and drug manufacturers, and the inspector general of the Department of Health and Human Services (HHS) has called for greater oversight of PBMs. 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. The FDA asserts that virtually all generic drugs can be
expected to have the same therapeutic effect as their brand-name counterparts. Some drugs do not currently meet the established standards for therapeutic equivalency (those drugs included on the FDA’s B list) and therefore cannot be safely substituted for a referenced “innovator,” or original, drug.

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 cause an adverse reaction with another drug the patient is 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. These 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 a therapeutic effect equivalent to the brand-name product’s. However, some physician organizations and advocacy groups have proposed that generic NTI drugs should not be substituted for brand-names 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.

A variety of approaches have been proposed to reduce prices that consumers pay for prescription drugs. In past years there were efforts to require “unitary” or nondiscriminatory pricing for prescription drugs by requiring drug manufacturers to offer retail pharmacies the same terms and conditions offered to insurers, managed care buyers, mail-order pharmacies and PBMs. While supporters of such measures contended that this approach would reduce prices charged to the cash-paying retail market, critics argued that these measures could curtail the discounts given to managed care buyers and have limited impact on reducing costs for those who pay for drugs out-of-pocket.

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 give Medicare beneficiaries the same price discounts they provide to their respective state Medicaid programs. Maine was the first state to require that both Medicaid pharmacy discounts and drug manufacturers’ Medicaid rebates be offered to low- and moderate-income residents who do not have prescription drug coverage. Although this program was enjoined by a federal appeals court, Maine is seeking federal approval to reinstate the program; other states are seeking to adopt 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 a pool and would pay the discounted price rather than the full retail price. This approach has been implemented in several states and is similar in effect to the discount card approach now being implemented for
Medicare. While this plan 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 5 percent to 10 percent. 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 group 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 two states—Maine and Hawaii—have enacted legislation to reduce drug prices statewide. Under these laws the state would establish a process to regulate prescription drug prices if it is not successful at using market-based approaches to provide consumers with the kinds of discounts that other purchasers are able to receive. In addition, drugs that did not have sufficiently low prices could be subject to prior authorization within the state Medicaid program. The US Supreme Court ruled that this approach was not unconstitutional but said the HHS secretary could stop such programs if he or she determined that the prior authorization requirement significantly harmed Medicaid beneficiaries. The secretary has since indicated that such plans must be approved by the Centers for Medicare and Medicaid Services. While this approach has the potential of lowering drug prices for residents of the state, its impact on the broader pharmaceutical market is unknown.

An increasingly popular strategy is to seek lower drug prices by importing or reimporting prescription drugs, particularly from Canada. (Reimportation is the practice of importing into the US prescription drugs that were originally manufactured and approved for sale here but were exported for sale in another country.) Because prescription drugs often are sold at lower prices outside of the US, some Americans use importation and reimportation to gain access to other countries’ potentially lower drug prices.

It is against current US law to import or reimport prescription drugs. (There are exceptions for drugs manufactured in the US and reimported by the original manufacturer and drugs required for “emergency medical care.”) It is also illegal to advertise or otherwise promote imported or reimported drugs. Despite these prohibitions, the federal government has not strictly enforced its ban on the importation of prescription drugs for personal use, and an estimated 12 million prescriptions were sold from Canadian pharmacies to the US in 2003, either in person or through Internet mail-order pharmacies. Americans are also importing or reimporting drugs from other countries, including Mexico. At least 13 states and some localities have developed programs to reimburse their employees for prescription drugs purchased from Canada, and some states have requested waivers from the HHS in an effort to lawfully establish drug importation programs. In addition, some
states have established websites that list Canadian pharmacies meeting state quality standards.

In the past, Congress has approved laws allowing for prescription drug importation predicated on the HHS secretary’s certification that such importation can be done safely. To date no secretary has so certified. For example, in 2000 Congress passed legislation that would allow wholesalers and pharmacists to import or reimport FDA-approved drugs for sale in the US as long as the HHS secretary could 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 the legislation believed 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 contended that there was no guarantee that pharmacists and wholesalers would pass along savings to consumers. Opponents also argued that loopholes in the legislation would have allowed manufacturers to block imports by withholding the necessary package labeling inserts required for sale in the US and that manufacturers could have entered into contracts with distributors to prevent them from selling reimported products. In December 2000 the HHS 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 HHS secretary has reiterated this position, and the provisions of this legislation have not been implemented.

More recently, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) directs the HHS secretary to promulgate regulations to allow US pharmacists and wholesalers to import prescription drugs from Canada. This law also requires the secretary to establish safeguards to ensure that drugs are safe and effective, and it establishes standards with which an importer must comply. However, like the 2000 provision, this measure will not become effective unless the secretary certifies that importation will “pose no additional risk to the public’s health and safety” and will “result in a significant reduction in the cost of covered products to the American consumer.”

The MMA also required the HHS to convene a task force to examine the feasibility of prescription drug importation. The task force’s December 2004 report concluded that it would be possible to safely import drugs through commercial distributors from Canada, but that doing so would result in little savings to consumers and would require substantial costs and legislative action to ensure safety. The report also recommended continuation of the ban on personal importation. The task force concluded that legalized drug importation would adversely affect research and development for new pharmaceuticals; could raise legal and constitutional challenges on enforcement of intellectual property rights and trade agreements with foreign
countries; and would impose substantial liability concerns for consumers, manufacturers, distributors, pharmacies and other entities.

**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 consumers’ ability 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 have 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 drug manufacturers allegedly have paid generic drug manufacturers to delay their marketing of competing generic products. In at least two cases the Federal Trade Commission (FTC) has charged brand-name drug manufacturers with restraining market competition by paying the maker of the first generic approved as a substitute for the brand-name drug 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.

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.” This is 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 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
Congress has considered—but has not passed—legislation to reduce evergreening. Subsequently, the FDA issued regulations in 2003 that while viewed by some as less strong than the proposed federal legislation, will close some loopholes that permit evergreening. Some of the FDA’s regulations were included in the 2003 MMA.

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 case, 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 2001 prescription drug manufacturers spent $19.1 billion marketing their products to consumers, physicians and other health care providers. Of this amount, about 14 percent, or $2.7 billion, was spent on direct-to-consumer (DTC) advertising, compared with $1.1 billion in 1997 and only $55 million in 1991. This advertising appeared in print media and on radio, television and the Internet. 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 in DTC advertisements and how well consumers—particularly older consumers—understand that information. However, some observers argue 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 promoting their products to physicians and other providers. In 2001 this included $10.5 billion for the retail value of drug samples left with physicians,
$5.5 billion for personal visits by pharmaceutical company representatives to office- and hospital-based physicians, and nearly $400 million for advertising in medical journals. In addition, drug companies spent $1.9 billion in 2000 (the most recent year for which data are available) 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 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. In 2003 the HHS inspector general issued guidance for pharmaceutical manufacturers on what types of actions might be considered fraudulent (for example, those that would inappropriately increase the use or price of certain prescription drugs paid for by federal health programs). At the state level, in 2002 Vermont passed legislation requiring drug manufacturers to disclose the amount of money spent on direct marketing of prescription drugs to physicians in the state.

**Marketing of drugs over the Internet**—According to the Government Accountability 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 illegal sale of prescription drugs to US residents by foreign Internet pharmacies poses the most difficult challenge for US law enforcement authorities. While many of the products sold by these pharmacies are identical to products sold in the US, some were never approved for sale in this country. In addition, some foreign Internet pharmacies lack identifying information about their country of origin, misrepresent themselves as being Canadian pharmacies, or do not maintain standards of pharmacy practice equivalent to those of US pharmacies. 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 regulation 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. The US Department of Justice and the FDA have moved against US-based entities that facilitate sales from foreign-based pharmacies. 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 the act 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 those offered by drugs 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 their safety and that the FDA needs to put greater emphasis on postmarketing surveillance of drugs in order to monitor adverse drug reactions. Critics have also suggested that there may be a conflict of interest in having the FDA rely so extensively on drug manufacturer user fees to finance its drug approval activities. 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, drugs 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, giving 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 insurance typically does not cover nonprescription drugs.

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 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 access, 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.

AARP supports the use of well-designed drug formularies or preferred drug lists under specific circumstances, because these mechanisms can be effective cost-containment and quality enhancement tools. However, states—and in the case of Medicare prescription drug plans, the Centers for Medicare and Medicaid Services (CMS)—should oversee and monitor health plans’ administration of pharmacy benefits (including the use of preferred drug lists in state Medicaid programs) to ensure that they meet the following standards:

- 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.

- When making formulary decisions about classes of drugs used to treat a particular medical condition, the P&T committee should include medical providers with expertise in that specific condition.
- 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.

- P&T committees give special consideration to evidence of factors that might contribute to variability in drug response among demographic groups (e.g., those that differ by race, ethnicity, gender or age) when developing the preferred drug list.

- Insurers and pharmacy benefit managers (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.

- Pharmacy benefit management systems that contain any financial incentives—such as manufacturer rebates to the third-party payers or PBMs, or payments to physicians or pharmacists—do not interfere with the delivery of high-quality, medically necessary care.

- Pharmacy benefit management systems do not require practices (in an effort to control costs) that may be unsafe for consumers, such as mandatory pill splitting.

- 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.

- Insurers permit exceptions to drug formularies and preferred drug lists when medical necessity dictates that a nonformulary or unlisted alternative is needed.

- 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.

- Insurers that apply different cost-sharing levels for “preferred” and “nonpreferred” brand-name prescription drugs have an exceptions process. This 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.

- Insurers should seek frequent feedback from physicians, pharmacists and consumers regarding whether the insurer’s formulary or preferred drug list is limiting access to appropriate medication. Processes for obtaining feedback should at a minimum include access to a toll-free telephone number for registering complaints and periodic surveys of providers and consumers.
■ Insurers maintain and provide on request data on the share of prescriptions for which prior authorization requests are made and the share of prior authorization requests approved.

States (and in the case of Medicare prescription drug plans, CMS) should require insurers to provide clear and easily understood information to enrollees—in both paper and electronic forms—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.

States (and in the case of Medicare prescription drug plans, CMS) should require PBMs to disclose to health plans the amounts and sources of revenues they receive from drug manufacturers (including, but not limited to, drug rebates) and how those revenues will be divided between the PBM and the health plan to lower costs to enrollees. PBMs should be able to require plans to maintain confidentiality of any proprietary data that they receive.

People whose prescription drug coverage employs a formulary or preferred drug list, or their physicians on their behalf, should have the right to an appeals process. The process would allow beneficiaries to appeal insurers’ decisions 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.

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**FEDERAL 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 (HHS) should strengthen consumer protections and regulatory accountability by enforcing its guidance
on the marketing of prescription drug products and by improving efforts to educate health care providers about the guidance.

The Food and Drug Administration (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. Congress also should institute financial penalties for advertisements that contain false or misleading information and require that the FDA approve all advertisements prior to their release (for additional policy on direct-to-consumer advertising of prescription drugs, see Chapter 12, Financial Services and Consumer Products: Drugs—Direct-to-Consumer Advertising).

Congress and/or the HHS 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 ensure their bioavailability and chemical equivalence to brand-name drugs, especially those drugs with narrow therapeutic indices or ranges.

The FDA must ensure that generic drugs are safe and effective and that the generic drug approval process is efficient. All manufacturers of generic drug products should be required to prove bioequivalence to the referenced “innovator,” or original, product before the generic drug can be substituted for the original.

The FDA should educate consumers and health professionals about the safety and effectiveness of generic drugs. The Federal Trade Commission (FTC) should examine the consolidation of the brand-name pharmaceutical industry with the generic pharmaceutical industry to determine its impact on competition and drug prices.

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 and safety of therapeutically similar prescription drugs and should require that research findings be made easily accessible to consumers, physicians and other providers, insurers and payers.

The 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.

Congress should allow American consumers, pharmacies and drug wholesalers to safely import prescription drugs. Importation should initially be limited to drugs from licensed pharmacies and wholesalers operating in Canada and should later be expanded to other countries that, like Canada, have drug distribution systems meeting US safety and quality standards. Strong consumer safety standards—including pedigree requirements, and antitampering and anticounterfeiting measures—must be implemented as part of an importation system. The FDA should be given sufficient resources and authority to ensure that the safety of drugs imported from Canada or other countries is comparable to the safety of drugs dispensed in the US.

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 the market entry of generic products. 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 FDA also should adopt policies and procedures that ensure fairness among applicants in the generic drug approval process.

The FTC should continue monitoring restraints of trade in the generic drug industry and initiate appropriate action against any brand-name or generic drug manufacturer alleged to have violated federal antitrust laws.

The HHS should implement legislation to base Medicare payment for drugs covered under Part B on the average sales price rather than the average wholesale price.
Congress should give Medicaid programs statutory authority to use prior authorization for prescription drugs in Medicaid as leverage to obtain price discounts from manufacturers for state residents not enrolled in Medicaid.

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 costs that enhance access to safe, effective and appropriate drug therapies.

States should attempt to reduce prescription drug costs by adopting market-based approaches such as price negotiation, well-designed preferred drug lists, and information on drug prices and quality for consumers, providers and third-party payers.

States should be able to develop approaches to expanding prescription drug coverage and reducing prescription drug prices, including strategies that use or allow selective contracting arrangements with pharmacies. States should not adopt “any willing provider” or “freedom of choice” laws that apply to pharmacies. However, states should ensure that any selective contracting arrangements provide enrolled members with sufficient access 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 or enhanced benefits to consumers.

AARP supports cooperative efforts among states to ensure access to prescription drugs of good quality at reasonable costs.

States should use the purchasing power of Medicaid and other state-funded prescription drug benefit programs (such as state employee benefits) to obtain prescription drug price discounts from manufacturers and pharmacies.

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 encourage 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 continue and, if necessary, expand their programs to cover gaps in the Medicare drug benefit for low- and moderate-income beneficiaries (including both aged and disabled beneficiaries).

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, replacing a prescribed drug with 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-order pharmacies.

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 retail prices.
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

● Consumer Protection and Consumer Information

Background

Antitrust

Federal antitrust laws are in place to protect open competition in economic markets. Antitrust laws reflect the general principle that competition results in the best-quality goods and services at the lowest price. In recent years the courts have made clear that these laws apply to entities involved in the delivery of health care. Federal enforcement agencies—the US Department of Justice and Federal Trade Commission—have published guidelines for applying antitrust laws and principles to the health care market. The guidelines were developed partially in response to the complaints of physicians and hospitals that antitrust laws prevented them from pursuing collaborative efforts that could result in more, not less, cost-effective health care. The guidelines attempt to distinguish between legal, procompetitive collaboration and illegal, anticompetitive collaboration. The agencies have shown an understanding of the dynamics of the health care market in the enforcement actions they have taken and in the guidelines issued.

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.
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. On the other hand billing errors may sometimes be mistakenly interpreted as intentional fraud.

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 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, 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

Health Care Fraud and Abuse

Adequate resources should be provided to support antifraud and antiabuse efforts at all levels of government and the education of consumers to involve them in these efforts. In addition, a balanced approach 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**

The Department of Health and Human Services (HHS) and the Department of Justice should continue conducting enforcement activities through research to understand the extent of fraud and abuse and the effects of initiatives to combat them, and through investigations, operations and prosecutions to reduce the impact of fraud and abuse on federal health care programs and beneficiaries. Congress should continue to oversee the effectiveness of these enforcement activities to ensure that they are appropriate and do not adversely affect access to patient care.

Restrictions on physician self-referral and provider kickback schemes must be maintained and enforced.

The HHS should expand and intensify its efforts to educate health care providers regarding compliance with Medicare billing rules and assist them in preventing and correcting billing errors.

**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 Control and Prevention, 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 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 healthful 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, also has a substantial impact on public 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. As of January 2004, 16 states had securitized their tobacco settlement funds in response to state budget shortfalls. That is, these states have issued bonds and are using current and future tobacco settlement revenues to repay those bonds, making settlement revenues permanently unavailable for funding public health programs.
With new demands 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 US population might be overlooked. However, the health benefits of sound nutritional habits have long been established (see Chapter 12, Financial Services and Consumer Products: Food and Nutrition—Nutrition Education); smoking cessation has been linked to decreased mortality and lower morbidity; research has demonstrated that better diet and nutrition and greater 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, Transportation: Alternatives to Driving).

**FEDERAL & STATE POLICY**

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

**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 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 efforts to expand access to long-term and
other health care services. 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:

■ 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;

■ direct sufficient financial and technological resources toward solving environmental problems and work cooperatively with the private sector to address environmental concerns;

■ provide financial support for research designed to identify effective strategies to adequately protect the public from biological assaults; and

■ 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:

■ identifying health-promoting behaviors, ways in which such behaviors are linked to health improvements, and the costs and benefits associated with health-promoting activities;

■ adequately funding health promotion programs (e.g., nutritional counseling; exercise and weight control programs; and drug-, alcohol-, and tobacco-addiction treatment programs), preventive health education programs for people most in need, and access to preventive health services;

■ 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);
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;

- supporting research that identifies the effects of health-promoting behaviors on public health with regard to the public and private sectors (e.g., the impact of exercise on cardiovascular health);

- 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);

- supporting the inclusion of prevention and health promotion content in curricula for health care professionals;

- supporting outreach and education about the value of engaging in healthy behaviors, with information targeted to policymakers, consumers and employers;

- supporting policies that promote healthful behaviors and provide incentives to engage in them; and

- strengthening the physical infrastructure that supports health-promoting behaviors (see Chapter 10, Transportation: Alternatives to Driving).

State governments should ensure that their public health infrastructures are adequate, strong and sustainable over the long term before they securitize tobacco settlement funds to balance state budgets.

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 advise 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 this chapter's section Protecting and Improving Health and Access to Care—Health Information, Privacy and Confidentiality).
Protecting and Promoting the Public’s Health

In order to promote government accountability, state governments should develop a public process for deciding how tobacco-settlement funds should be spent and for disclosing annually how they are spent. The disclosure method should be one commonly used by the general public.

Quality of Care at the End of Life

It is widely recognized that significant problems are associated with end-of-life care. The need for quality health care does not diminish as individuals approach the end of their life. 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 months.

A number of obstacles make it difficult for patients to receive the type of care they want. Key among these obstacles is inadequate physician education regarding death and dying, which prevents doctors from communicating effectively with their patients. In addition, a medical culture that emphasizes curing over other care goals too frequently propels doctors to use aggressive care against patient wishes. Another obstacle relates to the difficulties physicians have in making accurate prognoses for patients with life-threatening illnesses. This medical uncertainty discourages the timely initiation of end-of-life care planning, leaves the patient unable to make informed decisions, and may prevent or delay the use of palliative care such as hospice care. In addition, hospice care may be inappropriately discouraged or delayed as an unintended consequence of government attempts to discourage fraud and abuse in the Medicare and Medicaid programs. Finally, a lack of knowledge about palliative care—in particular, adequate management of pain and suffering and psychosocial support—results in an unnecessary degree of suffering by terminally ill patients and an unnecessarily traumatic experience for their loved ones (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 decisions regarding their care at the end of life and to ensure that they have an appropriate range of medical and palliative options, the knowledge base about such care must be substantially improved. There should be a sensitivity to cultural values and beliefs when end-of-life care interventions are considered.

AARP supports:

- improved palliative care, including better treatment for emotional distress, and the elimination of all barriers to the appropriate management of pain and suffering;

- improved training programs and continuing education programs for health care professionals in palliative care and in other issues associated with the care of dying patients—Programs that help providers improve their communication skills, particularly in imparting complex information to seriously ill patients and their families, should be part of standard medical, nursing and social work curricula;

- programs to assist patients in advance care planning and the creation of clear and comprehensive advance health care directives to be shared with providers and loved ones (see Chapter 13, Personal and Legal Rights);

- improved access to palliative care services regardless of patient setting (e.g., hospital, nursing home, residence)—All barriers to patient use of the Medicare and Medicaid hospice benefits should be eliminated. In addition, the reimbursement formula for Medicare hospice care—which has increasingly used costly interventions such as prescription drugs, radiation and even surgery to relieve symptoms—should be reassessed to ensure that it accurately reflects the current mix of services used by beneficiaries receiving state-of-the-art hospice care;

- changes in the way end-of-life care is financed to facilitate appropriate care, e.g., to promote more appropriate use of important palliative care services outside of hospice benefits; and

- research that provides information critical to further improving the quality of care provided at the end of life. Such research should focus on:

  - identifying the outcomes most important to terminally ill patients and their families and developing appropriate outcome measures;
identifying the care processes linked to improved outcomes for terminally ill patients and their families, which will assist in the development of clinical practice guidelines;

- developing information that improves physician’s ability to make terminal prognoses and determine probable outcomes of treatment options to discuss with patients and their families—In the meantime, the best currently available information must be communicated to patients and their families in a timely manner, and

- developing a better understanding 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.

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 physicians’ duty to provide palliative care sufficient to relieve patients’ pain, limited only by patients’ informed wishes and the limits of medical science; and

- statutes, such as the Uniform Health Care Decisions Act, that regulate advance health care directives and are enforceable-in-fact, flexible for patient preferences and unpredictable circumstances, and protective of appropriate end-of-life interventions (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 Health Care Quality Improvement Act of 1986 authorized the Department of Health and Human Services (HHS) secretary to create the National Practitioner Data Bank (NPDB). Administered by the HHS Health
Resources and Services Administration (HRSA) since it became functional in 1990, the NPDB has been the nation’s only central source of information on physicians, dentists, and other health care practitioners who have been either disciplined by a state licensing board, professional society or health care provider or named in a medical malpractice settlement or judgment.

The intent of the NPDB is two-fold. First, the data bank seeks to improve the quality of health care by encouraging state licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior. Second, it restricts the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payments and/or history of adverse actions.

The NPDB contains information on adverse actions in licensing, clinical privileges and professional society membership against physicians and dentists, as well as on practitioners who voluntarily surrender clinical privileges during competency investigations or in lieu of an investigation. Reports of medical malpractice payments made on behalf of health care practitioners are also collected. Although legally required to expand the NPDB to include information on nurses and other health care practitioners, the HRSA has not yet implemented this provision of the law.

Hospitals, health care entities (e.g., HMOs or group medical practices), and professional societies are required to submit adverse action reports to the relevant professional board, which in turn must submit reports to the NPDB and state licensing boards. Insurers and state medical boards are required to submit reports directly to the NPDB. Sanctions for noncompliance with these mandatory reporting requirements range from monetary civil penalties to a three-year suspension of peer review immunity for decisions based on a physician’s or practitioner’s competence and conduct.

Information in the NPDB is not available to the general public and paid access to information in the NPDB is restricted to state licensing boards, hospitals, health care entities, professional societies, plaintiffs’ attorneys, and physicians and other licensed practitioners. In addition, a hospital is required to request information from the NPDB when a health care practitioner applies for a staff position or clinical privileges at a hospital.

In a November 2000 report to Congress, the Government Accountability Office identified several issues that threaten the integrity of the NPDB. Among them were:

- incomplete medical malpractice payment reports;
- late reporting of state licensure actions;
- inaccurate or misleading information in submitted reports;
failures to include nurses and other practitioners in the NPDB, as required by federal law; and

lack of a plan to assess the adequacy of user fees that finance the NPDB operations.

**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 mission, functions and resources of the National Practitioner Data Bank (NPDB) 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 compliance with legally mandated reporting requirements, including implementing the federal requirement to include nurses and other practitioners in the data bank;

- 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 amount, be reported to the data bank;

- requiring that all types of health care organizations, including managed care organizations, query the data bank before credentialing practitioners; and

- the federal government’s taking steps to ensure that the NPDB is adequately funded so that reported data are complete and accurate.

The secretary of the Department of Health and Human Services should investigate changing the way 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).
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Protecting and Promoting the Public’s Health

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 that result from flaws in the complex interactions among several health care professionals, as well as problems at the interfaces between people and sophisticated technologies, products and organizational systems. They also result from individual negligence, impairment and incompetence. Preventable medical injuries may be subject to redress under an area of tort liability called medical professional liability or medical malpractice. Other areas of tort liability that may pertain to users of health and long-term care services—but are distinct from medical malpractice—are product liability (e.g., for certain side effects of drugs or devices) and liability for negligent injury resulting from neglect or abuse, such as in a nursing home or other long-term care setting.

In 1999 the Committee on Quality of Health Care in America, a function of the Institute of Medicine (IOM), issued To Err Is Human: Building a Safer Health System. The report reviewed 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 death. Costs associated with injuries resulting from errors were estimated to be between $17 billion and $29 billion each year.

In studies misinterpreting the IOM data, critics of the report have charged that it overstates the problem of medical injury. The fact is 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 the total annual cost 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. Types of preventable errors may 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., failing to provide prophylactic care or
providing inadequate follow-up care), and other errors resulting from failures
in communication and equipment and other system features. A systems
approach to preventing medical injury focuses on learning how and why
errors occur and developing and implementing systems that will avoid them.

Older patients are particularly vulnerable to preventable medical injury. An
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 to prolong their hospital stay.
This is approximately twice the rate of injury in younger patients. Iatrogenic
(provider-caused) 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.

To date, most discussions concerning preventable medical error and injury
have focused on the medical malpractice system instead of the injury
problem itself. Tort liability continues to be attacked as an important source
of problems with America’s health care system. Rapid increases in some
medical malpractice liability premiums are creating great concern within the
provider community and 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.
Because doctors are not always experience-rated by insurers, doctors with
good records of providing safe, high-quality care may be subsidizing
colleagues with poor records. Some observers consider the practice of
defensive medicine to be a key factor in rising health care costs.

According to a 2003 US Government Accountability Office (GAO) study on
medical malpractice insurance, multiple factors contributed to increases in
premium rates in seven states between 1999 and 2002. (It is important to
note that a lack of comprehensive data prevented the GAO from analyzing
the composition and causes of losses at the insurer level.) These factors
include falling investment income, rising reinsurance costs and losses on
claims. While losses on claims for the entire industry have shown a persistent
upward trend and appear to be the primary driver of rate increases in the
long run, insurers’ loss experiences varied dramatically across the states
studied, resulting in wide variations in premium rates.

The GAO conducted a companion study on the implications of rising
malpractice premiums for access to care by examining data from select states
(national data on providers’ responses to rising premiums are not reliable). In
five states with reported access problems, the GAO confirmed instances of
reduced access to hospital-based services affecting emergency surgery and
newborn deliveries in scattered, often rural, areas. Providers identified other long-standing factors affecting the availability of services in these areas. However, the GAO determined that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis. Case studies of 12 communities in 2002 and 2003 by the Center for Studying Health System Change also found that even in markets with high-profile malpractice insurance concerns, little evidence existed that patients’ access to care has been seriously compromised. Still, continuity of care and patient choice have been limited to some extent in most of these 12 markets.

The GAO also concluded that the overall prevalence and costs of defensive medicine have not been reliably measured. Other sources indicate that 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 nature of the recent medical malpractice debate has not generally focused on patient issues. From a patient perspective the most important purposes of the medical malpractice system are to compensate negligently injured patients and deter unsafe health care practices that lead to injury.

Consumers injured by medical errors are not well served by the current system. 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.

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. One dependable study of closed medical malpractice cases found that nonmeritorious medical malpractice claims had not been paid. That study also found that claimants were often undercompensated, but seldom overcompensated.

Although the malpractice system should help prevent injury, it actually discourages the reporting of medical error. Due both to the protection of information related to litigation and providers’ fear of liability actions, the tort system and some of its stakeholders impede the flow of complete information about errors and adverse outcomes to experts and researchers attempting to learn the nature of systems deficiencies that lead to patient injuries. The result is that the problems that cause injuries cannot be fully analyzed, effective preventive actions cannot be designed and shared across
the health care system as appropriate, needed changes cannot be implemented, and a portion of patient injuries that might otherwise be prevented cannot be avoided.

A variety of solutions to the current problems in the medical malpractice system have been proposed and in some cases, implemented. These include traditional tort reforms, alternative dispute resolution systems, insurance-based reforms, and risk-management approaches. Perhaps the most controversial of the proposed solutions is a limit or cap on damage awards. Because noneconomic damages are likely to constitute a larger share of an award for older, retired or poor people, such caps would exclude a larger portion of legitimate potential claims and, therefore, are expected to have the most negative impact on these groups. As of September 2003 caps of varying levels were in place for noneconomic damages in 27 states. In addition to damage caps other types of tort reforms affect patient access to full and fair compensation. Recent GAO research could not determine the extent to which differences in premiums and claims payments across states were caused by tort reform laws or other factors that influence such differences.

In the long run, approaches designed to address problems in the current medical malpractice system must still significantly reduce the number of preventable medical injuries and offer appropriate compensation for the injured despite improved safety efforts. One attempt to do this is the patient-centered, safety-focused, nonjudicial injury compensation system described by the IOM in late 2002 and recommended for immediate state-level demonstration. Under this system patients would be compensated for avoidable injuries based on a preset schedule of awards. Providers would be required to report and analyze medical errors, implement programs to reduce medical injury, and involve patients in safety improvement efforts.

FEDERAL POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE
• Protecting and Promoting the Public’s Health

Preventable Medical Injury and Medical Malpractice

AARP believes that any efforts to address medical malpractice concerns should begin with a patient-centered focus on reducing errors and promoting fair compensation. AARP does not support malpractice reform proposals that do not reduce errors or promote fair compensation.

AARP supports efforts to eliminate preventable medical injuries and accidents due to procedural errors or inadequacy, and endorses the recommendations of the Institute of Medicine (IOM) with regard to both patient safety and exploration of alternatives to the tort system. As steps toward that goal, AARP supports:
the work of the Center for Patient Safety (CPS), part of 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 so that states collect standardized data on 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 CPS 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 more broadly based responses;

voluntary reporting efforts, which should be encouraged and supported by the CPS—Such programs 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)—The data should be 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 various means of communication; recognize patient safety considerations in developing practice guidelines and standards on the introduction and
diffusion of new technologies, therapies and drugs; work with the CPS 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 are 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 system 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 for addressing 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, such as the comprehensive patient-centered, safety-focused, nonjudicial injury compensation system proposed by the IOM in the context of medical malpractice reform; 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

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. If malpractice exclusions or waivers are established for providers, states should not single out Medicaid beneficiaries or recipients of uncompensated care for reduced protection.

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.

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. Insurance regulators should identify and collect additional, mutually beneficial data necessary to further the understanding of conditions in current and future medical malpractice markets.

Hospitals should be held liable for injuries resulting from medical malpractice that occurs within their walls.
PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Protecting and Promoting the Public’s Health

Background

General Health and Mental Health Research

The US leads the world in biomedical, behavioral and intervention research. The country’s premier research agencies are the National Institutes of Health (NIH), which focuses on biological research, and the National Science Foundation (NSF), which focuses on breakthroughs in basic sciences (e.g., math, physics, chemistry and other disciplines).

The US biomedical research agenda covers a range of disorders and interventions that affect older Americans. The application of cutting-edge approaches to the identification and treatment of disease continues to place the US at the forefront of medical breakthroughs for diseases that affect Americans of all ages. Accomplishing our nation’s research agenda will in part require the participation of human subjects in clinical trials. (A clinical trial may, for example, test a new type of medical care, such as how well a new cancer drug works.)

Some examples of the potential role of medical research in improving health status and quality of life follow.

Dementia—The term “dementia” describes a group of symptoms that are caused by changes in brain function. Some conditions that cause dementia can be reversed, others cannot. The two most common forms of dementia in older people are Alzheimer’s disease (which may affect up to 4 million Americans and seriously limits a person’s ability to carry out daily activities) and multi-infarct dementia (sometimes called vascular dementia). It is important to note, however, that Alzheimer’s disease is not a normal part of aging. Although the cause of Alzheimer’s disease is still unknown, new research has shown that a vaccine aimed at preventing or reversing the formation of the pathologic lesions associated with the disease might be a useful therapy.

Parkinson’s disease—Parkinson’s disease is a progressive neurological disorder that results from degeneration of neurons in a region of the brain that controls movement. In the US at least 500,000 people are believed to suffer from Parkinson’s disease, and about 50,000 new cases are reported annually. Halting the progression of Parkinson’s disease, restoring lost function, and even preventing the disease are all realistic goals due to the accelerated pace of discovery in neuroscience research, advances in our understanding of the cause of Parkinson’s disease, and a wide range of new treatments on the horizon.
Mental health disorders—The most common mental health disorders among older Americans are anxiety and mood disorders. Studies show that mental disorders in older adults are underreported. Still, worldwide, elderly people lead the World Health Organization (WHO) list of new cases of mental illness: 236 elderly people per 100,000 suffer from mental illness, compared with 93 per 100,000 for those aged 45 to 64. Recent research identifying a genetic marker for depression holds the promise of helping millions of Americans of all ages combat the debilitation of depression.

Complementary and alternative medicine (CAM)—This group of diverse medical and health care systems, practices and products is not considered part of conventional medicine. Complementary medicine is used alongside conventional therapies. One example is using acupuncture to help lessen a patient’s discomfort following surgery. Alternative medicine is used in place of conventional medicine. An example is following a special diet to treat cancer instead of seeking surgery, radiation or chemotherapy. In 1997, 42 percent of Americans (83 million people) used some form of 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. However, the current body of medical literature about CAM is limited.

Health promotion and disease prevention—Healthy People 2010 is a set of health objectives for the nation to achieve between 2000 and 2010. The 28 focus areas of the agenda were developed by leading federal agencies with the most relevant scientific expertise. In addition, Healthy People 2010 identified ten major health indicators related to disease prevention and health promotion. Among them are physical activity and obesity, tobacco use, substance abuse, immunization and responsible sexual behavior. To support the goals of Healthy People 2010, various institutes within the NIH have developed a research plan around health promotion and disease prevention.

Healthy People 2010 has also identified the reduction of racial disparities in health care as one of the nation’s top goals. Research has shown that race-based disparities persist despite insurance status. Among Medicare beneficiaries, elderly African-Americans have higher rates of nonelective procedures (e.g., lower-limb amputation) associated with poor outcomes in the management of chronic disease than do older white patients. The causes of these disparities are not well understood, highlighting the need for more research in this area.

Stem cell research and molecular genetics—Cutting-edge sciences are revolutionizing our understanding of human disease, even those diseases that are not inherited. 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. 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 cannot be realized unless the supply of stem cells is adequate.

**Genetic research**—In April 2003 the scientific community completed a high-accuracy sequence of the human genome. Achieving this milestone firmly marks the entrance of modern biology into the genomic era. The intelligent and ethical use of sequence data from human and model organisms, along with technological innovations fostered by the Human Genome Project, will lead to significant advances in our understanding of diseases that have a genetic basis and, more importantly, in what health care is delivered from this point forward.

Between 1994 and 2001 Congress raised the NIH research budget from $11.5 billion to $19.7 billion—an increase of 71 percent. The NSF’s research budget during the same period experienced a 27 percent increase, from $2.5 billion to $3.1 billion. Adequate human, financial and physical resources are critical to ensuring the country’s continued investment in math, physics, chemistry and other basic knowledge. The future of our nation’s research agenda is heavily dependent on continuing breakthroughs in biomedical applications of these basic sciences.

**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:

- greater investment in research on the aging process, particularly on diseases associated with aging, such as dementia (including Alzheimer’s disease) and Parkinson’s disease. AARP also endorses continuing research on diseases, such as HIV/AIDS and chronic conditions affecting both younger and older Americans;

- equitable allocation of funding for research addressing the health concerns of women and minorities;

- equitable allocation of funding for research on racial and ethnic disparities in health care, especially health conditions for which minorities have disproportionately negative health outcomes;

- adequate funding for the National Institutes of Health (NIH), National Science Foundation, Agency for Healthcare Research and Quality, and Center for Mental Health Services—Any targeted NIH funding for specific diseases should be allocated fairly and equitably;
■ making available adequate support for basic science, stem cell and genetic 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;

■ further study of the safety and efficacy of particular complementary and alternative medicine treatments (see Chapter 12, Financial Services and Consumer Products: Food and Nutrition—Dietary Supplements);

■ sustained federal efforts to ensure that the national research agenda, especially that involving human subjects, is carried out with the highest ethical and safety standards; and

■ federal monitoring of the extent to which publicly sponsored research contributes directly to the development of commercial products by private entities.

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 effect on the ability to obtain health insurance coverage. As progress continues toward the inclusion of clinical data in national electronic health care information systems, there are justified concerns that these systems could jeopardize the confidentiality of individual’s health care information and imperil personal privacy.

There is an almost 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 privacy protections for medical information. The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that by the end of 2002, health care system providers and payers adopt uniform information transaction standards and use electronic health information data systems to process transactions. The HIPAA also required 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 (HHS) issued the health privacy regulation in December 2000. In August 2002 the HHS 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.

While the regulation gives important new privacy protections to health care consumers, it is not comprehensive. As provided for by the HIPAA, the regulation directly applies only 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 patients’ written consent before sharing their information for treatment, payment and health care operations. 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 patients’ 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 data 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. Entities 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.

The August 2002 revision eliminated the requirement to obtain written consent before sharing information for treatment, payment and 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 to know the identities of 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 personally identifiable health information and for what purpose. Guarantees of that right must be paramount.

AARP opposes the 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 denies 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.

While balancing the need for stringent safeguards, regulations protecting individually identifiable health information should not interfere with the safe and effective delivery of quality health care services. Entities that must comply with federal privacy regulations should make every effort to ensure that their implementation minimizes interference with the routine delivery of health care services. The Department of Health and Human Services should monitor and enforce compliance with privacy regulations and educate and guide covered entities about whether their policies and procedures are reasonable and appropriate.

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 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 was 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 and thus 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 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 government) and private (e.g., employer) 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 Specialists

Social, economic and demographic factors have created serious shortages and unequal geographic distribution of various health care personnel in the US, most notably nurses, pharmacists and nurse aides. Evidence indicates that these conditions will worsen and increasingly affect the quality and delivery of health care. Shortages in 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, which is 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. Providers commonly lack knowledge about the health care views of these patients. This impedes physician-patient communication and makes successful patient outcomes less likely. In addition, perceived lack of understanding and respect for varying 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 Specialists

Federally funded research should investigate the potential impact of the aging of the health care workforce, which is occurring simultaneously with the overall aging of society.

Federal funding for educating and training health care personnel should target 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 needed 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 complementary and alternative medicine (CAM). Additionally, physicians should encourage communication with their patients regarding CAM usage (for AARP’s position on research funding for CAM, see this chapter’s section Protecting and Improving Health and Access to Care—Protecting and Promoting the
STATE POLICY

PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE

Availability and Training of Health Care Personnel and Geriatric Specialists

States should:

■ mandate that professional schools with health and human services curricula require education in geriatrics and gerontology;

■ require providers renewing their license to submit proof of continuing education in geriatrics if they treat older adults;

■ establish and enforce appropriate educational, training and continuing competency standards for all health care providers, including those who represent themselves as having a specialty in geriatrics (for more on continuing competency requirements, see this chapter’s section: Protecting and Improving Health and Access to Care—Consumer Protection and Consumer Information—The Need for Strong Quality Protections and Consumer Information);

■ 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.