4/1/2022 Testimony relating to S.239 for the House Committee on Health Care

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I want to share with you the role that the Community of Vermont Elders (COVE) plays in the Medicare sphere here in Vermont. We are the sole administrators of the Senior Medicare Patrol for Vermont, which seeks to prevent, detect, and report instances of Medicare error, fraud, and abuse. As such, we handle complex cases of older adults who have been victimized, field calls from people who are confused, and provide public education around consumer protections. We work closely with the State Health Insurance Assistance Program (SHIP) which you will hear more about. Medicare is a complicated system, as you are well aware. It consists of three main parts:

Part A (Hospital Insurance): This helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care. Most people get Part A for free, but some have to pay a premium for this coverage.

Part B (Medical Insurance): This covers services from doctors and other health care providers, outpatient care, home health care, durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment), many preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). Part B is a voluntary program which requires the payment of a monthly premium for all months of coverage, as well as co-pays.

Part D (Drug coverage): This helps cover the cost of prescription drugs (including many recommended shots or vaccines). You join a Medicare drug plan in addition to Original Medicare (parts A and B) or you get it by joining a Medicare Advantage Plan with drug coverage. Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.

Medicare Supplemental Insurance (Medigap): Extra insurance you can buy from a *private company* that helps pay your share of costs in Original Medicare (Parts A and B). Policies are standardized, and in most states named by letters, like Plan G or Plan K. The benefits in each lettered plan are the same, no matter which insurance company sells it.

COVE and others in the field receive a lot of calls from confused or frustrated clients concerning Medicare Advantage plans. Medicare Advantage is a private insurance product that replaces original Medicare. It should be noted that an in-depth county-by-county analysis from the Commonwealth Fund has found that while MA plan costs per beneficiary were lower than traditional Medicare costs in urban areas, they were substantially higher in rural areas. Anecdotally, we find that most of our clients who have Medicare Advantage plans are fine with them while their health care needs are low, but as soon as they need more expensive care, those out-of-pocket costs skyrocket. Many people are looking for a financially secure way out of these plans, and in Vermont there is no way out without being financially penalized, every month, for the rest of their lives.

Original Medicare	**Medicare Advantage (also known as Part C)**
Original Medicare includes Part A and Part B.	Medicare Advantage is a Medicare-approved plan from a *private company* that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).	
You can use any doctor or hospital that takes Medicare, anywhere in the U.S.	In most cases, you'll need to use doctors who are in the plan's network
To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also buy supplemental coverage, like Medicare Supplement Insurance (Medigap), or have coverage from a former employer, union, or Medicaid	Plans may have lower out-of-pocket costs than Original Medicare.
	Plans may offer some extra benefits that Original Medicare doesn't cover — like vision, hearing, and dental services.

COVE supports the passage of S.239, and would in fact support the reintroduction of the original language that creates an annual enrollment period.

Yesterday someone said that the current situation is good because "insurers don't have to worry about consumers dropping [their] coverage." I would argue that if we are going to have a privatized, capitalist model for health insurance, then we must also include the foundation of the capitalist model: competition. You can't have your cake and eat it too. The ability to shop for a plan on a regular basis applies market pressure to those insurance providers to offer better plans at lower prices. Where are the consumer protections, if a person is held hostage to a decision they made 20 years ago?

The current model in Vermont is this (with some exceptions): At age 65 you join Medicare. During the months leading up to that moment, you are inundated with information, some of which is good, some of which is good for now, and some of which is misleading. You have 6 months to make a decision. From that moment forward you are locked into that decision. Say you live to be 95. This model assumes that at 65 you are able to predict and prepare for something that is 30 years in your future. This is ageist. What other 30 year span of the population would we expect this of? We wouldn't even consider lumping 10-year-olds with 40-year-olds. We wouldn't say that a person should be able to decide what is best for them at 60 when they are 30. The body changes along a continuum from the time we are born till the day we die. To suggest that a person should be penalized for attempting to make a decision that addresses their changing needs is ludicrous.

The issue we are facing in Vermont and across the nation is one of equity and access. Let me be very clear, to a potential customer, medical underwriting means their current health will be evaluated, all their risk factors will be weighed, and a person who is high risk may be denied coverage. Medicare Advantage plans are particularly susceptible to "cherry picking" and "lemon dropping" which are the act of using that medical underwriting interview process to determine who is going to cost the insurance

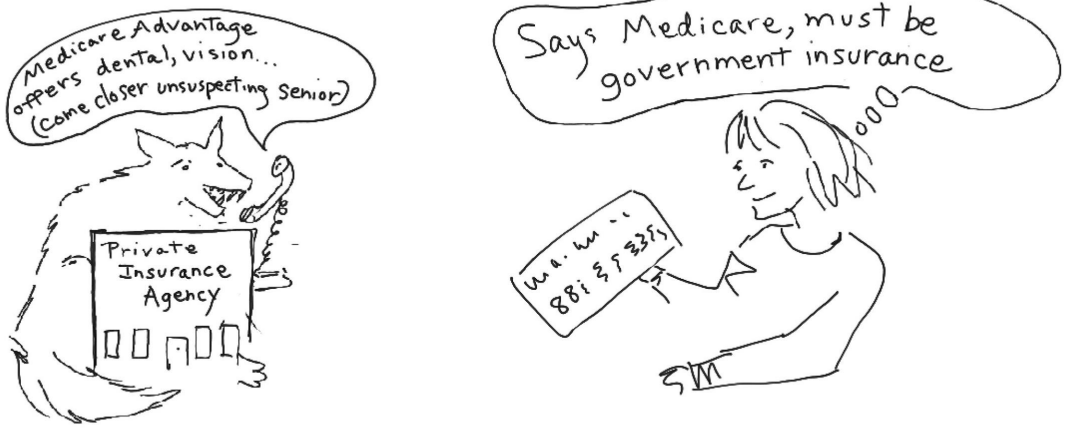
company the least amount of money (statistically) so that they can make the largest profits (as determined by the difference between the total amount paid in through premiums and the total amount paid out through claims.) That's cherry picking. Lemon dropping is forcing out or dropping clients who don't have guaranteed issue because they are becoming expensive. So who are the patients who are "lemons"? Two primary characteristics of "lemons" are obesity and diabetes, conditions that are much more common in women and patients of color. Roughly 56% of women of color are obese, as compared with 32% of white women. CMS openly acknowledges the problem of cherry picking and lemon dropping in MA plans, but has yet to do anything to regulate the issue and protect those most vulnerable. Medicare Advantage plans further ensure their own profits by limiting the networks of doctors and hospitals; limiting the care available for expensive conditions, so sicker patients will leave; not covering hospitals needed for the most expensive care; and not covering medications that are needed by expensive patients.

There may be many reasons that a person decides to switch. The main focus has been for reasons of affordability. Others might include access to care. This is especially a problem for people living in rural areas. A person may discover, 10 years down the road, that there isn't an in-network specialist in their area. A person may discover that their insurer is changing its network or that there is risk of that, as we saw with United Healthcare and UVMMC negotiations last week. I'll be honest, if I had a Medicare Advantage plan through United Healthcare and lived in Chittenden County, I would be very nervous about the negotiations of the MA and other plans that will be happening in 2023. I might even take advantage of that annual enrollment period to avoid an interruption in care or to ensure I can keep my provider. Another reason is that someone received bad, misleading, or partial information. *$0 PREMIUMS. PRESCRIPTION DRUG COVERAGE. DENTAL, VISION, AND HEARING COVERAGE. FREE GYM MEMBERSHIP.* At COVE, we say again and again, if it sounds too good to be true, it probably is.

This committee knows more about insurance than the average person, by far, and yet I have watched 2 days of discussion with multiple experts in an attempt to understand the issue here. The education that is happening from COVE, the Area Agencies on Aging, the Office of the Healthcare Advocate, DFR, and others simply can't drown out the profit-driven advertising of the insurers. Prevention is great. Education is great. COVE strongly supports the educational component of this bill. We would argue, however, that prevention must go hand in hand with protection. In circumstances where someone has made a decision that turns out to be inadequate for their needs, we need a "yes, and" solution here. We need education, certainly, *and* we need a study group, *and* we need a way out.

Mike Fisher recognized yesterday that there are many possible solutions here. I would like to see stronger language in the study group section that mandates that advocacy organizations be joined by individuals, care providers, and others to ensure that the seemingly "forgone conclusion" suggested by some entities yesterday is counterbalanced by a real desire to find solutions that work for Vermonters.

Older adults do not deserve to bear the brunt of the risk. Our insurance products should be designed to protect older adults, provide a spectrum of options that best serve their needs, and create fluidity that can allow for changing circumstances and needs that are difficult to predict.



Did you know? Medicare Advantage is run by Private Insurance companies and is <u>not</u> Medicare.