1. Reform Medicare without Undermining healthcare for 10 million beneficiaries.

Changes in the payment system for Medicare Advantage are appropriate. But these changes should be designed to minimize disruptions to the health care of the more than 10 million Americans enrolled in Medicare Advantage plans

Policymakers need to set stable, uniform standards for payments to Medicare Advantage plans. In April, the Centers for Medicare and Medicaid Services (CMS) projected that it would pay Medicare Advantage plans in 2010 at a level that assumes dramatic decreases in physician payments in fee-for-service Medicare. This is at odds with the Federal Budget for Fiscal 2010, as proposed by President Obama and revised by the Congress, which recognizes the Administration's and Congress's intent to cancel the scheduled 2010 cuts in payments to doctors. To compound the problem, a drafting error in the Deficit Reduction Act of 2007 inadvertently removed the 2 percent minimum update for Medicare Advantage county reimbursement rates.

To avoid disruptions in patient care, policymakers need to correct these mistakes and set stable payment rates for Medicare Advantage plans and their physicians. This means:

- Restoring the 2 percent minimum update for Medicare Advantage county reimbursement rates;
- Revising the CMS 2010 Medicare Advantage rates to take into account the 2 percent minimum update and the planned physician payment fix; and
- Allowing Medicare Advantage plans to revise their bids to improve benefits for enrollees in 2010, based on these corrections.

2. Make Medicare more user-friendly and affordable, especially for low-income beneficiaries.

A. Part D: Medicare's launch of a prescription drug benefit in 2006 filled a fundamental need for Americans with Medicare, especially those with limited incomes. Still, Part D can be improved, and healthcare reform offers the opportunity to make needed changes. .

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For many people, it is difficult to understand the benefits of enrolling in Part D and difficult to understand the plan most likely to work best. The Administration should bring together a task force of Part D sponsors and consumer counseling experts to simplify Part D education materials and streamline the government's website to allow for better educated consumers. People with Medicare who have limited incomes have a difficult time affording the out-of-pocket costs – premiums and co-payments – that are required by Part D. They find it even more difficult to pay the cost of medications – sometimes the entire cost – during the Part D coverage gap. Studies show that many people are forced to go without prescribed medications during the coverage gap.

As long as there is a coverage gap" in prescription drug coverage, Congress should ease the burden for people with limited incomes to enroll in the Extra Help program that covers most out-of-pocket costs. Because people with low incomes but modest savings should not be punished for their frugality, the asset test for the Extra Help program should be abolished. Already, several states, through reform of their Medicare Savings Program eligibility standards, have eliminated this asset test. This should be a federal standard. Further, Congress should synchronize the application process and eligibility criteria for the Extra Help program and Medicare Savings Programs. This would eliminate unnecessary confusion and paperwork that results in many needy and eligible people failing to get the benefits which can help keep them healthy.

B. "De Mimimis" Rule: In addition, to avert disruptions in patient care, CMS should restore its "de minimis" rule, so that small differences in the bids by Medicare Advantage plans will not result in moving large numbers of people from plan to plan. These moves often disrupt a patient's access to needed medications and cause unnecessary confusion and anxiety for the man or woman with Medicare.

C. Special Needs Plans: In another problem affecting low-income people, health care for "dual eligibles" – people eligible both for Medicare and Medicaid – is expensive and poorly coordinated. Medicare Advantage sponsors can offer Special Needs Plans designed to meet the needs of dual eligibles, but these plans are scheduled to be terminated in 2011. Community health centers are experienced in treating low-income patients but often lose dual eligibles to other providers when they become eligible for Medicare. This interrupts the continuity of care for low-income seniors and cuts into community health centers' revenues.

Because Special Needs Plans are essential for providing coordinated care to people eligible for Medicare and Medicaid – and for supporting community

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health centers which are indispensable for healthcare in many places – the Special Needs Program should be continued past 2011.

3. Provide more choices for seniors, especially in rural areas.

Currently, the Medicare Improvements for Patients and Providers Act of 2008 prevents there from being more than two Medicare Advantage private fee-for-service plans per county after 2011. Further narrowing seniors' choices, the law inadvertently allows both plans to be offered by the same Medicare Advantage company. This allows an entrenched company to eliminate its competition easily, denying consumers any meaningful choice.

There should be a technical fix to eliminate additional private fee-for-service plans only in those areas with network-based plans offered by two or more Medicare Advantage companies.

4. Offer new Medigap options.

Upcoming changes to Medicare Advantage, including payment cuts and new Private Fee-for-Service network requirements, will likely force a substantial number of enrollees out of the Medcare Advantage program. Many of these consumers are likely to seek supplemental "Medigap" coverage. Unfortunately, they will face much higher premium costs than they pay under Medicare Advantage today.

To help these seniors to afford their coverage, there should be a demonstration project where CMS contracts with Medigap insurers or Part D insurers to provide lower-cost Medigap plans.

As part of the demonstration, the insurer would process all Medicare claims for the enrollees. Also, the insurer would bid on a defined set of supplemental benefits – and that bid would become the beneficiary premium. CMS would make a small payment to the insurer to conduct care management activities, sharing the savings with the insurer.

In addition, there should be a new, lower-cost standard Medigap plan with a modest $300 deductible, a physician visit co-payment ($10 primary care/ $20 specialty), and an out-of-pocket limit ($2,500).

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5. Support patient-centered, results-oriented improvements to Medicare.

Patient-centered medical homes and accountable care organizations can improve patient care in fee-for-service Medicare. These innovations should be incorporated into Medicare.

Currently, fee-for-service Medicare delivers care through a fragmented delivery system that leaves beneficiaries to coordinate care from multiple physicians in multiple care settings. The incentives in the system reward the quantity of services, not the quality of patient outcomes.

Patient-Centered Medical Homes and Accountable Care Organizations hold the promise of coordinating patient care through a single primary care physician. These innovative approaches will also align incentives in the system toward better outcomes at lower costs. These valuable reforms should be incorporated into fee-for-service Medicare.

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