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MEDICARE AND MEDICARE ADVANTAGE: CHALLENGES AND OPPORTUNITIES WITH ENROLLMENT

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C O N T E N T S

MEDICARE AND MEDICARE ADVANTAGE: CHALLENGES AND OPPORTUNITIES WITH ENROLLMENT

Friday, February 23, 2024

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m. CT, at the Douglas County Health Center, Omaha, Nebraska, Hon. Pete Ricketts, presiding.

Present: Senator Ricketts

OPENING STATEMENT OF SENATOR PETE RICKETTS

Senator RICKETTS. This hearing is called to order. Isn't that cool? I actually get a gavel. This is pretty cool.

This is the first time I have been in charge of a hearing, so I am very excited to have all of our guests here today and I welcome everybody as a part of this. Thank you very much for taking time out of your schedules to be here. Again, this is the first time I have done this. Please give me a little grace in case we make mistakes or something happens here.

I really appreciate everybody coming here to discuss Medicare Advantage enrollment program and application process and how confusing and cumbersome it can be for older Americans and their loved ones. I want to start by thanking my lovely wife, Susanne. Susanne, where are you? Back there, thank you, Susanne. One of the inspirations for this hearing was the difficulty we had with Susanne's parents as we were going through this transition of Medicare and Medicare Advantage and so forth, and it raised a lot of questions.

One of the things, then, really what I hope for this hearing is that we are going to be able to maybe clear up some of the questions or maybe surface some issues, educate people about what they should be thinking about with regard to Medicare and Medicare Advantage. We have got a great group here of people to be able to help us.

I would also like to recognize LeadingAge Nebraska and the Douglas County Health Center for graciously hosting this event today.

As the population in the United States ages it is vital that we take a closer look at the institutions and programs that we trust to take care of our older folks. In addition, we must ensure pro-

grams like Medicare have accurate and easily understandable information that is accessible to those who rely upon it.

From 2008 to 2018, the population over 65 years of age grew from 39 million to 52 million. By 2060, that population will be 95 million people. According to the last census, 16.4 percent of Nebraska's population was over the age of 65. Every family has a loved one, a mother, a father, a grandparent, who is enrolled in Medicare or Medicare Advantage. One day, if we are all fortunate enough, we will also have to make these decisions for ourselves. That makes today's hearing topic an enormous concern for every American.

Our job is to protect America's most vulnerable citizens and ensure that they are equipped with the tools to make the best decisions for their own care.

I am going to start today by introducing each of our witnesses, so I will start over here on my right. Mr. Lange is from Omaha, Nebraska, and is a recently retired maintenance supervisor with Omaha Steaks. Mr. Lange turned 65 this month—so you have been going through this very recently, and is here to share his personal experience with the Medicare application process.

Next we have Jana Danielson. Ms. Danielson serves as the Vice President of Revenue Cycle for Nebraska Medicine. Oh, I am sorry. That is over here. Sorry, Jana. Sorry. That is Jina over there. Like what is going on over there? All right, sorry. They didn't put these in order. You guys all sat—okay, so here is an example, first time the host of this stuff. Rookie mistake.

All right. Well, next on my list actually, we are going to go this way as well, Jina Ragland. Ms. Ragland is the Associate State Director of Advocacy and Outreach of AARP Nebraska. Thank you, Jina, for joining us.

Kierstin Reed. Ms. Reed is the Chief Executive Officer of LeadingAge Nebraska, so thank you very much, Kierstin, for being here.

All right. Now we are going to go over here. We already covered Jana, so sorry, Jana, for getting out of order there.

Then, finally, Dr. John Trapp. Dr. Trapp is the System Vice President of Medical Affairs and Chief Medical Officer at Bryan Health. Thank you very much for joining us.

In a moment we will be hearing from all of them, so I think we are going to start with the witness testimony now. We will just kind of go in the order and swing this way and do the witness testimony. David, we will go ahead and start with you, and then we will go to Jina and kind of work our way around, so let's start with you.

STATEMENT OF DAVID LANGE, MEDICARE APPLICANT, PLATTSMOUTH, NE

Mr. LANGE. Thank you. Good morning. I appreciate the opportunity to be here. It is also my first time for anything like this so don't feel alone.

Dave Lange, 65 years old. I just had my birthday. I just turned 65 on the 16th of February. When I was 18 years old, I went into the United States Navy after finishing high school with a GED. I tested high on a mechanical scale, so they turned me into a boiler

technician, a rate that no longer exists as far as I know. A little while after my tour of duty I wound up applying to the Maintenance Department at the Swanson Building in downtown Omaha, owned by Campbell Soup. I was there 20 years. I met and married my wife of 25 years while working there. We lived in Plattsmouth and raised my daughter, her two sons, and her other daughter. Instant full household.

The kids are grown and moved away now. Both my wife Joyce and I have continued to work in various food production facilities throughout the metro area, companies such as Conagra, Tyson, Armor Swift. She is presently still the QA manager at Mammas' Tortillas in downtown Omaha. I just left Omaha Steaks. Unfortunately, I wasn't a supervisor there, but thank you. I have had that experience, but I was just turning a wrench there. There were two things I wanted for my birthday. One of my birthday presents was retirement at 65.

Sometime in late 2023, I received information in the mail that indicated enrollment in Medicare was required prior to my 65th birthday. I was also getting bombarded with phone calls, messages, emails, about Medicare plans, and what I needed to do about it all. After doing some research, asking a lot of questions from current retirees, recent retirees, et cetera, I was even more confused than when I started. Some of their information going back to older retirees had changed, so I expected some of that. I came to realize many of these were and are, in my opinion, "sales" opportunists. I contacted some of them only to find out whatever they offered, whether it be a "plan" or "service," it would come at a cost. Maybe I didn't make the right phone calls to the right people, but like I said, I tried to figure it out.

With good faith in mind, I set out to visit the website and see how far I could get. I have been fortunate in my life where I have had to learn and develop good computer skills in order to hold the management positions I have had. No prodigy but can hold my own. Unfortunately, me and passwords don't get along, so we went round and round a little bit.

Eventually this became a little more user friendly. I reviewed the "items/info required" list. Sorry, but this was pretty helpful. I don't mean sorry. It was very helpful, by the way. I gathered up everything and started the application. Once started it was very quick and went pretty smooth. It took probably 20 minutes because we were reading carefully. I am pretty sure I saw a box on the app that asked if I was presently covered by a health plan. I answered yes.

At the end of January 2024, I received a bill for $524.10 for Part B coverage for the time of 02/01/2024 to 04/30/2024. I received this prior to the first of February, so I hadn't even started it yet. This was a shocker. I reached out and was able to locate a reputable Medicare counselor. She was able to coach me and well as assist with the correct form to "un-enroll" from Part B. I am covered under my wife's employer-provided group health insurance plan, hopefully for the next five years. I have got a little parachute there. That is what I had to do in order to get out from underneath that bill, not that that was my only driving. I just didn't need it right

now. I was a little confused with why I was being told I had to do that prior to 65.

I think I got an explanation, but it was very confusing. The counselor tried to help me think my way through it, but once the problem was resolved we just moved on.

I have since gone back onto the website to check my status and have seen the correction has been made. In early February, I applied for Social Security benefits.

I am sorry. That was my Medicare application experience.

I have since gone back onto the website to check, and that has been corrected. In early February, I applied for Social Security benefits. This process was similar to signing up for Medicare, minus the previously endured "log in/password" issues. I am still awaiting news of acceptance. Overall, I would say the system works, needs a little getting used to, but hopefully will be fine. Oh, what was the second thing I wanted for my birthday? An ice-cold margarita.

Through it all, it was daunting, it is a big decision to make, and the more I dug the more it enveloped. It kind of mushroomed on me, and sorry, it kind of irritated me a little bit because I couldn't really nail down what I was looking for, and then when I thought I did, there would be a dollar sign at the end of the road. The Part B, the supplementals, the extras that you can buy when you retire strike me as a threat to what I am getting out of the basics. Already we are deducting from the basic that I will desperately need. I suspect someday she is going to retire, in five years hopefully. I am a little older than her. We don't have nest eggs, but I am hoping for the best. It is a big decision.

The website is a little bit better than I initially thought it was going to be, so good job on that one.

Senator RICKETTS. Good. Thanks, David. We will do some more questions in a little bit, too. We will let everybody kind of get a chance to do their testimony.

Mr. LANGE. Thank you for me being here today.

Senator RICKETTS. Thank you very much, David. I appreciate you sharing your experience with us. I have got some questions for you as well.

Jina.

STATEMENT OF JINA RAGLAND, ASSOCIATE STATE DIRECTOR OF ADVOCACY AND OUTREACH, AARP NEBRASKA, LINCOLN, NE

Ms. RAGLAND. Thank you for inviting AARP to participate in today's hearing. My name is Jina Ragland, and I am the Associate State Director of Advocacy and Outreach for AARP Nebraska.

AARP, which advocates for the more than 100 million Americans aged 50 and older appreciates the Senate Aging Committee's effort to examine the Medicare enrollment process and ways to improve it for older Americans. We would like to thank Senator Ricketts for leading the Improving Measurements of Loneliness and Isolation Act and for co-sponsoring the Alleviating Barriers for Caregivers Act.

There are currently over 66 million Americans with Medicare and roughly four million people join Medicare for the first time each year. In Nebraska alone there are over 370,000 Medicare beneficiaries, which is roughly 19 percent of our population.

For many, Medicare enrollment is a confusing and time-consuming process, often requiring the help of loved ones and trusted individuals to guide them through it. Congress and community partners like AARP can all play a role in making the enrollment process as stress-free as possible. I would like to take a few minutes to mention some positive steps that can be taken to improve the process for everyone.

First is beneficiary eligibility notification. One of most common complaints about initial Medicare enrollment is lack of awareness about eligibility timelines and enrollment requirements. Failure to timely enroll in Medicare can result in costly penalties that can be added to your premiums for as long as you have Medicare. The Social Security Administration should notify potential Medicare beneficiaries well before they reach Medicare eligibility at age 65. They should inform them about the steps that they will take to enroll and about the circumstances under which premium penalties may be assessed. Bipartisan legislation in the Senate, the Beneficiary Enrollment Notification and Eligibility Simplification Act would help people approaching age 65 punctually and properly enroll in Medicare, thereby preventing delays in coverage and costly penalties.

We must work to improve Medicare education. Even if a person knows they can sign up for Medicare they may not know how. The decision-making process can be overwhelming for many individuals, and AARP endeavors to be a trusted friend for older Americans to turn to, but oftentimes there are more complicated questions that come to play, so the State Health Insurance Assistance Programs, or the SHIPs, become a valuable resource. SHIPs provide local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers. Each state has a SHIP, and it is managed through the Nebraska Department of Insurance with Federal funding support. An important step the Federal Government can take to help people through the Medicare enrollment process is to increase funding for SHIPs, Area Agencies on Aging, and the Disability Resource Centers. We urge Congress to fully restore the $50 million in mandatory funding in the next spending deal to enable SHIPs and other entities to help make Medicare more affordable for low-income beneficiaries.

Next we should include family caregivers more. While it can be confusing or overwhelming for Medicare beneficiaries or those enrolling in Medicare to navigate the program, it can also be challenging for family caregivers who are assisting or advocating on behalf of a loved one. AARP supports two bipartisan bills that help make providing care easier and save family caregivers time and frustration when trying to navigate or get care for their loved ones in Medicare. First, the Alleviating Barriers for Caregivers Act would help reduce red tape by requiring CMS and Social Security to review their eligibility determination and application processes. We appreciate Senator Ricketts co-sponsoring this important legislation. Second, the Connecting Caregivers to Medicare Act would help inform people about the voluntary option for Medicare beneficiaries to allow family caregivers to access their health information through 1–800-MEDICARE. Supporting family caregivers helping their loved ones navigate Medicare is essential.

Fourth, we can better educate employers. Most people enrolling in Medicare for the first time are transitioning from employer-sponsored health coverage. The employer is well-positioned to help individuals make the transition to Medicare and avoid enrollment mistakes and costly penalties. Yet they are often ill-equipped to provide guidance or answer questions for their employers. Better employer education can help reduce information errors and provide another reliable source of information for consumers.

Last, we need clearer Medicare Advantage information. The explosion of Medicare Advantage plan availability with the average beneficiary having access to 43 different plan options in 2024 alone can make enrollment in the right plan a daunting process for even the most knowledgeable consumers. Plan marketing directly affects consumers' experience and ability to make informed choices. In many cases, deceptive marketing practices have led individuals to enroll in a plan that does not meet their needs. There are concerns about Medicare marketing abuses about MA plans, and there is a need for greater oversight, enforcement, and regulation of marketing materials and marketing standards for MA plans.

Improved transparency about agent, broker, and third-party organizations' compensation and financial incentives could better help inform consumer decision-making. It is also critical to equip consumers with a clear pathway to lodge a complaint about problematic marketing practices. Increasing access to unbiased sources of information, such as through SHIPs, is essential to helping consumers discern Medicare marketing information.

In conclusion, thank you for the opportunity to provide AARP's perspective on improving Medicare's enrollment process. I would be more than happy to answer questions, and we look forward to working with you to address this important issue and ensure continued access to affordable health benefits for Americans.

Senator RICKETTS. Thank you, Jina.

Kierstin.

STATEMENT OF KIERSTIN REED, CHIEF EXECUTIVE OFFICER, LEADINGAGE NEBRASKA, LINCOLN, NE

Ms. REED. Well, good morning, Senator Ricketts, fellow witnesses, and members of the public. Thank you for being here today. My name is Kierstin Reed, and I serve as the President and CEO of LeadingAge Nebraska.

We appreciate Senator Ricketts bringing this hearing to Nebraska. LeadingAge Nebraska is a membership association that provides advocacy and education for providers of long-term care services in our State. We represent 80 providers across the State and work with our national partner, LeadingAge, to provide support to over 5,000 long-term care providers across the U.S.

Since the inception of the Medicare system in 1965, there have been numerous development and changes with the system that now covers over 63 million beneficiaries across the U.S., with over 300,000 of them being in Nebraska. The most recent change to that system is the addition of Medicare Advantage, also known as Part C or private insurance option, that is meant to replace traditional A and B benefits.

The process for choosing to receive Medicare benefits is a daunting task, for beneficiaries and supporters, because the number of options has increased. The amount of information they need to wade through to try to understand the benefits that are available to them and the differences between traditional Medicare and Medicare Advantage plans can be very overwhelming. The number of services claiming to help seniors select an Advantage plan seems to be a never-ending list and that continues to provide difficultly to find a reputable, trusted source to provide their decision-making process.

LeadingAge Nebraska works with many nursing homes and home health providers across the State, providing support to older adults. When older adults find themselves in need of nursing care, either short term or long term, and they have generally already enrolled in a Medicare plan, it is often at this point in time that a professional is explaining the fine print of the plan that they chose and what services are available to them. When you find yourself or a loved one in a long-term care service it is already a difficult process to understand.

We find that beneficiaries and their family members may not fully understand what is covered in their Medicare plans. Many beneficiaries are under the belief that because they have Medicare, long-term care services are going to be completely covered without any out-of-pocket expense, and they will last until they no longer need them. Beneficiaries are often surprised by the limitations on the services that they receive and the overall cost of the care that they need. For those in skilled medical services, Medicare will pay a portion of their stay, if they are approved, for a period of time. If they no longer meet the skilled stay or they have used their maximum benefit, Medicare no longer covers these services. The average cost of nursing home care in Nebraska is $7,500 a month, for custodial care, which is not covered by Medicare.

As people are living longer and have more complex health conditions, we find that beneficiaries are often outliving their personal resources for care, even with their Medicare benefits. Currently, 60 percent of nursing home residents in Nebraska rely on the Medicaid system as their payer source because they no longer have funds to pay for service.

The expansion of Medicare Advantage programs has increased this confusion for beneficiaries when they are selecting a plan. There are numerous Advantage plans that muddy the waters of an already complicated system. Currently, more than 50 percent of beneficiaries nationally are enrolled in a Medicare Advantage option. For Nebraska, this average is closer to 30 percent, but the average continues to rise. These plans entice beneficiaries with many benefits that are not available through traditional Medicare model. However, beneficiaries find that these plans may not be widely accepted by every provider or that they are limited in their options for care. Beneficiaries may also find that Medicare services that they expect to receive are not the same through Advantage plans as compared to traditional Medicare, due to Advantage plans' authorizations, denials, and limitations of service. The intent of these plans was to provide equitable coverage that matches Parts A and

B, in addition to providing the extra benefits such as vision and dental, that are not included in the base plan.

Today there is evidence that Medicare Advantage plans are denying coverage for services and terminating before the beneficiary is ready to go home. We need to assure that beneficiaries are receiving equitable coverage regardless of how they choose to receive their benefits.

In order for our health system to work efficiently and effectively, there needs to be a focus on provider payment equity for services that are covered by Medicare. Traditional programs like Medicare and Medicaid have paid lower reimbursements than private insurance. The introduction of Medicare Advantage moved this to a deeper level. Some Advantage contracts to providers are equal to the State Medicare level, which experts agree does not begin to cover the cost of custodial care, let alone more intense skilled care that are provided through a beneficiary with significant health needs.

If the concerns of Medicare, particularly with the Advantage plans, continue, it will cause an erosion in our health care system. Providers of long-term care services are already closing at an alarming rate due to the rising costs of care, staffing shortages, and inadequate reimbursement system. Patients are waiting for weeks to months in our Nebraska hospitals for placement in long-term care. Nebraska has lost 17 percent of our nursing homes since 2017, and we are at risk for losing more in the coming years, particularly if the proposed Federal minimum staffing rule on the horizon that would require nursing homes to add more positions that cannot be filled under our current workforce or reimbursement constraints.

In closing, LeadingAge Nebraska wants to assure that older adults receive fair and equitable access to Medicare services. We want to assure that they understand the benefits that they are receiving and that they have made a clear choice in choosing between traditional Medicare and Medicare Advantage, and the long-term impacts of those choices are known to them. We also want to ensure that the services are available to them when they need them. There are improvements that can be made to address the access to these benefits and meet the needs of beneficiaries.

Thank you for the opportunity to testify today.

Senator RICKETTS. Thank you, Kierstin.

Dr. Trapp.

STATEMENT OF JOHN TRAPP, M.D., SYSTEM VICE PRESIDENT OF MEDICAL AFFAIRS AND CHIEF MEDICAL OFFICER AT BRYAN HEALTH, LINCOLN, NE

Dr. TRAPP. Thank you. Good morning. My name is John Trapp. I currently serve as the Vice President for Medical Affairs and Chief Medical Officer for Bryan Health. Bryan Health is a six-hospital, locally owned, locally governed Nebraska health system.

For those of you who don't know me, my background is in pulmonary medicine, critical care, and sleep disorders medicine. I also currently serve as the President of the Nebraska Medical Association for the current year, and we represent over 3,000 physicians, residents, and students in Nebraska.

We want to thank Senator Ricketts for his bringing attention to this important issue and providing a venue for which we may share our concerns about Medicare Advantage. Today I hope to outline a number of our concerns, namely that there are inappropriate practices by insurers offering Medicare Advantage that put vulnerable patients at risk and negatively impact hospital capacity, all while reducing payments to those who are actually providing the medical care to our patients.

In a recent Modern Healthcare article, published in February of this year, the author, Caroline Hudson, summarized many of the Medicare Advantage plans well - "Medicare Advantage plans generate billions of dollars for payers as they woo members with zero-dollar premiums and supplementary benefits."

Now, at its inception, Medicare Advantage's intention was to allow for highly coordinated, proactive, population-based care that would actually reduce health care costs over time, something that I believe we can all agree on. In reality, the financially driven interests of these insurance companies have resulted in Medicare Advantage programs becoming the most profitable arm of many of the major insurance companies, at the expense of the patient, the taxpayer, and the Medicare trust fund.

The Medicare Payment Advisory Commission, MedPAC, projects that the Federal Government will pay Medicare Advantage plans $88 billion more this year than if those same beneficiaries would have been covered under traditional Medicare. Yet these additional funds are not going to providers. Just the opposite. Most physicians will receive less in 2024 as their Medicare Advantage fees are tied directly to the Medicare provider fee schedule, which has been cut as of January of this year by 3.4 percent, and this culminates in roughly a 10 percent reduction in payments over the last four years.

At Bryan Medical Center, traditional Medicare reimburses us approximately 80 percent of our actual costs, meaning that we lose approximately $90 million per year on the Medicare patients we care for, which includes Medicare Advantage. Our contracts with Medicare Advantage plans call for reimbursement rates that are at least 100 percent of Medicare.

However, due to what we believe is inappropriate denials as well as delays in preauthorization and payments, we receive less than what traditional Medicare would have reimbursed. For one of the most prominent Medicare Advantage insurance programs in the country we receive approximately 88 percent of traditional Medicare reimbursement, despite fighting Medicare Advantage tactics along the way, expending numerous resources to fight through unfair tactics, where the advantage typically lies with the insurer.

More important than the impact on reimbursement, prior authorization and denial practices have, at times, overwhelmed hospital systems and created logjams that impact vulnerable patients and hospital capacity. Bryan Medical Center, located in Lincoln, Nebraska, has around 664 licensed beds, and we are often full. We consistently serve patients from all of Nebraska's 93 counties and surrounding states.

As an example, on a recent Friday morning earlier this month we had over 40 patients in our emergency department awaiting in-

patient beds. Several of these beds could have been made available except that a number of patients were effectively stuck at Bryan, awaiting preauthorization by Medicare Advantage plans to be discharged to the post-acute facility such as a skilled nursing or long-term care.

I would like to spotlight another reason why we are here today. This involves patients and delivery of high-quality care. I am going to provide you a couple of stories of two real-life patients from the last several weeks at Bryan Medical Center.

Example A, a patient has been accepted to a long-term care facility. Their Medicare Advantage plan requires authorization for them to move to the next most appropriate level of care. They no longer require acute care hospitalization. The authorization was submitted to their health insurance plan on January 26, 2024. We follow-up on February 1st. Just a few days later, our care transition talks to the insurer, asking for an update. Their reply, "We have 10 more days to make a decision," 10 more days of delay to receive the rehabilitation care that those patients require, 10 days of being unable to leave the hospital and move on with a rehabilitation course, 10 days for the hospital of unreimbursed care, 10 days of frustration for all.

This is what happens when patients select Medicare Advantage plans, thinking that they will have access to timely care and to expanded benefits. Rather, many are at the mercy of their health insurance plan, not necessarily what their doctor thinks is best for them. The hospital is not getting paid care for this patient because the patient no longer requires acute care medicine. The insurance company is getting days and weeks of free nursing care for their patient while they sit in a hospital at the expense of the patient's well-being, their family, and the hospital, all at the same time while the insurer is making record profits.

A second example. Patient B has been waiting for authorization since February 12th. For the subsequent three days our capacity management director has emailed the Medicare Advantage insurance company and called multiple times, trying to get an answer. They do not respond. The nursing facility has already accepted the patient, but it cannot take them over the weekend. If we don't get authorization by Friday, February 16th, the patient will not be able to be discharged for additional days, until the following Monday at the earliest. Again, this resulted in even more delays that the patient is in the hospital, really for no reason, thus allowing another patient with acute medical needs from accessing this inpatient care.

Now the insurance companies will tell us, and will tell you, that they will pay for these delayed days, simply not true. The patients they will pay for are very limited, and these patients that they will pay require an additional preauthorization to get those days to stay in the hospital, so therefore, the hospital is further burdened in trying to recoup costs because the Medicare Advantage plan wasn't efficient in the first time processing their authorization.

Why do Bryan and other hospitals continue to accept Medicare Advantage? Primarily because we take care of those who need us in our State. However, the current tactics of large national insurers, who hold essentially all of the power, we feel must be ad-

dressed for the sake of the vulnerable patients and for those who take care of them. The current model is not sustainable, as the insurers claim record taxpayer-funded margins and the hospitals and the health care providers subsist in the aim to fulfill our mission of care. Medicare Advantage plans are selling patients a bill of goods that they cannot and choose not to fulfill.

Thank you for the opportunity to share a small picture of the ways that we feel Medicare Advantage is impacting Nebraskans. Our State story is not unique. These behaviors are impacting Americans nationwide. As you hear from myself and others today I ask that we move to take action, and I would welcome any questions when the time is appropriate.

Senator RICKETTS. Great. Thank you, Dr. Trapp.

Ms. Danielson.

STATEMENT OF JANA DANIELSON, VICE PRESIDENT, REVENUE CYCLE AT NEBRASKA MEDICINE, OMAHA, NE

Ms. DANIELSON. Good morning. I am Jana Danielson, and I am the Vice President for Revenue for Nebraska Medicine. First, I wanted to say thank you for the opportunity to speak regarding the challenges associated with Medicare and Medicare Advantage. My testimony today will focus on challenges faced by health care providers, quite similar to Dr. Trapp, who are committed to caring for our Medicare and Medicare Advantage population.

Nebraska Medicine provides health care services to a significant number of patients who are covered by Medicare and Medicare Advantage. These patients represent 43.5 percent of health care services provided by Nebraska Medicine in Fiscal Year 2023. The Medicare-eligible population has been trending upward over the last several years, and we anticipate that trend will continue as our state's population ages. Of total Medicare-eligible patients, Medicare Advantage enrollees make up approximately 35 percent of the total Medicare-eligible population, and this proportion of patients enrolled in MA plans versus traditional Medicare for Nebraska Medicine continues to grow.

Medicare Advantage plans, offered as an alternative to traditional Medicare, are intended to provide the same benefits, as traditional Medicare is a minimum standard. Unfortunately, health care providers routinely face challenges securing medically necessary services when Medicare Advantage coverage has been chosen by the Medicare beneficiary. The greatest challenges include prior authorization requirements, reimbursement challenges, and inconsistent Medicare Advantage plan interpretation of Medicare rules.

The most recent CMS Interoperability and Prior Authorization Final Rule is a good start to address concerns related to denied or delayed care for Medicare Advantage beneficiaries, resulting from prior authorization requirements. However, opportunities remain to ensure timely access to appropriate care for Medicare Advantage beneficiaries while reducing administrative burden for providers.

APIs, or application programming interfaces, and timeframes for payer responses included in the rule do not address or standardize payer reasons for denial, which can vary across MA plans and are often out of sync with Medicare coverage guidelines. The contract

year 2024 Medicare Advantage final rule continues to allow Medicare Advantage plans to apply their own coverage criteria when Medicare coverage criteria is not fully established. This results in variability among various MA plans and a requirement for providers to navigate multiple payer policies, creating additional burden.

As an example, Nebraska Medicine routinely experiences authorization denials for medically necessary care, with requirements from the Medicare Advantage plan to complete a peer-to-peer discussion or a letter of medical necessity, even though the care plan is considered the best course of treatment by our providers. The care would meet standard of care guidelines and potentially Medicare coverage policy does not exist.

To further complicate matters, the appeal process for every Medicare Advantage plan is different. Some allow a peer-to-peer, some require a letter of medical necessity, while others may require a letter of medical necessity followed by a peer-to-peer discussion. Providers must navigate numerous different payer policies, as one Medicare Advantage plan is simply one Medicare Advantage plan.

Imagine a patient recently diagnosed with cancer, waiting for approval to begin cancer treatment, and having a payer question the treatment plan of a highly respected provider with excellent outcomes that the patient trusts. The patient wants to act quickly, they want their payer and provider to act quickly, yet delays occur due to prior authorization requirements that are simply administrative in nature. In most cases, final approval is received with no change to the original treatment plan, making all of the administrative work ultimately unnecessary.

Imagine the provider who is caring for the same patient, and many other, who is focused on quick, appropriate, medically necessary care for all patients. They see their patient face-to-face, talk to them, examine them, they are aware of the most up-to-date research and best courses of treatment, yet they are required to spend countless hours talking to payers, during the payers' business hours, or writing letters to substantiate their treatment plan. This additional burden placed on providers takes time away from caring for patients, which is their top priority.

Now consider the same patient may require hospital care followed by post-acute care needs. Hospital stays with Medicare Advantage plans present another set of challenges. In an acute hospital there is a difference in reimbursement for stays classified as observation and those classified as inpatient. Inpatient stays require a higher, more resource-intense level of care, and thus are reimbursed at a higher rate.

To simplify the classification, Medicare implemented a Two-Midnight Rule in 2013, which means that the inpatient services are considered appropriate if the physician expects the patient to require medically necessary care spanning two midnights. The contract year 2024 Medicare Advantage final rule clarified that the Medicare Advantage plans must comply with general coverage and benefit conditions included in traditional Medicare regulations, yet Nebraska Medicine is experiencing medical necessity denials for inpatient stays on cases with lengths of stay four midnights, or twice the requirement by the traditional Medicare plan. Medicare Advan-

tage plans continue to deny medically necessary care for patients that would have been approved for inpatient status based on the traditional Medicare Two-Midnight Rule.

Not only does the classification of care's observation or inpatient affect hospital reimbursement but it can also impact patient out-of-pocket costs. Those may increase due to the difference in deductible, co-insurance, and coverage guidelines associated with observation versus inpatient stays.

The denials are often received within the first 24 to 36 hours of care, and place additional administrative burden on the hospital to work with the payer to overturn the denial while the patient is being treated. The administrative burden in this case includes both nurse and physician time. The hospital is then forced to contract with outside physicians to simply battle the payer's physician to allow inpatient status. Holding the MA plans accountable to traditional Medicare Two-Midnight Rule would protect our patients and reduce administrative burden and cost for the provider and the payer.

Imagine this same patient is now ready for discharge and the care team agrees an acute rehab facility is necessary. Nebraska Medicine contacts the Medicare Advantage plan, who denies acute rehab authorization. A peer-to-peer is completed by the attending physician, and the MA plans confirms the acute rehab denial, but approves the patient for discharge to a skilled nursing facility. The family and care team identify a skilled nursing facility for discharge purposes. After a week of waiting for approval, the Medicare Advantage plan denies the SNF level of care.

At the same time that many MA plans are denying ongoing hospital care for lack of medical necessity, their process for approval of post-acute care creates barriers to accessing a lower level of care for these patients, which leads to longer lengths of stay in the hospital. When this occurs, the cost and burden of care falls to the hospital to supply services that go uncompensated while awaiting approval and acceptance to a skilled nursing facility, an acute rehab, or a long-term care hospital, and the patient waits.

After discharge, the same patient may require readmission back to the acute setting. The Medicare Advantage plans do not follow CMS readmission guidelines. Readmission denials have been escalating, and the only path to appeal is a written letter. At this time, some MA plans deny all readmissions without consideration for diagnosis or expected readmission rates.

In conclusion, administrative costs to comply with rules, monitor for denials, appeal for proper patient care, and pursuit of proper and fair reimbursement continues to escalate in cost and time, and is unsustainable.

Thank you for the opportunity to share my perspective.

Senator RICKETTS. Great. Thank you very much.

In 2023, CMS reported, and I think this was, Jana, what you were citing—364,469 Nebraskans enrolled in Medicare, representing about 18.5 percent of the statewide population. As of July 2023, 372,967 individuals were eligible for enrollment in Medicare Advantage, with 107,829, or about 29 percent, actively enrolled in that program, and I think, Ms. Danielson, you kind of referenced

that your experience is about 35 percent, so 29, 35 percent, kind of ballpark in the same area.

Medicare open enrollment periods run from October 15th through December 7th of each year, and during this time seniors may change their Medicare Advantage plan or switch to traditional Medicare. Seniors that regularly review their plans and opt to switch can save money and get better coverage for things they need. Unfortunately, studies have shown, however, that only about 10 percent of beneficiaries with Medicare Advantage or standalone prescription drug coverage are switching their plans during this period.

According to a recent report, one of the biggest challenges with Medicare Advantage plans is poor patient education. Some applicants opt to selecting a Medigap plan. A Medicare beneficiary may be enrolled in both Part A and Part B but not enrolled in a Medicare Advantage plan to be eligible for Medigap coverage. Medigap plans have Parts A through N, which can be confusing for older Americans when choosing the right plan for themselves. Furthermore, it is stated that nearly one-third, or about 32.5 percent of Nebraska hospitals, do not accept Medicare Advantage. I think that was a point, Dr. Trapp, you do accept to take care of people. Therefore, it is vital that beneficiaries living in rural areas know what plan is best for them.

Despite the difficulties that many seniors and caregivers face, there are a number of available resources that can help Nebraskans, and we hope to cover that here in the hearing today.

Maybe what I will start with is just a question for some of our testifiers here today to talk about that aspect that this is insurance, and that it can be reviewed on an annual basis, right. From that open enrollment period starting October 15th to December 7th, seniors can go back and review those, and like any insurance plan would you say they ought to be doing that? Ms. Ragland, I will start with you. Is that something that seniors ought to be doing?

Ms. RAGLAND. I think that opens Pandora's Box because Medicare plans with a supplemental plan, Senator Ricketts, once you are locked into that plan if you try to get out of it, you have a 12-month period where you can get into a Medicare Advantage plan and try it out for the first year and then get back out and get a Medicare supplement, but I think the problem we are finding is people don't understand that open enrollment period, when you are enrolling into Medicare, you have three months before your birthday month, your birthday month, and three months after. That is a period where there can be no preexisting conditions that are slapped on you by an insurance plan.

If you are doing that period of time and you go with a Medicare supplement you can purchase any of those products because they can't ask you any existing questions of your health. Medicare Advantage, again, you can try that out for the first year. They can't ask you any of those questions also, but the problem we are finding—and a lot of this is where I was talking about the transparency with the marketing and the targeting—a lot of times people on limited incomes are being targeted that maybe there is a better product that you pay less, but not understanding what the

benefits, those out-of-pocket costs and that sort of thing. They get stuck and maybe go beyond that year and want to get out and go to a Medicare supplement and they cannot do that.

Senator RICKETTS. They can't do that because they may have a preexisting——

Ms. RAGLAND. Correct.

Senator RICKETTS [continuing]. condition, and that may be the thing that prevents them? The plan providers can deny them for that.

Ms. RAGLAND. Correct. They cannot deny them as long as they are in that open enrollment period or if it is that year and then they want to try it out for the first time, but anything beyond that, you can't go in and out of Medicare supplemental plans. You can Medicare Advantage, but Medicare supplement, if you have any preexisting conditions, you are pretty much locked out.

Senator RICKETTS. Locked out of getting into the——

Ms. RAGLAND. Back into the Medicare supplemental plans.

Senator RICKETTS. Okay. What would your advice—maybe I should take a step back. Is this one of those things where when seniors are looking to apply for this, do they have to do it online?

Ms. RAGLAND. No, and that is one of the things, with Medicare supplement you can't apply for those things online. You can with Medicare Advantage. That is part of my testimony too, that I have given to you in my written form, but I think the Medicare Plan Finder, it is a great online tool, but I think it is a little bit misleading to consumers, because when you are going on there, there is no ability to enroll in specific Medicare supplement. It guides people to look at the Medicare Advantage plans, and you can enroll online on a Medicare Advantage plan along with your drug plan, but supplemental plans, you have to call the plan directly and work with them individually.

The SHIP program, which I have talked about also, cannot enroll people in the supplemental plans. They can guide them to the plan, but the Medicare Advantage plans, you can do those all online, so there is a difference in the two products.

Senator RICKETTS. Okay.

Ms. RAGLAND. The other piece of it—and then I will stop—Medicare supplement plans are regulated at the state level. They have the oversight of the Department of Insurance. Medicare Advantage plans are not. They are regulated through the Federal, so CMS regulates all of them, and we see a lot of those. There are some differences in——

Senator RICKETTS. In how they are being regulated?

Ms. RAGLAND. Yes, when there are complaints or problems with supplement you can go to the Insurance Department, but when there is Medicare Advantage we have to go back through Medicare and work that process at the federal level, so that would be one of the points, too, is the streamlining process of oversight at the state level, from our concerns.

Senator RICKETTS. Again, you talked about some of the difficulty if you have a preexisting condition, about being able to switch plans. If you don't have preexisting conditions are there still other difficulties in trying to switch plans, even if you are within the enrollment period?

Ms. RAGLAND. If you are within the enrollment period, I mean, you can call any plan and ask. If you don't have preexisting, some plans will probably entertain that. Other plans will be if you are outside of your open enrollment we don't have to, and therefore we won't do that. It just depends on the plans.

Senator RICKETTS. The open enrollment, is that an annual thing, though, from October to December, that anybody, like once you have a plan you can go in that period and try and change it?, but you have to do it within that period?

Ms. RAGLAND. Correct. Again, the caution is with Medicare supplement if you have already been in your open enrollment period, if you have already——

Senator RICKETTS. The first time.

Ms. RAGLAND. Correct, you have to be very careful because if you get out of that and go to Medicare Advantage you have 12 months to get back out that first year, but anything beyond that you do not have that ability. You can switch Medicare Advantage plans in between there.

Senator RICKETTS. You can't go back to the Medicare supplement plans.

Ms. RAGLAND. Most likely not.

Senator RICKETTS. Most likely not. Okay. It is, again, confusing, especially as you just said, you can do the Medicare Advantage online but then if you are doing the Medicare supplement you have to call to talk to somebody, so there are different processes even to do it.

Kierstin, can you just share kind of your perspective on that as well, like when you have got the open enrollment period for seniors, what ought they be doing the first time around, thereafter? I mean, what kind of difficulties do you see people having?

Ms. REED. Yes. Most folks that we see are coming into services into long-term care, and it is at that point that they realize that, boy, I maybe picked the wrong plan, and sometimes there is not a lot that they can do about that. In addition to the Medicare Advantage plans we also have special needs plans, so, I mean, just to muddy the waters even more.

I think, overall, seniors really want to make sure that they have the care that they need, when they need it, and that it is taking care of them, and right now I think we have got so much that is muddying the waters that it is really difficult to be able to guarantee that. They want to make sure that they are getting those services, so yes.

Senator RICKETTS. Okay. David, tell me about your experience. You know, what was the single biggest barrier when you were going through the process with regard to applying and trying to figure out what plan was right for you, and that sort of thing?

Mr. LANGE. I could honestly tell, as I sit here today, and I hear all of these fine folks talking about these issues, that is the nail on the head, and you made a very good point there too. Now, this all comes crashing in at you and you have got to make a decision.

Trying to sort through the data to make that good decision I thought would be very difficult for myself to make, but my wife and I sat down and we looked at certain things. You have been very

educational to me today in understanding some of the differences between the plans that I couldn't understand before.

Unfortunately, I hear a lot of you talking about the shortcomings of some of these plans and what you have to do to stay on the right path. I am the kind of guy that if I am going to sign up for this stuff, you know, I want to sit down, I want to pick what I need, sign up for it, and then, you know what, then I retire.

I didn't know about you could change things during the open enrollment period, so that was helpful. There again, we are old. We don't want to be messing around with that every year. We want to get our stuff and know, like you said, we want to know that it is the right decision at the time, and we don't have anything to worry about. Unfortunately, all the supplementals, all the additional plans, there again, I am looking at monthly payment from SSI, and I don't want to be disrespectful or anything like that, but everybody will question, can I live on that? Okay, so all these other plans, all these other extras are a takeaway from being able to do that.

It is very scary. I have to be blunt, but that is kind of where I am at right now, and will make this decision in five years when she goes to retire and we no longer have that employer group health plan to see us through this, so it is kind of scary.

Senator RICKETTS. Yes. Well, the good news is you have got five years to research it. It may take that much time.

Mr. LANGE. Yes, sir.

Senator RICKETTS. What was your knowledge of Medicare and Medicare Advantage before you had to go through this process? What did you know about it, leading up to your retirement?

Mr. LANGE. I had none. I wasn't smart, Senator. I didn't save a nest egg. Through all my entire retirement experience, I can say that is my biggest mistake, so I am kind of winging it. I have a little bit of money, but not much, and we are worried about the unplanned things coming up.

Senator RICKETTS. Would you say that your level of knowledge was actually pretty typical, though, for people in your situation?

Mr. LANGE. Oh, no. I think people are a lot smarter than me.

Senator RICKETTS. Do they know about Medicare and Medicare Advantage, though, leading up to retirement?

Mr. LANGE. No, sir, I did not. I assumed a lot of things, like you sign up for Social Security you are going to get this much a month money, so you sign up for Medicare you are going to assume, hey, I have got health coverage.

Senator RICKETTS. Do you think that is what most people think?

Mr. LANGE. Well, that is what I thought. I can answer for myself. That is kind of what I thought, and shame on me for not doing the homework and finding out, so I take 50 percent of that.

Senator RICKETTS. What kind of things do you think would be helpful as far as education or helping you do the research? Like what ways to reach you? You know, if we were going to try and make sure that folks who are approaching retirement age have a good background or knowledge and education about what they should be thinking about as they decide what they want to enroll for with Medicare and Medicare Advantage, what ways would be

helpful to be able to do that? What things would you have liked to have seen?

Mr. LANGE. There is too much. Streamline it. There are too many choices, with too many directions. I believe the lady down here was talking about different charges for this plan, handle this plan this way. I can only imagine what a hospital has to go through in order to keep all that straight.

Here as a patient or a benefactor or whatever, you know, you see that going on, and—okay, I am a mechanic from way back. Engineering-wise, you should keep it simple, you know. You know the rest of that, the K-I-S-S. Keep it simple, I think, would be very helpful. I know it would have been to me because it just added confusion because it was coming from so many different ways, so many different companies.

Senator RICKETTS. Would it have been helpful to start having that dialog earlier? I mean, if, say, the Federal Government had reached out sooner to you and said, hey, this is coming to you in two years, or something like that, would that have been helpful?

Mr. LANGE. Well, that is a good question. Possibly, if the person has the right frame of mind. I didn't when it came to initial investments 40 years ago when I started my maintenance career, but as I got closer I thought about stuff like that, so I was probably more open-minded, I think. Two years might have helped me. I can't say that for everybody.

Senator RICKETTS. Jana and Kierstin, you obviously deal with a lot of folks. I mean, do you have an opinion on what we could be doing better as far as trying to help people who are approaching that decision, what we could do and how we could reach them?

Ms. RAGLAND. I agree that earlier the better, and the repetition. My problem, though, is that we allow Medicare supplement, Medicare Advantage, all the plans themselves are out—I don't know if you get piles in your mail.

Mr. LANGE. It has been overwhelming.

Ms. RAGLAND. There are postcards that are coming all of the time, like pick my product, pick my product. I mean, they can buy those lists so they know who to go and find when they know they are turning 65, so that part is extremely overwhelming, first of all, and then you see the ads on TV. You know, it is buyer beware in the sense of know what you are buying and know what the product is.

I think, again, it is just that overwhelming fact of you have got all of these options, and if you don't know where to go. I do think that there is some responsibility that lies with CMS, and I do think earlier notifications and repeated notifications that are simplified. Also, again, using our SHIP programs if you need help or hear some assets of how you can go with that planning process. Again, maybe someone is not in that state of mind, but if you see it five times you are probably going to be more receptive than if you——

Senator RICKETTS. Repetition.

Ms. RAGLAND. Yes.

Senator RICKETTS. I think there is a common thing in marketing that you have to get a message out seven times before people start remembering it. Kierstin?

Ms. REED. You know, I think the other thing is there are so many people in the marketplace that are trying to talk to these beneficiaries, or potential beneficiaries, that it is so overwhelming who those trusted resources are and how you can get to them. My parents, as an example, they have a trusted person that they have been using for this for years, but at one point their phone rang, and the person on the phone talked them into setting up an appointment, and luckily my mom reached out to me and said, "What do you think? Should we do this?" and I said, "No. You have everything you need. We are not talking to them." You know, they initially contacted my dad, who has dementia, and he would have gladly met with them.

Who is watching out for people and who is making sure that they are not falling prey to these deceptive advertising practices? Ultimately, it is going to hurt them in the long run. These plans are what we face in long-term care and in our hospital settings that are not providing adequate payment or they are denying care, and ultimately, the beneficiary is going to be on the hook for those expenses when their claim gets denied, and it is going to cost them.

Senator RICKETTS. What would be the best way to reach out to folks who are approaching retirement age? Is it through the mail?

Ms. REED. I think Dave talked about that, you know, having them come to your employer and getting that involvement early, before you retire. I think that is a great idea.

I do think that we need to have more official information coming from CMS. It needs to be directly from the government that is explaining to them, transparently, what is expected and what is going to happen.

Senator RICKETTS. Very good. Well, I don't want to ignore our hospital systems over here, so maybe you could talk a little bit about, one of the things you both mentioned was the difficulty with the insurance plans, but some hospitals don't take insurance plans. Obviously, Nebraska is an agricultural state, and we have a lot of folks in our rural areas. Can you maybe talk a little bit about, you know, if you are in a rural area what are some of the things that, as you are thinking about these plans, should be the questions that maybe are different from if you are in Omaha or Lincoln, and asking those kinds of questions?

Dr. Trapp, do you want to start with that one?

Dr. TRAPP. Yes. David, you are not alone in not understanding Medicare Advantage plans. I mean, I am a physician. I look at this stuff. We can't figure it out, and most of my colleagues can't figure it out. We hire an army of people at our hospital to sort through this stuff, and we pay physicians to take our place to advocate for those plans, so you are not alone in that challenge of that.

What I will say is that health care is a real odyssey. You don't know what is going to happen next. When we leave places like this, if you were involved in a car accident you don't know what your health care needs would be at that time, so even if you signed up for a plan, you don't know what you might need down the road. Your next colonoscopy, they could find a polyp or a cancer. Your next chest x-ray you could find a new diagnosis, and you are left with saying, "What do I need to do?" If I was diagnosed with a cancer, a new diagnosis, I didn't know what the Medicare Advantage

plan covered and what it did not. Now you are seeking a new medication. Some of these medications are tremendously expensive, and now you are trying to figure out, does my plan cover that or not? It is a real challenge with trying to figure out what I might need next year and the year after.

As far as hospitals, how we select plans, I mean, there is a process that hospitals go through to really try to look at these plans. The challenge with it is the print looks good. The Medicare plans tell you, we will pay for this, we will pay for this, we will pay for this, and you say, okay, let's sign up, and then, all of a sudden, when you submit that bill, oh, you didn't submit that correctly, or we don't pay for that. You are like, but it says here that you do. Well, it is denied or there is a preauthorization process and there are delays.

The challenge is we sign up for a plan that we think we are going to receive adequate reimbursement from—again, supposed to be equal to Medicare—and then what we find is that they deny their way to pay less than that, closer to Medicaid rates. The challenge is, it isn't what is printed on the paper about what they promise to pay. It is actually can you collect that amount.

I don't know that I have an answer on how do we ferret that out. Experience tells us what we do, and as we find out that plans don't reimburse as promised, we re-evaluate those on a regular basis and decide, do we renew that plan or not, or we negotiate or eliminate that plan, realizing that puts everybody who signed up for that Medicare Advantage plan at risk that now they have to find a new hospital system, new doctors, and that is a real challenge, and then the patients still want to come to us. They don't understand that, and they may end up in our emergency room still seeking care, now of which they are out of network, and that presents its own problems.

Senator RICKETTS. Can you talk a little bit, though, about the challenges, urban versus rural? Do folks that are approaching, you know, signing up for this need to think differently if they are in a rural area versus an urban area? Are there different challenges?

Dr. TRAPP. Maybe I will let Jana answer that one.

Ms. DANIELSON. I think individuals in a rural area, you really need to think about who is in your immediate network and then take into consideration what may you require beyond that, and so in Nebraska Medicine, Bryan, we receive patients across the State of Nebraska. We receive patients from other states as well, and so along with Bryan we are in network with Medicare Advantage plans to make sure we can take care of folks.

I think that as you get out into maybe like private practice groups or some of those areas in the rural communities there is going to be a possibility that someone that you want to maintain established care with may not be in network, and so it is making sure they understand that, and then also understanding that that can change. You know, folks can be in network today and maybe out of network tomorrow.

Senator RICKETTS. Is that a question, as somebody who is looking to do this, maybe they are going through the open enrollment period for the first time, is that a question they should look at——

Ms. DANIELSON. Absolutely.

Senator RICKETTS [continuing]. and say, "Hey, I want to go to Nebraska Medicine because I have gotten great care there through my previous employer and the health plan I had there." Should they contact Nebraska Medicine and say, "What Medicare Advantage plans do you accept?"

Ms. DANIELSON. Yes, and most of us, as providers, also list the plans that we are in network with, and the individual trying to sell their plan should be able to answer those questions for a patient.

Senator RICKETTS. A good question to ask if somebody is calling you.

Ms. DANIELSON. It is a question to ask. I have had personal experience. I think, for some of us we are that resident expert for our family members and others when they are approaching Medicare age, and it is quite complicated even for those of us who are in the industry sometimes to answer the questions. I can only imagine David going through that process. It is not easy.

Senator RICKETTS. Do you list that, for example, on your website?

Ms. DANIELSON. yes.

Senator RICKETTS. Dr. Trapp, Bryan healthcare system as well?

Ms. DANIELSON. Yes.

Senator RICKETTS. You said it was about 35 percent Medicare Advantage.

Ms. DANIELSON. Of our Medicare population, about 35 percent is Advantage.

Senator RICKETTS. Is that similar?

Dr. TRAPP. I would say similar, but growing rapidly. The acceleration phase is expected to really rise over the next few years.

Senator RICKETTS. Why do you think that is growing so rapidly?

Dr. TRAPP. Well, those plans are enticing. They sound really good.

Senator RICKETTS. It is marketing.

Dr. TRAPP. You have the face of celebrities selling these plans. Hey, zero dollars this. They sound really good. You sign up for the plan thinking you are doing the right thing because they promise a lot, and then the challenge is the delivery of that, and oftentimes the patient receives the care. It is the provider who doesn't get reimbursed for that and then struggles to determine should we do that.

We don't oftentimes try to pit the patient and say—we don't walk in the room when you are still there 10 days later and say, "You shouldn't be here," and make them feel bad about it. We provide the care each and every day, make sure we take care of that. We value the quality and safety of that patient, but we struggle with, hey, we are waiting to hear back, or we are waiting for the nursing home to be able to accept you. It is not going to be today. It is going to be tomorrow. It is going to be Monday, and we just communicate that each and every day.

Patients oftentimes don't—this may be their first experience with a complex medical issue. They really don't know, okay, if it takes me eight days to get there, is that normal or not? It is hard to understand that unless you are a person who is really enmeshed with chronic health problems where you are struggling with this, but for many people health care is complex, it needs navigation, and we

try to do that, but for the first-time person who is experiencing a complex health issue, they really don't know what to expect, so we try to walk them along, but waiting six, seven, eight days, going through preauthorization, oftentimes they are not aware that that should not have to be that way.

Senator RICKETTS. Yes. Jana, you mentioned that sometimes you are the resident expert for friends and family, or something like that. How often—and I am going to ask Dr. Trapp the same thing for you as well, which is how often do you find somebody has a caregiver that can help them through this, and maybe talk a little bit about the challenge of the people who don't have that caregiver, and maybe also talk about difference in outcomes with regard to the kind of care they receive, if they have a caregiver versus not having a caregiver, or family expert, or whatever it is.

Ms. DANIELSON. Yes. In my circle, how small it is, I would say that the majority of individuals do not have somebody who is a caregiver or somebody who is in their circle that they can reach out to. I know that there are wonderful resources available for patients to access and to ask questions. Even from a hospital perspective, we will have patients ask questions to our financial counselors. They may call customer service and say what resources are available to get my questions answered.

I also don't feel like everybody understands what those resources are necessarily to reach out and ask the questions, to get them set up appropriately and in the best plan for them for the long term. To David's point, you don't want to have to change all the time or re-evaluate annually, and you get in the plan and you are good, you know.

Mr. LANGE. That is right. It is one more opportunity to make another mistake.

Senator RICKETTS. Dr. Trapp, what is your experience at Bryan?

Dr. TRAPP. The scenario I see is actually what Kierstin described. A family gets called. They are trying to follow the right things, being very Nebraska nice, if you will, willing to meet with those people, and unless they had a daughter like Kierstin that said, "No, wait. Time out. You have got all that. You don't need to meet," it doesn't happen for most of our patients. They wander the complex pathway of health care, and it just gets too complex, and you don't know what you don't know.

Senator RICKETTS. I know that there are even people you can hire to help you, right. There are consultants you can hire to help you navigate this process, but what about like low-income people that can't afford to hire somebody, don't necessarily maybe even have somebody that can help walk them through it. Would you say that the complexity of the system is disadvantaging people on lower incomes because maybe they don't have somebody to help them, they can't afford to hire somebody, they don't necessarily maybe know the right questions to ask because maybe they didn't have health care before they were going into this? I mean, can you talk a little bit about that?

Dr. TRAPP. Go ahead.

Ms. DANIELSON. My opinion would be, without having any data to support it, is that our low-income individuals are disadvantaged. If you think about even access to resources, to seek out somebody

to assist, if you think about the ability to either search for information online and all of those types of things, they certainly don't have the opportunity to pay somebody to help them through the process, and I know that exists. I have actually been asked why I don't do that, but I would prefer to do it for free, you know, just to help the individuals who ask.

I think there is a possibility that in some cases if low-income individuals are already potentially in Medicaid or if they have some of those things that are already in place, that they may have more input from someone to help guide them through the process, but I always feel like that we do have some individuals who are just lost in totality, and they just don't know what they don't know and where to go, and so somehow it would be great if we could figure that out and make sure everybody has the same opportunities to have a conversation and get enrolled appropriately.

Dr. TRAPP. I agree with that completely. I mean, your resources and who you know certainly is going to impact those with less education, less sources of revenue, less connection with the health care system.

Senator RICKETTS. Actually, Jina and Kierstin, I will throw the same question to you as well. If you are lower income and don't have the same sort of resources is that definitely a disadvantage with such a complex system?

Ms. REED. I think it is absolutely a disadvantage. There are public programs, like the SHIP program, that are out there for people, but again, sometimes people don't even know where to find those resources or what to do about it.

You know, CMS has really let this Medicare Advantage program expand to a point that I don't think anyone ever anticipated. I don't think it was the goal that we were going to have 50 percent of people on these plans, so they didn't put up enough guardrails. The rules for this were developed when three percent—we were actually trying to entice people to use these plans because enrollment was so low.

We are at a point now where we need to reevaluate the rules on this program, one of those being that there is a rule in place that CMS can't step in and set a floor for the base payment rate or the lowest payment rate for reimbursement, so they are kind of at liberty to do whatever they want at this point, and that is a really bad place for our consumers to be. That is a bad place for beneficiaries, so we need to make sure that we are stepping in, for all income levels, to look after folks and make sure that their best interests are being taken care of.

Senator RICKETTS. Jina?

Ms. RAGLAND. Yes, I echo all of the comments again. Yes, how could there not be a disadvantage, especially because they don't have access to the resources? Even our broadband, it is getting better, but to go online we have a lot of people who still don't have——

Senator RICKETTS. That is a great point.

Ms. RAGLAND [continuing]. appropriate broadband access that works, let alone do they have the skills to get on and be digitally literate to do that. You can make phone calls to Medicaid, you can make phone calls to SHIP, but I think, you know, again, sometimes

it is very overwhelming and it is very confusing, so I would definitely agree with that.

One other point, I wanted to go back, when we were talking about rural versus urban. One issue we see very frequently with people that call our office who might have been in Medicare Advantage, "I did all the checking. I know I am in network with my hospital," but there may be a specialist that is coming out to visit that is not, and that falls through the crack and then guess what, here comes your bill.

Senator RICKETTS. How could you even anticipate that?

Ms. RAGLAND. Correct. Well, I mean, again, it is empowering consumers, but those phone calls sometimes to figure out, you know, even to go onto the providers' networks or the payer's network, as it has been said, that network can change on a daily basis, so it is being due diligent on the part of the consumer, but how would you know that, especially if you have this looming medical procedure or surgery that has got to take place. It may be the last thing you think about, or because you are having it in that surgical procedure hospital, you think that that surgeon is covered, and it may not be.

Senator RICKETTS. You said with Medicare Advantage that is a problem. Is that with traditional Medicare? Is that less of a problem?

Ms. RAGLAND. It is less of a problem just because generally most providers in Nebraska accept Medicare assignment, yes.

Senator RICKETTS. Yes. Great. I also want to get back to something that both of you talked about with regard to the Medicare Advantage plans and this delay. You said they needed to be held accountable. What mechanisms are in place to hold the Medicare Advantage plans accountable for the Two-Midnight Rule, for example? I think you both said that they don't necessarily always do that. If somebody is not doing that, how do you hold them accountable?

Dr. TRAPP. Well, at a minimum, they should follow the same rules that Medicare sets up there. The challenge is if there is any gray area they take advantage of that, with regard to that. As far as getting timely returns on denials and preauthorization, oftentimes we get 24 or 48 hours. That can be done in a relatively short period of time. To take two weeks to come back and let us know whether or not that patient can go to the next level of care, it is just way too long.

Senator RICKETTS. Is that written in the rules, though, that two-week timeframe? Is that part of what is established by CMS, that they have that much time?

Dr. TRAPP. No. Medicare Advantage establishes its own.

Senator RICKETTS. It is a state-level thing, right? Is that established at the state level? What does that timeframe get set? you mentioned, I think——

Dr. TRAPP. By the Medicare Advantage plan.

Senator RICKETTS. Yes. Somebody said back to you, "We have 10 days to make that decision." Where do they get that 10 days?

Dr. TRAPP. They develop their own guidelines on when they will get back with that.

Senator RICKETTS. Okay, so that is not necessarily regulated at the state level that they have a specific thing. Could that be something that is regulated at the state level? Could the state say, hey, every Medicare Advantage plan in Nebraska has two days to get back, or five days?

Dr. TRAPP. Medicare Advantage is a Federal program, so it is going to require more of a Federal solution. State plans, things like that, can be done at the state level, but Medicare Advantage is a Federal plan.

Senator RICKETTS. That would have to be done at the Federal level, and CMS would have that.

Dr. TRAPP. Correct.

Senator RICKETTS. Okay. We are going to go back over here for a second. Go ahead.

Ms. DANIELSON. I agree with what Dr. Trapp says. You know, part of the problem is, too, that even with the new rules that are coming out to attempt to address the authorizations issues and other things, there still remains that gray area, and you know, we can file a complaint with CMS regarding an MA plan, but generally speaking we are held to all of the different plans' payer payment policies, which is really difficult to navigate, even as a provider, because one MA plan is one MA plan.

Senator RICKETTS. If you have seen one MA plan, you have seen one. Is that essentially it?

Ms. DANIELSON. Yes, and they are all different, but it is extremely difficult to navigate.

Senator RICKETTS. When you file a complaint letter with CMS, what does that do?

Ms. DANIELSON. Sometimes nothing. You know, you may get an answer back. I mean, there are times that it could come with a good result. There are also guidelines around when you can. You know, what can you complain about, or what can you file with CMS related to an MA plan, and it really has to be something that they can provide some oversight to. It can't be this gray area. You know, if CMS policy says an MA plan can still apply medical necessity criteria if Medicare does not have something specifically called out related to that condition, that is not something that you can file a complaint, because in reality that plan can still have those guidelines, and so, I mean, that alone is also difficult to navigate as far as which path can you take, if you are trying to hold the MA plan accountable, because they generally have the upper hand. Do you agree?

Dr. TRAPP. Oh, they definitely have the upper hand, and even when we try to pass guidelines that implement change to improve that, oftentimes the MA plans say, "We need time to change that. That is a massive change," so the changes may not take effect until 2026 or later, and it is just challenging to say, what do we do until then? We still are challenged by that revenue loss and just getting consistency.

Senator RICKETTS. Jina, did you have anything to add to that, or Kierstin?

Ms. REED. I just wanted to comment on that, so on the skilled nursing side and long-term care we call that the Three-Day Stay Rule—Two-Midnight, same thing, so we have addressed that issue

at LeadingAge with CMS, and what they tell us is this is a regulatory issue, so there is a law on the books that needs to be repealed in order to make that fair ground for everyone and get rid of that three-day stay. There is a bill in the House that would do that. We need a Senate companion bill to be able to address that issue.

I think that is a very important one because now that 50 percent of people are on Medicare Advantage, we have two different systems at play. We have folks that aren't required to meet that three-day stay and then we have folks that do need that, but the big problem is the reason that they aren't holding themselves to it is because they don't want to authorize inpatient services, so they keep people on an outpatient basis, and to that patient that is receiving care it doesn't look any different. It looks just the same. You are in the same hospital room. You are receiving the same services. Nothing about your stay looks different to you, but for those that are on Medicare, if they come out and they go into skilled nursing care and they didn't have that three-day stay, Medicare is not going to pick up any of their first 20 days or up to 100 days. They are not going to pay for that.

We need to make sure that we have got clear and consistent rules, and right now with the number of programs that are really able to make this up, we don't have it.

Senator RICKETTS. Yes. Of the roughly 300,000 Nebraskans that are eligible for Medicare, how many of them require that long-term care?

Ms. REED. Well, that is a good question. You know, I think all of them require long-term care from time to time. Long-term care could be for a rehab stay, where they are coming in and getting rehab after a surgery. It could be that they have a significant illness and they need some time in a skilled nursing facility to take care of that.

I think one of the big misconceptions about long-term care in Medicare is that their stay there is going to be paid at 100 percent, and that is simply not true. Unless they have a medical reason for being in that level of care that is when it is going to be paid, and it is still only time limited, so the only get so many days and they have to qualify through their plan.

We face the same types of denials and delays and preauthorization's. Sometimes someone will come into a skilled nursing facility and they may be authorized for 48 hours. They can't even get a plan together to be able to support that person, to do their rehab to recover within 48 hours, and then they are denying them and sending them home.

Senator RICKETTS. You are saying, with a lot of the folks that are coming to those skilled nursing facilities or whatever, that, kind of like David said, hey, I just want to get set up with the insurance and retire, and they are coming in and they are realizing, oh, this is actually not going to pay for everything for me, that I am going to come here, and I may not even able to get authorization for it.

Ms. REED. There are still co-pays.

Senator RICKETTS. There are still co-pays, even if I do.

Ms. REED. Sometimes upward of $1,000 plus a day.

Senator RICKETTS. A thousand dollars a day.

Ms. REED. Yes.

Senator RICKETTS. Oh, my gosh. David, could you afford to pay $1,000 a day if that is what was happening there? I mean, you don't have to answer that, but that seems like a lot of money for somebody who didn't realize that could be happening to him.

I think you also mentioned something about if they have to go back to the hospital after they have been in long-term care, that that is difficult as well.

Ms. REED. That Three-Day Stay Rule still applies, so if they are on traditional Medicare, and Advantage plans, again, don't have to necessarily do that, but we have got that inconsistency there. so yes, there are things that the skilled nursing facility or the nursing home can't take care of, and they do have to go back to the hospital. Obviously they try to avoid that at all costs, but if they do go back then they have to have that stay again before they can come back to get their skilled nursing facility services paid for.

Senator RICKETTS. That all requires preauthorization, so there could be delays with regard to that?

Ms. REED. Oh yes.

Senator RICKETTS. Okay. Very good. Well, I do want to be respectful to everybody's time. What I would like to do now is just with all of our witnesses give you a last chance to wrap up and say if there is anything that you didn't think about, didn't cover, would like to just comment on. David, we will go ahead and start with you.

Mr. LANGE. I would like to thank you again for letting me be here today. I don't know what I brought to the panel, but you have given me tremendous information today. I really appreciate that. That is going to help my educational side. I think you have struck on a couple of really good points. It is kind of a mess, guys. I am sorry. That is my first impression, but thank you again for letting me be here today.

Senator RICKETTS. Thank you, David. I appreciate it.

Ms. RAGLAND. I don't have any additional comments or thoughts, Senator, but I do appreciate us being able to be at the table and provide our comments, and we do look forward to working with you on this issue.

Senator RICKETTS. Okay. Great. Kierstin?

Ms. REED. Same. I think there are definitely improvements that CMS can make, but I think there are some issues where their hands are tied as well, and so that is where we need to have the House and Senate to be able to step in to address some of these problems. Thanks.

Senator RICKETTS. Okay.

Dr. TRAPP. Thank you for the opportunity to be a part of this and to have the community involved with this. You know, in the beginning Medicare Advantage plans were really designed to allow for highly coordinated, proactive, population-based health care that would actually reduce costs. It has grown tremendously. It is not meeting the needs. We need to re-evaluate.

Senator RICKETTS. I do have something to add. The whole point of Medicare Advantage plans was to be proactive and preventative, right, and you said that in your opening remarks. We all agree that

if we can be preventative that is actually going to reduce costs long term.

Dr. TRAPP. Absolutely.

Senator RICKETTS. Would you say then your evaluation of this, your assessment is we actually have not met that goal, that we are not being as preventative and we are not actually saving costs in this program?

Dr. TRAPP. Yes. They pay for some preventative care. There is no question, but I don't think that they have met the need of reducing costs overall of the patients' care.

Senator RICKETTS. Okay. Thanks.

Ms. DANIELSON. Thank you for the opportunity. I do want to say happy belated birthday to David, because I did hear you mention that that was quite recent. If it was later in the day I might take you for one, and then I do also want to agree with Kierstin on the SNF Three-Day Rule. I did have that in my original testimony and cut it for time.

Senator RICKETTS. Please go ahead. I am over here if you want to talk about that once more.

Ms. DANIELSON. Really, my comment was just that it does need to be re-evaluated and essentially repealed. It came into play when Medicare originally came into play, and it is problematic, and it is a discrepancy between traditional Medicare and the Advantage plans, and it can cause significant issues with getting a patient to an appropriate level of care.

You know, even if you are in a facility that is unnecessary, there are other risks to that as well, and then getting the patient to the right place, to have the appropriate rehab or other items is really, really important. Other than that thank you so much, and have a margarita later, David.

Senator RICKETTS. Well, again I would like to thank all of our witnesses for taking time this morning to be able to help talk about Medicare and Medicare Advantage and some of the opportunities we have to be able to improve the system. It sounds like the biggest thing is trying to reduce some of the complexity we have got going on here with regard to it, and that we have got lots of opportunities to be able to make those improvements, but I appreciate everybody sharing their time and expertise with regard to this, so thank you very much for being here.

I hope all of you who were here in the audience enjoyed learning more about this. I think that we certainly—I don't know that we have got things we specifically can say we have to take action on, but it does leave us a lot of opportunities to be able to work together to be able to find those improvements and work through the House and the Senate to be able to make those changes.

Again, folks, thank you very much. I appreciate it. Happy belated birthday then, David, and with that we will go ahead and close the hearing. Thank you.

[Whereupon, at 11:24 a.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements

U.S. Senate Special Committee on Aging

″Medicare and Medicare Advantage:
Challenges and Opportunities with Enrollment″

February 23, 2024

David Lange Prepared Witness Statement

Dave Lange, 65yrs. I just had my birthday. The 16th of February. When I was 18yrs. old, I went into the United States Navy after finishing high school via a G.E.D. I tested high on a mechanical scale so they turned me into a Boiler technician. A rate that no longer exists as far as I know. A little while after my tour of duty I wound up applying to the maintenance department at the Swanson building downtown Omaha. Owned by Campbell Soup, I was there 20 years. I met and married my wife of 25 years while working there. We lived in Plattsmouth and raised my daughter, her two sons, and one daughter.

The kids are grown and moved away. Both my wife Joyce and I have continued to work in various food production facilities throughout the metro area. Companies such as Conagra, Tyson, Armor Swift. She is presently still Quality Assurance manager at Mammas' Tortillas. My most recent employer was Omaha Steaks. There were two things I wanted for my birthday. One of my birthday presents was retirement at 65.

Sometime in late 2023 I received information in the mail that indicated enrollment in Medicare was required prior to my 65th birthday. I was also getting bombarded with phone calls, messages, e-mails, about Medicare plans, and what I needed to do about it all. After doing some research, asking a lot of questions from current retirees, recent retirees, etc. I was more confused than when I started. I came to realize many of these were/are in my opinion ″sales″ opportunists. I contacted some of them only to find out what ever they offered, whether it be a ″plan″ or ″service″ it would come at a cost.

With good faith in mind, I set out to visit the web site and see how far I could get. I have been fortunate in life where I have had to learn and develop good computer skills in order to hold the management positions I have had. No prodigy, but can hold my own. Unfortunately, me and passwords don't get along, so we went round and round a little bit. Eventually this became a little more user friendly. I reviewed the ″items/info required″ list. Very helpful by the way. Gathered up everything and started the application. Once started it was very quick and went pretty smooth. Took probably 20 minutes because we were reading carefully. I'm pretty sure I saw a box on the app that asked if I was presently covered by a health plan? I answered yes. At the end of January 2024, I received a bill for $524.10 for part B coverage 02/01/202404/30/2024. This was a shocker. I reached out and was able to locate a reputable Medicare counselor. She was able to coach me and well as assist with the correct form to ″un-enroll″ from part B. I am covered under my wife's employer provided group health insurance plan.

I have since gone back onto the website to check my status and have seen the correction has been made. In early February I applied for Social Security benefits. The process was similar to sign-

ing up for Medicare. Minus the previously endured ″log in/password″ issues. I am still awaiting news of acceptance. Overall, I would say the system works, needs a little getting used to, but hopefully will be fine. Oh, what was the second thing I wanted for my birthday?.....an ice-cold margarita!

U.S. Senate Special Committee on Aging

″Medicare and Medicare Advantage:
Challenges and Opportunities with Enrollment″

February 23, 2024

Jina Ragland Prepared Witness Statement

Thank you for inviting AARP to participate in today's hearing. My name is Jina Ragland and I am the Associate State Director of Advocacy and Outreach for AARP Nebraska. AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the Senate Aging Committee's effort to examine the Medicare enrollment process and ways to improve it for older Americans. In particular, we would like to thank Senator Ricketts for leading the Improving Measurements for Loneliness and Isolation Act and for cosponsoring the Alleviating Barriers for Caregivers Act. These bills will help Americans thrive as they age.

There are currently over 66 million Americans with Medicare, and roughly four million people join Medicare for the first time each year. In Nebraska, there are over 370,000 Medicare beneficiaries - roughly 19% of the population. For many, Medicare enrollment is a confusing and time-consuming process, often requiring the help of loved ones and trusted individuals to guide them through it. Congress and community partners, like AARP, can all play a role in making the enrollment process as stress-free as possible. The actions discussed below are just a few of the positive steps that can be taken to improve the process for everyone.

BENEFICIARY ELIGIBILITY NOTIFICATION

One of the most common complaints about initial Medicare enrollment is lack of awareness about eligibility timelines and enrollment requirements. Failure to timely enroll in Medicare can result in costly penalties that can be added to your premiums for as long as you have Medicare. AARP has long recommended that the Social Security Administration should notify potential Medicare beneficiaries, well before they reach Medicare eligibility at age 65, about the steps to take if they want to enroll and about the circumstances under which premium penalties may be assessed. Directing the Social Security Administration to work with the Department of Health and Human Services to inform potential Medicare beneficiaries of their eligibility annually for five years prior to turning age 65 will help ensure that older Americans have adequate time to plan for their transition to Medicare. Bipartisan legislation in the Senate, the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) 2.0 Act (S. 1687), would help people approaching age 65 punctually and properly enroll in Medicare, thereby preventing delays in coverage and costly penalties.

IMPROVED CONSUMER EDUCATION

Even if a person knows they can sign up for Medicare, they may not know how. The decision-making process can be overwhelming for many individuals. AARP endeavors to be a trusted friend for older Americans to turn to. The AARP Magazine and AARP Bulletin, delivered to all our members, regularly publishes tips and information on Medicare enrollment. In addition, we have developed

a web page of resources at aarp.org/medicare, as well as our online Medicare Enrollment Guide which offers a step-by-step tool for first time enrollees. We also try to meet people where they are through webinars, on-demand tutorials, and local seminars.

AARP is limited, though, when individuals require more hands-on or personalized assistance. That is why State Health Insurance Assistance Programs (SHIPs) are such a valuable resource. SHIPs provide local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers. Each state has a SHIP program administered by professional staff and volunteers who can help you navigate the Medicare program. Nebraska SHIP is managed through the Nebraska Department of Insurance with Federal funding support. An important step the Federal government can take to help people through the Medicare enrollment process is to increase funding for SHIPs, Area Agencies on Aging, Aging and Disability Resource Centers, the National Center on Benefits Outreach and Enrollment, and other programs administered by the Administration for Community Living which engage with people locally in our community. Additional resources could help to increase awareness of the SHIPs and increase the number of people the SHIPs can assist.

Unfortunately, one part of SHIP's funding has been stalled thus far this fiscal year. Mandatory funding for outreach and assistance to low-income Medicare beneficiaries was not included in the recent series of Continuing Resolutions which are currently funding the Federal Government. The modest funding has been regularly passed as a ″health extender″ in the annual appropriations process. We urge Congress to fully restore the $50 million in mandatory funding in the next spending deal to enable SHIPs and other entities to help make Medicare more affordable for low-income beneficiaries.

FAMILY CAREGIVER INCLUSION

While it can be confusing or overwhelming for Medicare beneficiaries or those enrolling in Medicare to navigate the program, it can also be challenging for family caregivers who are assisting or advocating on behalf of a loved one. There are more than 48 million family caregivers in the U.S. They assist their older parents, spouses, siblings, grandparents, adult children, and other loved ones so they can live independently in their homes - where they want to be. Caregivers provide an estimated $600 billion in unpaid labor each year, saving taxpayers billions of dollars. Without them, America's health and long-term care systems would collapse.

Caregivers help with everything including meals, bathing, dressing, medications and medical care, coordinating and providing care, chores, finances, grocery shopping, transportation, and much more, including assistance with Medicare enrollment, coverage options, appeals, and beneficiary advocacy. Caregivers provide, on average, about 24 hours of care each week. Over half (56 percent) of family caregivers advocate with care providers, community services, or government agencies on behalf of their loved one. One in four want help figuring out forms, paperwork, and eligibility for services. Among those coordinating care, 31 percent find it difficult to do so.

AARP supports two bipartisan bills to help make providing care easier and save family caregivers time and frustration when trying to navigate or get care for their loved ones in Medicare. First, the Alleviating Barriers for Caregivers Act (ABC Act, S. 3109) would help reduce red tape by requiring the Centers for Medicare & Medicaid Services and the Social Security Administration to review their eligibility determination and application processes, procedures, forms, and communications for Medicare, Medicaid, Children's Health Insurance Program, and the Social Security programs to reduce administrative challenges for caregivers. They must report to Congress within a year on issues identified and findings, actions they are taking, an estimated timeframe for completion, any recommended changes in Federal law to address identified issues, and more. We appreciate that Senator Ricketts has cosponsored this important legislation. Second, the Connecting Caregivers to Medicare Act (S. 3766/H.R. 7274) would help inform people about the voluntary option for Medicare beneficiaries to allow family caregivers to access their health information through 1-800-MEDICARE. This can make it easier for caregivers to communicate with Medicare to help their loved one or to advocate on their behalf. The sign-up form and other educational materials would be made available in non-English languages. The bill would also help ensure 1-800-MEDICARE operators provide appropriate resources and information for family caregivers. These two bills are bipartisan commonsense solutions that we urge Congress to enact into law. Supporting family caregivers helping their loved ones navigate Medicare is essential.

IMPROVED EMPLOYER EDUCATION

AARP understands that most people enrolling in Medicare for the first time are transitioning from employer-sponsored health coverage. The employer or, when available, the health benefits administrator is well positioned to help individuals make the transition to Medicare and avoid enrollment mistakes and costly penalties, yet they are often ill-equipped to provide guidance or answer questions from their employees. AARP is working to address this issue by developing educational programs and training resources designed specifically for employers. More than merely creating pamphlets and brochures, AARP is proactively reaching out to employers. In only the first couple years of this effort, already 1,700 employers have participated in our Medicare 101: For You, Your Employees, and Your Business program and 30,000 Medicare educational resources have been distributed to employers. Better employereducation can help reduce information errors and provide another reliable source of information for consumers.

MEDICARE ADVANTAGE INFORMATION

AARP supports enabling all Medicare beneficiaries to make their own health care coverage choices based on their specific health care needs, preferences, and history. The explosion of Medicare Advantage (MA) plan availability - with the average beneficiary having access to 43 different plan options in 2024 alone - can make enrollment in the right plan a daunting process for even the most knowledgeable consumers. With enrollment in MA plans eclipsing that in traditional Medicare, it is increasingly important for Congress to

ensure that beneficiaries are adequately served in both MA and traditional Medicare in terms of costs, benefits, quality of care, and patient outcomes. AARP has long supported efforts to improve the quality and affordability of all Medicare coverage options while working to ensure that consumers maintain a robust choice of both MA and traditional Medicare options.Plan marketing directly affects consumers' experience and ability to make informed enrollment choices. In many cases, deceptive marketing practices have led individuals to enroll in a plan that does not meet their needs. AARP has repeatedly raised concerns about marketing abuses around MA plans and advocated for greater oversight, enforcement, and regulation of marketing materials and marketing standards for MA plans. Despite the progress made by new consumer protections, additional policy improvements continue to be needed. For example, improved transparency about agent, broker, and third-party organizations' compensation and financial incentives could help better inform consumer decision making. It is also critical to equip consumers with a clear pathway to lodge a complaint about problematic marketing practices.

In addition, increasing access to unbiased sources of information, such as through SHIPs, is essential to helping consumers discern Medicare marketing information. Medicare.gov, in particular, is often the first stop when choosing a coverage option regardless of whether a person is enrolling in Medicare for the first time or thinking of making a change during Open Enrollment. The website's Plan Finder tool is useful for researching MA plans and Part D prescription drug plans. However, there are still improvements that can be made to the website that would help in a person's decision making. For instance, the tool does not readily present traditional Medicare as an alternative choice to Medicare Advantage for health coverage. While the tool provides some introductory information about the difference between traditional Medicare and Medicare Advantage, Plan Finder inadvertently steers beneficiaries towards MA by not presenting traditional Medicare as a meaningful choice while they are comparing plans. Additionally, it is often difficult to make apples-to-apples comparisons between plans on Plan Finder because it receives incomplete information on plan provider directories and coinsurance costs from insurers. At best, Plan Finder links to the insurer's own provider directory, which is often inaccurate or out of date. Greater transparency and reporting requirements are needed so that consumers have a full look at pertinent information.

In conclusion, thank you for the opportunity to provide AARP's perspective on improving Medicare's enrollment process. I would be happy to answer any questions. We look forward to working with you to address this important issue and ensure continued access to affordable health benefits for older Americans.

U.S. Senate Special Committee on Aging

″Medicare and Medicare Advantage:
Challenges and Opportunities with Enrollment″

February 23, 2024

Kierstin Reed Prepared Witness Statement

Good Afternoon, Senator Ricketts, fellow testifiers, and members of the public. My name is Kierstin Reed and I serve as the President & CEO for LeadingAge Nebraska. Thank you for allowing me to testify today. We appreciate Senator Ricketts bringing this hearing to Nebraska. LeadingAge Nebraska is a statewide membership association that provides advocacy and education for providers of long-term care services in our State. We represent 80 providers across the State and work with our national partner LeadingAge, to provide support to over 5,000 long term care providers across the US.

Since the inception of the Medicare system in 1965, there have been numerous developments and changes to the system that now covers over 63 million beneficiaries across the US, with 300,000 of them being in Nebraska. The most recent change to the system is the addition of Medicare Advantage, also known as Part C as a private plan option, replacing the traditional Part A and B benefits. The Medicare selection process can be a daunting task for beneficiaries and supporters because the number of options has increased. The amount of information they need to wade through to try to understand the benefits available to them can be overwhelming. The number of services claiming to help seniors select a Medicare plan seems to be never ending and it is difficult for seniors to find a reputable, trusted source to support them in the decision making process.

LeadingAge Nebraska works with many nursing homes and home health providers across the State supporting older adults. When older adults find themselves in need of nursing care, either short term or long term, they have generally already been enrolled in a Medicare plan. It is often at this point in time that a professional is explaining the fine print of the plan they have selected to them and what services are available to them.

When you find yourself or a loved one in need of long-term care services, it can be difficult for anyone to understand the entire process. We find that beneficiaries and their family members may not fully understand what is covered under their Medicare plan. Many beneficiaries are under the belief that because they have Medicare, their long-term care services will be completely covered without out-of-pocket expenses and will last until they no longer need the services.

Beneficiaries are often surprised by the limitations on the services they receive and the overall cost of the services they need. For those needing skilled medical services, Medicare will pay for a portion of their stay if they are approved for this level of care for a period of time. If they no longer meet the criteria for skilled care, or have used their maximum benefit, Medicare no longer covers their need for these services. The average cost of nursing home services in Nebraska is $7,500 per month for custodial care, which is not covered by Medicare. As people are living longer and have

more complex health conditions, we find that beneficiaries are often outliving their personal resources for care, even with their Medicare benefits. Currently, 60% of nursing home residents in Nebraska rely on Medicaid as their payor source because they have no longer have funds to pay for services.The expansion of the Medicare Advantage program has increased the confusion for beneficiaries when they are selecting a plan. There are numerous Advantage plans available, which can muddy an already complicated system. There are now 46%% of beneficiaries nationally enrolled in a Medicare Advantage option. For Nebraska, this is closer to 30%, however this number continues to rise. These plans entice beneficiaries with many benefits that are not available in the traditional Medicare model, however beneficiaries may find that these plans are not widely accepted at every medical provider, limiting their options for care. Beneficiaries may also find that the services they would expect from Medicare are not the same that they anticipated compared to traditional Medicare due to authorization denials and limitations of services.

The intent of these plans is to provide equitable coverage in Part A and B, in addition to providing other benefits, such as vision and dental. Today, there is evidence that Medicare Advantage plans are denying coverage for Medicare services and in other cases, terminating care before the beneficiary is ready to go home. We need to assure that beneficiaries are receiving equitable care, regardless of the plan the choose.

In order for our health care system to work efficiently and effectively, there needs to be a focus on provider payment adequacy for services covered by Medicare. Traditionally, programs like Medicaid and Medicare have paid at a lower reimbursement than private insurance. The introduction of Medicare Advantage continued this trend at a deeper level. Some advantage contract to providers is equal to the state Medicaid rates, which experts agreed don't begin to cover the cost of custodial care, let alone the more intense skilled care provided when a beneficiary has significant health care needs.

If the concerns with Medicare, particularly with Advantage plans continues, it will cause erosion in the health care system. Providers of long-term care services are already closing at an alarming rate due to the rising cost of care, staffing shortages, and an inadequate reimbursement system. Patients are waiting for weeks to months on average in Nebraska hospitals for a placement in long term care. Nebraska has lost 17% of our nursing homes since 2017 and we are at risk for losing more in the coming years.

In closing, LeadingAge Nebraska wants to assure that older adults receive fair and equitable Medicare services. We want to assure they understand the benefits they are receiving and that they have a clear understanding of the choices they make when selecting a plan and the long-term impact those choices may have for their health care coverage. We also want to assure that the services they need are available to them when they need them. There are improvements that need to be made to address the access to benefits that meet the needs of beneficiaries.

Thank you for providing me the opportunity to testify today.

U.S. Senate Special Committee on Aging

″Medicare and Medicare Advantage:
Challenges and Opportunities with Enrollment″

February 23, 2024

Dr. John Trapp, M.D., Prepared Witness Statement

Good morning, my name is Dr. John Trapp. I am the Vice President of Medical Affairs and Chief Medical Officer for Bryan Health, a six hospital locally owned and governed Nebraska health system, and a pulmonary, critical care physician. I have been in clinical practice in Nebraska for 25 years. I will begin by thanking Senator Ricketts for his attention to this issue and providing a venue by which we may share our concerns about Medicare Advantage and their practices with all of you. Today I will outline a couple of our concerns, namely that abusive practices by insurers offering Medicare Advantage programs put vulnerable patients at risk and negatively impact hospital capacity, all while reducing payments to those who are actually providing the care.

In a Modern Healthcare article published February 16th, the author Caroline Hudson summarized many of the MA plans well, ″Medicare Advantage plans generate billions of dollars for payers as they woo members with $0 premiums and supplementary benefits.″ At its inception MA's intention was to allow for highly coordinated, proactive, population-based care that would reduce health care costs over time - something we can all agree on. In reality, the financially driven interests of the insurance companies have resulted in MA programs becoming the most profitable arm of many of the major insurance companies at the expense of the patient, taxpayers and the Medicare trust fund.

The Medicare Payment Advisory Commission (MEDPAC) projects that the Federal Government will pay MA plans $88 billion more this year than if those same beneficiaries would have been covered under the traditional Medicare program. Yet these additional funds are not going to providers. Just the opposite. Most physicians will receive less in 2024 as their Medicare Advantage fees are tied directly to the Medicare provider fee schedule, which will be cut 3.4% this year, culminating in a roughly 10% cut over the last four years.

At Bryan Medical Center, traditional Medicare reimburses us approximately 80% of our actual costs, meaning that we lose more than $90 million dollars per year on the Medicare patients we care for (including MA). Our contracts with MA plans call for reimbursement rates that are at least 100% of Medicare. However, due to inappropriate denials as well as delays in preauthorization and payment we receive less than what traditional Medicare would have reimbursed. For one of the most prominent MA insurers in the country, we receive only 88% of traditional Medicare reimbursement despite fighting their tactics every step of the way expending numerous resources to fight through unfair tactics where the advantage always lies with the insurer.

More important than the impact on reimbursement, prior authorization and denial practices have at times overwhelmed hospital systems and created a log jam that impacts vulnerable patients and hospital capacity. Bryan Medical Center is located in Lincoln,

Nebraska, has 664 licensed beds, and is often full. We consistently serve patients from all of Nebraska's 93 counties and surrounding states. On a Friday morning earlier this month we had 40 patients boarding in the emergency department, waiting for a bed upstairs. Several beds could have been made available except that a number of patients were effectively stuck at Bryan awaiting authorization by Medicare Advantage plans to be discharged to post-acute facility such as skilled nursing or long term care.

Finally, I'd like to spotlight the reason we are all here, patients and the delivery of quality care. These are the stories of two real life patients from the last several weeks at Bryan Medical Center. Patient A has been accepted to a long term care facility, their MA plan requires authorization for them to move to the next, most appropriate level of care. They no longer need to be in the hospital. The authorization was submitted to their health insurance plan on January 26th, 2024. On February 1st, our care transitions staff called the insurer asking for an update - their reply ″We have 10 more days to make a decision″. Ten days of delay to receive the rehabilitative care they need, ten days of being unable to leave the hospital, ten days of unreimbursed care, ten days of frustration - this is what happens when patient's select MA plans thinking they will have timely care and access to expanded benefits. Rather, they are at the mercy of their health insurance plan not what their doctor thinks is best for them. The hospital is not getting paid to care for this patient because the patient no longer requires acute care. The insurance company is getting days and weeks of free nursing care for their patient, at the expense to the patient's wellbeing, their family, and the hospital while making record profits.

Patient B has been waiting for authorization since February 12th, for the subsequent three days our capacity management director has emailed the MA insurance company and called multiple times trying to get an answer - they do not respond. The nursing facility that has accepted the patient cannot take them over the weekend, so if we don't get authorization by Friday, February 16th, the patient won't be able to discharge until Monday at the earliest. This results in even more days the patient is in the hospital for no reason, disallowing another patient with acute medical needs from accessing care.Now the insurance companies will tell you that they will pay for the delayed days, this is simply not true. The patients they will pay for are one - a limited group and two - require another authorization for the excess days. The hospital is further burdened in recouping costs because the MA plan wasn't efficient in processing the authorization the first time.

Why does Bryan continue to accept Medicare Advantage? Because taking care of those who need us is our first priority, but the current tactics of large national insurers, who hold the power, must be reined in for the sake of both the vulnerable and those of us who take care of them. The current model is not sustainable as the insurers claim record taxpayer funded margins, and the hospitals and healthcare providers subsist in the aim to fulfil our mission of care. MA plans are selling patients a bill of goods they cannot and choose not to fulfill.

Thank you for the opportunity to share but a small picture of the ways Medicare Advantage is impacting Nebraskans. Our State's

story is not unique, these behaviors are impacting American's nationwide. As you hear from myself and others today, I ask that you be moved to take action. I would welcome any questions you may have for me at this time.

U.S. Senate Special Committee on Aging

″Medicare and Medicare Advantage: Challenges and Opportunities with Enrollment″

February 23, 2024

Jana Danielson Prepared Witness Statement

Thank you for the opportunity to speak regarding the challenges associated with Medicare and Medicare Advantage (MA). My testimony today will focus on challenges faced by healthcare providers who are committed to caring for our Medicare and Medicare Advantage population.

Nebraska Medicine provides health care services to a significant number of patients who are covered by Medicare and Medicare Advantage. These patients represented 43.5% of health care services provided in FY23. The Medicare-eligible population has been trending upward over the last several years, and we anticipate that trend will continue as our state's population ages. Of total Medicare-eligible patients, Medicare Advantage enrollees make up approximately 35% of the total of Medicare-eligible population, and this proportion of patients enrolled in MA plans versus traditional Medicare continues to grow.

Medicare Advantage plans, offered as an alternative to traditional Medicare, are intended to provide the same benefits as traditional Medicare as a minimum standard. Unfortunately, healthcare providers routinely face challenges securing medically necessary care when Medicare Advantage coverage has been chosen by a Medicare beneficiary. The greatest challenges include prior authorization requirements, reimbursement challenges and inconsistent Medicare Advantage plan interpretations of Medicare rules.

The most recent ″CMS Interoperability and Prior Authorization Final Rule CMS-0057-F″ is a good start to address concerns related to delayed or denied care for Medicare Advantage beneficiaries resulting from prior authorization requirements. However, opportunities remain to ensure timely access to appropriate care for Medicare Advantage beneficiaries while reducing administrative burden for providers.

Application Programming Interfaces (APIs) and timeframes for payer responses do not address or standardize payer reasons for denial which can vary across MA plans and are often of sync with Medicare coverage guidelines. The Contract Year (CY) 2024 Medicare Advantage Final Rule continues to allow MA plans to apply their own coverage criteria when Medicare coverage criteria is not fully established. This results in variability among various MA plans and a requirement for providers to navigate multiple payer policies creating additional burden.

As an example, Nebraska Medicine routinely experiences authorization denials for medically necessary care with requirements from the MA plan to complete a peer-to-peer discussion or a letter of medical necessity - even though the care plan is considered the best course of treatment by our providers, it meets standard of care guidelines, and a Medicare coverage policy (local or national coverage decision, LCD or NCD) does not exist. To further complicate matters, the appeal process for every MA plan is different. Some allow a peer-to-peer; some require a letter of medical necessity,

while others may require a letter of medical necessity first with a peer-to-peer as a next step. Providers must navigate numerous different payer policies, as one MA plan is simply one MA plan.Imagine a patient recently diagnosed with cancer waiting for approval to begin cancer treatment and having a payer question the treatment plan of a highly respected provider with excellent outcomes that the patient trusts. The patient wants to act quickly; they want their payer and provider to act quickly. Yet, delays occur due to prior authorization requirements that are simply administrative in nature. In most cases, final approval is received with no change to the original treatment plan, making all of the administrative work ultimately unnecessary.

Imagine the provider who is caring for the same patient and many others, who is focused on quick, appropriate, medically necessary care for all patients. They see their patients face to face, talk to them, examine them; they are aware of the most up to date research and best courses of treatment; yet they are required to spend countless hours talking to payers (during payer business hours) or writing letters to substantiate their treatment plan. This additional burden placed on providers takes time away from caring for patients which is their top priority.

Now consider this same patient may require hospital care followed by post-acute care needs. Hospital stays with Medicare Advantage plans present another set of challenges. In an acute hospital, there is a difference in reimbursement for stays classified as ″observation″ and those classified as ″inpatient.″ Inpatient stays require a higher, more resource-intensive level of care, and thus, are reimbursed at a higher rate. To simplify the classification, Medicare implemented a 2-midnight rule in 2013, which means that inpatient services are considered appropriate if the physician expects the patient to require medically necessary hospital care spanning at least two midnights. The Contract Year 2024 Medicare Advantage Final Rule clarified that Medicare Advantage plans must comply with general coverage and benefit conditions included in Traditional Medicare regulations. Yet, Nebraska Medicine is experiencing medical necessity denials for inpatient stays on cases with length of stays four days and greater - double the Traditional Medicare requirement. Medicare Advantage plans continue to deny medical necessity for patients that would have been approved for inpatient status based on the Traditional Medicare 2-midnight rule.

Not only does the classification of care as observation or inpatient affect hospital reimbursement, patient out-of-pocket costs may increase due to the difference in deductible, coinsurance and coverage guidelines associated with observation versus inpatient stays. The denials are often received within the first 24-36 hours of care and place additional administrative burden on the hospital to work with the payer to overturn the denial while the patient is being treated. The administrative burden in this case includes both nurse and physician time. The hospital has been forced to contract with outside physicians to simply battle payer's physicians to allow inpatient status. Holding the MA plans accountable to traditional Medicare 2-midnight rules would protect our patients and reduce administrative burden and cost for the provider and the payer.

Imagine this same patient is now ready for discharge, and the care team agrees that an Acute Rehab Facility is necessary, for example. Nebraska Medicine contacts the Medicare Advantage plan, who denies Acute Rehab authorization. A peer-to-peer is completed by the attending physician, and the MA plan confirms acute rehab denial but approves patient discharge to a Skilled Nursing Facility (SNF). The family and care team identify a SNF for discharge purposes. After a week of waiting for approval, the MA plan denies the SNF level of care. At the same time that many MA plans are denying ongoing hospital care for lack of medical necessity, their process for approval of post-acute care creates barriers to accessing a lower level of care for these patients, which leads to longer lengths of stay in the hospital. When this occurs, the cost and burden of care falls to the hospital to supply services that go uncompensated while awaiting approval and acceptance to a SNF, acute rehab unit (ARU) or long-term acute care hospital (LTACH). And the patient waits.

After discharge, this same patient may require readmission back to the acute hospital setting. The MA plans do not follow CMS readmission guidelines. Readmission denials have been escalating, and the only path to appeal is a written letter. At this time, some MA plans deny ALL readmissions without consideration for diagnosis or expected readmission rates.

Related to Traditional Medicare I would like to address two items: First, the three-day inpatient requirement for a SNF stay. For traditional Medicare patients, the requirement for a three-day inpatient stay prior to coverage for skilled nursing services is often viewed as an antiquated measurement of severity of illness and does not reflect recovery timeframes in today's healthcare world. Nebraska Medicine would advocate for dissolution of the 3-day SNF requirement. Second, proposed Medicare HOPD Cuts or ″site neutral″ policies. The concept of ″site neutral″ policies on the surface makes sense to address the goal of eliminating cost disparities between hospital outpatient departments and independent physician offices. Going beyond the surface, hospitals bear costs that physician practices or Ambulatory Surgery Centers do not, including 24 hours day availability, the ability to treat complex medical conditions, requirements to provide emergency care and to participate in emergency preparedness activities. Continued cuts have the potential to impact hospital's ability to provide essential care for the communities they serve.

In conclusion, administrative costs to comply with rules, monitor for denials, appeal for proper patient care, and pursuit of proper and fair reimbursement continues to escalate in cost and time and is unsustainable. Thank you for the opportunity to share my perspective.

/s/
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Vice President, Revenue Cycle
Nebraska Medicine

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