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HEARING ON THE FUTURE OF MEDICARE ADVANTAGE HEALTH PLANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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FUTURE OF MEDICARE ADVANTAGE HEALTH PLANS

THURSDAY, JULY 24, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:00 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225-3625
July 17, 2014
No. HL-14

Chairman Brady Announces Hearing on the Future of Medicare Advantage Health Plans

House Committee on Ways and Means Health Subcommittee Chairman Kevin Brady (R-TX) today announced that the Subcommittee on Health will hold a hearing to examine the status of the Medicare Advantage (MA) program and the impact of the Affordable Care Act (ACA) on the MA program. **The hearing will take place on Thursday, July 24, 2014 in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow and be posted on the Committee's website prior to the start of the hearing.

BACKGROUND:
Private health plans have served Medicare beneficiaries from the early years of the program and were strengthened through the 2003 Medicare Modernization Act with the creation of the Medicare Advantage program. The MA program now has nearly 16 million seniors in private Medicare plans, about one in four Medicare beneficiaries in 2012.

However, the program is now facing significant challenges because of the ACA. According to estimates by the Congressional Budget Office (CBO), the ACA will cut $308 billion from the MA program by 2023. CBO estimated that those beneficiaries who remain in MA will lose $816 worth of additional supplemental benefits they would have otherwise received in 2019. As a report by the Medicare Payment Advisory Commission (MedPAC) noted, over 23% of seniors enrolled in Medicare Advantage are low-income, dual eligible seniors as of data in 2012, and could face the most significant impact as a result of those reductions.

The Centers for Medicare and Medicaid Services (CMS) has taken steps to mitigate the ACA's payment cuts through its MA Star Demonstration Program and by utilizing a new

payment methodology regarding Medicare Sustainable Growth Rate. However, because of the ongoing transition to the new benchmarks established by the ACA, which will not be fully phased in until 2017, the independent and non-partisan Medicare Trustees have reported that enrollment in MA plans will begin to decline in 2015.

In announcing the hearing, Chairman Brady stated, **"Over the past decade enrollment in Medicare Advantage has tripled, and today more than half of new seniors chose a Medicare Advantage plan to receive their Medicare benefits. These plans are particularly popular with low income and minority seniors since these plans provide high quality and low cost care. Seniors that select Medicare Advantage plans are highly satisfied with the coverage and benefits they receive.**

But now the health plan options favored by the nearly 16 million seniors, particularly some of the most vulnerable groups of seniors, are being threatened by cuts in the Affordable Care Act and onerous regulations. Understanding the successful structure of the MA program and the compounding challenges the program is facing, is key to ensuring seniors now and into the future have access to plans they want that best meet their needs."

FOCUS OF THE HEARING:
The hearing will examine the current status of the MA program, and the effects of the Affordable Care Act to the program and its impact on seniors enrolled in MA.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:
Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, August 7, 2014**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:
The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.
Note: All Committee advisories and news releases are available on the World Wide Web at http://www.waysandmeans.house.gov/.

Chairman BRADY. Good morning, everyone. The subcommittee will come to order.

Today we will hear testimony regarding the Medicare Advantage Program. We will hear about these private plans that are chosen by an increasing number of seniors, and we will hear about how these private plans can combine high quality and low costs.

We will look to the future of the popular program and ask: when scheduled cuts to Medicare Advantage Plans in the Affordable Care Act take place, can these popular plans continue to effectively serve seniors?

Will the policies of the Obama Administration narrow choice and plan flexibility, further impacting our seniors?

Since seniors were first given the option to select a private health plan to receive their Medicare benefits, they have shown a strong preference for these plans. Over the past decade, enrollment in Medicare Advantage has tripled. Of new enrollees, more than half choose a Medicare Advantage Plan over traditional fee-for-service. Today nearly 16 million seniors are receiving their benefits through these private plans.

Medicare Advantage Plans are particularly popular with low income and minority seniors since these insurance plans are able to provide caps on out-of-pocket costs, coordination of care for seniors, and more predictable costs. The seniors that choose these plans are highly satisfied with the coverage and the benefits they receive.

Unfortunately, many of our elderly could lose access to the plans they have and like because of cuts that are just beginning to hit that are part of the President's Affordable Care Act.

Knowing just how unpopular these cuts were with the seniors that select these plans, the White House, acting through a new

demonstration program and other regulatory actions, masked and delayed the impact of initial stages of the $300 billion in cuts through the November 2012 elections. Those political delays are over. The difficult reality is 2015 is now upon us, and millions of seniors who rely on the Medicare Advantage Program may be in jeopardy of losing their plan, their doctor, and the financial protection and benefits they have chosen.

The future for Medicare Advantage may look grim. The questionable $8.3 billion quality bonus payment demonstration program used to mask ACA cuts is now coming to an end. In addition, the new payment methodology for Medicare Advantage Plans that assume Congress will fix the way Medicare pays physicians is only temporary. This leaves the looming threat to Medicare Advantage Plan rates could again include the broken physician reimbursement formula unless we finally and permanently fix the way Medicare pays our physicians.

So instead of improving the situation, CMS' regulatory actions are threatening plans through potential termination and limiting their ability to innovate. For example, plans serving largely low income populations find themselves struggling to meet the demands of the Medicare Advantage Star Rating Program. That could place them in jeopardy of being terminated in this coming year, just weeks before open enrollment is to begin.

Ironically, high performing Medicare Advantage Plans are also in the cross hairs. Plans that have consistently found ways to be rated highly in the star system now find themselves unsure of what supplemental benefits they must cut going forward due to backwards incentives under the benchmark cap created by the ACA.

As many of us predicted following the passage of the controversial Affordable Care Act, seniors and Medicare Advantage health plans have not yet experienced the full impact of these cuts, and as the full impact of these cuts is felt in the coming years, could millions of seniors be forced out of plans they have and they like?

A report released Monday by the American Action Network has mapped out likely benefit cuts per Medicare senior by congressional district, which I would like to enter for the record.

And without objection, so ordered.

[The information follows:]

AAN Releases Study Examining Medicare Advantage Cuts Per Congressional District

https://americanactionnetwork.org/press/aan-releases-study-examining-medicare-advantage-cuts-per-congressional-dist

HealthCare | Mon Jul 21, 2014

DontCutOurMedicare.com Features District-by-District Data of How Much Obamacare's Medicare Advantage Cuts Have Already Cost Seniors

WASHINGTON – The American Action Network today released a study examining the district-by-district impact of the Medicare Advantage (MA) cuts seniors will face in 2015 due to the Affordable Care Act (ACA), recent additional MA cuts by the Obama Administration, and other government regulations. This study quantifies how much on average a senior's MA has been cut in each congressional district, by comparing MA rates from before the ACA with the actual benefit cuts each year since the ACA, including the latest round of MA cuts finalized in April 2014.

Featured at DontCutOurMedicare.com, district-by-district data analysis finds that seniors in every congressional district in the U.S. will experience benefit cuts in 2015. On average nationwide, seniors will face an annual benefits reduction of $1,538 or 13.32%. The largest cuts per district are 26.16% and $4,796 per senior, both in districts in New York.

"The impact of Obamacare's assault on Medicare Advantage and seniors is clear in every district in America," said AAN Communications Director Dan Conston. "These cuts are already forcing millions of seniors to deal with higher costs, fewer benefits, and worse access to doctors. This is proof positive that Obamacare is an unmitigated disaster for seniors nationwide."

Nearly 16 million seniors rely on Medicare Advantage, roughly one third of all Medicare users. Obamacare directly cuts Medicare Advantage by over $156 Billion to help fund Obamacare, and since it became law, the Obama Administration has made additional annual MA cuts, including an over 3% cut this year.

A recent study by the American Action Forum estimates the cuts to MA benefits effective 2015 compared to 2014 and to a pre-ACA baseline. Using the study's county-level estimates, AAN computed average cuts for each congressional district weighted by the distribution of seniors within the district. The average cuts are also weighted by plan enrollment and star rating.

Earlier this year, American Action Network launched a $1 Million issue advocacy campaign opposing additional Medicare Advantage cuts. Thousands of seniors signed AAN's petition to stop the Medicare Advantage cuts at DontCutOurMedicare.com.

Chairman BRADY. The report points to one glaring conclusion. Seniors in every district in America, Republican or Democrat, now face damaging cuts to their health care and pharmacy benefits they selected because it fits their needs. The Medicare Advantage Program is popular among our Nation's seniors because it provides seniors with choices to select a plan that best fits their needs.

We need to ensure seniors continue to have this valuable option. It is no surprise then that many Members of Congress, even our colleagues in the Senate, have recognized the challenges facing seniors and have come out in bipartisan opposition to further cuts to Medicare Advantage.

Today you will hear from witnesses who will tell us the current picture of Medicare Advantage, the good, the bad and, yes, maybe even the ugly, and I am confident that as we look forward and work together we can break down barriers and improve Medicare

Advantage for America's seniors who depend upon these critical plans.

The ACA brings a new level of uncertainty to those who depend on Medicare Advantage, and the time is now to consider the feature of these Medicare programs and the importance Medicare Advantage Plans play for a growing number of seniors.

This Subcommittee will hold the Administration accountable to carefully examine the impact that any changes to Medicare health plans will have on seniors, the Medicare Program itself, and ultimately on taxpayers. We must work together to make sure that our Nation's seniors continue to have choices in their care and benefits.

I recognize the Ranking Member, Dr. McDermott, for the purposes of an opening statement.

And I ask unanimous consent that all members' written statements be included in the record.

Without objection, so ordered.

I now recognize the Ranking Member, Dr. McDermott, for five minutes for the purposes of his opening statement. Doctor.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to thank you for holding this hearing.

There is a good story to tell about the Medicare Advantage Program, and I am pleasantly surprised by my colleagues across the aisle having provided a stag for us to do that. I kind of wondered what it was about, but as I listened to the chairman, I realized it was more of the skewer tactics of the past.

Before we get to the good news about the program, we have to hear a lot of specious claims about the ACA's effect on Medicare Advantage, but the truth is somewhat entirely different. Thanks to the changes made by the ACA, both Medicare Advantage and traditional Medicare are on a much stronger footing, and we will hear that from the report from the Trustee shortly.

Since the passage of ACA, the MA Program has seen record high enrollment, with more than 15 million Medicare beneficiaries enrolling in the MA plan. Thirty percent of all Medicare beneficiaries are enrolled in Medicare Advantage at this point.

Since the passage of the ACA, premiums have been reduced or held steady. In total, Medicare Advantage premiums have fallen 14.3 percent. That means the average Medicare enrollee pays $31 per month. Underlying Medicare Advantage benefits have been increased in both MA and in traditional Medicare, meaning that the plans have more money to spend on these benefits. Those are the facts.

Now, one of the key improvements of the ACA made to MA was to cut down on overpayments that were threatening the solvency of the program. Thanks to misguided provisions put in by the Republicans' 2003 prescription drug legislation, the Federal Government was paying plans an average of 114 percent of the cost of traditional Medicare. That is 14 percent more than if people had stayed in Medicare. They were breaking the program.

Independent analysis from the GAO, Medpac, and countless others point out that the wasteful spending was putting Medicare on an unsustainable course. To fix this, the ACA improved how we calculate payment rates. These reforms have brought payments to

more in line with the costs of traditional Medicare, while emphasizing efficiency and quality.

Even though we have reduced Medicare Advantage overpayments, insurance companies are doing just fine. Which insurance company has gone in the tank in the last five years? Their stock prices have surged, and their profits continue to grow.

Reducing Medicare overpayments has also improved the Medicare Trust solvency and helped drive down Medicare spending. It is a fact that overall per capita growth in Medicare spending is at record lows, thanks to ACA. The savings, most of which were recommended from nonpartisan experts, including Medpac and others, come from changes to payments for plans and providers.

Despite their rhetoric, my colleagues on the other side must have thought they were well justified, too. In fact, every Republican on this dais has voted multiple times in favor of these very same cuts as part of the Reagan—Ryan budget. Reagan, Ryan, it is all the same. They are Irish.

At other times my Republican colleagues have been known to claim these savings have come at the expense of beneficiaries. That is false. We have increased benefits both in Medicare Advantage and traditional Medicare by expanding preventive care, eliminating cost sharing for preventive care, and improving coverage for prescription drugs.

My colleagues across the aisle also talk about declining choice and access in Medicare Advantage Plans, but the reality is that beneficiaries have more access to Medicare Advantage Plans. More than 99 percent of eligible beneficiaries have access to an MA plan, and the average beneficiary has the option to choose between 18 plans. That is not a loss of choice.

Given these facts, it does not sound to me that the program is having any real difficulty. So I am very interested to hear the witnesses.

And thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Today we are joined by four witnesses:

Chris Wing, Chief Executive Officer at SCAN Health Plans;

Dr. Jeff Burnich, the Senior Vice President and Executive Officer at Sutter Medical Network, testifying on behalf of the CAPG; Robert Book, Senior Research Director of the Health Systems Innovation Network, and Healthcare and Economics Expert at the American Action Forum;

And Joe Baker, President of the Medicare Rights Center.

Mr. Wing, you are now recognized for five minutes, and welcome.

STATEMENT OF CHRIS WING, CEO OF SCAN HEALTH PLANS

Mr. WING. Thank you, Mr. Chairman.

My name is Chris Wing, and I am the CEO of SCAN Health Plans. SCAN was founded in 1977 in Long Beach, California, by senior citizen advocates. Their mission back there was very elegant: help seniors stay healthy and independent.

I am happy to say that 37 years later we have the exact same mission statement. With our focus on our mission statement and the unique and disparate needs of seniors, since they are not a homogenous group, we have now emerged as one of the fastest grow-

ing MA plans in the Nation, and we are the fourth largest not-for-profit MAPD plan in the Nation.

SCAN and our provider partners now care for 170,000 seniors, up from 120,000 just three years ago. We care for the healthy, the poor, the chronically ill, the disabled, and those in their last days of life.

We provide unique products, medical care, and services tailored to meet the very unique and disparate needs of today's seniors. In fact, 30,000 of our members have chosen to participate with us through special need plans. We have C–SNPs or chronic special need plans to care for members with diabetes, heart disease, and end stage renal disease.

We have an institutional I–SNP specialty plan for members who are nursing home certifiable, and we also have D–SNPs that offer integration and care for members who are both eligible for Medicare and dually eligible. These are some of the most frail and underserved members in our Nation.

We think the diversity of these plan offerings is a major reason why Medicare Advantage has become such a great public policy. So whether you are healthy and yearn for a discounted gym membership or you require an integrated care team to help you deal with a chronic, complex illness, Medicare Advantage has a plan for you.

As Congressman McDermott mentioned, now 30 percent of seniors across the country are now enrolled in Medicare Advantage. In my home State, that is 38 percent, and actually based on an article from Health Affairs, now half of every Medicare beneficiary becoming eligible for the program is now selecting Medicare Advantage.

Perhaps the growth of Medicare Advantage is due to affordability. For our members in 2014, 90 percent of them pay no monthly premium. Perhaps it is because of low cost use for going to primary care physicians. Eighty percent of our current members have absolutely no copay for seeing a primary care physician. This is extremely important for seniors who have frail health or are on a fixed income. We do not want to create any economic barriers to see their primary care physician.

Perhaps the growth of MA is due to quality. Virtually all of the quality measurements now point to Medicare Advantage being better than traditional Medicare, better on diabetes testing, better on breast cancer screening, better on antidepressant medication management, and better on reducing hospital re-admit rates. No wonder people are voting with their feet and choosing MA.

With that being said, there are significant clouds on the horizon. Over the past few years the MA Program has sustained a series of significant funding cuts. These include the $2.5 billion cut as part of the American Tax Relief Act; and two percent sequestration cut that went into effect last year; and the $200 billion worth of cuts coming from the Affordable Care Act.

Some seniors have already begun, and I am talking about SCAN seniors, to feel the impact of these cuts with higher out-of-pocket costs, reduced benefits, and more limited provider choice. However, many more seniors in the future will be impacted as the vast majority of these cuts, almost 80 percent, occur in future years.

Now plans of providers are adapting and evolving to these cuts. We have no choice, and it is good that we are doing it. Some of the

larger plans are vertically integrating to create synergies in costs and care savings. SCAN is pursuing a more collaborative approach with the bigger systems in Arizona and California.

We are a not-for-profit, mission driven company, and we have enjoyed the trust of our provider groups for 37 years. So we have started an initiative called Provider Integration where we collaborate with the 14 best and biggest groups on the West Coast, and the goal really is how can we work together to improve the model.

The initial focus was on the CMS star program, and in just one year we took our star's rating in California from 3.5 to 4.5. That is a big deal.

But our seamless quality bonus can offset only so much of the cuts. So as Congress and CMS developed Medicare policy, we would ask you to be vigilant regarding the stability of Medicare Advantage. Reimbursement rates cannot continue their recent steep decline. As plans, we will work to minimize and mitigate as much of the impact as possible as we become more efficient, but we ask the Congress and CMS to do their best to keep payment rates as stable as possible.

CMS should also keep the five-star bonus program stable. As I mentioned, the CMS quality bonus program is probably the biggest sea change event that has changed the focus on quality in my 30 years on managed care.

Chairman BRADY. Mr. Wing, I apologize. The time has expired for the opening statement. So thank you very much.

[The prepared statement of Mr. Wing follows:]

Testimony

for

House Ways & Means Committee
Subcommittee on Health

The Future of Medicare Advantage Health Plans

by
Chris Wing
Chief Executive Officer
SCAN Health Plan

July 24, 2014

I. Introduction

Chairman Brady, Ranking Member McDermott, and members of the subcommittee, I am Chris Wing, Chief Executive Officer of SCAN Health Plan (SCAN). SCAN is the fourth largest not-for-profit Medicare Advantage Prescription Drug (MAPD) plan in the United States, serving approximately 170,000 members in California and Arizona. While most of SCAN's members are over the age of 65, we also provide care to some younger, disabled individuals who are dually-eligible for Medicare and Medicaid benefits ("dual eligibles").

We appreciate this opportunity to testify on the successes and benefits of the Medicare Advantage (MA) program. MA plans have pioneered successful strategies to manage the care of seniors with complex health needs. By emphasizing prevention and wellness through primary care, MA plans help beneficiaries achieve better health outcomes. Medicare fee-for-service (FFS) lacks the infrastructure necessary to support the coordination across provider networks that MA plans use to address beneficiaries' unique needs. In fact, a recent *American Journal of Managed Care* study found that MA plans outperformed FFS in 9 out of 11 clinical quality measures.[1] This means that MA beneficiaries received the level of care recommended by a physician with greater frequency than patients in FFS, for 9 of the 11 procedures studied.

Our testimony includes the following:

- An introduction to SCAN and the people we serve;
- Examples of how MA increases the value proposition of Medicare;
- An explanation of how MA program flexibility enables plans to more holistically serve Medicare beneficiaries;
- Evidence that MA exceeds FFS on quality of care;
- A discussion of how the alignment of incentives is encouraging plan and provider collaboration; and
- Recommendations to encourage the continued success of the program.

II. SCAN Health Plan

SCAN has a long history of serving older adults with complex health situations. SCAN was founded in 1977 by a group of Long Beach, California senior citizen activists who were frustrated by a lack of access to health and social services that addressed their unique needs. They specifically wanted assurance that they could continue living in their own homes, even if their declining health qualified them for a nursing home. SCAN's mission today is the same as it was then: to develop innovative ways to help our members manage their health and live independently. For more than two decades, SCAN participated in Medicare's Social HMO Demonstration, incorporating long-term services and supports (LTSS) with a comprehensive program of assessment and care management. It was through our experience as a Social HMO that SCAN developed an expertise in crafting benefits and services of particular importance to persons with special care requirements.

Because of the complex nature of our members' health conditions, SCAN has created a care management model that emphasizes prevention and early intervention, with a keen focus on medication management. Our model spans the continuum of a beneficiary's health status. Our disease management programs focus on recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, nutrition, self-

[1] Brennan N., Shepard M. (2010) "Comparing Quality of Care in the Medicare Program," The American Journal of Managed Care, 16(11): 841-848.

management and healthy behaviors, advance care planning, and medication management. Highly-trained care teams address the complex needs of the chronically ill population, and each program is coordinated with all others to ensure safe and effective care transitions between all levels of care and providers. All those involved work together in offering a person-centered, holistic approach for persons with multiple, complex, and ongoing care needs. The *New England Journal of Medicine* has cited SCAN's model as an example of a successful investment in primary care to provide better care at reduced costs through reductions in the use of hospitals and emergency rooms.[2]

III. Medicare Advantage as a Value-Add Proposition

The MA program has seen exponential growth and increased popularity over the last few years. As of March 2014, 30 percent of the Medicare population resides in MA, a total of 15.7 million beneficiaries.[3] That is a year-over-year increase of 10 percent, and a 41 percent increase since March 2010.[4] In my home state of California, about 38 percent of Medicare beneficiaries are currently enrolled in MA.[5] Perhaps most notable is the percentage of newly-eligible Medicare beneficiaries who are choosing MA – more than half, according to a January 2014 Health Affairs article.[6] It is clear that beneficiaries, especially younger beneficiaries, are voting with their feet for the benefits, the flexibility, and the comprehensive coverage that MA plans offer. It is expected that MA will only gain popularity as the Baby Boom generation – who are accustomed to the benefits and infrastructure of managed care organizations – continues to age into Medicare.

There are specific reasons for this significant growth. Medicare Advantage plans provide extra benefits and services that are not included in the Medicare FFS program, such as:

- Case management services
- Disease management programs
- Coordinated care programs
- Wellness and prevention programs
- Enriched Part D benefits
- Vision, hearing, and dental benefits coordinated with medical service

Many plans now offer personal health records to afford beneficiaries greater control over their health information. In addition, many Medicare Advantage plans offer all these additional benefits with either zero or low premium, making the program even more attractive to potential enrollees. In fact, in 2013, 55 percent of MA beneficiaries nationwide were enrolled in plans with zero premiums.[7] Nearly 90 percent of SCAN's members do not pay a premium as part of their plans, and over 80 percent pay $0 copays for visits with their primary care physicians. This is important not only because it saves seniors money, but also because of the benefits it brings

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[2] Bodenheimer T., Berry-Millet R. (2009) "Follow the Money – Controlling Expenditures by Improving Care for Patients Needing Costly Services," New England Journal of Medicine, 361:1521-1523.
[3] Gold, M., Jacobson, G., Damico, A., Neuman, T. "Medicare Advantage 2014 Spotlight: Enrollment Market Update," Kaiser Family Foundation, April 2014.
[4] Ibid.
[5] "Medicare Advantage / Part D Contract and Enrollment Data," Centers for Medicare & Medicaid Services, February 15, 2013.
[6] Martin, A., Hartman, M., Whittle, L., Carlin, A., and the National Health Expenditure Accounts Team (2014) "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year," Health Affairs, 33(1): 67-77.
[7] MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and landscape files, 2013.

to both the patient and the health system as a whole. A study published in the *New England Journal of Medicine* observed that as copayments for ambulatory care increased, elderly patients made fewer outpatient visits and experienced more hospital admissions.[8]

MA plans continue to be a vital source of coverage for low-income and minority beneficiaries. In 2011, 31 percent of African-American Medicare beneficiaries and 38 percent of Hispanic beneficiaries were enrolled in Medicare Advantage plans.[9] Forty-one (41) percent of Medicare beneficiaries with Medicare Advantage plans had incomes below $20,000; for comparison, 37 percent of all Medicare beneficiaries had incomes below $20,000.[10]

IV. Greater Flexibility for Beneficiaries

With the availability of such additional benefits tied to lower out-of-pocket costs, it is no surprise that beneficiaries are increasingly opting to receive their care through MA instead of through FFS, which was designed in the mid-20th century.

Perhaps most notably, Medicare Advantage allows plans to develop coordinated programs focused on individuals with particularly complex health conditions. These "Special Needs Plans" (SNPs), established by the Medicare Modernization Act of 2003, exclusively serve one of three types of special needs individuals: (1) institutionalized beneficiaries, or individuals living in the community who require an equivalent level of care (I-SNP); (2) dual eligibles (D-SNP); and/or (3) beneficiaries with severe chronic conditions (C-SNP).[11]

Because SNPs target their enrollments to particular patient populations, they can design programs that meet a group's unique health care needs and successfully reduce hospitalizations and institutionalizations. SNPs are subject to strict requirements and oversight from CMS and the National Council on Quality Assurance to evaluate quality of care. The advantages of SNPs to beneficiaries and public payors alike are evident in the results of the SNP Alliance's Annual Member Profile. The most recent profile shows that the SNPs profiled serve significantly more complex, high-needs beneficiaries than those in Medicare FFS. For example, while the average risk score, as calculated by CMS through its Hierarchical Condition Category system, for FFS beneficiaries living in institutions was 1.84, SNP Alliance members' median risk score for I-SNPs was 2.23, with an upper range of 2.45. The average risk score for SNP Alliance fully-integrated D-SNPs was 1.49 compared to 1.27 for dual eligibles in FFS. SNP Alliance plans also serve a higher percentage of people with what the National Quality Forum defines as "high-impact conditions." Despite these significantly higher risk levels, SNP Alliance members have been highly effective in reducing hospital utilization, readmissions, and emergency room visits.

Because SCAN's members are, overall, older and frailer than the average Medicare beneficiary, the availability of targeted, coordinated care options is particularly important. SCAN offers I-SNPs, D-SNPs, and C-SNPs to our members, with a total SNP enrollment of approximately 30,000 individuals. A host of case management services is available to enrollees in a SCAN SNP, including the creation of a personal care plan, assistance transitioning safely home after a

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[8] Trivedi, A., Moloo, H., and Mor, V. (2010) "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," The New England Journal of Medicine, 362(4): 320-328.
[9] "Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2011," AHIP Center for Policy and Research, February 2013.
[10] Ibid.
[11] "Special Needs Plans – Fact Sheet & Data Summary," Centers for Medicare and Medicaid Services. *Available at* http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/FSNPFACT.pdf.

hospitalization, disease management, and medication therapy management. Approximately 10,000 of our members are dual eligibles enrolled in one of SCAN's D-SNPs. In addition to the case management services available to other SNP members, D-SNP enrollees have access to a Personal Assistance Line (PAL) Unit. SCAN provides these dual eligibles with a "PAL," a member services representative who speaks their language and provides additional assistance in navigating the complexities of the Medicare and Medicaid programs. PALs act as liaisons between the member and SCAN staff, medical groups, providers, and community-based organizations, ensuring that the member has access to the services and supports that he or she needs.

This unique care management model has proven effective in improving patient health outcomes. A March 2012 study conducted by Avalere Health found:

- Comparing HEDIS 30-day All-Cause Readmissions Rates between dual eligibles enrolled in a SCAN Health Plan D-SNP versus Medicare FFS dual eligibles, SCAN's dual eligibles had a **hospital readmission rate** that was **25 percent lower** than a similar cohort of California FFS dual eligibles.

- SCAN also scored better than Medicare FFS on ARHQ's Prevention Quality Indicator (PQI) Overall Composite, demonstrating a **14 percent lower hospital inpatient admission rate** for conditions that compose the composite measure, including chronic obstructive pulmonary disease (COPD), congestive heart failure, and bacterial pneumonia.

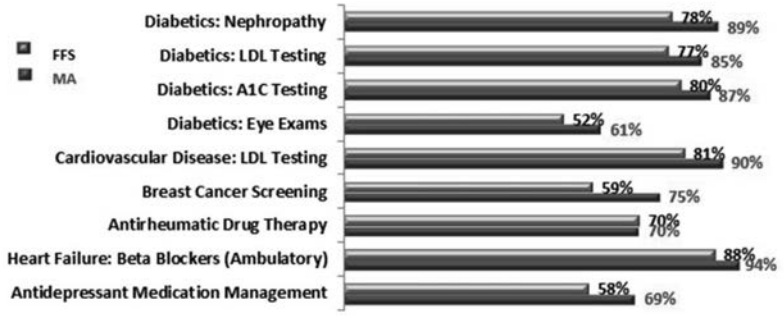
The study also found a potential for significant cost savings tied to the improvement in health status of SCAN's D-SNP enrollees. Based on the results of a matched cohort analysis, if California FFS duals had the same hospitalizations and readmissions rates as SCAN's duals, this would result in at least $50 million in annual savings to Medicare FFS in California.[12] Avalere based the calculation on expected reduced hospitalizations and re-hospitalizations for the 5,500 FFS dual members it examined in the CMS five percent sample, multiplied by 20 to approximate the impact to the full California FFS duals population. Avalere has said that savings could be greater across the entire California duals population if additional FFS duals matched the SCAN members' conditions.

V. Quality

The additional benefits and emphasis on care coordination found in Medicare Advantage translate into much more effective care compared to traditional Medicare. As mentioned above, a recent study in the *American Journal of Managed Care* discovered that MA plans outperformed FFS Medicare in 9 out of 11 clinical quality measures.

[12] "Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions," Avalere Health LLC, March 2012.

American Journal of Managed Care: **HEDIS measures**



The findings of this study reveal that breast cancer screening rates were approximately 15 percentage points higher in MA than in FFS. The quality of diabetes care received by beneficiaries was approximately four to 10 percentage points higher in MA across the four measures studied [rates of eye exams, A1C testing, LDL (cholesterol) testing, and nephropathy (kidney) screening or ongoing treatment]. Antidepressant medication management rates were 13 to 14 percentage points higher in MA. Receipt of beta-blockers prescription after discharge for AMI (heart attack) was nearly seven percentage points higher in MA, and LDL (cholesterol) testing for patients with cardiovascular disease was 7 to 8 points higher as well.

The positive effects of MA care coordination programs transcend specific episodes of care. Analysis of a large sample of administrative claims data found that the 30-day readmission rate for hospitalized MA patients was about 14.5 percent in the 2006-2008 period, about 22 percent lower than that for FFS.[13] Taking into account adjustments for readmission risk and disability entitlement status, the MA readmission rate was about still 13 to 20 percent lower than FFS.

SCAN and other MA plans take such benchmarking very seriously. We are constantly measuring ourselves to see how we are fulfilling the Triple Aim: improving the individual experience of care, improving the health of populations, and reducing the per capita cost of care. At SCAN, we actually reward our executives and other employees financially based on metrics that represent these goals. That is one reason why we are seeing high levels of patient satisfaction (97 percent among duals, for example), quality improvement going from 3.5 to 4.5 Stars in one year, and cost savings translating into higher benefits vs. FFS (for example, a $59 additional actuarial value per member per month in Part D benefits).

VI. Encouraging Creative Collaboration

One aspect of the Affordable Care Act that has not received enough attention is the Medicare Advantage Quality Bonus Program, which rewards plans that meet quality benchmarks of 4 Stars and higher. For the first time, CMS has begun paying plans based on quality of care as measured through HEDIS, HOS, and CAHPS. Plans and beneficiaries are responding to this incentive. In 2014, more than a third of MA contracts are now 4+ Stars, compared to 14

[13] Lemieux, J., Sennett, C., Wang, R., Mulligan, T., Bumbaugh, J. (2012) "Hospital Readmission Rates in Medicare Advantage Plans," The American Journal of Managed Care, 18(2): 96-104.

percent in 2011.[14] Even more impressive, 53 percent of Medicare Advantage beneficiaries are now enrolled in plans with four or more stars, compared to just 24 percent in 2011, according to the Department of Health and Human Services.[15]

The Quality Bonus Program has encouraged plans and providers to work together to hit quality benchmarks, especially in California where they frequently share financial risk for beneficiaries. Under the California Model, as it is called, plans pay providers a capitated amount of the premium to manage beneficiaries' medical benefits. Physicians and other providers have a natural incentive to provide efficient care under capitation. However, new developments are making closer collaboration between plans and providers essential to survival. A series of financial challenges – sequestration, rate cuts, an across-the-board penalty on coding intensity, the new HCC model, and specialty drug trends – are financially squeezing both plans and providers. Achieving 4 Stars and above to earn that bonus payment and mitigate at least some of the cuts is driving plans and providers to hit CMS' metrics and provide optimal care.

To give you some idea of the growing level of Physician/Plan collaboration, SCAN invited the leadership of 14 independent physician groups and health systems that serve SCAN's membership to test their interest in forming a joint effort to improve systems of care for the chronically ill population we collectively serve. We created a forum that would enable us to learn from each other and possibly make joint, cross-organizational investments to support improvement.

Given that the 5 Star Quality Bonus is earned by SCAN across its membership, it would not be enough for a best practice to focus on one or another of our contracted provider groups. Rather, we recognize that all boats must rise together if the SCAN network is to be rewarded by the Quality Bonus Program. The fact that SCAN and the 14 providers operate in markets where we compete against Kaiser Permanente, a well-respected 5 Star Medicare Advantage plan that uses the staff model Permanente Medical Group as their exclusive physician group, also provided us with a focal point to get the community-based physician group leaders' competitive juices flowing.

With the Quality Bonus Program providing the impetus to come together, the SCAN Provider Integration Steering Committee was formed and articulated the following goals:

- SCAN will achieve at least 4 Star results in the CMS Quality Bonus Program and strive for 5 Stars, seeking improvement in clinical quality measures and member satisfaction;
- Continue to grow the SCAN product by offering the communities we serve affordable products that meet the needs of Medicare beneficiaries, including those that are healthy and active as well as those living with multiple chronic conditions and becoming increasingly frail;
- Research, encourage and support geriatric best practices across all physician groups to improve care and then make the findings publicly available, and
- Improve administrative efficiencies between SCAN and our provider partners, with a particular focus on data exchange that can support better systems of care and service for our mutual customers.

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[14] "The Medicare Advantage Program in 2014," ASPE. April 7, 2014. *Available at* http://aspe.hhs.gov/health/reports/2014/MedicareAdvantage/ib_MedicareAdvantage.pdf.
[15] Ibid.

VII. Recommendations

Medicare Advantage is an excellent program, but it is far from perfect. There are actions that Congress and CMS could take to make it better. At the same time, Congress and CMS should be on guard that they do not take actions that undermine the stability and effectiveness of the program. Here are a few items that are top of mind:

- ***Rate stability*:** Over the past few years, the MA program has sustained a series of significant, statutorily-mandated funding reductions. These include a $2.5 billion cut as part of the American Tax Relief Act of 2012, a two percent funding reduction via Sequestration mandated by the Budget Control Act of 2013, and over $200 billion worth of cuts from the Affordable Care Act (ACA). Seniors have begun to feel the impact of these cuts in higher out-of-pocket costs, reduced benefits, and winnowing choice. The impact will likely become more manifest as the vast majority (80 percent) of the ACA-mandated cuts take effect in the future. As plans work to optimize coverage in an environment of diminishing resources, CMS must keep payment rates to MA plans stable. A February 2014 report from Oliver Wyman predicted that cuts of the magnitude proposed in CMS' 2015 advance notice would result in a "high degree of disruption in the MA market," including the "potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and MA plan disenrollment."[16] Thankfully, beneficiary outcry and strong bipartisan, bicameral opposition mitigated some of those cuts. But payments to the program should, at the very least, be held stable to prevent disruption and ensure that the programs upon which seniors have come to rely remain viable.

- ***CMS Stars stability*:** The CMS 5 Star ratings program is a powerful incentive for plans to adapt their practices to meet specific quality metrics. However, the lag between experience, reporting, and quality rating presents a challenge for plans, particularly given the dynamic nature of the Star ratings criteria year to year. Stars-based payments for a given year are based on data collected three years earlier. For example, a plan's payment in 2015 will reflect its 2014 Star rating, which is based on data collected between January 2012 and June 2013 (estimated). Because CMS makes changes to the criteria, as well as to the weighting of the criteria, each year, plans may make certain investments to comply with measures that cease to exist before those investments are realized. To ensure that Star ratings reflect plans' actual performance on those measures, CMS should hold the criteria as stable as possible.

  ***Part D benefit flexibility*:** We are coming upon a time when emerging medications can actually cure a patient's disease, not simply make life bearable for a few more months or years. The challenge for government and the health care community will be: how can we afford these miracle drugs which may help one population without financially undermining the rest of the health system? Much of this responsibility falls on the ability of health plans and pharmaceutical companies to negotiate affordable pricing, and rightly so. The market, if structured rationally, is always the best way to bring about reasonable pricing and therapeutic innovation. What we ask is that government officials be responsive to this developing situation and permit maximum flexibility within Part D to

[16] Oliver Wyman, "2015 Advance Notice: Changes to Medicare Advantage Payment Methodology and the Potential Effect on Medicare Advantage Organizations and Beneficiaries," February 2014.

accomplish that goal. CMS should also look at whether the current risk adjustment models should be updated to better predict the costs of high risk patients.

- ***Focus on the "near duals"***: Under current policy, Medicare does not cover the community-based long-term services and supports (LTSS) that play an essential role in keeping chronically ill beneficiaries from going into a nursing home. Once a person enters a nursing home, he or she stands a greater than 20 percent chance of spending down his or her assets and going on Medicaid.[17] Dual eligibles are some of the most expensive and ill-served beneficiaries in our health care system. To intervene in this downward spiral, Congress should support the creation of a "Community-Based Institutional Special Needs Plan" (CBI-SNP) demonstration, a concept advanced in Section 250 of S. 1871, the Senate Finance Committee's December 2013 SGR legislation. The CBI-SNP demonstration would provide LTSS to low-income Medicare beneficiaries (150 percent FPL) with two or more activities of daily living limitations – those who are euphemistically called the "near duals." Expanding the availability of these benefits to a lower income, Medicare-only population would improve quality of life for individuals and reduce Medicaid long-term care costs as well as Medicare acute and post-acute care costs. The demonstration would also contribute to the evidence base on how to most effectively target specific services to at-risk individuals. The National Governor's Association Health Care Sustainability Task Force has recently advocated for a similar solution to prevent the growth of the duals population. This is an issue that's time has come, and we recommend that this Committee embrace it.

VIII. Conclusion

The MA program continues to grow in popularity. It gives seniors and other eligible individuals what they want: choice, coordination of care, affordability. It has begun to put the incentives in place for constant quality improvement by rewarding collaboration between providers and plans. Congress should have a strong interest in seeing the continued advancement of Medicare Advantage. We stand ready to work with you toward that goal.

Thank you for this opportunity.

[17] Adams, E.K., Meiners, M., Burwell, B. "A Synthesis and Critique of Studies on Medicaid Asset Spend-Down," Report for the Office of the Assistant Secretary for Planning and Evaluation, DHHS, January, 1992. *Available at* http://aspe.hhs.gov/daltcp/reports/syncri.pdf .

Chairman BRADY. Dr. Burnich.

STATEMENT OF DR. JEFFREY BURNICH, SENIOR VICE PRESIDENT & EXECUTIVE OFFICER, SUTTER MEDICAL NETWORK, ON BEHALF OF CAPG

Dr. BURNICH. Chairman Brady, Ranking Member McDermott, and members of the Health Care Subcommittee, thank you for inviting me to testify today.

I plan to talk about Medicare Advantage and the benefit from a physician's standpoint, how it benefits our seniors. I will describe a program we have developed at Sutter Health to manage some of the sickest, frail patients in this population.

I am here as a representative of CAPG, the voice of accountable physician groups that represent 160 medical groups in 20 States and take care of 1.2 million Medicare Advantage lives. I am a physician, an internist, and I serve as a Senior Vice President and Executive Officer of the Sutter Medical Network.

Sutter Health is a not-for-profit integrated delivery system taking care of three million lives in 19 counties in Northern California. We manage the risk of 49,000 Medicare Advantage lives and have taken care of capitated lives for over two decades.

We do this with our 5,000 aligned physicians who are clinically integrating and managing care across our hospitals, clinical practices, home care, urgent care, and surgery centers.

So why is MA important to CAPG, Sutter Health and their physicians? Well, for one, it is a predictable model for population management. The physicians, the PCPs, the primary care physicians, know who their patients are. They get lists. We make sure that those patients get in to see their physicians on an annual basis for an annual wellness exam, an annual wellness visit. It is a benefit of the MA Program.

This helps us understand the risks of those patients, review their medications, their conditions and do better preventive planning.

Secondly, it is a predictable budget for managing a population. You get a per member per month payment so that you can budget each year to take care of these patients and budget for programs and the expenses you incur for those.

We have data to understand the utilization of the patterns of these patients so we can better manage the risk and the referrals.

MA incentivizes caregivers to coordinate care, reduce cost, and reinvest those savings in the care model like Sutter Health's Advanced Illness Management Program, otherwise called AIM. Fee-for-service does not do this.

So what is AIM and how does it align and support Medicare Advantage beneficiaries? Well, actually MA is the foundation of our AIM Program. In Sacramento, we have a large population of capitated lives, and it allowed us years ago to put care managers both in the hospital and in the practice to better coordinate the handoffs from discharge of patient and admission from office.

So who are these patients? They are very sick and they are very frail. You may know some of them or have members in your family. They average 17 days a year in the hospital, 12 days in the intensive care unit. They take 18 to 30 prescriptions and 54 trips to nine different physicians. These are really sick patients, hence the name AIM.

We target the patients with a care management model that manages the patients with a multidisciplinary team. We use common training and real time data, and we enroll these patients in several settings, notably in the physicians' offices of our network, 40 percent, both in the hospital and home care.

We go to the home, and we set goals with these patients. What is it that they want to accomplish? It can be as simple as a grand-

mother wanting to see her granddaughter graduate high school, and she is very ill and we need to manage her symptoms.

Symptom management is a key ingredient because it keeps those people from picking up the phone, calling 911 and going to the hospital as the usual routine.

And then we provide a wealth of services to evaluate emotional and nutritional needs.

In 2009, we piloted the program in Sacramento, again, because we had a large MA population. We also applied for an Innovation Challenge Award from CMMI and received that in July of 2012. Through that grant we have spread the program across 15 counties, taken care of 5,000 patients, with an average daily census of 1,800. We have met the patients' needs by maintaining them in their home environment where they want to choose to be treated. We have decreased unwanted, avoidable hospital emergency room/ICU stays and the costs associated with them.

The savings are reinvested into the care model and the training and event technology. We are adding video visits next year so we can better monitor the patients in their homes more frequently.

In conclusion, I believe Congress and the Administration should develop policies that encourage population payments to physician organizations in MA, as well as fee-for-service Medicare. Such payments should encourage the organized practice of medicine, strengthen and coordinate the care infrastructure, and build incentives for team-based care.

Thank you for the opportunity to speak to you today as the committee considers important Medicare and fiscal policies in the future. I hope you will reconsider and consider all that the MA Program has to offer our senior citizens.

Thank you.

Chairman BRADY. Thank you, Doctor.

[The prepared statement of Dr. Burnich follows:]

Statement of Dr. Jeffrey Burnich
CAPG – the Voice of Accountable Physician Groups
Before the House of Representatives Ways and Means Subcommittee on Health
July 24, 2014

Thank you Chairman Brady, Ranking Member McDermott, and Members of the Health Subcommittee for inviting me to testify today. I look forward to describing the role Medicare Advantage (MA) plays in driving innovative, high quality care for seniors. As an example of this, I will describe Sutter Health's Advanced Illness Management (AIM) program for our sickest patients. Our program is one example of the critical role MA plays in the development of a healthcare delivery system built on value rather than volume.

I am pleased to testify today on behalf of CAPG. CAPG is the largest association in the country representing capitated physician organizations practicing coordinated care. CAPG members include over 160 multi-specialty medical groups and independent practice associations (IPAs) in over 20 states. CAPG members provide healthcare services to over 1.2 million Medicare Advantage beneficiaries. CAPG believes that patient-centered, coordinated, and accountable care offers the highest quality, the most efficient delivery mechanism, and the greatest value for patients. CAPG members have successfully operated under a budgeted healthcare model for over two decades.

I also address you today as a Senior Vice President for Sutter Health, the Executive Officer of the Sutter Medical Network, the department of Sutter Health tasked with coordinating care to meet the needs of its communities, and as an internal medicine physician. Sutter Health is one of the nation's largest, not-for-profit healthcare systems. We provide

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healthcare to over three million patients spanning 100 communities in Northern California across all payer types, including 49,000 Medicare Advantage beneficiaries and a large proportion of Medi-Cal (California's Medicaid) beneficiaries. Committed to providing access to high quality, coordinated care, Sutter Health includes 5,000 physicians aligned with the Sutter Medical Network, 24 acute care hospitals, home healthcare, and more than two dozen surgery centers. Sutter Health employs about 48,000 people across northern California. This year, Sutter also launched its own HMO health plan offering commercial coverage in a small number of counties in our service area.

The Importance of Population Based Payments: Paying Physicians to Achieve Desired Results

Sutter Health has decades of experience contracting with physicians to provide high value healthcare to patients. Out of this experience, we have learned that a population-based, budgeted monthly payment is an efficient and effective way to incent high quality, low cost care. We see a sharp contrast when physicians are paid fee-for-service (FFS) as compared to a prepaid, population-based payment. In FFS, physicians are paid separately for every service provided. There is less incentive to coordinate the care for the patient or to keep the patient healthy. Incentives simply exist to provide as many services as possible – the greater the volume, the greater the payment.

In contrast, population-based payments to physician organizations in MA create a defined budget for patient care. In MA, the Centers for Medicare & Medicaid Services (CMS) makes a defined payment to a health plan for a pre-determined patient population. In the case of a physician organization, like Sutter Health's aligned medical groups, the health plan then makes a defined payment to the physician organization for the physician organization's patient population. The payment to the physician organization is typically a percentage of premium and is often described as a "per-member, per-month" payment. This amount does not change based

on the volume of healthcare services provided. The physician organization is accountable for operating within the monthly budget and, generally, there is no “extra” money for additional costs. Because there is no “extra” money, physicians have incentives to manage the patient population to stay within the budget.

Physician organizations are responsible for paying their employed or contracted primary care and specialty physicians, and sometimes hospitals depending on the contract with the MA plan. Under MA, physician organizations have the flexibility to tailor these payments to individual physicians to get the desired patient care outcomes. For example, the organization might pay an individual physician subcapitation, a salary, or even FFS in some cases. For example, if a group wants to incentivize higher rates of preventive services, FFS might be the preferred payment mechanism to drive higher utilization rates for these types of services.

The payment arrangements between the physician organization and the individual physician often include additional payment for physician performance and outcomes, like quality incentive payments for performance on certain measures. The internal quality measures, evaluations, and incentives that physician organizations use tend to be very robust and are closely linked with the CMS 5 Star Program in Medicare Advantage.

The population-based payment made by the MA plan to the physician group creates numerous benefits for patients that are not seen in the FFS environment. The population-based payment methodology incentivizes a team-based approach. This approach encourages deployment of other healthcare professionals, such as care managers, nurses, social workers, care navigators, pharmacists, and other “mid-level” professionals, as part of a team led by a primary care physician. Each team member practices at the top of his or her license. This team-based approach leads to better outcomes for patients. The AIM program, described below,

highlights the important role these practitioners play in addressing the full spectrum of healthcare needs of aging patients.

These arrangements also incentivize physicians to provide the right care, at the right time, in the most cost-effective setting. For example, rather than trying to maximize FFS payments in high-cost settings, when appropriate, patients are safely and appropriately treated in lower cost settings, such as their home. We have learned through the AIM program that patients have a strong preference to be treated in their homes (and other less-intensive settings), when it is safe and appropriate to do so.

Population-based payments also afford opportunities and incentives to address the environmental, social, and behavioral services that are often unavailable in the FFS context. For example, many of our patients need assistance with their mental health needs, commonly depression, in order to be able to truly improve their health status. Our approach takes into account all of these aspects of patient care.

I. The Advanced Illness Management Program: a Case Study in Coordinated Care

The AIM concept originated in the late 1990s, stimulated by challenges in prognosis and treatment in advanced chronic illness that could not be met by hospice or palliative care. When managed Medicare (Medicare+Choice) aligned financial incentives to reduce utilization and costs, it was clear that home-based transition services could help to limit unwanted admissions. Thus, AIM was built upon the coordinated care foundation of today's Medicare Advantage program.

In 2008, AIM's operational concept and geographic reach were expanded. The model targeted patients with very serious chronic illness, provided high-touch home visits combined with telephone support, and closely coordinated care among physicians, hospitals, home and community.

Many of these patients could be eligible for hospice, but for whatever reason are unprepared to take that step. On average, patients with advanced illness spend 17 days in the hospital; 12 days in the ICU; take 18-30 medications; and make 54 trips to nine different doctors. With all of these various touch points in the healthcare system it is not surprising that many of them do not know who is in charge of their care in a traditional FFS environment. Finally, it is notable that 28 percent of Medicare's total spending is devoted to these patients in the last year of life. Sutter Health recognized a tremendous opportunity to help these patients and their families have a better care experience at a lower cost to the system overall.

In the AIM program, Sutter Health offers an approach dramatically different from what is offered in traditional Medicare. Our approach is coordinated, patient-centered, and team-based. Sutter Health identifies advanced illness patients at the time of a hospitalization or physician office visit and invites the patient to enroll in the AIM program. Patients eligible for the program are those with more than two chronic illnesses (e.g., chronic heart failure, COPD, cancer); multiple prescriptions; clinical, functional and/or nutritional decline; high utilization of healthcare services; and those who are identified as high risk by their physician. To summarize, these patients are among the sickest in our population and prior to AIM, were the ones that cost the system the most in terms of their intensive healthcare needs and the resources associated with caring for them.

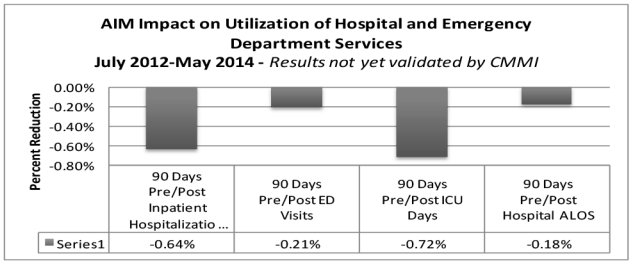
In traditional FFS Medicare, a patient with a chronic condition who is hospitalized has little post-discharge planning. The patient might have instructions to call her physician within a certain number of days of leaving the hospital, but there are few if any supports in place to ensure that the patient calls the doctor or that the appointment is actually scheduled. As a result, FFS patients typically begin a vicious cycle of emergency room visits followed by post-discharge complications, landing the patient back in the hospital multiple times.

In contrast, the AIM program provides an integrated, coordinated approach to healthcare for patients with advanced illness. The AIM program has embedded AIM care liaisons in the hospital. The AIM staff in the hospital approaches the patient and the patient's family to begin coordinating post-discharge care. AIM staff provides coaching for the patient's return home, provides education about the patient's conditions and provides instructions for what to do in the event of an emergency. And unlike traditional discharge instructions, the contact between AIM staff and the patient continues when the patient returns home. AIM staff coordinates care for patients in the home, including providing follow-up home visits. In the home, staff can address unsafe conditions, such as loose carpeting or lack of handrails, which can contribute to falls and repeat hospitalizations in older patients. The staff can reconcile medications, meaning that they look at what was prescribed in the hospital and what the patient was taking prior to their hospital admission to ensure there is no duplication or potentially dangerous drug interaction. The AIM staff also offers telephone support and management for patients who cannot get to a doctor's office.

Three factors fostered AIM's growth: rapid acceleration in demand from aging Baby Boomers with severe chronic illnesses, the emergence of accountable care, and pressure to seek partnerships that addressed concerns about rising costs. Sutter Health also recognized that AIM care management, which united multiple settings, promoted system integration. For all these reasons, Sutter funded the unreimbursed costs of an AIM care management pilot.

Sutter Health began testing the AIM care management pilot in three communities in Northern California in 2009 with its Medicare Advantage population. The pilot demonstrated highly positive outcomes and provided the foundation to expand system-wide in 2011-2012. In order to expand the program, we sought additional funding sources and were awarded a CMS Innovation Center Challenge Grant in 2012. The AIM program currently serves 15 counties and

we plan to continue to develop and improve the program through 2015. Throughout this piloting and implementation, the AIM program has achieved impressive results including substantial reduction in inpatient and emergency department utilization; reductions in ICU days; reductions in length of stay; and cost savings to the healthcare system.



If our experiment shows that the program is replicable and scalable, then AIM may contribute to the health and well being of some of the most vulnerable and costly recipients of American healthcare, and to the economic viability and ethical integrity of the system itself.

I would like to add a point on cost savings achieved in the physician-led coordinated care model. Our cost savings are reinvested in care programs that benefit the patient population. Programs like quality incentives, special care clinics for the frail elderly, and advances in medical records and disease registries are all funded by the reinvestment of cost savings achieved in the coordinated care model.

Care-management programs like AIM are made possible by the pre-payment of population-based, per-member, per-month amounts. These programs require investment in staffing (e.g, hiring case managers), infrastructure (e.g., establishing patient call centers), and electronic health records. All of this investment is only possible with a predictable budgeted payment that allows us to know what money will be coming in and when. The per-member,

per-month payments made by CMS to plans and then to physician organizations are best suited to facilitate this care model. In a FFS environment, a planned and proactive strategy to managing patient health is significantly more difficult and in some cases impossible.

II. MA Provides the Backbone for Care Coordination in Medicare

I recognize that there are efforts underway to move the Medicare Part B physician payment system to a coordinated care model that encourages physician organizations to accept risk (e.g., Accountable Care Organizations (ACO), bundled payments). As an example, recent bi-partisan, bi-cameral legislation to permanently repeal the sustainable growth rate (SGR) includes incentives for physician organizations to enter two-sided risk-bearing models in Medicare Part B.

When properly structured, such models can be successful in improving care coordination for the FFS Medicare population. CAPG members have seen some success with the ACO program in terms of improving outcomes for patients as compared to traditional FFS Medicare beneficiaries. However, in nearly every case, this success is directly linked to the organization's experience in the MA program. The AIM program is yet another example. As described above, Sutter Health began the AIM program in three Northern California communities, primarily around its Medicare Advantage population. We have since been able to expand this program to other populations. Without the infrastructure provided by Medicare Advantage and the certainty associated with pre-paid capitation for our patient population, the AIM program would have been impossible.

Even with the potential for these new delivery models to succeed, the truth remains that MA, with population-based payments made to physician organizations, is the best example within Medicare of a payment structure that provides appropriate incentives to keep patients healthy, coordinate care across specialists and primary care physicians, and hold physicians and

care teams accountable for the quality of services provided. MA is the only existing example where physician organizations successfully take on two-sided risk. To truly encourage and incentivize the development of additional two-sided risk models in Medicare Part B, the MA program should be not just protected, but strengthened. The lessons and best practices organizations like ours have learned in MA should be shared and disseminated. Cuts to the MA program place all of this innovation, learning, and development at risk.

III. Patient Interest in MA Continues to Grow

Given the success of care coordination programs in improving patient outcomes, it is no surprise that MA enrollment has grown steadily over the past several years. Recent analysis by the Kaiser Family Foundation shows that 15.7 million Medicare beneficiaries were enrolled in MA plans in 2014.[1] This is an increase in enrollment of 41 percent since 2010.[2] Although nationally 30 percent of Medicare enrollees are enrolled in an MA plan, there is broad variation across the states.[3] In California, nearly 40 percent of seniors enrolled in Medicare are enrolled in MA. I think it is because of access to programs like AIM that seniors' interest in MA has continued to grow. A recent report by *Health Affairs* showed that more than 50 percent of new Medicare enrollees are enrolling in MA.[4]

The benefits that flow to patients may be one explanation for the growth in enrollment over the years. Peer reviewed research has consistently shown that MA outperforms FFS Medicare. For example, MA patients are more likely to get preventive screenings, like mammograms, eye tests for diabetes patients, and cholesterol screening.[5] MA beneficiaries

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[1] Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, Medicare Advantage, 2014 Spotlight: Enrollment Market Update (May 1, 2014), available at http://kff.org/report-section/medicare-advantage-2014-spotlight-enrollment-market-update-overall-trends-8588/.
[2] *Id.*
[3] *Id.*
[4] Ann B. Martin, Micah Hartman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, National Health Spending in 2012: Rate of Health Spending Remained Low for the Fourth Consecutive Year, Health Affairs, 33, no. 1 (2014): 67-77.
[5] Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. all. *Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare.* Health Affairs 32. no. 1228-1235. July 2013/

have been shown to have lower rates of preventable readmissions than patients in FFS Medicare.[6]

Recent analysis has even shown that the benefits of coordinated care in MA may filter out to the rest of the healthcare system. In some circles it has been described as a halo or spillover effect, where benefits of coordinated care sufficiently improve physician practices such that even patients not enrolled in MA see the benefits of coordinated care.[7] The study showed that a 10 percent increase in MA penetration is associated with a 2.4 – 4.7 percent reduction in hospital costs for other patients.[8]

Surveys of Medicare beneficiaries have shown that seniors are highly satisfied with the MA program. A recent research survey showed that 94 percent of beneficiaries are satisfied with the quality they receive in MA and 90 percent of beneficiaries are satisfied with the benefits received in their MA plan.[9]

Notably, the MA program has been particularly popular among low-income and minority beneficiaries.[10] 41 percent of Medicare beneficiaries with MA had incomes of $20,000 or less.[11] 64 percent of minority beneficiaries enrolled in MA in 2010 had incomes of $20,000 or less; 64 percent of African American and 82 percent of Hispanic MA beneficiaries had incomes of $20,000 or less.[12] In urban areas, low-income beneficiaries rely on this program because of the comparatively low out-of-pocket spending and robust health benefits associated with the program. In addition, all MA plans have an out-of-pocket maximum, a protection that is not offered in the FFS program. This helps protect beneficiaries from catastrophic expenses that

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[6] Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care.* February 2012. Vol. 18, no. 2, p. 96-104.
[7] Baicker, Katherine. Chernew, Michael. Robbins, Jacob. *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization.* National Bureau of Economic Research. May 2013.
[8] *Id.*
[9] North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."
[10] America's Health Insurance Plans, Low Income and Minority Beneficiaries in Medicare Advantage Plans, 2010 (May 2012).
[11] *Id.*
[12] *Id.*

threaten seniors' financial security. Downward pressure on the MA program increases the chance that these beneficiaries will face higher cost sharing and will make the program a less attractive option.

V. Conclusion – Strengthen the Investment in Medicare Advantage and Population-Based Payment Models

Despite its success and popularity, the MA program is under severe stress due to a number of cumulative cuts to the program which, taken together, are having a dramatic and deleterious effect on physician groups in MA. In CY 2014, CMS cut MA payments to plans by about 6.5 percent. In CY 2015, CMS cut MA payments to plans by about 3 percent. Many of the cuts to MA were aimed at health plans in the form of direct reductions to the amount CMS pays to the health plan. In most cases, however, these cuts flow through directly as a reduction to the amount the plan pays its contracted physician organizations. Cuts are passed on without any corresponding reduction in physician responsibilities to patients. I am concerned that the cuts to the MA program will push both physicians and patients out of the program and back into fragmented FFS models.

MA provides a foundation on which the rest of the delivery system can build coordinated care. For example, physician organizations with the capability to accept two-sided risk arrangements, in most cases, have the experience required to be successful because of MA. Furthermore, many organizations that have been successful in deploying care coordination techniques in traditional FFS Medicare have leveraged off of their MA care processes and infrastructure to effectively do so.

Congress and the Administration should develop policies that encourage population-based payments to physician organizations in MA and in traditional FFS Medicare. This means encouraging the organized practice of medicine; strengthening the coordinated care

infrastructure; providing incentives for team-based care and primary care; encouraging physician organizations to develop the ability to accept two-sided risk arrangements.

Thank you for the opportunity to speak to you today. As the Subcommittee continues to consider important Medicare and fiscal policy in the future, I hope you will consider all that the MA program has to offer for seniors.

Chairman BRADY. Mr. Book, you are recognized for five minutes.

STATEMENT OF ROBERT A. BOOK, PH.D., SENIOR RESEARCH DIRECTOR, HEALTH SYSTEMS INNOVATION NETWORK, LLC, OUTSIDE HEALTHCARE AND ECONOMICS EXPERT, AMERICAN ACTION FORUM

Dr. BOOK. Thank you, Chairman Brady and Ranking Member McDermott and Members of the Subcommittee.

Chairman BRADY. Can you get your microphone and just see if that is on?

Dr. BOOK. I am sorry.

Yes, thank you, Chairman Brady, Mr. McDermott and Members of the Subcommittee. I thank you for the opportunity to share my research on the Affordable Care Act and its impact on seniors and disabled Americans enrolled in Medicare Advantage.

Fee-for-service Medicare has very high deductibles, high copayments and no limit on out-of-pocket costs patients can face. Nearly all Medicare beneficiaries seek alternative coverage to reduce those out-of-pocket costs. Some retirees have supplemental coverage from a former employer, and some have income low enough to qualify for Medicaid. For the rest, MA is now the most popular option.

The 30 percent of Medicare beneficiaries currently in MA that Mr. McDermott mentioned includes 44 percent of those who do not have access to retiree supplemental plans from a former employer. Most of the remainder have a Medigap or some other way of combatting those high out-of-pocket costs.

Medicare is more popular among beneficiaries who have lower incomes but above the Medicare threshold, and it is more popular among African Americans and Hispanics. Hispanics, in particular, historically have been more than twice as likely as the average Medicare beneficiary to enroll in MA.

CBO estimates that ACA cuts to Medicare Advantage will total $308 billion by 2023, and which is approximately 43 percent of the ACA's total cuts to Medicare. MA payments are tied to benchmark monthly payments individually for each county, and the ACA makes changes to the way those benchmarks are calculated with the result that every county in the country will see a cut by 2017, and in fact, 97.9 percent of counties will see a cut in 2015, for which rates have already been published.

The bonus system based on the star rating system that Mr. McDermott referenced, I think everyone agrees that paying more for good performance is a good thing. However the star rating sys-

tem does not necessarily accomplish that because CMS chooses the rating criteria after the period of performance. So, for example, in the first cycle, they measured performance between January 2010 and June 2011 and then October 2011 announced the criteria on which plans would be rated.

So since the rules are not determined until after the game is played, it is difficult for MA plans to tailor their performance to the criteria that CMS will reward. That system could, on the other hand, be used to reward favored plan sponsors by choosing criteria to give high ratings to those who are favored. Favored plans could then use the money to increase their profits and their increasing market share by offering benefits that other plans cannot afford to offer.

So instead of allowing plans to compete on a level playing field, the rating system could be used to herd patients into favored plans by manipulating their ability to offer benefits. This is the reverse of the original goal of Medicare Advantage, which was to increase patient choice.

Mr. McDermott mentioned that the dire predictions that many of us made for Medicare Advantage have not yet come to pass, and that is true because after the ACA was passed, CMS used its regulatory authority in a new way to mask the first few years of cuts. They created a new star rating bonus program different from the program in the Affordable Care Act which gave bonuses to almost all plans, with the result that most of those cuts have not actually hit patients or plans yet.

So based on published rates for each county in 2015, now that the bonus program has ended, the total cut will be about $317 per month compared to the year before, but $1,530, or 13 percent, below the pre-ACA baseline. So this demonstrates the extent to which the pilot program authority was used to offset cuts that were mandated by the Affordable Care Act.

Now, the Affordable Care Act phases in and calls for the rates to be phased in through 2017. So there are more cuts to come. Assuming the Affordable Care Act cuts are implemented as passed by Congress, by 2017 the cumulative cut relative to the pre-Affordable Care Act baseline will be $3,700 per beneficiary per year, which is nearly a 27 percent overall cut.

It is going to be extremely difficult, perhaps impossible for plans to maintain their prior level of benefits in the face of those drastic cuts.

Every beneficiary will see some combination of either higher copayments, higher deductibles, a higher monthly premium in excess of the Part B premium they already pay, or reduced benefits or plan services or smaller provider networks.

Now, this impact is going to be different for each plan as each plan deals with the cuts in its own way, but one way or another, it will affect everybody. This will affect not only seniors' financial stability, but also their access to health care.

Chairman BRADY. Mr. Book, I am sorry. Your time has expired. So thank you very much.

[The prepared statement of Mr. Book follows:]

Statement of

Robert A. Book, Ph.D.*

Senior Research Director, Health Systems Innovation Network, LLC

Outside Healthcare and Economics Expert, American Action Forum

Before the

Subcommittee on Health

Committee on Ways & Means

United States House of Representatives

Thursday, July 24, 2014

"Effects of the Affordable Care Act's Changes to the Medicare Advantage Program"

*The views expressed here are my own and not those of either the Health Systems Innovation Network, LLC, or the American Action Forum.

Chairman Brady, Ranking Member McDermott, and members of the Subcommittee:

Thank you for the opportunity to share my research regarding the impact of the Affordable Care Act on the seniors and disabled Americans enrolled in the Medicare Advantage program.

Since its inception, Medicare Advantage (MA) has proved to be one of the most popular and successful components of Medicare, with enrollment steadily increasing over time. Every Medicare beneficiary has the right to choose a Medicare Advantage plan, but no one is required to participate. If a beneficiary is unsatisfied with the chosen plan, he or she has the right to switch to another plan at least once a year, or swit`ch to the original Medicare fee-for-service plan at least twice a year.

As of March 2014, 30 percent of Medicare beneficiaries have chosen Medicare Advantage plans. This is estimated to include almost 44 percent of those who do not have access to a retiree supplemental plan from a former employer. Medicare Advantage is even more popular among beneficiaries who have lower incomes, or who are African-American or Hispanic. Hispanics, in particular, have historically been more than twice as likely to choose Medicare Advantage, compared to the average Medicare beneficiary.

Despite this success, both changes mandated by the Affordable Care Act (ACA), and various regulations enacted or proposed by the Administration, will impose substantial cuts to the Medicare Advantage program – both in dollars and in patient choice – that will reduce the health care benefits and options available to seniors and the disabled.

ACA Changes

The Congressional Budget Office (CBO) estimates that ACA cuts to Medicare Advantage will total $308 billion by 2023, which would be approximately 43 percent of the ACA's total cuts to Medicare.

MA payments are tied to a "benchmark" monthly payment set individually for each county (or similar jurisdiction) in the United States.

The ACA made several changes to the calculation of the benchmarks:

- Benchmarks are now specifically tied to average spending in the fee-for-service (FFS) program in every county, and based on the quartile rank of FFS spending in each county.

  This will have the effect of locking in geographical variation in Medicare spending that is difficult to explain based on costs or health status, and that many experts believe is irrational.[1]

- Changes to the FFS program will result in lower payments, which will be passed through to the MA program and will result in lower MA benchmarks, and thus lower benefits or higher premiums for patients.

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1 Elliott Fisher, David Goodman, Jonathan Skinner, and Kristen Bronner, "Health Care Spending, Quality, and Outcomes: More Isn't Always Better," Dartmouth Atlas Project Topic Brief, February 27, 2009, at http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf.

- A bonus system is established based on a plan's "star rating" on a five-star scale using criteria developed by the Centers for Medicare and Medicaid Services (CMS).

This rating system, originally developed only to assist beneficiaries in selecting a plan, is now being used to determine payment. However, because the rating criteria are chosen *after* the time period being rated, the rating system cannot incentivize quality performance, since the rules are not written until after the game is played. It could, however, be used as a way to reward favored plan sponsors by choosing criteria that make them appear to offer higher quality plans and therefore entitle them to higher payments.

> In addition, because plans with higher ratings will be paid more, they will be able to offer more benefits. Because the ratings are based on *ex post* criteria determined by bureaucrats rather than by the health outcomes or satisfaction of patients, bureaucrats would have the ability to "herd" patients into favored plans by enabling them to offer more benefits and lower costs. Instead of allowing plans to compete on a level playing field, the rating system could be used to tilt the field in favor of particular plans, and drive some patients away from the plans they would normally prefer. This represents a substantial diversion from the original goal of patient choice to meet each individual's particular needs.[2]

- The bonus will be doubled in certain "qualifying counties" based on demographic criteria that are unrelated to costs, performance, or patient satisfaction.

The ACA called for these changes to be phased in, with the effect that every county in the country would experience a cut relative to its pre-ACA baseline by 2017; in fact, 97.9 percent of counties will experience a cut by 2015. At the state level, every state is already experiencing a reduction in average benchmarks.

Regulatory Changes

CMS also periodically uses its regulatory authority to make adjustments to certain factors that affect MA payments. These adjustments include, for example, the formulas for risk-adjusting plan payments based on each MA enrollee's individual health status. The ACA made only relatively minor changes to this authority.

However, after the ACA was passed, CMS used its regulatory authority in a new way, which had the effect of masking the first few years of ACA cuts to the Medicare Advantage program.

The ACA specified that the new county benchmarks are to be phased in over six years, beginning in 2012. However, from 2012 to 2014, CMS used its pilot program authority to implement incremental bonuses for star ratings of 3 and 3.5 stars in addition to the 4-and-above bonuses mandated in the ACA. Very few MA plans have ratings of less than 3 stars, so nearly all plans got a "bonus" under this system.

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2 Douglas Holtz-Eakin, Robert A. Book, and Michael Ramlet, "Medicare Advantage Star Ratings: Detaching Pay from Performance," American Action Forum, May 2012, at http://americanactionforum.org/uploads/files/research/Medicare_Star_Ratings_Detaching_Pay_from_Performance.pdf.

The payment increases as a result of this program had the effect of mostly offsetting the cuts in benchmarks mandated by Congress. Because of this CMS-initiated regulatory program, many of the expected cuts in benefits and in plan choices did not occur, simply because the cuts mandated by Congress have not yet been felt by patients or plan sponsors.

However, now that the pilot program has ended, we will see substantial cuts in average payments for 2015 relative to 2014, and these cuts will continue until 2017 if current law remains in place.

Magnitude of Benefit Cuts

Based on published rates for each county, as well as enrollment data reported by CMS, I have calculated that the average MA enrollee will face a reduction in benefits in 2015 of about $317, or about 3 percent, compared to the year before.[3]

However, the total cut for 2015 relative to the pre-ACA baseline is estimated to be in excess of $1,530, or more than 13 percent. This demonstrates the extent to which CMS regulatory action offset the ACA's cuts for 2014.

Because the ACA calls for the new rates to be phased in through 2017, there are more cuts to come. The average reduction in benefits for 2017, relative to the pre-ACA baseline, is over $3,700 per beneficiary, per year, or nearly 27 percent.[4]

Impact of Benefit Cuts on Beneficiaries

Medicare beneficiaries – both seniors and the disabled – will experience these benefit reductions in a variety of ways, depending on the plan they select. Every beneficiary will experience some combination of higher copayments, higher deductibles, a higher premium in excess of the Part B premium, reduced benefits or plan services, and/or smaller provider networks. These are real impacts that will affect not only seniors' financial stability, but also their access to health care itself.

Disparate Impact

The ACA's reductions in MA benefits will have different impacts geographically and demographically. Because of geographic disparities in payment rates, the cuts will hit seniors in Louisiana the hardest, almost twice as hard as seniors in Montana.

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3 Robert Book, "Medicare Advantage Cuts in the Affordable Care Act: April 2014 Update," American Action Forum, April 17, 2014, at http://americanactionforum.org/research/medicare-advantage-cuts-in-the-affordable-care-act-april-2014-update.

4 Robert A. Book and Michael Ramlet, "What Changes will Health Reform Bring to Medicare Advantage Plan Benefits and Enrollment?" Medical Industry Leadership Institute, Carlson School of Management, University of Minnesota, October 2011, at http://www.carlsonschool.umn.edu/medical-industry-leadership-institute/publications/documents/Book_RamletFinal_10-13-2011.pdf.

Because of enrollment patterns, the cuts will hit those in lower-income groups nearly twice as hard as those in higher-income groups. For example, the ACA will cut benefits by almost twice as much on average, per Medicare beneficiary, from those with incomes just above the eligibility limit for Medicaid, as compared to those with incomes over $54,000.[5]

In addition, the Affordable Care Act's cuts to Medicare Advantage will hit Hispanic Medicare beneficiaries harder than those of any other ethnic group. CMS data indicates that Hispanics are more than twice as likely as the average Medicare beneficiary to enroll in Medicare Advantage.[6] This takes into account only the 50 states and DC. If Puerto Rico were included, the disparate impact on Hispanics would be even stronger, since about 70 percent of Puerto Rico's beneficiaries enroll in Medicare Advantage, higher than the enrollment rate in any state.[7]

Conclusion

For the last three years, Medicare beneficiaries have been shielded from the benefit reductions and cost increases imposed by the Affordable Care Act through the Administration's use of pilot program dollars to partially offset the first phases of benefit cuts imposed by law. Now that the pilot program is ending, Medicare beneficiaries will feel the full impact of the Affordable Care Act's benefit cuts over the next three years.

If current law remains in force, senior citizens and disabled Americans enrolled in the Medicare Advantage program will experience reductions in benefits and increases in out-of-pocket expenses at least through 2017 due to provisions in the Affordable Care Act. These reductions in benefits and increases in out-of-pocket spending will disproportionately harm those in the lower income ranges, particularly those just above the threshold for Medicaid eligibility. It will also disproportionately harm Hispanic seniors, who depend on Medicare Advantage at much higher rates than the rest of the Medicare-eligible population.

5 Robert A. Book and James. C. Capretta, "Reductions in Medicare Advantage Payments: The Impact on Seniors by Region," Heritage Foundation Backgrounder No. 2464, September 14, 2010, at http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf; based on data from AHIP Center for Policy and Research, "Low-Income and Minority Beneficiaries in Medicare Advantage Plans, 2006," September 2008, at http://www.ahip.org/MA-Low-Income-Report-2008, and additional data from the CMS Medicare Current Beneficiary Survey and the Bureau of Labor Statistics.

6 *Ibid.*

7 Kaiser Family Foundation, http://kff.org/other/state-indicator/medicare-advantage-penetration, based on CMS data.

Chairman BRADY. Mr. Baker, you are recognized.

STATEMENT OF JOE BAKER, PRESIDENT, MEDICARE RIGHTS CENTER

Mr. BAKER. Thank you. Thank you, Chairman Brady, Ranking Member McDermott, and distinguished Members of the Subcommittee on Health. Thank you for the opportunity to testify today on the future of Medicare Advantage.

Each year Medicare Rights Center counsels thousands of people with Medicare about topics ranging from enrolling in a plan to ap-

pealing a denied claim. For people with Medicare, we find there is no one size fits all choice. Medicare Advantage Plans are a good option for some, but for many, original Medicare remains a better choice for them.

My testimony today makes two key points about the MA program that I hope will inform your debate. First, the MA Program has been made more attractive to beneficiaries through benefits and protections contained in the Affordable Care Act.

Second, the MA Program continues to be stable and strong. There is rising enrollment and widespread plan availability with decreases in average plan premiums and no significant changes in benefits and cost sharing.

There are four significant ways in which the ACA has brought improvements to the MA Program. First, the ACA's decreasing reimbursement overpayments to MA plans. According to Medpac, on average MA Plans were paid 114 percent of cost, more than original Medicare, or about 1,000 more per enrollee. These overpayments drove up premiums for all Medicare beneficiaries, including those who remained in the original Medicare. The Affordable Care Act brings down these overpayments to level the playing field between original Medicare and Medicare Advantage.

Second, the ACA enhanced coverage and reduced costs for certain types of preventive care which are now available to both people in Medicare Advantage and in original Medicare.

Third, the ACA prohibited MA Plans from charging higher cost sharing for services used by sicker beneficiaries, including renal dialysis, chemotherapy, and skilled nursing care. Once again, these reforms leveled the playing field between the MA Program and original Medicare, but also among the MA plans themselves, lessening their ability to cherry-pick, select healthier, not select not so healthy enrollees.

Four, and finally, the Act mandated a medical loss ratio, requiring that Medicare Advantage Plans spend 85 percent of premiums on care, not on administrative costs or profits.

With these changes under the ACA, the MA Program remains stable and shows improvement by five different indicators. First, Medicare itself is on a stronger financial footing. Improved efficiency in the MA Program translates into tangible savings for all people with Medicare. This year the Part B premium paid by both people with original Medicare as well as those with Medicare Advantage remains at 2013 levels, at $104.90 per month.

Second, Medicare Advantage enrollment is at an all-time high, with nearly 16 million enrollees, and CBO projects future growth at a healthy clip.

Third, plan choice remains strong. In 2014, the average beneficiary has a choice of among 18 Medicare Advantage Plans.

Fourth, the premiums have gone down. The average Medicare Advantage premium was $44 a month in 2010 compared to $35 a month in 2014.

Fifth, plan benefits and cost sharing remain unaffected. Covered benefits and cost sharing remain stable from year to year. There is no evidence of an overall trend towards less generous benefits.

Even with this success, Congress can and should take steps to further improve Medicare Advantage, while also preserving and

strengthening original Medicare, for example: By increasing support for the SHIP Programs. These are the State health insurance programs which provided free and unbiased counseling in each State to support seniors and people with disabilities in their decision making.

Transparency of Medicare Advantage Plan performance can be enhanced through public release of plan reported data. This is especially important to see how Medicare Advantage Plans are managing claim denials or care denials and the appeals of those denials.

And also by encouraging meaningful variation among plans, and I stress that, meaningful variation. Congress should explore further standardizing Medicare Advantage Plan benefits to help consumers make apples-to-apples comparisons among plans.

Efforts are also needed to further consolidate plan choices for consumers so that they can make a meaningful choice to make sure that they are accessing the right plan for them or they are looking at Medicare Advantage in contrast to original Medicare in the correct way.

Once again, thank you for this opportunity to testify today.

Chairman BRADY. Thank you, Mr. Baker, and thank you for the testimony from all four witnesses.

[The prepared statement of Mr. Baker follows:]

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Testimony of Joe Baker
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Prepared for the
United States House of Representatives
Ways & Means Committee, Subcommittee on Health

"Hearing on the Future of Medicare Advantage Health Plans"

July 24, 2014

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Introduction

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Thank you for the opportunity to testify on the future of Medicare Advantage plans (also known as Part C, MA, or MA-PD).[1] Our testimony will explain the benefits of recent changes to MA under the Affordable Care Act (ACA), describe the current MA landscape based upon our client work and our analysis of the MA market in New York (NY) State, and offer recommendations to further strengthen MA, with an emphasis on beneficiary choice.

Medicare Rights answers 15,000 questions on our national helpline each year from older adults, people with disabilities, and those that help them—family caregivers, social workers, attorneys, and other service providers. Through our educational initiatives, including peer-to-peer learning networks, we touch the lives of another 140,000 people with Medicare and their families. In addition, our online learning tool, Medicare Interactive, receives over 1.2 million visits annually.

We counsel thousands of people with MA about topics ranging from enrolling in a plan to appealing a denied claim. This experience informs our support for changes made to MA plans by the ACA as well as other policies advanced by the Centers for Medicare & Medicaid Services (CMS). MA enhancements initiated by the ACA include equalizing MA and Original Medicare payments, limiting cost-sharing for select services, and improving quality measurement, among other initiatives.

The ACA advances a value-driven agenda for transforming our health care system, and Medicare is the testing ground for many critical payment and delivery system reforms. We believe that MA plans, alongside Medicare physicians, hospitals, and other health care providers, are contributing to and should continue to play a role in this broader transformation. Thus far, we find that the ACA's emphasis on value is producing positive returns in the MA marketplace. Specifically, the ACA sought to enhance MA plan quality, while also providing incentives for plans to compete for enrollee business. The available evidence illustrates that the quality of MA plans continues to increase.[2]

Many predicted that ACA changes to MA payment methods would lead to widespread disruption of the MA market. However, there is little evidence that this has occurred. In fact, it is important to note that MA enrollment is at an all-time high, with nearly 16 million beneficiaries now enrolled in an MA plan,

[1] MA plans cover Medicare Part A and Part B; MA-PD plans cover Medicare Part A, Part B and Part D

[2] O'Kane, M., "Testimony for the Senate Commerce, Science and Transportation Committee on Increasing Transparency on Health Care Costs, Coverage and Quality," (February 2013), available at: http://www.ncqa.org/Portals/0/Newsroom/2013/NCQA_POK_Senate_Commerce_Testimony.pdf

representing a steadily growing percentage of beneficiaries.[3] In addition, premium costs, benefit levels, and the availability of MA plans remain relatively stable across the country.[4]

MA remains a viable choice for Medicare beneficiaries, even after the ACA's payment reforms. Still, there is no one size fits all for Medicare beneficiaries. MA remains a good option for some, but not for all. As such, Congress must preserve and strengthen the Original Medicare program while also ensuring the availability of MA options through a strong, well-regulated marketplace. ACA provisions to enhance MA and recent actions by CMS provide a starting point to further strengthen MA plans, such as through additional funding for independent counseling resources, improved consumer protections when provider networks change, increased transparency on plan performance, and more.

Medicare Advantage: Strengthened by the Affordable Care Act

Delivery system and payment reforms are now being implemented in the private sector, in Medicare, and in other public programs through a variety of initiatives, many of which were initiated by the ACA. The ACA offers a blueprint for constructing a high-value health care system in which insurance plans, physicians, hospitals, and other providers are paid according to the quality of care delivered. Medicare is the incubator for many of these reforms.[5]

As such, the ACA included a set of policies designed to make the MA marketplace more efficient, and to enhance the quality of MA plans. Transforming our health system from one that rewards high-*volume* care to one that rewards high-*value* care is a goal shared by all. Alongside physicians, hospitals, and other health care providers, MA plans have been, and should be, playing an important role in this transformation. The MA provisions included in the ACA are ultimately intended to secure better quality care at the right price.

Among the most notable ACA changes to the MA market were adjustments to plan payments. In 2010 and 2011, maximum MA plan payments were frozen. Beginning in 2012, gradual reductions in plan payments were phased in according to county-specific, per beneficiary spending rates in Original Medicare.[6] These adjustments are intended to scale back payments to MA plans to better approximate payments and costs in Original Medicare.

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[3] Kaiser Family Foundation, "Medicare Advantage," (May 2014), available at: http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/; Schwarz, C. "New York's Medicare Marketplace: Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act," (Medicare Rights Center and United Hospital Fund: July 2014), available at: http://www.medicarerights.org/pdf/new-yorks-medicare-marketplace-july-2014.pdf

[4] Ibid.

[5] Blum, J., "Delivery System Reform: Progress Report from CMS" (Invited Testimony to the Senate Finance Committee: February 2013), available at: http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20(J.%20Blum).pdf

[6] Gold, M. "Making Sense of the Change in How Medicare Advantage Plans are Paid," (Commonwealth Fund: May 2013), available at: http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/May/Making-Sense-of-Changes-in-Medicare-Advantage-Plans.aspx

In 2009, before passage of the ACA, Medicare paid MA plans $14 billion more for care they provided to their members than if the same care had been provided under Original Medicare—or about $1,000 more per enrollee. Put another way, according to MedPAC, on average MA plans were paid 114% of costs under Original Medicare. These payments varied by plan type. For instance, the average Health Maintenance Organization (HMO) was paid 113% whereas the average local Preferred Provider Organization (PPO) was paid 118%.[7] From 2004 to 2009, these payments cost the Medicare program nearly $44 billion. Critically, despite being paid more, there was little evidence to suggest that MA plans consistently provided higher quality care than Original Medicare.[8]

Now, thanks to the ACA, reimbursement changes to plans are being phased in over nearly a decade to minimize disruptions in the MA market and to give plans time to adopt needed efficiencies. To date, payment adjustments are fully implemented in more than half of all counties, with another quarter of counties being fully phased-in by the end of 2015. Notably, MA enrollment increased in all counties since 2010.[9]

Furthermore, ACA savings secured largely from MA payment adjustments are producing positive returns for the Medicare program overall, benefiting both current and future beneficiaries. First and foremost, improved cost efficiency in Medicare translates into tangible savings for older adults and people with disabilities, both for those with Original Medicare and for MA enrollees. This year, the Part B premium (paid by both people with Original Medicare and MA enrollees) remains at 2013 levels, costing $104.90 per month.[10]

This news is particularly notable given that MA overpayments historically drove up premiums for all Medicare beneficiaries, including those who remained in Original Medicare. For instance, in 2009, a couple with Original Medicare paid $86 more in premiums as a result of MA overpayments.[11] Facts like this are troubling given that so many people with Medicare live on low and modest incomes. In 2013, half of all Medicare beneficiaries lived on annual incomes at or below $23,500—hovering at 200% of the federal poverty level. One in four had annual incomes of $14,400 or less. [12] Furthermore, for those with the lowest incomes who are enrolled in a Medicare Savings Program (MSP), MA overpayments increased costs to states as well.

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[7] MedPAC, Report to the Congress: Medicare Payment Policy," (March 2009), available at: http://www.medpac.gov/documents/mar09_entirereport.pdf

[8] Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: http://www.cbpp.org/cms/?fa=view&id=3243

[9] Neuman, T. and G. Jacobson, "Medicare Advantage: Take Another Look," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

[10] CMS, "Press Release: CMS announces major savings for Medicare beneficiaries," (October 2013), available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-10-28.html

[11] Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: http://www.cbpp.org/cms/?fa=view&id=3243

[12] Jacobson, G., Huang, J. and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2013 – 2030," (Kaiser Family Foundation: January 2014), available at: http://kff.org/report-section/income-and-assets-of-medicare-beneficiaries-2013-2030-issue-brief-income-of-medicare-beneficiaries/

Importantly, the ACA put the Medicare program on sound financial footing while improving benefits. By reforming MA payments and enacting additional delivery and payment system reforms for fee-for-service providers, the ACA brought Medicare per capita growth to record lows and added years of solvency to the Medicare Hospital Insurance (HI) Trust Fund.

According to the 2013 Medicare Trustees Report, the Medicare HI trust fund is solvent through 2026, extended by 10 years since passage of the ACA. This represents one of the longer periods of projected solvency throughout the program's history. [13] According to the Congressional Budget Office's (CBO) most recent estimates, the HI trust fund will be solvent through 2030.[14] And many predict that the forthcoming 2014 Medicare Trustees Report will, like the CBO, project additional years of solvency.[15]

In addition to reining in overpayments, the ACA has made many other critical improvements for people with Medicare. For instance, people with either Original Medicare or MA now benefit from increased coverage with no cost-sharing for select preventive services, like mammograms, colonoscopies, prostate cancer screenings, depression screenings, obesity screenings and counseling, and more. Medicare patients also now receive an annual wellness visit, largely to identify needed preventive care and risk factors.

In 2013, an estimated 37.2 million people with Medicare utilized a preventive service with low to no cost-sharing—nearly a 10 percent increase over 2012.[16] MA-PD and other Part D enrollees are also benefiting from ACA provisions to close the prescription drug coverage gap, known as the doughnut hole.[17] Interestingly, these benefit improvements, which apply to all Medicare beneficiaries, translate into *higher payments* for MA plans. Specifically, MA plans are now paid for services that some offered as supplemental benefits prior to the ACA. This gives plans the opportunity to redirect those extra funds to supporting other benefits or lowering premiums.

The ACA also limited the ability of MA plans to charge higher cost-sharing than Original Medicare for certain services, particularly those used disproportionately by sicker beneficiaries.[18] Specifically, as of 2011, MA plans are prohibited from charging higher cost-sharing for renal dialysis, chemotherapy, and skilled nursing facility stays. In addition, starting this year, plans must adhere to a Medical Loss Ratio (MLR). The MLR improves value for the beneficiaries and taxpayers by requiring that plans spend 85%

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[13] The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medical Insurance Trust Fund," (May 2013), available at: http://downloads.cms.gov/files/TR2013.pdf; P.A. Davis, "Medicare: History of Insolvency Projections" (Congressional Research Service: June 2012), available at: http://www.fas.org/sgp/crs/misc/RS20946.pdf

[14] CBO, "The 2014 Long-Term Budget Outlook," (July 2014), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/45471-Long-TermBudgetOutlook.pdf

[15] Adams, R., "Medicare, Social Security Trustees' Report Missing from Budget Debates," *CQ Healthbeat News*, July 16, 2014

[16] CMS, "Press Release: 7.9 million people with Medicare have saved over $9.9 billion on prescription drugs," (March 2014), available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-03-21.html

[17] Kaiser Family Foundation, "Explaining Health Reform: Key Changes to the Medicare Advantage Program," (May 2010), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8071.pdf

[18] Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: http://www.cbpp.org/cms/?fa=view&id=3243

of beneficiary premiums and federal payments on patient care, which in turn limits spending on marketing, CEO salaries, profits, and other administrative costs.[19]

Finally, the ACA established critical initiatives designed to improve MA plan quality. Specifically, the ACA ties payment bonuses to star ratings for MA plans. These ratings are determined through a wide array of performance measures and range from 1 to 5 stars, with plans receiving 1 star for poor performance, 3 stars for average performance, and 5 stars for excellent performance. Starting in 2012, MA plans with 4 or 5 stars began receiving bonus payments.

At the same time, CMS launched a demonstration program providing more modest bonuses to 3 and 3.5 star MA plans, and increased bonuses across the board in an effort to more rapidly enhance plan performance.[20] This demonstration will end in 2015.[21] In addition, the star rating system allows CMS to track poor-performing plans, and to encourage beneficiaries remaining in an MA plan ranked 3 stars or less for three consecutive years to switch to a better performing plan. CMS also has the option to terminate these poor-performing plans altogether.[22]

Data suggest that these pay-for-performance initiatives are improving MA plan quality. Consider that in 2014, 38% of MA plans scored 4 stars or higher, and 14 MA and MA-PD plans scored 5 stars—all increases from ratings in 2013. According to CMS, more than half (52%) of MA beneficiaries are now enrolled in a plan with 4 stars or higher, up from 37% in 2013.[23] These improved scores reflect advancement across several measures, including adult BMI assessment, colorectal cancer screening, beta-blocker treatment after a heart attack, and the detection of potentially harmful drug interactions.[24]

While the ACA serves as a platform for several notable improvements to MA, CMS has implemented key regulatory changes that further strengthen MA plans. Specifically, in 2011, CMS required that MA plans set an out-of-pocket maximum on beneficiary cost-sharing no higher than $6,700 annually and strongly encouraged plans to adopt a limit of $3,400 or less. Today, the average out-of-pocket maximum among MA plans is $4,797.[25]

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[19] Ibid

[20] Kaiser Family Foundation, "Medicare Advantage Plan Star Ratings and Bonus Payments in 2012," (November 2011), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf

[21] CMS, "Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," (April 2014), available at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

[22] Cotton, P., "Medicare Advantage Pay for Performance Results," (NCQA presentation to 9th Annual Medicare World Congress: July 2013)

[23] CMS, "Fact Sheet – 2014 Star Ratings," (September 2013), available at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

[24] National Committee for Quality Assurance (NCQA), "Improving Quality and Patient Experience: the State of Health Care Quality Report," (October 2013), available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf

[25] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/

Additionally, CMS undertook efforts to consolidate duplicative and low-enrolling plans.[26] Reducing the number of nearly identical offerings addresses some of the problems that beneficiaries face when choosing a plan. In general, we find that older adults and people with disabilities find selecting among multiple MA plans a dizzying experience. We encourage people with MA to revisit their plan's coverage each year, as annual changes to plan benefits, cost-sharing, provider networks, utilization management tools, and other coverage rules are commonplace.

Despite regular plan changes, research suggests that inertia is widespread and most people with Medicare fail to annually reevaluate their coverage options.[27] A recent series of focus groups conducted by the Kaiser Family Foundation validates much of what we hear on our helpline. According to the findings, "Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive…and their inability to organize the information to determine which plan is best for them."[28]

A recent *Health Affairs* study attributes some degree of beneficiary inertia with having too many plans from which to choose. The authors write, "Our study suggests that the Medicare Advantage program presents an overabundance of choices for elderly beneficiaries, posing a level of complexity far beyond that experienced by the nonelderly." Additionally, the findings show that difficulty selecting among MA plans and Original Medicare is more pronounced among older adults with low cognitive function, such as those in the early stages of dementia.[29]

On this topic, a Consumers Union literature review concludes, "…the evidence is clear. While a few choices are good, too much choice undermines consumer decision making, particularly high stakes decisions involving health insurance."[30] In other words, people are better able to make good decisions when there are a reasonable number of meaningfully distinct options to choose from. To that end, steps taken by CMS to consolidate and/or eliminate duplicative and low-enrolling plans have been welcome.

In sum, recent changes to MA advanced by the ACA and CMS have strengthened MA plans for current and future enrollees. In addition to improving the overall financial outlook for the Medicare program, the ACA enhanced MA on several fronts, including through added benefits, fairer cost-sharing, and improved plan quality. Importantly, policies advanced by CMS also improved MA plans, namely by introducing out-of-pocket spending caps and constructively consolidating plan choices. We expect the effects of these changes will only become more pronounced for people with Medicare over time.

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[26] Ibid

[27] Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switch Drug Plans to Save Money?" (Kaiser Family Foundation: October 2013), available at: http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/?special=footnotes - footnote-87213-9

[28] Jacobson, G., Swoope, C., Perry, M., and M. Slosar, "How are Seniors Choosing and Changing Health Insurance Plans?," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/

[29] McWilliams, J.M., Afendulus, C.C., McGuire, T.G., and B.E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs* 30:9 (September 2011)

[30] Consumers Union, "The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making," (November 2012), available at: http://consumersunion.org/pdf/Too_Much_Choice_Nov_2012.pdf

After the Affordable Care Act, the Medicare Advantage Market Remains Stable

Reductions to MA plan reimbursement mandated by the ACA raised concerns that the MA market—and people with MA—would suffer. Opponents claimed that MA enrollees would see increased premiums and cost-sharing, tightened provider networks, and fewer plan choices. Some predicted that enrollment in MA plans would decline after implementation of the ACA.[31] Yet, the opposite has proven true.

Today, MA enrollment is higher than ever before—with nearly 16 million enrollees, 6.3 million more than projected by CBO in 2010.[32] CBO now projects that MA enrollment will continue to rise, with 25 million enrollees expected in 2024.[33] In short, ACA payment adjustments to MA have not, and are not, expected to weaken enrollment, and predictions that the MA market will falter have not held up.

Nor has the ACA reduced the availability of ample plan options. Medicare beneficiaries continue to have a range of possible plans and plan types from which to choose, with some positive consolidation in the number of options. As noted above, some of the reduction in the number of plans is the result of efforts on the part of CMS to eliminate nearly identical plans offered by the same insurer in the same market, which added confusion but no real choice for consumers.

In 2014, the average Medicare beneficiary has a choice among 18 MA plans, compared to 20 in 2013.[34] Nearly all beneficiaries have one or more plans (99%) and a range of plan types to choose from—89% have access to an HMO and 83% have access to a local PPO. Consistent with past years, beneficiaries in urban areas have more plan choices than those in suburban and rural areas.

Not only do beneficiaries retain a sufficient number of plan choices, plan availability remains relatively stable from year to year. Specifically, analyses suggest little change in the availability of plans from 2011 to 2014.[35] From 2013 to 2014, for example, the national MA landscape experienced a net change of only 60 products, with a total of 2,014 MA plans available this year.[36]

Enrollment is on the rise, plan availability is strong, and other fluctuations in plan offerings—namely in premiums, covered benefits, and cost-sharing—are relatively unchanged after passage of the ACA. Most notably, MA premiums actually declined, from an average $44 per month in 2010 to $35 per month in

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[31] Neuman, T. and G. Jacobson, "Medicare Advantage: Take Another Look," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

[32] Ibid

[33] CBO, "CBO's April 2014 Medicare Baseline," (April 2014), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf

[34] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2013 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: December 2012), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8388.pdf

[35] Schwarz, C. "New York's Medicare Marketplace: Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act," (Medicare Rights Center and United Hospital Fund: July 2014), available at: http://www.medicarerights.org/pdf/new-yorks-medicare-marketplace-july-2014.pdf

[36] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/

2014.[37] At the same time, as evidenced by our recent review of the NY State MA marketplace, changes to benefits and cost-sharing remain largely unaffected, apart from expected year-to-year modifications.[38]

Through this analysis, conducted by Medicare Rights with funding from the United Hospital Fund (UHF), we compared the Evidence of Coverage (EOC) for a representative sample of NY MA plans and conducted qualitative interviews with plan administrators. Overall, we found that plan benefits have not changed substantially from 2011 to 2014. To the extent that beneficiary costs changed, there were no stark trends in cost increases or decreases. Instead, we saw both increases and decreases in costs over different years and across different plans. As with costs, we saw fluctuating adjustments within plan benefits on a year-to-year basis, as opposed to a steady, multi-year trend toward less generous plan packages.

Our qualitative interviews confirmed that reimbursement reductions to MA plans have mostly been shouldered by plans, rather than being passed on to consumers—though some voiced concern as to whether this practice can continue. That said, plan administrators expressed reluctance at increasing premiums or changing benefits, which may adversely impact their star ratings. Those interviewed suggested that plans were more likely to adopt other efficiencies to accommodate changes in reimbursement—like information sharing among network doctors, soliciting feedback on services and treatments, and investing in technologies that facilitate communication among health care providers.[39]

Critically, while MA plans continue to adapt to changing reimbursement rates, additional analyses reveal that they continue to profit. A companion report released by UHF on the NY State MA marketplace reveals that the average underwriting income among MA plans declined only slightly after the ACA, totaling $56.70 per member per month in 2010 versus $49.53 per member per month in 2012. Further, according to the report, "Even with this decline…HMOs still topped $401 million in underwriting income for MA in New York in 2012, which represented 60 percent of total HMO underwriting (or operating) income reported for 2012, compared to 48 percent in 2010."[40] On a nationwide basis, United Health Care—one of the largest MA issuers—recently reported second quarter gains in the MA market, with an increase in 65,000 MA enrollees year-over-year and a 7% increase in revenues year-over-year.[41]

And there is no evidence that changes to MA reimbursement have or will disproportionately harm low-income Medicare beneficiaries, most notably those dually eligible for Medicare and Medicaid, and diverse communities. The overwhelming majority of dually eligible beneficiaries receive their coverage through Original Medicare, not MA plans. Specifically, according to MedPAC, in December 2012, 23%

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[37] Neuman, T. and G. Jacobson, "Medicare Advantage: Take Another Look," (Kaiser Family Foundation: May 2014), available at: http://kff.org/medicare/perspective/medicare-advantage-take-another-look/

[38] Schwarz, C. "New York's Medicare Marketplace: Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act," (Medicare Rights Center and United Hospital Fund: July 2014), available at: http://www.medicarerights.org/pdf/new-yorks-medicare-marketplace-july-2014.pdf

[39] Ibid

[40] Newell, P. and A. Baumgarten, "New York's Medicare Advantage Market, 2010–2012," (United Hospital Fund, July 2014), available at: http://www.uhfnyc.org/assets/1218

[41] United Health Group, "News Release: UnitedHealthGroup Reports Second Quarter Results," (July 2014), avialable at: http://insidehealthpolicy.com/sites/insidehealthpolicy.com/files/documents/jul2014/he2014_0584.pdf

of dually eligible beneficiaries were enrolled in MA while 27% of non-dually eligible beneficiaries opted for MA.[42]

While MA plans may be a good option for some dually eligible beneficiaries, we equally find that dually eligible beneficiaries avoid enrolling in MA due to more restrictive plan networks and increased use of utilization management controls. Dually eligible beneficiaries are low-income by definition, and they also tend to be sicker than the general Medicare population and require more intensive, ongoing health care services.[43] In addition, depending on household income, Medicaid and MSPs help low-income beneficiaries with cost-sharing they would otherwise face in Original Medicare.

Given this, it is important to note that nothing in the ACA restricts the core Medicare benefit package for dually eligible beneficiaries—or anyone else—enrolled in MA. To the contrary, core Medicare benefits were enhanced in the ACA. While supplemental benefits may be altered in MA plans, adjustments to these benefits were also commonplace *prior to* the ACA. Further, provisions in the ACA to restrict MA plans from charging higher cost-sharing were intended to help sicker populations—like dually eligible beneficiaries—by limiting discriminatory practices intended to keep those with high health care needs from enrolling in MA plans.

Further, it is worth noting that a part of the MA program seems poised for growth. Many MA plans, as well as new plans that have not been part of the MA program, are engaged in developing new products intended solely for dually eligible beneficiaries through a demonstration program initiated by the ACA to improve care coordination and health care quality for this population, known as the Financial Alignment Initiative.[44]

For example, 23 private health care plans are participating in the New York State demonstration. A consumer advocacy coalition, led by Medicare Rights, is weighing in on the development and implementation of this demonstration. To date, the coalition is pursuing several reforms and protections to ensure that plans are optimally serving the dually eligible population, including setting appropriate plan reimbursement rates, integrating appeals processes, building an adequate interdisciplinary care team, and establishing a statewide ombudsman.[45] Plans themselves are participating in the coalition's work through a related advisory workgroup.

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[42] MedPAC, "The Data Book: Health Care Spending and the Medicare Program," (June 2014, pg. 143), available at: http://medpac.gov/documents/Jun14DataBookEntireReport.pdf

[43] Jacobsen, G., Neuman, T., and A. Damico, "Medicare's Role for Dual Eligible Beneficiaries," (April 2012), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8138-02.pdf

[44] CMS, "Financial Alignment Initiative," (last updated July 2014), available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[45] See the following examples that include policy priorities of the Coalition to Protect the Rights of New York's Dually Eligible (CPRYNDE): Letter to CMS and NY State Dept. of Health on three-way contract (July 2013), available at: http://www.medicarerights.org/pdf/CPRNYDE-letter-to-MMCO-and-NYSDOH-re-Contract-Priorities-FINAL-11-27-13.pdf; Letter to CMS and NY State Dept. of Health on enrollment (July 2014), available at: http://www.medicarerights.org/pdf/FIDA-enrollment-letter-to-CMS-and-NYSDOH-07-14-14.pdf

In sum, the news on the MA landscape post-ACA remains overwhelmingly positive: enrollment is on the rise, premiums are down, and plan availability and benefits remain stable. However, it is critical to examine MA plan offerings and performance on an ongoing basis. As implementation of the ACA moves forward, we will continue to advocate for vigilant monitoring of the MA plan landscape and individual offerings to help ensure that plans are optimally serving beneficiaries under the new payment system.

Recommendations to Improve Medicare Advantage

While many argued that ACA changes to MA reimbursement would unduly restrict beneficiary choice, this has not proven true. To the contrary, independent, empirical research soundly supports our experience in counseling Medicare beneficiaries: by and large, beneficiaries and their caregivers are hampered by *too many* choices.

Given this, steps must be taken to further improve the MA market for people with Medicare. First and foremost, we believe that it is critically important to preserve the MA payment and cost-sharing improvements advanced by the ACA. Additionally, we urge Congress to consider the following:

Support consumer counseling services: Adequate funding for SHIPs nationwide is absolutely vital to ensuring that people with Medicare are supported in making plan decisions. Supported by federal, state, and local funding, SHIPs are the go-to resource for people with Medicare and their families who have questions about Medicare and related programs.

As a technical assistance provider to NY State's Health Insurance Information Counseling and Assistance Program (HIICAP) network—NY State's SHIP—we understand the value of this federal resource administered by the states for older adults and people with disabilities. Additional resources are needed to enhance the capacity of SHIPs and to increase outreach to ensure that people with Medicare are aware of free SHIP resources. In a nationally representative survey of more than 2,200 seniors conducted by KRC Research, only 37% were aware of the availability of free Medicare counseling through the SHIPs, and only 11% had used these services.[46]

In addition to the above, federal policymakers should ensure that MA marketing materials, notices, and websites are additionally simplified and standardized with plain-language information. As a requirement, these plan resources should include a prominent referral to unbiased counseling resources for beneficiaries, including SHIPs and 1-800-MEDICARE. At the same time, Plan Finder should be improved, most notably through the addition of content on plan provider networks.[47]

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[46] KRC Research, "Seniors' Opinions about Medicare Prescription Drug Coverage: 8th Year Update," (Medicare Today: September 2013), available at: http://www.medicaretoday.org/MT2013/KRC Survey of Seniors for Medicare Today FINAL.pdf

[47] Medicare Rights Center, "Memo: Plan Finder Observations During Fall Open Enrollment: October 15 – December 7, 2013," (Addressed to CMS' Arrah Tabe-Bedward and Amy Larrick, from Stacy Sanders and Casey Schwarz; Sent May 2014), available at: http://medicarerights.org/pdf/2013-plan-finder-memo.pdf

Further, plans should be prohibited from asserting or implying that standard benefits, like an out-of-pocket cap or free preventive services, are unique to a given MA plan. Similarly, MA plans should not be permitted to suggest that income-based benefits, like the MSPs or the Low-Income Subsidy of Medicare Part D (also known as Extra Help), are dependent on enrolling in a particular MA plan. Rather, these benefits are available to all Medicare beneficiaries, whether enrolled in Original Medicare or an MA plan.

Lessen the impact of mid-year changes to MA provider networks: Changes to provider networks are one tool available to MA plans to control costs. When these changes occur in the middle of the plan year, it can be particularly disruptive to beneficiaries, risking the continuity of needed care. Our helpline counselors work with many beneficiaries who face hardship as a result of mid-year MA network changes, including increased financial burdens, impeded access to physicians with whom they have longstanding relationships, and confusion. We observe that the sudden loss of a provider can be particularly damaging to someone undergoing active treatment for a condition or illness.

As such, we strongly support efforts by CMS to ease these burdens, namely by encouraging MA plans to provide sufficient notice prior to network changes, committing to investigating significant network changes, and granting a Special Enrollment Period (SEP) to beneficiaries where significant changes occur. To date, CMS relies on MA plans to define what constitutes a significant network change.

While we understand the need to permit some plan-level interpretation, beneficiaries need a consistent policy to ensure equal protection regardless of plan choice. As such, we continue to advocate that CMS engage in rulemaking to more clearly delineate the requirements of MA plans with respect to network issues.[48] In addition, CMS should be vigilant in its oversight of plan behavior, ensuring that notice is properly delivered, transition planning is provided as appropriate for people in active treatment, and unbiased counseling sources are prominently publicized.

Beyond rulemaking, we believe that more can and should be done to help ensure the continuity and stability of MA provider networks through the plan year. Toward this end, we urge Congress to pass the Medicare Advantage Participant Bill of Rights Act (H.R. 4998 and S. 2552).[49] This legislation ensures that MA enrollees obtain transparent, reliable, and accurate information about their plans' networks during the annual open enrollment period. Additionally, the bill provides assurance to MA enrollees that they will retain the ability to see the providers who were part of the plan's network when they made the choice to enroll in the plan. This helps to protect beneficiaries against the loss of trusted providers while the beneficiary is locked into the plan.

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[48] CMS, "Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," (April 2014), available at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

[49] Senator Sherrod Brown, "Press Release: Sens. Brown, Blumenthal, and Rep. Delauro Introduce Legislation to Protect Seniors by Preventing Them From Losing Their Doctors," (June 2014), available at: http://www.brown.senate.gov/newsroom/press/release/sens-brown-blumenthal-and-rep-delauro-introduce-legislation-to-protect-seniors-by-preventing-them-from-losing-their-doctors

Enhance transparency through data and notification: A recent report by the Office of the Inspector General (OIG) found that CMS regularly reviews plan-reported data, but rarely follows up on this information. Furthermore, none of this plan-level data is yet made available to the public.[50]

Toward this end, we support CMS' April 2014 proposal to release the first public-use file on Part C and Part D plan-reported data.[51] And we ask members of Congress to urge for the release of this data. Maximizing transparency would ultimately better inform consumers, while also facilitating greater accountability among MA plans—particularly in areas like grievances and appeals, where we believe significant improvements are warranted.

Encourage meaningful variation among plans: As reflected in numerous studies as well as our experience serving helpline callers, many people struggle to make choices when presented with several MA plans and multiple, complex plan variables. To encourage efficient plan selection, distinctions among plans must be made more meaningful, furthering recent efforts by CMS, described earlier, to eliminate plans too alike to other plans offered by the same insurer. At the same time, members of Congress should consider standardizing MA benefit packages, similar to the rubric required for supplemental Medigap plans (e.g., Plan A, Plan B, Plan C) to encourage "apples-to-apples" comparisons.[52] This would make it easier for beneficiaries to make an informed choice, while creating an environment in which plans compete based on price and quality.

Some argue that the ACA's increased emphasis on quality and efficiency must be coupled with increased flexibility for MA plans, specifically to alter cost-sharing and benefits. These suggestions concern us not only because they would further complicate the marketplace for consumers but might also lead to discriminatory practices. Given our experience, having helped tens of thousands of beneficiaries through the years, this market needs to be more standardized and well-regulated with clear rules that protect benefits, beneficiaries, and taxpayers. Increased flexibility for MA plans could encourage development of discriminatory plan designs intended to deter sicker, more vulnerable beneficiaries and skew risk unfavorably among products.

Enhance star ratings: As discussed above, the MA and Part D star rating system shows promise as a vehicle for improving both plan quality and simplifying consumer choice. In the short term, efforts to improve the star rating system should ensure that beneficiaries are educated and engaged, as many people

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[50] OIG, "CMS regularly reviews Part C reporting requirements data, but its followup and use of the data are limited," (March 2014), available at: http://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf

[51] CMS, "CMS First Public Use File (PUF) of Plan-Reported Data," (HPMS Memo from Tracy McCutcheon and Danielle Moon to all Part C and D Sponsors; Sent April 28, 2014); Medicare Rights Center, "Re: CMS First Public Use File (PUF) of Plan-Reported Data," (Comments submitted May 12, 2014)

[52] O'Brian, E. and J. Hoadley, "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice," (Commonwealth Fund: April 2008), available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue Brief/2008/Apr/Medicare Advantage Options for Standardizing Benefits and Information to Improve Consumer Choice/OBrien_Medicare_Advantage_options_1117_ib pdf.pdf; Precht, P., Lipschutz, D. and Burns, B., "Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans," (California Health Advocates and Medicare Rights Center: September 2007), available at: http://cahealthadvocates.org/_pdf/advocacy/2007/InformedChoice.pdf

with Medicare are still unfamiliar with the system. According to KRC Research, only 23% of seniors interviewed through a national survey were aware of the star rating system.[53] Clear, regular explanations of the rationale, meaning, and importance of the star rating system are needed. In addition, stars should reflect timely quality measures so beneficiaries can make choices based on the most recent data available.[54]

In the long term, the star rating system should be enhanced to provide consumer-specific information relevant to individual choices. As the program evolves, people with Medicare should be able to "self-weight" various factors to create individualized quality ratings, sorting plans by the metrics most relevant to their individual needs.

Conclusion

In conclusion, the experience of our clients at Medicare Rights demonstrates that for some older adults and people with disabilities, MA plans are a good option, but for many others Original Medicare is a better choice. Thanks to recent advancements made possible by the ACA and additional efforts by CMS, the market for MA plans has significantly improved. These changes to MA plans must be preserved.

MA plans can play an important role in the value-driven agenda advanced by the ACA—and are already doing so. MA plan quality continues to increase, a trend attributable to quality improvement initiatives embedded in the ACA. While some may be inclined to link any annual plan changes to the ACA, like altered cost-sharing and changes to provider networks, it is important to recall that these practices have been the norm within the MA landscape since its inception. As always, people with MA have the option to switch their coverage during the annual Medicare open enrollment period if their plan no longer meets their health and financial needs.

Despite all of these improvements, our experience and empirical research indicate that Congress and CMS should do more to simplify plan selection and coverage rules for people with MA. To achieve this goal, we recommend adequately funding unbiased counseling resources, such as SHIPs; improving beneficiary notice regarding annual plan changes; appropriately limiting the ability of MA plans to make mid-year changes to provider networks; further streamlining and standardizing plans; and making available public data on the performance of MA plans, particularly with respect to appeals and grievances.

Thank you for the opportunity to testify.

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[53] KRC Research, "Seniors' Opinions about Medicare Prescription Drug Coverage: 8th Year Update," (Medicare Today: September 2013), available at: http://www.medicaretoday.org/MT2013/KRC Survey of Seniors for Medicare Today FINAL.pdf

[54] Goggin-Callahan, D. "New York's Medicare Marketplace: Examining New York's Medicare Advantage Plan Landscape in Light of Payment Reform," (Medicare Rights Center: June 2012), available at: http://www.medicarerights.org/pdf/New-York's-Medicare-Marketplace.pdf

Summary of Testimony by Joe Baker, Medicare Rights Center

The Medicare Rights Center is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Medicare Advantage Strengthened Since the Affordable Care Act: Today, MA plan enrollment is at an all-time high, with nearly 16 million enrollees. The ACA included a set of policies designed to make the MA system more efficient and to enhance plan quality. This emphasis on value is producing positive returns in the MA marketplace, and MA plan quality continues to improve. Importantly, the ACA put the Medicare program on sound financial footing while improving benefits. The ACA made many critical improvements to MA, benefitting current and future beneficiaries, including:

- Equalizing MA payments with the costs of providing the same care under Original Medicare
- Enhancing coverage and reducing costs for select preventive services
- Prohibiting higher cost-sharing for renal dialysis, chemotherapy, and skilled nursing stays
- Mandating a medical loss ratio requiring that 85% of premiums and MA payments are spent on care

After the Affordable Care Act, the Medicare Advantage Market Remains Stable: Many predicted that ACA changes to MA payment methods would lead to widespread disruption of the MA market. Some claimed that MA enrollees would see increased premiums and cost-sharing and fewer plan choices. Yet, the opposite has proven true. Since passage of the ACA:

- Estimates suggest that MA enrollment will continue to rise, with 25 million enrollees by 2024
- Plan choice remains strong: in 2014, the average beneficiary has a choice among 18 MA plans
- MA premiums declined from an average of $44 per month in 2010 to $35 per month in 2014
- Changes to benefits and cost-sharing remain unaffected, apart from expected year-to-year modifications

Recommendations to Improve Medicare Advantage: Today, MA remains a good option for some, but not for all. Congress must preserve and strengthen the Original Medicare program, while also ensuring the availability of MA options through a well-regulated marketplace. While many argued that ACA changes to MA reimbursement would unduly restrict beneficiary choice, this has not happened.

To the contrary, our experience and independent research confirm that consumers are by and large hampered by *too many* choices. Given this, steps must be taken to further improve the MA market for people with Medicare. We urge Congress to consider the following:

- Support counseling services and adequately fund State Health Insurance and Assistance Programs (SHIPs)
- Lessen the impact of mid-year changes to MA provider networks
- Pass the *Medicare Advantage Participant Bill of Rights* Act (H.R. 4998 and S. 2552)
- Enhance transparency through publicly available data and notification, particularly on appeals
- Encourage meaningful variation among plans, specifically through standardization and consolidation
- Enhance the quality star ratings program to help consumers make better choices

Chairman BRADY. The reason we are holding this hearing is that the Affordable Care Act cut, slashed more than $300 billion out of Medicare Advantage that so many of our seniors rely upon. Now, the cuts were delayed through various actions. That is what Mr. Baker's testimony is all about. It did not happen. I agree. It did not happen because the cuts were delayed.

Now they are becoming real, and there is no way it will not have some impact on seniors. The hearing today is to figure out what will that impact be.

Mr. Book, as you describe in your testimony, the cuts to Medicare Advantage are becoming real for millions of seniors. There is no magic bean here. These cuts will land on them. Some suggest and your testimony said that you would be forced to spend $3,700

less per senior as a result of these cuts. Some suggest these simply eliminate inflated profits for Medicare Advantage Plans or have made them more efficient.

But as we all know, CMS requires MA Plans to bid on Medicare's guaranteed benefits, A, B, D, as well as administrative costs. So this is all part of the bid.

So the question to you is: what is the real impact on our seniors as results from the cuts that really begin next year for Medicare Advantage?

Dr. BOOK. That $3,700 per senior per month or per enrolled member is going to have to be made up for by either reductions in benefits, increased copays, increased premiums. That is really all there is.

They can restrict provider networks so that there are fewer physicians seniors can see. Those are about all of the options they have.

You mentioned profit. The average health care company makes a profit of about three to five percent on all of their business, including their commercial and private sector business, and these cuts are 27 percent. So there is no way they can make up these cuts just by reducing their profit, even if they were willing to run profit down to zero. There is simply not enough room. They are going to have to make significant, very significant cuts in the benefits they provide to seniors or increase their prices that seniors pay above what they can afford.

Chairman BRADY. They have to reduce the benefits.

Dr. BOOK. Right.

Chairman BRADY. Or you have to increase the costs to seniors.

Dr. BOOK. Right. There is no other room. That is correct.

Chairman BRADY. You do not have a magic bean that you will be using somehow——

Dr. BOOK. Perhaps one of the physicians here could mention a magic bean, but I think if we had that we would have used that already.

Chairman BRADY [continuing]. Yes, I would think so.

Mr. Wing, Dr. Burnich, let us talk about what we know has already happened. I was around the last time Congress went after Medicare private plans in the 1997 Balanced Budget Act. According to the CBO estimates, at the time that law took $97 billion out of the plan. This is three times greater than that.

But I was there when almost two and a half million seniors lost their plan, some of them in our communities. I remember taking calls. I remember trying to figure out how we were going to get them in other plans. I remember how upset they were. They liked what they had, and there was an uproar.

So much so Congress intervened in 2003 and created new incentives through Medicare Advantage Plans, resulting in the successful program we have today. Now with the $300 billion in cuts, it feels like, as Yogi Berra said, "It's deja vu all over again."

Are we not likely to see similar levels of upset seniors once they start to feel the pain of these cuts, Mr. Wing, Dr. Burnich?

Mr. WING. I think the answer is yes. I cannot speak for the industry, but we submitted our bid for 2015 in the first week of June,

and there will be withdrawals from markets. There will be withdrawals of products from certain markets.

Chairman BRADY. Withdrawals from markets means there will be fewer Medicare Advantage Plans offered to fewer seniors.

Mr. WING. I cannot speak for the total industry, but I know that there is one geographic region where SCAN will be leaving in 2015 entirely. There are probably four or five counties where we are withdrawing some of our special need products, and in virtually all of our markets, we will be increasing what we ask seniors to pay, especially on the Part D, the Rx benefits.

Chairman BRADY. Sure.

Mr. WING. There will also be slight trimming of the networks, both in Arizona and California.

Chairman BRADY. They will be able to see fewer doctors, fewer hospitals, less choice.

Mr. WING. Yes.

Chairman BRADY. And that impact would not be occurring without these Affordable Care Act cuts?

Mr. WING. You know, we are a not-for-profit, but we need to have a margin, and right now in 2014 we have a negative margin. So we love caring for seniors.

Chairman BRADY. Negative margin means your profits are so large you are actually losing money?

Mr. WING. We are losing money.

Chairman BRADY. Yes. Dr. Burnich.

Dr. BURNICH. So about 1997, I lived through it. I practiced it in Ohio. It was not pleasant. It was painful for those that we cared for. It left a bad taste in the physician's mouth.

I think you have to have choice. Narrow networks take away choice, but it also takes away quality physicians, and I am here as a physician. I am not here as a health planner, and I think it is important to offer choice and a broader network so that there is a broad palate of services.

The programs like AIM would never get off the ground, and when you look at the expenditures in Medicare, 28 percent of all CMS dollars are spent in the last year of life, and half of that is in the last month.

Chairman BRADY. So the plan that targets the most sick and chronically ill seniors would not have gotten off the ground?

Dr. BURNICH. No, and it will not be sustainable either.

And then the last piece I would say is physicians have to manage overhead, and at some point those cuts past down to them through the health plans is they will just disengage, and even the plans that do exist in counties, they will not be in them. They will go back to fee-for-volume, and if you recall after BBA 1997, if you looked at the rate of increase of expenditures, they plateaued a little bit after 1997, and then they went up much faster than they did in the previous ten years.

I think the same thing could occur if you do that now.

Chairman BRADY. You think the impact on seniors will be the same or greater than the cuts in the Balanced Budget Agreement?

Dr. BURNICH. I do not know, but I know that physicians will figure out how to cover their overhead by doing more things.

Chairman BRADY. Doing more things, seeking revenue from other sources?

Dr. BURNICH. They will do more testing. They will do more invasive procedures. They will do what they did after 1997.

Chairman BRADY. Can I finish with this?

Dr. BURNICH. I hate to say that, but I think——

Chairman BRADY. No, I know. Look. No magic bean here.

Care coordination innovation within Medicare Advantage I think has been hugely helpful long term for our seniors. What is the impact of that when you are facing these cuts? Is that a risk?

Mr. WING. Well, I think the care coordination is very, very valuable for the population we serve, the dual-eligibles, the seniors and our C–SNPs, our seniors and our I–SNPs. Every year we have to do an up-front assessment, an HRA, if you will. We have to develop a care management plan, a multidiscipline care management plan, and we love to do the special need plans.

But they are underfunded. So they will be uniquely impacted with these cuts as opposed to vanilla MAPD program.

Dr. BURNICH [continuing]. So in the 20th Century, a physician could practice and manage 25 to 30 drugs and a dozen tests, and now people are living longer. They are more complex. There are more complex drugs. You need a village of people to take care of people.

So team-based care is a 21st Century concept, and it is evolving. Some people call it patient-centered medical home. I call it team-based care. Those teams are comprised of individuals such as care managers, nurse practitioners, sometimes a pharmacist, social worker, behavioral therapist because these people that are living longer are having much more complex problems, and physicians by themselves, internists like myself cannot do it alone, and if they do not have those teams around them, the patients will go back to falling through the cracks like they have in the past.

And so I think the members of those teams, those budget cuts will take those people right out of the program.

Chairman BRADY. Yes. A final point, thank you for the testimony, all of you. You know, around here if there is a $3 billion cut to Medicare the place goes crazy. We are ending Medicare as you know it. A $300 billion cut to seniors today, some say, "Oh, it is not problem. Nothing is going to happen."

There is going to be real impact. It is coming at us soon. I think seniors need to know what the impact is, and I think Congress needs to find a way to try to avoid these serious cuts on our seniors.

Dr. McDermott, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I asked to have a couple of graphs put up on the monitors because one of them shows the Medicare Advantage premiums, and you see that line that starts up high there and goes down and is flat. That blue line is the premiums of Medicare.

Now, we have had these harbingers of disaster come in here and tell us that, "Oh, my God, this is the end of Medicare. What we have done with these cuts is going to just end Medicare and it is going to price it out of people's ability."

But the fact is the premiums have stayed down. Now, the CBO, if you look at those three lines, the green line is what CBO projected would happen to MA in terms of enrollment before the enactment of the law. The red line is what they projected after it passed, and the blue line, the one that goes up to almost 15 million, is the fact of what has actually happened.

CBO has not projected correctly on what was going to happen with MA. All the disaster folks who come out here like Cassandra telling us it is the end of the world are clearly not being able to project what is going on.

We have made the cuts. They have already been started in 2011. We have been gradually reducing the amount that Medicare Advantage Programs are getting. What that does is force doctors and programs to figure out how to do it more efficiently.

Now, what I am hearing from the three of you is give us more money. Do you people understand that you came to the wrong place? These guys are not going to give you more money. They cannot raise taxes for highways, much less more money for Medicare. So you are asking for more money. They are not telling you you are going to get more money. They just want to scare the old people, and your job is going to be how do you deal with the money that you are going to get because they are voting for these cuts.

The Ryan budget has had them in every single time.

Chairman BRADY. Just for the record, I would say no Republican voted for the Medicare Advantage cuts in the Affordable Care Act. No Republican voted for it, and this chart does not recognize that the Administration delayed the cuts, 80 percent of them.

Mr. MCDERMOTT. Mr. Chairman, the Ryan budget uses the savings from the Affordable Care Act, and you can parse it any way you want, but you voted for it.

Chairman BRADY. The Ryan budget is not the law today. These are people who are living under real cuts and real law.

Mr. MCDERMOTT. Right. Mr. Baker, you have listened to this. Should seniors be worried as we go into this election about these cuts?

Mr. BAKER. Given the experience that we have had thus far, I do not think so. In our discussions with plan executives both in New York State and in other areas of the country, we have heard that certainly plans are concerned, but they are also very concerned with keeping market share in their MA products which they think are profitable and which they think are, you know, very valuable to their product lines, particularly in an environment now under the Affordable Care Act where they could potentially cover someone, you know, cradle to grave, as it were.

Mr. MCDERMOTT. Are they putting in bids?

I mean, we hear that somebody is pulling out of a market. So I guess maybe some are, some are not?

Mr. BAKER. Yes. I mean, I think that the experience, once again, every particular plan is making a decision about whether or not to increase market share in particular markets, pull in or pull out, and that is what we have seen consistently over the course of the history of the Medicare Plus Choice and the Medicare Advantage Program.

These are private entities that make business decisions based upon reimbursement and a number of other factors about whether to enter a particular market or leave a particular market, and certainly BBA, other reimbursement changes can affect that behavior, but there is a whole host of other issues that can be specific to particular plans that have nothing to do with reimbursement overall.

Mr. MCDERMOTT. Let me ask you one quick question. Are those plans open so that you can see what they are offering seniors in their Medicare Advantage?

Mr. BAKER. Open how? I am sorry.

Mr. MCDERMOTT. Open to look at them and see if they are cutting benefits.

Mr. BAKER. Yes. I mean, we studied plans in New York, and we have looked at plans across the country, and we have not seen any significant change in benefits year to year and no trend in that regard.

Mr. MCDERMOTT. They are making a bid based on the law as it presently is and the cuts that are being phased in over a period of time, slowed down by the Administration; they are making bids on that basis, and they say they can make it?

Mr. BAKER. Many of the plans that I talk to say they can make it. Many, and I think in the testimony of some of the witnesses today there are a variety of strategies like looking for those four and five-star ratings that still bring significant bonuses to, you know, weather this and also other efficiencies to bring to bear.

Mr. MCDERMOTT. Thank you.

Chairman BRADY. Thank you.

Just for the record, Mr. Baker, the trends have not changed because the cuts have not occurred. This hearing is about the future and the impact on our seniors.

Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Wing, Dr. Burnich and Mr. Book, you know, my district back home includes Collin County, Texas. That is Dallas and Plano. My district is about 24 percent Medicare beneficiaries, and they have opted out of traditional fee-for-service Medicare and enrolled in Medicare Advantage because there are more advantages, obviously.

Since Obamacare became law, Medicare Advantage enrollment has doubled in our county, yet benefits are expected to be cut over $2,600 per person, and the total number of plans has already begun to decline.

I wonder if each of you can just explain what cuts mean for Medicare beneficiaries in my county and in the Nation, and if these beneficiaries lose access to their Medicare Advantage Plan, what challenge will they face when they have to re-enroll in a fee-for-service Medicare, and is that going to work?

Mr. Wing.

Mr. WING. If I may, I will just speak to the SCAN experience, and SCAN is operational in Arizona, Northern California, and Southern California.

I do not think the experience in Texas is going to be much different than in California or Arizona for 2015, 2016, and 2017. We are trying to shoot for a small margin, but no margin, no mission, and we are being forced to do things we do not want to do.

We are a not-for-profit. Our whole mission is to improve the health and independence of our members, but with the cuts and the changes, we are going to have, as I mentioned, to withdraw from one geographic market, withdraw products, especially the special need products that are probably the most important products of the MA Program because they deal with the most frail seniors.

But we cannot sustain. They are hard for us to sustain in good times. With these cuts, in some geographies we are going to have to withdraw them, and for our core programs, we are going to have to make some changes, more cost share participation on the part of the beneficiaries. I think you will see that in Texas. I think you will see that across the land.

Mr. JOHNSON. Thank you.

Chairman BRADY. Dr. Burnich.

Dr. BURNICH. I think the biggest concern for me is access to care for patients, particularly if they get disenrolled from a Medicare Advantage Plan. Fee-for-service Medicare and primary care, it is hard to run a practice off of that. You have to really kind of manage a percentage, if you will, of the patients. Those patients, if they get disenrolled from an MA plan, might have trouble getting into a PCP, not to mention we have a shortage of PCPs.

We have an aging population that is growing. So we are really putting pressure on access to care.

Mr. JOHNSON. Yes, and do you not see some docs even getting out of the business?

Dr. BURNICH. Absolutely.

Mr. JOHNSON. That is what I am seeing.

Dr. BURNICH. Yes. I do not think California and Texas are different there.

Mr. JOHNSON. Yes. Mr. Book.

Dr. BOOK. I think the type of impact is going to be the same throughout the country. The individual dollar amount of the impact is going to vary from county to county and State to State, and the reason for that is the benchmark rates are set at the county level.

In the past they have been set by a somewhat arbitrary formula, and now we are just transitioning to a different, somewhat arbitrary formula. So the difference between the old rates and the new rates is going to vary from place to place.

So the counties that are hit worst are in Louisiana. The counties that are hit least are in Montana, on average, but the types of impacts we are going to see are the same. Everybody is going to see a reduction in benchmarks. Everybody is going to see an increase in out-of-pocket spending and/or a reduction in benefits. It is going to happen everywhere.

You put up that nice chart about what would have happened if the Affordable Care Act has been implemented, but it was not implemented. So, of course, the predictions did not come true. That is kind of like if you say if you jump off a building, you will hit the ground, but if you say, "Well, I am not going to jump off the building yet so I am still fine," that does not really mean that it is okay to jump off a building.

Mr. JOHNSON. I hope we do not go jump off a building.

Mr. Chairman, I am ashamed that this Administration decimates Medicare, especially Medicare Advantage, to pay for Obamacare,

and while they are playing political games and covering up these cuts until after the election, Medicare beneficiaries in my district and around the Nation are losing benefits and access to their preferred Medicare Advantage Plans.

So I just want to thank you for holding this hearing, and I yield back the balance of my time.

Chairman BRADY. Thank you.

Mr. Gerlach, you are recognized.

Mr. GERLACH. Thank you, Mr. Chairman.

I want to start with the premise that Dr. Book made in his testimony that the average reduction in benefits for 2017 relative to the pre-ACA baseline is going to be over $3,700 per beneficiary per year, about 27 percent. So if you would, make that an assumption for the purpose of my question for each of you.

What do you think that kind of impact is going to have particularly on the area of the dual-eligibles?

And of course, that varies. The affluence of counties, of course, varies. The number of dual-eligibles per county varies. The benchmarks therefore vary.

But in terms of the scope and breadth of your current activity, recognizing that unique population of the Medicare patients, the dual-eligibles who tend to be more disadvantaged, who tend to have more severe health risks, what do you think the impact of Dr. Book's prognostication would be particularly with regard to that patient population?

And I would start with you, Mr. Wing.

Mr. WING. Well, thanks. It is a great question.

We have been dealing with the dual-eligibles in California where they only integrate Medi-Cal and Medicare streams, 27 percent over the next three years. Just take what I said about what we are doing for 2015 and magnify it by three or four. You know, these frails, they need a lot more. They are the frailest of the frail, and to reduce the network and especially when all of the pilots are counting on past enrollment, but if they lose the continuity of care with their trusted physician, they are going to bounce back into Medicare fee-for-service, and that is going to really cost the system because it is not just going to be the Medicare dollars that are at risk.

Without a good care management program, they could very well end up in custodial and long-term care, and when members typically go into custodial care, typically they do not come out. And that is not as far as the dignity, the cost of the system.

So much narrower network which has a corresponding impact as far as the passive enrollment will go way down. They will opt back into Medicare fee-for-service, and without the care management the doctor just talked about, they will probably end up in institutions and then long-term care.

You talk about a shortsighted strategy. We need more care management for the more frail populations, whether they are dually eligible, ESRD, chronically ill. We need more care management to keep them out of the ERs, to keep them out of the acute settings, and most importantly for the duals, to keep them out of custodial care.

Mr. GERLACH. Doctor.

Dr. BURNICH. The primary care physician for most dual-eligibles in this country is the emergency room, and then they clog up the emergency room for people who really need the care. It is not that they do not need the care, but they can be managed in a lower cost setting.

In those 1,800 patients that are in AIM a day right now, 11 percent of them are dual-eligible, and I can tell you that in a poor county like Sonoma and Santa Rosa, the residents came to me and said, "This is the greatest program because now we do not have to manage these people in the hospital, and they are in the hospital for a long time and they take up a lot of resources and then they get lost to follow-up because they have no care coordination."

So that is the concern I have.

Mr. GERLACH. Dr. Book.

Dr. BOOK. I would agree with that, and I would also add that dual-eligibles get assistance from Medicaid in paying their fee-for-service copays and, if they are enrolled in Medicare Advantage, their Medicare Advantage premiums and copays.

So in addition to getting access to coordinated care through Medicare Advantage, they also end up saving the States money because the amount Medicare has to pay to put someone into a Medicare Advantage program is a lot less than the copays they would pay if that same person were in fee-for-service.

So if we reduce the Medicare Advantage benchmarks and plans end up exiting markets and there are fewer MA Plans and they take fewer patients, we are going to have dual-eligibles who are transitioning out of Medicare Advantage, losing their coordinated care, losing the doctors and hospitals that know them and that they know, and in addition, costing the Medicaid Program more money.

So if we cut the program we do not actually save the money. We just put it somewhere else.

Mr. GERLACH. Mr. Baker.

Mr. BAKER. I think it is important to note that the Affordable Care Act has made significant investments in dual-eligibles through demonstration projects, and those are getting underway now. I think certainly we all agree that there needs to be better care coordination for this population which is very vulnerable, and that needs to occur across the board, both in MA but also in the fee-for-service program through either these demonstration projects or through things like accountable care organizations or other efforts that the ACA has put forward so that really they are available to all people with Medicare, not just people on Medicare Advantage.

Mr. GERLACH. Thank you all for your testimony.

Chairman.

Chairman BRADY. Thank you.

Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you very much, Mr. Chairman, and I appreciate being able to have a little deeper dive on some of the impacts of Medicare Advantage.

I think my community has the highest penetration of Medicare Advantage in the country, or close to it, and so I have been following this closely.

Part of the issue is that there is an opportunity to coax more value. There are some extraordinarily high cost areas around the country. We kind of think we are a little discriminated against in our community. We have pretty high value outputs, low costs, and we see these things scattered around the country. So I think there is nationally an opportunity to extract more value, and we ought to do it carefully, and I appreciate the admonition from some of our witnesses.

One of the areas, however, in terms of coaxing more value out of managed care, I think, is an opportunity to deal with value-based insurance design, and rather than quack on, my friend and colleague, Congresswoman Black, I am looking forward to working with her co-sponsoring legislation, but since she is the lead co-sponsor, I would like to yield if I could to her because she is a little further down the line and may need more time, if you would care to comment or ask questions.

Mrs. BLACK. Well, thank you, Mr. Blumenauer.

I am so delighted that we are working together on this concept because this is one that I believe down the road is going to show us real benefit. Having been a nurse for 40 years, I know specifically in nursing if we can get someone, particularly those who have chronic conditions like diabetes and cardiovascular disease, if we can get them to stay on their regimen, they are going to be a lot more healthy. They are going to save costs in the long run and quality of care for them is certainly going to be better.

So this bill that we have together, and we have just filed it, is H.R. 5183, and it would incentivize the insurance companies. It would set up a demonstration project to incentivize the insurance companies to use those kinds of mechanisms that would give incentives to the patients for them to make sure that they are using what we know will make them healthy.

For instance, if you are diabetic, there would either be low copays or no copays on things such as insulin. Maybe there would be no cost to go and see your primary care doctor for things like foot mapping and so on that we know already proven to keep people healthy.

So I am delighted that we are able to have this bill together, and I hope that it will pass so we can get this demonstration project, show that it does work, and then roll it out all across this country.

So, Mr. Blumenauer, I will yield back to you so that you can ask whatever questions of the witnesses.

Mr. BLUMENAUER. I think it is important for us to be able to push. One of the things that I like about the Affordable Care Act is that there were a number of pilot projects. There are tests because we are going to be in the middle of health care reform for the next decade, but I think this is an opportunity to provide the right sort of incentives for patients, doing it on a couple of pilot projects, a couple of plans, to be able to see what works and what does not.

I know there are some people who have some concerns. They want to make sure that it is done appropriately, and I think we can do that.

So I am looking forward to the rollout of the bill. I hope that this might be on the list that I have talked to the chairman about, but

I think there are a variety of areas that we ought to be able to agree that have nothing to do with Obamacare. These are things that we can move forward on.

Mr. Gerlach has a proposal that I think has great merit. I have been working with Dr. Poe on the end of life care, with some 50 bipartisan co-sponsors.

I would hope, Mr. Chairman, that there would be an opportunity for us to have hearings on things that we are not necessarily going to be hearing about on the Sunday talk shows, but could make a difference, and I think this is an example. I look forward to working with my colleague, and I hope we can bring it back before the committee for further discussion.

Thank you, and I yield back.

Chairman BRADY. Thank you, Mr. Blumenauer.

Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chairman, and I want to thank you for holding this hearing, and thank the witnesses.

I think it is incredibly important that we focus on what is going to happen. We know what has happened to date, and many of us differ on what the effect of that has been regarding the Obamacare/ACA.

I do want to touch on something that Dr. McDermott said though because it is important for the witnesses to know. It is important for the folks in this room to know. It is important for the people across this country to know that no Republican voted for these cuts to MA, not one, not one in the House, not one in the Senate. And my friend from Washington State talks about them being included in the budget. The budget is required when we pass a budget; we are required to assume current law. That is where we start. And so what we do is take the money that has been stolen and raided from Medicare and put it back into Medicare. That is how we secure, save, and strengthen Medicare. So it is important that we set the record straight on that.

Dr. Book, I want to touch on this star rating program and dive a little deeper on it. This is a program that as I understand was put in place by CMS to allow beneficiaries to be able to tell different things about plans and compare the plans. Yet it has now morphed into a program where Medicare, where CMS uses it to provide payments.

Dr. BOOK. Right. That is correct.

Mr. PRICE. Does that make any sense at all?

Dr. BOOK. Well, not as the program is currently constituted, no. Originally the idea was that CMS would help Medicare beneficiaries to choose an MA plan by giving ratings based on their criteria, and if a beneficiary wanted to use those criteria to choose their plan, they could, and if they wanted to go and investigate on their own and call up a plan and see what doctors do you cover and what services do you cover, they could ignore the star ratings if they wanted to and make their own decision.

That makes sense. I think that is fine.

Mr. PRICE. That makes some sense.

Dr. BOOK. But once you take that system and use it to make payments, you are adjusting the benefits that eh plans can offer,

and you are saying to a senior whose criteria are different from that of the bureaucrats in CMS——

Mr. PRICE. Right.

Dr. BOOK [continuing]. "If you like a different plan, you are going to have to pay more and accept lower benefits if your criteria are different from the bureaucrats' criteria."

I think that undermines the goal of patient choice, which was one of the goals of having Medicare Advantage in the first place.

Mr. PRICE. Right. We would agree. This is another Washington knows best.

Dr. BOOK. Yes, exactly.

Mr. PRICE. We know what is best for you as a patient.

Dr. BOOK. And from what I understand, CMS instituted the star rating program on its own just as a way of helping seniors, and then later it was incorporated by the Affordable Care Act, assuming it would continue to exist and saying, "Okay. Now, pay people that way."

Mr. PRICE. That is my understanding as well.

Dr. BOOK. Yes.

Mr. PRICE. Now, in your testimony you talk about some perverse incentives, some disincentives in the star rating program for having docs care for the sickest patients out there, the ones with the highest comorbidities, the ones with the greatest health challenges.

Can you expand on that?

Dr. BOOK. So some of the criteria give negative ratings to plan if certain things happen, and a plan could game the system by treating, you know, a healthier mix of patients, and we really do not want that. Really the people who need the treatment are the sickest patients.

If you set up a criteria that says, you know, how many people achieved some certain benchmark without adjusting for how healthy or unhealthy they were when they came to see you, then, you know, we are not really being fair to the doctors. We are saying we are going to penalize you if you take care of the hardest cases, and I think that is the opposite of what we ought to be incentivizing.

Mr. PRICE. One of the huge challenges that we have is to try to incentivize physicians to continue in practice. Mr. Johnson mentioned docs fleeing practice. As a former practicing physician I hear from my former colleagues all the time. Many of them are just looking for the exit doors because of these kinds of rules and regulatory oppression that they are working under right now.

Dr. BOOK. This exists also in the fee-for-service system. There is this notion of pay for performance where you pay doctors for doing, you know, what they call evidence-based care. What it really is is they have a list of things that you are supposed to do for a patient with a particular diagnosis, and if you check all of these boxes, you get more money.

So, for example, you are supposed to tell everyone who has had a heart attack to take aspirin. Well, that is great for most patients, but what if the guy is allergic to aspirin?

Mr. PRICE. Yes.

Dr. BOOK. If you get patients who are allergic to aspirin, are they going to pay you less?

Mr. PRICE. Yes. It is again Washington knows best.

I want to touch very quickly on this $3,700, Mr. Wing, because you mentioned your margin was two to three percent, as I recall.

Mr. WING. I have no margin. I will lose money in 2014.

Mr. PRICE. So if what Mr. Book says is correct and that is that payments are going to go down from the Federal Government per patient $3,700 a year, what happens to your model?

Mr. WING. Well, we have levers, and first I have to become more efficient. We spent $40 million on a new IT system that should be implemented——

Mr. PRICE. Can you absorb $3,700 per patient?

Mr. WING [continuing]. No, not without extraneous changes.

Mr. PRICE. Thank you.

Mr. WING. Thank you.

Chairman BRADY. Mr. Smith is recognized for five minutes.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you to our witnesses as well.

The chart that we saw earlier is very interesting, and certainly it is enlightening in terms of the trends they indicate. I am sure you saw the chart as well. Mr. Book, now the cuts would take place in 2015; is that correct?

Dr. BOOK. We already have published rates for 2015 that incorporate those cuts, yes. The specific rates are published one year at a time. So we have seen the first year of cuts already.

Mr. SMITH. So are we going to see some different trends from the lines in this graph?

Dr. BOOK. I believe so, yea. In fact, as my colleague mentioned, they are already withdrawing from one geographic area, and that is one plan sponsor withdrawing from one area. I think we are going to see more withdrawals and more increases in premiums.

Again, this year the change from last year is only three percent, but that is because the Affordable Care Act's cuts for last year were offset by regulatory action. So the transition from 2014 to 2015 is going to be less than it would have been before.

Once you start moving forward, we are going to see substantial changes unless there is some other action that causes the Affordable Care Act not to be implemented.

Mr. SMITH. Mr. Baker, do you believe that these trends can continue with the impending changes?

Mr. BAKER. Well, certainly recent projections by the CBO continue to indicate that there will be rising enrollment in Medicare Advantage and that the initial projections and the CBO took into account these changes in reimbursement methodology, that there will continue to be different projections, better projections about ongoing enrollment in Medicare Advantage.

So it does look like plans will be able to absorb these cuts. They will be able to innovate around and——

Mr. SMITH. Well, how long do you think they can absorb and just kind of continue amidst many of these conditions?

My concern is overall that health care professionals are frustrated. They do not like the view of the future. It concerns me greatly, especially as a representative of a part of rural America,

that health care providers, when I hear from them, they are just discouraging young people, especially family members, from going into health care, and this is because of the Federal Government making such a bureaucracy of health care.

And I am very concerned about such a reduction in providers. It is already difficult to find providers in rural America, and it stands to get much worse, and lack of providers means less competition in urban areas and less mere access in rural areas.

We see that there will likely be disproportionate impact to Medicare Advantage choices in rural America. Mr. Book, can you elaborate on that perhaps?

Is it correct that there would be a disproportionate reduction of choices in rural America?

Dr. BOOK. I have not looked specifically at the rural-urban distinction, but if you want, I can get back to you on that later.

In general, some of the rural counties had upward adjustments in their benchmarks prior to the ACA. That indicates they might be hit harder, but I would have to check the numbers to be sure.

Mr. SMITH. Okay. I would appreciate any further information on that.

Dr. BOOK. I can do that, yes.

Mr. SMITH. I am very concerned about the frustration that this is causing across health care, and that this would actually lead to——

Dr. BOOK. There is an extra bonus in the Affordable Care Act for certain types of urban areas. There is a set of demographic criteria for what counts as a qualifying county. It does not include every urban area, but it does include any rural area. Again, I would have to look at numbers to be sure, but I would not be surprised if it turns out that rural areas are harder hit.

Mr. SMITH [continuing]. Okay. Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

Thank you to all of the witnesses for being here.

Mr. Wing, I want to circle back on what the gentleman from Georgia questioned about, and that is the star program. You are a four and a half star program.

Mr. WING. Yes, sir.

Mr. THOMPSON. I am interested to know if the quality has improved because of the star program and to get your input on this, give you a chance to respond to the issue of star.

Mr. WING. Thank you.

For five years prior to my being at SCAN, I was the Chief Operating Officer for HealthCare Partners, which has big operations in California and Nevada and Florida. There was a sea change event with the stars. When you start having incentives for quality and there are benchmarks where we can compare plans versus plans, providers versus providers, you can start having really robust conversations about how do you improve best practices, and that is what we are doing with our provider integration.

We bring these 14 groups together, and we do not hide the data. They have an economic incentive to group quality. They know who

is best at each one of those 50 metrics, and then we have the physicians from those 14 groups share how do they get this best practice.

I think we may debate this, but for my 30 years of being in health care, we now have a standard, and it has caused a sea change event amongst the providers that I deal with in Arizona and California to really focus on quality. And I would say there is some debate as far as are the metrics all the right metrics, but it does deal with patient satisfaction. It does deal with medication adherence, which does reduce cost long term.

It is not perfect, but I applaud the stars program.

Mr. THOMPSON. Dr. Burnich, do you support the ACA's effort to create payment parity between the MA plans and fee-for-service?

Dr. BURNICH. Based on the demographics of the current patients that are in MA, no, because they are a sicker population that choose MA at least at this point. It is not apples and apples. The sicker patients pick MA, and you need more resources, which means you need more revenue to manage them.

Mr. THOMPSON. Mr. Baker, same question.

Mr. BAKER [continuing]. I think, you know, the solution there is increasing and better risk adjustment for those folks rather than across the board subsidies or overpayments to Medicare Advantage Plans.

Once again, we look to the dual eligible special demonstration projects and others where risk adjustment certainly is a challenge, but you know, we cannot make the perfect the enemy of the good and need to keep on that continuum.

I think also the same holds true with the special needs plans. Rather than across the board and saying to plan, you know, "Here is a pot of money. Allocate it as you will or cross-subsidize your product lines," but rather in those product lines making sure that Medicare is paying the right reimbursement for the right payments, given their risk of incurring cost, and of course, those that are more vulnerable and sicker are going to have a higher risk and so there should be higher reimbursement for those folks and less reimbursement, in turn, for those that are healthier or, as was said earlier, going to the gym through the gym membership.

So that balance is always difficult to strike, and many plans are striking it on their own, and I think they have a partner now in CMS and trying to strike it, although, you know, there are going to be bumps along the way.

Mr. THOMPSON. Mr. Baker, to continue, if you could list three or four top ways that we could improve the MA program, what would be on your list?

Mr. BAKER. Well, I think, you know, better risk adjustment would be one of those, and continuing to enhance the star rating program and making sure that, you know, it is reflective of what consumers need to know. I think continuing to simplify and standardize plan products.

You know there has been a lot of talk about choice here, but we find that consumers are paralyzed even by, say, ten or 15 plan choices. So you know, with the average consumer now having 18 plans we just find that they are not able to kind of make an intel-

ligent choice because they are not having apples to apples comparisons. So further work there on simplification.

And then finally, some work on midyear provider changes. There have been some midyear provider changes that have really bumped people out of providers, and they are stuck in an MA plan where their provider no longer is contracting with. So that is another issue that we would like to work on.

Mr. THOMPSON. Thank you.

Chairman BRADY. Thank you.

Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

You know, one of the interesting things about sitting up here and watching you as you are watching us is watching your faces as each one is giving different testimony, and I think it would be a very interesting thing to do color commentary of congressional hearings because when Mr. Baker made the assertion that there is no evidence of trend toward less generous benefits and then sort of following that on with the inquiry from Dr. Price about the ability to absorb $3,700 and so forth, I just was looking at Mr. Wing. The expression that I saw, and these are my words and not your words, "Absorb what?" You know, like how much more capacity can you absorb?

So, Mr. Wing, my question is not to weigh in on my color commentary of congressional testimony, but that is to give some more insight. What I have heard today described are various levers, various tools that are pretty uniform across the witnesses. That is here is how this works. You can do higher costs. You can reduce benefits. You can shrink choices. You said we can vertically integrate and drive savings and so forth, but you also said something that I found interesting, and I did not quite pick it up.

Did you say that people with special needs are going to be uniquely impacted? Was it special needs or another word?

Mr. WING. It is special needs, frail populations, seniors with multiple chronic conditions, the duals. You know, when I take a look at our data, 14 percent of our members with five or more chronic conditions consume more than half of our in-patient confinements, and so accelerating the risk adjustment for the chronically ill as Medpac says, the risk adjustment for chronically ill members is not where it needs to be.

So economic incentives, we love taking care of the frail and the chronically ill, but the rest of the industry may not, and they have an economic incentive not to, and that is where we need to focus our efforts. The Medicare chart book says 62 percent of seniors with multiple chronic conditions were 92 percent of the total Medicare spent.

We have to be very careful about what we do, especially the impact to those seniors who have got four, five or six or more chronic conditions, and of those, if I may, 50 percent or more of them have got heart disease, which is probably not a surprise. Fifty percent or more have diabetes, which is not a surprise, but 50 percent of them or more are depressed, and they are probably depressed because they are so sick and they are not getting everything they need.

Mr. ROSKAM. So this trend, to pick up on one of the examples that Dr. Burnich used, you talked about trying to deal with the grandmother who is probably like Mr. Wing is describing. The grandmother who wants to go to her granddaughter's graduation, that type of patient with this cumulative nature of a lot of difficulties or special needs is going to be uniquely impacted, uniquely negatively impacted or hurt by this. Is that fair enough?

Dr. BURNICH. Yes.

Mr. WING. Yes.

Mr. ROSKAM. I yield back.

Chairman BRADY. Thank you.

Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman.

I want to thank all of our witnesses for taking the time today.

I am personally very concerned. In my district in Florida, my congressional district, we have over 54,000 on Medicare Advantage. In Florida alone, it is 1.4 million, over that, in Medicare Advantage. The State is growing back now at three, 400,000 people a year. I talked to a lot of medical providers, a lot of our doctors. Everybody is disillusioned with where we are at, and when you think about 10,000 a day turning 65 for the next 30 years, 400,000, a lot of them are coming to Florida. So I am very, very concerned about these cuts and the impact it will have on our seniors, especially when you look out over quite a few years.

Mr. Book, I wanted to ask you as it relates to the next year, what are the cuts and benefits anticipated that you mentioned earlier?

Dr. BOOK. Each Medicare Advantage Plan has a number of levers they can pull. They can increase premiums to patients. They can reduce copays or they can reduce benefits or they can narrow their networks.

Mr. BUCHANAN. Is there a percentage or a number?

Dr. BOOK. I do not have that.

Mr. BUCHANAN. Have you heard that number?

Dr. BOOK. I do not have specific numbers on what plans are actually doing. We can look that up and get back to you on that I am sure.

Mr. BUCHANAN. The bigger issue, looking down the road, because a lot of seniors might be 67, we have a lot of people staying active to 90.

Dr. BOOK. Right.

Mr. BUCHANAN. One of the things I am concerned at is looking over ten years, the Congressional Budget Office is saying over 300 billion in cuts. What is the impact to the providers and to our seniors, you know, all over the country, but especially in Florida with $300 billion in cuts?

Dr. BOOK. So that is cumulative cuts over ten years. Starting in 2017, that is going to be about $3,700 per patient on average. It is going to vary from place to place. You know, we have specific numbers for each country that I can share with you. The money has to come from somewhere. The only place it can come from is cutting benefits or making seniors pay more. Those are the only two choices. If you cut benefits, you know, they are not allowed to cut, you know, the most basic health care benefits, but they can cut everything else that they add on top of that.

So, for example, if you cut coordinated care or if you cut preventive care that is not affected by the preventive care mandate, you might end up increasing people's need for health care down the road. You might end up cutting one particular category but making you worse off.

Mr. BUCHANAN. Let me just move on.

Dr. Burnich, do you want to comment on that, the $300 billion in cuts over the next ten years, the impact? Let us say the medical community, the providers, I can just tell you a lot of people in our area are very disillusioned. A lot of doctors with practices for 30 years are being consolidated by hospitals. I am very concerned with the need going forward, with the anticipated cuts, but I would like to get it from your perspective.

Dr. BURNICH. It will diminish, as I said before, access. There will not be physicians to see unless they do concierge medicine where you pay an annual fee out of your own pocket. But this cohort of patients does not have that kind of money. So I do not see that it is sustainable.

The only place other than cutting benefits or increasing premiums to accessing real dollars is in the last six months of life, and it is in the very last month of life is where we spend all the money.

In our AIM Program, there is probably 30 percent that are Hospice eligible, but they choose not to go into Hospice for various reasons, emotional. They are not ready there yet, but when we get them to go into this program, and I cannot talk to you about the dollars yet because I am bound by CMMI not to do so, but they are significant, and I think they are significant enough at least in this populations, not all the MA lives, to provide some real savings to minimize those cuts.

Mr. BUCHANAN. One other question. My time is running out. Mr. Book, can you comment? We are seeing terminations in Medicare Advantage in our region. Is that because of the ACA or do you know?

Dr. BOOK. It is quite likely that it is. When payments are reduced, if a health plan does not think that they can attract patients and serve them well with the level of payment they are going to get, then they might just withdraw from the market instead of having a bunch of unsatisfied patients they cannot take proper care of.

Mr. BUCHANAN. That is what I am hearing.

Thank you, and I yield back.

Chairman BRADY. Thank you.

Mrs. Black, thank you for joining us today. You are recognized.

Mrs. BLACK. Thank you, Mr. Chairman, and thank you again for allowing me to sit in as a non-member. I am so interested in these issues, and I really appreciate your allowing me to be here.

I want to go back to the idea that Congressman Blumenauer talked about in the bill that we have to have a demonstration project, and I am just convinced that we need to look at this and make sure that it is what we have seen in our work, but to actually have the study to show that it does work.

So probably, Dr. Burnich, I would like to have you talk a little bit about what your thoughts are on such programs since you have had an innovation grant, which I understand was initiated under

MA. So if you could talk a little bit about whether you think this is something that is important.

Dr. BURNICH. I think any time we can focus on value and setting value, i.e., decreasing cost and improving quality by whatever method is the right directional approach, and I think that is what I gleaned from wherever you were headed.

Then it becomes so what costs are we talking about. That is where, you know, you get into the nitty-gritty, and that was the only piece I did not understand about what you were saying with your bill.

Mrs. BLACK. Well, the idea of this is to show that if we are able to incentivize people to use the kinds of care that the physician recommends, that they are going to have a better outcome, therefore less admissions to the hospital especially for our diabetic patients and our cardiac, as you have already talked about. If we can keep them on a regime, we know that they are going to use less services and the quality of life is going to be better.

Mr. Wing, would you like to weigh in on that as well since you are a care provider.

Mr. WING. You know, I think anything we can do with the system, with the providers, with the members to be more compliant with proven prevention that is going to reduce system cost and reduce and improve quality, like medication adherence for hypertensives, for diabetes, I applaud.

Mrs. BLACK. Mr. Book, do you have a thought on it as well?

Dr. BOOK. I admit I have not seen the bill yet, but it sounds like a good idea. One thing I would add is we talk about value based medicine. The fees in the fee-for-service system are not set based on value to the patient. In fact, they are based on a rather crude estimate of cost, and they specifically exclude any consideration of value to the patient.

So by definition they pay more for a high cost, low value service than a low cost, high value service, and I think that is one thing that drives up cost in the fee-for-service system and also drives patients and physicians away from low cost, high value services. It might be better for everybody if they did not have these perverse incentives caused by the fee-for-service pricing system.

Mrs. BLACK. I think you are making the point for my concept here.

I want to go back to the risk adjustment model. I know we have talked a lot about that, but I would like to know, and especially from you, Mr. Wing, and probably you, Dr. Burnich, as well, what you seek. Obviously we do have to take a look at these frail patients and make sure that we are reimbursing for the true care and the nature of taking care of that patient, but can you give me an idea about long term, what you think we should do about proper payment to be sure that we are taking care of these patients adequately and also making sure that we are reimbursing the care providers for the services that are provided?

Mr. Wing.

Mr. WING. Sure. Well, I think that one of our first recommendations, and it is from Medpac. Mark Miller consistently talks about the slowness of the HCC model to correctly and accurately address

members with chronic illnesses, and if we take a look at what is ailing America, it is seniors with multiple chronic conditions.

So I did a survey about the large national plans to just take a look at why are they not investing or are they investing in C–SNPs like SCAN, and they are all fine companies, but if you take a look at United or the Humanas, the WellPoints, the Signas, there is only one that has close to five percent of their membership, and this is as of March of this year, that are in chronic special needs plans, and that is United who bought XLHealth a couple of years ago.

I believe most of these plans are publicly traded. They are really smart people, but the economic incentives, because of the slowness of the agency model for chronically ill members is this is not good business.

We need an agency model to encourage all of us to go after those seniors with two, three, four, five, six or more chronic illnesses. That is where the 92 percent of the spending is.

Mrs. BLACK. Doctor?

Dr. BURNICH. I would agree with those statements.

The other thing, aside from risk is really understanding outcomes. You know, what is the output of the decisions and procedures and testing that are done by physicians with patients?

And our industry as a whole is very poor at longitudinal outcomes. We track more process metrics than anything. So when somebody gets coronary artery bypass grafting, do we know that it really gave them a better quality of life for the next X number of years or did they really live longer?

You know, one thing that I think has gotten abused, and there is literate to support it, was all of the stenting of patients. I actually got called down to the OR one day by my old chief resident who was the Chief of Surgery. He had the patient's chest open, and he said, "Jeff, take a look."

And I thought, you know, he was asking me one of these trick questions. He said what do I see, and I could not distinguish the coronary anatomy because there were 27 metal stents in this patient. So you know, that kind of overuse and abuse, we are not tracking that, and we have really got to get transparent with the output of what physicians do.

Mrs. BLACK. Absolutely. Transparency is a big part of this.

Thank you again, Mr. Chairman.

Chairman BRADY. Thank you.

I want to thank all of our witnesses for expert testimony today and for the detailed discussion of the current status and future of private health plans and Medicare.

Clearly significant cuts are on the horizon for the Medicare Advantage Program in 2015 and beyond, as Mr. Book analyzed, $3,700 per senior by 2017. Seniors have a right to be concerned about what will happen to the health care plan they depend upon?

I just remind any member wishing to submit a question for the record will have 14 days to do so, and if any questions are submitted to the witnesses, I ask that you respond in a timely manner.

With that, this Subcommittee—yes, sir.

Mr. MCDERMOTT. May I ask unanimous consent to enter in the record a GAO study entitled "Medicare Advantage Specialty Needs

Plans Are More Profitable on Average Than Plans Available to All Beneficiaries," an article from the paper which says, "Despite cuts, Medicare Advantage enrollment ensures stocks still surging," and three articles that say "Paul Ryan budget keeps Obama Medicare cuts Full Stop" from the Washington Post.

Thank you, Mr. Chairman.

Chairman BRADY. Since none of them relate to the issue, they will be inserted as submitted.

[The information follows:]

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Despite cuts, Medicare Advantage enrollment, insurers' stocks, still surging

By Paul Demko | April 5, 2014

Insurers want healthy seniors enrolling in their Advantage plans. (Photo taken at Leon Medical Centers' Healthy Living Center in Miami.)

Last October, EmblemHealth's Medicare Advantage HMO became the first Advantage plan in New York City to achieve a coveted four-star rating from the CMS.

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That was the result of four years of work to improve the HMO's quality measures, said John Kennedy, the for-profit insurer's vice president for direct-to-consumer sales. Now, if EmblemHealth officials notice that an enrollee with diabetes is overdue for blood tests, they'll reach out to the member and doctor to encourage them to schedule an appointment. "I think (members)

sense that the health plan is really concerned about their quality of care," Kennedy said.

The four-star rating (on a scale of 1–5) allows EmblemHealth to receive bonus payments from the CMS at a time of heightened rate pressure on **Medicare Advantage** plans. The bonuses typically amount to an increase of a couple of percentage points—$281 per enrollee in 2012, according to the Kaiser Family Foundation. That amount can make the difference between profit and loss in a narrow-margin business.

Despite widespread projections that **Medicare**'s reduced payments to Advantage plans mandated by the Patient Protection and Affordable Care Act would lead to enrollment reductions, private Medicare plans are booming. Currently, there are nearly 15.9 million seniors enrolled in Advantage plans, compared with 11.4 million in 2010, an increase of almost 40%. Nearly one-third of all Medicare beneficiaries now are enrolled in Advantage plans, with roughly two-thirds of them opting for HMO products.

The Congressional Budget Office projects Advantage enrollment will hit 21 million by 2023.

MH Takeaways

Defying predictions, Medicare Advantage enrollment continues to grow rapidly, benefiting the nation's large insurers most.

The growing significance of Advantage revenues helps explain why the insurance industry has fought so fiercely against proposed cuts to the program. In February, the CMS released proposed payment policies for 2015, with most analysts projecting the updated policies would lead to a 3% to 5% cut to health plans if enacted. The final 2015 payment policies will be released on April 7.

Despite the threat of cuts, insurers see Medicare Advantage as a very desirable business, given that the average Medicare payment per plan beneficiary is roughly

$10,000 a year, much higher than premiums in the under-65 market. Last year, the federal government spent $146 billion on the program, according to the **Medicare Payment Advisory Commission**. Per-beneficiary spending on Advantage enrollees remains 6% higher than in the traditional Medicare fee-for-service program.

The market is mostly dominated by large, publicly traded companies, though not-for-profit **Kaiser Permanente** is one of the leaders. **Humana** and **UnitedHealth Group** had roughly 6 million Advantage customers combined at the close of open enrollment for 2014.

More than 80% of Medicare beneficiaries around the country had access to a Humana Medicare plan, while nearly 70% had access to a UnitedHealth plan, according to the Kaiser Family Foundation. **Aetna**, **Cigna** and **WellPoint** combined have more than 2 million additional Advantage enrollees. Together, those five plans control more than half the Advantage market, while Kaiser Permanente has roughly 1.2 million Medicare enrollees. No other plan has more than 400,000 customers.

Many of these key players have boosted their market share in recent years through acquisitions. Humana President and CEO Bruce Broussard expected the trend toward consolidation to continue. “The barriers to entry are going up,” Broussard during an appearance last month at the Barclays Global Healthcare Conference. “I think the smaller plans will continue to be at a disadvantage over time.”

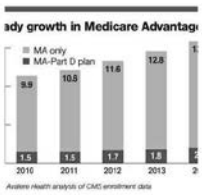
Humana's business is dominated by Medicare Advantage. In 2013, the company reported $27 billion in payments from the program, or two-thirds of its total revenues. That was up slightly from 2012, when 63.5% of revenues came from the Advantage program.

America's Health Insurance Plans has waged a vigorous lobbying and advertising campaign warning that the ACA-driven cuts will force plans to reduce benefits and hike out-of-pocket costs, including premiums and copayments. That's potent stuff in a congressional election year when seniors are expected to make up a disproportionate share of voters.

“When you introduce premiums to beneficiaries who are used to zero dollar premium products, or increase premiums in general, there are negative implications. Many Medicare beneficiaries are on fixed incomes, and any changes in premiums impact them,” said Fran Soistman, Aetna's executive vice president of government services. “So many of these Medicare beneficiaries are on fixed incomes.”

So far, though, there's little evidence that premiums have spiked as a result of spending reductions included in the ACA. The average monthly Advantage premium for 2014 is $49, according to the Kaiser Family Foundation, down from $51 in 2013. But caps on out-of-pocket costs have increased by more than 10% for 2014, to an average of $4,797.

To keep costs down, Advantage plans have moved to narrow their provider



networks. UnitedHealth sparked an uproar among seniors and physicians last fall when it sharply pared back its networks, which caused some customers to lose access to their doctors. That led to lawsuits in Connecticut and New York challenging the insurer's authority to terminate doctors without sufficient notice.

The payment reductions included in the ACA were designed to bring the per-beneficiary cost of the program in line with traditional Medicare and to help fund premium subsidies for consumers in the Obamacare insurance exchanges. In 2009, Medicare spent about 14% more on Advantage enrollees, according to MedPAC. It's projected that Advantage members still will cost 2% more in 2017, according to the Commonwealth Fund.

At the time of the ACA's passage, the CBO projected payment reductions would result in 7 million fewer seniors enrolling in Advantage plans by 2019. But the opposite happened. Demographics explain part of the big enrollment increase. Roughly 10,000 baby boomers are becoming eligible for Medicare every day, and that generation is accustomed to managed-care health plans with limited provider networks. Roughly half of all new Medicare beneficiaries are opting for Advantage plans.

Humana's 2014 enrollment growth was significantly greater than anticipated. The Louisville, Ky.-based company saw its Advantage membership increase by roughly 15% over 2013, to nearly 2.8 million, according to research and consulting firm Avalere Health. That was more than three times the growth rate for UnitedHealth, and it represented roughly a quarter of all new private Medicare enrollees. Humana declined to comment for this article.

But some analysts warn that growth isn't necessarily a sign of financial strength. In February, Citi Research downgraded Humana's stock to sell status. Its analysts cautioned that Humana seemed to have picked up many higher-risk, costlier beneficiaries in the Florida market who had been shed by UnitedHealth in its efforts to control costs by shrinking its networks. "Growing much faster than the rest of the industry rarely ends well in managed care," the analysts said.

UnitedHealth's decision to tighten its networks is a likely reason for Humana's enrollment boom, said Jay Wolfson, a professor at the University of South Florida. He agreed that Humana likely picked up many UnitedHealth refugees in Florida. "Many (seniors) decided that they wanted to change, either to remain with their physician or because they were angry with UnitedHealth and wanted out," Wolfson said.

Aetna's business doubles

Medicare Advantage insurers, 2013-1

	2013 ENROLLMENT	2014 ENROLLMENT
ealth Group	3,037,520	3,167,629
	2,422,958	2,797,121
oundation Health Plan	1,148,866	1,206,149
	827,753	1,091,406
nt	567,259	663,693
oup	442,355	455,744
es and Blue Shield of Michigan	298,163	357,152
rk Health	344,279	341,368
e Health Plans	250,983	339,818
lert	231,389	251,182

Avalere Health analysis of CMS enrollment data.

Aetna, Cigna and WellPoint's respective acquisitions have also strengthened their presence in the Advantage market. Aetna's Advantage business has more than doubled since its $5.7 billion acquisition of Coventry Health Care was completed last year. The Hartford, Conn.-based company now has more than 1 million Advantage enrollees.

Cigna completed its acquisition of HealthSpring for $3.8 billion in 2012, adding 340,000 Advantage enrollees. That has led to a tenfold increase in the Bloomfield Conn.-based company's Medicare business in the past three years. WellPoint's 2011 acquisition of CareMore Health Group bolstered its Advantage business in California, Arizona and Nevada, adding more than 50,000 customers.

In the next tier of competitors, WellCare Health Plans boosted enrollment by 35.4% in 2014. In January, the Tampa, Fla.-based company completed acquisition of Windsor Health Group, which added Advantage customers in four states. Last October, WellCare announced it was expanding plan offerings to Medicare beneficiaries in Arizona, California and Kentucky.

Some hospital systems also are eyeing the Medicare Advantage market. New York City's Mount Sinai Hospital recently announced that it will launch its own Advantage plan next year, and Wolfson said other providers are weighing similar moves.

But critics say that few hospital systems have the insurance expertise to succeed in running their own Advantage plans, and that they haven't done well with such endeavors in the past.

To boost payments, health plans have worked on improving their star ratings. Starting in 2015, only plans that receive at least four stars will be eligible for CMS bonuses. This year, 38% of Advantage plans received at least four stars, up from 28% in 2013, according to an analysis by HealthPocket, an online insurance broker. More than a third of Humana's Advantage plans received at least four stars in 2014, compared with 20% for UnitedHealth.

Health plans are warning of dire consequences if the CMS implements its proposed cuts when it announces its final 2015 rates on April 7. But the credibility of AHIP on the issue has been weakened by its previous inaccurate predictions about how rate reductions would undermine the Advantage program.

Further undercutting those warnings, investors have reacted bullishly since the CMS announced its proposed payment policy Feb. 21. The five publicly traded companies with the largest number of Advantage enrollees have seen their stock prices rise by at least 6% since then.

But Sheryl Skolnick, a managing director with CRT Capital Group who tracks insurance stocks, said she doesn't think the upbeat investor reaction necessarily shows that insurers are crying wolf. "It's almost as if Wall Street has willfully disregarded all of the warnings, which is never a smart thing to do," she said.

Follow Paul Demko on Twitter: @MHPDemko

Tags: Insurers, Medicare Advantage, Medicare, Payers

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 19, 2013

The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Medicare Advantage: Special Needs Plans Were More Profitable, on Average, than Plans Available to All Beneficiaries in 2011

Dear Mr. Levin:

In 2011, the federal government paid approximately $124 billion to Medicare Advantage (MA) organizations—entities that offer a private health plan alternative to Medicare fee-for-service (FFS). The private plans offered by MA organizations are generally available to all Medicare beneficiaries in the plans' service areas, although there are some MA plans with more specific eligibility requirements. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the establishment of special needs plans (SNP) that exclusively serve Medicare beneficiaries in one of three classes of special needs: (1) beneficiaries dually eligible for Medicaid, (2) beneficiaries with severe or disabling chronic conditions, or (3) institutionalized beneficiaries.[1] As of November 2011, approximately 1.4 million beneficiaries, or about 12 percent of all beneficiaries enrolled in MA, were in SNPs.

Medicare payments to SNPs tend to be higher than payments to other MA plans, in part, because the beneficiaries enrolled in SNPs are generally in poorer health and are expected to use more health services relative to enrollees in other MA plans. However, even after accounting for differences in relative health status, payments to SNPs were higher in 2011, on average, than payments to the average MA plan. The Medicare Payment Advisory Commission (MedPAC) reported in March 2011 that payments to SNPs for 2011 were projected to be, on average, 113 percent of FFS costs for a like set of beneficiaries enrolled in Medicare FFS. In contrast, the payments for all MA plans—including SNPs—were projected to be, on average, 110 percent of costs for a like set of beneficiaries enrolled in Medicare FFS.

Earlier this year, you asked us to provide information on how MA organizations' self-reported actual expenses and profits compared to their projections for all MA plans, including SNPs. To address this, we examined how MA organizations' actual expenses for 2011—the most recent year for which data were available at the time of your request—compared to the organizations' projections for the same year. This information will be contained in a forthcoming report.

You asked us to provide additional information about how SNPs allocated the payments they received to medical expenses, nonmedical expenses (such as marketing, sales, and administration), and profits, and how these allocations compared to those made by MA

[1]Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207(2003) (codified at 42 U.S.C. § 1395w-21(a)(2)(A)(ii)).

plans available to all beneficiaries.[2] In this report, we examined the extent to which actual expenses and profits in 2011 differed, if at all, between SNPs and MA plans available to all beneficiaries. On November 27, 2013, we presented our findings to committee staff (see enc. 1).

To report actual 2011 medical expenses, nonmedical expenses, and profits for SNPs and MA plans available to all beneficiaries, we analyzed 2013 bid data,[3] which MA organizations submitted to the Centers for Medicare & Medicaid Services (CMS) in 2012 and which include MA organizations' actual experience for 2011.[4] For our analyses of SNPs and plans available to all beneficiaries, we excluded (1) plans that were not included in both an MA organization's 2011 and 2013 bids;[5] (2) regional preferred provider organizations (PPO);[6] (3) plans that had values equal to zero for per member per month (PMPM) total revenue, PMPM medical expenses, PMPM nonmedical expenses, or total member months; and (4) Part D benefits.[7]

For our analyses of MA plans available to all beneficiaries, we also excluded (1) SNPs, (2) employer group plans,[8] and (3) plans with fewer than 24,000 member months (equivalent to 2,000 beneficiaries enrolled for a full year).[9] After all exclusions, our analysis of plans available to all beneficiaries included 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011.

For our analyses of SNPs, we also excluded (1) MA plans available to all Medicare beneficiaries, (2) employer group plans, and (3) SNPs with fewer than 24,000 member months. After all exclusions, our SNP analysis included 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011.

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[2]Profits refer to plans' remaining revenue after medical expenses and nonmedical expenses are paid. In certain circumstances, a plan may have a negative profit, meaning that the plan's revenue is less than its combined medical and nonmedical expenses.

[3]In some cases, plans available in 2011 were consolidated with other plans by 2013 or the plans were closed and the enrollees were expected to primarily be enrolled in other plans offered by the MA organizations in 2013. In either of these situations, MA organizations may have reported data in their 2013 bids that reflected the combined actual expenses and profits for more than one plan. The bid data were not structured in a way that allowed us to disaggregate the expenses and profits by plan in these cases. As a result, we assigned the expenses and profits reported on the bid to the plan that submitted the bid.

[4]CMS is the agency that administers the Medicare program.

[5]We used similar exclusions for this report and our forthcoming report on how MA organizations' actual and projected expenses and profits compared in 2011. We required plans to be included in both 2011 and 2013 bids to ensure that we had reliable data on MA organization's projected and actual expenses and profits for 2011.

[6]Beneficiaries in PPOs can see both in-network and out-of-network providers but pay higher cost-sharing amounts if they use out-of-network services. Regional PPOs serve state or multistate regions established by CMS. We excluded regional PPOs from our analysis because of differences in the way such plans are paid by Medicare.

[7]Medicare Part D provides coverage for outpatient prescription drugs to beneficiaries purchasing such coverage. MA plans may provide coverage for Medicare Part D benefits and bid separately to offer this coverage.

[8]Employer group plans are MA plans offered by employers or unions to their Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such plans.

[9]We excluded plans with fewer than 24,000 member months because CMS officials stated that they do not consider data from these plans to be fully credible.

To determine how SNPs and plans available to all beneficiaries allocated their revenues, we calculated enrollment-weighted profits, medical expenses, and nonmedical expenses. We examined the distribution of profit margins among SNPs and MA plans available to all beneficiaries. We also examined SNPs' profits and expenses by the type of SNP—dual-eligible SNP (D-SNP), chronic condition SNP (C-SNP), and institutional SNP (I-SNP). Using publicly available county-level MA enrollment and benchmark data from CMS, we stratified our analysis by whether a plan had a high or low enrollment-weighted average benchmark.[10] We defined an enrollment-weighted average benchmark as low if it was equal to or below the enrollment-weighted average benchmark for MA plans in our analysis that were available to all beneficiaries. Similarly, we defined an enrollment-weighted average benchmark as high if it was above that threshold. To determine whether differences between SNPs and plans available to all beneficiaries varied on the basis of plan characteristics, we stratified our analysis by plan type. Specifically, we compared SNPs and plans available to all beneficiaries that were health maintenance organizations (HMO) or PPOs.[11] We excluded private fee-for-service (PFFS) plans from this analysis because there are no SNPs with a PFFS plan type.[12] We also performed several analyses after excluding SNPs located in Puerto Rico. The MA market in Puerto Rico has some unusual characteristics, such as having benchmarks that are substantially higher relative to Medicare FFS than other areas of the United States.

The results we report are for 2011 and may not be representative of or generalizable to other years. We took several steps to ensure that the data used to produce this report were sufficiently reliable. Specifically, we assessed the reliability of the CMS data we used by reviewing our previous work on MA bids, examining data documentation, and analyzing the data for obvious errors. We determined that the data were sufficiently reliable for the purposes of our study.

We conducted this performance audit from November 2013 through December 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found that SNPs reported having higher profit margins and spending a lower percentage of total revenues on medical expenses, on average, than plans available to all beneficiaries in 2011. SNPs also had higher profit margins, on average, and reported spending a lower percentage of total revenues on medical expenses relative to plans available to all beneficiaries regardless of the type of SNP (D-SNP, C-SNP, or I-SNP); whether the plan had a high or low enrollment-weighted benchmark; or the type of plan (HMO or PPO).

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[10]A benchmark is the maximum amount Medicare will pay plans to serve an average beneficiary. Benchmarks vary on the basis of plans' service areas. CMS's publicly available county-level MA enrollment data do not include enrollment counts for counties in which a plan has 10 or fewer enrollees. Because of this exclusion, we used approximately 98 percent and 93 percent of our SNP population and population in plans available to all beneficiaries, respectively, to calculate benchmark weights.

[11]Beneficiaries in HMOs generally are restricted to seeing providers within a network.

[12]Beneficiaries enrolled in PFFS plans generally may see any provider that accepts the plan's payment terms; however, since 2011, these plans generally have been required to maintain a network of contracted providers, and beneficiaries that see out-of-network providers may pay higher cost-sharing amounts.

Agency Comments

We requested comments from CMS, but none were provided.

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As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, interested congressional committees, and others. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. In addition to the contact named below, individuals making key contributions to this report include Christine Brudevold, Assistant Director; Sandra George; Gregory Giusto; Brian O'Donnell; and Elizabeth T. Morrison.

Sincerely yours,

James Cosgrove
Director, Health Care

Enclosure

Enclosure

GAO

MEDICARE ADVANTAGE: Special Needs Plans Were More Profitable, on Average, than Plans Available to All Beneficiaries in 2011

Briefing to staff of the
House Committee on Ways and Means

November 27, 2013
(updated)

Page 1 For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov

Enclosure

GAO

Introduction

- In 2011, the federal government paid approximately $124 billion to Medicare Advantage (MA) organizations—entities that offer a private health plan alternative to Medicare fee-for-service (FFS).
- The health plans offered by MA organizations are generally available to all Medicare beneficiaries in the plans' service areas, although there are some MA plans with more specific eligibility requirements. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the establishment of special needs plans (SNP) that exclusively serve Medicare beneficiaries in one of three classes of special needs: (1) beneficiaries dually eligible for Medicaid, (2) beneficiaries with severe or disabling chronic conditions, or (3) institutionalized beneficiaries.[1]
- As of November 2011, approximately 1.4 million beneficiaries, or about 12 percent of all beneficiaries enrolled in MA, were enrolled in SNPs.

[1]Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207 (2003) (codified at 42 U.S.C. § 1395w-21(a)(2)(A)(ii)).

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Introduction (cont.)

- Medicare payments to SNPs tend to be higher than payments to other MA plans, in part, because beneficiaries enrolled in SNPs generally are in poorer health and are expected to use more health services relative to enrollees in other MA plans.
- However, even after accounting for differences in relative health status of beneficiaries enrolled in SNPs and in the average MA plan, payments to SNPs were higher in 2011, on average.
  - The Medicare Payment Advisory Commission (MedPAC) reported in March 2011 that payments to SNPs for 2011 were projected to be, on average, 113 percent of FFS costs for a like set of beneficiaries enrolled in Medicare FFS.
  - In contrast, the payment for all MA plans—including SNPs—was projected to be, on average, 110 percent of costs for a like set of beneficiaries enrolled in Medicare FFS.

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Introduction (cont.)

- At the time of your request for this work, little was known about how SNPs allocated the payments they received to medical expenses, nonmedical expenses, and profits,[2] or how these allocations compared to those made by MA plans available to all beneficiaries.

[2]Profits refer to plans' remaining revenue after medical expenses and nonmedical expenses are paid. In certain circumstances, a plan may have a negative profit, meaning that the plan's revenue is less than its combined medical and nonmedical expenses.

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Objective

This report examines the extent to which actual expenses and profits in 2011 differed, if at all, between SNPs and MA plans available to all beneficiaries.

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Scope and Methodology

- To report actual 2011 medical expenses, nonmedical expenses, and profits for SNPs and MA plans available to all beneficiaries, we analyzed 2013 bid data, which MA organizations submitted to the Centers for Medicare & Medicaid Services (CMS) in 2012 and which included MA organizations' actual experience for 2011.
- For both our analysis of SNPs and plans available to all beneficiaries, we excluded
  - plans that were not included in both an MA organization's 2011 and 2013 bids;
  - regional preferred provider organizations (PPO);[3]
  - plans that had values equal to zero for per member per month (PMPM) total revenue, PMPM medical expenses, PMPM nonmedical expenses, or total member months; and
  - Part D benefits.[4]

[3]Beneficiaries in PPOs can see both in-network and out-of-network providers but pay higher cost-sharing amounts if they use out-of-network services. Regional PPOs serve state or multistate regions established by CMS. We excluded regional PPOs from our analysis because of differences in the way such plans are paid by Medicare.

[4]Medicare Part D provides coverage for outpatient prescription drugs to beneficiaries purchasing such coverage. MA plans may provide coverage for Medicare Part D benefits and bid separately to offer this coverage.

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Scope and Methodology (cont.)

- For our analysis of plans available to all Medicare beneficiaries, we excluded
  - SNPs;
  - employer group plans;[5] and
  - plans with fewer than 24,000 member months (equivalent to 2,000 beneficiaries enrolled for a full year).
- After all exclusions, our analysis of MA plans available to all beneficiaries included 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011.

[5]Employer group plans are MA plans offered by employers or unions to their Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such plans.

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Scope and Methodology (cont.)

- For our analysis of SNPs, we excluded
  - MA plans available to all beneficiaries;
  - employer group plans; and
  - SNPs with fewer than 24,000 member months.
- After all exclusions, our SNP analysis included 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011.
- We examined the distribution of profit margins for SNPs and MA plans available to all beneficiaries.[6]
- We also examined SNPs' profits and expenses by the type of SNP—dual-eligible SNP (D-SNP), chronic condition SNP (C-SNP), and institutional SNP (I-SNP).

[6]Throughout the report, we calculate profit margins by dividing profits by total revenue.

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Scope and Methodology (cont.)

- Using CMS's publicly available county-level MA enrollment and benchmark data, we also stratified our analysis by whether a plan had a high or low enrollment-weighted average benchmark.
  - We defined an enrollment-weighted average benchmark as low if it was equal to or below the enrollment-weighted average benchmark for MA plans in our analysis that were available to all beneficiaries and as high if it was above that threshold.
- To determine whether differences between SNPs and plans available to all beneficiaries varied on the basis of plan characteristics, we stratified our analysis by plan type. Specifically, we compared SNPs and plans available to all beneficiaries that were health maintenance organizations (HMO) or PPOs. We excluded private fee-for-service (PFFS) plans from this analysis because there were no SNPs with a PFFS plan type.[7]
- We also performed several analyses after excluding SNPs located in Puerto Rico. The MA market in Puerto Rico has some unusual characteristics, such as having benchmarks that are substantially higher relative to Medicare FFS than other areas of the United States.

[7]Beneficiaries in HMOs generally are restricted to seeing providers within a network. Beneficiaries enrolled in PFFS plans generally may see any provider that accepts the plan's payment terms; however, since 2011, these plans generally have been required to maintain a network of contracted providers, and beneficiaries that see out-of-network providers may pay higher cost-sharing amounts.

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Scope and Methodology (cont.)

- The results we report are for 2011 and may not be representative of or generalizable to other years.
- We took several steps to ensure that the data we used were sufficiently reliable. Specifically, we assessed the reliability of the CMS data we used by reviewing our previous work on MA bids, examining data documentation, and examining the data for obvious errors. We determined that the data were sufficiently reliable for the purposes of our study.
- We conducted this performance audit from November 2013 through December 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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Background

- Payments for SNPs and MA plans available to all beneficiaries are based in part on the relationship between MA organizations' plan bids—their projection of the revenue required to provide beneficiaries with services that are covered under Medicare FFS—and a benchmark—the maximum amount Medicare will pay plans to serve an average beneficiary and which may vary based on plans' service areas.
  - If an MA organization's bid is higher than the benchmark, the organization must charge beneficiaries a premium to collect the amount by which the bid exceeds the benchmark.
  - If an MA organization's bid is lower than the benchmark, the organization receives the amount of the bid plus additional payments, known as rebates, equal to a percentage of the difference between the benchmark and the bid. MA organizations are required to use rebates to provide additional benefits, such as dental or vision services; reduce cost-sharing; reduce premiums; or some combination of the three.
- CMS adjusts payments to MA organizations to account for differences in projected and actual enrollment, beneficiary residence, and health status.

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Results

- SNPs had higher profit margins and reported spending a lower percentage of total revenues on medical expenses, on average, than MA plans available to all beneficiaries in 2011.
- SNPs also had higher profit margins and reported spending a lower percentage of total revenues on medical expenses relative to plans available to all beneficiaries regardless of
  - the type of SNP plan (dual-eligible, chronic condition, or institutional);
  - whether the plan had a high or low enrollment-weighted benchmark; or
  - the type of plan (HMO or PPO).

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SNPs were more profitable than MA plans available to all beneficiaries

Compared to plans available to all beneficiaries, SNPs had substantially higher profit margins and reported spending a lower percentage of total revenue on medical expenses.

SNPs received higher total revenue per beneficiary than plans available to all beneficiaries, which could be, in part, because beneficiaries enrolled in such plans may have greater health care needs (see table 1).

After excluding SNPs in Puerto Rico, the average profit margin for SNPs fell from 8.6 percent to 7.3 percent but remained substantially higher than the 4.6 percent average profit margin for plans available to all beneficiaries.

Table 1: Actual Expenses and Profits for Special Needs Plans and Plans Available to All Beneficiaries, 2011

	Special needs plans			Plans available to all beneficiaries		
	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)
Medical expenses	82.7%	$10,711	$10.5	86.4%	$8,579	$60.0
Nonmedical expenses	8.7	1,133	1.1	9.0	895	6.3
Profits	8.6	1,115	1.1	4.6	461	3.2
Total revenue		$12,959	$12.8		$9,934	$69.4

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. Medical expenses, nonmedical expenses, and profits may not equal total revenue due to rounding.

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SNPs were more profitable than MA plans available to all beneficiaries (cont.)

Twenty-three percent of beneficiaries enrolled in SNPs were in plans with profit margins of 15 percent or higher, while only 6 percent of beneficiaries enrolled in plans available to all beneficiaries were enrolled in plans with profits of 15 percent or higher (see table 2).

The median plan-level profit margin for SNPs was 7.1 percent, compared to 3.2 percent for plans available to all beneficiaries.

Table 2: Distribution of Profit Margins for Special Needs Plans (SNP) and Plans Available to All Beneficiaries, 2011

	Special needs plans			Plans available to all beneficiaries		
Profit margin	Number of beneficiaries in SNPs	Percentage of beneficiaries in SNPs	Cumulative percentage of beneficiaries in SNPs	Number of beneficiaries in plans available to all beneficiaries	Percentage of beneficiaries in plans available to all beneficiaries	Cumulative percentage of beneficiaries in plans available to all beneficiaries
≥ 15	229,607	23%	100%	444,284	6%	100
10 to <15	197,632	20	77	765,050	11	94
5 to <10	258,414	26	57	1,990,476	28	83
0 to <5	189,603	19	30	1,772,470	25	54
-5 to <0	54,362	6	11	1,431,968	20	29
< -5	55,135	6	6	585,442	8	8

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011.

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Dual-eligible, chronic condition, and institutional SNPs were more profitable, on average, than MA plans available to all beneficiaries

With average profit margins of at least 8.4 percent, all three types of SNPs had higher average profit margins than the 4.6 percent profit margin for plans available to all beneficiaries.

None of the three types of SNPs reported spending more than 82.9 percent of their total revenue on medical expenses, which is less than the 86.4 percent of total revenue that plans available to all beneficiaries spent, on average, for medical expenses (see table 3).

Table 3: Actual Expenses and Profits for Dual-Eligible, Chronic Condition, and Institutional Special Needs Plans, 2011

	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)
Dual-eligible special needs plans Beneficiaries = 904,483			
Medical expenses	82.9%	$10,585	$9.6
Nonmedical expenses	8.8	1,117	1.0
Profits	8.4	1,067	1.0
Total revenue		$12,770	$11.5
Chronic condition special needs plans Beneficiaries = 56,522			
Medical expenses	80.6%	$9,702	$0.5
Nonmedical expenses	9.8	1,182	0.1
Profits	9.6	1,149	0.1
Total revenue		$12,033	$0.7
Institutional special needs plans Beneficiaries = 23,748			
Medical expenses	80.1%	$17,928	$0.4
Nonmedical expenses	7.1	1,590	0.0
Profits	12.8	2,855	0.1
Total revenue		$22,372	$0.5

Source: GAO analysis of CMS data.

Note: The table includes 79 percent of the total 2011 Medicare Advantage dual-eligible SNP population; it includes approximately 30 percent of the total populations of chronic condition and institutional SNPs. In total, the table includes data from 121 SNPs, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. Medical expenses, nonmedical expenses, and profits may not equal total revenue due to rounding.

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SNPs were more profitable than MA plans available to all beneficiaries, regardless of high or low benchmarks

On average, SNPs had higher profit margins and reported spending a lower percentage of their total revenue on medical expenses in both high and low benchmark areas compared to plans available to all beneficiaries (see table 4).

After excluding SNPs in Puerto Rico, the average profit margin for low benchmark SNPs fell from 9.5 percent to 6.9 percent but remained substantially higher than the 3.5 percent average profit margin for plans available to all beneficiaries. The average profit margin remained the same for high benchmark SNPs after excluding SNPs in Puerto Rico.

Table 4: Actual Expenses and Profits for Special Needs Plans and Plans Available to All Beneficiaries by High or Low Benchmarks, 2011

	Special needs plans			Plans available to all beneficiaries		
	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)
High benchmarks		Beneficiaries = 400,224			Beneficiaries = 2,222,954	
Medical expenses	84.0%	$12,766	$5.1	85.1%	$9,807	21.8
Nonmedical expenses	8.4	1,274	0.5	8.3	961	2.1
Profits	7.6	1,162	0.5	6.5	749	1.7
Total revenue		$15,202	$6.1		$11,518	$25.6
Low benchmarks		Beneficiaries = 584,529			Beneficiaries = 4,766,736	
Medical expenses	81.5%	$9,305	5.4	87.1	8,006	38.2
Nonmedical expenses	9.1	1,036	0.6	9.4	864	4.1
Profits	9.5	1,082	0.6	3.5	326	1.6
Total revenue		$11,423	$6.7		$9,196	$43.8

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 691plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. We defined an enrollment-weighted average benchmark as low if it was equal to or below the weighted average benchmark for MA plans in our analysis that were available to all beneficiaries and as high if it was above that threshold. Percentages may not add to 100, and medical expenses, nonmedical expenses, and profits may not equal total revenue due to rounding.

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SNPs were more profitable than MA plans available to all beneficiaries, regardless of plan type

SNPs were predominantly HMOs.

For both HMOs and PPOs, SNPs, on average, had higher profit margins and reported spending a lower percentage of total revenue on medical expenses compared to plans available to all beneficiaries (see table 5).

After excluding SNPs in Puerto Rico, the average profit margin for HMO SNPs fell from 8.4 percent to 7.1 percent but remained substantially higher than the 5.4 percent average profit margin for HMOs available to all beneficiaries. The average profit margin remained the same for PPO SNPs after excluding SNPs in Puerto Rico.

Table 5: Actual Expenses and Profits for Special Needs Plans and Plans Available to All Beneficiaries by Type of Plan, 2011

	Special needs plans		Plans available to all beneficiaries	
	Percentage of revenue	Total (dollars in billions)	Percentage of revenue	Total (dollars in billions)
HMO	Beneficiaries = 958,488		Beneficiaries = 5,273,550	
Medical expenses	82.8%	$10.2	86.0%	$46.9
Nonmedical expenses	8.7	1.1	8.6	4.7
Profits	8.4	1.0	5.4	2.9
PPO	Beneficiaries = 26,266		Beneficiaries = 1,228,214	
Medical expenses	77.0	0.3	87.4	9.3
Nonmedical expenses	8.7	0.0	10.0	1.1
Profits	14.3	0.1	2.5	0.3

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 625 plans, which enrolled the equivalent of approximately 6.5 million beneficiaries—76 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. Percentages may not add to 100 due to rounding. Regional PPOs were excluded from the PPO category in this analysis because of differences in the way such plans are paid by Medicare. Private fee-for-service plans were excluded from our analysis because there are no special needs plans with a PFFS plan type.

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Paul Ryan's budget keeps Obama's Medicare cuts. Full stop.

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By Ezra Klein August 14, 2012 Follow @ezraklein

Since the Romney campaign wants to run against President Obama's cuts to Medicare, it's something of a problem for them that Paul Ryan's budget includes those very same cuts to Medicare. And so they've come up with a somewhat confused and confusing argument to distinguish the two plans.

Obama's cuts to Medicare are different because Ryan "keeps that money for Medicare to extend its solvency" while Obama uses it "to pay for a new risky program of his own that we call Obamacare."

Ryan's budget keeps Obama's Medicare cuts. (Joshua Roberts – Bloomberg)

This is basically a misunderstanding of how budgeting works. Or, at the least, it's predicated on the listener misunderstanding how budgeting works.

What they're doing is switching between two questions very quickly. The first question is: "How much money are you cutting from Medicare?" The second question is: "How much overall deficit reduction is contained in your plan?" And the second question isn't getting answered.

Here's what everyone agrees on: Ryan and Obama include the same cuts to the Medicare program itself. So if you're an insurance company participating in the Medicare Advantage program, you're getting the same cut no matter who wins the election. So the answer to the first question is, "the same amount as the Obama administration."

What Romney/Ryan are saying is that they then take the money saved from their cuts to Medicare and put it toward deficit reduction while Obama takes that money and spends it on health care for poor people. The

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argument here is that by using the money to cut the deficit, Romney/Ryan make future cuts to Medicare less likely.

But Romney/Ryan also add a trillion dollars to the defense budget. And they have trillions of dollars in tax cuts they haven't explained how they're going to pay for. So those decisions make future cuts to Medicare more likely. Meanwhile, Obama cuts defense spending by hundreds of billions of dollars, raises about $1.5 trillion in new taxes, and puts all that money into deficit reduction. So that makes future Medicare cuts less likely.

So if the argument is that Romney/Ryan protect Medicare by putting the $770 billion in cuts towards deficit reduction, Obama protects Medicare by twice as much by putting the $1.5 trillion in new tax revenues towards deficit reduction. So far as the deficit is concerned, there's no difference between a dollar from Medicare and a dollar from taxes.

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Which just leaves us where we began: Romney/Ryan want to do more of their deficit reduction by cutting social services while Obama wants to do more of his deficit reduction through raising taxes. Deciding whose plan makes more sense requires making judgments about whether Romney/Ryan will ultimately pay for their tax cuts. But deciding who is cutting Medicare by $700 billion just requires looking at who is cutting Medicare by $700 billion. And at the moment, that's both Obama and the Republican budget.

The Romney/Ryan campaign is aware of the difficulties in their argument, and so they've introduced a new wrinkle. They told Avik Roy, who also serves as a health adviser to the campaign, that "A Romney-Ryan Administration will restore the funding to Medicare." If that's true, then their budget math just got completely impossible, as I'll explain in a coming post.

Chairman BRADY. With that, the hearing is adjourned.
[Whereupon, at 11:35 a.m., the Subcommittee was adjourned.]
[Submissions for the Record follow:]

Alliance of Community Health Plans, ACHP

Statement for the Record
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
July 24, 2014

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to submit a statement for the record for a hearing on the Medicare Advantage program conducted by the Health Subcommittee of the House Ways and Means Committee.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations. ACHP members provide coverage and care for more than 18 million Americans in the commercial market, for newly insured families through the exchanges, and for Medicare, Medicaid, and federal, state, and local public employees. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. They share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

Summary

ACHP would like to bring two issues to the Committee's attention: First, a statutory cap on Medicare Advantage (MA) benchmarks that are used to set payment rates undermines an important Congressional policy decision that Medicare payment should promote high quality performance. We urge the Committee to amend the statute so that the benchmark cap does not act as a disincentive to achieving high quality care. Second, restrictions on Medicare payment for telehealth-based services increasingly limit the gains that beneficiaries could realize in maintenance of good health, treatment of disease, patient convenience and satisfaction, and access to care. The Committee should consider changes that would promote use of electronic technologies in Medicare.

Medicare Advantage Benchmark Cap

ACHP strongly supports the Medicare Advantage program. Our member plans provide coverage to 2.2 million Medicare beneficiaries –14 percent of enrollees in private health plans. Beneficiaries across the country are embracing the program. Contrary to projections, there has been a remarkable growth of about one million beneficiaries per year, so that MA now constitutes 30

1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org

percent of Medicare enrollment. Most observers believe that MA will continue to expand, as new retirees are more comfortable with a managed approach to their care. They are likely to be attracted as well to the idea of receiving services for a fixed monthly premium, rather than incurring the greater financial exposure of fee-for-service payments in the traditional program.

Congress adopted a policy change of great significance when it decided that Medicare should adopt value-based purchasing – or "pay for performance" – in the MA program. Building on the 5-star rating system, which had been developed to enable consumers to compare plans in their area, Congress authorized Quality Incentive Payments (QIP) to be made to MA plans at 4 stars and above. Congress has also authorized value-based payment in the fee-for-service segments of the program.

The 5-star rating system and the quality payments are based on widely accepted measures of clinical quality and patient satisfaction, with the addition of measures of customer service and compliance with CMS administrative requirements. This system is refreshed each year with modifications to measures, introduction of new measures, or the retirement of measures on which plans have achieved uniformly high levels of performance. The Quality Incentive Payment system has worked as Congress intended: performance has improved so that approximately half of all MA enrollees are now in plans rated at 4 stars and above. ACHP members have long been committed to quality as a core element of their mission, and 7 of the 11 Medicare 5-star plans nationally are ACHP members. Eighty-seven percent of Medicare enrollees in plans offered by ACHP members are in 4.5 and 5 star plans.

The capitated payments to MA plans are determined by calculating a benchmark level for every county and comparing the bids from each plan to the benchmark. If a plan is eligible for a quality payment, it essentially raises the benchmark by 5 percent. The additional revenue available to the 4-star plans and above must be used to increase the benefits to enrollees.

We think it is unlikely that Congress would want to undermine the important step it took towards value-based purchasing, but a separate provision of Medicare law could have that effect. In adopting a new system of calculating the county benchmarks, Congress mandated that benchmarks under the new methodology could not be greater than they would be if calculated under the old methodology. This is called the benchmark "cap." The crux of the problem that we want to call to your attention is that the new Quality Incentive Payments were included in the comparison of new v. old benchmarks for calculating the cap, even though they were not part of the old methodology.

The goal of reducing MA benchmarks to be more in line with local fee-for-service costs, as Congress mandated, is being achieved. However, *the benchmark cap, in some areas, reduces or even eliminates the quality payment made for achieving a rating of 4 stars or above*. As we noted,

because the quality payment is simply an increase in the benchmark, reducing the benchmark under the cap reduces or eliminates the increment achieved for a 4 star quality rating. In other words, the cap weakens the incentive to achieve 4 stars and go beyond that. We do not think that Congress intended to take away with one provision the significant policy change towards paying for value that it enacted in another provision.

The impact of the cap is felt particularly in rural counties and counties which received "floor" payments under the old methodology. Without going into details, these are counties that Congress previously determined would need a minimum payment level in order for MA plans to be viable in those areas. The impact on ACHP member plans is substantial. For example:

- Priority Health, based in Grand Rapids, MI expects a revenue loss of $28 million due to the revised benchmark calculation. Of that amount, $5.2 million, or 19 percent, is attributable to the effects of the cap. Further, of the $5.2 million reduction from the cap, Priority Health loses $4.2 million that it otherwise would have achieved for its rating as a 4.5 star Medicare plan. To reiterate, that loss is a loss in the value of benefits that Priority can offer to its beneficiaries.
- Security Health Plan, serving beneficiaries in Wisconsin, expects a revenue loss of $18.5 million due to the revised benchmark calculation. Of that amount, $7.6 million, or 41 percent, is attributable to the effects of the cap. Further, of that $7.6 million, Security loses $5.7 million that it otherwise would have achieved for its rating as a 4.5 star Medicare plan.
- Geisinger Health Plan, serving beneficiaries in Pennsylvania, expects a revenue loss of $32 million under the revised benchmark calculation. Of that amount, $14.3 million, or about 45 percent, represents the effects of the cap. And of that amount, Geisinger loses $8.6 million that it otherwise would have achieved as a 4.5 star plan and would have had available for benefits to Medicare enrollees.

The effects of the benchmark cap are exacerbated by the cumulative impact of a series of MA payment reductions mandated over the past several years. Reductions in the benchmarks, negative annual percentage updates to the capitated payment, significant negative adjustments for "coding intensity," and certain changes to the risk adjustment model all have a substantial effect on revenue available to provide benefits. MA plans are committed to reducing costs where they are able to do so, but the magnitude and cumulative effect of these Medicare policy changes put plans in the position of considering reductions in benefits, available plan options, and service areas.

ACHP urges the Committee to amend the statute in order to mitigate the negative effects of the benchmark cap and the inclusion of the Quality Incentive Payments in the calculation.

Telehealth-Based Services

The second issue we would raise for Committee consideration is Medicare coverage for telehealth-based services, which some refer to as remote access technologies. A combination of statutory and regulatory restrictions currently inhibits the use of these technologies in both the traditional Medicare program and in MA. We believe there would be a benefit to a Committee hearing and further study of the issue, with the goal of making appropriate changes that enable Medicare enrollees to benefit from significant new strides in the use of telehealth.

ACHP members and many other health plans increasingly utilize remote access mechanisms to provide clinical care and strengthen coordination of services across settings; these efforts are enhanced by our members' reliance on an electronic medical record. Health plans are using electronic visits, video technology, and remote monitoring to provide maintenance and preventive care for their enrollees, as well as diagnosis and treatment when it is clinically appropriate. Our members are finding very high enrollee satisfaction with this approach and no degradation in the quality of care; in fact, remote technologies provide the opportunity for improvements in the quality of care because they increase the amount of interaction between the patient and health care team and the information available on the patient's health status.

ACHP believes that the appropriate approach for Medicare is to consider remote access technologies to be an alternative modality or complementary means of providing clinical services, and not a service itself. *T elehealth is a different way of delivering an already covered service*, whether that is a physician visit or preventive service. In other words, telehealth should not be seen as simply a supplement or complement to face-to-face encounters. Patients increasingly expect their health plans to provide the access to services and convenience that remote technologies facilitate. State Medicaid programs have recognized the advantages of telehealth-based services, providing at least some level of reimbursement , particularly for real- time interactive video visits. Many states also require commercial health plans to provide reimbursement for services provided via telehealth, although not necessarily at parity with services provided in person.

A key question for Committee consideration is whether the Medicare statute limits covered services to those provided in a physical location or prohibits covering services when the provider is remote from the patient. Another question is the extent to which requirements for traditional Medicare apply to the MA program. We believe that the MA program provides an ideal environment for testing how Medicare enrollees can benefit from telehealth-based services, because the capitated MA payment provides no incentive for overutilization of services.

Dramatic changes in the use of visits via email and video link, clinical advice lines, remote consultation by specialists, electronic medical records, monitoring devices, and other aspects of telehealth hold the promise of improving access to and timeliness of needed care, increasing communication between providers and patients, enhancing care coordination, maintaining health and treating many medical conditions. ACHP urges the Committee to consider appropriate changes that will position Medicare as a leader in promoting innovative clinical approaches using remote access technologies; that leadership would have a substantial impact on the entire delivery system.

ACHP thanks the Committee for considering our views and would be happy to provide additional information on these issues.

American Federation of State, County and Municipal Employees, AFSCME

Statement for the Record
by the

American Federation of State, County and Municipal Employees (AFSCME)

for the Hearing
on the

Future of Medicare Advantage Health Plans

Before the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

July 24, 2014

American Federation of State, County and Municipal Employees, AFL-CIO
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Statement for the Record
by the
American Federation of State, County and Municipal Employees (AFSCME)
For the Hearing on the
Future of Medicare Advantage Health Plans
Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
July 24, 2014

This statement is submitted on behalf of the 1.6 million working and retiree members of the American Federation of State, County and Municipal Employees (AFSCME) for the hearing held July 24, 2014 on the status of private health plans in Medicare and the Affordable Care Act (ACA).

AFSCME is proud of labor's historic role in the creation of Medicare. Medicare provides what commercial health insurance companies did not, would not, and could not: affordable, adequate health coverage for America's elderly population regardless of income or health status. Before the enactment of Medicare in 1965, only half the population age 65 and older had health insurance and, those who did have coverage, paid close to triple what younger people paid for premiums and other out-of-pocket costs. For nearly 50 years, Medicare has helped generations of Americans to keep a foothold in the middle class as they age.

Despite the reasons for the establishment of Medicare, Congress has nonetheless allowed private insurance companies to offer Medicare beneficiaries insurance policies that replace the benefits Medicare provides. Insurers are paid by Medicare to provide these benefits. Since the 1980s Medicare's private insurance program has had several variations and has been called the Medicare Risk Program, Medicare+Choice and now Medicare Advantage (MA). By any name these are private insurance plans offered as a substitution for traditional Medicare. They are not a supplemental plan and do not have the guarantees inherent in traditional Medicare.

In calling for this hearing, Chairman Kevin Brady (R-TX) suggests that the ACA threatens private Medicare plans and the seniors who enroll in these plans. We are concerned that such claims distort facts and misinform seniors.

The Affordable Care Act protects seniors and Medicare from the worst abuses of private insurers.

In the years before the ACA, these private insurance companies preyed on seniors with abusive marketing and sales tactics, [1]were inefficient,[2] did not provide improved care to justify

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[1] State insurance departments, State Health Insurance Assistance Programs (SHIPs), and consumer advocacy organizations consistently reported that they received a disproportionately high number of complaints and found patterns of overly aggressive, deceptive and abusive marketing and sales practices related to Medicare private plans. National Association of Insurance Commissioners, Senior Issues Task Force, *White Paper on Regulation of Medicare Private Plans*

[2] *MedPAC Report to the Congress*, Glenn Hackbarth Testimony before the Subcommittee on Health, House Ways and Means Committee, March 11, 2008.

the excessive cost[3] and were largely unregulated. Extra payments to Medicare Advantage plans, enacted as part of the Medicare Modernization Act of 2003, were contributing to projections of future shortfalls in the HI Trust Fund as well as adding to the costs of Part B for both Medicare and its beneficiaries.

The year before the enactment of the ACA, MA plans were being paid on average $1.14 for what it would cost traditional Medicare $1.00 for the same beneficiaries. These extra payments put added strain on the Medicare trust fund and beneficiaries' budgets. In 2009, these extra payments meant an extra $1,280 per MA enrollee or $14 billion in higher aggregate payments from Medicare funds, and a couple with traditional Medicare paid $86 more in their Medicare premiums to fund these extra payments to insurance companies. From 2004 to 2009, these overpayments cost the Medicare program nearly $44 billion.

The ACA addresses these significant problems with the MA program and improves MA beneficiary protections.

- The ACA changed Medicare payments policies to reward high-value - not high-volume - care.
- The ACA changed how Medicare pays MA plans. It scaled back the overpayments and established polices so that the payments made to MA plans are close to payments and costs in traditional Medicare.
- The ACA makes changes to MA so that plan payments are done gradually and are phased in over nearly a decade so plans have time to adopt needed efficiencies.
- The ACA also forbids these private insurers from charging higher co-payments than traditional Medicare. This is particularly important to sicker beneficiaries.
- The ACA also stops MA plans from spending too much of premium dollars on overhead expenses, such as CEO salaries and perks, marketing, profits, administrative costs, and agent commissions. Insurers must use at least 85 cents out of every premium dollar to pay medical claims and provide activities that improve the quality of care.
- The ACA eliminates out-of-pocket costs for Medicare beneficiaries enrolled in MA plans or traditional Medicare for important preventive services, like mammograms, prostate cancer screenings, colonoscopies or key immunizations.
- The ACA sets up new initiatives to improve the quality of MA plans.

The ACA strengthens Medicare and improves beneficiaries' benefits.

With the ACA, seniors now have more affordable access to medications through Medicare Part D. Thanks to the ACA's required prescription drug discounts nearly 8 million people with Medicare have saved $10 billion on their medications. In 2021, the ACA ends the coverage gap for Medicare prescription drugs – known as the donut hole.

As mentioned previously, the ACA improved access to life-saving preventive services. Before the ACA, seniors had to pay part of the cost of recommended preventive screenings. This created a financial stumbling block for many seniors and prevented them from accessing key cancer screenings and immunizations. Now these and other preventive services have no

[3] Department of Health and Human Services, *The Medicare Advantage Program in 2014* (April 2014).

deductible or co-payment. Thanks to the ACA, some 37.2 million people with Medicare used at least one free preventive service last year.

Because of the ACA improvements affecting traditional Medicare and MA plans, the solvency of the Medicare Hospital Insurance Trust Fund has been extended by a decade, through 2026. And, many predict that the soon-to-be released 2014 Medicare Trustees Report will project additional years of solvency.

Medicare is an amazing success story and the ACA helps it to be even better for this and future generations.

Because of Medicare, older Americans have access to modern medicine no matter what their health status or individual income. Traditional Medicare's guaranteed benefits protect seniors and their families from financial ruin due to illness or injury. Now, many of the significant problems with the system's MA plans have been addressed by the ACA – making MA a better program for its participants and a better partner for Medicare. By curbing overpayments to insurers, the ACA is helping to rebuild fiscal solvency for the trust fund and has helped protect vulnerable beneficiaries from the predatory tactics of some insurance companies. The changes made by the ACA make Medicare stronger – both for current beneficiaries and for future generations.

Priority Health

Statement Submitted for the Record by
Michael P. Freed
President and CEO
Priority Health

Before the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Hearing on the Future of Medicare Advantage Plans
July 24, 2014

Statement for the Record
Submitted by Michael P. Freed, President & CEO, Priority Health

House Committee on Ways and Means
Subcommittee on Health

Hearing on the Future of Medicare Advantage Plans
July 24, 2014

On behalf of Priority Health, I would like to thank Chairman Brady, Ranking Member McDermott and Members of the Health Subcommittee for holding a hearing on the Future of Medicare Advantage. I am pleased to have the opportunity to submit this statement on behalf of Priority Health. My testimony will include background on Priority Health as part of the Spectrum Health System, examples of how we work with our provider network to deliver high value care to our member beneficiaries, and a few of our concerns about the impact of the Medicare Advantage (MA) payment methodology, particularly the impact of the "benchmark cap" on the MA Quality Improvement ("5 Star") program.

Priority Health is a Michigan-based non-profit health plan nationally recognized for improving the health and lives of its members. It continues to lead in engaging members in their health, delivering effective health and disease management programs and working with physicians to improve health care outcomes and performance. All of our Medicare Advantage plans have earned 4.5 stars from CMS for three consecutive years. Priority Health is one of only 20 health plans nationwide with wellness programs accredited by the National Committee for Quality Assurance, an organization that also rated our Medicare Advantage plans in the top 3% in the nation. Our portfolio of Medicare plans offers quality, affordable options to our more than 97,000 Michigan beneficiaries.

Priority Health is part of Spectrum Health System, the largest not-for-profit health care system in West Michigan. Our integrated health care system is dedicated to evidence-based, patient-centered medicine and patient safety. Together our quality is among the nation's best, while our costs are among the nation's lowest. Priority Health's premiums rank in the lowest quartile when benchmarked against regional competitors.

Priority Health understands that health optimization is foundational and requisite to ensuring that our valued beneficiaries live well. We offer services that advance quality care for our members and go above and beyond traditional Medicare Fee-for-Service (FFS) offerings.

Our core purpose of "Improving the health and lives of our members" is brought to life through our medical management programs and systems of care in partnership with our network providers. By transforming the care model and attacking chronic illness, we have demonstrated improvements in population health. Our sophisticated population analytics inform us of subpopulations in need of alternative approaches to care, to more effectively address their unique concerns. Our innovative approaches to transforming care include:

- Home-Based Primary Care - This innovative initiative brings the care team into the homes of our patients who are at the far end of the population health continuum - the advanced chronically ill – and whose multiple medical conditions are complicated by functional and/or cognitive limitations that make it difficult for them to adequately access traditional ambulatory care in a physician's office. We have changed not only how the patient accesses their care, but provided a team-based model of care to meet all the needs of the patient. This is a fundamentally transformative way of delivering care that provides powerful insight into the holistic needs of the patient. This program has served over 200 patients since inception and we are now scaling this program across our network.

- Post-Acute Care Transformation - As the Committee knows, Medicare's payment for services following hospitalization includes a great deal of waste, low-value care and, all too often, lack of coordination of services that result in readmissions. Across the health care landscape, post-acute care is responsible for the greatest degree of variation; a striking conclusion from the Institute of Medicine's[1] recent report on geographic variation in Medicare spending is that post-acute care is the largest driver of overall variation. The real impact of post-acute care reform lies in better coordination and improved evidence-based care. As a result, Priority Health is leveraging a predictive tool, in conjunction with clinical management and patient/family engagement, to ensure the right care in the right setting for the right amount of time. The results are optimized care and outcomes, reduced hospital re-admissions, and reduced avoidable skilled nursing rehab days. Additionally, performance metrics will promote greater clinical decision support to consumers, who will then be able to choose high performing skilled nursing settings based on quality and efficiency metrics—improving their engagement in the management of their care, and reducing the clinical and performance variability that is pervasive in this environment.

- Clinical Decision Support via Advanced Care Planning - Priority Health has been a leader in the advancement of the patient's voice regarding their goals, wishes, and preferences for care at the end of life. Our Plan Care Managers conducted a demonstration of this capability

[1] Newhouse JP, Garber AM. Geographic variation in Medicare services. N Engl J Med 2013;368:1465-1468

that was recently published in the Journal of Palliative and Supportive Care 'Telephonic advance care planning facilitated by health plan case managers'. Priority Health is working with, and providing incentives for, providers in our networks to promote this much needed conversation with our members, which in turn will promote a person-centered approach to health care decision making that respects the goals, wishes and preferences of our members for end of life care.

- Care Management (CM) competency and alignment with our providers - Although modern medicine has generated evidence-based treatment protocols that have eradicated illness and prolonged life expectancy, far too many people still struggle to live well with complex illness, often complicated by the social determinants of health. We are aligning our CM teams with Accountable Care Networks to build relationships and patient-centered plans of care that are transparent at all touch points. We are engaging our network partners in the design of the ideal model of care, sharing tools and resources to optimize the care experience, and collaborating in the development of a common care plan utilizing common technology platforms. This collaborative approach will permit excellence in care management across all settings and eliminate duplication and/or redundancy, while allowing CM to scale their solution to reach a larger percentage of patients in need.

A critical component in driving clinical value with our network of providers is through better economic alignment. We are transforming the care model by paying for value instead of volume (pay for value), which aligns the payer/provider relationship to advance this new equation. By promoting best practices and identifying waste in the system, we are working together to develop patient management innovations that create value in clinical care and drive quality outcomes at lower cost.

When Congress authorized Quality Incentive Payments for Medicare Advantage plans with 4 stars and above, it created a significant incentive for plans like Priority Health to further invest in the innovative approaches to care delivery and payer/provider alignment that have been critical to advancing care model transformation, much as it is attempting to do in the fee-for-service Medicare program. When an MA plan becomes eligible for a Quality Incentive Payment it can result in a 5% increase to their benchmark, thus incentivizing plans (and their provider partners) to continue to develop programs that result in improved care quality.

Congress also authorized a new methodology for calculating benchmarks, mandating that the benchmarks cannot be greater than what they would have been under the old benchmark methodology (thus creating a "cap"). Unfortunately these two policies are increasingly at odds, with the result that plans' quality incentive payments are being eroded by the cap. The reduction in quality inventive payments makes it more difficult to (1) pass those savings on to our members in the form of lower premiums, (2) to provide more robust benefits and most importantly, (3) to

enhance our ability to make investments in innovations resulting in higher quality care. We don't believe Congress intended the benchmark cap to act as a disincentive to achieving high quality care but that is now increasingly the effect.

We are concerned that the cap on the benchmarks to pre-ACA levels fails to recognize efforts to advance quality. We estimate that almost 60% of the counties in our service area are being capped and that over 25% of the counties in our service area will have no difference in benchmarks between a 5 star plan and a 2.5 star plan. As this is an issue that will be more regional in nature, it will have a more significant impact and cause greater uncertainty for smaller, state-based regional plans than national carriers, and may be more likely to cause disruption in rural areas where options are already limited for members.

Medicare Advantage plans have become a valued choice for beneficiaries. The steady rise in the percentage of beneficiaries that choose an MA plan year after year is evidence that these plans offer attractive, affordable, and high quality benefits. As the Baby Boomer generation ages into Medicare, MA plans will continue to experience significant growth. This generation is better acquainted with the benefits of managed care and has a higher propensity to choose an MA plan. They understand the benefit of having case and disease management, wellness, preventive care, coordination of care and added services like dental and vision care that are unavailable with traditional Medicare.

Medicare Advantage has also put in place incentives that drive quality outcomes by rewarding alignment between provider and plan. By working towards healthier outcomes, reducing costs, increasing satisfaction and promoting quality, MA plans will become the preferred plan of beneficiaries.

We hope this statement provides some valuable feedback on the impact that Medicare payment policy has on our ability to continue to invest in the innovative programs that are transforming the care model, improving care quality, and bolstering the long-term sustainability of both regional health plans like Priority Health and the entire health system. Thank you and we look forward to working together toward the continued advancement of improved care and better value for Medicare beneficiaries.

Senior Whole Health, SWH

Statement Submitted for the Record by
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Chief Executive Officer
Senior Whole Health

Before the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Hearing on the Future of Medicare Advantage Health Plans
July 24, 2014

Statement of Wayne Lowell, CEO, Senior Whole Health

House Committee on Ways and Means
Subcommittee on Health

Hearing on the Future of Medicare Advantage Health Plans
July 24, 2014

On behalf of Senior Whole Health, I would like to thank Chairman Kevin Brady, Ranking Member Jim McDermott, and Members of the Health Subcommittee for holding a hearing on the Future of Medicare Advantage Health Plans and for the opportunity to submit testimony on this important topic. My written testimony will describe the impact of the health insurance fee, certain reductions in Medicare Advantage reimbursement that have been made, and the effect these policies will have on our ability to continue offering the full breadth of critical services to Medicare – and in some cases, Medicaid – enrollees.

Senior Whole Health is a Full-Integrated Dual Eligible Special Needs Plan (FIDESNP). We offer individualized, specialized, and vital services to Medicare and Medicaid beneficiaries with the greatest health needs and least financial and societal resources. Our services ensure that thousands of beneficiaries are able to access and receive the care they need with a focus on community and home care needs to avoid institutionalization This is what our members and their families want and we coordinate both the Medicare and Medicaid benefits on their behalf.

This whole-person, community-centered approach to care also saves money for the States where we provide these services. By providing in-home, preventative, and person-centered services, thousands of our enrollees are able to remain in their homes where they and their families want them to be. By keeping these people in their homes, the Commonwealth of

Massachusetts alone has realized savings of approximately $170 million per year, because the State is able to forego the high cost of institutionalized care in a large number of cases. We know this model can and should be replicated across more states – but existing and upcoming policy changes to the Medicare Advantage program may hurt the expansion of these efforts.

There are a few concerns that we have about policies that are affecting these programs:

1. The impact of the health insurance tax established under section 9010 of the Affordable Care Act (ACA); and
2. Reductions in the base Medicare Advantage rate.

Insurance Fee

Senior Whole Health is fully subject to the health insurance tax established under section 9010 of the Affordable Care Act (ACA). Section 9010 of the ACA imposes a new tax on health insurance issuers, with the amount of the tax to be determined based on the issuer's share of net applicable premiums written for health insurance in the United States by applicable issuers in a given year. The first year's tax payment is due to the Internal Revenue Service by September 30, 2014. Other Medicare Advantage plans, including non-profit Special Needs Plains (SNPs), were carved out under the ACA. Senior Whole Health – as a tax-paying organization – remains liable for the **entirety** of the added fee. Additionally, we, as a FIDESNP, do not and cannot charge our beneficiaries a premium. As such, we have no ability to recover this extra cost. At the same time, we cannot adjust benefits to account for the fee, as other plans may, because the majority of benefits we offer are required by law. At the same time, 100% of our revenue is derived from participation in the Medicare and Medicaid programs. While we believe this should afford us some degree of relief from the health insurance tax, the

statute does not permit us to be excluded – exclusively based on our tax-paying status. This also means that we have no private source of income to counterbalance the impact of persistent and often unpredictable statutory and regulatory payment reductions.

We strongly encourage the Committee to repeal this health insurance tax. At a minimum we ask that SNPs receiving 80% or more of their revenue from government programs be treated the same, regardless of our income tax-paying status. This would treat Senior Whole Health the same as entities exempted in Section 9010(c)(2)(C) of the Affordable Care Act. In its current form, this tax is only raising the costs of coverage for many Americans, including those who are very poor and very vulnerable and need the services provided.

Medicare Advantage Reductions

In the Centers for Medicare & Medicaid Services' (CMS) final 2015 call letter, the Agency implemented regulatory updates to payments for Medicare Advantage plans that resulted in an effective rate cut of roughly 2.5% for contract year (CY) 2015. In light of existing and upcoming policies that will significantly add to our costs over the coming years, such as the health insurance tax, these regulatory cuts are increasingly difficult for Senior Whole Health.

These are not the only ways in which we are severely disadvantaged. Findings from a Milliman study indicate that, as a result of recent rate changes, Medicare Advantage plans overall are being paid roughly two percent less than fee-for-service (FFS) for high-risk/high-need beneficiaries, including dual eligibles. Given that our enrollees are, by definition, high-risk/high-need beneficiaries, this disparity disproportionately impacts Senior Whole Health, as compared to the average Medicare Advantage plan. We expect this disparity will persist – if not worsen – under the CY 2015 regulations.

Conclusion

For Senior Whole Health, the simultaneous implementation of these policies means that Senior Whole Health and its enrollees cannot sustain any further cuts without jeopardizing access to the care that our beneficiaries have come to rely on for their health, well-being, and quality of life.

We have encouraged Congress to repeal the health insurance tax – especially as a result of its impact on FIDESNPs. We cannot charge or increase premiums, we cannot reduce benefits, and we do not have private income to supplement the losses we are facing in the coming years. We again urge Congress to act on this proposal to ensure that we can continue providing quality, cost-effective, and critical services to the Medicare and Medicaid beneficiaries that rely on us.

We also encourage CMS to ensure that all Medicare Advantage plans are paid no less than FFS rates for duals and other high-risk beneficiaries. Implementing such equity in rates would have a meaningful impact for SNPs – especially for Senior Whole Health, as we undertake the difficult task of balancing the ACA's health insurance fee with our limitations on adjusting premiums or benefits.

We hope that this testimony provides insight into the impact that recently implemented and upcoming Medicare Advantage payment policies have on our ability to continue providing access to the critical services our beneficiaries rely on. Thank you and we look forward to working with all Members on these important issues.