

EXAMINATION OF THE MEDICARE ADVANTAGE PROGRAM

HEARING BEFORE THE COMMITTEE ON FINANCE UNITED STATES SENATE ONE HUNDRED TENTH CONGRESS FIRST SESSION

APRIL 11, 2007



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EXAMINATION OF THE MEDICARE ADVANTAGE PROGRAM

WEDNESDAY, APRIL 11, 2007

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:02 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Kerry, Lincoln, Wyden, Stabenow, Cantwell, Salazar, Grassley, Hatch, Snowe, Thomas, Crapo, and Roberts.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order. I want to welcome everybody to today's hearing.

Medicare did not have any private plans when it first started in 1965, but in the early 1970s, Congress began down a path that would allow private plans to play a large role in Medicare. The goal was to offer choices that could improve the health of beneficiaries and reduce their out-of-pocket costs, while saving Medicare money. The vision was a promise of integrated and efficient health plans providing high-quality, comprehensive care to consumers.

Here we sit some 30 years later, and it is time to take stock of where we are. Congress has been lax in its oversight of how private plans are working for Medicare beneficiaries, and we are here to change that.

One of the questions I hope that we will all keep in mind today is whether the promise of efficient and effective managed care has been realized. Do plans coordinate care? Do they improve the health of their enrollees? And do they lower health care costs? Do they add value to the program? And are they worth what we are paying?

My understanding of Medicare Advantage is that it has had a long, but rocky history. Until 1993, enrollment in Medicare private plans was largely stagnant; then it tripled from 1993 to 1997. In an effort to define the role of private plans in Medicare, Congress then created the Medicare+Choice program in the Balanced Budget Act of 1997.

At that time, the Congressional Budget Office projected that nearly one-third of all people with Medicare would enroll in private plans.

But the new law's effect was the opposite of what Congress intended: plans dramatically reduced their service areas, and some plans left the program altogether. Enrollment and plan access declined significantly.

In 2003, Congress acted to stabilize and revive Medicare+Choice through the Medicare Modernization Act. I supported that act because it provided a prescription drug benefit, which I thought was long overdue. That act also added much-needed resources for rural providers, and I also supported the MMA because of the provisions to stem the rapid decline in Medicare+Choice.

The Medicare Modernization Act renamed Medicare+Choice Medicare Advantage. It increased Medicare Advantage payment rates across the country. It also allowed new types of Medicare Advantage plans to enter the program—that is, regional preferred provider organizations and special needs plans.

Seniors who enroll in MA plans may be able to receive extra benefits that the traditional Medicare program does not provide. For example, they could receive lower copayments for doctor visits, better coverage of prescription drugs, vision care, and gym memberships. These extra benefits vary widely. MA plans often do not charge a premium for these additional benefits.

Over the last 3 years, there has been explosive growth in the number of plans and the number of beneficiaries choosing them. Today, beneficiaries in every part of the country have access to at least one Medicare Advantage plan. Nearly one in five Medicare beneficiaries gets care through a private plan rather than the traditional fee-for-service program. Four years ago this number was one in ten.

In my home State of Montana, about one in ten Medicare beneficiaries has opted for Medicare Advantage. Most of them receive benefits through a “private fee-for-service plan” rather than an HMO. That means 89 percent of Montana beneficiaries remain in traditional Medicare, and I suspect that that percentage is comparable to the percentage participation in other rural States. The vast majority are happy with the program, and we can never lose sight of their needs as well.

The recent changes we have seen in the Medicare Advantage program have touched millions of beneficiaries. But they are not without controversy. MedPAC and CBO tell us that, on average, plans are paid 12 percent more than fee-for-service. This difference varies significantly by plan and by region of the country.

For several years, MedPAC has recommended that Congress set payment for plans equal to fee-for-service. The Congressional Budget Office estimates that such a policy could generate a significant savings, that is, \$54 billion over 5 years, and \$149 billion over 10 years. Paying Medicare Advantage plans at fee-for-service rates could, however, also result in many plans leaving the program and mass disruptions to beneficiaries yet again.

Plans can provide services that traditional Medicare does not cover—such as calls or visits from nurse practitioners to help beneficiaries manage chronic illness. Plans can coordinate care across providers to improve patient health outcomes and lower costs. We are here today to find out if they really do, and if these strategies really do lower health care costs.

We will hear more on these points from our witnesses, but I want to emphasize this hearing is not simply about payment or extra benefits. Plans have the potential—and the resources—to do more than just receive Medicare payment and pay providers.

In order for Congress to assess the impact of such proposals, it needs more information about how specific geographic areas would be affected. I cannot stress enough how important it is for Congress to have accurate, timely data from its congressional support agencies. Often, national data are all that we need, but in this case, we need a more detailed or disaggregated picture.

Our job today will be to listen, ask questions, and learn so that we can decide whether Medicare Advantage brings value to beneficiaries and to American taxpayers.

Again, I thank our panelists for coming today.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Before I thank you and all that sort of stuff, I want to bring emphasis, before I forget it, to something you just said, because it takes us back to the days when you and I were sitting through 2 or 3 months of negotiating with the House of Representatives, and one of my goals that you were a part of was to do just what you said here to make sure that we got plans all over the country. And we succeeded in doing that because I know, except in one of the 99 counties in Iowa—the one county that had it was Pottawattamie across from Omaha; they were in a Medicare Advantage—the other 98 counties did not have it. And one of the things that I was intent upon doing and we got done was to make sure that throughout the country people had the same choice in Montana and Iowa as they had in California, Washington, Oregon, Texas, New York, New Jersey, Florida, States like that. And we got it done. So thank you for bringing that to my attention, and I wanted to emphasize that, because we do have that choice for Medicare Advantage now for people all over the country. And that is a matter of fairness.

Well, it is very important that you do hold this hearing, and I am glad this hearing is called, so I thank you.

As Chairman Baucus has said, health plans have served Medicare beneficiaries for a long time, going way back to the 1970s. But until not long ago, only beneficiaries in urban areas had health plan choices. I often heard from Medicare beneficiaries in my own State, “How come I do not have the same type of choices that they have in Florida, New York, and Pennsylvania?” They would ask, “Why can’t I have the choice that would give me additional benefits?” They were learning about getting health club memberships. They were learning about getting eyeglasses, et cetera, and even lower costs in the process, and they wanted a part of that. I am sure that other members of the Committee heard the same from people in their State.

In large part, low payments were the primary reason that choice was either limited or non-existent in rural parts of the country. These payments, as we all know, are set on a county-by-county basis. A decade ago, before the Balanced Budget Act of 1997, the

highest-paying county was more than 3 times greater than the lowest-paying county. Beginning with the Balanced Budget Act of 1997, Congress took a number of actions—actions that had support from members on both sides of the aisle—to reduce that disparity in payment and to promote availability of health plan choices.

As I indicated in my comment to Senator Baucus, he and I worked during the conference committee to do that. At that hearing we received a letter that I am going to ask to be put in the record, signed by 18, 19, 20 Senators, something like that, members of this Committee—John Kerry, Senator Smith, Senator Bunning, Senator Schumer, Senator Wyden, Senator Cantwell—wanting to make sure that we improve payments in that.

It said here, “We are writing to ask you, as a member of the Medicare conference committee, to ensure that the final Medicare bill includes a meaningful increase in Medicare+Choice funding. . . . While the Senate bill makes a modest step toward this goal, we hope that the stronger provisions in the House bill will be preserved in conference.”

The CHAIRMAN. Without objection, it will be included.

[The letter appears in the appendix on p. 55.]

Senator GRASSLEY. This prescription drug bill included these provisions, the increased funding as well. And so today beneficiaries across the Nation have health plan choices. Beneficiaries can choose among plans that provide additional preventive benefits, such as cancer screening, physical exams. Beneficiaries can choose a plan that lowers their cost sharing compared to fee-for-service, and they can choose plans that have catastrophic caps on their out-of-pockets. And just to be clear, there is no catastrophic cap in fee-for-service Medicare. So that means that beneficiaries in traditional Medicare face potentially unlimited liabilities for the health care costs.

According to CMS, the average value of these additional benefits through Medicare Advantage is \$86 a month, but many plans offer these additional benefits for no additional premium or maybe a small additional premium. For a beneficiary living on a fixed income, that protection from catastrophic costs can bring great peace of mind. These and other facts about the Medicare Advantage program are laid out clearly in a document called “The Facts: Medicare Advantage,” and I would ask that that document also be included in the record.

The CHAIRMAN. Without objection.

[The document appears in the appendix on p. 57.]

Senator GRASSLEY. Studies also have shown that in many cases Medicare Advantage plans outperform traditional Medicare on a number of quality measures, including delivery of preventive services such as immunizations, and, during deliberation of that 2003 act, there was a lot of interest in trying to promote better coordination of beneficiaries’ care. Medicare Advantage plans have this capacity. Plans have special programs for beneficiaries with chronic illnesses, such as diabetes and congestive heart failure, and I am looking forward to hearing from our witnesses on the type of care coordination services that can be offered. All of these improvements are the benefits that we often cite as much needed improvements, and we already have those in Medicare Advantage.

Now, I know some folks want to compare spending in the traditional fee-for-service program to payments of Medicare Advantage. They then want to equalize Medicare Advantage to fee-for-service spending, and we are going to hear from Mr. Hackbarth from MedPAC about this. That sounds like an easy thing to do, but I do not think that it is as simple as it seems. That is a very precise instrument.

It would undo policies supported by members on both sides of the aisle to promote availability of Medicare coverage choices, especially for beneficiaries in rural areas. Beneficiaries now have choices that can provide them with lower out-of-pocket costs and benefits not otherwise available in traditional Medicare.

Medicare Advantage plans can better coordinate the beneficiaries' health care, and that leads to better outcomes. We should be doing everything we can to offer beneficiaries better Medicare choices, not eliminating or cutting them back.

Now, I have been watching these programs unfold since 2003. I know that there has been a lot of growth, particularly in private fee-for-service plans and special needs plans. So I would not be one to say that we should not take a close look at how this program is evolving. In fact, we should. Like many things we do in Congress, this is a work in progress. Improvements can always be made, and we should be working to do that. But we do need to be careful and deliberate in how we do it and understand how the program is changing. This will help better inform any discussions that may occur about the need for further change.

Thank you, Mr. Chairman.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Thank you, Senator, very much.

Now I would like to welcome our panel. First we will hear from Dr. Peter Orszag, Director of the Congressional Budget Office; second, Mr. Glenn Hackbarth, the Chairman of the Medicare Payment Advisory Commission (MedPAC); third, Dr. Debra Draper, who is the associate director, Center for Studying Health System Change; and, fourth, Dr. Steven Udvarhelyi, senior vice president and chief medical officer for Independence Blue Cross.

Dr. Orszag, why don't you begin? I might urge you all to stay to 5 minutes, and your full statements will be included.

**STATEMENT OF DR. PETER R. ORSZAG, DIRECTOR,
CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC**

Dr. ORSZAG. Mr. Chairman, Senator Grassley, members of the committee, thank you for having me in this morning to discuss the Medicare Advantage program. My testimony makes four basic points.

First, as has already been noted, Medicare Advantage plans are growing rapidly. In 2004, they accounted for 13 percent of Medicare enrollment. They are now up to 19 percent of enrollment, and CBO projects that by 2017, under current law, they will hit 26 percent of Medicare beneficiaries. That projected increase is driven largely by CBO's expectation of continuing rapid growth in private fee-for-service plans within the Medicare Advantage program. Private fee-for-service plans added almost 500,000 beneficiaries in January

2007 alone, and CBO projects that enrollment in such plans will reach 5 million members by 2017. Almost all of that projected increase from today is accounted for by private fee-for-service plans.

The second point is that Medicare's payments to beneficiaries enrolled in Medicare Advantage plans are higher on average than what the program would spend if those beneficiaries were in the traditional fee-for-service part of the program. As a result, shifts in enrollment out of fee-for-service and into Medicare Advantage increase net Medicare spending and increase Part B premiums for all beneficiaries and also somewhat adversely affect Part A trust fund financing.

For 2007, CBO calculates that benchmarks will be 17 percent higher on average than projected per capita fee-for-service costs nationwide. Net payments to plans, which are reduced by a quarter of that differential of that 17 percent, are thus expected to be approximately 12 percent higher than local fee-for-service costs this year across the Nation on average. CBO's estimates are basically in line with MedPAC's estimates.

I would also note that that 12-percent differential is greater for private fee-for-service plans than for other types of Medicare Advantage plans, and the continuing growth in private fee-for-service plans is likely to put some upward pressure on that differential in coming years.

My third point is that the cost differential underscores a number of policy options that would reduce Medicare spending. For example, in my testimony I provide you with the figures for reducing payments to Medicare Advantage plans to 100 percent of local fee-for-service costs, which, as has already been noted, would reduce Medicare spending by \$54 billion over the next 5 years and \$150 billion over the next 10 years.

Those cost reductions and the lower payments to Medicare Advantage plans would reduce the ability of Medicare Advantage plans to offer supplemental benefits and reduce premiums to beneficiaries and, as a result, lead both some plans to withdraw from the market and beneficiaries not to take up the benefit that might be offered. As a result, by CBO's estimates, enacting this policy would reduce enrollment in Medicare Advantage by about 6.2 million beneficiaries in 2012, which is about 50 percent of projected enrollment at that time.

I do want to emphasize there has been some confusion about that figure. It is not 50 percent lower than today. It is 50 percent lower than in 2012, the projected level. So basically it is sort of taking away the projected growth, plus a little bit, instead of reducing by half relative to today.

Other options are also possible. We provide estimates for reducing local benchmarks to 110 or 120 percent of local per capita fee-for-service spending, for example. I would note, the fact that there is any cost saving at all from moving to, say, 140 percent of local fee-for-service costs, or 150 percent, suggests that there are some counties where the differential is that large; in other words, there is a 40- or 50-percent differential in some counties.

My final point is that one possible benefit of the Medicare Advantage program is the higher quality of care that beneficiaries may receive through more disease management, care coordination, and

preventative care than under the fee-for-service program. However, current data sources and reporting requirements do not provide sufficient information to assess whether health plans are delivering better health outcomes than in the traditional program, and the limited information that does exist, if anything, suggests that the private plans are no better than the fee-for-service program and, thus, on a cost-effectiveness basis, based on that limited information, they are less cost-effective because of their higher costs.

I would also note that the most rapidly growing component of Medicare Advantage, the private fee-for-service plans, are exempt from many of the reporting requirements that do exist, and as a result, we have much less information about their efficacy than other types of Medicare Advantage plans.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Orszag. Very interesting.

[The prepared statement of Dr. Orszag appears in the appendix.]

The CHAIRMAN. Mr. Hackbarth, good to see you again.

STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC

Mr. HACKBARTH. Thank you, Chairman Baucus, Senator Grassley, members of the committee. I have been a proponent of private plans in Medicare for a long time, since I first joined the Reagan administration in 1981. Senator Baucus and Senator Grassley well summarized the reasons I have been a long-time believer in the idea of private plans in Medicare. I think potentially they have the opportunity to provide a higher-value, distinct product to Medicare beneficiaries that not only can reduce costs but improve care.

When I left the Reagan administration in 1988, I became an executive at Harvard Community Health Plan in Boston and then subsequently CEO of Harvard Vanguard Medical Associates. I think most people will tell you these are two of the very best managed care organizations in the United States. In my decade in Boston, I saw firsthand the potential of true managed care and what it can do for patients of all types, including Medicare beneficiaries.

Despite this background, or perhaps because of this background, I am concerned about the current state of Medicare Advantage. Between mid-2006 and February, 2007, 75 percent of the growth in Medicare Advantage enrollment was in private fee-for-service plans. To me, this is a warning light. Medicare beneficiaries are not enrolling in well-run managed care plans like Harvard Community Health plan or its successor, Harvard Pilgrim Health Care, but, rather, in plans that largely duplicate traditional Medicare, except that they have higher costs, including higher administrative costs.

Well, how could it be that such plans are prospering in a market-oriented system like Medicare Advantage? Private fee-for-service plans are thriving because of improperly set administered prices, not market prices. Those administered prices are known as benchmarks. In addition, private fee-for-service plans can compel hospitals, physicians, and other health care providers to accept Medicare payment rates—Medicare's administered prices. They are not market prices. In short, private fee-for-service plans are prospering

not because of their intrinsic value but because they take advantage of government-set rules.

I am focusing on private fee-for-service because it is the most rapidly growing portion of the program, but it is not the core problem in Medicare Advantage. It is but a symptom of an overly generous payment system.

Proponents of the current Medicare Advantage system present a number of arguments in its defense. Two are particularly important, and they have been mentioned already: the extra payments are being used to fund added benefits for Medicare beneficiaries, in particular low-income beneficiaries; and, second, the Medicare Advantage payment systems correct imbalances in traditional Medicare under which States with efficient health care systems are penalized.

I do not have time in my opening statement to give these arguments their due attention, but I hope I will during the question-and-answer session. For now, let me just close with an observation about the fiscal context for this policy discussion.

As you know all too well, Medicare's resources are limited, especially now that we have 77 million baby boomers ready to hit 65 within 4 short years. Whatever your policy goals—support for low-income beneficiaries, redressing regional imbalances, increasing payments to physicians that have been held down due to the SGR system, funding SCHIP—whatever your policy goals, MedPAC would like to help you find ways to pursue them as efficiently as possible.

One concern about Medicare Advantage is that it is being used to pursue legitimate goals that I think we can all identify with, but in an especially costly way, thus depriving you and the country of the resources needed to address other problems that we face. I wish I could tell you that we have a painless solution to this problem, but we do not. Peter has outlined some of the possibilities. I can say this, however: that solving this problem will only get more difficult over time as more and more Medicare beneficiaries enroll in these plans, in particular, private fee-for-service plans.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Hackbarth appears in the appendix.]

The CHAIRMAN. Dr. Draper?

STATEMENT OF DR. DEBRA A. DRAPER, ASSOCIATE DIRECTOR, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, DC

Dr. DRAPER. Chairman Baucus, Senator Grassley, and members of the committee, thank you for the opportunity to testify today. My name is Debra Draper, and I am a health services researcher and the associate director of the Center for Studying Health System Change. The Center is an independent, nonpartisan health policy research organization funded principally by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. My testimony today will focus on three key points.

First, although our research has not specifically looked at Medicare Advantage plans, we have seen a growing trend among commercial health plans offering more care management activities.

Second, while many commercial health plans offer care management activities, there is considerable variation across plans as to what is specifically offered and to whom.

And, third, there is limited evidence to date as to what impact, if any, the care management activities that commercial health plans offer have on cost, quality, and outcomes.

There is considerable variation among health plans as to specific care management activities they offer. Much of this has to do with how they package, brand, and market the activities that they offer, which is often a way in which they differentiate themselves within the marketplace.

Health plans provide care management activities through internal capacity, through external vendors, or some combination of the two. Some of the larger national health plans have subsidiary companies that actually specialize in these services.

There are many health plan activities that can be broadly construed as care management. Today I am going to be focusing on the following activities.

Case management and coordination activities target enrollees with conditions that put them at risk for incurring large medical expenses. These activities are individually customized and may include care planning, coordination of follow-up care, and telephone-based support and assistance.

Disease management activities target enrollees with certain conditions such as asthma and diabetes and encourage enrollees' adherence to standardized treatment guidelines in self-care and generally are facilitated by mail and telephone contact.

Health promotion and wellness activities target enrollees irrespective of disease status or health utilization. These activities encourage enrollees to pursue healthy behaviors. They also provide support to enrollees interested in changing unhealthy behaviors such as smoking.

Nurse advice lines provide enrollees with telephone access to registered nurses and typically operate 24 hours a day, 7 days a week. Nurses provide enrollees with education and advice on health conditions and self-care, as well as triage services to assess symptom acuity to determine next steps.

Utilization management encompasses a range of activities that health plans use to manage the use of health care services, including activities to prevent medically unnecessary services.

Health plans typically identify enrollees for more care management through an analysis of medical and pharmacy claims data. Health plans often apply technologies to model the data to predict future health expenditures of enrollees, and based on these results, enrollees are often stratified by projected risk level, which allows health plans to better tailor their care management activities to the individual enrollee.

Another tool that health plans are increasingly emphasizing to identify potentially at-risk enrollees is a health risk assessment. This is a questionnaire, often available online, that collects information provided by the enrollee on items such as personal and

family medical history and health behaviors such as diet, physical activity, and tobacco and alcohol use.

Once an enrollee has been identified as potentially benefitting from more care management, it can often be a challenge getting and keeping that enrollee engaged. Participation in most health plans' care management activities is voluntary, and many believe that some type of incentive is necessary, such as a cash payment, to get enrollees involved and to keep them engaged.

There is considerable potential for health plans to apply many of their care management activities to Medicare, particularly if they find them to be effective. These activities may be even more beneficial for a Medicare population where chronic illness and other high-cost conditions are more prevalent. But current evidence of their impact is sparse for a number of reasons, including the newness of many of these efforts as well as the complexity of quantifying and measuring their effectiveness.

So the question for Medicare is: to what extent is it willing to support experimentation, and does this justify any of the extra payment to Medicare Advantage plans? Since health plans are pursuing these activities in their commercial products, Medicare's role in experimentation is less clear. But if Medicare does want to pay for experimentation, there are a number of other questions that are important to address, including whether it should pay directly for selected activities rather than paying higher overall rates.

So, to conclude, intuitively, health plan activities aimed at improving the quality and efficiency of care are a good thing. However, it is difficult to justify financial support unless care management activities will eventually yield results that justify the investment. And to the extent, too, that care management activities save money, they are self-financing and may not require extra support.

Thank you.

The Chairman. Thank you very much, Dr. Draper.

[The prepared statement of Dr. Draper appears in the appendix.]

The CHAIRMAN. Dr. Udvarhelyi?

STATEMENT OF I. STEVEN UDVARHELYI, M.D., SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, INDEPENDENCE BLUE CROSS, PHILADELPHIA, PA

Dr. UDVARHELYI. Thank you, Mr. Chairman, Senator Grassley, members of the committee. I appreciate the opportunity to testify this morning about the Medicare Advantage program.

My company, Independence Blue Cross, is strongly committed to the long-term success of the Medicare Advantage program, and our Medicare Advantage plans offer many services and innovations that are not included in the Medicare fee-for-service program, and they serve a critical role in providing comprehensive, coordinated benefits for many seniors and disabled Americans, including low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program.

One of the fundamental differences between Medicare Advantage plans and the fee-for-service program is that the former have an established infrastructure for improving health care quality on an ongoing basis, and this is critical because it is well-documented

that we have significant shortcomings in the quality of health care under our general system, but also in the Medicare program in particular. Medicare Advantage plans focus on identifying members with important clinical needs, including those not receiving preventive care, those who are frail, those with chronic illness, and there is a proven track record of these plans making a positive difference in the lives of Medicare beneficiaries.

For example, in 2005, approximately 94 percent of Medicare beneficiaries in Medicare Advantage plans received beta blocker drugs, which are life-saving drugs administered after a heart attack. Nine years earlier, that number was close to 60 percent, and that increase has not been matched in the Medicare fee-for-service population.

One of the principal ways that Medicare Advantage plans have improved care for Medicare beneficiaries is through chronic care initiatives and other innovations designed to improve care and overall quality of life, and these initiatives are important since at least one study suggests that over 80 percent of Medicare beneficiaries have at least one chronic condition.

At Independence Blue Cross, we offer a variety of programs, and I would like to provide the committee with a few examples.

Our Connections Health Management program provides members with information about their health conditions, with assistance and guidance on making difficult treatment decisions, with tools to help them and their physicians improve the management of chronic disease, and with coordination of care.

We use predictive modeling, a sophisticated data-mining technique, to identify members who are at high risk for future health care events and who have specific gaps in care. And what I mean by that is, for example, a congestive heart failure patient who is not on appropriate medication, or a patient with heart disease who has an elevated cholesterol level that is not being treated, or a diabetic who is either not getting appropriate monitoring of their blood sugar or who has a known elevated blood sugar level that is not being treated.

Specifically trained health coaches, typically nurses, are available to these members 24/7, and they perform telephonic outreach to members to address their gaps in care, to help them understand their physician's treatment plan so that they can improve self-management.

The health coaches also contact the member's physician, and these physicians receive a comprehensive registry that lists each of their patients with chronic illness and what specific gaps in care exist for each patient. The results of this program I believe are impressive: 87 percent of the participants were satisfied, 90 percent would recommend the program to others—and I may say parenthetically that when we launched this program in 2003, in the very first week we got 300 unsolicited phone calls from Medicare beneficiaries telling us that this is the best program they had ever had in health care—69 percent of the participants with chronic conditions stated that the program helped them better manage their condition, and 90 percent stated that the program improved the quality of their care.

Through the prevention of complications and relapses of chronic illnesses, there was a 10- to 15-percent reduction in the use of hospital services and of professional services such as doctor visits, and overall medical cost trends came down 1.5 to 2 percent in the first year and 3 to 5 percent in the second year. And there were also specific increases in quality-of-care measures for each of those conditions.

We also offer another program in our Medicare Advantage plans which we call the Physician Home Visit program, and this is a program targeted for homebound members. It arranges for a physician to conduct a proactive home visit, or a "house call," to assess that member's needs, and then that physician actually provides follow-up care in the home. The physician coordinates with the member's primary care physician and specialist physicians, and it is designed to improve the control of chronic illnesses and reduce the use of emergency services for these frail members who cannot keep appointments with their doctors due to their homebound status.

We also provide Medicare Advantage members with access to care coordination throughout their health care experience, and I would be happy to give examples of that later on this morning.

Finally, in addition to improving patient care for chronic illnesses, the Medicare Advantage program provides many additional benefits that are not included in the Medicare fee-for-service program. According to CMS, the Medicare Advantage plans are providing enrollees with, on average, savings of more than \$1,000 annually through both improved benefits and lower out-of-pocket costs. Research studies indicate that these additional benefits are particularly important to low-income and minority Medicare beneficiaries, especially those who fall short of qualifying for Medicaid. Beneficiaries in the lower-income categories are less likely to have employer-based coverage, and those with incomes in the range of \$10,000 to \$20,000 are generally not eligible for Medicaid, meaning that Medicare Advantage is their primary option for comprehensive, affordable coverage.

I would like to highlight one important role that these benefits play by quoting from a study, a bipartisan survey that was released by America's Health Insurance Plans on March 20th: 35 percent of seniors overall but, more importantly, 62 percent of low-income seniors said if they were not enrolled in their Medicare Advantage plan, they would forego treatment they are receiving today. They would skip medically necessary services, if their option of having a Medicare Advantage plan went away.

So, in closing, I thank you for considering our perspective of the Medicare Advantage program. We urge the committee to continue to support adequate funding for this system of competition, choice, and innovation that is delivering savings and value to more than 8 million Medicare Advantage enrollees.

Thank you.

The CHAIRMAN. Thank you very much, sir.

[The prepared statement of Dr. Udvarhelyi appears in the appendix.]

The CHAIRMAN. Thank you very much, sir.

I would like to ask Mr. Hackbarth first and also Dr. Orszag to respond to the same question, and it is a "What if?" What if we

were to lower the payment rates to the Medicare Advantage plans to fee-for-service or significantly in that direction? What would the result be? What would plans do? Would they leave? Dr. Orszag, you testified that many would leave and beneficiaries would not be able to participate. So the question is: What would plans do, in your judgment? Would that force efficiencies or not? Would plans lower their bids in order to maintain benefits? Would the impact vary according to geography, you know, in some parts of the country versus others? And would the response vary according to plan type, that is, private fee-for-service or HMO, or whatnot?

I am just asking a "What if?" question, if you could give us your best judgment as to what would happen.

Mr. HACKBARTH. Well, you asked a lot of questions there.

The CHAIRMAN. Right.

Mr. HACKBARTH. If I miss some key parts, remind me.

The CHAIRMAN. Would they lower their bids? Does it vary by geography, and also according to plan type?

Mr. HACKBARTH. Peter is in a better position to address the effect on overall enrollment. They do estimates of that. Certainly there would be a decline in projected enrollment. I think in all likelihood the decline in enrollment would be particularly large in private fee-for-service plans as opposed to tighter, more tightly run coordinated care plans.

The effect would be disproportionate in some parts of the country, namely, those parts of the country where the benchmarks are highest relative to fee-for-service costs.

The CHAIRMAN. Would it create efficiencies?

Mr. HACKBARTH. Well, that was going to be my next point. I am a believer in markets, and that is one of the reasons why I have supported this program for a long time. Prices send signals, information about what customers want. Right now Medicare is sending the signal that we want private plans, even if they cost substantially more than traditional Medicare.

I think what we need, not just in Medicare but in the country more broadly, is to send the signal that we want plans that more effectively manage care.

The CHAIRMAN. That are more efficient, that could result in some efficiencies.

Mr. HACKBARTH. Right, and we are not doing that now.

The CHAIRMAN. My time is about to expire. Dr. Orszag?

Dr. ORSZAG. Sure. As I said in my oral remarks and in my written testimony, we estimate that moving to 100 percent of local fee-for-service costs would reduce enrollment in 2012 by about half. That would be disproportionately in areas with currently low fee-for-service costs because those are the areas where the differential is largest. Those are disproportionately in rural areas, and if you look at a map of the country, those are sort of not on the coasts and tend to be disproportionately rural.

I agree that the effect would be disproportionate on private fee-for-service, in part because they are the plans that are operating disproportionately in those areas. The other effect that I think is important to remember, though, is that there would be an impact not just on Medicare Advantage beneficiaries but on all other Medicare beneficiaries, because the cost reductions that would result

would reduce Part B premiums and also affect Part A financing in a beneficial way for everyone else.

So there is sort of a trade-off between the directly affected beneficiary—

The CHAIRMAN. Right. But would there be any efficiencies, though, under the Medicare Advantage plans?

Dr. ORSZAG. I do think that there may be efficiencies for the following reason: the fastest-growing component of Medicare Advantage and the one where most of the growth is occurring is in private fee-for-service. The types of things that we were talking about—disease management, care coordination—are much less salient and much less prevalent in private fee-for-service. The theory behind it is it is a lot different than in HMOs and PPOs within Medicare Advantage.

The CHAIRMAN. Thank you very much. My time has expired.

Senator Grassley?

Senator GRASSLEY. Yes, I want to follow on the discussion we just had, but I would ask you if you could be a little more specific in regard to the disproportionate rural areas. But I would like to point out that they might not all be rural, and some of it is based on what we think would happen, and we think that Seattle, Portland, Minneapolis, parts of New Mexico, parts of Arizona, and parts of upstate New York would be very definitely hit if we were to cut too much—or maybe cut at all. I do not know exactly at what level.

I would like to know if you have studied it that precisely, if you could verify what I have just said, or speak around it and be a little more definitive than you have, instead of just saying disproportionately rural. That is to the both of you.

Mr. HACKBARTH. The effect would not be solely on rural areas. I do not know all of the cities that you mentioned, but I certainly know that Portland, OR is a place that is a floor area, so the Medicare Advantage payments are well above the existing traditional Medicare costs. And so there are urban areas like the ones you mentioned that would be affected as well as rural areas.

Senator GRASSLEY. All right. Dr. Orszag?

Dr. ORSZAG. I cannot give you an exact answer, but what I can tell you is that, again, the effect is disproportionately in areas with fee-for-service costs that are lower; so, low fee-for-service cost areas, and that we do have information on from the Dartmouth Atlas. In fact, because the differences are so huge, I walk around with a little chart of where fee-for-service costs are regionally with the dark—

The CHAIRMAN. Is that in your testimony?

Dr. ORSZAG. No. I just walk around with it. [Laughter.]

The CHAIRMAN. Well, we would like to have it in the record.

Dr. ORSZAG. All right. Well, we can do it. It is from the Dartmouth Atlas of Health Care.

The CHAIRMAN. We will put that in the record.

[The chart appears in the appendix on p. 105.]

Dr. ORSZAG. But the point is the darker areas—I can show you what else I walk around with, too. [Laughter.] The darker areas are the ones with higher fee-for-service costs. The lighter areas are the ones with lower fee-for-service costs. And you can see that

there is a particular pattern to the colors, and it is in the lighter areas where the effect of reducing Medicare Advantage payments would be disproportionately large.

Senator GRASSLEY. All right. That map will help us very much. Then if we want to do further research, go to those areas where the benchmark is highest for fee-for-service. I think you said that. You said you could not name specifically, but we could go by what you said.

Mr. HACKBARTH. In general, the effect would be greatest where the difference is largest between the benchmark and fee-for-service costs.

Senator GRASSLEY. Well, I think you folks have contributed greatly to this debate, for those of us in rural areas who want to make sure that we have the same choice they do in cities, but I think some of you also pointed out that there are some cities that are going to be hurt as well. So we need to take a very close look at the impact of what we do in this area, if we do anything.

I am going to speak to Dr. Udvarhelyi and ask you—I want to state that from your testimony I think it is clear that Independence has invested a lot of resources into care coordination and care management programs, and I want to point out that this was one of the goals that we had in some of the things that we did in the Medicare Modernization Act.

My question is simple. Do you have quality measures so that you know how these programs work?

Dr. UDVARHELYI. Senator, yes, we do.

Senator GRASSLEY. In other words, do you know they are working?

Dr. UDVARHELYI. Yes, Senator. For example, we do track for chronic conditions trends in specific quality measures. So, for example, because of extensive data collection efforts, for example, in diabetes, we can actually track the percentage of beneficiaries that have poor control in diabetes with the percentage of beneficiaries who are not having their cholesterol managed with heart disease. And we have seen significant improvement year over year in those measures. At the same time we are seeing overall moderation in health care cost inflation.

Senator GRASSLEY. Dr. Orszag, following on that, in your testimony you suggest that plans should submit more information on health outcomes to measure quality and to help determine what impact coordination activities have. What type of data do you think plans should submit? And how quickly do you think we could have plans reporting data?

Dr. ORSZAG. Well, I would imagine it could happen relatively quickly, if you demanded it. I should say CBO would be happy to work with the committee on options for expanded health outcome reporting, but very basically the things you are interested in are mortality, morbidity, and overall health care costs, and then within some of those categories you would want to measure some specific contributors to overall health care costs, like whether disease management reduces overall costs, et cetera. And you would want that at a fairly fine level of detail so that you could see whether this program was producing that kind of result.

In a sense, what one can imagine is we are spending public funds on these programs, and they are doing various different things, and yet we as the Federal Government do not really know the results of what is working and what is not. I think the point is that you could get a lot more information on those various different experiments, if you want to think about it that way, with expanded reporting.

Senator GRASSLEY. Yes. Dr. Draper, you are kind of cynical, I think as I read your testimony, about these measurements. How do you react to what Dr. Orszag or Dr. Udvarhelyi said?

Dr. DRAPER. Well, I think what we have seen in our experience is that, as I mentioned in my testimony, there are a lot of care management activities that health plans are pursuing, and these seem to be increasing in recent years. However, identifying, specifically tracking costs, quality, and outcomes related to these individual initiatives is difficult, and there is not really credible evidence broadly related to the effectiveness of these different initiatives. And I think the important thing is, when you have initiatives that you are able to track, whatever the outcome that you are tracking effectiveness of related to quality, cost, and outcomes, that you are able to track it specifically to that particular initiative that you are instituting. So there could be other things that are affecting some of the things, the changes that you are seeing. So I think it is important to collect—claims data is a wealth of information to be able to track to collect data. It provides good information on service utilization. It provides good information on gaps in related services which could identify some potential quality issues. And I think also gathering information from the enrollees that are impacted by these, like, you know, changes in their health status and changes in their knowledge about their conditions and satisfaction with the quality of care and their quality of life and satisfaction with overall care.

So I think there are a lot of things that still need to be proactively done to really get a sense of how well these initiatives are progressing.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Thank you very much, Senator. Thank you, Dr. Draper.

According to our early-bird list, the next five Senators in order are Senator Wyden, Senator Crapo, Senator Cantwell, Senator Roberts, Senator Thomas—I will keep on going here—Senator Bingaman, Senator Rockefeller, Senator Hatch, Senator Stabenow, and Senator Salazar.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Hackbarth, great to have an Oregonian back, and it seems to me what we have learned is, not all Medicare Advantage plans are cut from the same mold. Up and down the West Coast, for example, we have plans like Kaiser with lots of low-income subscribers, lots of minorities, low administrative costs, and that is pretty different than these private fee-for-service plans, as you have pointed out.

In addition, if Medicare Advantage is not addressed properly, we will be hit by a double whammy because, as you know, our pro-

viders have historically not been reimbursed in a reasonable fashion.

My question to you is: most of the data we have on Medicare Advantage is national data. Isn't it going to be necessary to beef up the Medicare Advantage data by region in order to really get our arms around trying to address this responsibly so you do not hurt a lot of people that, for example, Senator Cantwell and I represent on the West Coast?

Mr. HACKBARTH. Senator, there are some types of data we do have by region. With regard to the Medicare payment rates, the differentials between the Medicare Advantage rates and private fee-for-service, we do have that at local levels. There are other pieces of data that we do not have on a localized basis. For example, we do not know a lot about how private plans' cost structures vary by geographic region, and so that would be a hole, if you will, in the database.

Senator WYDEN. My concern is that, except for a handful of isolated examples, we really do not have any sense per region how to proceed. I am concerned that the national data, in effect, is masking what is really going on in Medicare Advantage.

Can you further flesh out what kind of information you think would be necessary here?

Mr. HACKBARTH. I could maybe try to approach it from a different direction. If you think I am unresponsive, let me know.

We have talked before in this committee about the regional disparities in Medicare payments per capita, and some parts of the country, including our State of Oregon, have much lower Medicare fee-for-service costs. Other parts of the country have dramatically higher costs. That then plays through the Medicare Advantage payment system.

In the long run, the challenge for us in Medicare is to bring down total costs for the program because of the baby-boom generation retiring.

The basic policy question that we face is: Do we lower the high-cost States or do we increase the low-cost States? I am proud of what Oregon does, but I do not think for the long run we should be about trying to lift Oregon's payments to Florida's level. What we ought to be doing is trying to drive Florida's payments down to Oregon's level. That is what the fiscal situation requires.

Senator WYDEN. I think, again, we have some questions about the adequacy of the data. I know our staff has some questions about whether the data is adequate. I think that this question of just regional competition is somehow masking what we have to do if you look at the demographic tsunami. We have to make decisions that work for Senator Stabenow, for Senator Wyden, and everybody else. And if we do not have adequate data by region, we are not going to be able to do it. I have tried to follow this as closely as I can, and I actually asked CRS, the Congressional Research Service, to give us some additional information because we did not even have good numbers of how many people and who is in these programs. So we are going to want to follow up with you on this.

Mr. HACKBARTH. I would be happy to do that, Senator.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Crapo is not here. Next is Senator Cantwell.

Senator CANTWELL. Thank you, Mr. Chairman, and I thank the panelists.

Mr. Hackbarth, I am sure that there are Medicare Advantage issues we should be looking at, but it seems like your proposal is a pretty blunt instrument, particularly as it relates to the State of Washington. We rank 35th in the Nation in Medicare fee-for-services per beneficiary. So our payments are about 25 percent lower than the rates of the top five States in the Nation. So if you just look for an example, compared to States at the top of the list, Medicare payments are \$2,500 lower per beneficiary.

You are making a proposal that would significantly—and we are hearing from CBO how it would impact us—impact the good work that is being done by HMOs in that region that are providing coordinated care, reporting on quality outcomes, and doing all of the things that produce efficiencies. And you are throwing the baby out with the bath water with this recommendation. Shouldn't we be looking at the overall fee-for-service reimbursement rate and the lack of efficiencies in the delivery of fee-for-service?

Mr. HACKBARTH. My concern about Medicare Advantage is—

Senator CANTWELL. You do agree that this would be a great disadvantage? I think the numbers indicate it could reduce current Medicare Advantage enrollment by 1.8 million. I do not have the numbers for Washington State, but you agree that people in Washington State could be significantly impacted, losing coverage and care?

Mr. HACKBARTH. I do not know the numbers for Washington State off the top of my head. It is quite possible, as in the case of Oregon, that the fee-for-service traditional Medicare costs are low in Washington and, thus, the impact might be greater there. I do not know that for sure, but that is quite possibly the case.

Medicare Advantage, increasing Medicare Advantage payments is a very inefficient way to achieve the goals that you are talking about. By increasing payments indiscriminately for good plans—and there are many of them, as Steve has described, but there are many plans that are low-value plans as well. What we are doing is spending a lot of money that we do not need to spend.

Private fee-for-service plans, which we are promoting through this payment system, cost more than traditional Medicare, and only about a half of that additional cost is going to beneficiaries. It is not going to added benefits for Medicare beneficiaries. It is going to higher company costs, higher administrative costs, and that is the problem with just saying let us increase Medicare Advantage payment rates. We are avoiding bad as well as good.

Senator CANTWELL. I am trying to draw the point of differentiating between private fee-for-service and HMOs. Your proposal, which strikes at the good work that HMOs do in providing Medicare Advantage, is a pretty blunt instrument. Dr. Orszag, am I getting this right as it relates to the impact? Is that your number, 1.8 million people could be reduced?

Dr. ORSZAG. Our number is for 2012, and there would be a reduction of roughly 6 million then off of a base of over 12. So you may be comparing where you would wind up in 2012 to today, which is

a little bit over a 1 million reduction or so, a million and a half, something like that.

Senator CANTWELL. My assumption is what the Congress was originally trying to do in the Balanced Budget Act was to make sure that there was coverage. Now, I am not saying that there are not problems with Medicare Advantage, but it seems like we ought to be focusing on what is working efficiently, and coordinated care through HMOs and reporting of quality outcomes work well, I would think. What is not working well is some of the other aspects of private fee-for-service.

Mr. HACKBARTH. Senator, I am a proponent of HMOs. As I said earlier, that is my background. But not all HMOs are created equal. Let me just give you some figures on quality measures of performance.

As Steve said, on average, plans are improving quality. But on some basic, very basic, simple measures of quality, there is a huge range in performance. For example, on flu shots, providing flu shots when needed, the range is from 89 percent in the best plan to 15 percent in the lowest plan. These are HMOs. Mammograms: 89 percent in the highest plan; 35 percent in the lowest plan. Eye exams for plan members with diabetes: 87 percent for the best plan; 8 percent for the lowest plan.

So the label, HMO—there are good ones, there are terrific ones, and there are not-so-good ones. So it is not as simple as saying, well, we just want to lop off private fee-for-service, and all HMOs are good.

Senator CANTWELL. I am simply trying to get you to recognize the already disadvantaged delivery of health care in Washington State. We have lower utilization and higher efficiency in delivering traditional Medicare, and we continue to be disadvantaged by that payment system. Your particular proposal disadvantages us even more.

I know my time is up, Mr. Chairman, and we will look forward to continuing to discuss this issue.

The CHAIRMAN. You bet. Thank you very much, Senator.

Senator Roberts, you are next.

Senator ROBERTS. Thank you, Mr. Chairman. I do not know whether to go first with my rant or my questioning. I guess my rant should go first.

The CHAIRMAN. Why don't you try something different this time? [Laughter.]

Senator ROBERTS. All right. I will do that. Thank you.

My first question is very straightforward to Dr. Udvarhelyi. What will happen to my 25,000 Medicare Advantage beneficiaries in Kansas and the thousands that your program serves in Pennsylvania, especially in rural areas, if Congress cuts payments to the MA plans? And I am talking about no cost sharing, protection against out-of-pocket costs, preventive screening, comprehensive drug benefits, vision, dental, hearing benefits, house calls—amazing, house calls in today's health care world. What will happen to these folks? It is a 426-percent increase since the inception of this program, by the way.

Dr. UDVARHELYI. Senator, I think as has been stated today, one of the intents that Congress had through the Medicare Moderniza-

tion Act was to expand access, and I think that has been achieved. Almost 100 percent of Medicare beneficiaries now have access to a Medicare Advantage plan.

I think that access would be compromised with funding reductions, and there was a study done by Ken Thorpe at Emory University that suggests that as many as 3 million beneficiaries would lose the coverage they have under Medicare Advantage today. And as I stated in my testimony, when that happens they will forego necessary treatments that they are receiving today. So I think the quality of their care will go downhill.

Senator ROBERTS. I appreciate that. I also want to agree with your commentary in regards to focusing on preventive health care rather than focusing just on treating patients when they are sick. And I could not agree more with that.

Mr. Chairman, I think it was 12 years ago I was sitting at a joint Senate-House session over in the House, and Bill Thomas was in charge, which tells you a lot, and we were going through the Medicare program and talking about strengthening and preserving Medicare. And this whole subject came up again about what benefits people have in city areas as opposed to rural areas, and I would identify with the comments made by the distinguished Senator from Iowa.

I know we have to make things efficient. I know we must have better facts. Senator Wyden made an excellent point. I would introduce you to Aunt Harriet out in St. Francis, KS. Now, if she did not have this program, she would be in a world of hurt. And I just think that, as opposed to efficiency, we have to consider rationing; we have to consider discrimination. I know those are harsh words. I intend them to be. There has been a lot of talk about the 12-percent increase in cost. That does not take into account the 6-percent budget neutrality funding that Congress already cut starting in 2007, this year; the 1-percent underestimate from the doc fix; 3-percent medical education costs excluded by MedPAC. And it was the intent of Congress to spend more money, to invest more money in the rural health care delivery system.

How many times do we have to go through—how many decades do we have to go through with less service in rural areas? And by rural areas, I mean western Kansas and starting with Senator Salazar's area out there in terms of eastern Colorado. It is not the end of the world, but you can see it from there. And these people deserve and merit at least the same kind of service that other people are getting.

My Lord, I do not know how many hospitals with 50 beds or less that we have now—I think it is over 100 in Kansas—that had to put up with HCFA, now CMS, and everything else. And we finally got a program where we at least were on par, and there is a whole chart here that I have in terms of services. And it jumped up 426 percent—and that was the intent of Congress to do that—and 25,000 people.

So I would just like to register my concern with this approach to my colleagues on this committee. Actually, it is not concern. I am opposed to it. The chairman is not here, so I will just talk to Jeff. Jeff, I am opposed to this. John, I am opposed to this.

I enjoyed your program, by the way, last night with Newt. [Laughter.]

I enjoyed your program with Newt. I am not going to buy your book. I might, you know, get it on loan or something. But at any rate, I just do not think this is right. What part of “no” do you not understand in regards to Congress’s intent so at least to make this an equitable Medicare program in terms of the benefits that people receive? And, again, I do not think the 12 percent is accurate.

And I am quitting with 17 seconds to the good. That is a record for me.

Senator BINGAMAN [presiding]. I am advised Senator Thomas is the next person to ask questions. Go right ahead.

Senator THOMAS. Thank you. I was going to ask about the rural aspect, but I think my friend from Kansas has covered that pretty well. We have had some difficulties, and you can see it in your chart, Dr. Orszag, that was passed around.

To the gentleman on the end, you are a proponent of this program, I assume. What are the extra benefits? We have been awfully detailed here, but, in general, what are the benefits from the Medicare Advantage plan as opposed to traditional Medicare?

Dr. UDVARHELYI. Senator, the benefits obviously vary by plan, but the types of benefits include reduced cost sharing, which I think is an important benefit because, as I mentioned in my testimony, that cost sharing, particularly for low-income beneficiaries, can be a barrier to care. There are expanded benefits for preventive care. There are expanded benefits for wellness and prevention.

So, for example, in our plan we have a substantial number of seniors, including those with chronic illness, who actually take advantage of a fitness program that gets them to maintain a more active lifestyle. And, interestingly enough, those seniors actually have a higher completion rate of the target wellness objectives for fitness than our commercial members. Once they have enrolled, sir, they appear to be a much more motivated population.

Senator THOMAS. By commercial members you mean what?

Dr. UDVARHELYI. I mean under 65, the under-65, so the employer-sponsored programs we have, the 45-year-old individual.

So there is a wide range of those benefits, and then our perspective would be that many of the programs that I have described—which do not exist in the fee-for-service market—are a benefit to those beneficiaries. And if you would allow me just to give an example of what would happen to an individual: we had a 73-year-old member who went into the hospital to get a total knee replacement. It appeared to be routine. As is our normal course, we do discharge planning before the patient goes into the hospital.

The orthopedic surgeon, however, on discharge forgot to write an order for the blood thinner that the patient was on when they came in, and they had blood clots in their leg. Had our case manager not called them—which is a routine practice—48 hours after discharge and identified the fact that their medications they were on before surgery had been omitted, called the surgeon, said, “You forgot to write this,” and they said, “You are right, I did; it was an oversight,” and put that patient back on, that patient would have been rehospitalized with a complication from that blood clot.

That just does not exist in the fee-for-service arena. We think that is a benefit.

Senator THOMAS. I see. How do Medicare Advantage plans benefit low-income seniors who make too much money to qualify for Medicaid but do not make enough to purchase Medigap supplemental coverage?

Dr. UDVARHELYI. Thank you, Senator. For those beneficiaries, our programs are really a critical safety net because they allow them to enroll in the plan. That reduces their out-of-pocket expenses and provides them with those comprehensive benefits. If they were left without that option and they simply had the standard fee-for-service program, they would not have the enhanced benefits, and they would have substantially higher cost sharing.

So that is how it benefits that group that is in, again, as I said, sort of that \$10,000 to \$20,000 income range, and we believe that we serve a very large percentage of those members.

Senator THOMAS. Why do you think we are here? What is the controversy now with respect to this program?

Dr. UDVARHELYI. I think the controversy appears to be centered on several things. One is whether the financing levels are appropriate and whether or not—

Senator THOMAS. They need to be higher than regular Medicare?

Dr. UDVARHELYI. Well, I would comment as follows. The details of financing are obviously not my area of expertise, so I would be happy to follow up with you and others on that. But I am not sure that the fee-for-service payment level is necessarily the correct benchmark, and I would say that for a couple of reasons.

One, it is well documented that we are not necessarily providing the necessary care to individuals in our traditional fee-for-service system. For example, a RAND study showed that only 55 percent of individuals are getting services that anyone in medicine would agree are clearly recommended for them to get. And I believe even a recent MedPAC study also showed that there were substantial shortfalls in the necessary services.

So that fee-for-service benchmark does not necessarily include all the care that people ought to be getting today.

Senator THOMAS. All right. My time has expired. Thank you.

The CHAIRMAN. Thank you, Senator Thomas.

Senator Bingaman?

Senator BINGAMAN. Thank you all very much. Let me just cite three things that occur to me as areas we ought to try to move and make progress on, and you can then tell me if I am missing the boat on any or all of these three, or which of them makes sense.

From what I have picked up here, it sounds as though expanding health care outcome reporting requirements for private fee-for-service plans is a good thing to do; that we do not have the same kind of reporting requirements, health care outcome reporting requirements, in private fee-for-service that we perhaps do in HMOs.

First, do you have any reaction to that, Dr. Orszag?

Dr. ORSZAG. I would agree with that, but I would also say that even for HMOs and PPOs there is expanded outcome reporting that would be beneficial. But it is more glaring with regard to private—

Senator BINGAMAN. Mr. Hackbarth, do you have a view?

Mr. HACKBARTH. I agree, Senator. The other thing I would add is that Medicare beneficiaries ought to be able to know the quality results for traditional Medicare in their area so that they can compare that to the private plans available.

Senator BINGAMAN. So we should require these health care outcome reporting requirements, expand those for all, everything that Medicare is funding.

Second, to what extent do we need to do a better job of differentiating between those Medicare Advantage plans that are providing high-quality health care, as I gather we are hearing testimony on, and those that are not? What do we need to put in the law to reflect the fact that we are willing to pay for high-quality care, we are not willing to pay more for low-quality care?

Mr. HACKBARTH. Pay for performance is what I would do and what MedPAC has recommended before. It is not as simple as saying, you know, private fee-for-service is bad, HMOs are good, PPOs are somewhere in the middle. There are good plans and bad plans in all—

Senator BINGAMAN. So you have to get back to these health care outcome—

Mr. HACKBARTH. Pay for results. Pay for results. Pay more for demonstrable quality, not for labels.

Senator BINGAMAN. All right. Yes, go ahead.

Dr. ORSZAG. And, Senator, the variation that Mr. Hackbarth already alluded to with regard to what even HMOs are doing opens up the possibility that you could tie payments to performance along the Healthcare Effectiveness Data and Information Set (HEDIS) measures or other measures, so you are basically only paying for the things that we think work and not for the things that do not.

Senator BINGAMAN. All right. And then the final thing, which I know is a very big subject, but it strikes me, you know, the main job we would have here is to restructure traditional Medicare so that the same high-quality care that is being talked about in some of these HMOs is available to everybody who is participating in Medicare. I do not really see why traditional Medicare should not be held to that same standard. If any of you have comments on that, I would be glad to hear them.

Dr. ORSZAG. Senator, I think that is the central fiscal challenge facing the United States over the long term. Medicare and Medicaid are the biggest fiscal problems facing the country. The rate at which health care costs grow determines to a first approximation the entire fiscal ball game over the long term. And moving towards more effective care is the most important thing that we could do, and there are lots of steps that I think would help.

Senator BINGAMAN. And one of those important preliminary steps is getting much better information on health care outcomes from everybody that is paid through Medicare. Mr. Hackbarth?

Mr. HACKBARTH. I agree with that, Senator, and I would just add that, as we have discussed in this committee before, there are a number of very important pilots and demonstrations under way in Medicare, testing how to incorporate some of these ideas into the traditional program. There is a disease management pilot. There are a number of different demonstrations under way on coordinated care and the like.

So I think you are absolutely right that we ought to be trying to introduce some of these into traditional Medicare as well.

Senator BINGAMAN. Why are we so tentative that we are just doing these by pilot? Why do we not just go ahead and require some of these improvements to be integrated into health care more generally?

Mr. HACKBARTH. Well, Dr. Draper may also want to address this. Some of them have yet to be well established as working effectively. Disease management is an idea that has been around for a while. It sounds compelling. It makes sense. It is intuitively reasonable. But the evidence, such as it is at this point, is somewhat mixed on how effective it is in improving care for patients. And we are starting to see some of that in the pilot, the Medicare pilot. There are some questions about whether, in fact, it is really working all that well.

So we have to get beyond the labels and ideas that sound good to really find out what works, and pilots and demonstrations are useful in that process.

Senator BINGAMAN. I think my time is up, Mr. Chairman.

The CHAIRMAN. Thank you very much. That is a very interesting line of questions, and, frankly, I think it is the key to what we have to do here, what the committee has to do. I thank the Senator for raising those questions, because it will determine later on the decisions we make in this committee.

Senator STABENOW?

Senator STABENOW. Thank you, Mr. Chairman. I appreciate all of you being here, and this clearly is not a one-size-fits-all. There are a number of different pieces to this puzzle.

But if I could just back up a moment and look at the big picture, I think it is important we do not lose sight of the fact that originally under Medicare+Choice the rate that was put into place was 95 percent of fee-for-service because of the argument of competition and it could be done more efficiently and so on. And then it went up to 111 percent when Medicare Advantage was put into place, and now we see a chart from CBO that even if we capped this at 150 percent, we would save money. That is a big difference. That is a really big difference.

So I hope when we are looking at this and when we hear that—and, Mr. Hackbarth, I believe you said that in some other plans, 50 percent actually goes towards beneficiaries and 50 percent towards not only overhead but I assume profit, I assume a number of other things.

And so I guess my question—Senator Bingaman was talking about the challenge of wanting to increase assistance for all beneficiaries so that everyone is getting access to good care. If the theory is that providing 150 percent of payment provides people with more care, more benefits, help with the doughnut hole on prescription drugs or lower cost copays for doctors, why would we not just say then everybody should do that?

Now, obviously, I am not suggesting that. We do not have the resources to do that. But if the theory is we need these more dollars because we can give people better care, I think that is an interesting debate given what we often hear from folks about the ques-

tion of health care. So I just wanted to make that statement, that the argument is being made: more dollars, more care can be given.

But at the same time, we are also in another hat, and MedPAC is suggesting we do away with the Sustainable Growth Rate (SGR) for physician payments because it is not fair, and I happen to agree with that. But we are seeing physician payments being frozen. So one of the concerns I have in rural Michigan is that fewer physicians are able to take Medicare as a result of what we have done under fee-for-service in some cases.

So I am just suggesting there is a broad picture here to look at, and when we look overall about whether we continue with some folks getting 150 percent, or 140 or 130, versus others seeing their fees frozen, physicians seeing their fees frozen, the bigger question is: Is it fair to say that these overpayments, first of all, will advance the date when the Medicare Part A trust fund becomes insolvent? Dr. Orszag, is that a fair statement?

Dr. ORSZAG. Yes, it would.

Senator STABENOW. And that curbing the overpayments would move back the date of insolvency?

Dr. ORSZAG. That is correct.

Senator STABENOW. And also that the overpayments actually increase the premiums for folks under fee-for-service, which you have indicated. Is that correct?

Dr. ORSZAG. That is correct, and I think that highlights a very key point, which is these additional benefits or reduced premiums for a select number of beneficiaries are being paid for by the rest of the beneficiaries and then workers through the Part A contribution. So it is not free.

Senator STABENOW. So would you then say it is fair to say that, if we were to, in a reasonable fashion, understanding there are differences in plans and so on, if we were to cap or roll back, that we would then be able to provide services to more people, potentially, or at least redistribute the dollars and certainly cap the premium increases that the majority of people are finding themselves receiving as a result of this program?

Dr. ORSZAG. That would be one way that you could use the funds that were—

Senator STABENOW. Or we could go back into solvency, certainly looking at other things. But the point is a small program versus—while everybody else sees their premiums going up, correct, to pay for it and in some cases only 50 percent of those dollars are actually going to the beneficiary. So I think there is a different kind of picture that can be painted here than some of what has been talked about, and it is one that concerns me greatly, Mr. Chairman, when we look at the dollars overall. Dr. Orszag, do you want to comment?

Dr. ORSZAG. I was just going to say I think what you are raising is, is this the most efficient way of delivering benefits of a certain type, and that is obviously a question for you to consider.

Senator STABENOW. That is the big question, yes.

Thank you very much.

The CHAIRMAN. Thank you, Senator.

Senator Salazar?

Senator SALAZAR. Thank you, Mr. Chairman.

Let me just ask two quick questions, and I would like Dr. Orszag and Mr. Hackbarth to answer the question.

The first is, Peter, on the chart that you sent around, which now we have copied but we do not have the color, it is incredible to me that in some places of our country—Colorado, for example—we have what appears to be a \$3,000-per-year disparity in terms of Medicare spending per capita from what we do in most of the internal part of our country, most of the Mountain West, the rural areas of Kansas and Montana, versus what is being spent in places along the coast and in the Southeast. So I would like to know, give me the top three quick reasons as to what explains that disparity in terms of spending. So that is one question.

The second question that I want you to answer is, give me the top three reasons as to why. You know, your conclusion in your report, Peter, is Medicare payments for beneficiaries in the Medicare Advantage plans are higher than traditional fee-for-service. That is what we have been discussing here. But why is that? Give me the top two or three reasons why Medicare Advantage ends up being more expensive than the fee-for-service program under Medicare?

So why do you not take a couple of minutes on that, Peter, and then, Glenn, why do you not take a couple of minutes on that as well.

Dr. ORSZAG. Sure. This variation, I think, is critically important and deserves a lot of scrutiny, the variation in fee-for-service costs across the country. It does not seem to correspond to improved health outcomes. In other words, the higher-spending regions do not generate better health outcomes than the lower-spending regions. And, if anything, it goes in the wrong direction.

Senator SALAZAR. Has anybody taken a look at it?

Dr. ORSZAG. Yes. There is a lot of work, and, in fact, CBO will be—MedPAC has a group, Dartmouth has—CBO will be doing a lot more work on this.

What I would say is you can tie it to specific things like rates of readmission to hospitals following incidents, but a lot of the variation is arising in areas where we do not know what works and what does not, and, therefore, doctor norms become dominant.

For example, if you look at hip fracture surgery, when you fracture your hip, you are going to get surgery. There is very little variation. Follow-up costs to hip fracture surgery—I cannot tell you whether you should go see a doctor twice a month or four times a month following that. There is a lot of variation in the follow-up costs, and that is because in some areas, you know, there is a norm to do it a lot, and in other areas not. And that additional cost does not buy you anything.

Senator SALAZAR. I would like to find out a lot more about that, and I am sure it is going to be a continuing conversation.

On my second question, why do we have this disparity in terms of fee-for-service as in Medicare Advantage? Why is there that disparity there? Give me the top three reasons for that disparity.

Mr. HACKBARTH. What causes the Medicare Advantage rates to be higher than fee-for-service?

Senator SALAZAR. Yes.

Mr. HACKBARTH. There are a few basic elements. One is what is known as the floors in the rates. By statute, Congress established

floors on the Medicare Advantage rates in some parts of the country, lifting the payments to Medicare Advantage above fee-for-service costs.

The second issue is how indirect medical education costs are paid for, and basically they are double-counted, as we see it.

Then the third major element here I am forgetting. Those are the two biggest.

Senator SALAZAR. So if Congress were to do something with the floors, we could address that issue.

Mr. HACKBARTH. Yes, that is where it comes from. Principally the floors are the single biggest item.

Senator SALAZAR. In terms of some of the concepts, I think about the 150,000 or so people—many of them in rural areas, many of them low-income—in my State who receive great benefits from the Medicare Advantage program. I am in a position, like Senator Roberts, where I care a lot about those people out there in the rural parts of my State, and I do not want them to be in a place where we end up having such a disparity in terms of the health care that they receive. And when I look at some of the coaching programs and sort of the comprehensive health care under Medicare Advantage that is provided to those people, I am concerned about what happens if we go to a fee-for-service for them as well.

Mr. HACKBARTH. Yes. Well, I think Senator Stabenow had it just right. The question is, how we do this most efficiently. I think a lot of us would agree with the goal of providing better support for low-income people. Do we accomplish that most efficiently through high payments, overpayments in my view, for Medicare Advantage plans and then only a fraction of that finds its way to beneficiaries and only a fraction of that finds its way to low-income beneficiaries? Or do we do more targeted support to low-income beneficiaries, as we have in the Part D program, as we have in the Medicare program more broadly?

If the goal is to target low-income beneficiaries and support them, we know how to do that much more efficiently than we do it through Medicare Advantage.

Senator SALAZAR. My time is up, and I thank you both and the entire panel for your answers and testimony today.

Senator LINCOLN [presiding]. Well, apparently, I am acting and it is also my turn to ask questions, so thanks to the panel. We appreciate so much your input on this really critical issue of health care delivery. So many questions and so little time. I will try to get to the first part of mine.

Dr. Orszag, you raised a very important point in your testimony about considering the rapid growth of Medicare Advantage and how critical it is that we determine whether or not the program is really providing the kind of high quality and cost-effective care.

I know that Mr. Hackbarth also brings up the payment for more measurable results, making sure that there is a pay-for-performance type movement so that we are actually getting that quality of care, which in turn saves us money in the long run.

I have certainly been a long-time advocate of chronic care management, having seen through our Center on Aging that when you deal with multiple diseases and the care of those chronic disease initiatives, particularly in our aging population, you get much bet-

ter results in the end in terms of both quality and cost. But I know that we also find that the results of chronic care management are very difficult to measure.

One of the problems we have here—and it is an important note, I think—is that when CBO scores a bill for us—I have introduced a bill in the past and will introduce it again on chronic care management—the benefits of the chronic care management may not fully be realized within a 5- or 10-year budget window. So considering the realities of chronic disease prevalence in America and its impact on our health care utilization, do you think that maybe at some point CBO will have to adapt to some kind of dynamic scoring methodology or some consideration? We never get any scoring through CBO that indicates whether the use of prescription drugs is helpful in terms of bringing down costs, making sure of access, a host of different things.

Is that going to play a role? Can we see a role in that?

Dr. ORSZAG. What I would say, Senator, is CBO—and I personally am very interested in providing qualitative information to you about the things that may help bend the curve over the long term. The budget scoring window is defined by Congress, and so, you know, we are implementing your rules. So in many cases—and disease management is among them—there are two questions: one is when would any savings occur; and then, secondly, to what degree are those savings based on solid evidence and information?

With disease management, we have written that certain programs in selective cases that are targeted seem to produce savings, but, in general, the literature on that actually—and I think this was mentioned in one of the other testimonies—is not as robust and rigorous as one would have hoped, and so we are actively searching for continued information and more information on disease management. But based on what has been done so far in a rigorous fashion, the examples of cost reductions are selective rather than general.

Senator LINCOLN. Well, it is interesting because you mentioned the follow-through and the ability to be able to determine, you know, the methodology of actually the practitioner. I am thinking of issues like therapy caps and other things. Where the hip fracture happens, you have the surgery, and then what is the next step and how do those things—how many of those types of things play into, again, the quality of care and the sustainability of the kind of chronic conditions that maybe we are creating as opposed to the savings we could be realizing if we implemented things that could be predictable, like removing therapy caps? We certainly know that the elderly, without a doubt, if they get that physical therapy, they are much more likely to become more independent and certainly deal with a better quality of life later on. There are things there that perhaps we could do a lot more in.

Dr. ORSZAG. Senator, there is a wide variety of evidence suggesting, consistent with this variation that does not correspond to improved health outcomes, that you could take cost out of the system without harming health. And I think the central challenge is finding out how to do that.

One step that would be beneficial is, we need to expand the set of activities so that we are actually measuring what works and

what does not, so various people are talking about comparative effectiveness organizations or creating an entity to do or expand that work. It seems to me like we need to substantially expand the share of medical costs where we know what works and what does not, move much more towards the clear guidance on hip fracture surgery, much less from who knows how many times you should go and see a doctor following that surgery.

Senator LINCOLN. Well, we appreciate your work and certainly want to continue to work with you on how we can be more effective. And if we need to do something up here, I am certainly game.

Mr. Hackbarth—the prescription drug program. I supported it, worked my tail off when I got home to Arkansas to ensure that as many of my constituents as I could were educated on how we move forward on that. We know its implementation has not been without problems, and despite the incredible outreach we were able to demonstrate in Arkansas, working through multiple organizations in the community, we still have a lot of confusion among our seniors. It is a complex program, and one of the problems that has been brought to my attention since the implementation is that some seniors are enrolling in Medicare Advantage plans without really understanding what they are. I do not know. This may have been brought up by others, particularly those who are mentioning the rural aspects of things or who have low-income populations. They thought they were getting a prescription drug plan, and they did not realize that they were getting out of traditional Medicare and into a Medicare Advantage. And once they discovered what had happened—usually there is some problem. Their normal provider is not covered, what have you, and they want to switch back. According to our caseworkers in our office, re-enrolling them back into traditional Medicare is an administrative nightmare.

So I am just looking at this problem twofold. First, MA plans need to be 100 percent clear in their marketing on how they compare to the traditional Medicare; and, secondly, if a senior inadvertently or without full understanding enrolls in a plan that is inappropriate for his or her needs, there should be a way to remedy that situation without undue burden.

Have you come across this problem during your review of the Medicare Advantage program? And do maybe any of the other panel members have comments on it?

Mr. HACKBARTH. Only anecdotal evidence, Senator Lincoln. It is not something that we have systematically collected data on.

At various points in time the Commission has talked about the daunting complexity of the choices that Medicare beneficiaries now face—

Senator LINCOLN. Particularly dual eligibles.

Mr. HACKBARTH [continuing]. With Medicare Advantage and the prescription drug program and so on, and they clearly struggle. We looked at it fairly closely, did some focus groups and the like, specifically around the Part D program, and heard firsthand how difficult it was for many beneficiaries.

So, generally speaking, I agree that there are challenges, and we do not provide nearly enough support to beneficiaries to help them navigate their way through this increasingly complex—

Senator LINCOLN. We were using Sunday school classes and Rotary Clubs. They could not get the assistance they needed from the Government.

Mr. HACKBARTH. Yes.

Senator LINCOLN. Well, any further information you have on how we do better on that, I would certainly appreciate it.

The CHAIRMAN. Thank you, Senator.

Senator SNOWE?

Senator SNOWE. Thank you, Mr. Chairman.

Dr. Draper, reviewing this book that is issued by CMS on "Medicare and You," obviously the way in which it describes which plans people should join or encouraging them to join, it certainly in the descriptions would indicate that the way in which it is described for Medicare Advantage, it becomes much more attractive. In the original Medicare plans, your costs may be higher than in Medicare Advantage plans. Under Medicare Advantage, it says your costs may be lower than the original Medicare plan, and you may get extra benefits.

I am wondering, do you have a profile of those who have joined the Medicare Advantage plans? Do we know who has joined these plans? For example, in my State there are only 800 Medicare beneficiaries who have joined a Medicare Advantage plan. So do we know exactly who has been attracted to this plan?

Dr. DRAPER. We have not done any work specifically on that, and maybe some other folks can comment on that. But we really do not have profiles on individuals who have joined the Medicare Advantage plans.

Senator SNOWE. Dr. Udvarhelyi, do you know?

Dr. UDVARHELYI. I do not recall off the top of my head, but we could get that information to you. I think that we could give you some information of the types of individuals who joined.

Senator SNOWE. I think just a cursory review of this, and it then goes on further. "When you look at the Medicare Advantage plan," it goes on to say, "they generally offer extra benefits. Many include Part D coverage, in many cases your costs for services can be lower than the original Medicare plan." Medicare pays an amount of money for your care every month to these private health plans whether or not you use services.

Dr. DRAPER. One thing I will say, though, we do know that—and I think it has come up quite a bit in the conversation this morning—there is a lot of variation from plan to plan.

Senator SNOWE. That is a very attractive description for anybody who is, you know, giving it a cursory examination, not to mention the book is overall, I think, very indefinite and could be somewhat confusing to anybody in terms of sorting it out. But if they were to look at the initial description, then obviously the Medicare Advantage would be a very attractive plan.

Dr. DRAPER. Right, but you have to look specifically as to what specific added benefits may be provided by plans.

Senator SNOWE. Dr. Orszag?

Dr. ORSZAG. There is information available through, for example, the current beneficiary survey, access to care files that we could provide to you on the types of beneficiaries who are taking up Medicare Advantage.

Senator SNOWE. Well, it would be interesting to know, because obviously we are dealing with a distortion and an inequity in the overall Medicare plan, and making the distinction between, you know, plans in terms of what services are being offered, particularly on prevention, which has been, you know, lagging certainly in the traditional fee-for-service. And at the same time, we are looking at the acceleration of enrollment when we are looking at the numbers for the future, not only in the costs that are estimated to be \$194 billion over the next 10 years in terms of the subsidy for Medicare Advantage, but also an acceleration in terms of overall enrollment and growth in the program.

That brings me to the next question. What about the hold-harmless provision that is phased out in 2011, Mr. Hackbarth? Is that something that we should do anything with in advance of 2011?

Mr. HACKBARTH. As you know, Senator, the hold-harmless payments are designed to protect plans from lower payments due to the implementation of a risk adjustment system. I think everybody agrees that we need to risk adjust the payments and that that system is going to reduce payments for some plans. So hold-harmless tries to protect plans against lower payments.

MedPAC's view—and we last took this up several years ago—was that those payments ought to be phased out as quickly as possible. We made a recommendation then to Congress that that be written into statute. The schedule that you refer to is the schedule that was written into law at that point. So we are in favor of getting to zero on that number as quickly as possible.

Senator SNOWE. Dr. Orszag?

Dr. ORSZAG. I would just add one thing, which is that another component of the risk adjustment system is the, not evil, but just natural incentives facing private plans relative to the traditional program for classification of risk. There are upcoding incentives for the private plans to make sure that beneficiaries are coded in perhaps the appropriate but the highest-risk category possible that is not present in the traditional program, and that could be adjusted for in the payment structure but is not currently.

Senator SNOWE. I see. Well, I think the point is here, too, you can be building in inefficiencies in the program given the level of subsidies and the way in which this is designed.

And for my final question, Mr. Hackbarth, you stated that private fee-for-service obviously is the fastest-growing part of the plan. At the same time, program payments on behalf of private fee-for-service are 19 percent of the traditional fee-for-service in Medicare, but only half of that excess amount is used to finance extra benefits. Exactly what is the other amount going for? Do we have a breakdown of how the increased amounts are being distributed?

Mr. HACKBARTH. Yes, Senator, actually there is a table in my testimony, if you have that in front of you, that may be helpful. It is on page 4, Table 2. Let me just focus on the last column. Do you have that?

Senator SNOWE. Yes. Which page?

Mr. HACKBARTH. Page 4, Table 2. Let me just tell you what those numbers means in the last column.

For private fee-for-service plans, the average bid for Medicare Part A and B services—page 4, Table 2, Senator.

The CHAIRMAN. Page 5, I think. Table 2, page 5.

Mr. HACKBARTH. The version you have is a more recent one.

The CHAIRMAN. Thank you.

Mr. HACKBARTH. So Table 2, the average bid for private fee-for-service plans is 109 percent of what it costs traditional Medicare to provide those same benefits. The total payment going to private fee-for-service plans, as Senator Snowe said, is 119 percent of traditional Medicare's costs. Of that 119 percent, 10 percent goes into what we refer to as the rebate. That is the added benefits for beneficiaries. The rest of the money the plans keep to cover the fact that they have a higher cost structure.

Now, in that 10 percent that goes into the rebate for beneficiaries, a piece of that is also due to plan administrative costs and profit, executive salaries and the like, so it does not all get into the hands of beneficiaries. So, again, the general point is, if we are trying to help, say, low-income beneficiaries and this is the vehicle we are using to do it, a lot of the money is not making its way to low-income beneficiaries. It is going to other purposes. A lot of this money goes to high-income beneficiaries. Even the piece that gets through to beneficiaries at all is going to high-income, not just low-income.

Senator SNOWE. Thank you very much.

The CHAIRMAN. Thank you very much, Senator.

Senator Kerry?

Senator KERRY. Thank you very much, Mr. Chairman.

Thank you, folks. A lot of questions have been asked here, but I am still troubled by a couple things which I want to try to get at.

The question is, how do you get at the efficiency here? Currently, in Massachusetts I think about one out of five people is in the Advantage, in the private, somewhere in that vicinity. Now, if their service is being repaid at whatever it is, 115 percent, 120 percent in some cases in the privates, the difference is being picked up by the folks in Part B, correct?

Mr. HACKBARTH. Part of it.

Senator KERRY. That is being spread to them in a higher premium.

Mr. HACKBARTH. Yes, so Medicare beneficiaries in general pay a higher Part B premium to help the—

Senator KERRY. To pick up the additional on the upside of what is being paid.

Mr. HACKBARTH. Right.

Senator KERRY. So that, in and of itself, on its face, sort of seems inefficient, number one.

Number two, the original figure—this is an article in the Tampa Tribune a few weeks ago: "Tom Scully, who masterminded the shift of billions of Medicare dollars into private HMOs, admitted Friday that he overdid it. As Director of the Centers for Medicare & Medicaid Services from 2001 to 2003, he said he funneled extra money into Medicare Advantage plans. He knew the plans would have to spend the extra money on their members, offering zero-premium plans, eyeglasses, hearing aids, gym memberships, and other freebies. It was done to 'prime the pump' and get people to go back to HMOs, but it is a much bigger subsidy than we intended."

Obviously, you agree with that, and I think it is important to get a threshold beginning place here.

But the question, again, is sort of this issue of efficiency. What would happen if everybody opted for Medicare Advantage? I assume we would have a serious financial problem.

Dr. ORSZAG. Yes, and just coming back to your previous line of questioning, about half of the additional cost is paid through higher Part B premiums and about half comes out of the Part A trust fund, basically. So if you expanded the program and expanded the payments going into the program, there would be more pressure put on a dwindling share of people left in the traditional side of it.

Senator KERRY. But does that not in and of itself—and perhaps you all want to weigh in, doctors—say something about the efficiencies here? Our job is to try to get the efficiencies and to try to have a system that is paying—I mean, there is a certain stupidity in paying out a whole bunch extra to private folks who may not be as efficient as what we are trying to achieve. Is that not correct?

Dr. UDVARHELYI. Senator, if I could comment, I think one of the fundamental differences I mentioned is that there is no infrastructure in the private and in the traditional fee-for-service Medicare arena to do some of the interventions that I described. It just does not exist. So they will not happen there. So you need an infrastructure and that—

Senator KERRY. Describe that to me.

Dr. UDVARHELYI. The infrastructure that I am talking about includes all the care management, disease management, but one of the fundamental differences is we do not just interact with the beneficiary; we also interact with the physician. We have a relationship with the physicians and the hospitals and with the member. And so it is that relationship—which takes people to do—that is a part of that infrastructure, is a part of our administrative costs. We think it provides value, and I think the data do show that in—

Senator KERRY. And what you are saying is, if you went down to the level of the standard Medicare fee, in effect, you are going to be losing that, and that is, in effect, losing a quality. Now, is that a quality that we are not measuring somehow appropriately?

Mr. HACKBARTH. You know, I agree with Steve to a point. But I think it was before you came, Senator. The other side of this story is that not all of the plans are doing the things that Steve talks about. And even among some who say they are doing it, they are not producing results.

Senator KERRY. Right. Understood.

Mr. HACKBARTH. But we treat them all, we pay them all the same amount as if they are all doing good things. And they are not.

Senator KERRY. So the fix here, our job, is rather than to have this one-size-fits-all fix, to think of a middle ground that, in effect, comes up with standards? Maybe you already went over this. I am not sure. But is it to come up with standards that, in effect, guarantee what is happening to that dollar and still provide the options to people?

Mr. HACKBARTH. Yes. Before you arrived, Senator Bingaman was actually sort of walking through this and saying some of the building blocks are things like we need data on all types of plans, and we do not get data on all types of plans and how they perform.

Another potential building block is pay for performance. If we want to reward good care coordination of disease management, let us pay for it where it produces results and not where it is just a slogan or it does not exist at all.

Senator KERRY. That is fair and, therefore, I would ask the question: Does the current payment system for Medicare Advantage reward efficiency and does it reward quality? And if we were to find a way to put those two elements in there, would you skin this cat more effectively?

Mr. HACKBARTH. As currently structured, I do not believe it rewards either efficiency or quality.

Senator KERRY. That would be my judgment, too.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

Continuing on this point here, Mr. Hackbarth earlier today said there are excessive costs—I think those are your words—in Medicare Advantage plans, so one question is really what are those costs, if you could identify what you regard as “excessive.” But that gets to the points we all kind of grapple with here, namely, it is efficiencies and how do we separate the wheat from the chaff. That is, how do we separate the good plans from the not-so-good plans? How do we know? We do go back to data to some degree to answer that question, and if that is your sole answer, what data do you really need? But if that is not your sole answer, how do we separate the wheat from the chaff? How do we make that separation? I will ask Dr. Orszag first and then Mr. Hackbarth that same question.

Dr. ORSZAG. I think it is obviously a critical question, and I think there are ways of tying payments to Medicare Advantage plans to the performance on specific measures, like the ones that have already been mentioned. Then, furthermore, going beyond that, starting to tie payments to actual outcomes, which would be the ideal situation, outcomes in terms of both quality and in terms of mortality and morbidity and what have you.

We need to be moving the Medicare Advantage system towards that objective aggressively if you want to move towards higher-value health care, but we cannot leave out the rest of Medicare either. Even in 2017, remember, under our projections, the vast bulk of beneficiaries are going to be in the——

The CHAIRMAN. Right. That is right.

Mr. Hackbarth, your thoughts on that question.

Mr. HACKBARTH. I think that there are three basic levers that you can pull. One is plan type. Although I have said several times that not all HMOs are created equal, I think we can point to private fee-for-service and say it inherently has the least potential——

The CHAIRMAN. That is the one that has more latitude.

Mr. HACKBARTH [continuing]. And it has the least potential to alter patterns of care in constructive ways.

The CHAIRMAN. Right.

Mr. HACKBARTH. Second, we need to, on an ongoing basis, improve the measurement of quality, and Peter has addressed that, so I will not dwell on it further.

Then the third piece is to start linking payment to quality, pay for performance, which I know you have advocated, in traditional Medicare as well.

I think those are three levers to try to improve the efficiency of what we are buying here, get more bang.

The CHAIRMAN. Let me ask Dr. Draper and Dr. Udvarhelyi that same question. Your thoughts, either of you?

Dr. UDVARHELYI. Well, Senator, just one observation. I think one of the challenges we have is that, while we would advocate for, you know, accountability in the system and improved information on outcomes, the challenge we have right now is that the best data we have are in HMOs and in some cases PPOs. We really have the least data in the traditional fee-for-service environment.

So I do not really think we know what that comparison would be, and there is room for improvement across the board. But I do not think we really understand—

The CHAIRMAN. Who can design that comparison? Who can design the data that we want? What outfits?

Dr. UDVARHELYI. Well, some of the work is—

The CHAIRMAN. They are doing that, but it seems to me it is a fundamental question.

Dr. UDVARHELYI. Some of that work is ongoing. For example, we and others, there are about 125 organizations now participating in AQA, which has produced 121 measures of quality. There are demonstration programs going on with CMS in six cities right now to get that information. And it is not just for purposes of measuring performance that could lead to pay for performance, not only at the health plan level but also at the physician and hospital level, but to give members, individuals, better information about how to make their health care decisions, where they would want to go and seek care.

The CHAIRMAN. Dr. Draper?

Dr. DRAPER. I also think it is a value proposition. Are you paying for value, and how do you define value? And to define value you really have to have, you know, accountability and ways to really measure that. And I think on the commercial side we see that, as employers are requesting plans to demonstrate that, they are providing value. And I think it is the same question on Medicare as well. What are you paying for?

The CHAIRMAN. To what degree does the cost structure in Medicare Advantage plans, that is, in salaries and administrative costs and so forth—because they are private outfits—outweigh or is less than the additional quality of care given, whether it is managed care, whether it is immunizations, and all the extra things that we are talking about here?

Dr. ORSZAG. Senator, in my written testimony, we tried to address that question. Unfortunately, the lack of reporting means that we cannot definitively answer. The limited information we have suggests that the quality of care delivered through private plans is not better than in the traditional program and, therefore, on a cost-effectiveness measure, it is not better.

The CHAIRMAN. Does anybody disagree with that or want to modify that statement?

Mr. HACKBARTH. Well, what I would say is that, again, the performance of private plans varies greatly. Peter is referring to an average, which is a blend of a lot of different plan types with very different—

The CHAIRMAN. On average, would you agree?

Mr. HACKBARTH. Let me put it this way: I would not disagree. I have not looked specifically at their calculations. But some private plans—and here I would be with Steve. Some private plans demonstrably are better than traditional Medicare.

The CHAIRMAN. So I am asking the same question. How do we identify those plans?

Mr. HACKBARTH. We have crude measures, and I would be the first to admit that they are limited at this point. This is not just an issue for Medicare or Medicare Advantage. This is an issue for society as a whole. A lot of effort is being invested in a lot of different forums in improving our ability to measure quality of care, in private plans, in traditional Medicare, everywhere. I am cautiously optimistic that we can continue to improve those measures.

Frankly, more support from the Congress could help advance that cause of better quality measurement. But, you know, it is not something we are going to get to the goal, you know, 2 years from now or 3 years from now. It is going to be an evolutionary process.

The CHAIRMAN. We need to start.

Mr. HACKBARTH. We do, absolutely.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. I just have one last question.

Mr. Hackbarth, I continue to believe that there are significant regional implications in this issue, and that for the Finance Committee to really get its arms around what to do, certainly in the short term, we have to get information on these plan bids that is below the national level, that essentially is at the State level.

My understanding is that you all have that information. If that is correct, can you give us within a week—this committee, the staff of the Finance Committee, you know, both sides—that information so we can look at it?

Mr. HACKBARTH. Well, first of all, the information that we have is the information that we get from CMS, and in that information, as I understand it, the plan bids are not broken down by geographic area. They are not required to do that.

Senator WYDEN. I understand that. Is there anything then below the national level? Remember, you already told me that there was valuable information below the national level. Is there or is there not such information?

Mr. HACKBARTH. I do not mean to be difficult, Senator. I am really trying to answer your question. The information that we have at a much more granular level is about the Medicare side of this proposition, how Medicare payments vary geographically. What we do not have at the same granular level is how private plan costs vary geographically. That is because they are not required to report it.

Senator WYDEN. What I am being told is that that is not accurate. I think I will ask it this way: I would like to have from your organization all of the information, whether it is county or State,

all the information you have below the national level, because we have to see that to get our arms around it. You have heard a number of Senators talk about it. It goes right to the heart of the efficiency question as well.

Mr. HACKBARTH. And I am eager to support you, Senator.

Senator WYDEN. So you will get that to us? Can we have that within a week?

Mr. HACKBARTH. I cannot make that commitment, because I do not know.

Senator WYDEN. But my understanding is, hasn't the Finance Committee been talking to you about getting that information for some time?

Mr. HACKBARTH. There have been discussions at the staff level, and——

The CHAIRMAN. The answer is yes. According to our staff, the answer is yes.

Mr. HACKBARTH. Yes. And so——

Senator WYDEN. Would the people at CBO want to say something?

Dr. ORSZAG. Yes, I would. This may help clarify it. I do not know. What we have, or at least what I know we have at the regional or the State level is the benchmark and the local fee-for-service costs. So we have that ratio. That is different from the bid that the plans put forward, and it is an important element in how much Medicare pays the plan. So we have enrollment and we have those benchmarks relative to fee-for-service.

Senator WYDEN. I would like both of your organizations—you, Mr. Hackbarth, and the people at CBO—to give us all of the information you have on these plans that is below the national level. We have to see everything you have, and can we have that within a week? Because we have been asking for it for some time. This is obviously an issue, as you know, Mr. Hackbarth, of great importance in our State. And what I am concerned about is we are just going to go to this one-size-fits-all, cookie-cutter approach. And a place like Oregon that has already been hammered for doing the right thing—being innovative, holding costs down, reducing volume—is going to get hit again. So I need to see this information, and that is my request to both of you, that we have everything you have below the national level to the Finance Committee staff within a week.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. Just a couple of final questions.

Dr. Udvarhelyi, you quoted I think in your testimony, talking about higher rates of satisfaction among beneficiaries enrolled in Medicare Advantage plans, and then you go on to quote the MedPAC report where you tell us that care coordination is more difficult to do in fee-for-service programs because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structure.

My understanding is that MedPAC reports on what is and not necessarily what will be, but I am hoping that you and Mr. Hackbarth can help me better understand why we cannot coordi-

nate under fee-for-service. And maybe you might consider for a moment that payment methods and organizational structure are starting to evolve to better account for changes in demographics and clinical needs for the beneficiaries and moving more towards care-setting, neutral methodologies. And if that is the case, then, you know, would you support efforts to improve chronic care management under fee-for-service? Which I think is an important move in the right direction.

Dr. UDVARHELYI. Senator, I would support efforts to improve chronic care management because I think it is critically important, particularly in the Medicare population.

But to give an example of why I think there are challenges in the fee-for-service Medicare arena, now that we have Part D coverage, let me just give you an example from prescription drugs about what a plan like ours has, and I think this is true for other Medicare Advantage plans.

When a physician is seeing a patient in their office, they know the drugs they are prescribing. They do not know whether the patient filled them at the pharmacy. They do not know what drugs their colleague down the street prescribed. And even if they have total electronic medical records with instant access, they will not know that.

What we will know is, we will know what prescriptions were prescribed by that physician, all other physicians that are seeing that patient, what those drug-drug interactions may be if they are dangerous for that patient, and whether, in fact, the patient actually filled the prescription. And that is the type of coordination that we can provide both to the physician and the member that makes a difference.

As I said before, that takes an infrastructure, and that infrastructure—which is what Medicare Advantage plans are providing today—does not exist in the fee-for-service environment.

Senator LINCOLN. Well, the reason I say that is because to me it seems that the bang for the buck that we save is really more in the fee-for-service if you have chronic care management there, as opposed to what you were already doing. So if what we are looking to do is manage our Medicare dollars in a better way, we get a better bang for our buck in doing it through Medicare fee-for-service.

Dr. UDVARHELYI. That may be true, but I think it was mentioned—I think Mr. Hackbarth mentioned it—that some of the early results for the pilots in the fee-for-service arena may not be showing some results. I would suggest to the committee that, maybe the reason for that is there really is not the same integrated infrastructure by just overlaying a simple sort of “disease management lite” would be my term for it, on top of a traditional fee-for-service environment. The relationships with the physicians, the hospitals, the integration there, and, more importantly, the investments in data management—

Senator LINCOLN. That goes to my second question, which is the IT issue and the whole investment that needs to be made in terms of providing—I do not really necessarily understand your answer of why electronic records would not provide better information for that physician practicing and realizing that what other physicians

are prescribing may have a conflict of interest in terms of what that physician might be doing.

We are seeing in our State one of our corporate citizens who is providing now to their health care beneficiaries and their company an option of electronic records that I think will be setting a stage for a tremendous infrastructure of where the patient himself can begin to go towards electronic.

Of course, we have a lot of bugs to work out in that in terms of interoperability and merging of records. I know my most recent visit to a physician was one that had upgraded and gone to IT and electronic records, but they had had to go back to an old system because incoming patients had to be duped into the system in a way that it would be useful.

But I think the infrastructure investment in IT is going to be critical if we are ever going to get all of this data that you all keep telling us does not exist.

Mr. HACKBARTH. Senator, I am hopeful that we can improve Medicare, traditional Medicare fee-for-service and figure out ways to better reward care coordination and the like. It is not a slam-dunk, but I think it can be done.

There are, as Steve says, limits to what can be accomplished in traditional Medicare by virtue of its structure, and this sort of brings us full circle to Senator Baucus' opening statement. The original reason for this program was the conviction, which I shared, then and now, that private plans can do some things better than traditional Medicare, especially when they are working with defined networks of providers with whom they have close relationships, maybe linked by special information systems and the like.

The point, though, that I am making about Medicare Advantage is, it is not just rewarding those plans doing those good things. The money is being paid out indiscriminately and rewarding poor-performing plans just as much as the good plans.

Senator LINCOLN. That is a point well taken.

Thank you, Mr. Chairman.

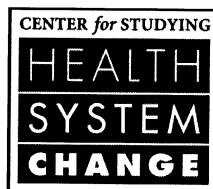
The CHAIRMAN. Thank you, Senator, and thanks to everybody here. I appreciate it very, very much. This has been very constructive. I think at some point we need a hearing on health IT, frankly, so we move that ball as efficiently and as productively as possible. But this has been very, very helpful. Thank you very, very much, all of you.

The hearing is adjourned.

[Whereupon, at 12:07 p.m., the committee was adjourned.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD



Commercial Health Plans' Care Management Activities and the Impact on Costs, Quality and Outcomes

Statement of Debra Draper, Ph.D.
Associate Director
Center for Studying Health System Change

**Before the United States Senate
Committee on Finance**

Hearing on the Medicare Advantage Program

April 11, 2007

Statement of Debra A. Draper, Ph.D.
 Center for Studying Health System Change
 Before the Senate Finance Committee, April 11, 2007

Chairman Baucus, Senator Grassley and members of the Committee, thank you for the invitation to testify about the Medicare Advantage Program. My name is Debra A. Draper, and I am a health services researcher and Associate Director of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded principally by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research.

HSC's main research tool is the Community Tracking Study, which consists of national surveys of households and physicians in 60 nationally representative communities across the country and intensive site visits to 12 of these communities. We also monitor secondary data and general health system trends. Our goal is to inform policy makers with objective and timely research on developments in health care markets and their impacts on people. We do not make policy recommendations. Our various research and communication activities may be found on our Web site at www.hschange.org.

My testimony today is intended to inform the Committee about what we and other researchers know about commercial health plans' care management activities and the impact of those activities on costs, quality and outcomes.¹ My comments draw largely from our most recent site visit work in the 12 Community Tracking Study sites—Boston, Cleveland, Greenville, S.C., Indianapolis, Lansing, Little Rock, Miami, northern New Jersey (Newark), Orange County, Calif., Phoenix, Seattle, and Syracuse, N.Y.² These sites were chosen randomly to be representative of metropolitan areas in the United States, and we have conducted site visits to each bi-annually since 1996.

Our sixth round of site visits is currently underway, and they include interviews with key stakeholders of the local health care systems, including employers, health plans, policy makers, providers and others. We have found our triangulation (asking different stakeholders about their interactions with other stakeholders) is critical for getting not only a more complete perspective on a local site, but such an approach also provides us a mechanism to validate and ensure the reliability of the data that we collect. As in other recent site visit rounds, we expect to conduct approximately 1,000 interviews during this round. For our health plan interviews, we target three leading plans in each community and within each plan, speak with executives responsible for marketing, medical management and network management. The quotes found in this document are all from our 2007 interviews.

¹See for example, G.P. Mays, M. Au, G. Claxton, "Convergence and Dissonance: Evolution in Private Sector Approaches to Disease Management and Care Coordination," *Health Affairs*, forthcoming 2007. A. Short, G.P. Mays, J. Mittler, "Disease Management: A Leap of Faith to Lower Cost, Higher Quality Care," *HSC Issue Brief*, No. 69, (Washington, DC: Center for Studying Health System Change, 2003). S. Felt-Lisk and G.P. Mays. "Back to the Drawing Board: New Directions in Health Plans' Care Management Strategies." *Health Affairs*, vol. 21, no. 5 (2002): 210-217.

²Additional information on our site visit methodology and findings may be found on our Web site at www.hschange.org.

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My testimony today will focus on three key points:

- Although we have not specifically looked at Medicare Advantage plans in recent years, we have seen a growing trend in commercial health plans offering more care management activities, such as disease management, case management, and health promotion and wellness. Since our research has not specifically focused on Medicare Advantage, we do not know if these activities are also being conducted by Medicare Advantage plans, but the potential is there.
- While many commercial health plans offer care management activities, there is considerable variation across plans as to what is specifically offered and to whom. Health plans often package and brand these types of activities as a way to differentiate themselves in the marketplace. Consequently, determining the extent of these activities or the degree to which they are engaging their enrollees is difficult to assess.
- There is limited evidence to date as to what impact, if any, many of the care management activities that commercial health plans offer have on costs, quality and outcomes. Thus, financial support for these activities is difficult to rationalize unless those providing the funding expect that as health plans gain more experience and sophistication, results will eventually justify the investment.

COMMERCIAL HEALTH PLANS' CARE MANAGEMENT ACTIVITIES

As the cost of health care continues to increase, there has been a resurgence of interest in finding effective ways to curb the escalating trend. Much of the recent impetus has come from employers concerned about the growing financial burden of sponsoring employee health benefits. But it has also been fueled in part by the "consumerism" movement in health care, which among other things, shifts greater responsibility to the consumer for not only their health care costs, but also to more actively engage in managing their health and health care decisions. Many employers are looking to their health plans to offer effective strategies that respond to these issues. Health plans have often responded with a variety of activities around care management.

While many of the care management activities that health plans currently offer are not new, there is growing pressure from not only employers, but from the health plans themselves, to make them more effective. For example, a health plan executive in Seattle recently told us, "When disease management programs were more popular in the marketplace 10-15 years ago, these programs were popular for a period of time, but entities couldn't show quantitatively the impact of the programs so they faded from popularity. People are taking a swipe at it now and advertising better bells and whistles to show it makes a difference. They are promising that it works but whether they are effectively delivering on that promise, I'm not sure I know the answer to that. I also think that in the population of people and in the media at large, there's a huge demand for it. So as recognition becomes widespread about the high cost of health care and lack of good health, people are questioning what entities are doing about that. When they read

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about the obesity epidemic, diabetes, heart disease, cancer and certain way of life issues that are contributing to those issues, it brings back the focus to these programs.”

Funding for health plans’ care management activities comes from several sources. For self-insured employers, they are usually provided at an additional cost, while for fully insured employers, the cost is typically incorporated into the premium.

There is considerable variation among health plans as to what specifically they offer in the way of care management activities. Much of this has to do with how they package, brand and market these activities, which is often a way in which they differentiate themselves in the market. As one Cleveland health plan executive noted, “All plans offer these things. But it comes down to how you package these tools so that it looks like what you’re doing really works, try to differentiate yourselves. No health plan has the gimmick that no one else has. We all try to do it.” Health plans provide their care management activities through internal capacity, through external vendors, or some combination of the two. Some of the larger national health plans have subsidiary companies that specialize in these activities.

There are many health plan activities that can be broadly construed as care management. For purposes of my testimony today, however, I am focusing only on selected activities that include both enrollee-focused activities, such as case management and coordination, disease management, health promotion and wellness, and nurse advice lines, as well as process-focused activities, such as utilization management. Conceptually, these are all activities that aim to reduce costs and improve health outcomes by:

- Intervening with plan enrollees identified as having chronic conditions to delay (or prevent) further deterioration of health;
- Delaying (or preventing) the onset of chronic illness for those plan enrollees identified as being at risk for disease development; and
- Eliminating preventable, unnecessary and duplicative health care services.

Case Management

Case management and coordination activities target enrollees with health conditions that put them at risk for incurring large medical expenditures. These activities are individually customized to the needs of the enrollee and may include care planning, coordination of follow-up care, and telephone-based support and assistance.

A health plan in Cleveland is doing what a plan executive describes as “situation management.” After an enrollee is discharged from the hospital, the health plan assigns a care counselor to ensure that the enrollee understands discharge instructions, to determine if the enrollee has any unmet needs, and to make sure that all medications are being filled. The health plan instituted its “situational management” activities after identifying quality of care issues when enrollees were moving from one care setting to another, such as from hospital to home or hospital to nursing home.

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Disease Management

Disease management activities target enrollees with certain diseases or health conditions, commonly diabetes, asthma and other prevalent conditions. The objective of these activities is to encourage enrollees' adherence to standardized treatment guidelines and self-care and are generally facilitated by mail and telephone contact.

Across the communities that we study, nearly all health plans offer some type of disease management activities, although the number of these and the diseases or conditions they target vary by plan. Among the more common disease management activities that health plans offer are programs that focus on asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, high-risk pregnancies and hypertension. Additionally, health plans sometimes report offering programs for other conditions such as pain management and depression. An important challenge that health plans face around disease management initiatives is how to engage the enrollee's physician since these activities primarily interface directly with the enrollee. A plan in Cleveland, for example, is currently developing a data integration initiative in collaboration with one of its key provider organizations to better ensure consistency of efforts between the plans' disease management efforts and what takes place in physicians' offices.

Health Promotion and Wellness

Health promotion and wellness activities target enrollees irrespective of disease status or health utilization. These activities encourage enrollees to pursue healthy behaviors, including healthy eating and exercise. They also provide support to enrollees interested in changing unhealthy behaviors such as smoking. Across the communities we study, we see health plans offering a range of activities, including health risk assessments, gym memberships, weight management support and smoking cessation programs. In Seattle, a health plan executive said, "What we found are that expectations of employer groups are changing. About 55 percent of 1.2 million members spend less than \$500 a year. So if health care premiums are \$3,600 a year, people are asking 'what's in it for me?' So we're being more aggressive on the front end to keep people from deteriorating health. We're giving equal focus to wellness as to disease management. We've made changes by adding programs with a wellness focus—health coaches, for example. So if you do a health risk assessment and say you'd like to lose 10 pounds, the health coaches will work with you to achieve that goal." A health plan in Cleveland has wellness teams, which include nurses that go worksites to do health fairs. In northern New Jersey, a health plan there has a healthy eating program, where enrollees along with their primary care physicians decide on a goal weight, which includes periodic incentives in the form of a gym membership or cash for meeting targeted goals. The growing sophistication of information technology has helped facilitate plans' activities around health promotion and wellness. Enrollees are often able to access a variety of health-related information online.

Nurse Advice Lines

Nurse advice lines provide enrollees with telephone access to health plan clinical staff. The lines are usually staffed by registered nurses and operate 24 hours a day, 7 days a week. Nurses provide enrollees who call with a range of services, including education and advice on health

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conditions and self-care. They also provide triage services working with the enrollee to assess the acuity of symptoms to determine an appropriate course of treatment, and where alternative choices may be available, the most cost efficient. Health plans actively encourage enrollees' use of these services. A health plan in Cleveland, for example, includes a nurse line card and magnet in its packets to enrollees.

Utilization Management

Utilization management encompasses a range of activities that health plans use to manage the use of health care services. Among other things, these activities are intended to prevent medically unnecessary services. In many of the communities we study, over-utilization of high-end imaging services, such as magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, and positron emission tomography (PET) scans, has been problematic in recent years. In Cleveland, for example, health plans there reported seeing 20-40 percent growth trends in the utilization of these services, which prompted some to institute pre-certification of these procedures, which requires a medical necessity review, rather than a pre-notification, which typically only requires a courtesy notification to the plan. As one Cleveland health plan executive noted, "The interesting thing is that the denial rate is running only 1.4-1.5 percent. We're not saying no that much, but because people have to justify what difference the test is going to make, they aren't requesting it as much."

IDENTIFYING AND ENGAGING ENROLLEES

Health plans typically target enrollees that account for the largest share of costs for more intensive care management activities – often those with chronic such as asthma and diabetes, or rare health conditions. There appears to be a renewed interest on also focusing on enrollees with specific unhealthy conditions or behaviors, such as obesity, smoking and sedentary lifestyles. As one New Jersey benefits consultant describes it, "Now there is much more emphasis on appropriate discharge planning, catching folks before they need hospital care, figuring out who is at risk for incurring charges and getting those people into disease management programs or getting them a health coach."

The most common way in which health plans identify potential enrollees for more intensive care management is through claims data, both medical and pharmacy. With these data, for example, health plans identify potentially high-risk enrollees based on claims for hospitalizations, emergency department use, or other high cost services or procedures. Health plans often apply modeling software technologies to the claims data to predict the future health care expenditures of enrollees. Based on the predictive modeling results, enrollees are often stratified based on their projected risk levels. This allows health plans to better tailor the types and intensity of care management activities to the individual enrollee. For example, a designated low-risk enrollee may receive educational mailings, while an enrollee determined to be at higher-risk may receive more intensive services, including telephone contact.

Claims data are also used to identify gaps in care that may indicate that the quality of care that an enrollee is receiving is poor, which if not addressed, might eventually lead to further

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deterioration in health and higher costs. For example, a review of claims data may reveal that a diabetic enrollee has failed to receive certain services, such as a periodic blood test (hemoglobin A1c) to monitor how well they are controlling their blood glucose levels.

Another tool health plans are increasingly emphasizing to identify potentially at-risk enrollees is a health risk assessment. With the resurgence of interest in health promotion and wellness activities, we have seen interest in and use of health risk assessments grow across the communities that we study. A health risk assessment is a questionnaire, often available online, that collects information provided by the enrollee on items such as personal and family medical history, current diagnoses and symptoms, use of preventive and screening services, and health behaviors such as diet, physical activity, and tobacco and alcohol use. This enrollee-supplied information is then used to predict health risk, which may then flag the enrollee for more intensive care management. As one Seattle health plan executive describes, “We’ve introduced a health risk assessment tool for our entire membership and all of this self-reported data is put into electronic records. This tool is just beginning and we have only a small percentage of members using it. We are trying to promote its use more and more so that patients will use it on an annual basis to bring us up to date on health behaviors and if they fit into any chronic disease category.”

Once an enrollee has been identified as a potential recipient of more intensive care management, the next step is getting and keeping them engaged. Participation in most health plans’ care management activities is voluntary on the part of the enrollee. Many health plans report that engaging enrollees in care management activities is challenging. Most believe that some type of incentive is necessary to get and keep enrollees engaged, but few currently exist. The existing incentives vary widely and include, for example, free supplies (insulin and blood glucose monitoring test strips) for diabetics, cash incentives for the completion of a health risk assessment, and discounts off of gym memberships.

EVIDENCE OF IMPACT ON COSTS, QUALITY AND OUTCOMES

While it is relatively easy to measure the degree to which data analysis identifies at-risk enrollees with the potential for more intensive intervention, it is much harder to measure how successful these activities are in changing costs, quality and outcomes. It becomes even harder to measure long-term impacts.

Given too that many of the care management activities that health plans currently offer are new or not being extensively applied, the evidence suggests that most health plans do not know how effective they are, let alone researchers.³ Commenting on a wellness program offered by one

³Research evidence has grown in recent years but continues to be quite limited. For example, a review of selected peer-reviewed literature found estimates of return-on-investment from selected care management interventions ranging from zero impact to 640 percent. The literature mainly focused on programs for asthma, diabetes and heart disease that were implemented in controlled clinical setting—not a typical health plan setting. See, H.G. Dove and I. Duncan, *Estimating Savings, Utilization Rate Changes, and Return on Investment from Care Management Interventions: Selective Literature Review of Care Management Interventions*, Schaumburg, IL: Society of Actuaries, 2005.

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health plan, a New Jersey broker said, “The wellness program will cost \$50,000 a year, but they guarantee the return on that investment will be \$50,000 or more. We asked, how do you measure that? That’s where it got very cloudy.” The broker went on to add, “They say, we see medical indications that your obesity will result in two heart attacks, we think we can prevent those heart attacks, then we’ll tell you that you saved the price of those two heart attacks.”

Assessing effectiveness is complicated further, because health plans often introduce these types of activities on a trial or pilot basis, and depending on their assessment of that limited effort, decide whether to discontinue it or expand. A health plan in Little Rock, for example, recently piloted a health coaching program in its health maintenance organization (HMO) product. It worked with an external vendor to identify high-risk patients with diabetes and heart disease to target for more intensive care management. Based on an assessment of subsequent claims, the decision was made to extend the effort to the rest of its business.

There is, however, growing pressure on health plans from employers to demonstrate the effectiveness of care management activities. There is evidence that health plans are trying to respond, but assessing the effectiveness of many of their care management activities is still evolving. For example, a health plan in Cleveland that provides smoking-cessation support, began tracking the data less than a year ago. Preliminary evidence, however, showed a quit rate of 40-45 percent among a group of enrollees participating in the program that used both nicotine replacement therapy and smoking cessation counseling.

Despite the lack of evidence, some health plans and employers appear willing to invest in these activities—at least for now. Employers that we have interviewed often say that they believe activities like health promotion and wellness are the right thing to do and are particularly important as employees continue to assume a larger share of health care costs. In each of our communities, we hear from health plans, employers and others about the need to better engage consumers to be more aware of what health care costs and to be more proactive in their knowledge of health care and the use of services.

IMPLICATIONS FOR MEDICARE ADVANTAGE

There is considerable potential for health plans to apply many of their care management activities to Medicare, particularly if they find them to be effective. These types of activities may be even more beneficial for a Medicare population where chronic illness and other high cost health conditions are more prevalent. But the current evidence on their impact on costs, quality, and outcomes is sparse for a number of reasons, including the newness of many of these efforts, as well as the complexity of quantifying and measuring their effectiveness.

Despite the lack of evidence, we have seen some self-insured employers willing to pay for these activities, at least for now. So, the question for Medicare becomes to what extent is it willing to support experimentation and does this justify any of the extra payment to Medicare Advantage plans when plans would reap any savings? Since health plans are pursuing these activities in their commercial products, Medicare’s role in supporting experimentation is less clear. But if Medicare does want to pay for experimentation, should it pay directly for selected activities

Statement of Debra A. Draper, Ph.D.
Center for Studying Health System Change
Before the Senate Finance Committee, April 11, 2007

rather than paying higher overall rates? Further, how long should Medicare pay for experimentation and what outcomes over what timeframes should it expect?

Intuitively, health plan activities aimed at improving the quality and efficiency of care for their enrollees are a good thing. But without credible evidence on what impact they have on costs, quality and outcomes, it is difficult to justify financial support unless those providing the funding expect that the impact of health plans' care management activities will eventually yield results that justify the investment. To the extent too that care management activities do save money, they are self-financing and may not require extra support.

Debra Draper, Ph.D.
Associate Director



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*Providing Insights that Contribute
to Better Health Policy*

May 22, 2007

The Honorable Max Baucus
Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus:

Thank you for the opportunity to testify before the Senate Committee on Finance on April 11, 2007. Below, please find my response to the question from Senator Smith.

Question:

It has been noted that the efficiency by which managed care plans deliver services varies by the type of plan. Health Maintenance Organizations (HMOs) tend to deliver care most efficiently, while private fee-for-service plans appear—at least from MedPAC's analysis—to be the least efficient. It may very well be that by design HMOs are more efficient than other types of managed care models. Apart from the model used to provide care, what sort of other factors contribute to a plan's efficiency in delivering care? How could these factors be better utilized by all plans in the current MA program?

Response:

When considering different health plan designs, it is useful to think of them in terms of level of care management provided. Fee-for-service plan designs are at one end of the continuum; these designs provide the least amount of care management. HMO plan designs are at the other end of the continuum; these designs provide the greatest amount of care management. PPO plan designs lie somewhere between the two. At least conceptually, therefore, managed care plan designs are likely to be more efficient than fee-for-service plans as they are designed to more actively manage care, thereby reducing medically unnecessary and/or inappropriate service use. While it is increasingly difficult to differentiate HMO and PPO product designs in the private market as features of these products continue to converge (e.g., access to a broad network of providers), this is less the case in Medicare Advantage. Medicare Advantage HMOs continue to reflect many of the more active care management characteristics of traditional HMOs.

There are a number of factors that contribute to health plan efficiency, many of which are generally absent in fee-for-service plan designs, including for example:

- Provider network management activities, which may include:
 - Development and maintenance of an adequate provider network to ensure access to a full range of medically necessary services.
 - Credentialing of network providers to ensure that medical care is provided by qualified providers.
 - Establishment of reimbursement mechanisms for non-physician health care professionals (e.g., nurse practitioners, physician assistants) to receive payment for the provision of medically necessary services for which they are qualified to provide.
 - Negotiation of discounts with providers to achieve cost savings.
- Utilization management activities, which may include:
 - Prior authorization of services by the health plan prior to services being rendered, which often includes a clinical review to assess medical necessity. Failure to obtain prior authorization usually results in some form of financial penalty levied against the provider and/or enrollee, including the disallowance of payment for the services rendered.
 - Prior notification of the health plan by the provider and/or enrollee prior to services being rendered. While this is generally a “courtesy” notification (no clinical review to assess medical necessity is involved), failure to notify the health plan usually results in some form of financial penalty levied against the provider and/or enrollee, including the disallowance of payment for the services rendered.
 - Concurrent clinical review conducted by a registered nurse or other health care professional to determine the appropriateness of care and care setting. These reviews typically include recommendations to the provider and/or enrollee as to the course of care.
- Quality management activities, which may include:
 - Analysis of health plan and other data to identify and intervene with providers determined to have quality of care deficiencies, which if not adequately addressed, may lead to more extensive and expensive medical care.
 - Analysis of health plan data (e.g., medical and pharmacy claims data) to determine gaps in services – particularly for those enrollees with chronic and/or high-cost health conditions – that if not adequately addressed, may result in the need for more extensive and expensive medical care.
- Customer service and support, which may include:
 - Steerage of enrollees who call to request a referral to those providers deemed by the health plan to be high performing based on an assessment of quality and efficiency measures.

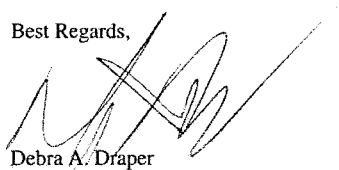
- o Providing enrollees with the necessary tools to help inform their medical decision-making, including for example, information about provider quality and efficiency in a readily accessible and understandable format (e.g., online).

Perhaps the most fundamental difference between fee-for-service and managed care plan designs is that the former lack a network relationship with providers. As a result, fee-for-service plans are less able to contemplate many of the activities that HMO or PPO plans do to manage care. This difference has significant implications for not only health plan efficiency, but also quality of care.

While the factors described above are likely to contribute to improved health plan efficiency with many being more compatible with an HMO or PPO plan design, plan design alone does necessarily mean higher efficiency. As discussed during the hearing, there is considerable variation in health plan efficiency and quality even among those of the same plan design. Consequently, an important goal of the Medicare Advantage program would be to institute the necessary measures to monitor and hold accountable, all participating plans for ensuring that efficient and high quality care is being delivered to all beneficiaries.

Should you have any additional questions, please do not hesitate to let me know.

Best Regards,



Debra A. Draper
Associate Director

United States Senate
Committee on Finance



Sen. Chuck Grassley · Iowa
Ranking Member

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Opening Statement of Sen. Chuck Grassley
 Senate Finance Committee Hearing,
 “An Examination of the Medicare Advantage Program”
 Wednesday, April 11, 2007

I want to thank Senator Baucus for holding today’s hearing. Health plans have served Medicare beneficiaries for a long time – going all the way back to the seventies. But until not long ago, only beneficiaries in urban areas had health plan choices. I often heard from Medicare beneficiaries in my home state who would ask, “How come I don’t have the same types of choices that beneficiaries in Florida or New York or Pennsylvania have?” They would ask, “Why can’t I have a choice that would give me additional benefits or lower my cost sharing?” I’m sure that other members of the Committee heard the same from beneficiaries in their states.

In large part, low payments were the primary reason that choice was either limited or non-existent in certain parts of the country. These payments, as we all know, are set on a county by county basis. A decade ago, before the Balanced Budget Act of 1997, the highest payment county was more than three times greater than the lowest payment county. Beginning with the BBA, Congress took a number of actions – actions that had support from members on both sides of the aisle – to reduce that disparity in payments and to promote the availability of health plans choices for beneficiaries.

When Senator Baucus and I were working on the Medicare law, we received a letter signed by eighteen members of the Senate – both Republicans and Democrats – who wanted us to work to take steps to improve payments. The MMA included those provisions as part of the Medicare Advantage program. I would ask that this letter to the conferees be inserted into the record at this point.

And today, beneficiaries across the nation have health plan choices. Beneficiaries can choose among plans that provide additional preventive benefits, such as cancer screenings and physical exams. Beneficiaries can choose a plan that lowers their cost sharing compared to fee-for-service, and they can choose plans that have a catastrophic cap on their out of pocket spending. And just to be clear, there’s no catastrophic cap in fee-for-service Medicare. So that means that beneficiaries in traditional Medicare face potentially unlimited liability for their health care costs.

According to CMS, the average value of these additional benefits is eighty-six dollars a month. Many plans offer these additional benefits for no additional premium or for a small additional premium.

For a beneficiary living on a fixed income, that protection from catastrophic costs can bring great peace of mind.

These and other facts about the MA program are laid out clearly in a document entitled, "The Facts: Medicare Advantage" prepared by the Health Policy Consensus Group. I would ask that this document be inserted into the hearing record at this point as well.

Studies also have shown that in many cases, MA plans outperform traditional Medicare on a number of quality measures including the delivery of preventive services such as immunizations. And during deliberation on the MMA, there was a lot of interest in trying to promote better coordination of beneficiaries' care.

Medicare Advantage plans have this capacity. Plans have special programs for beneficiaries with chronic illnesses such as diabetes and congestive heart failure. And I'm looking forward to hearing from our witnesses on the types of care coordination services that plans can offer. All of these improvements in Medicare are the benefits that we often cite as much needed improvements and here we have them in Medicare Advantage.

Now, I know that some folks want to compare spending in the traditional fee-for-service program to the payments to Medicare Advantage plans. They then want to equalize MA payments to fee-for-service spending. We're going to hear from Mr. Hackbarth from the Medicare Payment Advisory Commission on that. That sounds like an easy thing to do, but I don't think that it's as simple as it may seem. That's a very imprecise instrument. And it doesn't make sense. It would undo policies supported by Members on both sides of the aisles to promote the availability of Medicare coverage choices, especially for beneficiaries in rural areas. Beneficiaries now have choices that can provide them with lower out of pocket costs and benefits not otherwise available in traditional Medicare. Medicare Advantage plans can better coordinate a beneficiaries' health care and that leads to better outcomes. We should be doing everything we can to offer beneficiaries better Medicare choices not eliminating them.

Now, I've been watching the MA program closely since the 2003 law. I know that there's been a lot of growth, particularly in private-fee-for-service plans and special needs plans. So I'm not saying that we shouldn't take a close look at the MA program. We should. Like many things we do in Congress, this one is a "work in progress." Improvements can always be made and we should be working to do that. But we need to do it in a careful and deliberate manner and understand how the program is changing and why. This will help better inform any discussions that may occur about the need for any further program changes.

United States Senate
WASHINGTON, DC 20510

September 30, 2003

Dear Medicare Conferee:

We are writing to ask you, as a member of the Medicare conference committee, to ensure that the final Medicare bill includes a meaningful increase in Medicare+Choice funding in fiscal years 2004 and 2005. While the Senate bill makes a modest step toward this goal, we hope that the stronger provisions in the House bill will be preserved in conference.

For nearly 5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high quality, comprehensive, affordable health coverage. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because of their excellent value. To preserve this important option for seniors across the country, bipartisan legislation was introduced in the Senate as S. 590, the "Medicare+Choice Equity and Access Act."

Co-sponsored by Senators Schumer and Santorum, S. 590 sought to increase reimbursement rates and add new reimbursement options for Medicare+Choice programs. Although the Senate version of the Medicare bill does include a modest increase in reimbursement rates in FY 2005, we were pleased to see that the House version contains a more comprehensive commitment to strengthening Medicare+Choice beginning in 2004.

Medicare+Choice uses private sector innovations to offer all of the traditional Medicare benefits in addition to extra benefits such as prescription drug coverage, vision benefits, and hearing aids. These added services are particularly important to low-income seniors who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. In many cases, this program is the only option for low-income seniors to receive comprehensive, affordable health coverage.

But in recent years, lack of adequate government funding for the Medicare+Choice program has steadily reduced the health plan choices and benefits of seniors across the nation. As funding increases have continually fallen short of rising health care costs, seniors have watched the quality of their health care decline. Each year, health plans deprived of essential funding have been forced to eliminate benefits, increase seniors' out-of-pocket costs, or even withdraw completely from certain areas.

We strongly support additional Medicare+Choice funding for two very important reasons: (1) to protect the health care choices and benefits of the nearly 5 million Medicare beneficiaries who are currently enrolled in private sector health plans; and (2) to strengthen the foundation for future health plan choices.

We believe that the Medicare+Choice funding provisions in H.R. 1 are critically important to preserving choice and quality for America's seniors. We urge you to include these provisions in the final bill reported out of the Medicare conference committee.

Sincerely,

<u>Rep. Sisk</u>	<u>Charles Schumer</u>
<u>Tom F. Kelly</u>	<u>Frank R. Lautenberg</u>
<u>Allen DeLoach</u>	<u>Hillary Rodham Clinton</u>
<u>John G. Dingell</u>	<u>Ron Wyden</u>
<u>Ch. R. Smith</u>	<u>Mark Dayton</u>
<u>Jim Bunning</u>	<u>N. C.</u>
<u>Janice Stein</u>	<u>Mary L. Landrau</u>
<u>J. Miller</u>	<u>Maria Canino</u>
<u>Patty Murray</u>	<u>Christopher J. Dodd</u>
<u>_____</u>	<u>_____</u>

**The Facts:
Medicare Advantage**

By Members of the Health Policy Consensus Group

Presented to the Senate Committee on Finance

Hearing on

“An Examination of the Medicare Advantage Program”

April 11, 2007

THE FACTS

MEDICARE ADVANTAGE

Competing Medicare Advantage plans are offering more choices, more generous benefits, and lower cost-sharing to beneficiaries than Medicare fee-for-service. Seniors who especially value MA are those living in rural areas and those with modest incomes who can't afford supplementary coverage.

WHAT IS MEDICARE ADVANTAGE AND HOW IS IT DIFFERENT FROM TRADITIONAL MEDICARE?

Medicare beneficiaries have the option of receiving medical coverage either through the traditional fee-for-service program or by joining private Medicare Advantage plans, which generally offer better benefits and lower costs for enrollees.

All Medicare Advantage (MA) plans cover the standard benefits offered by traditional Medicare, including hospitalization, outpatient and physician care, diagnostic services, laboratory tests, and other services, often with lower cost-sharing than under traditional Medicare. Many MA plans also provide coverage for services that traditional Medicare doesn't pay for, such as vision and dental care, added preventive services, and protection against catastrophic medical costs. In addition, most beneficiaries in MA plans receive more comprehensive prescription drug coverage than under the standard Medicare Part D plan.¹

All beneficiaries, including those living in rural areas, have access to at least one MA plan.² So far in 2007, about 8.3 million beneficiaries—19 percent of people eligible for Medicare benefits—are enrolled in private Medicare plans (which include Medicare Advantage and other private plans).³ Enrollment is up from 12.1 percent in 2004.⁴

WHAT KINDS OF HEALTH PLANS PARTICIPATE IN MEDICARE ADVANTAGE?

Medicare Advantage offers a wide array of plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), Medicare medical savings accounts (MSAs), and private fee-for-service (PFFS) plans. In addition, private special needs plans (SNPs) provide comprehensive coordinated care for beneficiaries with severe and chronic illnesses.

HMOs generally offer lower co-payments and deductibles for services that seniors receive through a network of physicians, hospitals, and other health care providers. PPOs have broad provider networks and also allow members to use out-of-network providers if they pay more of the cost of care. That's the same

This fact sheet was jointly prepared by health policy experts from the American Enterprise Institute, the Center for Medicine in the Public Interest, the Galen Institute, The Heritage Foundation, the Institute for Policy Innovation, the Institute for Research on the Economics of Taxation, the National Center for Policy Analysis, the Pacific Research Institute, and Project Hope. See end of document for contact information.

THE FACTS: MEDICARE ADVANTAGE

kind of coverage that most people under 65 receive through their employers. Beneficiaries have access to these types of plans in all areas of the country.

Private fee-for-service plans allow greater choice because beneficiaries can visit any doctor or hospital that accepts Medicare payment. These plans may pay providers at Medicare's standard reimbursement rates, without network restrictions. This makes them particularly popular in rural areas. The plans often offer added services that traditional Medicare doesn't cover. Enrollment in PFFS plans jumped to more than 800,000 as of last August, up from 20,000 three years ago.⁵

Medicare medical savings plans were introduced on January 1 of this year. They combine a high-deductible health plan with a medical savings account that is funded with an annual deposit made by the Centers for Medicare and Medicaid Services (CMS).⁶ Medicare MSAs give beneficiaries more control over their health care utilization and costs while providing them with coverage against major medical bills. HHS says that beneficiaries in 39 states have access to Medicare MSA plans in 2007.⁷

Special needs plans provide specialized care for patients with severe and chronic illnesses, including diabetes, mental disorders, congestive heart failure, and HIV/AIDS.⁸ Many SNP patients are eligible for both Medicare and Medicaid ("dual eligibles"), and some are institutionalized. Similar to other types of plans, SNPs receive risk-adjusted payments to ensure that the greater health needs of these patients are met. Because beneficiaries with low incomes and higher health risks are eligible for additional subsidies, the premiums they pay to join special needs plans are often lower than premiums for other types of MA plans and on par with HMO premiums, despite the higher level of medical services the plans offer.⁹



HOW MUCH CAN BENEFICIARIES SAVE BY ENROLLING IN A MEDICARE ADVANTAGE PLAN?

Because Medicare Advantage plans offer more comprehensive benefits, most MA enrollees pay less for full medical coverage than they would under traditional Medicare supplemented with individual Medigap coverage. Take, for example, a senior with a modest income who has no supplementary retiree coverage and who does not qualify for subsidies to help with her Medicare premiums, deductibles, or copayments.

If she were to opt for traditional Medicare coverage, she would pay \$93.50 a month this year for her Medicare Part B premium; she would pay a separate premium to obtain Part D prescription drug coverage. She likely would pay an additional premium for Medigap coverage if she also chose to protect herself against other medical costs that Medicare doesn't cover.

But if this same senior were to choose a Medicare Advantage plan, she would still pay \$93.50 for her Part B premium, and in addition to Medicare-covered services, she could receive prescription drug coverage and dental, vision, and preventive care services for little or no additional premium.¹⁰ The 2007 Report to Congress of the Medicare Payment Advisory Commission (MedPAC) finds that 99 percent of Medicare beneficiaries have access to Medicare Advantage plans with zero added premiums, and 86 percent have access to MA plans that also cover prescription drugs at zero premium.¹¹ It is not surprising that seniors with limited means and with no supplementary coverage find Medicare Advantage plans to be particularly attractive.

HOW ARE THE GOVERNMENT'S PAYMENTS TO MA PLANS DETERMINED?

Medicare pays MA plans a capitated monthly payment to provide all Part A and B services, plus Part D if drug coverage is offered by the plan.¹² That payment is based on bids submitted by the plans, and it is risk-adjusted so that higher payments are made for enrollees who are sicker and are therefore likely to use more services during the year.

The plan bids for Part A and B services are compared to a complicated formula to determine county and regional benchmarks. If the plan bid is less than the benchmark, 25 percent of the difference is retained by the Medicare program. The remainder is returned to enrollees as lower premiums and/or better benefits.¹³ If the plan's bid is higher than the benchmark, the full additional cost is added to the premium paid by enrollees.

MedPAC's analysis suggests that the benchmarks are generally greater than the cost of providing Medicare services through traditional Medicare.¹⁴ If the MA plan bid is higher than the cost in traditional Medicare but below the benchmark, the plan receives the difference between the bid and the traditional program's cost as an extra payment, without any additional requirement to charge lower premiums and/or provide better benefits for the amount of that difference.

WHY ARE MEDICARE ADVANTAGE PAYMENTS AN ISSUE?

Several studies have concluded that Medicare Advantage plans are overpaid in relation to fee-for-service Medicare. Some congressional leaders have said that they want to reduce payments to private MA plans and spend the money on other things, such as increasing payments to physicians under fee-for-service Medicare, or expanding the State Children's Health Insurance Program.

House Ways and Means Health Subcommittee chairman Pete Stark told an Urban Institute forum recently: "Depending on what is called upon to do in the budget, the overpayment of [Medicare Advantage] plans looks like an attractive pot of money."¹⁵ An analysis by Brian Biles of George Washington University argues that transferring beneficiaries enrolled in Medicare Advantage plans to the traditional fee-for-service program would save Medicare \$5 billion annually.¹⁶

But revising payment schedules to MA plans across the board would harm lower-income seniors who are attracted to the more generous and more affordable benefits that MA plans offer, and those in rural and under-served areas who could lose the option of signing up for more comprehensive coverage.

SO IS THE EXTRA MONEY BEING SPENT ON MA PLANS BEING WASTED AND SHOULD THEREFORE BE CUT?

Cutting payments to Medicare Advantage plans would reduce benefits and raise costs to their beneficiaries. For example, two-thirds of Medicare Advantage HMOs do not charge beneficiaries extra to receive the new prescription drug benefit.¹⁷ If MA were not an option for them, seniors would have to pay more for coverage of their medicines.

Medicare Advantage gives more than \$1,000 a year in added health services to the average beneficiary enrolled in the plans, or an average of \$86 a month over standard Medicare coverage.¹⁸ Savings for the chronically ill are even larger.

 ARE MA PLANS AVAILABLE ONLY TO MEDICARE BENEFICIARIES IN URBAN AREAS?

Until enactment of the Medicare Modernization Act (MMA), which improved the methodology for determining payments to MA plans, millions of seniors living in rural areas had no choice but to enroll in fee-for-service Medicare. As a result of MMA, all beneficiaries, including those in rural areas, have access to at least one MA plan.¹⁹

The MMA established the Medicare Advantage regional stabilization fund to ensure that beneficiaries in all states and in both rural and urban areas have access to private health plans. The stabilization fund is designed to provide beneficiaries choices of plans in areas where it was expected to be most difficult for private health plans to participate in MA due to, for example, the expense of developing provider networks. Additional funding would be granted for a limited time to MA plans in underserved regions to ensure that beneficiaries have at least two regional plan choices.

The MA stabilization fund already has been cut. The Tax Relief and Health Care Act of 2006 reduced the funds available in the stabilization fund by \$6.5 billion, and the law limits the availability of the remaining \$3.5 billion to expenditures during 2012 and 2013.²⁰

 SOME PEOPLE SAY THAT TRADITIONAL MEDICARE FULLY MEETS BENEFICIARY NEEDS, SO MA PLANS ARE NOT NEEDED.

If traditional Medicare fully met beneficiary needs, millions of seniors would not purchase supplemental Medigap coverage. But while Medigap plans are popular with middle-income seniors who seek protection against the gaps in Medicare fee-for-service coverage, poorer seniors may find the premiums too costly. MA plans are particularly attractive to those who do not have other sources of supplemental coverage and are more sensitive to price.²¹ As a result, seniors with the most limited resources have been most attracted to the broader coverage and more predictable costs of MA plans.

Medicare Advantage plans have been an especially important option for low-income and minority seniors, according to data from the Medicare Current Beneficiary Survey for 2004. Forty-nine percent of Medicare Advantage enrollees in 2004 had incomes of less than \$20,000. The two main reasons that beneficiaries cited for choosing MA plans were lower costs (34 percent) and better benefits and coverage than fee-for-service Medicare (21 percent).²²

In addition, racial and ethnic minorities represent 27 percent of total MA enrollment, compared with 20 percent in fee-for-service.²³ If MA plans were no longer available to current enrollees, according to a study by Ken Thorpe of Emory University, 39 percent of them would go without supplementary coverage and 59 percent of African-American beneficiaries in counties that have MA plans would not have supplementary coverage.²⁴

John Gorman, a former Medicare official in the Clinton administration, says that “we should never lose sight of the fact that [Medicare Advantage] has been an absolutely key safety net for low-income people.”²⁵

In a recent letter to members of Congress, an official of the NAACP said that MA plans “disproportionately provide coverage to low-income and racial and ethnic minority beneficiaries” and provide “more

comprehensive benefits and lower cost-sharing than traditional Medicare.” The NAACP, as well as the League of United Latin American Citizens, have called upon congressional leaders to oppose reductions in funding for Medicare Advantage plans.²⁶

ARE PAYMENTS TO MEDICARE ADVANTAGE PLANS EXCESSIVE?

CMS, MedPAC, and other organizations agree that MA plans are paid more than the cost of providing Medicare services to their enrollees under traditional Medicare. There is considerable debate over the magnitude of the additional payments. MedPAC says that in 2006 Medicare spent 12 percent more to cover an individual in Medicare Advantage than in traditional Medicare.²⁷ The Commonwealth Fund concludes that overpayments to MA plans in comparison to the average cost of providing traditional Medicare fee-for-service (FFS) care to the same enrollees add \$922 to the cost to taxpayers for each beneficiary.²⁸

CMS argues that other comparisons of MA payments and costs under traditional Medicare are flawed.²⁹ Using data for 2007, CMS estimates that if one is only measuring the equivalent cost of delivering Part A and B services alone, MA plans are paid 2.8 percent more than the cost of traditional Medicare. CMS points out that part of that extra payment is the result of implementing risk-adjusted payments to the plans on a “budget neutral” basis. By 2011, risk adjustment will no longer be budget neutral, which will mean lower payments on average to the plans. However, CMS also indicates that nearly 93 percent of enrollees are in MA plans that are paid above the cost of traditional Medicare in 2007.³⁰

Extra payments to MA plans produce extra benefits that are not available through traditional Medicare. These extra benefits are the result of congressional policy that sought to expand the availability of MA plans and plan types and to ensure that 75 percent of the savings from competitive bidding would be directed to enhanced benefits or lower premiums for beneficiaries.

Describing these benefits as “excessive payments to plans” fails to account for the fact that both taxpayers and beneficiaries gain when MA plans bid below the benchmark. In those cases, 25 percent of the Medicare payments which are above the plan bids for the cost of delivering Part A and B services go back to the Treasury and the remainder is returned to beneficiaries in the form of these extra benefits. Thus the higher benchmark payments have provided a mechanism to convey extra benefits to enrollees.

In addition, the payments foster private plan participation in Medicare, which in turn allows seniors to benefit from competition among the private plans vying to offer better benefits at better prices.

WOULDN'T IT BE BETTER TO SIMPLY ADD TO TRADITIONAL MEDICARE THE EXTRA BENEFITS THAT MEDICARE ADVANTAGE PLANS OFFER?

Traditional Medicare pays for acute care after patients are ill and for some preventive services. Medicare Advantage plans offer added services for prevention and early detection of disease, and they are better able to provide coordinated medical care. This is the 21st century approach to medical care that the commercial market is finding offers better care at lower long-term costs.

One of the most critical issues in the future is how the Medicare program will address the growing numbers of beneficiaries with chronic conditions. In the traditional Medicare program, this responsibility either has to be taken on by one of the beneficiaries' many providers, or by a separate entity that would need to coordinate with the variety of providers and with the beneficiary. Medicare cannot duplicate this role of MA plans by simply adding more services such as preventive care, more comprehensive drug coverage, and dental and vision care to the Medicare payment schedule. A strong MA program provides the best opportunity for creating a program to meet the growing need for coordinated care.



SO WHAT'S THE BOTTOM LINE?

In 2003, Congress decided to boost funding for Medicare Advantage plans to attract private health plans that could introduce competition into Medicare. Cuts in those payments would disadvantage millions of beneficiaries who find that Medicare Advantage meets their needs better than traditional coverage. Enrollment in all private Medicare health plans has now reached an all-time high of 8.3 million beneficiaries, up from 5.3 million in 2003³¹ and the percentage of beneficiaries who have chosen Medicare Advantage has grown from 12.1 percent of all Medicare beneficiaries in 2004 to 19 percent this year.³² The added funds also increase the options available for seniors living in rural areas.

As we have seen with Medicare Part D, competition among private plans leads to more choices and greater value for seniors. Competing Medicare Advantage plans are offering more choices of plans, more generous benefits, and lower cost-sharing for beneficiaries than Medicare fee-for-service.³³ Seniors who especially value this option are those with modest incomes who do not have supplementary coverage.

We can enhance competition in Medicare Advantage if we follow the lead of Part D. Part D plans bid against each other rather than against an inflated benchmark, which puts greater market pressure on all the plans to improve efficiency and keep costs down. A similar system in which Medicare Advantage plans and traditional Medicare bid against each other would yield sharper bids and stronger incentives for efficiency.³⁴ Simply cutting MA payments will not solve the underlying problem that leads to plan overpayment.

We want much more competition in Medicare, including private plans competing with traditional Medicare. And we need it sooner, not later. The vibrant private plan sector that Medicare Advantage has created is an essential step toward that goal and lays out an initial pathway to the future which should include premium support for Medicare beneficiaries. Even more competition will promote greater efficiency, which over time can slow the growth of Medicare spending and improve the value that seniors and taxpayers receive from the program.

For more information, please contact Consensus Group signatories:

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- 18 Leslie Norwalk, Acting Administrator, Centers for Medicare and Medicaid Services, testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 13, 2007, at waysandmeans.house.gov/hearings.asp?formmode=view&id=5446. Norwalk also told the committee that the Medicare Advantage (MA) program has already been cut and that the President's budget would result in lower payments to MA plans. See also Centers for Medicare and Medicaid Services, "Medicare Advantage in 2007," March 2006, at www.cms.hhs.gov/HillNotifications/CHN/itemdetail.asp?filterType=none&itemID=CMS1197064. Note that because of the link between fee-for-service and MA payments, MA payments would decrease by \$15.2 billion over five years if the budget were enacted. Payments are also decreasing due to the phase out of the budget-neutral risk adjustment. This "hold-harmless" adjustment had increased benchmark rates for MA plans in 2006 by the amount CMS had otherwise expected MA payments to decrease that year because of risk adjustment due to the better average health status of MA plan enrollees. The phasing out of budget neutral risk adjustment begins this year, and it will decrease MA plan payments by \$2.3 billion in 2007 alone. Medicare Payment Advisory Committee, *Report to the Congress: Medicare Payment Policy*, p. 245. Further, the stabilization fund, designed to support broad access to MA has already been cut \$6.5 billion.
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- 34 MedPAC recommends setting the benchmarks at 100 percent of traditional Medicare costs, phased in to avoid disrupting the market. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 252.



TESTIMONY

The Medicare Advantage Program and MedPAC Recommendations

April 11, 2007

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Committee on Finance
U.S. Senate

Chairman Baucus, Ranking Member Grassley, distinguished Committee members, I am Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss the Medicare Advantage program and recommendations that the Commission has made for the program.

MedPAC is charged by the Congress with making recommendations on payment policy both for providers in Medicare's traditional fee-for-service program and for Medicare Advantage organizations. The Commission's goal is for Medicare payments to cover the costs that efficient providers and organizations incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and that beneficiaries have access to the care they need. MedPAC focuses on ensuring that Medicare program dollars are spent wisely—ensuring that beneficiaries are getting efficient, high-quality care, and that beneficiaries and taxpayers are getting maximum value for each dollar spent in the program. We are striving to make Medicare a more efficient program while at the same time improving the quality of care beneficiaries receive.

The Commission believes that greater efficiency is achieved when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional fee-for-service (FFS) program and the Medicare Advantage (MA) program. This financial pressure, coupled with meaningful measurement of quality and resource use in order to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program.

Medicare's private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Efficient plans could be able to provide extra benefits to enrollees choosing to enroll in such plans, and better efficiency would lead to higher plan enrollment. Unfortunately, MA has instead become a program in which there are few incentives for efficiency. Although MA uses "bidding" as the means of determining plan payments and beneficiary premiums, the bids are against benchmarks which are often legislatively set. Setting benchmarks well above the cost of traditional

Medicare signals that the program welcomes plans that are more costly than traditional Medicare. Inefficient plans—as well as efficient plans—are able to provide the kind of enhanced coverage that attracts beneficiaries to private plans because of generous MA program payments that are in excess of Medicare FFS payment levels. All taxpayers, and all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—are funding the payments in excess of Medicare FFS levels.

MedPAC's recommendations on private plans in Medicare

MedPAC has a long history of supporting private plans in the Medicare program. The Commission believes that Medicare beneficiaries should be able to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans may have greater flexibility in developing innovative approaches to care, and these plans can more readily use tools such as negotiated prices, provider networks, care coordination and other health care management techniques to improve the efficiency and quality of health care services.

The Commission believes that payment policy in the MA program should be built on a foundation of financial neutrality between payments in the traditional FFS program and payments to private plans. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. This approach underpins many of the recommendations that the Commission has made to improve the MA program, which are shown in the text box, p. 12.

Current MA program payment rates reflect previous statutory changes that provided for minimum payment levels in certain counties, which were often well above FFS levels. These inflated benchmarks, coupled with the distribution of MA enrollment across the country, undermine the goal of financial neutrality. Currently, program payments for MA plan enrollees are well above 100 percent of FFS expenditure levels: on average, MA program payments are at 112 percent of Medicare FFS levels. Note that based on where plans tend to operate, the payments vary among plan types, ranging from 110 percent of

FFS for HMOs, for example, to 119 percent of FFS for private fee-for-service (PFFS) plans.

To pay MA plans appropriately, the Commission recommends that benchmarks—the basis of plan payments in MA—should be set at 100 percent of Medicare FFS expenditures. The Commission first made this financial neutrality recommendation in March 2001. For the past several years, we have analyzed payments to private plans compared to FFS and have found consistently that plan payments exceed FFS expenditure levels.

The excess payments to private plans allow them to be less efficient than they would otherwise have to be, because inefficient plans can use the excess payments—rather than savings from efficiencies—to finance extra benefits that in turn attract enrollees to such plans. As shown in Table 1, enrollment has grown substantially in MA as result of this situation.

Table 1 Enrollment has grown substantially in the Medicare Advantage program in the last two years

Plan type	Enrollment			Net enrollment growth	
	December 2005	August 2006	February 2007	Dec. 2005 to Aug. 2006	Aug. 2006 to Feb. 2007
Local HMOs and PPOs	5,157,627	5,921,837	6,064,666	15%	2%
PFFS	208,990	802,068	1,327,826	284%	66%
Regional PPOs	None available	89,492	120,770	N/A	35%

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable).

Because of the impact on beneficiaries enrolled in plans with extra benefits, the Congress may wish to employ a transition approach in implementing the Commission's recommendation on payment rates. Possible approaches might be to (a) freeze all county rates at their current levels until each county's rate is at the FFS level; (b) differentially reduce MA rates, with counties in which payments are highest in relation to Medicare FFS facing a larger reduction to more rapidly arrive at FFS rates in each county; or (c)

reduce rates in all counties at the same percentage each year until arriving at FFS rates in each county. Other transition strategies are also possible.

Efficiency in Medicare Advantage and extra benefits

Historically, policymakers have tried to structure the Medicare private plan program so that efficient plans could provide extra benefits to plan enrollees. To the extent that a private plan could provide care more efficiently than FFS Medicare, the plan could use its efficiency gains to finance extra benefits—reduced out-of-pocket costs, and coverage of services Medicare did not cover, such as dental, hearing, vision services, and (most importantly before the advent of Part D) outpatient prescription drugs. The ability to offer extra benefits would attract beneficiaries to enroll in these plans. Having plans compete against each other would also promote efficiency. In a system in which plan payments are appropriately risk-adjusted, a richer benefit package would generally signal that one plan was more efficient than another competing plan—and that a private plan offering extra benefits was more efficient than the traditional Medicare FFS program in the plan’s market area.

There are efficient plans operating in the MA program. Such plans are able to provide the traditional Medicare Part A and Part B benefit at a lower cost than the FFS program. As shown in Table 2, on average in 2006, HMO plans were able to provide the Medicare benefit for 97 percent of Medicare FFS expenditure levels. Because, in 2006, HMOs had such a large share of the overall enrollment, on average across all plan types, the “bid” for Medicare Part A and Part B services was 99 percent of Medicare FFS expenditures.

Table 2 MA plan payments relative to Medicare FFS spending by plan type, weighted by enrollment, and plan enrollment, July 2006

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Bid (for Medicare A/B benefit) in relation to FFS	99	97	108	103	109
Rebate as percent of FFS	13	13	9	7	10
Payment (bid + rebates)/FFS	112	110	117	110	119
Enrollment (in thousands) as of July 2006	6,877	5,195	285	82	774

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Special needs plans and employer-only plans are included in all-plan total but plan data not shown.

Table 2 indicates the level of “rebates” or extra benefits that plans provide at no charge to the enrollee, expressed as a percent of Medicare FFS expenditures for the geographic areas from which plans draw their enrollment. These rebate amounts are determined based on the plan bid and its relation to the area “benchmark,” which is the maximum program payment to an MA plan in a given county or geographic area. If a plan is able to provide the Medicare Part A and Part B benefit package for less than the benchmark level, enrollees receive extra benefits valued at 75 percent of the difference between the benchmark and the plan bid for the Medicare package (with 25 percent of the difference retained by the Medicare Trust Funds). (Plans may also provide extra benefits that enrollees pay for through an additional premium to the plan.)

Except in the case of regional PPO plans, benchmarks are set at the county level. The benchmarks vary significantly from county to county, and the difference between a given county’s benchmark and FFS expenditure levels in the county can also vary significantly. Table 3 shows the relationship between benchmarks and FFS expenditure levels for the different plan types in July of 2006, based on the counties from which the plans drew their enrollment.

Table 3 MA benchmarks by plan type, compared to Medicare fee-for-service expenditure levels, weighted by enrollment, July 2007

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Benchmark/FFS expenditures	116	115	120	112	122

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service).

The ratio of benchmarks to FFS expenditures differs by plan type because of the counties that plans choose to serve and where they attract enrollees (Table 3). PFFS plans, for example, are primarily drawing their enrollment from higher-benchmark counties—specifically counties that were historically “floor” counties. MA benchmarks in these counties reflect a minimum payment level established by statute, resulting in benchmarks far above FFS expenditure levels in most cases. While PFFS plans are drawing enrollment from floor counties, HMOs are drawing their enrollment from counties in which benchmarks are closer to Medicare FFS expenditure levels.

Enrollment trends in relation to payment

Within MA, PFFS is by far the fastest growing type of plan (see Table 1). If current enrollment patterns continue—with PFFS growing more rapidly than other plans and continuing to draw enrollment from higher-benchmark counties—the difference between Medicare FFS expenditure levels and MA payment rates will widen further. More enrollees will come from counties with very high benchmarks in relation to FFS. This enrollment trend will counteract the phase-out of the “hold-harmless” provision, which would otherwise narrow the difference between FFS and MA payment levels.

The hold-harmless provision affects risk-adjusted payments to MA plans. Plan enrollees, on average, are healthier than beneficiaries in FFS Medicare. Under the current system, though payments at the individual beneficiary level are fully risk adjusted for health status as of 2007, plans receive an additional payment during a phase-out period. During the phase-out period, plans are paid a portion of the difference between risk-adjusted payments and the payment that would have been made without the health status risk adjustment. This approach is being phased out over the next few years to move towards

payments solely at the risk-adjusted level. The net result of phasing out the hold-harmless provision would have been an overall reduction in average plan payments. However, we are concerned that the opposing MA enrollment trend could potentially eclipse the effect of the phase-out of the hold-harmless provision, thus producing higher overall MA payments.

Varying efficiency among different types of plans

Table 2, p.5, also illustrates that there is varying efficiency among plan types in MA. While HMOs can provide the Medicare benefit at 97 percent of Medicare FFS costs, as noted above, not all plans achieve the same level of efficiency. At the other end of the scale from HMOs are PFFS plans. From a taxpayer point of view, PFFS plans are paid 9 percent more than the Medicare program, on average, to provide the traditional Medicare FFS benefit package. Although PFFS plans provide enrollees with rebates valued at about 10 percent of Medicare FFS expenditures, program payments on behalf of PFFS enrollees are 19 percent above FFS expenditure levels—so only about half of the excess amount is used to finance extra benefits for enrollees.

For HMOs, what the 97 percent means is that, on average across HMO plans, some of the extra benefits are financed by rebate dollars that are generated because these plans can provide the Medicare benefit package more efficiently than the Medicare FFS program in the counties where HMOs have their enrollees. This also means is that, if benchmarks are reduced, there could still be extra benefits provided to enrollees in the MA program. It is not the case that, if benchmarks were reduced to 100 percent of FFS, no plans would be able to provide extra benefits.

Equity between sectors and among plan types

The Commission supports equity between the two sectors—the Medicare private plan sector and traditional Medicare. Supporting the principle of equity between the sectors takes many forms. For example, most of the private plans participating in Medicare are required to report various types of quality measures. The Commission believes that the same approach should apply in the traditional FFS program. That is, there should be quality information reported for FFS Medicare that allows Medicare beneficiaries to

compare FFS Medicare with private plans in terms of their performance on quality measures. To that end, the Commission has specifically recommended that the Secretary of Health and Human Services should calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans.

The Commission also supports the concept of equity in the treatment of different plan types within the private plan sector. For example, the Commission recommended that the Congress eliminate the benefit stabilization fund, which provided an unfair advantage to the regional preferred provider organizations introduced in the Medicare Modernization Act (see text box, p. 12). Similarly, the Commission is exploring whether there are unwarranted advantages currently in place for special needs plans, PFFS plans, and medical savings account (MSA) plans in the MA program.

Table 4 illustrates the ways in which different requirements apply to different plan types in MA. In general, the Commission favors a level playing field for all plan types, with no plan type having an advantage over another plan type unless special circumstances dictate otherwise. The Commission believes, for example, that PFFS plans and MSA plans should be required to report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging these plans. Payment rules that give one plan an advantage over another—as described above with regard to regional PPO plans—should be eliminated. The MSA plan option raises this question: why are these plans not required to have 25 percent of the difference between the MSA plan bid and the benchmark retained in the Trust Funds, as is the case for other plan types?

Table 4 Different requirements and provisions apply to different types of Medicare Advantage plans

	PFFS	MSA	HMO/ Local PPO	Regional PPO	SNP
Must build networks of providers ^a			✓	✓	✓
Must report quality measures			✓	✓	✓
Protected from some risk through risk corridors				✓	
Must return to the Trust Funds 25 percent of the difference between bid and benchmark ^b	✓		✓	✓	✓
Must offer Part D coverage ^c			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures				✓	
Can limit enrollment to targeted beneficiaries ^d					✓

Note: PFFS (private fee for service), MSA (medical savings account), PPO (preferred provider organization), SNP (special needs plan).

^aPFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare FFS rates.

^bThis provision applies when bids are under the benchmark. For regional PPO plans, one-half of the 25 percent amount is retained, and the remainder is included in the stabilization fund that, as of 2012, may be used to retain or attract such plans.

^cMSA plans are prohibited from offering Part D coverage. PFFS plans may offer Part D coverage, but special rules apply to such plans (e.g., it is not required that receive drugs at a discounted rate when the deductible applies or the person is in the Part D coverage gap).

^dMA plans must allow all Medicare beneficiaries in their service area to enroll with few exceptions, e.g. beneficiaries with end stage renal disease. Other exceptions apply to MSA plans (e.g., Medicaid beneficiaries may not enroll in an MSA). SNPs are permitted to limit their enrollment to their targeted beneficiary population, i.e. dual eligibles, beneficiaries who reside in an institution, or those with a chronic or disabling condition. SNPs can be local or regional coordinated care plans. They cannot be MSAs or PFFS plans.

Efficiency in MA and broader equity issues

Some argue that paying plans more than FFS is a worthwhile expenditure because plans provide extra benefits to enrollees. While it is true that plans provide extra benefits, there are some equity and efficiency issues that need to be considered. The overarching equity issue is that all beneficiaries and all taxpayers are paying the cost in excess of Medicare FFS when payments to plans exceed 100 percent of Medicare FFS expenditure levels. When MA rebate dollars exist only because MA program payments are far higher than expenditures in the FFS program—not because plans are being efficient—then the extra

benefits are being funded through taxes from all taxpayers, and Medicare Part B premiums from all Medicare beneficiaries, not just those enrolled in these plans. Only some Medicare beneficiaries, therefore, derive a benefit from the way in which the MA program is financed, while the majority of Medicare beneficiaries are paying for the benefits that only some beneficiaries receive. To quantify what this means, our preliminary estimate is that on average every Medicare beneficiary is paying in the range of \$2.00 more per month in his or her Medicare Part B premium to finance the payments being made in MA that exceed Medicare FFS expenditure levels; and only some of that money is being used to provide extra benefits to beneficiaries who choose to enroll in these plans.

If the justification for higher payments to plans is that extra benefits are being provided to low-income beneficiaries who choose these plans, there are less costly and more efficient ways to achieve this result—the Medicare savings program, for example, or the approach used for low-income subsidies in Part D. What is occurring now is that the most inefficient plans are expanding their enrollment, and providing extra benefits with taxpayer dollars in an inefficient manner. The longer the current situation continues, the more difficult it will be to reform the program to restore the right incentives in the MA program to promote efficiency and improved quality. As millions of beneficiaries enroll in products shaped by the current policy, it will become ever more difficult to change direction. As difficult as it seems today, it will be even more difficult next year or the year after. The constituency with a stake in the current policy, both plans and beneficiaries, will be that much larger. This is especially worrisome given that the most heavily subsidized and fastest growing plans are the least efficient ones.

If beneficiaries are able to choose between Medicare FFS and an array of private plans—and if the Medicare program pays the same on behalf of the beneficiaries making the choice—then over time, beneficiaries will gravitate either to the FFS system or to the plan that provides the best value in terms of efficiency and quality. The Medicare program would not subsidize one choice more than another. The Medicare program should be financially neutral regarding whether the beneficiary chooses to remain in the

FFS system or enroll in a plan. This neutrality provides beneficiaries with the incentive to select the system that they perceive as having the highest value.

The equity and efficiency issues that we have described here are of particular concern in an era in which Medicare is facing long-run sustainability issues. We should take all steps possible to promote efficiency in both FFS Medicare and in MA. The Medicare program should strive towards improving plan efficiency by paying appropriately, by ensuring a level playing field among plans and across the sectors, and by promoting fair competition among plans and across sectors to induce greater efficiency. The basic question for us is, "What kind of plans do we need to participate in Medicare?" Given Medicare's sustainability issues, the obvious answer is more efficient plans. However, the current benchmarks are sending the opposite signal to plans and beneficiaries. Overpaying in the short run—especially overpaying indiscriminately without requirements—is never a strategy for achieving long-run efficiency.

Medicare Advantage recommendations from MedPAC's June 2005 Report to the Congress

MA recommendations from the June 2005 Report to the Congress are summarized below:

- A number of MMA provisions give the new regional PPOs a competitive edge over other plans, as well as added funding. One provision is the regional stabilization fund, initially funded at \$10 billion. The Commission recommended that the Congress eliminate the stabilization fund for regional PPOs.
- Regional PPOs can have an advantage over local plans as a result of the MA bidding process. Because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans, and because of the bidding approach used for regional plans, there can be distortions in competition between regional and local plans. The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population.
- MA rates set at 100 percent of FFS include medical education payments, but at the same time Medicare makes separate indirect medical education payments to hospitals treating MA enrollees. The Commission recommended that the Congress remove the effect of payments for indirect medical education from the MA plan benchmarks.
- The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans, with equitable payments among private plans. The Commission recommended that the Congress set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of fee-for-service costs. However, the Commission recognizes that higher MA rates reflect the desire of Congress to expand the availability of plans and that payment reductions may result in disruptions for beneficiaries and for plans, so that benchmarks may need to be adjusted differentially across the country.
- The Commission believes that pay-for-performance should apply in MA to reward plans that provide higher quality care. Funding can come from the amounts that are retained in the Trust Funds when plans bid below benchmarks, as recommended by the Commission in stating that the Congress redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.
- The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system. The Commission therefore recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans.

Another recommendation the Commission made in 2005 was a provision of the Deficit Reduction Act. This specified in statute the time line for phasing out the hold-harmless policy that offsets the impact of risk adjustment on aggregate plan payments through 2010.



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Glenn M. Hackbarth, J.D., Chairman
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 Mark E. Miller, Ph.D., Executive Director

May 25, 2007

The Honorable Max Baucus
 Chairman, Committee on Finance
 219 Dirksen Senate Office Building
 Washington, DC 20510

Re: Questions for the record from the Finance Committee Hearing entitled, "An Examination of the Medicare Advantage Program"

Dear Senator Baucus:

This letter is in response to the questions you sent us on May 4, 2007. Answers to the questions are as follows:

Replies to questions from Senator Grassley

The Commission and I share a strong interest in moving Medicare toward payment systems that promote and recognize quality. MedPAC has recommended that Congress should consider using funds retained by the Treasury when Medicare Advantage bids come in below the benchmark to create a pay for performance system for Medicare Advantage. Senator Baucus and I spelled out how we thought that could work in our bill – the Medicare Value-Based Purchasing Act, but I'd be interested in hearing your thoughts on this matter too. How do you think that quality payments could work?

In our March 2004 *Report to the Congress*, the Commission recommended that the Congress establish a quality incentive payment policy for all MA plans. There were a number of reasons for making this recommendation, including the relatively advanced state of quality measurement for plans, and the position of these organizations, who take risk for the full array of benefits, to use incentives to promote quality among plan providers. We know that there is wide variation among plans in their performance on the existing measures—indicating that there is room for plans to improve their performance. We also have recommended pay-for-performance systems for the traditional fee-for-service (FFS) program. Measuring quality at the plan level may help identify effective mechanisms for better coordination, imparting lessons that may be useful in the FFS program.

Most MA plans [other than private fee-for-service (PFFS) and medical savings account (MSA) plans] are reporting information on a number of quality measures through the Health Plan Employer Data and Information Set (HEDIS®), with preferred provider organizations reporting on a more limited set of measures. The Medicare program also obtains information on the health status of MA enrollees through the Health Outcomes Survey, and information on satisfaction measures through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). In other words, there are well-accepted quality measures in use. The measure sets should evolve over time, and there could be new measures, such as those dealing with efficiency and appropriate use of resources.

The Commission supports pay-for-performance incentives for both improvement and attainment. With regard to the financing of the extra payments, in our March 2004 *Report to the Congress* we suggested that there could be a small reduction in plan payments to finance budget-neutral funding of a pay-for-performance pool for plans.

Replies to questions from Senator Smith

In its analysis of the Medicare Advantage program, MedPAC noted that plan benchmarks in certain areas—such as rural communities—tend to be higher than what traditional Medicare would pay. This is based upon a number of factors, such as direct congressional intervention to help markets develop. MedPAC has recommended that to improve the MA program overall, all plan benchmarks be set at a rate not to exceed 100 percent of Medicare fee-for-service rates.

How can Congress make the MA program a more level playing field for all plans without harming the market in areas such as rural communities?

How can Congress create an improved MA payment system that avoids making the case-by-case exceptions that have become so controversial in the current debate?

It is very difficult to create playing fields that are level both across the traditional-FFS / private plan dimension and across the geographic dimension. The best way to do that would be to make changes to the Medicare FFS payment systems that reward quality and efficiency so that geographic differences are reduced. It makes little sense to use the MA payment system to address geographic differences. If we pay plans more than FFS in areas where the FFS system supplies high quality care and is relatively efficient, and less than FFS in areas where FFS is less efficient, we would be encouraging beneficiaries to leave FFS and join plans where FFS is most efficient and encouraging beneficiaries to remain in the FFS system where that system is inefficient. Our analyses over the years have not found that beneficiaries are getting lower quality care in rural areas, so why would we want to encourage beneficiaries to leave that efficient system in those areas?

Two other policy recommendations from the Commission may reward providers in areas of the country where there is higher quality of care and lower resource use. Pay-for-performance programs would redistribute funds from lower quality providers to higher quality ones. The Commission has called for CMS to report to physicians on the resource use associated with their practice patterns. These data could become the foundation for a

pay-for-performance or other incentive program that rewards providers who are most efficient.

The Commission recognizes that moving Medicare Advantage payment levels to 100% of fee-for-service rates would be disruptive to beneficiaries enrolled in plans with extra benefits. As such, the Congress may wish to employ a transition approach in implementing the Commission's recommendation on payment rates. Possible approaches might be to (a) freeze all county rates at their current levels until each county's rate is at the FFS level; (b) differentially reduce MA rates, with counties in which payments are highest in relation to Medicare FFS facing a larger reduction to more rapidly arrive at FFS rates in each county; or (c) reduce rates in all counties at the same percentage each year until arriving at FFS rates in each county. Other transition strategies are also possible.

I support the use of special needs plans in Medicare Advantage and I am pleased that their availability has grown over the last several years. Yet I am somewhat concerned with the variability in that growth. Beneficiary access to plans focusing on the management of specific chronic illnesses lags behind that of other types of special need plans. What factors have accounted for this uneven growth in the types of special needs plans? What administrative or legislative actions could be taken to encourage better access to special needs plans that focus on chronic care management?

Since the Congress created special needs plans (SNPs) in the MMA, available SNPs have largely been those for dual-eligible beneficiaries. Most SNPs (82 percent) available in 2006 were for dual-eligible beneficiaries (Figure 1). However, this year the availability of the three types of SNPs—dual eligible, chronic condition, and institutional—has become less concentrated. Enrollment in dual eligible plans as a share of total SNP enrollment has gone from 83 percent in July 2006 to 74 percent in March 2007.

In 2007, dual-eligible plans still account for the largest share of SNPs (67 percent). However, institutional and chronic condition SNPs grew at faster rates, 127 percent and 446 percent, respectively (not shown). The share of SNPs that serve beneficiaries with chronic conditions has grown from 5 percent to 15 percent.

Figure 1. The number of SNPs increased from 2006 to 2007

	July 2006		March 2007	
	Number of SNPs	Share of total	Number of SNPs	Share of total
Dual eligible	226	82%	321	67%
Chronic or disabling condition	13	5%	71	15%
Institutional	37	13%	84	18%
Total	276		476	

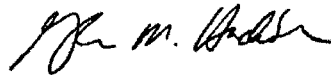
Source: CMS special needs plans fact sheet and data summary, February 14, 2006 and CMS special needs plans comprehensive report, March 21, 2007.

During site visits last year, SNP officials told us that of the three types of SNPs, chronic condition and institutional SNPs required the longest amount of time to establish, which may explain why they were a slower share of the total in the first years of the program. Officials stated that in order for these SNPs to be successful, they needed to invest time and resources into creating tailored networks of providers. They predicted more growth for both types of SNPs as insurers and providers gained experience.

We do not have legislative recommendations on SNPs at this time.

Please feel free to follow up with me on any of these issues. Again, we appreciate the opportunity to testify on this topic and commend the Committee's leadership in this area.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with the first name "Glenn" being more prominent.

Glenn Hackbarth, J.D.
Chairman

CBO TESTIMONY

**Statement of
Peter R. Orszag
Director**

The Medicare Advantage Program: Enrollment Trends and Budgetary Effects

**before the
Committee on Finance
United States Senate**

April 11, 2007

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CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, Senator Grassley, and Members of the Committee, I am pleased to appear before you today to discuss the Medicare Advantage program. My testimony focuses on several themes:

- Unexpectedly strong growth in enrollment in the Medicare Advantage program during 2006 and the beginning of 2007 led the Congressional Budget Office (CBO) to increase its projections for both enrollment in and spending on the program.
- Medicare's payments for beneficiaries enrolled in Medicare Advantage plans are higher, on average, than what the program would spend if those beneficiaries were in the traditional fee-for-service (FFS) sector. As a result, shifts in enrollment out of the FFS program and into private plans increase net Medicare spending. Policymakers need to weigh that additional cost against any differential benefits provided by Medicare Advantage plans.
- The rate of growth in enrollment and the cost differential with the traditional fee-for-service sector are particularly large in private fee-for-service (PFFS) plans, whose enrollment is concentrated largely in rural and some suburban areas.
- Reducing the payment differential between Medicare Advantage and the fee-for-service program could result in substantial savings to the Medicare program but also in a reduction in the supplemental benefits and cash rebates that Medicare Advantage plans can offer to enrollees and reduced enrollment in those plans.
- Many Medicare Advantage plans offer disease management, care coordination, and preventive care programs, but little information is available on the degree to which the plans generate better health outcomes than the traditional Medicare program. Expanded reporting of health outcomes would be helpful in assessing the value of the care management services provided by the plans.
- The central long-term fiscal challenge facing the nation involves health care costs. Policymakers face both challenges and opportunities in addressing those costs. Over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private-sector health markets. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing cost growth in the health sector as a whole. A variety of evidence suggests opportunities to constrain health care costs without adverse health consequences. So a basic challenge will be to restrain cost growth without harming incentives for

innovation or Americans' health (and perhaps even improving it). Moving the nation toward that possibility—which will inevitably be an iterative process in which policy steps are tried, evaluated, and perhaps reconsidered—is essential to putting the country on a sounder long-term fiscal path. Changes to the Medicare program should be evaluated with that broader perspective in mind.

Background on Medicare Advantage Plans

Medicare provides federal health insurance for 42 million people who are aged or disabled or who have end-stage renal disease. Part A of Medicare (Hospital Insurance) covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B of Medicare (Supplementary Medical Insurance) covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. Home health care is covered by Part A and Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit beginning in 2006 under Part D.

The majority of Medicare beneficiaries receive services through the traditional fee-for-service part of the program, which compensates providers using a set fee for each service. In nearly all areas of the country, however, Medicare beneficiaries have the option of enrolling in Medicare Advantage—the program through which private plans participate in Medicare—rather than receiving their care through the FFS program.¹ As of January 2007, about 19 percent of beneficiaries were enrolled in private health plans, which accept the responsibility and financial risk for providing Medicare benefits.² Although the payment system for private plans has been modified several times during the more than 20 years that they have participated in Medicare, a key feature of the system has remained intact: Plans that offer Medicare benefits for less than the amount of their payment from the government are required to give enrollees additional benefits or, in an option that became available recently, rebates on their Part B or Part D premiums.³ Those additional benefits and rebates of premiums are a major incentive for beneficiaries to enroll in Medicare Advantage plans and are particularly attractive to people without Medicaid or employer-sponsored supplemental health insurance.

About 75 percent of the Medicare beneficiaries enrolled in private plans are in health maintenance organizations (HMOs) or preferred provider organizations

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1. The program through which private plans participate in Medicare is also called Part C. Previously, the Medicare Advantage program was called Medicare+Choice.
 2. That figure includes about 1 percent of beneficiaries who are enrolled in group plans besides Medicare Advantage plans (which include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans).
 3. Plans have had the option of giving their enrollees rebates on their Part B premiums since 2003. Beginning in 2006, plans can also offer rebates on the Part D premiums.

(PPOs). Both HMOs and PPOs have comprehensive networks of providers, but PPOs allow beneficiaries to obtain care outside the network if they pay a higher amount. Some HMOs offer coverage for services received outside their network (and thus resemble PPOs), while others require that their enrollees receive all of their nonemergency care within the network. PPOs under Medicare Advantage are either local or regional; regional PPOs, an option that became available in 2006, are required to serve broad regions of the country rather than defining their service areas on a county-by-county basis. A key feature of many HMO and PPO plans is care management services, which are intended to promote better coordination and more effective use of health care.

The other main type of Medicare Advantage plans is private fee for service. PFFS plans allow their enrollees to obtain care from any provider who will furnish it and are not required to maintain networks of providers. Providers must decide each time they see a patient whether to accept a PFFS plan's terms of participation and thus agree to its payment rates, usually those of Medicare's FFS program.

In 2007, 82 percent of beneficiaries live in a county served by an HMO or a local PPO, up from 67 percent in 2005.⁴ Nearly all beneficiaries who do not have access to a local HMO or PPO have access to a regional PPO (and 99 percent have access to one of the three). All beneficiaries have access to a PFFS plan in 2007, up from 80 percent in 2006 and only 45 percent in 2005.

The Payment System for Private Health Plans

The latest changes to the payment system for private health plans were enacted in 2003 in the Medicare Modernization Act. The modified payment system is analogous to the previous system, and the incentives facing plans and beneficiaries are similar.

Beginning in 2006, private plans wanting to participate in Medicare must submit bids indicating the per capita payment for which they are willing to provide Medicare's Part A and Part B benefits.⁵ The government compares those bids with county-level benchmarks that are determined in advance through statutory rules.

4. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2007), Chapter 4, "Update on Medicare Private Plans," pp. 237–266.

5. Plans must also submit bids for the voluntary prescription drug benefit and their premiums for any supplemental benefits they intend to offer.

Table 1.

**Private Plans' Bids for Providing Medicare Benefits
Relative to Costs in the FFS Program, 2007**

Average per Capita FFS Expenditures in Plans' Service Areas (Dollars)	Difference Between Plans' Bids and per Capita FFS Expenditures (Percent)	Plans' Projected 2007 Enrollment in Category (Percent)
More Than 750	-9	26
700 to 749	1	19
650 to 699	3	25
600 to 649	9	17
Less Than 600	16	13
National Average	2	100

Source: Congressional Budget Office based on data submitted by private plans to the Medicare program for 2007.

Note: FFS = fee-for-service.

The benchmarks are the maximum payments that the government will make for enrollees in private plans.^{6,7}

Under current law, benchmarks are required to be at least as great as per capita FFS expenditures in every county and are higher than FFS expenditures in many counties. For 2007, CBO calculates that benchmarks will be 17 percent higher, on average, than projected per capita FFS expenditures nationwide. Net payments to plans will be approximately 12 percent higher than per capita FFS costs. Bench-

6. The description of the MMA payment mechanism in this section pertains to plans that participate in Medicare on a county-by-county basis (or local plans). The payment mechanism for regional PPOs is analogous to the mechanism described here for local plans but uses a modified approach to compute benchmarks. See Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (June 2005), pp. 59–81.

7. The benchmark for a plan that serves more than one county is a weighted average of the county-level benchmarks in its service area (using the plan's expected enrollment in every county as weights). Plans are paid their bid (up to the benchmark) plus 75 percent of the amount by which the benchmark exceeds their bid. Plans must return that 75 percent to beneficiaries as additional benefits or as rebates of their Part B or Part D premiums. Plans whose bid is above the benchmark are required to charge enrollees the full difference between the two as an additional premium for the Medicare benefit package. For 2007, the Medicare Payment Advisory Commission reports that nearly all (99 percent) of beneficiaries have access to Medicare Advantage plans that do not require an additional premium for Parts A and B benefits and any supplemental benefits offered by the plans but not offered by Medicare. See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 248.

marks are updated each year by either the growth in national per capita Medicare spending or 2 percent, whichever is greater.^{8,9}

For 2008, the Centers for Medicare & Medicaid Services recently announced that benchmarks for Medicare Advantage plans will increase by 3.5 percent.¹⁰ Plans' bidding behavior, geographic patterns of enrollment, and other factors will also affect the ultimate change in spending per capita in 2008.

Geographic Patterns of Enrollment

The relationship between the cost of offering Medicare benefits and the benchmarks is an important determinant of the types of plans that are available in various areas of the country. To offer a product that is attractive to beneficiaries, a plan must have a cost of offering Medicare benefits that is low enough, relative to the benchmarks, to enable it to provide some combination of additional benefits and cash rebates. Those additional benefits—which generally are similar to the supplemental benefits offered by medigap insurance—often include reduced cost sharing for medical services or prescription drugs. They may also include coverage of services that are not covered by Medicare, such as dental care, and they

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8. The benchmarks for 2007 were updated from the payment rates for private plans that were established by the Balanced Budget Act of 1997 (BBA) and modified through subsequent legislation. Before the enactment of the BBA, plans were generally paid 95 percent of the local per capita FFS costs. Under the BBA, the payment rate in each county was the greatest of three amounts: a minimum, or "floor," rate; a blend of a local rate and the national average rate; and a minimum increase from the previous year's rate (which was equal to 2 percent in most years). The floor amount established in 1998 (\$367 a month that year) was increased each year by the national rate of increase in per capita Medicare spending. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 increased that floor amount to \$475 for 2001 and established a \$525 floor for metropolitan areas with at least 250,000 residents. Those amounts also were increased each year by the national rate of increase in per capita Medicare spending.
 9. The BBA's rules resulted in rates in some counties that were higher—in some cases, by a substantial amount—than local per capita spending in the FFS program. In other counties, however, the update mechanism resulted in payment rates that were lower than local per capita FFS spending. The MMA modified the benchmarks to be the higher of the BBA benchmarks or local per capita spending. The MMA also requires that the government "rebase," or reestimate, per capita FFS expenditures in each county at least once every three years using the most current data available. In those years in which rebasing occurs, the benchmark for each county will be the greater of the rebased per capita FFS expenditures or the update from the previous year's rate. The Centers for Medicare & Medicaid Services rebased the FFS rates in 2004, 2005, and 2007.
 10. In response to projected increases in risk scores (measures calculated for the purpose of having payments to plans reflect their enrollees' health), the Centers for Medicare & Medicaid Studies will reduce them across the board by 1.1 percentage points. Plans with increases exceeding 1.1 percentage points will see payment increases above 3.5 percent; those with lower increases in risk scores will see lower increases in payments.

often include disease management, care coordination, and preventive care programs to promote better use of services.

HMOs and PPOs incur substantial administrative costs to establish and maintain networks of providers, to acquire and maintain enrollment, and to manage utilization. To the extent that they negotiate payment rates with providers that are higher than Medicare's payment rates for services furnished in the fee-for-service sector, those plans may also incur higher costs for medical services. Private health plans that participate in Medicare have higher administrative costs per enrollee than the traditional Medicare program does because of their smaller scale of operations and their costs associated with network development and retention, care management, marketing, and reinsurance. As a result, private plans can provide Medicare services at a lower cost than the FFS program only if they can achieve savings through lower utilization or reductions in payment rates for providers that more than offset their higher administrative costs. The ability of plans to achieve such savings varies greatly among geographic areas.

Previous work by CBO has shown that plans' bids for operating Medicare Advantage plans vary less from county to county than per capita FFS spending does (see Table 1 on page 4). As a result, in areas with high FFS costs per capita, Medicare Advantage plans' bids are relatively low in comparison with FFS spending, and vice versa. In particular, in areas with the highest per capita FFS spending, health plans' bids are about 9 percent below FFS spending. By contrast, in the lowest-cost FFS areas, health plans' bids are about 16 percent above FFS spending. Benchmark rates in those areas vary in similar fashion, from an average of about 4 percent above FFS costs in high-cost FFS areas to an average of about 26 percent above in low-cost areas.

Most enrollment in HMOs and PPOs tends to be in relatively densely populated areas (where it is easier to establish provider networks) with relatively high benchmarks and generally high per capita FFS spending.¹¹ Because private plans try to restrain medical costs by managing the level and intensity of service utilization, they have greater potential to achieve savings relative to the FFS program in geographic areas where FFS practice involves relatively high utilization of costly services—which also tend to be areas with high per capita FFS expenditures. Private plans have much less opportunity to achieve such savings in areas where utilization rates for expensive services in the FFS sector are already relatively low.

11. It is easier for a plan to establish a network in a relatively densely populated area that has a relatively large number of providers than in a more sparsely populated area because the plan's leverage in negotiations with providers (to get them to accept relatively low payment rates and to cooperate with the plan's efforts to manage utilization) is to promise them some volume of business by diverting to them patients from providers who do not participate in the network.

In contrast to HMOs and PPOs, private fee-for-service plans do not incur the costs of establishing and maintaining networks of providers or managing utilization, and the payment rates PFFS plans receive generally are the same as Medicare rates. However, PFFS plans incur administrative costs for acquiring and maintaining enrollment, and they do not realize comparable savings from utilization management, which is often cited by supporters as an important public policy benefit from other types of Medicare Advantage plans.¹²

The structure of the payment system and plans' characteristics result in significant variation in the supplemental benefits and rebates offered to beneficiaries by region and county. HMOs are generally more successful in urban and suburban areas but struggle to operate in rural areas because of the difficulty and expense of creating provider networks in sparsely populated communities. PFFS plans have generally targeted rural and suburban areas of the country. PFFS and regional PPO plans are the only options for beneficiaries wishing to enroll in private health plans in some places—where HMOs find it difficult to create networks but relatively high benchmarks allow plans with limited networks to submit bids well above local FFS costs and still offer some extra benefits or rebates to attract beneficiaries. (That phenomenon is particularly notable in the rural counties with benchmarks at the floor amounts.¹³) And the PFFS plans may also find it difficult to compete in urban areas, where the benchmarks tend to be closer to FFS costs.

Care Management in Medicare Advantage

Medicare's FFS program provides a generally unmanaged approach to the delivery of medicine because providers are paid for the number of services they deliver and not for the quality of the outcomes they bring about.¹⁴ Health plans may be more able to manage care through their knowledge of members' health conditions, contact with providers, and centralized administrative arrangements. Medicare Advantage plans also have strong incentive to manage care to reduce costs, as any savings that they can generate accrue directly to them. Health plans' various efforts at disease management, care coordination, and preventive care often include:

12. Some PFFS plans employ certain utilization controls, such as counseling and monitoring of patients with phone calls from nurses.

13. In 2006, the average benchmark in urban counties with benchmarks at the floor amounts was 121 percent of per capita FFS spending, the benchmark in other "floor counties" (largely rural) was 134 percent, and the benchmark in other counties was 111 percent. (A floor county is paid at one of the two minimum rates established by the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act of 2000 and updated each year.) See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 244.

14. See Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (June 2006), Chapter 2, "Care Coordination in Fee-for-Service Medicare," pp. 53–80.

- Phone calls from nurses or caseworkers to provide reminders and periodic health assessments,
- Health coaches to encourage healthy behaviors,
- Educational programs to teach members and physicians about guidelines for effective treatment, and
- Efforts to connect members with resources in the community.¹⁵

Such programs have the potential to reduce plans' costs to the extent that they eliminate unnecessary services or manage chronic conditions so as to avoid relatively costly episodes (such as extended hospital stays). Initially, any cost savings that health plans realize (after bids and premiums are set) from such activities accrue entirely to the plans, not to the government. Medicare spending would not be reduced, for instance, if inpatient admissions in Medicare Advantage plans decline in 2007. Plans (except for regional PPOs for a limited period of time) accept the full risk for their beneficiaries, so, within the payment period, they also realize all gains from their medical management strategies.

In the long run, any reductions in cost achieved by health plans should be passed back to the beneficiaries (75 percent) and the government (25 percent) through the operation of the bidding mechanism. If a plan can provide services for a lower cost, it has a strong incentive to reduce its bid in order to increase the extra benefits and rebates that it can use to attract members. Similarly, any care management technologies that cause plans to increase their bids will result in reduced benefits and rebates for beneficiaries and increased costs to the government. Even if improvements in care management yielded significant improvements in efficiency in Medicare Advantage, the government would realize, at most, 25 percent of those savings.

Reporting on Measures of Health Plans' Quality

One possible benefit of the Medicare Advantage program is the higher quality of care beneficiaries may receive through more disease management, care coordination, and preventive care than they would receive in the Medicare fee-for-service program. But the extent to which such services lead to improved health outcomes is difficult to assess with the currently available data. Policymakers may therefore want to explore options for expanded reporting of outcomes.

Most Medicare Advantage plans are required to report on the quality of care they provide, as measured by several surveys administered by the National Committee for Quality Assurance (NCQA):

15. See Blue Cross and Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management* (February 2007); and America's Health Insurance Plans, *Innovations in Chronic Care* (March 2007).

- The Health Plan Employer Data and Information Set (HEDIS), which collects information on the quality of care delivered by plans and their affiliated providers;
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS), which collects information on members' experience in interacting with plans and their affiliated providers; and
- The Health Outcomes Survey (HOS), which collects information on the overall mental and physical health of plans' populations.

Some of the information collected is made available to the public through Medicare's "plan finder" Web site and other distribution channels.

The current data sources and reporting requirements, however, do not provide sufficient information to assess whether health plans produce better health outcomes or deliver more cost-effective care than the FFS sector (as indicated by the quality of care per dollar of federal spending). PFFS plans, the fastest growing component of Medicare Advantage, are exempt from many of the reporting requirements.¹⁶ Furthermore, the measures collected by the HEDIS and CAHPS surveys largely measure the quality of the process of delivering health care rather than the outcomes of that care. Plans are surveyed about their adherence to medical recommendations (for instance, treatment of heart attack patients with beta blockers and management of antidepressants), ability to deliver preventive health services and screenings (for instance, controlling high blood pressure and providing breast cancer screenings), availability of care, and members' perceptions of their responsiveness and accessibility. The HOS collects population-level health information on each plan but does not provide insight into the plans' efficiency of operations.

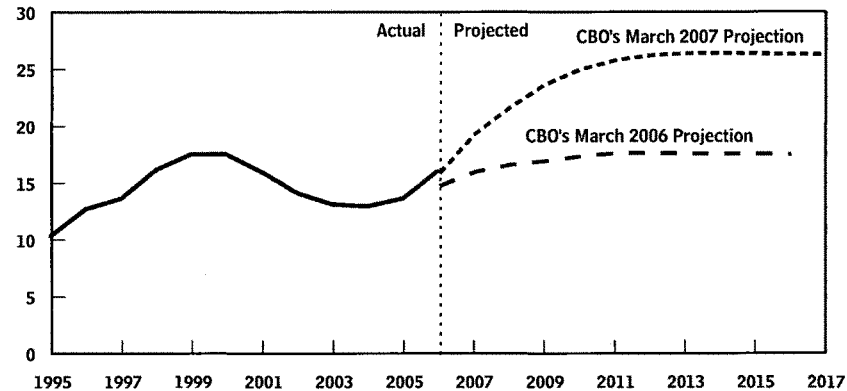
Though Medicare Advantage plans cost more than care under the FFS program does, on average, they would be more cost-effective if they delivered a sufficiently higher quality of care. The limited measures available suggest that the plans are no more cost-effective than the FFS program.¹⁷ The development of reporting systems to comprehensively measure health outcomes in the Medicare Advantage and

16. PPO plans are also exempt from some reporting requirements. In comparison to HMOs, both PFFS and PPO plans have less access to medical records, making some reporting requirements more difficult for them. All plans are required to report on only a subset of the measures in HEDIS; in particular, plans are not required to report on the cost-of-care measures implemented in recent versions of the survey.

17. See Medicare Payment Advisory Commission, *Issues in a Modernized Medicare Program*, p. 70.

Figure 1.**Enrollment in Medicare Advantage as a Percentage of Total Enrollment in Medicare, 1995 to 2017**

(Percentage of Part A enrollment)



Source: Congressional Budget Office based on data from the Centers for Medicare & Medicaid Services.

Note: The figure shows fiscal year averages calculated as a percentage of Part A enrollment.

FFS programs would be helpful in assessing the value of disease management and other techniques employed by Medicare Advantage plans. Expanded reporting on outcomes would also allow analysis of varying approaches adopted by different plans, which could be a valuable tool in the search for ways to restrain the cost of health care in the United States while maintaining or improving the quality.

Anticipated Trends in the Medicare Advantage Program

Increasing spending in Medicare Advantage is driven by rapidly increasing enrollment in private plans and is partially offset by decreasing enrollment and spending in FFS Medicare. Payments to private health plans in the Medicare Advantage program increased from about \$40 billion in 2004 to about \$56 billion in 2006. CBO projects that those payments will increase to \$75 billion in 2007 and \$194 billion by 2017 and will total \$1.5 trillion over the 2007–2017 period.¹⁸ Because payments to Medicare Advantage plans are higher than payments made to FFS pro-

18. Those amounts include payments to group health plans besides Medicare Advantage plans (which include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans). Under current law, CBO projects, payments to those group plans outside of the Medicare Advantage program will decline from \$4 billion in 2007 to \$1 billion in 2017.

viders, shifts of enrollment to Medicare Advantage plans result in higher net costs for the Medicare program overall. CBO projects that the share of Medicare spending for Part A and Part B benefits that is paid to Medicare Advantage plans will increase from 17 percent in 2006 to 27 percent in 2017.

Increasing Enrollment in Medicare Advantage

In 2004, Medicare Advantage plans accounted for 13 percent of enrollment in Medicare, the lowest level since 1996. Over the past two years, however, enrollment in those health plans has increased to about 19 percent of all enrollment, or 8.3 million beneficiaries.¹⁹ That increase resulted from changes enacted in the Medicare Modernization Act that increased payment rates and added the prescription drug benefit to complement the medical benefits provided under Parts A and B of Medicare. CBO projects that enrollment in Medicare health plans will continue to increase rapidly in coming years, to 22 percent of total Medicare enrollment in 2008 and 26 percent by 2017 (see Figure 1).

The projected increase in enrollment in Medicare Advantage is driven largely by CBO's expectation of continuing growth in enrollment in private fee-for-service plans, which rose from 200,000 members at the end of 2005 to more than 1.3 million members in January (see Table 2). Nearly 500,000 of those members were added in January 2007 alone. CBO projects that enrollment in PFFS plans will reach 5 million members by 2017, accounting for one-third of all Medicare Advantage enrollment at that time, up from about one-sixth now.

HMOs and local PPOs grew strongly in 2006, as well, adding approximately 1.1 million members from the end of 2005 to January 2007. Membership in such plans now numbers approximately 6.2 million. Growth in January 2007 for these types of Medicare Advantage plans was somewhat slower than that for 2006, however, and, according to CBO's projections, that portion of the program will grow more slowly than the PFFS portion over the next several years. In addition, the expiration of the authorization for a special needs program after December 31, 2008, will eliminate one of the fastest-growing components of local HMOs and PPOs, limiting the future growth of such plans under current law.²⁰

The recent growth of PFFS plans has changed the geographic pattern of Medicare Advantage enrollment. In 2006, PFFS plans drew 39 percent of their membership from rural areas, while HMOs and local PPOs drew only 4 percent and 10 percent,

19. Those figures include about 1 percent of beneficiaries (or about 600,000) who are enrolled in group plans besides Medicare Advantage plans.

20. Special needs plans were authorized by section 231 of the Medicare Modernization Act. Currently, about 840,000 beneficiaries are enrolled in such plans, the majority of whom are in HMOs. Those plans are permitted to market to and restrict enrollment to specific subgroups of beneficiaries, including people who are dually eligible for Medicare and Medicaid, who have chronic conditions, and who reside in institutions.

Table 2.**Recent Enrollment in Medicare Advantage and Other Group Health Plans**

(Thousands of people)

	Total, December 2005	Additions		Total, January 2007
		During 2006	In January 2007	
Medicare Advantage				
Local HMOs and PPOs	5,160	840	240	6,240
Private fee for service	210	660	470	1,350
Regional PPOs	0	100	20	120
Subtotal, Medicare Advantage	5,370	1,600	730	7,700
Other Group Health Plans ^a	760	-130	-40	590
Total, All Group Health Plans	6,120	1,470	690	8,290

Source: Congressional Budget Office based on data from the Centers for Medicare & Medicaid Services.

Notes: HMO = health maintenance organization; PPO = preferred provider organization.

Figures do not add up to totals because of rounding.

a. Other group plans include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and some demonstration plans.

respectively, of their membership from such areas.²¹ The disproportionately rapid growth of PFFS plans thus increased the market share of private plans in rural areas from about 4 percent in 2005 to about 7 percent in 2006, and CBO expects that market share to continue to grow under current law as PFFS plans play an increasingly large role in the Medicare Advantage program.

Rising Costs for Medicare Advantage

CBO projects that payments to health plans will rise from an estimated \$64 billion in calendar year 2006 to \$197 billion in 2017, or at an annual average growth rate of 11 percent (see Table 3).²² Spending in Medicare Advantage is projected to total approximately \$1.5 trillion over that 11-year period.

CBO projects that private fee-for-service plans will account for a rapidly growing share of Medicare Advantage spending, with payments to them increasing from approximately \$5 billion in 2006 to \$13 billion in 2007 and \$59 billion in 2017.

21. See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 248.

22. As noted in the text above, spending during fiscal year 2006 was \$56 billion. The discussion here focuses on calendar years because changes in enrollment (open seasons) and payment rates are implemented on a calendar year basis and because spending on a fiscal year basis is complicated by timing shifts. (Plans are paid on a monthly basis. There can be 11, 12, or 13 payments during a fiscal year; there are always 12 payments during a calendar year.)

That increase represents an annual average nominal growth rate of 25 percent over the 11-year period and reflects a 20 percent average rate of growth in enrollment and a 4 percent average annual rate of growth in net payments per enrollee. In 2006, PFFS plans accounted for approximately 8 percent of Medicare Advantage spending; CBO anticipates that those plans will account for 17 percent of that spending in 2007 and 29 percent in 2017.

Despite the rapid projected growth in PFFS plans, local HMOs and PPOs are projected to continue to account for the largest portion of spending throughout the projection window. According to CBO's estimates, payments to those organizations will increase from approximately \$54 billion in 2006 to approximately \$63 billion in 2007 and \$127 billion in 2017, reflecting an annual average nominal growth rate of 8 percent. That increase results from projected annual average growth of 4 percent in enrollment and 4 percent in net per capita payments. Growth in enrollment is more rapid in the early portion of the period, with 11 percent projected for 2007.

Regional PPOs are projected to grow from the current 120,000 members to about 800,000 in 2017 (under an assumption that current law remains in place). Payments to such plans were approximately \$1 billion in 2006 and, by CBO's projections, will be \$1 billion in 2007 and \$10 billion in 2017—representing an annual growth rate of 8 percent, 4 percent from enrollment and 4 percent from growth in net per capita payments.

CBO's baseline projections also include approximately \$3.5 billion in spending in 2012 and 2013 from the "stabilization fund" established under the Medicare Modernization Act to encourage regional PPOs' participation in the Medicare Advantage program.

Recent Changes in CBO's Projections

Enrollment in the Medicare Advantage program has been growing more rapidly than CBO had anticipated, and the agency expects that rapid growth to continue under current law. Accordingly, since last year, CBO has raised its projections of Medicare Advantage enrollment and spending. In March 2006, CBO anticipated that 18 percent of Medicare beneficiaries would be enrolled in Medicare Advantage by the end of the projection window at that time (2016); the current projection for that year is 26 percent (see Table 4 on page 16). That 8 percentage-point difference translates to an increase of almost 5 million beneficiaries who will be enrolled in Medicare Advantage plans in 2016.

Most of that increase is attributable to increased projections of enrollment in PFFS plans. In 2006, CBO projected that enrollment in those plans would be 400,000 in 2016; that projection has since risen sharply, to 4.9 million beneficiaries. CBO has also raised its projection of enrollment in local HMOs and PPOs but has lowered its projection of enrollment in regional PPOs.

Table 3.**CBO's Baseline Estimates for Medicare Advantage**

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2017	2008-2017	2006-2017
Enrollment (Calendar year average, in thousands)															
Local HMOs and PPOs	5,740	6,400	6,790	7,230	7,380	7,460	7,560	7,720	7,920	8,120	8,320	8,530			
PFFS	650	1,670	2,290	3,120	3,720	4,170	4,490	4,680	4,770	4,840	4,900	4,960			
Regional PPOs	70	140	180	240	290	350	420	490	570	650	730	810			
Subtotal, Medicare Advantage	6,460	8,210	9,260	10,590	11,390	11,980	12,470	12,890	13,260	13,610	13,950	14,300			
Other Group Plans ^a	640	590	520	310	160	160	150	150	150	150	150	140			
Total, Medicare Group Plans ^b	7,100	8,800	9,780	10,900	11,550	12,140	12,620	13,040	13,410	13,760	14,100	14,440			
Group Plan Enrollment as a Percentage of Hospital Insurance Enrollment	17	20	22	24	25	26	26	26	26	26	26	26			
Spending (Calendar year incurred, in billions of dollars)															
Local HMOs and PPOs	54	63	70	78	83	87	92	97	103	110	118	127	411	965	
PFFS	5	13	19	27	33	39	44	47	50	52	55	59	162	424	
Regional PPOs	1	1	2	2	3	4	4	5	6	8	9	10	15	53	
Subtotal, Medicare Advantage	60	77	91	107	119	130	140	149	159	169	182	196	587	1,442	
Other Group Plans ^a	4	4	4	2	1	1	1	1	1	1	1	1	8	13	
Total, Medicare Group Plans ^b	64	81	95	109	120	131	141	150	160	170	183	197	596	1,455	
Fiscal Year Outlays ^{c,d}	56	75	91	106	117	140	128	150	158	167	195	194	582	1,446	
Number of Capitation Payments ^d	11	12	12	12	12	13	11	12	12	12	13	12	60	121	
Enrollment Growth (Percent)															
Local HMOs and PPOs	16	11	6	6	2	1	1	2	3	2	3	3	3	3	4
PFFS	435	156	37	36	19	12	8	4	2	1	1	1	22	12	20
Regional PPOs	n.a.	98	30	36	23	21	19	16	16	14	12	11	25	19	25
Subtotal, Medicare Advantage	27	27	13	14	8	5	4	3	3	3	3	3	9	6	7
Other Group Plans ^a	-13	-8	-11	-41	-48	-1	-1	-1	-1	-1	-1	-1	-24	-13	-13
Total, Medicare Group Plans ^b	22	24	11	11	6	5	4	3	3	3	3	3	7	5	7

Continued

The changes in CBO's projections of spending for Medicare Advantage are largely accounted for by the higher enrollment projections. The baseline issued in March 2006 projected spending for Medicare Advantage of \$66 billion in fiscal year 2007, \$134 billion in 2016, and \$967 billion over the 2007–2016 period (see Table 4).²³ CBO currently projects spending of \$75 billion in fiscal year 2007, \$179 billion in 2016, and \$1.31 trillion over the 2007–2016 period. The current 10-year figure represents an increase of

23. This discussion uses fiscal years to facilitate comparison with the baseline estimates for the fee-for-service components of Medicare. Effects of timing shifts are removed.

Table 3.**Continued**

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2008-2017	2008-2017	2006-2017
Annual Net per Capita Spending Growth (Percent)														
Local HMOs and PPOs	8	4	6	4	4	4	4	3	4	4	5	5	4	4
PFFS	0	4	6	4	4	4	4	3	4	4	5	5	4	4
Regional PPOs	n.a.	4	6	4	4	4	4	3	4	4	5	5	4	4
Subtotal, Medicare Advantage	6	2	5	3	3	4	3	3	4	4	5	5	4	4
Other Group Plans ^a	5	4	4	-5	-18	4	4	3	4	4	5	5	-3	1
Total, Medicare Group Plans ^b	7	3	5	4	4	4	3	3	4	4	5	5	4	4
Annual Spending Growth (Percent)														
Local HMOs and PPOs	26	16	12	11	6	5	5	6	6	6	7	8	8	8
PFFS	437	167	45	42	24	17	12	8	6	5	6	6	27	25
Regional PPOs	n.a.	107	38	42	28	26	23	20	20	19	18	17	31	31
Subtotal, Medicare Advantage	36	30	18	18	11	9	8	7	7	6	7	8	13	11
Other Group Plans ^a	-9	-4	-8	-44	-58	3	2	2	2	2	3	4	-25	-12
Total, Medicare Group Plans ^b	32	27	17	16	10	9	8	7	7	6	7	8	12	9

Source: Congressional Budget Office.

Notes: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee-for-service; n.a. = not applicable.

- Other group plans include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and some demonstration programs.
- Does not include spending from the stabilization fund for regional PPOs or for certain demonstration programs.
- Includes spending from the stabilization fund for regional PPOs and for certain demonstration programs.
- In general, capitation payments to group health plans and prescription drug plans for the month of October are accelerated into the preceding fiscal year when October 1st falls on a weekend. However, the Balanced Budget Act of 1997 required that the October payment in 2006 be made on October 2 instead of September 29.

36 percent over the previous 10-year figure. Because beneficiaries can be enrolled in only the Medicare Advantage program or the FFS program, increasing enrollment in the former leads to partially offsetting decreasing spending in the latter. However, because payments to Medicare Advantage plans are higher, on average, than costs in the FFS sector, shifts in enrollment out of the FFS program and into private plans increase net Medicare spending.

Estimated Spending Reductions from Alternative Policies

A number of policy options exist that would reduce spending on Medicare Advantage. This testimony presents three options drawn from CBO's recent *Budget Options* report.²⁴

24. Congressional Budget Office, *Budget Options* (February 2007). See Options 570-2, 570-3, and 570-4.

Table 4.**Change in CBO's Baseline Projections for Medicare Advantage**

(Billions of dollars, by fiscal year)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2007- 2016
March 2007												
Medicare outlays for Part A and B benefits	373	397	420	445	472	502	535	568	605	649	700	4,965
Outlays for group plans	75	91	106	117	128	140	150	158	167	179	193	1,311
Outlays for group plans as a share of Medicare outlays for Part A and B benefits (Percent)	20	23	25	26	27	28	28	28	28	28	27	n.a.
Group plan enrollment as a share of Hospital Insurance enrollment (Percent)	20	22	24	25	26	26	26	26	26	26	26	n.a.
March 2006												
Medicare outlays for Part A and B benefits	380	399	423	448	477	508	547	590	637	690	n.a.	5,100
Outlays for group plans	66	72	78	83	91	99	106	115	124	134	n.a.	967
Outlays for group plans as a share of Medicare outlays for Part A and B benefits (Percent)	17	18	18	19	19	19	19	19	19	19	n.a.	n.a.
Group plan enrollment as a share of Hospital Insurance enrollment (Percent)	16	17	17	17	18	18	18	18	18	18	n.a.	n.a.
Difference (March 2007 minus March 2006)												
Medicare outlays for Part A and B benefits	-7	-3	-3	-4	-5	-6	-12	-22	-33	-40	n.a.	-135
Outlays for group plans	10	19	28	34	37	41	43	43	44	45	n.a.	344
Outlays for group plans as a share of Medicare outlays for Part A and B benefits (Percent)	3	5	7	8	8	8	9	8	8	8	n.a.	n.a.
Group plan enrollment as a share of Hospital Insurance enrollment (Percent)	4	5	7	8	8	8	8	8	8	8	n.a.	n.a.

Source: Congressional Budget Office.

Notes: n.a. = not applicable.

Figures do not add up to totals because of rounding.

This table uses fiscal years (rather than calendar years, as in the other parts of the testimony) to provide a better comparison to the baseline estimates for the fee-for-service components of Medicare.

Effects of timing shifts are removed to simplify the presentation.

Pay Plans at Local FFS Rates

The first policy would reduce the county-level benchmarks under Medicare Advantage to the level of local per capita FFS spending. Relative to spending under current law, CBO estimates, this policy would save \$9.5 billion in 2009, \$54 billion over the 2009–2012 period, and \$149 billion over the 2009–2017 period (see Table 5).²⁵

25. The county-level benchmarks for 2008 have been announced, and the bidding process is under way. The estimates assume that the policies under discussion would take effect in 2009 to avoid interrupting the bidding process for 2008.

Table 5.**Estimated Budgetary Effects of Alternative Policies**

(Billions of dollars, by fiscal year)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008- 2012	2008- 2017
Pay Plans at Local FFS Rates	0	-9.5	-13.7	-16.2	-14.6	-16.8	-17.7	-18.5	-21.2	-20.8	-54.0	-149.1
Eliminate Double Payments for Indirect Medical Education	0	-0.8	-1.1	-1.3	-1.1	-1.3	-1.4	-1.5	-1.8	-1.7	-4.2	-12.0
Eliminate the Remainder of the Regional PPO Stabilization Fund	0	0	0	0	-1.6	-1.6	-0.4	0	0	0	-1.6	-3.5

Source: Congressional Budget Office.

Notes: Figures do not add up to totals because of rounding.

The estimates are net of changes in premium receipts resulting from policy changes.

All counties have benchmarks set at or above local FFS rates. Many counties have rates well above local per capita FFS costs, particularly counties where the floor payment rates were in effect before the enactment of the Medicare Modernization Act. Reducing payment rates to FFS levels would result in a significant reduction in payment rates in most counties. CBO estimates that in 2007, the average payment will be 12 percent above FFS rates; that difference will be greater for PFFS plans and lower for HMOs and PPOs. The continuing growth of PFFS plans is likely to push that payment difference still higher in the future (although other changes to the calculation of the county rates and the reported health characteristics of enrollees could offset or reinforce that increase).

Reducing payment rates would leave less money for health plans to offer reduced premiums or supplemental benefits. That change, in turn, would make the program less attractive to beneficiaries and lead some to return to the traditional fee-for-service program. Others who would have joined Medicare Advantage plans would remain in the fee-for-service program. The change also would make the Medicare Advantage program less attractive for health plans and cause some to leave the program, as they did after the Congress cut payment rates in the Balanced Budget Act of 1997. By CBO's estimates, enacting this policy would reduce enrollment in Medicare Advantage by about 6.2 million beneficiaries in 2012 relative to the baseline projection, a decline of about 50 percent from projected levels—leaving total Medicare Advantage enrollment at about 6.5 million (and the program's share of total enrollment in Medicare at 13 percent), which is roughly 1.8 million enrollees fewer than there are today.

CBO also has estimated the budgetary effect of variations on this option that would limit the benchmarks to certain levels above local FFS costs (see Table 6). For example, the Congress could limit all local benchmarks to 110 percent or

Table 6.

Estimated Budgetary Effects of Policies Capping the Benchmarks under Medicare Advantage

(Billions of dollars, by fiscal year)

Limit on MA Benchmarks as a Percentage of FFS Costs	Change in Direct Spending	
	2008–2012	2008–2017
100	-54	-149
105	-43	-120
110	-32	-90
115	-23	-64
120	-15	-42
125	-10	-28
130	-6	-18
135	-4	-10
140	-2	-7
145	-2	-5
150	-2	-4

Source: Congressional Budget Office.

Notes: MA = Medicare Advantage; FFS = fee for service.

The estimates are net of changes in premium receipts resulting from policy changes. Each policy would limit the Medicare Advantage program's county benchmarks to some level above local per capita FFS costs.

120 percent of local per capita FFS spending. Such policies would have similar, but smaller, effects on payments to plans and enrollment. CBO estimates that capping payment rates at 110 percent of local per capita FFS costs would reduce spending by \$32 billion over the 2009–2012 period and \$90 billion over the 2009–2017 period. Capping rates at 120 percent of FFS costs would save \$15 billion from 2009 to 2012 and \$42 billion from 2009 to 2017.

In general, those spending reductions mirror the spending distribution of Medicare Advantage payments. About 52 percent of Medicare Advantage spending is in counties where the benchmark is greater than 110 percent of local FFS costs, meaning that about one-half of spending would be affected by reducing benchmarks to be no more than 110 percent of local FFS costs (see Table 7). (That fact does not mean, however, that one-half of spending would be cut from the program, because the portion of spending below 110 percent of local FFS costs in those counties would be unaffected by the change. CBO anticipates that such cuts would lead to decreases in enrollment, bringing some additional savings as beneficiaries left private plans and returned to the FFS program.)

Because the payment reductions would be largest in counties with the highest rates relative to local FFS costs, the reductions in extra benefits and declines in enrollment under the policy would be largest in those areas. Plans in counties paid at one

Table 7.

Distribution of Medicare Advantage Spending by Ratio of County Benchmarks to Local per Capita FFS Costs

(Percent)

Ratio of Benchmark to FFS Costs	Portion of Medicare Advantage Spending	
	Within Category	Within or Above Category
100	10	100
100 to 109.9	38	90
110 to 119.9	31	52
120 to 129.9	12	21
130 to 139.9	5	9
140 to 149.9	1	4
150 and Higher	3	3

Source: Congressional Budget Office.

Note: The ratio used is the Medicare Advantage program's local county rate divided by the local fee-for-service (FFS) rate. The total spending is calculated as if all bids were equal to the benchmark and all beneficiaries had average expected costs. It is intended to be an illustrative simplification of the calculations used in the Congressional Budget Office's cost estimates. The analysis includes all counties with reported FFS spending for 2007 (including Puerto Rico).

of the two floor rates would experience the largest payment and enrollment reductions; those counties are generally rural ones or suburban and urban counties with low FFS costs. Plans in counties with payment rates nearest FFS costs would see the smallest payment and enrollment reductions; those counties are generally urban and suburban counties with relatively high local FFS costs. In virtually no county would plans avoid a payment cut, however; the minimum update requirement has kept the rates for counties where payments were at FFS rates in 2004 (the first year plans were paid at the local FFS level) above FFS costs subsequently in the majority of cases.

Eliminate Double Payments for Indirect Medical Education

Medicare's payments to teaching hospitals for inpatient services in the traditional fee-for-service sector include an "indirect medical education" (IME) adjustment. That adjustment is intended to account for the fact that teaching hospitals tend to have greater expenses than other hospitals. For example, teaching hospitals typically offer more technically sophisticated services than other hospitals do and treat patients who have more-complex conditions.

Those IME payments are included in the benchmarks in counties where the benchmark is tied to historical spending in the fee-for-service sector. Nevertheless, Medicare also pays the IME amount to teaching hospitals that treat patients enrolled in Medicare Advantage plans.

This policy would eliminate that double payments by removing IME payments from the benchmarks in counties where the benchmark is tied to historical spending in the fee-for-service sector. By CBO's estimates, such a change would save \$0.8 billion in 2009, \$4 billion over the 2009–2012 period, and \$12 billion over the 2009–2017 period (compared with spending under current law).

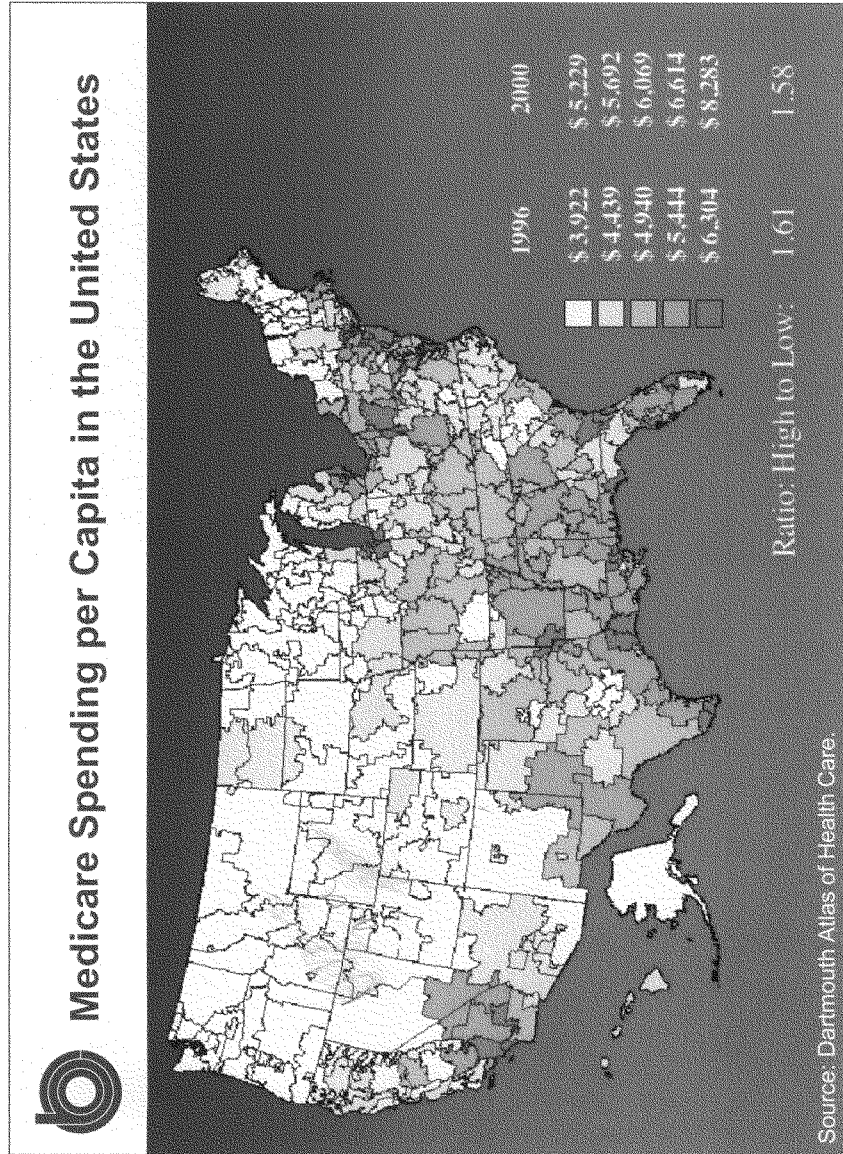
This option is only one method of implementing such a payment reduction. The Administration's budget for fiscal year 2008 proposed an alternative approach: remove the double payments for IME in all counties (not just the FFS-based counties) by eliminating the separate IME payments for Medicare Advantage enrollees treated in teaching hospitals. The Administration's proposal would phase in that change over the 2008–2016 period. According to CBO's estimates, that provision would save \$500 million in 2008, \$5 billion over the 2008–2012 period and \$19 billion over the 2008–2017 period (this policy generates savings in 2008 because payments to hospitals can be cut more quickly than payments to plans made through the bidding system). The choice of whether to eliminate the double payments from the health plan side or from the hospital side could have important financial consequences for health plans and teaching hospitals.

Eliminate the Remainder of the Regional PPO Stabilization Fund

The stabilization fund established by the MMA was authorized to spend \$10 billion over the 2007–2013 period to encourage the participation of regional PPOs in the Medicare Advantage program. The Tax Relief and Health Care Act of 2006 repealed \$6.5 billion of that amount and prohibited spending the remainder until 2012. This option would eliminate that fund and would save an estimated \$1.6 billion in 2012 and \$3.5 billion over the 2008–2017 period.

Conclusion

The Medicare Advantage program has been growing rapidly and is projected to continue to do so. Such growth, under current payment policies, increases net costs to Medicare because payments made to Medicare Advantage plans exceed costs under the traditional fee-for-service program. Policymakers evaluating options for reducing payments to Medicare Advantage plans need to weigh the cost savings against any benefits that the plans provide in managing care, the effect on health care costs overall, and the impact on beneficiaries. Finally, expanded reporting on health outcomes may help policymakers better evaluate both the overall effects and specific care management results of Medicare Advantage plans.





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**Responses to Questions for the Record for
CBO's April 11, 2007 Testimony on Medicare Advantage
Before the Senate Finance Committee**

Question by Senator Grassley. In the conclusion of your testimony, you mentioned that Congress needs to weigh the impact of reducing payments on beneficiaries. Could you please elaborate on what the impact on beneficiaries could be?

Response. The system for paying Medicare Advantage plans conveys subsidies to participants in those plans that are not available to beneficiaries in fee-for-service Medicare. Plans in Medicare Advantage with bids lower than the benchmark are required to return 75 percent of the difference between the benchmark and their bid to beneficiaries in the form of supplemental benefits (reduced cost-sharing and coverage for services not covered by Medicare, such as dental and vision services) or reduced premiums for Parts B and D. Reducing benchmarks would leave less money for health plans to offer those extra benefits. That change, in turn, would make the program less attractive to beneficiaries and lead some to return to the traditional fee-for-service program, where they would not receive the supplemental benefits or lower premiums available from their MA plans. Others who would have joined Medicare Advantage plans would remain in the fee-for-service program. Beneficiaries remaining in Medicare Advantage plans would have to pay more or receive fewer benefits than under current law. The change also would make the Medicare Advantage program less attractive for health plans and might cause some to leave the program.

Questions by Senator Smith. I support the use of special needs plans in Medicare Advantage and I am pleased that their availability has grown over the last several years. Yet I am somewhat concerned with the variability in that growth. Beneficiary access to plans focusing on management of specific chronic conditions lags behind that of other types of special needs plans.

What factors have accounted this uneven growth in the types of special needs plans?

What administrative or legal actions could be taken to encourage better access to special needs plans that focus on chronic care management?

Response. The Medicare Payment Advisory Commission reported in March 2007 that the Centers for Medicare & Medicaid Services (CMS) approved 424 special needs plans (SNPs) for 2007. Such plans were authorized for a limited period of time by the Medicare Modernization Act in 2003 to provide specialized services to certain distinct populations. Of the 424 plans in 2007, 271 are for beneficiaries eligible for both Medicare and Medicaid, 81 are for beneficiaries institutionalized in a nursing home or other setting, and 72 are for beneficiaries with chronic conditions. In 2006, there were only 13 plans for beneficiaries with chronic conditions, so it appears that the number of those plans is growing rapidly. (Authorization for special needs plans expires after 2008, so further growth in the future would be contingent on reauthorization.)

Almost two-thirds of the special needs plans serve beneficiaries dually eligible for Medicare and Medicaid. Many of those plans are able to draw on their experiences serving as Medicaid HMOs. Likewise, many plans serving institutionalized beneficiaries had experience with Medicare contracting under prior demonstration authority. There was little comparable experience serving beneficiaries with chronic conditions in either Medicare or Medicaid, so plans have had to create new models and strategies to serve those populations. As a result, enrollment in those types of plans has grown more slowly than enrollment in plans that specialize in the institutionalized or dually eligible populations.

CMS has sought to encourage the offering of plans serving beneficiaries with chronic conditions, as reflected in the significant increase in the number of such plans in 2007. Further growth will require reauthorization of the special needs program beyond 2008. A long-term reauthorization would probably be more effective at encouraging the establishment of new plans than a short-term one. Increasing payment rates to plans that focus on chronic care management could encourage additional growth in the number of plans offered and enrollment.

STATEMENT OF SENATOR GORDON H. SMITH

U.S. Senate Finance Committee

“An Examination of the Medicare Advantage Program”

April 11, 2007

Thank you, Chairman Baucus and Senator Grassley, for providing the Finance Committee with an opportunity to learn more about how the Medicare Advantage (MA) program works, how well it serves beneficiaries’ needs and what might need to be done to ensure that it is operating as efficiently as possible.

I support the MA program in concept, as I believe that in terms of service delivery, it is the direction the Medicare program should be taking. With the demographic tsunami that will soon hit the federal entitlement programs, I believe we inevitably will be required to expand access to the type of care coordination services MA plans provide if we expect to maintain current services levels. However, as with any government program, there is always the need to reduce identified inefficiencies and MA is no different. While much attention has been paid to so-called “overpayments” in the MA program, I do not believe we should react by arbitrarily reducing funding. This is a complicated issue and Congress needs to thoroughly consider all the factors that drive MA payment policy—including the direct legislative interventions that were aimed at supporting markets in underserved and rural areas—before any changes are enacted.

I understand the need to generate additional revenue in the current budget environment to allow Congress to move forward with other critical health priorities this year, including the reauthorization of State Children’s Health Insurance Program (SCHIP), expansion of health insurance coverage and Medicare physician payment reform. And while the need for new revenue is significant, I do not believe we should pursue funding sources that might potentially weaken one program in order to benefit another. There are other available alternatives that should be explored before we start going down the path of “robbing Peter to pay Paul.” For instance, I have proposed increasing the federal tax on tobacco products to fund SCHIP—an option the Senate supported by a vote of 59-40 during consideration of the Fiscal Year 2008 budget. There may be room to make the MA program operate more efficiently, however, I have yet to see evidence that supports the type of wholesale funding reduction that has been proposed by some.

MA plans provide valuable benefits to Medicare beneficiaries, including reduction or elimination of premiums and cost-sharing, care management services and, in many cases, additional coverage such as vision and dental, that traditional Medicare does not cover. It is true that MA payment rates for some types of plans are typically higher than rates Medicare fee-for-service would pay, but there are a number of reasons this disparity has developed over the years. The very law that sought to strengthen MA—the Medicare Modernization Act—created a new bidding process for plans that based benchmarks for local plans on minimum payment levels that were previously mandated by Congress. For a number of reasons, those rates were higher than traditional Medicare, especially in rural areas. I believe it is unfair to criticize the entire concept of the MA program because of variations in the payment system Congress designed for it.

That being said, it is certainly fair to ask whether the current payment system is as efficient as it could be. However, I would argue that the real policy question facing Congress in this debate is how best to balance the extra benefits MA plans provide beneficiaries with their higher than average operating costs. Managed care plans initially were introduced in the Medicare program to generate greater efficiency in the delivery of services, so that any savings generated could be reinvested back into benefits for seniors. I believe we need to carefully explore whether that intention is fully being realized, in light of the generally higher payments MA plans receive.

The Committee also should devote sufficient time to better understanding why some plans, mainly Health Maintenance Organizations (HMOs), appear to operate at a cost below that of traditional Medicare. MedPAC has found that HMOs also provide the greatest number of “add on” benefits and provide beneficiaries the greatest amount of cost-sharing relief. It very well may be that the HMO service delivery model is inherently more conducive to generating efficiencies than other types of plans, but that is not entirely certain. There may be other administrative and operational policies that HMOs and other efficient plans have developed that could be used as models for other plans. If the MA program truly is to operate on the principles of market-based competition as intended, it may be necessary to address current gaps in the payment system to better reflect that. However, such changes should not be made arbitrarily and at the expense of beneficiary choice and access to quality coverage.

As we head down the path of trying to improve the MA program, I would like to make one point of caution about one of the recommendations MedPAC has made. While in concept it appears reasonable to set all MA plan benchmarks at a rate not to exceed fee-for-service Medicare, I am concerned about the potential impact that could have in certain underserved areas, especially rural communities. Over the last few years, plan participation in the MA program has grown overall, but especially in rural parts of the country. As noted, payments to plans in rural areas typically are higher than what traditional Medicare would pay, but I do not believe there is sufficient evidence yet available to support reducing those payments. As we all know, rural areas face unique challenges in delivering healthcare services and I applaud the progress MA plans have made recently to better service seniors in those communities. In my home state of Oregon, some of the most rural counties now have access to multiple MA plans—a level of service that simply did not exist three years ago. Because of that, I am very wary of any sort of payment reform that would reduce beneficiary access to plans, especially in hard-to-serve rural communities. It will be essential that any proposed payment changes to the MA program ensure that service access is not unduly harmed.

I look forward to today’s discussion and hope that it marks the first step in the Committee beginning a thoughtful examination of the Medicare Advantage program. I believe it is a valuable component of Medicare and should be preserved, if not expanded, so that more beneficiaries have access to the better coordinated and enhanced benefits offered by plans. I hope my colleagues on both sides of the aisle will act thoughtfully to enact MA payment reforms that not only improve efficiency, but help place the program on solid footing for years to come.

Thank you.

Senator Craig Thomas
Senate Finance Committee Hearing:
“An Examination of the Medicare Advantage Program”

April 11, 2007

Chairman Baucus and Ranking Member Grassley, thank you for holding today’s hearing. As the Finance Committee debates making changes to the Medicare Advantage program, I hope we will work to protect Medicare beneficiary coverage choices – especially choices for folks living in rural and frontier areas.

Under Medicare Advantage, private health plans receive a monthly payment to provide seniors all the benefits covered by traditional Medicare. However, Medicare Advantage plans offer much more to beneficiaries. Medicare Advantage provides a wide range of additional benefits not available to folks enrolled in traditional fee for service Medicare. These benefits include vision, hearing, and dental care, routine physical exams, and cancer screenings. Most importantly, Medicare Advantage plans have chronic care management programs that help seniors deal with serious illnesses like diabetes. Medicare Advantage helps these folks control their conditions and stay healthy.

We all must not forget that private health plans participating in Medicare is not a new thing. Congress has authorized programs going all the way back to the 1970s that allowed private health plans to serve Medicare beneficiaries. Most of those plans were only available in urban areas, however, until the late 1990s. Beneficiaries in rural and frontier areas had very few, if any, Medicare plan choices.

In Wyoming, we had a really difficult time keeping Medicare+Choice plans in the state because payment rates were too low. Folks in my state wanted to participate in these plans because they were the only plans offering supplemental health benefits like dental care and drug coverage. Unfortunately, Medicare+Choice plans dropped many Wyoming beneficiaries. This left my constituents with very limited Medicare coverage.

This circumstance led Congress to take action. The Medicare Modernization Act (MMA) took steps to promote plan availability in rural and frontier areas. And yes, the MMA increased payment rates to compensate for the fact that Medicare payments in urban areas were higher – and in some cases, a lot higher – than payments in rural areas. These incentives leveled the playing field. Rural beneficiaries would now have the same choices as their urban counterparts.

The MMA ensured all beneficiaries would have more coverage choices, more benefits, and lower out-of-pocket costs. Surveys show beneficiaries are satisfied. It is easy to forget that policy decisions supported by both Republican and Democrat members helped achieve these results. Hopefully this Committee will continue its longstanding bipartisan tradition and work to protect beneficiary choices and access.

I look forward to hearing the witness testimony. Thank you.

**Testimony on
The Medicare Advantage Program**

**By
I. Steven Udvarhelyi, M.D.
Senior Vice President and Chief Medical Officer
Independence Blue Cross**

**Before the
U.S. Senate Committee on Finance**

April 11, 2007

I. Introduction

Mr. Chairman, Senator Grassley, and members of the committee, my name is Dr. Steven Udvarhelyi. I am Senior Vice President and Chief Medical Officer of Independence Blue Cross, and I appreciate this opportunity to testify about the Medicare Advantage program and its role in providing Medicare beneficiaries with options for high quality, affordable, comprehensive health coverage. Independence Blue Cross is a non-profit health insurer that serves 3.4 million members, approximately 225,000 of which are Medicare beneficiaries; and is part of the national network of 39 Blue Cross and Blue Shield plans that insure approximately one out of every three Americans. Most of our members are in the greater Philadelphia region, and we are both the region's most preferred health insurer as well as the insurer of last resort. We offer a range of coverage options to Medicare beneficiaries, including HMO plans, point-of-service (POS) plans, PPO plans, Medicare Part D coverage, and supplemental coverage.

Independence Blue Cross is strongly committed to the long-term success of the Medicare Advantage program. We are proud to sponsor plans that offer many services and innovations that are not included in the Medicare fee-for-service program. Our Medicare Advantage plans serve a critical role in providing comprehensive, coordinated benefits for many seniors and disabled Americans – including low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program.

My testimony today will focus on three broad areas:

- the conceptual rationale for why Medicare Advantage plans add value over the Medicare fee-for-service program;
- advances in care coordination and disease management that are significantly improving patient care for beneficiaries enrolled in Medicare Advantage plans; and

- the value the Medicare Advantage program offers beneficiaries, particularly those who need assistance managing their multiple chronic conditions.

II. Why Medicare Advantage Adds Value Not Found in Medicare FFS

The fundamental difference between Medicare Advantage plans and the Medicare fee-for-service program is that the former have established an infrastructure for improving health care quality on an ongoing basis. This is critical, because it is well documented that we have significant shortcomings in the quality of health care under our current system in general and the Medicare program in particular. Over the past decade, the Institute of Medicine (IOM) has focused the nation's attention on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. A 1999 IOM report¹ found that medical errors could result in as many as 98,000 deaths annually, and a more recent IOM report acknowledged the fragmented nature of care delivery in the FFS Medicare program, which does "little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes."²

Other studies have documented specific shortfalls in quality. For example a study conducted by RAND³, found that patients received only 55 percent of recommended care for their medical conditions, and a recent study by MedPAC⁴ showed that only two-thirds of Medicare beneficiaries received necessary care for 20 of 32 indicators. The MedPAC report concluded that "care coordination is more difficult to do in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structure." Additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and

¹ "To Err is Human," Institute of Medicine, 1999

² IOM Report: "Rewarding Provider Performance: Aligning Incentives In Medicare," IOM, 9/21/06

³ "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003

⁴ MedPAC, Report to Congress: Increasing the Value of Medicare, June 2006

treatments. Such inappropriate care includes the overuse, underuse, or misuse of medical services.

Medicare Advantage plans focus on identifying members with important clinical needs, including those not receiving preventive care, those that are frail, and those with chronic illness. Because Medicare Advantage plans have an infrastructure to coordinate and improve the care for these members, there is a proven track record of making a positive difference in the lives of Medicare beneficiaries. The 2006 NCQA State of Quality Report documents significant improvements over time in the quality of care for Medicare beneficiaries enrolled in Medicare Advantage plans, and a good example of this is the improvement in care for cardiac patients. In 2005, approximately 94 percent of Medicare beneficiaries in Medicare Advantage plans received a beta-blocker upon discharge from a hospital after having a heart attack. Nine years earlier that number was close to 60 percent. Beta blockers have been proven to save lives if given after a heart attack, so this significant increase in the use of beta blockers is saving lives and the favorable trend for Medicare Advantage members is not matched in the FFS program.

III. Advances in Care Coordination and Disease Management

The participation of private health insurance plans in Medicare has enabled millions of seniors and disabled persons to benefit from chronic care initiatives and other innovations that are improving their health care and enhancing their overall quality of life. Many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – and one recent study suggests that over 80 percent of Medicare beneficiaries have at least one chronic condition.⁵ Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly.

⁵ Wolff, Starfield and Anderson, "Prevalence, Expenditures and Complications of Multiple Chronic Conditions in the Elderly," *Archives of Internal Medicine*, November 11, 2002.

Health insurance plans are playing a leadership role in developing strategies and programs to improve patient care for persons with chronic conditions. We are focused not only on ensuring that patients with chronic conditions live longer – but we also are helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy. This requires a strong emphasis on preventive care, personal responsibility for healthy lifestyles, and early intervention to promote care strategies that are effective in improving the patient's quality of life.

Health plans have a strong track record of encouraging prevention and evidence-based care for individuals with chronic conditions. We also are working on an ongoing basis to continue to develop new tools and greater expertise to help physicians customize care strategies to meet the unique needs and circumstances of individual patients. Building upon the success of early innovations in disease management, we are taking personalized service to a new level through a new generation of chronic care initiatives. Recent publications by America's Health Insurance Plans (AHIP)⁶ and the Blue Cross Blue Shield Association⁷ document numerous examples of health plan programs that provide the frail elderly and others with chronic conditions the care they need. These efforts reflect the following interconnected trends:

- First, plans are using increasingly sophisticated data mining techniques, such as informatics and predictive modeling, to identify high risk members and members with document gaps in care. The most recent advances in the use of information technology including moving toward personal health records (PHRs) for health plan enrollees – to improve the delivery of care, enhance health care quality, and increase productivity. In November 2006, the Board of Directors of our industry association, AHIP, endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based PHRs. These recommendations, developed in partnership with the BlueCross BlueShield Association, will facilitate both information sharing between consumers and caregivers, and portability when a consumer changes health plans.

⁶ AHIP, *Innovations in Chronic Care*, March 2007

⁷ Blue Cross Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management*, February, 2007.

- Second, plans are proactively reaching out to members who are at high risk, and to their physicians, to offer information, guidance and support on closing these gaps in care, increasing the use of preventive care, and improving self-management and provider management of chronic illnesses.
- Third, plans are offering health coaching to change patient behavior. Through the use of nurses and other health professionals who are trained to serve as health coaches, we are helping health plan enrollees to better understand their treatment options to make more informed health care decisions; to make lifestyle changes to improve their health; to understand and follow their doctors' treatment plans; and to address other health and social service needs.
- Fourth, plans are recognizing that patients are well served by a comprehensive strategy that addresses the needs of each person as a whole, rather than a narrow approach that targets individual diseases. Accordingly, we are using nurse case managers to identify barriers to effective care (including financial, transportation, or social support issues, and a lack of integration between health care providers) and are helping individuals overcome these barriers and get their care better coordinated.
- Finally, plans are placing a greater focus on prevention, wellness and the continuum of health care services that people need throughout their lives. By providing a full spectrum of services – ranging from wellness and prevention to acute, chronic, and end-of-life care – we are improving health outcomes and addressing the unique needs and circumstances of each individual patient.

Allow me to provide some examples of these types of programs that are in place at Independence Blue Cross. Our Medicare Advantage members benefit from a variety of programs aimed to improve their care, that include the promotion of prevention and wellness. Here are some specifics of these programs:

- Our ConnectionsSM Health Management program is designed to help our Medicare Advantage members by making them more informed about their health conditions, assisting them in making difficult treatment decisions, helping them and their physicians improve the management of chronic conditions, and assisting members and their physicians with the coordination of care.
 - This program is available to all 175,000 of our Medicare Advantage members, and only about 2% of these beneficiaries opt out of the program.
 - Approximately 75,000 of these members have one or more of five common chronic illnesses: coronary heart disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, or asthma. An additional 2600 members have one of 16 less common chronic illnesses such as Parkinson's Disease, rheumatoid arthritis, or seizure disorders; and 500 have end stage renal disease.
 - Using sophisticated predictive modeling tools, we identify those members who are at highest risk for future health care events, and identify specific gaps in care. Examples of these gaps in care would include such events as members with congestive heart failure not on appropriate medication therapy, elevated cholesterol levels in members with heart disease, lack of appropriate monitoring of blood sugars in diabetics or blood sugar levels that are too high, or the lack of a prescription for a medication included in evidence based recommendations for a particular disease or condition.
 - Specially trained health coaches, who are typically RNs and are available 24/7, 365 days a year, do telephonic outreach to these members to address their care gaps, and to help them understand their physician's treatment plan and improve self-management of their chronic conditions.
 - These health coaches can also provide shared decision-making support for any member facing a number of specific treatment decisions, such as the treatment of low back pain, or the treatment of prostate or breast cancer.
 - The physicians caring for these patients receive a comprehensive registry, the SMARTTM Registry that lists each of their patients with a chronic illness, what specific gaps in care exist for each patient, and how that practice's overall performance in the management of chronic disease compares to their peers. In

addition, patient specific “action” sheets are provided to the physician to place in each patient’s chart.

- The results of this program are impressive:
 - 87% of the participants were satisfied and 90% would recommend the program to others.
 - 69% of participants with chronic conditions stated that the program helped them better manage their condition, and 90% stated that the program improved the quality of their care
 - Through prevention of complications and relapses of chronic illness, there was a 10% – 15% reduction in the use of inpatient hospital days and of professional services such as office visits.
 - Overall medical cost trends came down 1.5 to 2% in year one of the program and 3% to 5% for year two of the program.
 - There have also been increases in specific quality indicators related to each of the chronic conditions.

Medicare Advantage members have enthusiastically embraced wellness programs in addition to the support for chronic illness. At Independence Blue Cross, during 2006 over 9,000 seniors enrolled in our fitness programs, designed to encourage and promote healthy, active lifestyles. Almost 60% of these seniors completed the program target of 120 visits per year, double the rate of or non-Medicare members who enrolled in the program!

Another program we have implemented for Medicare Advantage members is our Physician Home Visit program. This is program targeted at keeping home bound members healthy. These members are some of the most medically frail members we have, but their underlying condition is often a barrier to them keeping appointments for physician visits, and in the absence of timely care their condition deteriorates. Home visits by a physician are an ideal solution, but no longer available to most of our members. Therefore, we identified a group of physicians willing to make “house calls.” Our program provides for a physician to conduct a proactive home visit to assess members, and then the physician provides follow up care as needed. This physician also

coordinates care with the member's primary care physician and other specialty physicians as needed. While our program only began this year, other health plans have implemented similar programs and seen high levels of member satisfaction, improved control of chronic illnesses and reduced use of emergency services.

Finally, on an ongoing basis we provide Medicare Advantage members with access to care coordination throughout their health care experience. Examples of this are proactive coordination of post-hospitalization care needs. When a member is scheduled for an elective admission, such as a total knee replacement, we reach out to the member to identify their anticipated post-hospital needs, coordinate with their surgeon, and begin to make arrangements for post-hospital care, such as rehabilitation, before the member actually goes to the hospital. In selected cases, we have identified important pre-operative risks that needed to be resolved before surgery. Upon discharge, we follow up with 48 hours of discharge to make sure the member understands their post-hospital treatment plan and that all necessary care has, in fact, been put in place.

Our programs are carefully selected to meet the local needs of our members, but are similar to those of other health plans. In fact, most Medicare Advantage plans offer these types of valuable services to their members. The latest generation of innovations builds upon the lessons health insurance plans have learned over the past decade about outreach strategies that work, about incentives that encourage healthy lifestyle changes and the use of effective treatments, and about how to track patients' progress in obtaining recommended care. While traditional population-based approaches have offered educational materials and other services to individuals identified as having certain conditions, a growing number of plans are now implementing multi-dimensional programs that offer customized care to reflect the severity of each individual's illness.

For example, an asthma patient who has experienced multiple trips to the emergency room would receive specialized attention, including regular phone consultations with a nurse case manager. Another asthma patient who also suffers from depression would be paired with nurses and social workers who could provide a more intensive level of case management. Yet another

asthma patient who takes his medications regularly and has not had any recent emergencies would receive quarterly newsletters and access to a toll-free hotline so he can contact a nurse with questions or concerns.

Another major area of activity for health insurance plans is the movement to promote greater transparency and value-based competition throughout the U.S. health care system. This effort is focused on empowering consumers to be more actively engaged in making decisions – based on reliable, user-friendly data – about their medical treatments and how their health care dollars are spent. To meet this challenge, we are working through a broad-based coalition – known as the AQA – to develop uniform processes for performance measurement and reporting. Those processes are ongoing, and would *first*, allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and *second*, enable practitioners to determine how their performance compares with their peers in similar specialties. This effort now involves more than 125 organizations, including AHIP, BCBSA, consumer groups, physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, and government representatives.

The AQA has approved 121 clinical performance measures for the ambulatory care setting, many of which are being incorporated into provider contracts. These measures represent an important first step in establishing a broad range of quality measurement and helping to give consumers the information they need to make informed health care decisions. In addition, a standard tool designed by the Agency for Healthcare Research and Quality (AHRQ) to measure patient satisfaction in the ambulatory care setting has been approved for use by consumers.

Additionally, the AQA has implemented a pilot program in six sites across the country, with support from the Centers for Medicare & Medicaid Services (CMS) and AHRQ, to combine public and private sector quality data on physician performance. This pilot program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information they can use to make choices about which physicians best meet their needs. Ultimately, we anticipate that the results of this pilot program will lead to a national framework for measurement and

public reporting of physician performance, which is an important step toward advancing transparency and providing reliable information for consumer decision-making.

Through all of these activities, health insurance plans are working on a daily basis to add value to the U.S. health care system and improve patient care for Americans – including Medicare beneficiaries – who have chronic conditions. By promoting healthy behaviors and preventing unnecessary complications and health emergencies, our innovative tools and programs are promoting the best possible use of our nation’s health care dollars and enhancing the health, well-being, and productivity of the American people.

IV. The Value of the Medicare Advantage Program

The creation of the Medicare Advantage program, as renamed and revitalized under the Medicare Modernization Act of 2003 (MMA), has provided valuable opportunities for seniors and disabled Americans to benefit from the innovations developed and implemented by private health insurance plans. Approximately 8 million beneficiaries currently receive high quality coverage through the Medicare Advantage program.

Medicare Advantage plans offer a different approach to health care than beneficiaries experience under the Medicare fee-for-service program. Instead of focusing almost exclusively on treating beneficiaries when they are sick or injured, we also place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, and work to avoid preventable illnesses.

The chronic care initiatives outlined in the previous section have special significance for our nation’s Medicare beneficiaries. Independence Blue Cross and other Medicare Advantage plans have been at the forefront in offering care coordination and management services that are not available in the Medicare fee-for-service program. The entire scope of private sector strategies – from health coaching to predictive modeling to customized care plans – are an integral part of the

value beneficiaries receive through Medicare Advantage. These benefits are particularly important to the frail elderly and others with multiple chronic conditions.

In addition to improving patient care for chronic illnesses, the Medicare Advantage program also provides many additional benefits that are not included in the Medicare fee-for-service benefits package. According to CMS, Medicare Advantage plans are providing enrollees with, on average, savings of more than \$1,000 annually – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the Medicare fee-for-service program. Examples of the additional benefits Medicare Advantage plans provide to beneficiaries include:

- **Protection against out-of-pocket costs:** 93% of all beneficiaries nationwide have access to Medicare Advantage plans that provide protection against out-of-pocket costs for Medicare-covered (non-drug) benefits of \$2,500 or less. This protection is not available in the fee-for-service program.
- **No cost sharing for preventive screening:** All Medicare beneficiaries have access to a Medicare Advantage plan that does not require cost sharing for screenings for breast cancer, cervical cancer, and prostate cancer.
- **Extra benefits not available in FFS:** Medicare Advantage plans are widely available that provide hearing, vision, and other benefits that the Medicare program does not offer. For example, all Medicare beneficiaries can choose from a Medicare Advantage plan that covers hearing benefits. Over 98% of beneficiaries can enroll in a Medicare Advantage plan offering preventive dental benefits.
- **Comprehensive prescription drug benefits:** Almost every Medicare beneficiary can choose from a Medicare Advantage plan that provides protection in the Part D coverage gap. Almost 90% of beneficiaries can choose a Medicare Advantage plan that provides Part D benefits for no additional premium. Only Medicare Advantage members can access their A, B, and D benefits through a single card.

Research studies indicate that these additional benefits are particularly important to low-income and minority Medicare beneficiaries, especially those who fall just short of qualifying for Medicaid.^{8,9} Beneficiaries in the lower income categories are less likely to have employer-based coverage and those with incomes in the range of \$10,000 to \$20,000 generally are not eligible for Medicaid – meaning that Medicare Advantage is their only option for comprehensive, affordable coverage.

The study published by AHIP in February 2007 indicated that 49 percent of Medicare Advantage enrollees in 2004 had incomes below \$20,000 and among minority (non-white) beneficiaries in Medicare Advantage, 68 percent had incomes below \$20,000; while 70 percent of African-American and Hispanic Medicare Advantage enrollees had incomes below \$20,000. These findings demonstrate that Medicare Advantage plans play an important role in providing health care coverage to many minority beneficiaries and many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program.

Finally, I want to highlight the findings of two new surveys, released by AHIP on March 20, regarding the important role Medicare Advantage plans play in providing health security to Medicare beneficiaries.

The first survey¹⁰ found that beneficiaries are highly satisfied with the Medicare Advantage program and, additionally, that more than one-third of seniors would skip needed medical services if their Medicare Advantage plan was taken away. The second survey¹¹ found that a large majority of physicians believe Medicare Advantage funding cuts would harm seniors. Moreover, when physicians were asked about options for preventing cuts in Medicare physician reimbursement, more than 80 percent suggested that Congress should either cut other programs

⁸ AHIP, *Low-Income and Minority Medicare Beneficiaries in Medicare Advantage Plans*, February 2007

⁹ Atherly, A. and Thorpe, K.E. *Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries*, Emory University, September 20, 2005.

¹⁰ Ayres, McHenry & Associates, Inc. and The Glover Park Group, *National Survey Of Seniors Regarding Medicare Advantage*, February 26 - March 2, 2007

¹¹ Ayres, McHenry & Associates, Inc., *National Survey of Physicians Regarding Medical Issues*, October 6 - November 2, 2006

or raise taxes, rather than cut Medicare Advantage, to offset the costs of a Medicare physician payment “fix.”

Key findings of the two surveys include:

- Thirty-five percent of seniors – including 62 percent of low-income seniors – enrolled in Medicare Advantage say they would skip some of the health care treatments they currently receive if the option of choosing a Medicare Advantage plan was taken away. Another 42 percent say they would pay higher out-of-pocket costs if the option of choosing a Medicare Advantage plan was taken away.
- Ninety percent of beneficiaries enrolled in Medicare Advantage are satisfied with their coverage overall.
- Seventy-four percent of physicians believe that cutting funds from the Medicare Advantage program would have a negative effect on seniors enrolled in the program.

V. Conclusion

Thank you for considering our perspectives on the Medicare Advantage program. We appreciate this opportunity to testify about the role health insurance plans are playing in providing Medicare beneficiaries with high quality, affordable, comprehensive health coverage. We urge the committee to continue to support adequate funding for the system of competition, choice, and innovation that is delivering savings and value to more than 8 million Medicare Advantage enrollees.

Responses to Questions for the Record From Dr. Steven Udvarhelyi**Senator Grassley:****1. Question to Dr. Udvarhelyi:**

In your testimony, you mentioned a number of different approaches that Independence takes to coordinate Medicare beneficiaries' care. I think some concrete examples would help the Committee get a better understanding of how these programs would work. Could you provide the Committee with some examples—a couple of case studies if you will—of how care management would work from the moment you identify a beneficiary who would benefit from it?

***Case Management Examples
From Independence Blue Cross (IBC)***

Case #1

A morbidly obese member (> 400 lbs) with a congestive heart failure and ischemic heart disease, and a history of frequent hospital admissions, was admitted to an acute care hospital with exacerbation of her heart disease. This member was identified as high risk through the routine discharge planning process (conducted by our nurse case managers) because of the combination of her diagnoses, obesity, and the fact that she lives alone. The member was discharged from the acute care hospital to a skilled nursing facility, and then went home after a brief stay at the skilled nursing facility. Due to this member's high risk status, the case manager arranged for a home visit by a physician as part of our Physician Home Visit Program. This physician determined that the member was not complying with effective weight management, and without on-going weight management support, cardiac and respiratory complications would recur quickly, requiring re-admission. The physician worked with the IBC case manager, who obtained an appropriate scale for this member to monitor weight loss progress. The case manager worked daily with the member on a telephone to instruct and encourage the member in her dietary regimen. Re-admission was avoided and the member is successfully losing weight.

Case # 2

A 73 year old member with bilateral total knee replacements developed an infection in one of his knee replacements with Methicillin Resistant Staph Aureus (MRSA), a type of staph infection that is highly resistant to antibiotic therapy. This serious infection was not able to be effectively treated and caused the joint replacement to fail. Subsequently the member needed a second total right knee replacement. The surgery was performed successfully and the member was discharged to a home. As part of IBC routine process of discharge planning and follow-up, a

case manager called the member after discharge to home to assess their status. The IBC case manager knew the patient had a history of deep vein thrombosis (blood clot in the leg) and had been on coumadin (a blood thinner) before surgery. The coumadin was discontinued prior to surgery to prevent bleeding complications, but should have been restarted at discharge. During the post-discharge follow-up call, the case manager learned that member had not been placed back on coumadin at discharge. The case manager contacted the member's physician who determined that failure to order coumadin was an oversight. Coumadin was obtained for the member and lab draws set up to monitor blood levels. Member is recovering at home without complications. Without the intervention of the case manager, the member would likely have had a recurrent blood clot.

Case # 3

A 67 year old member with diabetes has lived alone since the recent death of his wife. The member is also blind due to complications of the diabetes. Since the death of his wife, he is only able to check his blood glucose levels when a sighted visitor is present (generally 2-3 times per week), and this has led to less optimal control of his diabetes. As part of our Connections Health Management program, a health coach performed an outreach call to this member, when he was identified as high risk due to blood glucose levels that were too high. The health coach did a full assessment of the member's status and identified the problem with checking blood glucose levels. The health coach worked with the member's physician to obtain orders for diabetic home nursing visits and to obtain a new "talking" blood glucose meter. With training from the home nurse, the member has learned to independently monitor his own glucose levels and his blood glucose level has come down to a more controlled range.

COMMUNICATIONS



**AARP Statement for Record
on the
Medicare Advantage Program**

**Submitted to the
Senate Finance Committee**

April 11, 2007

WASHINGTON, D.C.

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On behalf of AARP's 38 million members we thank you for holding this hearing on the Medicare Advantage program. AARP supports a genuine choice of health plan options for Medicare beneficiaries. The traditional Medicare plan should remain a viable and affordable option, while a range of private plan options, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations, and point-of-service plans should be available.

Medicare Payments Should Not Favor MA Over Traditional Medicare

Private plans have been available in Medicare almost since its inception. Among its original objectives in authorizing private health plans in Medicare, Congress sought to limit growth in Medicare spending, improve the payment method for certain providers, and provide beneficiaries (including those residing in rural areas) with more choices and enhanced benefits.

Today, more than 80 percent of Medicare beneficiaries still receive services through the traditional Medicare program, however, nearly all beneficiaries (99 percent) have access to Medicare Advantage (MA) plan options. MA options include HMOs, local and regional PPOs, special needs plans, and private fee-for-service plans.

But the availability of multiple coverage options has not come without a cost. In its March 2007 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that current Medicare program payments for MA plan enrollees are 12 percent higher, on average, than payments for fee-for-service enrollees. MedPAC has recommended that Medicare should pay the same amount, regardless of which Medicare option a beneficiary chooses. AARP agrees.

AARP believes Medicare payments should be neutral with respect to coverage options. Therefore, AARP urges Congress to set the benchmarks upon which

MA plan payments are based so that MA payments do not exceed fee-for-service costs.

Right now Medicare payments clearly favor the MA program over traditional Medicare, which is unfair to the majority of beneficiaries who participate in the traditional program. All taxpayers and all Medicare beneficiaries – not just the 18 percent of Medicare beneficiaries enrolled in private MA plans – are funding these excess payments. It is important to note that while MA is often referred to as Part C, there is no separate Trust Fund to pay for Medicare's private plan options. Thus, spending for MA comes from both the Part A and Part B trust funds. Ultimately, the solvency of the Medicare Trust Fund is negatively affected by current payment policies to MA plans.

When private plans were introduced to Medicare, they were expected to provide extra benefits to beneficiaries by achieving greater efficiencies at a lower cost to the program than traditional Medicare through the use of care coordination, negotiated prices, provider networks and other strategies. Given the fact that MA plans have control over hospital and physician services as well as the opportunity to manage and coordinate care, it is reasonable for Congress to hold MA plans to payment levels that are no more than those for the fee-for-service program.

Savings Should Be Reinvested in the Medicare Program

According to the Congressional Budget Office, the federal government could save \$65 billion over five years and \$160 billion over 10 years, if MA plans were paid at the same rates as traditional Medicare providers. In order to minimize the disruption to beneficiaries who rely on MA plans for their health care, AARP believes Congress should phase out MA plan payments that exceed fee-for-service costs over a period of time.

In addition, while we know Congress has many competing priorities on which to spend any budgetary savings, AARP believes Medicare savings should be reinvested in the Medicare program. In particular, AARP strongly supports

helping more low-income Medicare beneficiaries get needed help with prescription drug costs. Eliminating the Part D asset test is one of AARP's top priorities for improving the Medicare drug benefit. The Part D drug benefit is helping tens of millions of Americans get the drugs they need. And one of its most important features is the extra help it provides to people with limited incomes. But not everyone is sharing in the benefits of Part D because the asset test that AARP and others have opposed all along is proving to be a serious barrier.

As a first step toward helping low-income Medicare beneficiaries get needed help with prescription drug costs, AARP has endorsed H.R. 1536, introduced by Rep. Lloyd Doggett, to raise the asset limits and streamline the low-income subsidy application process. AARP has been working closely on similar bipartisan legislation with Senators Bingaman and Smith and hope to endorse their bill soon as well.

Other Medicare priorities for AARP that we've expressed before the Committee include reforming the physician payment system so that it is built on a foundation that emphasizes four key elements: information technology; greater use of comparative effectiveness research; performance measurement; and enhanced care coordination.

We also recognize that Congress has other health care priorities. AARP supports the reauthorization and strengthening of the State Children's Health Insurance Program. Covering children's health care needs is a cost-effective use of taxpayer dollars, given the substantial long-term benefits that relatively low-cost children's health care coverage can provide. After all, productive working years and healthy aging both require an early start.

Conclusion

MA plans remain an important alternative for many Medicare beneficiaries. AARP strongly urges Congress and the Centers for Medicare and Medicaid Services to monitor carefully the effects of private health plan options by plan

type and health plan payment rules on beneficiary access, the stability of Medicare beneficiaries' health coverage, and their out-of-pocket spending.

The Medicare program should not pay more for services and benefits provided under the MA program. MA plans should be given an incentive to provide services more efficiently. Traditional Medicare and MA should compete on a level playing field.

AARP believes that reductions in payments to MA plans should be done gradually to prevent widespread withdrawals from markets by plans. Any savings achieved should be ideally reinvested in the Medicare program.



Champaign County Health Care Consumers

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Grassroots organizing for health care justice since 1977.

April 12, 2007

Senate Committee on Finance
Attn. Editorial and Document Section Rm. SD-203
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

Dear Senate Committee on Finance,

The Champaign County Health Care Consumers and our Medicare Task Force support the decision by the Senate Committee on Finance to hold a hearing examining the Medicare Advantage Program. Our Medicare Task Force has worked to educate our community and elected officials the experiences of Medicare beneficiaries in dealing with the new Medicare Part D prescription drug program. The commonalities and interconnections between the Medicare Advantage Program and the Part D prescription drug program are a source of concern and we ask that this letter become part of the hearing record.

The Medicare Advantage Program as well as the Part D Program were enacted by Congress and it is up to Congress to make changes to these programs to ensure that they meet the needs of Medicare beneficiaries while using federal tax dollars as efficiently as possible.

The total reliance of these programs on the private insurance industry without strong government regulation is a fundamental problem that must be resolved. Private insurance companies are inherently less efficient than traditional Medicare as their administrative costs include advertising expenses and high rates of executive compensation as well as the expense of shareholder dividends.

Champaign County Health Care Consumers and the Medicare Task Force believe that Congress must act as a good shepherd to federal tax dollars as well as those Americans who rely on the Medicare program for their health care needs. Therefore, Congress must act to change the Medicare Advantage Program as well as the Part D Program.

Overpayments to insurance companies operating in the Medicare Advantage Program must cease. Medicare would save \$65 billion over the next five years if it paid HMOs and other private health plans (now known as Medicare Advantage plans) the same amount per enrollee that it costs to care for an individual covered by the government-run traditional Medicare program.

The \$65 billion saved could be used to expand eligibility for the Qualified Medicare Beneficiary program (QMB), one of the Medicare Savings Programs (MSPs). QMB pays the Part B premium and Medicare deductibles and coinsurance for people with Medicare living below the poverty line. QMB is a far better deal than the "extra" benefits available from Medicare Advantage plans—and it doesn't

require people to give up the traditional Medicare program they trust for a private plan that every year can choose to change its benefits, raise its costs, or pull out entirely.

In addition, people enrolled in a MSP automatically qualify for Extra Help, the federal program that helps pay the out-of-pocket costs of Part D drug coverage for people with very low incomes. By expanding MSP, more low-income people with Medicare would qualify for Extra Help, enabling them to afford the medicines they need and avoid the dreaded "doughnut hole" coverage gap in the Part D prescription drug program.

The Part D program's sole reliance on private insurance companies creates a myriad of problems for Medicare beneficiaries accessing their prescription drugs while also being fiscally inefficient and irresponsible. Medicare beneficiaries must sort through numerous prescription drug plans, each with different costs and different formularies of covered prescription medications.

The costs associated with this confusing benefit place a disproportionate burden on Medicare beneficiaries. Part D program members must pay a monthly insurance premium, an annual deductible, and co-insurance for their medications at the pharmacy. The program has a built in coverage gap, dubbed the "doughnut hole," during which program members must pay 100% of their medication costs in addition to their monthly insurance premiums.

Several national reports including research conducted by FamiliesUSA and the Consumers Union found that the cost of medications covered by Part D insurance plans have increased with the rate of inflation and are nearly twice as high as those paid by members of the Veteran's Administration. The extreme variance in cost is due to the fact that the Veteran's Administration negotiates discounts on behalf of their members. Medicare beneficiaries are forced to pay higher prices for their medications because Medicare is prohibited by law from negotiating drug prices.

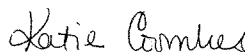
Champaign County Health Care Consumers and our Medicare Task Force support reforming the Part D program to allow Medicare to negotiate discounted drug prices, create a Medicare-administered benefit, and eliminate the harmful "doughnut hole" coverage gap.

We call on the Senate Finance committee to continue to address the overpayments to Medicare Advantage Plans. In addition, we ask the Senate Finance committee support HR 4 which would amend Part D to require the Secretary of Health and Human Services to negotiate lower covered Part D drug prices on behalf of Medicare beneficiaries.

Sincerely,



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STATEMENT SUBMITTED

By the

**NATIONAL ASSOCIATION
FOR HOME CARE AND HOSPICE**

To the

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

On

THE MEDICARE ADVANTAGE PROGRAM

**April 11, 2007
Washington, DC**

**For further information, contact:
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The National Association for Home Care and Hospice (NAHC) is the largest national trade association representing the interests of home care and hospice service providers. Among our members are all types and sizes of Medicare-participating care providers, including nonprofit agencies such as visiting nurse associations, for-profit chains, public and hospital-based agencies and free-standing agencies. NAHC is pleased to submit this statement for the record to the Committee on Finance on the Medicare Advantage program.

Home health agencies throughout the nation experience numerous difficulties in their efforts to serve patients enrolled in private plans under Medicare. Since Congress reconstituted private coverage under the Medicare Advantage (MA) program and created stronger incentives for beneficiaries to migrate to private plans under the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (MMA), enrollment has grown significantly. The tensions between home health agencies and MA plans have also grown.

Historically the main problems that home health agencies have faced in providing services to Medicare private plan enrollees have included: time-consuming requirements for pre-approval of services, approval of services on a single visit or limited number of visits basis, per visit payment levels set below the cost of care delivery, and failure of Medicare systems to maintain timely records on beneficiaries' enrollment status.

In recent years new issues have emerged, including: inconsistencies between the home health benefit provided under fee-for-service (FFS) Medicare and MA, confusion on the part of beneficiaries regarding how FFS and MA home health coverage differs, charges of exorbitant copays for services by MA plans, limited provider appeal rights, and payment levels to MA plans set at levels far in excess of the costs incurred by Medicare for services to FFS beneficiaries. To address these troubling developments, Congress should:

REQUIRE MEDICARE ADVANTAGE PLANS TO PROVIDE A HOME HEALTH BENEFIT FULLY EQUIVALENT TO ORIGINAL MEDICARE.

Under FFS Medicare, home health is delivered as an episode-based service paid on a prospective basis. Agencies serve as care managers and providers of services with the responsibility to achieve positive patient outcomes. Most MA plans have not transformed the home health benefits they provide in a similar way; instead, they approve home health services on a visit by visit basis. All this occurs despite the fact that, under law, MA plans are required to provide, at a minimum, benefits equal to those provided under the fee-for-service program. Congress should require that MA plans provide an episodic, care management home health services benefit.

PROVIDE ACCESS TO MEDICARE ADVANTAGE ENROLLMENT INFORMATION/ ESTABLISH PROVIDER 'HOLD HARMLESS'.

Unless a client provides accurate information to the agency, home health agencies

often have no way of knowing on a timely basis if a patient is enrolled in a MA plan. If an agency is provided inaccurate information by a beneficiary, Medicare information sources rarely reflect current beneficiary enrollment information until two or three months after MA enrollment has become effective. It is frequently the case that a home health agency will provide care in good faith, only to find out when a claim is rejected that the patient was enrolled in a MA plan. Rarely will a MA plan agree to cover the cost of the care delivered since it was not "pre-approved" by the plan. To correct this situation, several steps should be taken. First, Congress should require MA plans to furnish immediate notification to providers and suppliers that are actively caring for an individual that the individual has become enrolled in the plan. Second, Congress should establish a "hold harmless" that ensures direct Medicare payment (and concomitant reduction in MA payments to plans) to providers who in good faith give needed care to MA enrollees before notification is received. Finally, Congress should require CMS to upgrade the timeliness of enrollment information sources and make the information available on a nationwide basis.

ENSURE PATIENTS RIGHTS AND 'TRUTH IN COVERAGE' IN MANAGED CARE PLANS.

Many enrollees are unaware that MA plans may offer less generous coverage for certain basic Medicare benefits than are available under FFS, and may charge higher copays, as well. Plans fail to disclose this important information to prospective enrollees. Congress should establish MA plan "truth in coverage" requirements that include consumer education provisions that ensure consumers understand the cost sharing requirements and other limitations on home health services under managed care plans; potential MA beneficiaries should be given clear explanations of how plan requirements for copayments and accessibility of home health benefits will differ from traditional Medicare.

RESTRICT EXORBITANT COST-SHARING IN MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS/PROHIBIT HOME HEALTH COPAYS.

Under MA private fee-for-service (PFFS), if the plan has established a network of service providers, it is permitted to charge higher copayments for services delivered by non-network providers. Plans have been approved by the Centers for Medicare & Medicaid Services that charge as much as a 50% copay on services delivered by non-network providers. Congress should either rescind the ability of PFFS plans to restrict access to services/supplies through selected networks or establish reasonable limits on beneficiary cost-sharing.

On a related issue, many PFFS and HMO-type MA plans offer benefit packages that include a copay for home health services, despite the fact that Congress eliminated copays on home health services in order to encourage use of this more cost-effective service. Congress should prohibit MA plans from imposing copays on Medicare home health services.

ESTABLISH PROVIDER APPEAL RIGHTS IN MEDICARE ADVANTAGE.

Under the rules governing MA, enrollees have detailed and extensive rights of appeal regarding any adverse decision related to the coverage of an item or service by the plan. These rights essentially mirror the rights afforded Medicare FFS beneficiaries. However, neither network nor non-network providers of service have stated appeal rights beyond those specified by the contract or by state law. The absence of an administrative appeal system for providers in MA plans is in stark contrast to the system of appeals available under the Medicare FFS, where providers have full appeal rights comparable to Medicare beneficiaries. The absence of provider appeal authority in MA plans results in lost revenues to providers who deliver care to MA enrollees in good faith and later receive claim denials. Congress should amend the Medicare law relating to MA plans to network and non-network providers of services with administrative appeals rights comparable to those existing under the Medicare FFS program.

CONDUCT IN-DEPTH STUDY OF VARIATION IN HOME HEALTH SERVICE USE AND OUTCOMES IN MEDICARE MANAGED CARE AS COMPARED TO THE FEE-FOR-SERVICE SECTOR.

During the 1990s studies concluded that Medicare private plan-participating home health patients received less visits and had less positive outcomes than their FFS counterparts. Since that time there have been a number of changes that have affected the provision of care. Under FFS, agencies serve as care managers and providers of services with the responsibility to achieve positive patient outcomes, while the home health benefit under MA is, for the most part, still provided on a visit by visit basis. Data from old studies is no longer applicable to the Medicare home health benefit. Congress should authorize and fund study of variations in the use of services and outcomes between MA and FFS clients. The beneficiary groups studied should be risk adjusted in order that a true comparison of treatments and outcomes can be made.

LIMIT MEDICARE ADVANTAGE PLAN REIMBURSEMENT TO THE COST OF CARE UNDER FEE-FOR-SERVICE.

Congress created options under Medicare for beneficiaries to enroll in private health plans in hopes of reducing Medicare's financial outlays. Recent studies indicate that MA plan payments average 112 to 120% of the costs incurred by Medicare for FFS enrollees. Despite these excessive payments, many MA plans charge higher cost sharing for some basic Medicare benefits, and pay providers substantially less than the FFS program for the services they provide. Given concerns that the Medicare program may not be sufficiently funded to meet its financial obligations as the baby-boom generation retires, Congress should limit payments to MA plans to the cost of care under FFS.

Mr. Chairman, NAHC appreciates the opportunity to provide these comments to the Finance Committee. We look forward to working with the Committee as it considers NAHC's recommendations on much needed reforms to the Medicare Advantage program.

