THE MEDICARE ADVANTAGE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED TENTH CONGRESS

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THE MEDICARE ADVANTAGE PROGRAM

WEDNESDAY, MARCH 21, 2007

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

The Subcommittee met, pursuant to notice, at 2:51 p.m., in room 1102, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 14, 2007
HL–6

CONTACT: (202) 225–3943

Health Subcommittee Chairman Stark Announces a Hearing on Medicare Advantage

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare Advantage Program. **The hearing will take place at 2:00 p.m. on Wednesday, March 21, 2007, in Room 1100, Longworth House Office Building.**

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

BACKGROUND:

Of the 43 million Medicare beneficiaries, 8.3 million (19%) are enrolled in what are currently known as 'Medicare Advantage' (MA) plans. These private health plans must provide benefits covered under traditional fee-for-service (FFS) Medicare (Parts A&B). Medicare Advantage plans often limit the network of providers that are available to beneficiaries, may charge an additional premium and often have different cost-sharing requirements than traditional FFS Medicare. Medicare Advantage plans can provide additional benefits that are not covered by traditional Medicare, such as eyeglasses and yearly physical exams, but often finance these benefits through changing the coverage structure of FFS benefits.

The number of private plans available to Medicare beneficiaries has grown steadily since 2003, as plan payments and options have increased. There are now eight different types of MA plans: Health Maintenance Organizations (HMOs); Provider Sponsored Organizations (PSOs); Preferred Provider Organizations (PPOs); Regional PPOs; Private Fee For Service Plans; Cost Contract Plans; Special Needs Plans (SNPs); and Medical Savings Account plans.

According to the Medicare Payment Advisory Commission (MedPAC), 'Medicare Advantage' program payments were on average 112 percent of FFS expenditure levels in 2006. To create financial neutrality between private plan and FFS payment rates, MedPAC has recommended setting MA benchmarks equal to 100 percent of FFS.

"In the past five years, the Ways and Means Health Subcommittee has failed to conduct oversight of the so-called 'Medicare Advantage' program," said Chairman Stark in announcing the hearing**. "We are long overdue for an analysis of this program. I look forward to discussing who is enrolled in these plans—and how beneficiaries are recruited to these plans. We should also review what benefits they do and don't provide, and at what cost to America's taxpayers. I'm pleased to offer CMS, MedPAC and CBO the opportunity to testify on the MA payment system at this first of what will be numerous hearings on the Medicare Advantage program."**

FOCUS OF THE HEARING:

The hearing will focus on the structure and costs of the Medicare Advantage program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, April 4, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

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

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

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

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

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If our guests would find seats, we can begin the hearing. Certainly begin it with an apology for the unexpected voting series that makes us almost an hour late. For that I, to the witnesses and our guests, I apologize, but it was entirely unavoidable and we will proceed.

The Medicare Modernization Act of 2003 (MMA) (P.L. 108–173) made changes in how private plans are paid in Medicare and the types of plans that exist and it dramatically increased the number of plans. Now Medicare Advantage (MA) covers about 19 percent of the Medicare beneficiaries back to the highs that it enjoyed perhaps 8 years ago, still less than one in five Medicare beneficiaries.

We spent about $56 billion on these plans in 2006 and without any changes, were informed that the growth in enrollment and spending will continue to increase.

In spite of these changes, we have as a Committee never held a hearing on the Medicare Advantage Program and so this is the first of what will be a series of hearings on the program.

When private plans asked to join Medicare in 1982, they told us they could provide Medicare benefits better and cheaper than the Government. As we fast forward 25 years, we are now losing money for every person who enrolls in a private plan. The latest analysis by the Medicare Payment Advisory Commission (MedPAC) indicates that Medicare is on average overpaying Advantage plans by 12 percent, we are paying 112 percent of what we otherwise would pay.

Now that number varies geographically and by plan. In some areas, plans are getting north of 140 percent. Of plan types, private fee-for-service plans are the highest in the outlier portion of that, receiving an average of 119 percent of Medicare fee-for-service plans—payments. We will hear more from all of our witnesses on these details.

The Academy of Health Information Professionals, Blue Cross, Blue Shield and others have been claiming that payment reductions will reduce health care access for lower and moderate income seniors and decrying a goal they ascribe as wanting to get rid of the Medicare Advantage program. I would like to be clear on that.

I know of no one on this Committee who has any intention of eliminating Medicare Advantage Program plans. However, neither should we allow any Medicare provider or sector to insulate itself from both oversight and consideration of payment changes. To do so would be completely irresponsible for this Committee and for any Member of Congress.

We have a major task in front of us, between the physician payment issue, the need to reauthorize and improve the State Children's Health Insurance Program (SCHIP), the need to manage and oversee Medicare. To do all of that, I believe that everything must be on the table, doctor's payments, hospital payments, post acute payments, drug plan payments. Indeed, Medicare Advantage payments as well.

Medicare Advantage overpayments raise the part B premiums for everyone and decrease the part A trust fund faster than would occur if payments were equalized. In an effort to improve and protect Medicare, we can't focus on one part of the program at the expense of others. They must all work together to ensure that Medicare meets its design and that is providing health care for America's senior citizens and people with disabilities, with quality care for the beneficiaries, reasonable reimbursement for the providers.

We have experts before us representing the Centers for Medicare and Medicaid Services (CMS), which runs the Medicare Advantage Program; MedPAC which provides Members of Congress with expert, nonpartisan, empirical advice on Medicare payment policies; and the Congressional Budget Office (CBO), which calculates the costs or savings of proposals that we choose to enact.

I look forward to today's discussion and to collaborating with my colleagues to plan additional hearings to investigate all facets of

the Medicare Program. We need to refine the payment structures to ensure an equitable and efficient program that serves all the beneficiaries and taxpayers well.

I again apologize to all of the witnesses and to Mr. Norwalk, who thought she was getting off easy by being first, going to get out of here by now.

I would make, before you start with your testimony, Ms. Norwalk, I would make one admonition. It is basically for our staffs.

Witnesses have generally been asked, where possible, to get us testimony and/or exhibits at least a day ahead. I can read quickly and I can read on my way to work. You sent yours last night, but for the staff, they have to stay until eight or nine o'clock at night to go through it. So I say this, generally to all witnesses who will appear before us. If you want to be friends with the staff, get the testimony in ahead of time. It will make their job a lot easier and I know your staff appreciates that as well.

So, we look forward to your testimony. Please enlighten us in any manner you would like.

I am sorry, Mr. Camp. Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. Thank you for holding this important hearing. I too wanted to thank everyone for waiting while we had that lengthy series of votes on the Floor.

I think by now we are all well aware of MedPAC's recommendations to reduce payments to Medicare Advantage plans to that of traditional Medicare. In doing so, according to CBO, we would save $65 billion over 5 years. As a result, some advocates and Members of Congress have indicated that this $65 billion could be an easy and noncontroversial way to fund a variety of health care spending efforts. I think we have to consider carefully who will be affected by these proposed payment cuts.

History has shown that reducing payments to these types of plans will reduce access for seniors living in rural areas like mine. Beneficiaries will lose the additional benefits and care coordination that Medicare Advantage offers. We also know that low-income seniors may be negatively affected.

Administrator Norwalk has noted that Medicare Advantage plans have a disproportionately greater number of lower income beneficiaries enrolled in their plans, which provide assistance in paying Medicare deductibles, copays and catastrophic costs that Medicare doesn't cover. We also know that arbitrary reductions will fall hardest on minority seniors. Twenty-7 percent of Medicare Advantage enrollees are minorities, compared to just 20 percent in fee-for-service Medicare.

That is why, just last week, national organizations representing minority groups like the National Association for the Advancement of Colored People (NAACP) and League of United Latin American Citizens (LULAC) voiced their opposition to cutting Medicare Advantage Programs.

Cuts to Medicare Advantage may also affect chronically ill Medicare beneficiaries. CMS data shows that Medicare Advantage enrollees are more likely to utilize preventative care and less likely to delay care because of costs than those enrolled in traditional Medicare. These proactive steps are the keys to better managing

the health care needs and improving the overall health of chronically ill Medicare beneficiaries.

I agree with those who have raised concerns about the various types of plans and whether they provide the same level of benefits and coordination to justify higher payments. We must closely examine this issue and I welcome the Chairman for this hearing to do that, but also we must do so carefully, lest we risk dramatically reducing access to quality care.

I hope to work with the Chairman on any proposed changes to the Medicare Advantage program to ensure that beneficiaries continue to receive access to many of the benefits that many plans currently offer, while also ensuring taxpayer funds are being wisely used. I thank the Chairman again and yield back my time.

Chairman STARK. Ms. Norwalk, please proceed.

STATEMENT OF LESLIE V. NORWALK, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. NORWALK. Thank you. Chairman Stark, Representative Camp and distinguished Members of the Subcommittee, thank you for inviting me today to discuss the Medicare Advantage Program. As you know, this program is a valued, important option for millions of people with Medicare.

Working closely with Congress, and this Subcommittee in particular, we have refined Medicare Advantage (MA) over the years to promote strong plan participation across the country. With a vibrant marketplace of plans for 2007, beneficiary enrollment is now at an all-time high. I am proud of these successes and stand committed to working with you in the days ahead to preserve choice for people with Medicare.

I am pleased to report that this year, beneficiaries selecting a Medicare Advantage plan are receiving, on average, an estimated $86 per month in benefits, over and above what original Medicare provides. Such additional benefits vary by plan but can include lower cost-sharing, enhanced Part D prescription drug coverage, part B and D premium reductions, and access to items and services like hearing aids, routine physicals, or vision exams that original Medicare does not cover.

All Medicare Advantage plans offer care coordination and disease management services currently not available through original Medicare. These added benefits yield important results. For example, MA beneficiaries are more likely than those in original Medicare to receive necessary preventative services, including pneumococcal vaccines and influenza vaccines, mammography, colorectal cancer screening and prostate screening.

Seventy-three percent of Medicare Advantage enrollees receive immunizations to protect them against pneumonia, compared to 64 percent of beneficiaries in the traditional Medicare program. These findings are corroborated by MedPAC and others.

MedPAC's March 2007 report to Congress stated that private plans have the flexibility to use care management techniques that fee-for-service Medicare does not encourage, and they have greater incentive to innovate.

Thanks to the hard work of this Subcommittee, CMS and many others, legislation has significantly impacted plan participation and beneficiary interest in Medicare Advantage over the years.

Chart 1, up on the screen, demonstrates payment reforms enacted by the MMA have helped propel beneficiary enrollment in Medicare health plans to nearly 8.3 million people, up from a low of 5.3 million in 2003.

In other words, nearly 20 percent of beneficiaries are now enrolled in a private plan, which includes Medicare Advantage and other plan options such as pace or cost plans. Clearly, we have learned from two sentinel pieces of legislation that preceded the MMA, the Balanced Budget Act 1997 (BBA) (P.L. 105–33) and the Benefits Improvement and Protection Act of 2000 (BIPA) (P.L. 106–554).

The BBA increased rural payment rates, but also significantly restrained payment in areas that historically had relatively high private plan participation. Following the BBA, BIPA attempted to stop the decline in the program by increasing the national floor and creating a second, higher urban floor. Unfortunately, plan offerings remained compromised and enrollment continued to decline.

Not until the MMA's immediate payment improvements took effect in 2004, did plan participation and enrollment rates begin to improve. In addition, the MMA's payment refinements have helped smooth over some of the geographic payment differences we see in original Medicare. I appreciate how important resolving such differentials is to many on this Subcommittee.

Concurrently, both enrollment and plan participation are better distributed geographically than ever before. Prior to the MMA's program refinements, beneficiaries in many States, and rural areas in particular, lacked access to a Medicare Advantage plan.

As Chart 2 shows in red and yellow, a vast majority of the country either had no plans or just a single Medicare Advantage plan option in 2003. Los Angeles County and South Florida were, in fact, the only areas in the country with 10 or more plans.

In contrast, today 10 or more plans are available almost nationwide as indicated by the blue area in Chart 3. A significant portion of the country has more than 25 plan offerings, and rural areas in the upper Midwest, New England, and even Alaska, have multiple plan offerings.

Improved choice and plan availability lead, in turn, to strong enrollment. Chart 4 highlights the current distribution of Medicare Advantage enrollees across the country. As you can see, people with Medicare from California to the Carolinas, from Minnesota to Miami, in Michigan, North Dakota, Texas and Illinois all are relying on Medicare Advantage plans and the valuable benefits that they provide.

For example, one plan available for no premium in California provides the following: a zero deductible drug benefit, including generic drug coverage in the gap; coverage for lengthy hospital stays with no copayment including days beyond what original Medicare allows; $1,000 aggregate deductible in contrast to the original Medicare $992 hospital deductible per illness and the $131 part B deductible; a $10 copayment for network physician visits rather than 20 percent coinsurance; and a $3,000 catastrophic limit on

out-of-pocket expenses for Part A and B benefits. Then finally, vision services and physical exams that are not covered by original Medicare.

These benefits are not unique. Beneficiaries in North Dakota who, prior to the Medicare Modernization Act, had virtually no private Medicare plan option, now have access to very similar plans, including: a zero premium plan that features zero dollar deductible for prescription drugs; coverage for an unlimited number of hospital days each benefit period; a $15 copayment for primary care physician visits; dental, hearing, and vision benefits; and, coverage for preventive services.

To further demonstrate the significance of this program, Medicare Advantage plans are also a valuable choice for low-income and minority beneficiaries. A higher proportion of low-income beneficiaries and minorities have chosen Medicare Advantage plans over traditional fee-for-service.

We have prepared for each of you an initial packet of background information showing the status of Medicare Advantage in your State.

In closing, I believe Medicare Advantage is a critical component of Medicare's future. Beneficiaries are turning to Medicare Advantage plans at unprecedented rates for better benefits, better care management, and better protection against catastrophic expenses.

I look forward to continuing this discussion with each of you to preserve these choices for current and future beneficiaries.

Thank you, and I am happy to take any questions.

[The prepared statement of Ms. Norwalk follows:]

Final Testimony of
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Before the
House Ways & Means Subcommittee on Health
On
The Medicare Advantage Program
March 21, 2007

Chairman Stark, Ranking Member Camp and members of the Subcommittee, I am pleased to be here today to discuss the Medicare Advantage (MA) program. The MA program is providing an affordable, high value choice for all Medicare beneficiaries. Enrollment is at an all-time high and plans are available in every state across the country, including rural areas.

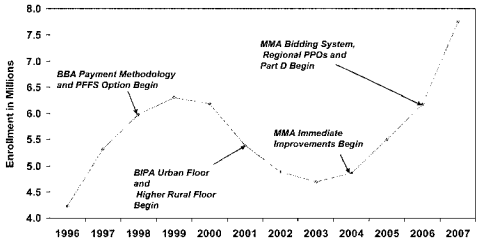
Trends in Medicare Advantage Plan Access and Enrollment

Medicare has a long history of offering alternatives to the traditional Medicare fee-for-service (FFS) program. In the 1970's, Congress authorized Medicare risk contracting with managed care plans, and in the 1980's further modified the program to make it more attractive to managed care companies and the Medicare beneficiaries they serve. Under that program, health maintenance organizations (HMOs) contracted with Medicare to provide the full range of Medicare benefits in return for monthly "per person" or "capitated" payment rates. In the Balanced Budget Act of 1997 (BBA), Congress created the Medicare+Choice program to correct perceived flaws in the risk contracting program, including significant payment differences across geographic areas. Since then, Congress has continued to refine the program, including changing its name to "Medicare Advantage" under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).[1]

The chart below illustrates how legislation has affected the availability of and enrollment in MA plans.

[1] For consistency, we will use the term "Medicare Advantage" or MA throughout the testimony rather than Medicare+Choice or other superseded names.

Medicare Advantage Enrollment History and Major Payment Changes*



*The Medicare Advantage program began in 2004. Enrollment for 1996-1997 reflects risk plan enrollment, 1998 – 2003 reflects Medicare+Choice enrollment.

Source: Centers for Medicare & Medicaid Services, Analysis of State-County-Plan Enrollment Reports, 1999-2005, OACT 2006 (MMR), 2007 MIIR Medicare Advantage options exclude HCPPs, Cost Plans and Demos (except PPO Demonstration)

[

Before 1998 and up until the MMA, MA options were concentrated largely in urban areas. In 1997, private plan payment rates were based on FFS utilization patterns and geographic differences, resulting in payment rates in urban areas that were higher (and sometimes significantly higher) than those in rural areas. This difference contributed to Medicare beneficiaries in urban and suburban areas often having access to MA plans, while those in smaller urban and rural areas either had no options or options with less robust benefit packages. The fact that these options and benefits were largely unavailable to rural beneficiaries led to interest by Congress in making changes to encourage more plan participation in rural areas, and to enhance benefits available in some smaller urban areas that had lower payment rates and lower plan participation.

The BBA expanded the types of contracting options available under MA plans. It also dramatically increased payment rates in rural areas by creating a national payment floor. However, while it increased many rural payment rates, it also significantly restrained payment in areas that historically had relatively high private plan penetration. Following the BBA's enactment, enrollment in private Medicare plans peaked at 6.3 million in 1999, before beginning a decline that continued for four years as the BBA's payment restraints took their toll.

The Benefits Improvement and Protection Act of 2000 (BIPA) attempted to stop the decline in the program by increasing the national floor and creating a second, higher urban floor. The BIPA also added 1 percentage point to the minimum update for the period from March 2001 through the end of the calendar year. Even with this action, plan offerings remained compromised and enrollment continued to decline (though at a somewhat slower rate), reaching a low of 4.7 million in 2003. Not until the MMA's immediate payment improvements took effect in 2004 did plan participation and enrollment rates begin to improve.

Current Medicare Advantage Enrollment

With the MMA's changes and immediate payment improvements effective in 2004, plan participation and beneficiary enrollment in MA again began to grow. Medicare implemented the Part D prescription drug benefit as well as a new regional preferred provider organization (PPO) option in 2006, and the payment methodology for MA plans changed to a bid-based payment system in 2006.

Today, in 2007, beneficiaries in all fifty states have access to MA plan options. Almost one in five beneficiaries (8.3 million) elected private plan coverage for 2007. Of these enrollees, 93 percent are in MA plans, with the remainder in other private Medicare plan options such as cost contract plans or PACE plans. Medicare Advantage includes HMOs, local and regional PPOs, and Private Fee-for-Service (PFFS) plans. PFFS plans are important for rural enrollees. Thirty-one percent of beneficiaries in PFFS plans come from rural areas.

One new type of coordinated care plan is called a Special Needs Plan (SNP). SNPs were first available in 2004, when some demonstrations were converted to SNP contracts, and in 2006 new market entrants become available. These plans are able to target their services at particularly vulnerable populations, including those with chronic conditions, the institutionalized or dual eligibles. Medical Savings Accounts (MSAs) are also MA plans, but because they are an option that is newly offered to beneficiaries they have not enrolled a significant number of beneficiaries to date.

MA enrollment by plan type from 2006 to 2007

Plan type	2006 (August)	2007(February)	Increase in enrollees	Percent change
Local CCP	6,126,100	6,275,341	149,241	2%
PFFS	802,068	1,327,826	525,758	66%
RPPOs	89,492	120,770	31,278	35%
Total	**7,017,660**	**7,723,937**	**706,277**	**10%**

Note: These numbers include employer sponsored group health plans. Special Needs Plans are included in the Local Coordinated Care Plans (CCP) totals. Cost and Program of All-Inclusive Care for the Elderly (PACE) plans are excluded.

Enrollment in rural areas has grown significantly. From 2003 to 2007 605,115 beneficiaries in rural areas joined the MA program, a 426 percent change. The chart below illustrates the types of choices Medicare Advantage enrollees are making. Thirty one percent of PFFS enrollees are from rural areas.

Urban/Rural Enrollment by Plan type, 2007

	Urban	Rural
	% of Total	% of Total
Eligibles	78.0%	22.0%
MA Enrollment		
local CCP	92.9%	7.1%
Regional CCP	79.7%	20.3%
PFFS	68.8%	31.2%
Total	88.4%	11.6%

Medicare Advantage Payment Overview

Under the revised payment methodology included in the MMA, MA plans submit bids for costs of delivering Part A and Part B services. These bids are compared to plan-specific benchmarks to determine the total payment to plans.

- **Plan Bids** - The plan bid is each plan's estimate of the cost of delivering Part A and Part B services. It is risk-adjusted based on the health status and other characteristics of plan enrollees. To the extent the plan provides care coordination services, these costs are included as part of their bid for Part A and B services. The plan bid is each plan's estimate of the cost of delivering Part A and Part B services to the average Medicare beneficiary. It is risk-adjusted based on the characteristics of individual plan enrollees. Pursuant to the Deficit Reduction Act and a CMS announcement in 2005, budget neutral risk adjustment, which increases plan payments, is being phased out. The phase-out began in 2007, with 55 percent of the budget neutrality factor included in plan payments. The phase out will be completed in 2011. To the extent the plan provides care coordination services, these costs or savings are included as part of their bid.

- **Plan Benchmarks** - Benchmarks are the maximum amount Medicare will pay a plan for delivering Part A and B benefits in a specific geographic area; they are determined by the

Secretary each year under a methodology provided in the Medicare law. For most plans, benchmarks are based on the county capitation rates used for payment purposes before the bidding system began in 2006. Plan benchmarks are averages of county rates weighted based on projected plan enrollment in each county in the plan service area. (Regional plan benchmarks are based primarily on county capitation rates, but plan bids are also factored in). ***The vast majority of plan bids are below their respective benchmarks.*** If a plan bid is above the benchmark, the enrollee must pay the difference in the form of a premium, referred to as the "basic beneficiary premium."

- **Beneficiary Rebates** - If a plan's bid is less than its benchmark, 75 percent of the difference, termed the rebate, must be provided to enrollees as extra benefits in the form of cost-sharing reductions, premium reductions for Part B or Part D, or additional covered services. For local plans, the remaining 25 percent of the difference is retained by the Federal Treasury. For regional PPOs, 12.5 percent of the difference is retained by the Federal Treasury and the remaining 12.5 percent is directed to the MA Regional Plan Stabilization Fund.

Simplified Example

	Plan A (vast majority)	**Plan B (few)**
Benchmark amount	$700	$700
Plan bid	$600	$750
Difference	$100	($50)
Plan receives from Medicare	$600 (risk adjusted) + (.75*$100) = $675.*	$700 (risk adjusted)
Basic beneficiary premium	None	$50

***The additional 75 percent must be rebated to beneficiaries, either as extra benefits or Part B or D premium rebates.**

Some have suggested in recent years that Medicare is overpaying MA plans. The March 2007 MedPAC report concludes that in 2006, payments to MA plans were on average 12 percent

higher than estimated costs if MA enrollees were still in FFS Medicare. Both the MedPAC analysis and a recent Commonwealth Fund study define this "payment differential" as the amount by which payments for Medicare beneficiaries in the MA program exceed estimated payments that would have been made if the MA enrollees had remained in FFS Medicare. There are important factors to keep in mind in considering the payment differential presented by these analyses:

Payment for Added Benefits – In fact, payments to MA plans are ***not*** just for the costs of delivering Part A and B services (i.e. plan bid); payments also include the cost of providing the additional benefits that plans bidding below the benchmark are required by statute to offer. Any additional benefits must be a part of the overall bid, available through beneficiary rebates as required by the statute.

Original Medicare Payments Are Reduced by excluding IME Payments – Before MedPAC or the Commonwealth Fund compared payments made to MA plans to estimate Medicare FFS amounts, each group reduced the FFS amounts to carve out payments for certain teaching hospital expenses (i.e. indirect medical education (IME)) while leaving similar IME payments in the MA side of the equation. In both the MedPAC and Commonwealth analyses, IME costs were removed from estimated FFS costs to reflect the current double payment for IME (one going to hospitals, and one included in plan payments) on the part of Medicare. The President's FY 2008 budget has proposed to eliminate this double payment to hospitals.

Budget Neutrality - Pursuant to the Deficit Reduction Act and a CMS announcement in 2005, budget neutral risk adjustment, which increases plan payments, is being phased out. The phase-out began in 2007, with 55 percent of the budget neutrality factor included in plan payments. The phase out will be completed in 2011. The comparison of 2006 FFS and MA payments does not show the effect of phasing out the budget neutrality adjustment. To the extent the plan provides care coordination services, these costs/savings are included as part of their bid.

In large part, any remaining differential reflects Congressional decisions to increase the benchmark above FFS in certain areas, such as rural areas, to ensure access to private plans across the country.

The Value of Medicare Advantage

Competition in the MA program creates significant value for beneficiaries. For example, care coordination generally is not available under the traditional Medicare FFS program, but is routinely offered by MA plans. Due to the current payment structure of the MA program, MA plans provide important benefits beyond the FFS package relied on by Medicare beneficiaries. For example, MA enrollees typically benefit from reduced cost-sharing relative to FFS Medicare; all regional PPO enrollees have the protection of a required catastrophic spending cap and a combined Part A and B deductible. In addition:

- 64 percent of plans have coverage for eye glasses;
- 77 percent have coverage for routine eye exams;
- 87 percent cover additional acute care stay days; and
- 90 percent cover SNF stays beyond the FFS benefit.

In 2007, enrollees in MA plans are receiving, on average, additional benefits with a value of $86 per month. Medicare Advantage plans restructure and reduce cost-sharing relative to traditional Medicare. $67 in average monthly savings is included in the $86 MA value. Examples using 2007 data include:

Medicare Advantage Has Better ***Hospital Benefits*** for Beneficiaries

Original Medicare FFS

- $992 deductible –
- days 61- 90
  - $248 per day
- days 91 – 150
  - lifetime reserve days - $496 per day

Albuquerque, New Mexico	Unlimited with a $200 copay per stay
Portland, Oregon	Unlimited with a $50 copay per stay
Los Angeles, California	Unlimited with a $0 copay per stay
Lincoln, Nebraska	Unlimited with a $100 copay per stay
Tampa, Florida	Unlimited with a $100 copay per days 1-5 of a stay

Plans selected were those with the lowest estimated out of pocket costs according to *Medicare Options Compare* for a beneficiary age 65 – 69 in poor health

Example 1: In Medicare FFS a beneficiary would pay $992 inpatient hospital deductible and daily coinsurance of $248 for days 61 to 90 of a hospital stay. A Medicare Advantage enrollee in Albuquerque, New Mexico only pays $200 per stay.

Medicare Advantage Has Better ***Physician Benefits*** for Beneficiaries

Original Medicare FFS

- $131 deductible (all Part B services)
- 20% coinsurance
- No out of pocket limit

Albuquerque, New Mexico	No deductible - Copays of $5 - $15 for plan physicians
Portland, Oregon	No deductible - Copays of $10 for any willing physician
Los Angeles, California	No deductible - $0 Copays for plan doctors
Lincoln, Nebraska	No deductible Copays of $10 for in-network physicians
Tampa, Florida	No deductible - Copays of $0 - $10 for plan doctors

Plans selected were those with the lowest estimated out of pocket costs according to *Medicare Options Compare* for a beneficiary age 65 – 69 in poor health

Example 2: In Medicare FFS. A beneficiary would pay a $131 deductible and 20% coinsurance for physician services. A Medicare Advantage enrollee in Lincoln, Nebraska has no deductible and pays $10 per plan physician visit.

Finally, many MA plan enrollees also receive basic Part D prescription drug coverage at a lower cost than stand-alone Part D plans (PDPs) can provide. Enrollees in MA plans that include Part D coverage (MA-PDs) save money on drug coverage in two ways. First, MA plan drug premiums for basic coverage are on average about seven dollars less than average PDP premiums for basic coverage. Second, the MA payment structure allows MA-PDs to use rebates to further reduce Part D premiums. On average, Part D premium savings from rebates is more than $13 per month.

Medicare Advantage is an Important Option for Low-Income and Minority Beneficiaries

Low-income beneficiaries rely on the availability of MA plans and the extra benefits they provide. An analysis of the 2005 Medicare Current Beneficiary Survey (MCBS) shows that a disproportionate percentage of low-income beneficiaries enroll in MA plans. Fifty-seven percent of MA beneficiaries have annual income between $10,000 and $30,000 as compared to 46 percent of FFS beneficiaries. The table below illustrates the important choice the MA program provides to beneficiaries with incomes in this range.

Income Status Distribution of Beneficiaries by Type of Coverage

	$10,000 – 20,000	**$20,000 – 30,000**
Medicare Advantage	35%	22%
FFS	27%	19%

Minorities also rely heavily on the MA program. The 2005 MCBS data analysis also shows that a disproportionately higher percentage of minorities are in MA plans. As shown in the chart

below, twenty-seven percent of MA beneficiaries are minorities, as compared to 20 percent of FFS beneficiaries, illustrating the importance of MA options for these Medicare beneficiaries.

Minority-status Distribution of Beneficiaries by Type of Coverage

	Non-Hispanic White	Minorities*
Medicare Advantage	73 %	27%
FFS	80%	20%

*Includes non-Hispanic African-American, Hispanic, and other (including Asian, Native American, and Pacific Islanders)

The Future of Medicare Advantage

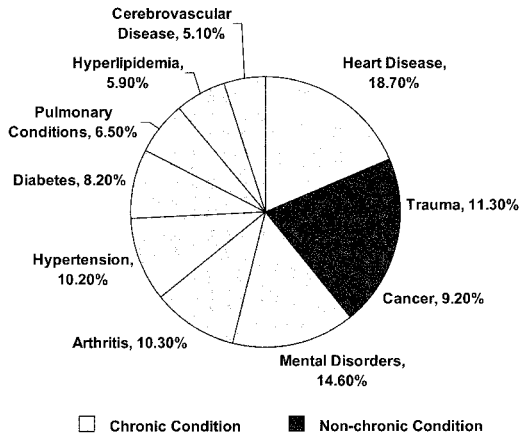
Beneficiaries with chronic conditions are a large and growing portion of the Medicare population for whom optimal care is critical. According to the Congressional Budget Office (CBO), in 2001 over 75 percent of high cost beneficiaries had one or more of seven major chronic conditions. In a 2003 report released in the *New England Journal of Medicine,* researchers found that patients with chronic conditions received necessary care just 56 percent of the time. More Americans with these chronic conditions are becoming eligible for the Medicare program, and at the same time are living longer. Avoiding the costs associated with preventable acute episodes is one of the central challenges for the Medicare program in the future.

MA plans have led the way in developing care management programs for chronic diseases and integrating them into their overall approach to care. This is because they have the incentives (capitated payments) and the clinical and administrative structures such as provider networks and complete medical records that allow the application of data-driven clinical protocols that drive disease management and appropriate utilization of expensive services. In addition, MA plans are required on an ongoing basis to collect and apply quality performance data to quality improvement and chronic care management projects that also drive improvement in overall clinical management. Quality performance information on MA plans is also made public, and can be used in choosing health plans.

Capitated payments in the MA program provide incentives to manage utilization and in particular to work with beneficiaries to prevent unnecessary admissions, including readmissions, and complications that would arise from poorly controlled diseases. According to the MedPAC SGR Report on Alternatives to the SGR, "Capitated payments also provide incentives for plans without networks of providers to work directly with providers and beneficiaries, as many disease management companies do, to ensure enrollees receive appropriate follow-up and preventive services."

Care coordination services are not required in the FFS program; to create them would require enactment of legislation. FFS providers are not currently expected or required to coordinate care across settings or over time with patients after they leave their specific setting of care and in fact, the existing payment system and Medicare's current rules actively discourage coordination of care. Integral to the long-term sustainability of the Medicare program is better managing the care of those with chronic illness. The ongoing support and expansion of a stable MA program may provide an effective strategy for caring for the unique needs of the growing Medicare population.

Eight of the top ten drivers of increases in Medicare costs are chronic conditions



Note: The top ten conditions account for 66 percent of total Medicare health care spending increases, 1987-2002.
Source: K.E. Thrope, D.H. Howard. "The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Change in Treatment Intensity' *Health Affairs:* w378-w388. 22 August 2006

Conclusion

Mr. Chairman, thank you again for this opportunity to testify on the MA program. We look forward to working with Congress to further strengthen this system that promotes access, excellent benefits, and high quality care.

I would be happy to answer any of your questions.

Chairman STARK. Let us do some numbers. You have a real advantage over me, because I have my shoes and socks on, but you have several times in your testimony, and I can't find the exact wording, but you have implied that there is a higher percentage of both minority and low-income beneficiaries in Medicare Advantage plans, disproportionately so. The numbers that I am looking at, and tell me where I am wrong, suggest that among all Medicare beneficiaries, approximately, for example, 11 percent are African American. Does that jive with your——

Ms. NORWALK. Sir, the number I have is almost 4.3 million out of 43, so just under——

Chairman STARK. So, somewhere around 10 percent.

Ms. NORWALK. Right.

Chairman STARK. Then what I am showing is that among all Medicare beneficiaries, less than 20,000 a year in income, we have about 47 percent, 20 percent less than 10, 27 percent in the 10 to 20 range.

Ms. NORWALK. I think that is—yes.

Chairman STARK. Then I am showing that in the Medicare Advantage programs, which is only 20 percent or a little less than 20 percent of the entire Medicare population, 10 percent are African Americans.

Ms. NORWALK. I actually have a slightly higher number. So, I have 851,000 versus just under 8.3. So, actually, it is over 10 percent.

Chairman STARK. Okay, but not very much different from the 11 percent. So, what I would——

Ms. NORWALK. Slightly under fee-for-service and over——

Chairman STARK. What I would suggest to you is the makeup ethnically of Medicare Advantage plans is no different than the makeup of the entire Medicare Program. Would you stipulate to that?

Ms. NORWALK. The proportion is slightly more in Medicare Advantage for African Americans, also for Hispanics.

Chairman STARK, but slightly. Like 1 percent of 20 percent, which by my numbers is a half a percent of the entire population. The same thing would hold true for lower income.

Now less than $10,000, I am reading that people under $10,000 in income make up 16 percent of Medicare Advantage but they make up 20 percent of all Medicare beneficiaries. So, there are slightly fewer poor people.

Ms. NORWALK. I actually think that is because of Medicaid, the Medicaid provisions that——

Chairman STARK. I would just go on to tell you that Medicaid in Qualified Medicare Beneficiary (QMB) and Specified-Low Income Medicare Beneficiary (SLMB) is a whole heck of a lot better than any Medicare Advantage plan.

Ms. NORWALK. They are very important programs.

Chairman STARK. Much more. You haven't mentioned them, which I think is somewhat—I won't call it disingenuous; somebody got their words taken down for that, but to ignore the fact that a majority of the lower income people, particularly those in the less than $10,000 group are dual eligibles or QMBs and SLMBs, which have the best possible economic—the dual eligibles pay nothing.

Ms. NORWALK. As they should.

Chairman STARK. It doesn't get much better than that.

Ms. NORWALK. Right.

Chairman STARK. Okay. Well, I just wanted to suggest this idea that there is a huge number of people—now, that is not to suggest that in the urban areas where there is a larger concentration by number of low income and, unfortunately, minority population, there are a large number of Medicare Advantage members and for many of them, their premiums are lower, but what you don't mention is that in many of these plans, that is great if they don't get sick.

You have said, for instance, Medicare Advantage beneficiaries face lower hospital copayments, but I could tell you there are a lot of plans out there that charge more than $200 a day for the first 10 days in the hospital. Now that, by my math, is a whole heck of a lot higher than the $992 the fee-for-service deductible covers.

So, what I would further, and I wonder if you would agree, there is a wide difference in the efficiency and generosity of these plans. That they are not monolithic. Is that a fair assessment?

Ms. NORWALK. It is a fair assessment that the benefit packages from plans vary greatly across either areas across the country and so forth. So, I can tell you generally, in terms of the extra benefits, that 90 percent of all plans do provide additional hospital day stays. All regional Preferred Provider Organization (PPO) plans are required by statute to provide catastrophic coverage across-the-board.

So, other than that, I think generally they do need to provide A, B benefits. I know that, in the past, you have been concerned about discrimination and whether or not plans have set up their benefit packages that may be in a way that is discriminatory.

Chairman STARK. Sure. Offering health club memberships as an extra benefit is not apt to appeal to a sedentary person like myself. If I got a discount at Thank God It's Friday's on the first pint, that might be different.

Okay, well, I have used up more than my time and I would like to hear what Mr. Camp has to say.

Mr. CAMP. Thank you very much.

Going back to this issue of who gets served by Medicare Advantage plans, I notice in the letter that the NAACP released, they said 40 percent of African Americans without Medicaid or employer coverage rely on comprehensive benefits and lower cost-sharing in Medicare Advantage that they don't find in traditional Medicare. Is that an accurate statement?

Ms. NORWALK. I don't know if I have the numbers with me—that focus specifically—I don't know if I have them here, that have the employer plan piece taken out, but we can certainly get them to you. I think that is an important point.

With all the questions that we ask today, there are often differences in everything from payments—or everything from the bids that plans submit and the employer community often does things differently than what people may have access to in the individual Medicare Advantage market. So, I think they are important questions to ask.

I don't think we have it here today, but I will see if I can get it for you for the record.

[The information follows:]

I don't find that figure at all surprising since Medicare Advantage offers great value, especially to individuals of limited means who don't have supplemental Medicare coverage through Medicaid or a former employer. We have not done an analysis looking specifically at the proportion of minorities who don't have other supplemental coverage who have joined MA plans. My written statement indicates that we have looked at MA enrollment of individuals from minority groups. That analysis showed that MA enrollees are more likely to be from minority groups than beneficiaries in FFS Medicare. Specifically, of beneficiaries in MA plans, 27 percent are minorities, whereas in FFS Medicare, 20 percent are minorities.

Mr. CAMP. All right, I appreciate that.

I guess to try to highlight some people that have argued that there really aren't additional benefits in Medicare Advantage compared to those in traditional Medicare, is that criticism—there has been criticism of the Medicare Advantage plan to that effect. Is that criticism accurate and, if not, could you please describe some of the additional benefits that plans offer?

Ms. NORWALK. I think that most plans offer, as they are required to by statute, some very significant additional benefits. The statute requires if there is a difference between their bid and the payment benchmark, that they return 75 percent of that difference to the beneficiary in the form of additional benefits. The other 25 percent reverts back to the Treasury.

So, what I did is, I took a look at a number of different types of benefits. So, as I noted earlier, 90 percent of all plans offer additional day stays in the hospital. Most plans waive the 3-day hospital stay requirement before they are admitted to a skilled nursing facility. I have a whole list here in terms of percentages.

Seventy-seven percent provide routine hearing tests, 98 percent have routine physical exams and so on and so forth.

So, there is a significant range of benefits that are provided to beneficiaries. Some of the most popular relate to cost-sharing, such as zero premiums, rebate of the part B premium, zero premium drug benefits, coverage in the gap, particularly for generic drugs, and the like. So, there are, without question, some very important additional benefits provided to Medicare beneficiaries.

Mr. CAMP. Yes. I think it is important to know that that goes beyond just sort of optical and physicals.

Ms. NORWALK. I actually have an example in Midland, Michigan. There is, for a $25.50 premium, a plan that has drug coverage with no deductible, a $3 copay for preferred drugs, no inpatient hospital costs at all and no copay when something is provided in-network. For doctor visits, there is a $7 copayment for primary care and a $20 copayment for specialists. Not only that, they have got dental services, hearing services, physical exams and health and wellness education. So, in your county in Michigan, I think that beneficiaries have some pretty good options available to them.

Mr. CAMP. Thank you very much.

In the Balanced Budget Act, Congress reduced and cut the Medicare Advantage payment. What happened after that?

Ms. NORWALK. I think what—if I recall my history from 10 years ago—do you want to put up that one chart, the first chart? Thanks.

The Balanced Budget Act was really—one of the things it wanted to do—the first one—was to pay more to rural areas. This Committee, this Subcommittee, has discussed with me earlier in budget testimony the concern about the payment differentials between fee up front and fee-for-service. A lot of what the Balanced Budget Act wanted to do was recalibrate some of that to provide more choice in rural areas, something that you didn't see very much of before 1997 and, frankly, even thereafter.

Those payment changes, one of the things that happened was it reduced payments in other areas. Consequently, as you can see from this chart, you can see that the enrollment, which is the left-hand column, peaked after the Balance Budget Act amendments took effect and then enrollment declined precipitously thereafter and started to rise after some of the BIPA changes and then the Medicare Modernization Act changes. So, there is no question that the legislation that has happened around Medicare Advantage makes a very big difference in enrollment and, not only that, additional benefits that are provided.

Mr. CAMP. All right. Thank you.

Thank you, Mr. Chairman. I see my time has expired.

Chairman STARK. Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. Thanks for holding this hearing. Ms. Norwalk, thank you for being here to testify.

In your written statement, you note that Congress created the Medicare+Choice program to correct perceived flaws, including significant payment differences across geographic areas. I don't see this helping. As a matter of fact, I can point to and hear a lot about disparity in payments between northern and southern California. I know on this Subcommittee, we have had discussions, the same issue raised by other Members.

Why is this still such a huge issue, huge and outstanding issue, with the Medicare Advantage program?

Ms. NORWALK. Well, I think what these payment changes were intended to do, particularly the MMA payment changes, were to increase floor payments. So, for example, in a rural area, where typically if you compare the payments, for example, Dade County is one of the most prosperous—or most expensive counties from a fee-for-service perspective. If you compare, say, Dade County with any of the number of rural floors, so the rural floor this year is $692. That is an increase from what you would be paid in a rural county typically.

Consequently, so if you are looking—if you are in many areas around the country, the fee-for-service differentials between fee-for-service and Medicare Advantage generally would have been even higher if there hadn't been a rural floor adjustment. So, the rural floor is intended to——

Mr. THOMPSON. Let me just submit for your consideration that if you are in a northern California county and you are paying more than someone in—considerably more than someone in a southern California county, it is little comfort to know that you could be paying even more. There is a very glaring disparity that is hurting real people trying to get health care. I think we need to take a little different approach to this.

Ms. NORWALK. I actually think the floors, when the MMA was passed, the floors were really intended to address the fee-for-service disparities. That is why you have rural floors and urban floors at a set level without regard to what the fee-for-service reimbursements are there.

So, that is not to say that there isn't plenty of work to do generally around fee-for-service differentials, as we have discussed before. I think that there is, but in the meantime, a lot of what the discussion is, is going back to basically a flat fee-for-service rate for Medicare Advantage. My point is, that merely can perpetuate the differences that you would see in Dade County, Florida, for example, versus planned payments in North Dakota or——

Mr. THOMPSON. My point is that there are people who are being affected because of this disparity and it is a problem.

You had mentioned earlier, made some comments about the extra benefits on the MMAs and I would just like to know that if CMS has data on the utilization of the extra benefits in the plans? It is one thing to have extra benefits. It is another thing if they are not being used.

Ms. NORWALK. I will have to ask whether or not we—I will have to check whether or not we—what information, specifically, we collect on that piece. If we have it, I am more than happy to give it to you and otherwise figure out if we have some proxy if we don't have the specifics.

[The information follows:]

In 2007, enrollees in MA plans are receiving, on average, additional benefits with a value of $86 per month. Plans provide an average of about $108 in additional benefits, primarily cost sharing and premium buydowns, as well as specific benefits such as routine vision and dental care. Plans charge, on average, a monthly premium of about $22 for these benefits, yielding a net average value for enrollees of $86 per month.

The Centers for Medicare & Medicaid Services (CMS) monitors the care delivered by managed care organizations (MCOs) through the collection and analysis of standardized clinical performance measures and beneficiary satisfaction surveys. For this purpose CMS has been collecting MA data via Health Employer Data and Information Set (HEDIS), **Consumer Assessment of Healthcare Providers and Systems (CAHPS),** and Medicare Health Outcomes Survey (HOS) for nearly 10 years. Additionally, CMS has created the Complaints Tracking module, a tool that collects and tracks beneficiary complaints. CMS also collects data from MCOs in conjunction with the annual bidding process.

Mr. THOMPSON. It seems to me it is something we have got to get because it doesn't really matter if benefits are available if nobody is using the benefits.

Ms. NORWALK. No, I appreciate that. We should have that for purposes of considering risk-adjustment and the relative health of beneficiaries. I am just not sure if it is exactly as you would describe it, but I will see what we can provide to get you that.

Mr. THOMPSON. Then I was just informed that the American Association of Retired Persons (AARP) has come out against the overpayments for the Advantage plans. Do you have any comment on that?

Ms. NORWALK. Well, I don't characterize it as an overpayment. I characterize it as additional benefits for Medicare beneficiaries as——

Mr. THOMPSON. So, is AARP still against it, irrespective of what you call it?

Ms. NORWALK. I haven't seen what AARP said, so I am going to presume that you know better than I do.

Mr. THOMPSON. I didn't mean to interrupt you. Go ahead. Your comments on that? Irrespective of what you consider it, what are your comments on their opposition to the overpayments?

Ms. NORWALK. I think it is unfortunate. They have many beneficiaries—of the 8.3 million, a significant portion, of course, are going to be those who are members, I would imagine, of AARP and I think that they do receive important benefits from that.

Moreover, the importance of the changes that the MMA did is beyond just the additional benefits. It is really to ensure that people in rural areas of the country have access to these sorts of plans. Reverting back to where we were at, the MMA may lead us to lose a significant amount of ability for many beneficiaries to sign up for Medicare Advantage plans. So, I think it really serves a dual purpose.

So, I would have to disagree with the outcome of the AARP analysis, whatever it happens to be.

Mr. THOMPSON. Thank you.

Chairman STARK. Mr. Hulshof, would you like to inquire?

Mr. HULSHOF. Thanks. Welcome back, Ms. Norwalk.

Looking about the room, I think probably most folks here are intimately acquainted with many of the acronyms we have used. I think we chased off a student group who were here momentarily. Which is interesting, when you consider that as we move to 78 million senior citizens that will depend on Medicare when the Baby Boomer generation has retired, it is going to be the young folks who will be in the work force who will be supporting this right now unsustainable program down the road. So, as I do each time you come before us, just for the record and those that may review the record later, BBA of course is the Balanced Budget Act. It was signed into law in 1997, I believe.

Then BIPA is the Benefits Improvement and Protection Act and that was the year 2000. Again, I would note parenthetically that each of those two bills was with a divided Government, a legislative branch of one party, executive branch of another. There was some give and take in the fact that these changes were made. Certainly as we move forward, I hope again that spirit of cooperation is there with this continued divided Government.

I also acknowledge we have an exceptional panel coming up. One of the things, Ms. Norwalk, that we are allowed to do is to anticipate and read their testimony coming up. So let me mention a couple things and get a reaction from you.

Dr. Miller, in his written testimony, will tell us that the Medicare Program needs to put some financial pressure on both fee-for-service and the Medicare Advantage programs, in addition to bringing quality initiatives in. I think the idea is to compare apples to apples.

One of the things that Dr. Miller points out in his testimony is that Medicare Advantage, while they use bidding, and he puts that in quotation marks, as the means of determining plan payments and beneficiary premiums, the bids are against benchmarks which are often legislatively set. Again, I acknowledge that. As he will tell us later, I am sure, the commission believes that financial neu-

trality is important as we consider possible changes between fee-for-service and Medicare Advantage or other private plans that we may contemplate.

I take that point but let me also make sure that my facts and figures are correct. Is it not true that CMS employs roughly 4,000 individuals and contracts with about another 22,000 to run Medicare and Medicaid? Are those numbers roughly?

Ms. NORWALK. 4,500 employees and I thought we had 80,000 contractors but maybe it is less than that.

Mr. HULSHOF. I think the information I have is at least in fiscal year 2006, CMS, Centers for Medicare and Medicaid Services, spent roughly 3.2 billion in operation costs. How am I on that number?

Ms. NORWALK. That sounds right.

Mr. HULSHOF. Okay. Medicare Advantage overhead costs are actually built into their plan bids, is that true?

Ms. NORWALK. That is correct.

Mr. HULSHOF. You mentioned a couple things of actual legislative mandates or requirements for anyone who wishes to offer a Medicare Advantage plan. For instance, I think you mentioned PPOs are required to provide catastrophic coverage. Is that also true?

Ms. NORWALK. That is correct.

Mr. HULSHOF. Are other Medicare Advantage plans required to provide disease management programs to enrollees?

Ms. NORWALK. No, they are only required to provide Medicare part A and Medicare part B benefits.

Mr. HULSHOF. Are there any other requirements that the Medicare Advantage plans have to factor in, however? The point of this, Dr. Miller, as you come up later, is we try to talk about this neutrality. There you are. Good to see you.

What other mandates or legislative requirements are there that Medicare Advantage plans have to factor in, in addition to the overhead costs we have talked about and the catastrophic coverage?

Ms. NORWALK. There are a number of different things. The first, you alluded to it earlier in terms of the quality requirements and quality reporting that they do and provide indications of quality metrics to their enrollees.

In addition, of course, you are automatically in fee-for-service as a default, but from a Medicare Advantage plan, you need to market in order to get enrollment to tell people your existence and so forth. So, there are a fair number of costs that may be associated with that. You also need to do appeals and grievances and a lot of other things that can add additional costs if you are in a Medicare Program that would have to be included in the bid. So, call centers and all sorts of things to make sure that beneficiaries can have access to information, whatever it is that they need.

Mr. HULSHOF. I guess as a final comment I would make, and Mr. Camp, I think, has brought out the fact that especially in rural areas and preventive care, and again I know I am flogging the same dead horse—it is not a dead horse necessarily—but the frustration that we consistently have that we aren't able to factor in the inherent costs that we will save through preventive care. We

again touched on this many times as far as Medicare Part D picking up the costs of certain drugs. Of course, we know it is going to eventually save lives and have procedures that don't have to be done. I think if we are truly trying to find that comparing apples to apples, that preventive care that is offered through Medicare Advantage, unfortunately we don't get to count the cost savings as we are trying to make these comparisons.

Ms. NORWALK. Correct.

Mr. HULSHOF, but that is my editorial comment. I appreciate it, Mr. Chairman. I yield back.

Chairman STARK. Mr. Kind, would you like to inquire?

Mr. KIND. Thank you, Mr. Chairman. Thank you, Director Norwalk, for your testimony here today and your patience with us.

I also appreciate the efforts you have made, and your staff, as far as getting together with me in the not-too-distant future to talk about an interest very important to the State of Wisconsin, and that is the survival of Senior Care, which is due to expire, the Federal waiver, at the end of June. It is an incredibly popular program with 103,000 seniors enrolled in it in the State. It has received bipartisan support from the creation to the existence to the extension, hopefully, with the Administration's cooperation later this year.

Just from budgetary terms, it seems like a no brainer, because if we extend Senior Care for another three years, as the Governor is proposing in his waiver application, it would save the Federal Government $403 million that 3 years because, per beneficiary, it is much cheaper to provide services under Senior Care than Part D. The combined State and Federal savings is close to $700 million.

So, I am looking forward to having that meeting so we can discuss in more detail what the Administration's vision is with Senior Care, what we can do working together. Hopefully we can set that up soon.

As a new Member of the Committee, I haven't had a chance to really wade into the weeds yet in regards to Medicare Advantage program, certainly not to the extent that you have, but a few things do jump out at me initially.

If you take a look at the Congressional Budget Office score with Medicare Advantage plans, for every new enrollee that we do have going into Medicare Advantage, the budget baseline goes up. Do you accept that proposition? Is that a fact of budgetary life that we are facing right now?

Ms. NORWALK. Yes. With the way the program is currently structured, most Medicare Advantage payments would be higher than fee-for-service. I might add that our actuaries may have different assumptions than the CBO and I don't think——

Mr. KIND. I think we will have Mr. Orszag here a little bit later testify about the budgetary implications. Some call it the overpayment, you refer to it as more services, which can be a good thing, but I think at some point, we in Congress need to wrestle with just the fundamental philosophical fact and that is, what the goal ultimately is. Is it extending more coverage, providing more options with more services but at a higher price to seniors compared to traditional fee-for-service? Or is it, try to find savings so we can extend some coverage to all people in this country, including children,

the SCHIP program? We are trying to find tens of billions of dollars right now in the budget resolution and how we can maintain the integrity of SCHIP over the next 5 years, but also dealing with the 46 million uninsured. That is just a fact that we are going to have to come to grips with in regards to where Medicare Advantage is going, but including these private fee-for-service plans.

My question for you is, how confident are you that you are getting—CMS is getting enough data in regards to the administration of these Medicare Advantage plans, the efficiencies of these plans, the administrative costs, the profit margin in order for us as policymakers to make some of these policy determinations?

Ms. NORWALK. We do have a fair amount of information in terms of all the things that you listed. I think you each will have a handout that looks at the ratio of the Medicare Advantage plan bids to fee-for-service, it looks something like this. I thought this was important because it looks at the different types of plans, the local coordinated care plans, the regional PPOs, the private fee-for-service, and then segments out the individual plans versus the employer plans.

One of the things that you see here is that local Health Management Organizations (HMOs) and PPOs submit their bids to us—and the bid to CMS is basically what are we bidding to pay for regular Medicare part A and part B benefits. One of the things you will notice is that the local coordinated care plans actually come in under Medicare fee-for-service.

Now, it is the legislatively set benchmarks, as Dr. Miller will testify to later, I am sure, that change the payment rates. The regional preferred provider organizations are new. They have basically just started, so they do have some additional startup costs. They also have to provide the catastrophic coverage. You will see that their average rate for individual plans is just under 113 percent of fee-for-service.

Private fee-for-service and regional PPOs also need to network across an entire——

Mr. KIND. Let me ask you on that in particular, because based on what little information I know about private fee-for-service, and I understand they are still in their infancy, this seems to be on the cusp of really exploding. Especially if companies figure out the advantages with their retirees out there under this.

Do we have the capability of gathering enough data to make some judgments about these private fee-for-service plans?

Ms. NORWALK. I think we do. I was referring to the regional PPOs, which are yet a separate plan option than private fee-for-service, and they have different goals in terms of the reasons why those plans were set up. Now, private fee-for-service, their average bid is just under 115 percent of regular fee-for-service, in terms of what they would provide the A, B benefit for.

We do have a lot of information on each of these plans, differentiated between individual and employer. I think, looking at that very carefully, combined with where these plans are being offered and the access that is available to Medicare beneficiaries is important to consider, as we look at all the important——

Mr. KIND. Can we get our hands on information with regards to administrative costs in administering these plans, profit margins that these plans are realizing?

Ms. NORWALK. I don't know in terms of what—typically, in terms of what we collect, specifically as to that, I will have to go back and ask. I think that what they have asked for recently has changed, or the past number of years has changed as the bidding process changed, but I will go back and find out what is available.

[The information follows:]

CMS has historically published aggregate payments by plan type, and CMS continues to publish the county rates used to develop plan-specific benchmarks. However, CMS does not publicly release monthly prospective payment amounts, administrative costs, or the profit margins by plan due to concerns about propriety information being distributed.

Mr. KIND. That would be helpful. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Ms. Norwalk, good to see you again. Thank you for being with us. I would like to follow up on Mr. Kind's questions.

Is there any information, any data—are there data that you would like to have with regard to the administration and efficacy of the Medicare Advantage program that you are currently not collecting or not allowed to collect?

Ms. NORWALK. Not that I can think of. I will have to give that some more thought and get back to you.

[The information follows:]

The Medicare Advantage program would benefit greatly from being able to collect the HEDIS and HOS measurement sets from Private Fee for Service (PFFS) plans. HEDIS is the most widely used measurement set in managed care, and the HOS survey is the only measurement set in use that produces health outcomes measures. Both of these measurement sets are used by CMS for internal contractor surveillance purposes, for audit selection purposes, and for public reporting initiatives.

Currently, all Medicare Advantage contracts except for PFFS and MSA plan contracts are contractually obligated to report these two measurement sets at their own expense. A provision in MMA section 722 currently excludes PFFS contracts from these data reporting requirements. As PFFS continues to grow, it is critical that CMS collect these measurement sets from these contractors for its internal contractor assessment programs and for publicly reporting quality of care information on the various choices available to beneficiaries.

There is nothing that jumps to mind, jeez, if we only had that piece of information, it would make it much easier to make these determinations. So, I have a good sense of why I think we are seeing these different bidding amounts for the different types of plans.

Medicare Advantage, particularly if you are a local HMO, typically costs you 97 percent versus 100 percent fee-for-service to provide the Medicare A and B benefits. They have been around a long time, so that sort of makes sense.

Mr. BECERRA. Do we have a profile of the people who are signing up with Medicare Advantage, to get a sense how they fit the profile of the average senior, of the average individual that age, health wise, geographically, all the demographic information?

Ms. NORWALK. We do. We do have a lot of that.

Mr. BECERRA. What about the information about the private fee-for-service plans? As I understand it, there is some information

that is proprietary that CMS cannot review in determining how they—how they come up with their level of reimbursement?

Ms. NORWALK. Yes, the rules around private fee-for-service are, indeed, different from the regional PPOs and the local coordinated care plans.

Mr. BECERRA. Is there any information from the private PPOs——

Ms. NORWALK. I do think that you have raised a good point. To step back a second, so private fee-for-service, separate from the other Medicare Advantage plans, one of the concerns when they initially created——

Mr. BECERRA. I am going to run out of time, and I have one other very pressing issue.

Might there be, if there is an area, if you can just let us know, identify that, maybe we can work with you to see if that is something we can move into.

Ms. NORWALK. Absolutely. Great.

Mr. BECERRA. I want to spend the rest of my time, and Mr. Chairman, I hope you will indulge me, a more pressing issue for me back in southern California, in Los Angeles, in the next 10 days, King Hospital, which is a hospital that has helped a very modest income, a very disadvantaged community for many, many years, is on the verge of losing its contract with CMS to provide services under the Medicare provider agreement that it has with CMS. I know they have been waiting for a while for CMS to give them word. I know CMS has been working with them closely to try to help them in this process of radically reforming their services, because of the difficulties they have been having.

I think they are doing everything they can to get to the point where they will be able to pass any type of test about their services that they are providing, but I know they are waiting for word. They are asking for an extension until mid-August, August the 15th. My understanding is that CMS has not given them word or is telling them perhaps 1 month.

That won't help them do or complete the radical transformation they are undergoing. It won't help them preserve the 250 residency slots that they have to help teach the next generation of physicians, which also provide services to a lot of folks who have very modest insurance policies that they can use.

I am wondering if you could tell me today what CMS is planning to do to make sure that King Hospital continues to operate, and a lot of folks in southern California continue to receive services that are critical and of quality?

Ms. NORWALK. As you know, Martin Luther King Hospital initially had some significant quality issues. So this is really about the quality of care that is provided.

Mr. BECERRA. I am there with you, if you could fast forward to——

Ms. NORWALK. I have been working closely with Bruce Chernof, who is the medical director of LA County. One of the issues, really the only issue under which we granted them the initial extension from October until March 31, was so that they could downsize.

Mr. BECERRA. Yes.

Ms. NORWALK. Their initial assessment to us was, in fact, that they were on track to downsize by the end of this period. So, they have recently sent in new information to us saying that they need more time to downsize. We are reviewing that and taking a look at that, and that is what we will be basing our determination on. That is different, by the way, than giving them more time to pass a survey.

So, we want to be sure that we have a full understanding of the facts before we make a decision. I also appreciate it is critical that this decision be made in short order.

Mr. BECERRA. I think that is their point. They are doing something that most hospitals would never do, in that they are re-shifting virtually everything, their operation. What they are finding is that it is not as easy as you think, because they are also providing care at the same time.

If for 1 day the contract expires, were let to expire, they lose all 250 of those residency slots, because the contract is with USC—excuse me, with the county. So they cannot renew a contract if it is to another provider. So it is essential that we get word. Not on March 30, the day before it expires. They need to continue planning, because they are spending millions of dollars in preparation for this at the behest of CMS.

So, I am hoping that we can get word very quickly from CMS.

Ms. NORWALK. Absolutely. I have every intention of getting—there is a phone call I have already made today to figure out if we can resolve the issue.

Mr. BECERRA. Thank you so much.

I yield back, Mr. Chairman.

Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

Ms. Norwalk, do you know how many plans bid under the benchmark this past year?

Ms. NORWALK. Well, I know the majority of the Medicare Advantage plans did, so I think it is a high——

Mr. JOHNSON. Those plans enjoyed extra benefits as well, did they not?

Ms. NORWALK. Yes, those beneficiaries in those plans do enjoy significant extra benefits, that is correct.

Mr. JOHNSON. Tell me how the benchmark changes over time.

Ms. NORWALK. The benchmark over time has changed mainly because of legislative changes. So, one concern, for example, is that there were not a sufficient number of plans in rural counties. So those beneficiaries who lived in rural areas did not have the advantage of choosing a plan. So, what they did is, they put in a floor which would raise the payment levels to Medicare Advantage plans and did that above the fee-for-service rate. So, that was something intentional to increase the plan participation as well as enrollment in rural areas, and it has succeeded tremendously. We have much more enrollment in rural areas and far greater numbers of plans and choices for beneficiaries in rural areas.

Mr. JOHNSON, but if you raise the benchmark, is it costing them more in rural areas to run those?

Ms. NORWALK. It doesn't necessarily cost beneficiaries any more in a rural area. In fact, rural areas often have plans with low

or no premiums and have all the same types of additional benefits that you might see in other areas. It really depends on where that floor payment is in terms of the amount of the additional benefits.

Mr. JOHNSON. Would competition lower the benchmark over years, do you think?

Ms. NORWALK. The benchmark is legislatively set and it really focuses on an update to either fee-for-service payments where Congress says the floor is X. Now, what does impact changes are the bids. The bids are intended to be competitive.

Mr. JOHNSON. You think the system is okay in that regard?

Ms. NORWALK. Well, I do think it does provide terrific extra value for Medicare beneficiaries. Many of them count on it, and particularly those who can't afford additional supplemental benefits, many who don't have the luxury of retiree coverage, for example. They, in particular, would miss additional benefits if there were plan changes, much like what happened after the Balanced Budget Act.

Mr. JOHNSON. It might be helpful to have information on clinical outcomes of patients as opposed to traditional Medicare which pays for whatever services are needed. Are there steps to move toward capturing that information?

Ms. NORWALK. I think we might be able to provide some of that. We do know a lot from a Medicare beneficiary survey we did a couple years ago about the ability to access providers, for example, the trouble of getting care, how easy it was to see a doctor, and so forth, as well as preventative services compared to fee-for-service. Uniformly across all measurements, the Medicare Advantage plans did a better job with their beneficiaries in making sure they had their preventive care, or it was easier for those beneficiaries to see a physician, for example, or they were more likely to have a regular doctor.

Mr. JOHNSON. It just costs more to go first class, doesn't it?

CBO indicates there will be consequences of lowering the payment and plans will leave the areas and beneficiaries will not have the options that they do now. So, it seems to me that the 65 billion that seems to be on the table for the taking is not free. Could you discuss that?

Ms. NORWALK. I do think it is an accurate assessment, if you look historically at what happened after the Balanced Budget Act, where they changed the payments, you found plans did a number of things before they pulled out. The first thing they did was they basically restricted their provider network, so fewer providers were available. They reduced the number of additional benefits that were available to plans, and then ultimately they pulled out of the market.

I can assure you, having talked to a lot of Medicare beneficiaries, they were incredibly irate at losing their Medicare Advantage plan. So, I do think that we, in looking at these payment streams, do need to consider what the ultimate effects will be.

Mr. JOHNSON. It probably would effect the rural areas first?

Ms. NORWALK. It will absolutely affect the rural areas.

Mr. JOHNSON. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. I would, Mr. Chairman, thank you.

I will begin by saying I don't know much about Medicare Advantage plans, they haven't been too prevalent in my market. Even though I have been a Committee on Ways and Means Member now for three terms, I have had very little traffic into my office to discuss Medicare Advantage plans.

I used to be an insurance commissioner. In fact, I am the only former insurance commissioner in Congress, so I am surprised that those that are advocates of Medicare Advantage plans filling the room today have not been beating a path to my office to discuss this interesting new dynamic of health insurance reimbursements and this value added to Medicare. It would have been obviously advantageous to them, I think, to begin the discussion with other Members of the Congress and the preceding Chairman at an earlier date.

That said, as I try to get a handle on what is represented in Medicare by the value of this extra payment, I am just not quite certain. We get extra benefits, some get extra benefits. Well, that is good. Is it equitable then across Medicare to offer a Medicare Advantage mechanism that gets some extra benefits while others don't get extra benefits?

Then other questions that will be before this Congress are, well, if you look at that extra payment providing these extra benefits to a few Medicare recipients, would that be—is there a more compelling aspect of health policy, for example coverage for children, where that money should be applied instead?

So, as we sort our way through this, your comments I found very interesting. You are the CMS director, so I don't suppose it is fair to ask you to weigh whether or not we should put the extra money here, plussing up a Medicare benefit for a few, or whether we should redirect it toward uninsured children. That really goes beyond what we pay you to do on our behalf as the CMS director.

I would say this, though. You are in charge of administering a Medicare system. Why should we find it compelling to continue to support Medicare Advantage plans and their extra cost when those not in those plans don't get those extra benefits?

Ms. NORWALK. I think it reminds me a little bit of the discussion we had during the budget hearing. How, if I recall, you were very unhappy with the variation in payment rates for fee-for-service. That, particularly if you look at Dade County or Miami, Florida, the payments there are significantly higher than the fee-for-service payments that you see in North Dakota.

Well, if you base the Medicare Advantage payment system entirely on Medicare fee-for-service, you end up perpetuating that differential. What the intention was with the MMA and having a rural floor was to close that gap between fee-for-service and Medicare Advantage, so that in rural areas of the country, we could provide benefits that normally you would see in very populated urban areas like Miami or in any number of other places across the country, where the fee-for-service rate was higher——

Mr. POMEROY. Actually, if I might just pursue this, I think you raised an interesting point. We are very concerned about this disparity in rural reimbursements. That led me to negotiate with the then Chairman about a $25 billion addition to rural reimburse-

ments under fee-for-service. In fact then Committee Member Nussle and I offered an amendment which was included in the MMA, plussing up those rural reimbursements. I incurred some dissatisfaction by some of my Democrat colleagues in supporting the bill.

Many of those provisions are expiring, having run their 3 years. It was contemplated at the time they would be reauthorized, but the 3 years are running out. Clearly, they have had a lot more to do about bringing fairness to rural reimbursements than Medicare Advantage.

Do you have a position on extending the 3-year authorizations that are expiring that were initially put in relative to rural reimbursement rates under the MMA?

Ms. NORWALK. Can I get back to you and get the official Administration position? I didn't ask that question before I came today. Perhaps I should have, but I didn't anticipate it.

[The information follows:]

The Centers for Medicare & Medicaid Services (CMS) has made a strong commitment to rural health issues and has made many significant regulatory and departmental reforms to address the needs of rural America.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included a number of provisions to enhance beneficiary access to quality health care services and improve provider payment in rural areas. The provisions in the MMA continued two payment policy trends that have increased rural provider payment rates in recent years: (1) an expansion of opportunities for rural hospitals to receive cost-based payments from Medicare and (2) an increase in rural PPS payment rates so that they are closer to urban payment rates. These provisions include the creation of a new Physician Scarcity Area bonus payment program along with an updated Health Professional Shortage Area bonus payment program, which reward both primary and specialist care physicians for furnishing services in the areas that have the fewest physicians available to serve beneficiaries; the development of a graduated adjustment/add-on payment for low-volume hospitals; the redistribution of unused resident positions, with hospitals located in rural areas receiving top priority for such positions; and significant improvements to the Critical Access Hospital program, including increased payments to 101 percent of reasonable costs and flexibility to use up to 25 beds for acute care.

CMS has also been directed to conduct a number of demonstrations focused on the delivery of care in rural areas. For example, section 409 of the MMA established a demonstration to test the delivery of hospice care in rural areas; section 410A of the MMA established a 5-year demonstration for up to 15 hospitals to test the feasibility of establishing Rural Community Hospitals; and section 434 of the MMA authorized a new demonstration project under which Frontier Extended Stay Clinics in isolated rural areas are treated as providers of items and services under the Medicare program.

Many of the provisions in the MMA were time limited but have been extended in later legislation, including the Deficit Reduction Act of 2005 (DRA) and the Tax Relief and Health Care Act of 2006 (TRHCA). CMS has worked expeditiously to implement all of the provisions in recent legislation, recognizing their importance to rural communities. Although the President's fiscal year (FY) 2008 Budget did not include proposals to extend the expiring rural provisions, CMS will continue to work with Congress to address disparities in rural reimbursement and to improve the quality and value of care delivered to all Medicare beneficiaries.

Mr. POMEROY. I would be interested.

Ms. NORWALK. Yes, absolutely.

Mr. POMEROY. I would like your acknowledgment. Obviously, that has much more to do about rural rate equity than Medicare Advantage; is that correct?

Ms. NORWALK. I think both are important in terms of rate equity, but I would not disagree with you that it is a critical piece, vis-à-vis——

Mr. POMEROY. For example, we have 104,000 Medicare recipients. We have 4,000 on Medicare Advantage. Obviously, fixing the Medicare reimbursement has much more to do with rural equity.

Ms. NORWALK. I think that is in part because the plans are new to North Dakota.

Mr. POMEROY. I am not saying where the future may go or whatever. I am asking you a specific question. Which is the bigger deal?

Ms. NORWALK. For today, that is correct. I would agree, your point today is correct—that it has a bigger impact today, but I think that over time, if the program was allowed to continue, Medicare Advantage would have a bigger impact in North Dakota because a lot of the plans that you have there today are new and beneficiaries haven't learned about them.

Mr. POMEROY. It is my understanding you are reimbursing agents significantly higher to enroll in the Medicare Advantage plans. How are companies enrolling? What are the market distribution reimbursements to get people into a Medicare Advantage plan? I have had insurance agents tell me it is a great deal.

Ms. NORWALK. Well, it probably depends on the plan and the broker. I can't speak to it generically, but I am more than happy to see if we can find some information and get back to you.

[The information follows:]

CMS Medicare Marketing Guidelines provide specific guidance regarding the use of persons employed by an organization to market a plan. Organizations that directly employ or contract with a person to market a plan must ensure through monitoring that all marketing activities comply with applicable MA and/or Part D laws and all other Federal healthcare laws.

The guidelines explicitly state that compensation structures must:

"Provide reasonable compensation in line with industry standard for services provided."

CMS is aware that organizations sometimes use performance-based compensation, tying compensation of a person performing marketing to the volume or value of the person's sales. As a result, the rate of payment may vary between an MA plan, MA–PD plan and a PDP. Based on a marketing representative's reasonable measure of service and industry standards, rate of payment may vary among one organization's plans and between competitors.

It is important to CMS that the beneficiary chooses a plan based on the beneficiary's needs as opposed to the financial interests of the person performing the marketing. Therefore, the rate of payment to a marketing representative should not vary based on the health status or risk-profile of a beneficiary.

Because an organization is required to use only a State licensed, registered, or certified individual to market a plan, if a State has such a requirement, CMS expects an organization to comply with a reasonable request from a State which is investigating a person that is marketing on behalf of a organization, if the investigation is based on a complaint filed with the State. CMS also encourages an organization to report a person that markets on the plan's behalf to the appropriate State entity, if an organization believes that the person is violating a State's licensing, registration, certification, insurance or other law.

Mr. POMEROY. Are those extra costs coming back into agent reimbursements?

Ms. NORWALK. No, all additional costs, 75 percent by statute, need to go back to the beneficiary. The additional 25 percent goes back to the trust funds.

Mr. POMEROY. Thank you.

I yield back, Mr. Chairman.

Chairman STARK. Ms. Tubbs Jones?

Ms. TUBBS JONES. Mr. Chairman, I seek unanimous consent to be skipped for this round if I can go up first on the next round.

Chairman STARK. You want to rest up a little?

Mr. Emanuel.

Mr. EMANUEL. I have one question, Ms. Norwalk. Mike Thompson had asked about this, so I want to follow up. He had talked to you about the actual benefits side and the payment. It deals with the reporting by Medicare Advantage plans.

We don't actually have any record of actual benefits that individuals are receiving. The question I have for you is, yet we are making the payments with no record. We know that the benefits exist, a la on paper, but as an option, as a potential, do we have any way of getting that information so we know that we are getting what we are paying for?

Ms. NORWALK. We have to know something, because we risk-adjust every beneficiary. So, the healthier beneficiary, somebody who is 65 and joins a Medicare Advantage plan, for example——

Mr. EMANUEL. I am more than willing to yield to the Chairman of you would like.

Chairman STARK. Yes, that isn't responsive. The risk adjustment just deals with the beneficiaries and their health status. It has nothing to do with the benefits they receive or the extra benefits. That is not used in the compilation of the risk adjustment.

Ms. NORWALK. Well, actually the point I was making, Mr. Chairman, is that in order for us to figure out what their health status is, we actually have to know something about the services that were provided to them.

Mr. EMANUEL. So, you think this information——

Chairman STARK. No, you don't.

Mr. EMANUEL. I am going to take back my time from both of you for 1 second.

Ms. Tubbs Jones, she can have also the first question next time if that works it out.

All right. How do we get to the fact of what actually are the benefits for the payment in a very specific way? Could you help me on that?

Ms. NORWALK. I will go back and check and find out exactly what it is that we have in-house to determine any number of things and just see what we could either do as a proxy, or see what we have specifically.

[The information follows:]

In 2007, enrollees in MA plans are receiving, on average, additional benefits with a value of $86 per month. Plans provide an average of about $108 in additional benefits, primarily cost sharing and premium buydowns, as well as specific benefits such as routine vision and dental care. Plans charge, on average, a monthly premium of about $22 for these benefits, yielding a net average value for enrollees of $86 per month.

The Centers for Medicare & Medicaid Services (CMS) monitors the care delivered by managed care organizations (MCOs) through the collection and analysis of standardized clinical performance measures and beneficiary satisfaction surveys. For this purpose CMS has been collecting MA data via Health Employer Data and Information Set (HEDIS), **Consumer Assessment of Healthcare Providers and Systems (CAHPS),** and Medicare Health Outcomes Survey (HOS) for nearly 10 years. Additionally, CMS has created the Complaints Tracking module, a tool that collects and tracks beneficiary complaints. CMS also collects data from MCOs in conjunction with the annual bidding process.

Mr. EMANUEL. The only worry we would have, and I don't think it is by party, I think it is more of a concern from a side point of being an advocate for taxpayers, we obviously don't want to be paying for a service if it is not being provided and only exists on paper. Okay?

Ms. NORWALK. I anticipate that one of the things that we could look at, for example, are appeals processes. So, if a beneficiary is in a plan and doesn't have access to a service, the beneficiary would complain about it.

Mr. EMANUEL. I think that is safe to assume.

Ms. NORWALK. Yes, it is safe to assume. So, that is one of the things that leads me to think that these plans are actually providing benefits.

Not only that, when we did the Medicare beneficiary survey that I referred to earlier, the information we have comparing Medicare Advantage to Medicare fee-for-service leads me to believe that they have a usual doctor, and so on and so forth, they have an easier time finding a doctor, and so forth.

So, whatever else it is that we have in-house, I am more than happy to figure out a way to provide that.

Mr. EMANUEL. Since you will look at that, just do me one favor as you ask other folks to look at it and get the information. The assumption if people aren't complaining about it, because that assumes, the assumption you made was that they then are receiving it because they are not complaining, it is a double negative, basically. Don't assume people know they have something. I couldn't tell you everything that my Blue Cross plan offers me in the Federal health employee system. Now, mainly because I don't have patience. My wife always said if we had a fourth child, we would name it Patience as a subtle reminder to me. I don't sit down and study it.

So, don't assume that folks are sitting there studying that, so therefore if they are not complaining, therefore they are receiving it. That makes a presumption I am not sure I would be comfortable with. Okay?

Ms. NORWALK. Fair enough.

Mr. EMANUEL. Thank you very much. I yield back.

Chairman STARK. Mr. McDermott, would you like to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman, for allowing me to sit in on the Committee and participate. I really come because when we put in the Medicare Advantage plans, we based it on fee-for-service rates. I come from one of those places where fee-for-service is considerably less than other parts of the country. That is true of Oregon and some plans in Minnesota, perhaps some in Wisconsin. I think it is important for the Committee to understand that the basing on fee-for-service in the area makes for huge inequities in this program.

So, part of what we are talking about here is not applicable to some areas of the United States like the Northwest. I think you would confirm that?

Ms. NORWALK. Absolutely. There is no question that a lot of what I wanted to bring to people's attention today is that the reason you have the legislated floors that we have, particularly in rural areas, was to address some of the variation that you see with

fee-for-service and to not carry that over into the Medicare Advantage program. So, that is correct.

Mr. MCDERMOTT. I would also like to put in a word for the floor in urban areas.

Ms. NORWALK. Likewise, the urban floor has made a very big difference. So, both the rural and urban floors, and I don't mean to put one over the other, but both have the same concept. Legislatively, let us make sure if there are disparities on the fee-for-service side, that we don't carry them over into Medicare Advantage.

Mr. MCDERMOTT. Any kind of proposal that would say, let us take a percentage reduction as though it was one program in the country would only increase the problems of areas like mine where we are barely making it with the floor.

Ms. NORWALK. I think that is correct. There are lots of difficult choices in front of this Committee. I think it is important that we appreciate all the different facts. We are more than happy to get for you, if you would like, some details about your State and all the specifics in terms of payments. If that would be helpful, we can provide that.

Mr. MCDERMOTT. I would appreciate it if you would provide the Committee with some estimate of what an across-the-board cut would mean to Oregon and Washington and Minnesota and several others.

Ms. NORWALK. We have that information by State and we are more than happy to give it to you.

[The information follows:]

Establishing an MA payment policy such that plan payment rates would not exceed 100 percent of FFS would adversely affect most counties in the United States. Only 5.5% of counties with about 7% of enrollment already have benchmarks established at 100% of FFS in 2007. Capitation rates in all other counties (94.5%) and for all other beneficiaries (92.7%) would be reduced. The counties where the impact would be the largest are the counties that were paid on the basis of either of the floors or the blend in 2004. These categories represent almost 2/3 of all counties and more than half of all MA enrollment.

In terms of specific impacts on Oregon, Washington, Minnesota, and other States:

- Preliminary estimates of the impact in Minnesota of limiting payment to 100 percent of FFS are **−$629 million** over 5 years (FY 08–12, effective 1/1/09). Ninety-four percent of Minnesota counties, with 98% of Minnesota MA enrollees, would likely have benefits or plan choices reduced under a proposal that limits payments to 100% of FFS.
- Preliminary estimates of the impact in Oregon of limiting payment to 100 percent of FFS are **−$1,836 million** over 5 years (FY 08–12, effective 1/1/09). Ninety-seven percent of Oregon counties, with 98% of Oregon MA enrollees, would likely have benefits or plan choices reduced under a proposal that limits payments to 100% of FFS.
- Preliminary estimates of the impact in Washington of limiting payment to 100 percent of FFS are **−$1,275 million** over 5 years (FY 08–12, effective 1/1/09). One hundred percent of Washington counties, with 100% of Washington MA enrollees, would likely have benefits or plan choices reduced under a proposal that limits payments to 100% of FFS.
- Preliminary estimates of the impact in California of limiting payment to 100 percent of FFS are **−$6,001 million** over 5 years (FY 08–12, effective 1/1/09). Ninety-eight percent of California counties, with 100% of California MA enrollees, would likely have benefits or plan choices reduced under a proposal that limits payments to 100% of FFS.
- Preliminary estimates of the impact in New York of limiting payment to 100 percent of FFS are **−$1,812 million** over 5 years (FY 08–12, effective 1/1/09). Ninety-four percent of New York counties, with 63% of New York MA enrollees, would likely have benefits or plan choices reduced under a proposal that limits payments to 100% of FFS.

Mr. MCDERMOTT. I would appreciate that. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. I am going to take a second round here if I may for a minute.

Ms. Norwalk, one of the statements that you made was that beneficiaries in Medicare Advantage enjoy extra benefits. I think the operative word there is enjoy. Now, it would seem to me to enjoy it, you have to use it. You also suggested that they are doing a better job and implied, because of incentives, that Medicare Advantage plans are doing disease management, care coordination, providing—not offering—preventative services. That they have good clinical outcomes.

I am going to ask you, and I would imagine half that second row behind you is CMS staff.

Ms. NORWALK. Bless them.

Chairman STARK, but it is my understanding that you have and receive absolutely no data on service utilization from any of the Medicare Advantage plans. Is that not correct?

Ms. NORWALK. Well, that has certainly been discussed here today. I am going to have to go back and find out exactly——

Chairman STARK. No, no, no. Stop.

Is there anybody back there in the CMS staff that can raise their hand and say you get any service utilization data? The fact is, you don't. It has never been required.

So, to even suggest that you know what kind of extra benefits are being used is fallacious. You don't collect the data.

Now, quit kidding us. They may put the data on their web, but if people aren't using it, if they are not paying for it, if they are not doing disease management, if they are not doing care coordination—and you don't know.

Ms. NORWALK. It certainly is in their best interest to do disease management.

Chairman STARK. Wait a minute. All right, look, what is in their best interest is profit. Let us not go down that road.

What I am suggesting is that—and it may not be important. I am not suggesting it, but to suggest to me that enjoying extra benefits, I understand that many of them may have it on their list and in their sales promotion. Certainly if you do have that utilization data, we would love to see it, but I am, I think, advised that it is not collected.

So, then I would like to go on one other area. That is, do you know, and if you don't will you provide us within the next week, how many marketing complaints? I am getting back to where Mr. Pomeroy was. How many marketing complaints have you received on Medicare Advantage plans? Can you tell us whether any of those people have been penalized? That would be of some interest. I don't care from whom, but——

Ms. NORWALK. I believe we responded to you in January about that very same issue with the full panoply of what we are doing. It concerns me greatly the abuse of marketing agents.

One of the things that we are doing with the National Association of Insurance Commissioners is we've got an MOU that has been out, I think 15 States or so have signed it, so that we can do

better coordination to make sure that marketing agents are properly reprimanded. Of course, they are State licensed. We have also been working very closely with the plans and if we find out that there is a problem with a marketing agent——

Chairman STARK. Well, I guess what I am asking you is have you found out any? Could we have some indication of how many complaints there have been? We hear of episodes, but that does not necessarily give us any idea of if there are marketing abuses.

Ms. NORWALK. I will update our January letter.

[The information follows:]

The Part C Complaints Tracking module (CTM) contained 242 complaints related to marketing for Medicare Advantage-Prescription Drug Plans from January 1, 2007 through mid-April 2007. Of these 242 complaints, 78 are still considered "open," while 164 are considered "closed."

Where appropriate, CMS takes corrective action against plans who have had marketing complaints filed against them. Since the fall of 2005, seven Medicare Advantage plans have had actions, including warning letters and corrective action plans, taken against them in response to marketing violations.

Chairman STARK. I would like to know the answer. On the assumption that there is no data collected on service utilization, my feeling is that that should be done. I don't think we can make any decisions on the value of these plans unless we know not what they are offering but what they are actually doing. I am more concerned about disease management, preventative services that are actually being carried out rather than just in the breach.

I would end my second round by asking two questions, I guess. If, as is suggested in one of the next witness's testimony, that 32 million people in round numbers are paying $25 a year extra in their part B premium to support the overpayments, as they are referred to, to Medicare Advantage plans, I fail to see the fairness in that. I would lead second to suggest that if these extra benefits, whatever they may be, are—and you have mentioned coordination of care, disease management, which we don't have in fee-for-service, but why not? If these benefits are, in fact, desirable, disease management, care coordination, preventative services, clinical outcomes data, then why don't we get busy to put them into the service of the vast majority that four out of five beneficiaries are using? That would be doing something for the entire country and I think would be fair. We may not be able to afford it right out of the box, but we could work toward that.

Doesn't that seem reasonable? That if these benefits are good, they should be in fee-for-service?

Ms. NORWALK. I actually have two points to that. The first is that all beneficiaries have the option of choosing a Medicare Advantage plan. That is one of the benefits that the MMA has done, it has given beneficiaries options when they didn't have them before.

To your second point, one of the programs that the MMA also added is the Medicare Health Support Program, or what was then called the Chronic Care Improvement Program. The intent of the program was to figure out how we could implement disease management and chronic care improvements and coordinated care and so forth in Medicare fee-for-service. Now, we have some pilot programs that are under way currently. If they end up providing some

positive results, I think that we would do that across the fee-for-service setting.

Chairman STARK. I will end this, but what you are in effect saying is the Government is encouraging people if they want extra services to go into the higher cost programs because, on average, 112 percent. Therefore, you are depleting the Medicare trust fund by encouraging people to move that way. The more that do it, the more financial peril you will put the Medicare Program into. That doesn't wash either, I'm afraid.

Mr. Camp, would you like a second round?

Mr. CAMP. I would.

Ms. Norwalk, I just wanted to say that there is a difference between—to follow up on some of the other questioning—between traditional fee-for-service Medicare and Medicare Advantage with regard to administrative expenses. The 3.2 billion in administration that CMS has is not factored into fee-for-service Medicare but is factored into Medicare Advantage plans; is that correct?

Ms. NORWALK. Correct. Yes.

Mr. CAMP. Also, the disease management, care coordination, prevention programs and others are important aspects of Medicare Advantage that could bring down costs in the future. Is that accurate?

Ms. NORWALK. Absolutely.

Mr. CAMP. The other point I would like to ask you about is that Medicare Advantage plans, according to your testimony, are required to collect and apply quality performance data to quality improvement and chronic care management projects; is that correct?

Ms. NORWALK. Correct.

Mr. CAMP. They are also required to——

Ms. NORWALK. Except I don't think private fee-for-service is, but the rest are.

Mr. CAMP. Medicare Advantage plans are required to collect quality data?

Ms. NORWALK. Generally correct.

Mr. CAMP. They are also required to make this information public?

Ms. NORWALK. Correct.

Mr. CAMP. That information can be used by beneficiaries in making a choice of whether or not to enroll in a traditional fee-for-service or Medicare Advantage plan?

Ms. NORWALK. Absolutely.

Mr. CAMP. Tell me if you could quantify the administrative expense in Medicare Advantage, what would that be?

Ms. NORWALK. I don't know that I have the number off the top of my head, but the administrative loss ratio would vary, I suspect, across plan types. Not only across plan types, but across individual plans. So, for those regional PPOs, for example, covering a wider area, they would have a more expensive administrative package because they need to contract with providers across a wider area. So, new plans have typically higher costs and those that are established would have lower costs.

Mr. CAMP. Following up on Mr. Stark's question, if there is something we need to address in fee-for-service Medicare, I would be interested in knowing what you think that is.

Ms. NORWALK. Absolutely. If I might get back to the Chairman for 2 seconds, if you would indulge me?

Mr. CAMP. Yes.

Ms. NORWALK. My crack staff pointed out that in terms of the additional benefits of the $86 additional on average, about $18.40 are the additional benefits. All of the rest of the benefits relate to cost-sharing. So, in terms of whether or not they are used, if you actually get a service, most of them buy down the amount of cost-sharing that you have, buy down the premium amounts, savings on the basic drug coverage and the like. So, the——

Chairman STARK, but if they got the service, but if they don't get the service, there is no savings in cost-sharing.

Ms. NORWALK. Well, for premiums there would be, obviously. So, premium buydowns and the like.

Thank you, Mr. Camp.

Mr. CAMP. Thank you.

If good value is or is not being provided for fee-for-service plans, what do we need to address in fee-for-service?

Ms. NORWALK. I think there is a lot that needs to be addressed in fee-for-service. Quality is top among them. Making sure that we are paying for quality services.

That is not to say that physicians don't all want to provide quality services, but oftentimes what we will see is, for example, the number of hospital readmissions that we have in this country, of the hospital admits, readmissions in 30 days, half of them haven't seen a doctor since they were discharged from a hospital.

A lot of things that are happening are far less likely to happen in the Medicare Advantage world because they are going to do better care coordination because it is in their best interest. So, I think there are a lot of things that we could learn from Medicare Advantage and it would be great to apply some of those in the traditional Medicare fee-for-service program. So that is just one example. I could come up with many if I had more time.

Mr. CAMP. All right, thank you. Thanks very much for your testimony.

Chairman STARK. If there are not any other Members who wish a second chance to inquire, I would like to thank you, Ms. Norwalk, for your patience and again apologize for keeping you later than I think you ever dreamed you would be here.

Ms. NORWALK. Thanks for having me on the first panel.

Chairman STARK. The second panel will consist of Dr. Mark Miller who is the executive director of the Medicare Payment Advisory Commission, who serves as our right and left hand in advising us in the intricacies of the Medicare system.

Dr. Peter Orszag, who is the director of the Congressional Budget Office.

Welcome, gentlemen.

Hi-tech testimony here.

Mark, I guess you are first on the list, so we will let you lead off. How is that? Whenever you are settled, proceed to enlighten us in any manner you would like.

STATEMENT OF MARK E. MILLER PH.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Dr. MILLER. Okay, Chairman Stark, Ranking Member Camp, distinguished Members of the Subcommittee, MedPAC is a congressional advisory commission charged with making payment recommendations.

Chairman STARK. Just one question. If you are as sight challenged as I am, are your slides—do I have them someplace? Okay, thank you.

Go ahead. I am sorry.

Dr. MILLER. MedPAC is a congressional advisory commission charged with making recommendations for both fee-for-service and managed care plans. When we make these recommendations, we try to consider three perspectives, assuring beneficiary access to quality of care, assuring that each tax dollar is well spent, and assuring that providers are paid fairly. When we make these recommendations, we also keep in mind that our legislative mandate asks us to consider what is necessary to pay an efficient provider.

The commission has long supported managed care plans as an option in Medicare. We believe that plans do have the flexibility to use care management techniques that fee-for-service does not have. We believe that if paid appropriately, they have the incentive to be efficient.

The commission supports a principle that Medicare payments should be neutral. That is, we should pay the same amount regardless of whether a Medicare beneficiary enrolls in fee-for-service or a managed care plan.

The current Medicare managed care payment system is not neutral to beneficiary choice and does not encourage efficiency. This is because it is based on an inflated set of administratively determined benchmarks that plans bid against. On average, those benchmarks are 116 percent of fee-for-service payment rates. That is the number that is the upper right-hand corner of your slide.

If plans bid below these benchmarks, and most plans do, they keep three-fourths of that payment to use for additional benefits. Under this system of benchmarks and bids, we estimate that on average plans are paid 112 percent of fee-for-service. That is the far right number in the second row of your slide.

It is important for you to understand that this 12 percent goes to additional benefits, but it is also important for you to understand that these payments are financed from trust fund, general revenue and beneficiary premiums, premiums paid by all beneficiaries regardless of whether they are in managed care plans or not. We estimate that approximately $2 per month is charged each beneficiary in Medicare to pay for the 12 percent above fee-for-service.

For these reasons and others, for the last several years, MedPAC has recommended that Medicare set the managed care benchmarks at 100 percent of fee-for-service. The commission recognizes that this proposal would create disruptions for some beneficiaries and plans and has pointed to the need for a transition, but at the same time, the commission recognizes that current enrollment trends toward the highest paid plans makes the situation more and more difficult to address as time goes on.

A second principle that the commission has embraced is that payments should be equal across plan types. Given the current system, we have very different payment levels across plans. For example, HMOs are paid 10 percent above fee-for-service. Whereas private fee-for-service plans are paid 19 percent above fee-for-service. Those are the two circled numbers on your slide.

This is based on where plans draw their enrollment from. As you have heard, different counties have different payment rates. That results in significant variation in what we pay and in what plans offer.

Furthermore, there are other differences among the plans in terms of administrative requirements. That gives some plans advantages over other plans. For example, regional PPOs are protected with risk corridors. Medical Services Account (MSA) plans do not have to return any money below the bid to the Treasury. Private fee-for-service plans do not have to report at the same level quality data and they are not required to create networks.

The commission has made recommendations to try and level the payments across plans. One of those recommendations was to eliminate the PPO stabilization fund. Other recommendations we have made are in the appendix of your testimony.

A third point that I would like to make is that there is some good news here. There is evidence that plans can be more efficient than fee-for-service. Again, you have sort of heard this. Plans that do submit bids to CMS that essentially say how much does it cost for us to provide the traditional fee-for-service benefit? Those bids vary from 97 percent of fee-for-service—sorry about that—97 percent of fee-for-service to 9 percent above fee-for-service for private fee-for-service plans. Let me say that again.

HMOs are able to deliver this benefit on average at 97 percent of fee-for-service, whereas private fee-for-service plans deliver it at 9 percent above.

To put this differently, private fee-for-service plans are not more efficient than fee-for-service and all additional benefits, on average, that they provide are through the additional payments.

In contrast, on average, HMOs are more efficient than fee-for-service and at least some of the additional benefits that they provide are provided through efficiency. We believe at the commission that it is this efficiency that we should be pursuing through our payment policy.

I know I am over or just out of time. In closing, I would like to say that given the long run sustainability problems in Medicare, we think that all steps should be taken to promote efficiency in fee-for-service and managed care plans. We acknowledge that there are efficiency losses in fee-for-service and much of the work that we do at the commission is designed to create policies to make fee-for-service a better operating system.

Similarly, we believe that we should be striving for greater efficiency among managed care plans and paying them more appropriately.

I look forward to your questions.

[The prepared statement of Dr. Miller follows.]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

The Medicare Advantage Program and MedPAC Recommendations

March 21, 2007

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

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Chairman Stark, Ranking Member Camp, distinguished Subcommittee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon 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).

[a]PFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare FFS rates.

[b]This 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.

[c]MSA 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).

[d]MA 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.

Chairman STARK. Thank you very much.

Dr. Orszag.

STATEMENT OF PETER R. ORSZAG, PH.D., M.SC., DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Dr. ORSZAG. Thank you very much, Mr. Chairman, Congressman Camp, other Members of the Committee.

I can be brief because many of the key points have been made, but let me just focus on three primary points.

First, Medicare Advantage plans have grown rapidly both in terms of enrollment and in terms of Medicare spending. You can see that in the uptick between 2005 and 2006. CBO now projects that enrollment in Medicare Advantage plans will continue to increase rapidly in coming years, rising from roughly 19 percent of Medicare beneficiaries this year to 26 percent of beneficiaries by 2017.

That projected increase is driven largely by CBO's expectation of very rapid 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 2007. Almost all of the difference between our March 2006 projection, which you can see on the screen, and the March 2007 projection is because we now expect much more rapid growth in private fee-for-service and, as the chart shows, in January alone almost 500,000 beneficiaries were added in the private fee-for-service sector of the Medicare Advantage program.

In terms of spending, payments to Medicare Advantage plans amounted to almost $60 billion in 2006. CBO projects that those payments will total $1.5 trillion over the 2007 to 2017 period, and that the share of Medicare spending on Medicare Advantage plans will increase from 17 percent last year to more than 25 percent in 2017.

Again, consistent with what I just said about enrollment, private fee-for-service plans will account for a rapidly growing share of Medicare Advantage spending with payments to such plans increasing from approximately $5 billion in 2006 to almost $60 billion in 2017.

The second point which has come up repeatedly already and I won't belabor it is that Medicare 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 program and, as a result, shifts in enrollment out of the fee-for-service program and into private plans increase net Medicare spending. Our estimates are roughly consistent with the ones that have already been presented by MedPAC, suggesting that payments to Medicare Advantage plans are approximately 12 percent higher than per capita fee-for-service costs this year.

Third, that cost differential underscores a number of policy options that would reduce spending in the Medicare program. I will mention two briefly.

The first option would be to reduce the county level benchmarks under Medicare Advantage to the level of local per capita fee-for-service spending. Relative to spending under current law, CBO es-

timates that this policy would save $65 billion over the next 5 years and $160 billion over the next 10 years.

In addition to this reduction in costs, reducing payment rates in this way would leave less money for health plans to offer reduced premiums or potential 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. Indeed, by CBO's estimates, enacting this policy would reduce enrollment in the Medicare Advantage program by about 6.2 million beneficiaries in 2012, or about half of the projected enrollment in that year.

I have also shown here the budget savings from other reductions that are less significant than going to 100 percent of local fee-for-service costs. One thing that I would point out is the fact that there are any savings at all in reducing to say 150 percent of local fee-for-service or 140 percent shows that there are some counties that are that high, in which the benchmark is that high relative to the average local fee-for-service costs.

Another option discussed in the testimony involves eliminating the double payments for indirect medical education. As you may know, under traditional fee-for-service, Medicare pays an additional amount to compensate for the costs associated with teaching hospitals. Those payments under the Medicare Advantage program are both included in the benchmark and then also paid for each Medicare Advantage beneficiary, so there is a double payment. CBO estimates that if you eliminated that by taking the Indirect Medical Education (IME) payments out of the benchmark in most counties, the reduction would be roughly $13 billion over the next 10 years.

I just want to conclude by noting that the primary, the central long-term fiscal challenge facing the Nation involves health care costs. There is a wide variety of evidence suggesting that health care cost growth can be constrained at minimal or no adverse consequences in terms of health for most Americans, and moving the Nation toward that possibility, which will inevitably be an iterative process, is essential to putting the country on a sounder long-term fiscal path. So, I would hope that changes to the Medicare Program would be evaluated with that broader perspective in mind.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Orszag follows:]

CBO TESTIMONY

Statement of
Peter R. Orszag
Director

The Medicare Advantage Program: Trends and Options

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

March 21, 2007

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Mr. Chairman, Congressman Camp, and Members of the Subcommittee, 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 (MA) 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 would result in potentially substantial savings to the Medicare program but also in a reduction in the supplemental benefits and cash rebates that plans can offer to enrollees and reduced enrollment in Medicare Advantage 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 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 Health 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 ser-

vices provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. Home health care may be covered by either Part A or 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 may be particularly attractive to people with relatively low income.[4]

About 75 percent of the Medicare beneficiaries enrolled in private plans are in health maintenance organizations (HMOs) or local preferred provider organizations (PPOs). The other main types of available plans are regional PPOs and private fee-for-service plans. 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. 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 under Medicare Advantage is wellness programs and case management services; those services are intended to promote bet-

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.

4. Research has shown that enrollees in Medicare Advantage plans tend to have relatively low income. See Adam Atherly and Kenneth E. Thorpe, Blue Cross and Blue Shield Association, *The Value of Medicare Advantage to Low-Income and Minority Beneficiaries* (September 2005), p. 4.

ter coordination and more effective use of health care. 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 at the time of service whether to accept a PFFS plan's terms of participation and thus agree to its payment rates, usually those of FFS Medicare.

In 2007, 82 percent of beneficiaries live in a county served by an HMO or a local PPO, up from 67 percent in 2005.[5] 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.[6] The government compares those bids with county-level benchmarks that are determined in advance through statutory rules. The benchmarks are the maximum payments that the government will make for enrollees in private plans.[7,8]

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5. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* (March 2007), Chapter 4, "Update on Private Plans," p. 248.

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

7. 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.

8. 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, *Report to the Congress: Medicare Payment Policy*, p. 248.

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, which are reduced by 25 percent of the amount by which their bid is lower than the benchmark and adjusted for the expected cost of enrollees, will be approximately 12 percent higher than per capita FFS costs. Benchmarks are updated each year by either the growth in national per capita Medicare spending or 2 percent, whichever is greater.[9,10]

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's cost of offering Medicare benefits must be low enough, relative to the benchmarks, to enable it to provide some combination of cash rebates and additional benefits. 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 often include care coordination and disease management programs to promote better use of services.

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9. 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.

10. 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.

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, utilization management, disease management, marketing, and reinsurance. 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 across 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). 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 FFS per capita spending, health plans' bids are about 10 percent below FFS spending. By contrast, in the lowest-cost FFS areas, health plans' bids are about 21 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.

That pattern of variation helps explain why 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] Private plans try to restrain medical costs by managing the level and intensity of service utilization. They have much 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 tends 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 patients from providers who do not participate in the network.

Table 1.

Private Plans' Bids for Providing Medicare Benefits Relative to Costs in the FFS Program, 2006

Average per Capita FFS Expenditures in Plans' Service Service Areas (Dollars)	Difference Between Plans' Bids and per Capita FFS Expenditures (Percent)	Plans' Projected 2006 Enrollment in Category (Percent)
More Than 750	-10	17
700 to 749	-2	9
650 to 699	1	16
600 to 649	4	20
550 to 599	8	24
Less Than 550	21	15
National Average	4	100

Source: Congressional Budget Office based on data submitted by private plans to the Medicare program for 2006.

Note: FFS = fee-for-service.

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 their payment rates 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 rebates returned 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 generally target rural and suburban areas of the country. In many places, PFFS and regional PPO plans are the only options for beneficiaries wishing to enroll in private health plans because of the higher payment rates relative to FFS costs in those areas (particularly in the rural counties with benchmarks at the floor amounts[13]) and the lack of competition from HMOs in markets where it is difficult to establish provider networks. PFFS plans

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.

may also find it difficult to compete in urban areas where the benchmarks tend to be closer to FFS costs. In general, and despite their access to Medicare payment rates, PFFS plans are not able to offer rebates or supplemental benefits as large as HMOs can because of the higher cost of doing business in the plans' operating areas and their lesser control over utilization (relative to HMOs').

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.[14] And because payments to Medicare Advantage plans are higher than payments made to FFS providers, the enrollment shift results in higher net costs for the program. 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.[15] That increase resulted from changes enacted in the Medicare Modernization Act that increased payment rates and added a 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).

That projected increase 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

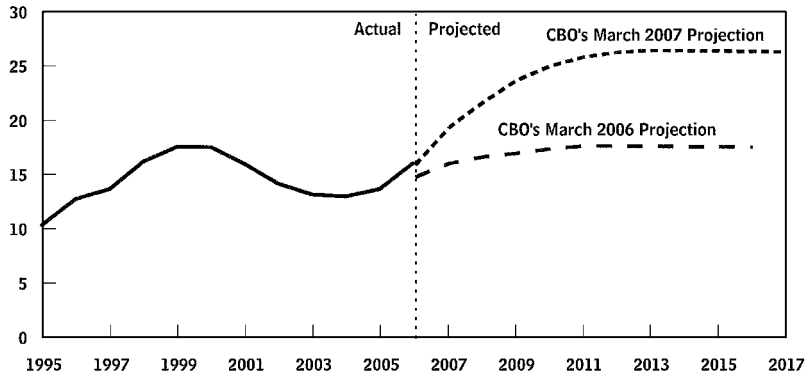
14. Those amounts include payments to group health plans besides Medicare Advantage plans (which include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans). Under current law, CBO projects, payments to those group plans outside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

15. That includes about 1 percent of beneficiaries (or about 600,000) who are enrolled in group plans besides Medicare Advantage plans.

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.

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 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 the 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.[16]

The 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,

16. Special needs plans were authorized by section 231 of the Medicare Modernization Act. Currently, about 820,000 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 beneficiaries dually eligible for Medicare and Medicaid, beneficiaries with chronic conditions, and beneficiaries residing in institutions.

Table 2.

Recent Enrollment in Medicare Advantage and Other Group Health Plans

(Thousands of people)

	Total, December 2005	Additions: During 2006	Additions: In January 2007	Total, 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 rural areas.[17] The growth of PFFS plans 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.

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, an annual average growth rate of 11 percent (see Table 3).[18] Spending in Medicare Advantage is projected to total approximately $1.5 trillion over that 11-year period.

Local HMOs and PPOs are projected to constitute the largest portion of spending throughout the budget window. According to CBO's projections, payments to those organizations will increase from approximately $54 billion in 2006 to approximately $63 billion in 2007 and $127 billion in 2017, an annual average

17. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 248.

18. 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.)

Table 3.

CBO's Baseline Estimates for Medicare Advantage

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	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

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. Enrollment growth is more rapid in the early portion of the period, with projected growth of 11 percent for 2007.

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. That increase represents an annual average nominal growth rate of

Table 3.

Continued

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

Source: Congressional Budget Office.

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

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

b. Does not include spending from the stabilization fund for regional PPOs or for certain demonstration programs.

c. Includes spending from the stabilization fund for regional PPOs and for certain demonstration programs.

d. 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.

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.

Regional preferred provider organizations have experienced slower enrollment growth than CBO expected in the March 2006 baseline. CBO now projects that such plans will eventually 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.

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.

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 now expects that rapid growth will 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 per-

cent (see Table 4). 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.

The changes in CBO's projections of spending for Medicare Advantage are largely accounted for by the changes in projections of enrollment. 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).[19] 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 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.[20]

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 $8 billion in 2008, $65 billion over the 2008–2012 period, and $160 billion over the 2008–2017 period (see Table 5).

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

19. 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.

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

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	-8.1	-12.2	-13.7	-16.2	-14.6	-16.8	-17.7	-18.5	-21.2	-20.8	-64.8	-159.8
Eliminate Double Payments for Indirect Medical Education	-0.7	-1.0	-1.1	-1.3	-1.1	-1.3	-1.4	-1.5	-1.8	-1.7	-5.2	-12.9
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.

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

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.

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—leaving total Medicare Advantage enrollment at about 6.5 million (and the program's share of total enrollment in Medicare at 13 percent), about 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 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 $38 billion over the 2008–2012 period and $95 billion over the 2008–2017 period. Capping rates at 120 percent of FFS costs would save $18 billion from 2008 to 2012 and $45 billion from 2008 to 2017.

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	-65	-160
105	-51	-128
110	-38	-95
115	-26	-67
120	-18	-45
125	-12	-29
130	-7	-19
135	-4	-11
140	-3	-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.

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 (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 FFS.)

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 equals per capita spending in the fee-for-service sector. Nevertheless,

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).

Medicare also pays the IME amount to teaching hospitals that treat patients enrolled in Medicare Advantage plans.

This policy would eliminate that double payment by removing IME payments from the benchmark in counties where the benchmark equals per capita spending in the fee-for-service sector. By CBO's estimates, such a change would save $1 billion in 2008, $5 billion over the 2008–2012 period, and $13 billion over the 2008–2017 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 payment 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. The choice of whether to eliminate the double payment 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 the evidence suggests that the 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 plans provide in managing utilization, the effect on health care costs overall, and the impact on beneficiaries.

Chairman STARK. I want to thank both of you.

Mark, in addressing the access issue in the service of low-income people in urban areas, my sense is that Medicaid, QMB and SLMB would be a far better financial deal for those low-income people if all the people who were eligible in those areas put into it, but I am somewhat puzzled as to what we would do in rural areas.

I am presuming that the rural areas would have at least primary care physician service and some hospitalization, either emergency rooms or available acute care, but how do you proceed to provide in the rural areas the advantages or perceived advantages of the better—and by better, I mean in terms of quality of services, preventive care and so forth—how do you cover that in the rural areas?

I want to say one other thing. Don't you have on your board—and I am sure they weren't all universally agreeing. You don't have to name your MedPAC trustees, but you have representatives who represent rural areas, rural hospitals, as well as urban centers. I presume that this was not a unanimous choice among your trustees to level the playingfield on Medicare. Maybe it was, but I presume it wasn't.

Dr. MILLER. I don't remember the specific vote, but it was overwhelmingly—there was an overwhelming majority that voted for this. That is one point.

Another point, you asked about the rural——

Ms. TUBBS JONES. Mr. Miller, could you put your mic down a little more, because we are having a hard time hearing you over here. I know you can hear me, because I talk loud.

Dr. MILLER. You can't hear me?

Chairman STARK. That mic is a little weak, so we will let you squeeze in closer.

Dr. MILLER. Now I can't remember the question.

The vote was—I got it—the vote was relatively unanimous on the payment rate.

You said something about rural representation. We don't try to and we don't think of people of rural, urban, but there a number of people on the commission who have a rural background and a rural experience and have dealt with rural issues through their careers. We don't try to categorize people rural, urban, but there are several people who have rural experience.

Then I think your question was, how do you deal with these benefits in rural areas. A couple of things. We have made a series of recommendations on the fee-for-service side in order to begin to take the fee-for-service sector toward a more accountable and measurable outcome, with the hope that behind that, Medicare's fee-for-service payments will also begin to reflect that. So, that if physicians practice conservative medicine and practice medicine that results in providing preventive benefits, they would be paid more or hospitals would be paid more. That is certainly one way to go at it.

Another thing implied in your question is really, if this is a question about expanded benefits for people in rural areas or low income people or whatever the case may be, I think the question, the way the commission would go at the question is, what is the benefit

that we are getting? Who is eligible for it? How should we pay for it?

If this mechanism of five different plan types, paying different amounts of money, providing different benefits packages, I think the commission's view of that would be this is not a particularly targeted way of doing that.

You mentioned these other programs like the QMB and SLMB programs which would be available to beneficiaries whether they are in urban or rural areas and arguably are more targeted.

Chairman STARK. One more question. You do not, as I understand it, call for the benchmark of these Medicare Advantage plans to be immediately dropped to 100 percent? I think you have some different recommendations of how we could ease down over time to approach over time getting to parity or getting to 100 percent. Can you explain what you have in mind there?

Dr. MILLER. Yes, and it is not real complex. We have started to have—we made this point when we made the recommendation. We have discussed it actually some in our last meeting, but just think about it logically. There are sort of three ways you could proceed, and there are all kinds of variants but just to keep it relatively straightforward, you could freeze the rates at their current levels and let fee-for-service catch up. That would be a very long transition and that might be viewed as a positive thing, but on the other hand, it means that the highest paid areas would remain the highest paid for the longest.

A second strategy you could use is to bring all of the rates down at the same rate. So, if you are at a high 140 percent county, you come down at the same rate as, say, a 110 percent county. There again, that has the virtue of being equal across all of the areas, but probably leaves the highest cost areas alone the longest.

The third, and you can figure this out logically where I am going, the third is that you come down fastest on the highest areas. So, you bring the 1forties, the 1thirties down faster and then you pick up the twenties and the 10s as you come down. That would have the effect of hitting the highest cost areas immediately and the lower cost areas later.

Chairman STARK. Thank you.

Mr. Camp, would you like to inquire?

Mr. CAMP. Thank you, Mr. Chairman.

We have had a lot of testimony about Medicare Advantage plans providing disease management and there have been several examples that show that those programs have reduced costs, emergency room visits, hospitalizations and even some procedures. Did CBO take into account the ability of Medicare Advantage plans to control program costs by managing chronic disease? Something that a traditional fee-for-service program is not able to do?

Dr. ORSZAG. Briefly, yes, but let me make three quick points. The first is that CBO, in other contexts, has looked at disease management and other programs like that. The evidence is often not as compelling in terms of cost reduction as some reports would suggest. We are always welcoming more evidence on that.

The second thing, actually I will just make two points. The second thing is, as I mentioned in my testimony, most of the growth that for example explains the difference relative to last year in our

projections involves private fee-for-service plans where many of the care coordination and disease management programs are at least a less salient feature of their activities.

Mr. CAMP. Well, certainly it is going to take some time before you see cost savings, in that it is a long-term project. This is part of my problem with MedPAC's recommendation, is that I don't think that the programs are inherently comparable because they are different programs. Yet MedPAC continues to suggest that one is paid differently than the other without really taking into account, in my view, the difference in the two programs.

So I guess I would like your comment on that, Dr. Miller.

Dr. MILLER. I think there are a couple of things to say there. I think some of the thinking at the commission is that managed care plans, the idea behind them is that they come in using, let us just say for the moment, a closed network and care coordination techniques and should be able to underbid fee-for-service.

When we talk about using fee-for-service as a standard, we don't necessarily think it is a great, well functioning program, but why would you actually go and pay more for something that is not functioning as well as fee-for-service?

So, the philosophy works like this. That if the managed care plans come in, and can actually underbid fee-for-service, they can use that money to provide additional benefits, attract beneficiaries to fee-for-service, and grow their enrollment. We do see them as very much operating different types of care, but we think that the payments and the ability to do the additional benefits should come from efficiencies.

There is one other point that I would like to make. I think there is another concern on the part of the commission that you will hear this, that plans will say, I know you are paying a lot now but we will be efficient in the future and you will save money. There is a feeling among the commissioners that there is not a lot of incentive to produce efficiencies in a system where plans are being paid this much.

Mr. CAMP. Dr. Orszag, which areas of the country would be affected the most by your assumption of a 100 percent benchmark as a percentage of fee-for-service costs? How would that affect the country, not only geographically but also what populations of the country would be affected and how?

Dr. ORSZAG. In Table One of our testimony, we provide some evidence or some information about the distribution of, for example, the difference between plan bids and per capita expenditures. There is related information on the ratio of benchmarks to average fee-for-service costs, but clearly, the distribution will mimic to some degree what you saw with Ms. Norwalk's charts about the distribution of where Medicare Advantage beneficiaries are. It is also important to remember that Medicare Advantage costs vary, or bids, I should say, vary a lot less across the country than fee-for-service costs do. So, in high fee-for-service cost areas, you tend to see Medicare Advantage bids that are not as high than in the lower cost areas.

Mr. CAMP. So, just to summarize, which areas of the country would that be?

Dr. ORSZAG. That will often—well, it depends, but it will often involve many of the things that we mentioned in the testimony. It include rural areas and other areas where the previous floor payments are still significant.

Mr. CAMP. I realize my time has expired, but just to finalize, how many seniors would lose their Medicare Advantage plans if the benchmark were at 100 percent?

Dr. ORSZAG. As I mentioned in my oral testimony, by 2012, if you move to 100 percent of fee-for-service in each county, we project that Medicare Advantage enrollment would be roughly 6 million people lower than in our baseline, and that is about a 50 percent reduction.

Mr. CAMP. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Ms. Tubbs Jones, who cut a deal. Forbearance last time earns her second spot.

Ms. TUBBS JONES. It is okay, I cut a deal, Mr. Chairman. Thank you very much for holding to the deal.

Dr. Miller, how are you this afternoon?

Dr. MILLER. Okay. How about you?

Ms. TUBBS JONES. I am blessed, thank you.

I come from Cleveland, Ohio. In Cleveland, according to the Census statistics, 13 percent of the individuals age 65 and older are below the Federal poverty line, and 56 percent of the population is African American, 2 percent Hispanic.

I want to make inquiries of you with regard to the impact that the cuts to Medicare Advantage plans will have on the delivery of health care services to the minority populations in my congressional district and across the country. What is your assessment of what impact that will have, sir?

Dr. MILLER. I don't have a specific impact by minority status or income status, but I think that your point is taken. It is correct that in areas that are currently paid, where the counties are currently paid well above fee-for-service, and I don't know your area specifically, but there may be a floor in place there, it is likely that plans will have to scale back their benefit packages or, in fact, have to pull out.

What I would like to say is that we have looked at the data and we believe, and this is a point that I was trying to make with the slide, there are managed care plans now and they have, on average, and they have a lot of the enrollment now, they are able to deliver fee-for-service benefits below what the fee-for-service program provides. That means that there would still be plans that are able to provide benefits and able to provide additional services.

Ms. TUBBS JONES. Mr. Miller, were you around back in 1997 when the Medicare Advantage plans left Ohio and left people high and dry with no kind of health care at all, sir?

Dr. MILLER. I was around when the plans exited, yes.

Ms. TUBBS JONES. You realize how many people were left out there, aged people, concerned about what doctor they would go to, who would they see, how would they be covered.

I want to, before you go on, are you familiar with a doctor by the name of Kenneth Thorpe, sir?

Dr. MILLER. Yes, I am.

Ms. TUBBS JONES. From Rollins School of Public Health, sir?

Dr. MILLER. I know where he is.

Ms. TUBBS JONES. Are you familiar with his research?

Dr. MILLER. I have seen a letter that he did for Blue Cross Blue Shield.

Ms. TUBBS JONES. Even though it was done for Blue Cross or Blue Shield doesn't mean that his research isn't of value, though, right?

Dr. MILLER. I am just saying that is what I saw.

Ms. TUBBS JONES. Yes, but I am just trying to make the record clear that just because it was done for Blue Cross or Blue Shield doesn't denigrate his research at all?

Chairman STARK. Would the gentlelady yield just on that point?

Ms. TUBBS JONES. Yes.

Chairman STARK. I have a letter from Mr. Thorpe here expanding on that. I would like to make it a part of the record and I will share it with you.

Ms. TUBBS JONES. I thank you very much, Mr. Chairman.

[The information follows:]

ROLLINS SCHOOL OF PUBLIC HEALTH

Kenneth E. Thorpe, Ph.D.
Robert W. Woodruff Professor & Chair
Department of Health Policy & Management

EMORY

March 21, 2007

Pete Stark
Chairman Ways and Means Subcommitee on Health
239 Cannon House Office Building
Washington, DC 20515

Dear Chairman Stark:

Thank you for your March 20, 2007 letter asking me to clarify the implications of my work on Medicare Advantage enrollment and more specifically on policy changes to the Medicare Advantage payment rates.

My most recent work for the Blue Cross Blue Shield Association (dated September 20, 2005) was a descriptive piece examining the characteristics of Medicare beneficiaries that select Medicare only, Medigap and Medicare+Choice plans (now Medicare Advantage). By itself, the paper does not comment on the policy choices involving the Medicare Advantage payment rates. The paper is purely descriptive in nature. The major conclusions in that paper were that beneficiaries not Medicaid eligible, and do not have access to employer-sponsored insurance, 53% of Hispanics and 40% of African-Americans selected Medicare+Choice plans. Both are higher proportions than selected Medigap and for Hispanics Medicare+Choice was the most popular of the three choices (Medicare only, Medicare+Choice, Medigap). The paper also examined enrollment trends by education and income.

The Medicare Prescription Drug,Improvement, and Modernization Act of 2003, Public Law 108-173 provided for several new plans including regional preferred provider organizations (PPO)s and special needs plans. The legislation also added a fourth category for determining increases in payments to MA plans (in addition to a blend, floor or 2% it added a projected increase in fee-for-service Medicare costs (excluding direct medical education and including a VA/DoD adjustment). This fourth category was designed to increase payments to MA plans, and with it the expectation of higher enrollment. As a result of the change, payments to MA plans have increased from approximately 107% of fee-for-service costs in 2004 compared to 112% today according to Medpac. The increased spending in the program has resulted in an increase in supplemental benefits, and with it an increase in enrollment. Today over 7.4 million Medicare beneficiaries are enrolled in MA plans--about the same share as the program's peak in 1999.

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I now turn to address your specific questions.

1. *Does your analysis on the participation rates of minorities in MA plans include any specific recommendations regarding MA payment rate policy?*

The short answer is no. We simply examine the demographic characteristics of Medicare beneficiaries that enrolled in Medicare only, purchased a medigap plan, or enrolled in Medicare+Choice (our original analysis used the most recent data we had—2003).

2. *Can your work in this area be fairly and accurately portrayed to mean that you oppose any reductions in payment rates to private plans?*

My work is really just descriptive and my views of changes in payment policy are not addressed in this work. I will address prospective policy changes in the MA program below.

3. *Do you believe there are appropriate savings to be achieved from the elimination of the stabilization fund and from equitable payment rates to PFFS plans?*

These are both areas that make sense for Congress to examine closely for potential savings. The stabilization fund was established to provide plans with incentives to remain in MA regions. It is not currently being used, and would be a fruitful area for achieving savings. My preference would be to use any savings from the fund (about $3.5 Billion over the next 10 years) to reinvest in health care.

With respect to PFFS, their payment rates were increased by Congress to create more opportunities for rural beneficiaries to join plans with augmented benefits (like their more suburban and urban counterparts). However, PFFS plans also receive among the highest payments relative to fee-for-service. Moreover, they do not perform care coordination—a critical direction the Medicare program needs to address more systemically. Properly balanced, a more equitable alignment of PFFS payments with the remaining portion of the MA program seems reasonable.

4. *Would any such reforms to the stabilization fund and PFFS plans have a detrimental and disproportionate impact on minorities?*

Our analysis relied on 2003 data, and did not specifically include either PPOs or PFFS plans. My sense is given their geographic locations (Wisconsin for instance) the impact on minority populations may be small. To my knowledge, though, we have little, if any, information on the demographics of who enrolls in these plans.

5. *Are there any savings to be achieved in MA plans that are worthy of consideration, and is there a balance policy makers should strive for?*

There are several areas that would be worthy of exploration—I have already noted two, the elimination of the stabilization fund, and aligning PFFS payments with rates ultimately paid to HMOs in the program. Reductions in payments to HMOs could generate substantial savings. Under one scenario examined by the CBO, paying MA plans at 100% of local fee-for-service rates would generate nearly $65 Billion in savings between 2008 and 2012.Any reductions in payments to HMOs in particular should balance the trade-offs. On the one hand, there are substantial savings to be achieved. On the other hand, reduced payments will lead to fewer supplemental benefits and less enrollment in the plans. Changes in plan payments implemented under the BBA of 1997 are illustrative of the potential impacts of these policy changes (in this case, payments to most plans were capped at 2% during a time of high cost growth)—enrollment declined from 6.9 million in 1999 to 5.5 million by 2002 and 5.3 million by 2003. These reductions, however, contributed toward the move to balance the budget.

ROLLINS
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Kenneth E. Thorpe, Ph.D.
Robert W. Woodruff Professor & Chair
Department of Health Policy & Management

EMORY

March 12, 2007

Alissa Fox
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association
1310 G Street, NW
Washington, DC 20016

Dear Alissa:

You asked me to estimate the impact of potential Congressional proposals to cut funding for Medicare Advantage (MA) by limiting payments to county-level costs under traditional Medicare. This letter includes some of the preliminary findings from a forthcoming paper that will assess the impact of such changes on Medicare Advantage enrollees.

Medicare beneficiaries join Medicare Advantage plans because they provide lower cost-sharing and additional benefits compared to those in traditional Medicare. Setting Medicare Advantage payments at the level of county costs under traditional Medicare would result in a reduction in benefits and cause enrollment in Medicare Advantage to decline.

Our model predicts reductions in Medicare Advantage enrollment that are similar – though potentially larger – than those observed in the period following enactment of the 1997 Balanced Budget Act, which limited payment increases to only 2 percent for most plans during a period of high medical cost inflation. During this period, nearly two million beneficiaries lost their health plan coverage. Preliminary findings from the research indicate that:

- **Three million MA enrollees – roughly one-third of current MA members – would lose MA coverage** due to increases in premiums, reductions in benefits, or withdrawal of their MA plan.
- **More than one million of those who would lose coverage would go without any additional coverage.** These beneficiaries would face higher cost-sharing and fewer benefits than they currently receive with their MA plan.

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As my previous research has indicated, Medicare Advantage plays a critical role in providing affordable coverage to low-income and minority beneficiaries. The program is particularly important for low-income beneficiaries, because it provides protection against the high cost-sharing in traditional Medicare. My 2005 research on this topic found the following:

- **Medicare Advantage disproportionately covers low-income beneficiaries:** 35.6% of Medicare eligible beneficiaries with incomes below $10,000 annually and 37.8% of those with incomes from $10,000 to $20,000 without Medicaid or employer coverage enroll in Medicare Advantage plans.

- **Medicare Advantage serves a high proportion of minority beneficiaries:** 40% of African American and 52.9% of Hispanic beneficiaries without Medicaid or employer coverage rely on Medicare Advantage, as compared with 32.7% of non-Hispanic, white beneficiaries.

My forthcoming paper will evaluate in greater detail how proposed cuts will impact minority and low-income beneficiaries and reduce geographic access to Medicare Advantage plans.

The Medicare Modernization Act provided additional funding to Medicare Advantage to stabilize the program and expand its geographic access. This additional funding has increased the dollar value of supplemental benefits relative to those offered prior to the MMA. While reducing MA funding could generate savings to the government, these savings would come at the expense of reduced benefits for MA enrollees and loss of coverage options, particularly in rural areas.

Sincerely,

Kenneth Thorpe, Ph.D.
Department of Health Policy & Management

Ms. TUBBS JONES. I thank you very much, Mr. Chairman.

I just want to refer to some of his research. Thanks, everybody. I got the letter, too. One of my eyes in my glasses is out, so if I don't read it—as a matter of fact—thanks.

I want you to go to the back of the letter. The back of the letter says that my 2005 research on this topic found the following, that Medicare Advantage disproportionately covers low-income families and that Medicare Advantage serves a high proportion of minority beneficiaries.

Then on the front of the letter it says that if you reduce the cost to these Medicare Advantage programs, we are going to find ourselves in a similar situation as 1997.

The reason that we created or that we went into this new proposal for health care coverage for seniors was it was to deliver better services to the seniors. The Medicare Advantage programs cover seniors who don't fall into the—and I don't know these acronyms—SLMB and QMB. So, that means they are just above the low-income level that QMB and SLMB cover.

Meaning that if you take out Medicare Advantage programs or you address or deal with that funding problem, you are targeting a group of folks who have nowhere else to go.

I am sure I am almost out of time, so I will give you whatever time I have to answer my question.

Dr. MILLER. Okay, I think there are three things to say. We have not independently gone through these numbers, but you did hear some of the exchange at the beginning. There are a couple of different ways you can do this analysis and I think Ken's analysis very much focuses on a specific income group and then eliminates people who either would be eligible for Medicaid and have employer coverage and then calculates his numbers. I think it is just important, because there is confusion and there are different ways that one can calculate this number.

To that point, we haven't independently done it. So I don't——

Ms. TUBBS JONES. You haven't done it.

Dr. MILLER. That is——

Ms. TUBBS JONES. Let me finish. Experience says to you that if you close down the Medicare Advantage programs, there is a population of people who are without health care coverage and they are a population who have chronic health problems that are not covered by other health care plans.

Dr. MILLER. Well, just to be clear, they are not uncovered. They are eligible for Medicare. For traditional Medicare, first point. The second point that I would like to make is that what this comes down to in terms of an argument is a benefit expansion for a group of people.

I think if the Congress is interested in a benefit expansion for low-income beneficiaries, and this is part of the exchange that was over here, I think the question is what benefit, who is eligible and who pays?

What is happening right now with these particular plans are, you have very different benefit packages, you are paying very different amounts of money. I think this is really important, it is not just available to the low income. A person of high income can also enroll in these plans.

Ms. TUBBS JONES. I am not arguing that high-income folks can't enroll in the plan and high-income folks are not my worry, because high-income folks can buy whatever kind of health care they want to buy. All they have got to do is walk up to the Cleveland Clinic and say, I want to buy a heart or I want to buy whatever it is.

The concern that we are talking about right now is the people who are at the lower echelon of income, who most often have access and need for programs like this. See, understand, I am one of those who support providing health care to everybody and we figure out how we pay for it, but in light of one of the fact that I am one of the few people that support that kind of process, we are stuck with 7,000 different types of plans and it is as a result of your recommendations and others who said that this is the way we ought to do health care, that we ought to package it out and sort it out and different people get different things and pay different money.

So, all I am saying to you, Dr. Miller, is before we go down the road of changing what we have right now, let us make sure we don't change it on the backs of low-income and minority people who already receive disparate health service and access to health care. All the studies say that. That is all I am saying to you, Dr. Miller.

Dr. MILLER. I understand your point.

Ms. TUBBS JONES. I am out of time. I thank you very much for the opportunity.

Dr. MILLER. I understand your point.

Chairman STARK. Mr. Hulshof, would you like to inquire?

Mr. HULSHOF. Thank you, Mr. Chairman.

I would say to my friend from North Dakota that I have just been copied by your scheduler, and she has been inundated with schedule requests for you.

Dr. Miller, just a couple of—see if you agree with these statements. I recognize the time. I will stick to my 5 minutes.

Does MedPAC believe that Medicare beneficiaries should be able to choose between the traditional program and the alternative delivery systems that private plans can provide?

Dr. MILLER. Yes.

Mr. HULSHOF. Does MedPAC believe private plans may have greater flexibility in developing innovative approaches to care?

Dr. MILLER. Yes.

Mr. HULSHOF. Does MedPAC believe 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?

Dr. MILLER. They have the potential to do that, if they are paid in a way that drives that, yes.

Mr. HULSHOF. No trick question. I took this exactly out of—this is your testimony. I just wanted for the record to underscore those points.

Dr. MILLER. Right.

Mr. HULSHOF. In the few minutes I have left, Dr. Orszag, you said no compelling cost reduction based upon the chronic disease management or preventive care. So, there are some cost reductions but what does not compelling mean? Or elaborate when you said

in your response or perhaps in your testimony there have not been compelling cost reductions that you have seen at CBO?

Dr. ORSZAG. CBO has done a review of disease management, the literature on disease management programs. I want to emphasize, we would welcome additional evidence and additional studies.

The cost impact as opposed to perhaps the quality impact, the cost impact from disease management programs has not been overwhelmingly proven. Which is why, in a lot of CBO scoring and other things, those programs often do not yield cost savings.

Mr. HULSHOF. In the period of time, and perhaps we can do this via letter or maybe later conversation, the period of time that you considered would have been what period of time to determine cost savings?

Dr. ORSZAG. That was a CBO report that was based on the available literature over varying periods of time.

Mr. HULSHOF. Okay, I will get back with you on it, because what I am mindful of is that it took an act of Congress for us to force traditional Medicare to have preventative care like colorectal screenings, pap smears, mammograms and a host of other things, it took an act of Congress for us to put that into law. It took another act of Congress for us to have this pilot program Ms. Norwalk talked about as far as chronic disease management. That, of course, was just recently done. So I think the period of time that CBO included is important.

This is not a criticism of you or anybody at CBO. In 1997, we cut the capital gains tax rate and we heard from joint tax Committee, here is what we expect the revenue impact to be, and it was wildly off, just as it was again in the most recent reduction of the capital gains rate. That is again—you are bound, as we are bound by you, as your official scorekeeper for us, we are bound by the limits to which human behaviors or what have you are included in your assumptions.

So, again, maybe now is not the time——

Dr. ORSZAG. If I could just add very quickly, one of my key priorities over the next several years is to expand CBO's health work. We have formed a new panel of health advisors. We are going to be revisiting all of the evidence on these key topics. I would again welcome additional evidence. I was just reporting what CBO has found thus far.

Mr. HULSHOF. Very good. The last few minutes I have is to underscore again, because I had pulled out on page 15 and 16, and you have touched on this briefly, and that is eliminating double payments for IME, indirect medical education.

Dr. ORSZAG. Yes.

Mr. HULSHOF. Now, again, the idea was payments to teaching hospitals in the traditional fee-for-service sector should include this adjustment to account for the fact teaching hospitals often have greater expenses than other hospitals and often treat more complex conditions. Is that an accurate statement?

Dr. ORSZAG. That is correct.

Mr. HULSHOF. Now, one of the proposed suggestions you have for us as policymakers is to eliminate the double payment. Often the teaching hospitals, I understand it then, are getting the IME

amount to treat patients that are enrolled in Medicare Advantage; is that right?

Dr. ORSZAG. That is correct.

Mr. HULSHOF. All right. So, we are actually talking about reducing the IME payments to the teaching hospitals, or just the way that we are using the county benchmarks?

Dr. ORSZAG. The option that I provided to you is to take the IME payments out of the benchmarks in the counties where the fee-for-service spending was the binding constraint on determining that benchmark in 2004, 2005, or 2007. The Administration has proposed, instead, doing it on the other side. That obviously could have different incidents and different results.

Mr. HULSHOF. Thanks for that. I will yield back to the Chairman.

Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Miller, in your SGR report, didn't you say that capitated payments would help encourage more efficient health care?

Dr. MILLER. Yes.

Mr. JOHNSON. Medicare Advantage plans, I think, provide those kinds of incentives for efficiency, isn't that true?

Dr. MILLER. That is also what I said here. They can, given the way that they are structured, they definitely have the potential for efficiency gains if they are paid an appropriate amount.

Mr. JOHNSON. So, if CBO is right and these plans will leave if we take away the extra payment, which means extra benefits, how can we make sure all Medicare beneficiaries are encouraged to sign up for anything? Plans are going to leave them and they will lose benefits. Is that true or not?

Dr. MILLER. What my response to that would be, is that again, through our analysis, we think that there are plans currently available that can provide the benefits—can provide services that are more efficient than fee-for-service and still provide additional benefits on top of that. It will not be as many plans as are currently available, and plans will probably have to adjust their benefit packages, but there are plans that can provide additional benefits even under 100 percent benchmarks.

Mr. JOHNSON. Well, are there any particular parts of the country that would be affected more than others?

Dr. MILLER. Yes, this was touched on earlier. Any part of the country that has the so-called floor counties, which are counties where the payment rates are set very high above fee-for-service, for example, they can be as high as 140 percent and even more than that in some instances, areas like that which can be rural areas, but there are also urban areas, certain urban areas that have what is called an urban floor. Those payment rates are set well above fee-for-service. Those would be the areas that would probably feel it first.

Mr. JOHNSON. Okay, but you can't predict for certain what will happen, can you?

Dr. MILLER. The reason that you can't is because plans could respond in a number of ways. Plans could respond by running tighter coordinated care programs and trying to become a more effi-

cient entity. Or they could respond by leaving the program. That is why it is difficult to predict.

Mr. CAMP. Will the gentleman yield for just a minute?

Mr. JOHNSON. I yield.

Mr. CAMP. I just want to follow up on something Mr. Johnson is saying which is, you say that capitation is good because it brings efficiencies into the system.

Without the enhancements of additional services, why would anyone go into a capitated plan? That is the real problem with your testimony today.

Dr. MILLER. I hear you. I think a couple of things. I just go back to a point that I was making. There are some plans, and I put that slide up, there are some plans that right now can deliver traditional fee-for-service benefits more efficiently than fee-for-service. For many, that was the going in proposition of managed care plans. In theory, they should be able to do that. If they are coordinating care, they should be able to be more efficient. Then, with that efficiency, provide the additional benefit to the beneficiary, bring more beneficiaries in and work in that way. That is the underlying assumption.

The other side, just to try and respond to your question, I think the dilemma the commission sees to the way that you have constructed the question is, if you set the higher payments out and you bring people in through these benefits and ultimately the program can't sustain it, it is two problems. What motivation do I have as a plan to be efficient if I am being paid well above fee-for-service? Two, if in the long run we can't sustain those payments, then basically we have brought plans and people in and then had to pull the rug out from under them again.

Mr. CAMP. I just wanted to make the point. It is Mr. Johnson's time. So, I yield back.

Mr. JOHNSON. Thank you for your comment.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Johnson.

Mr. Pomeroy, would you like to wrap up for us?

Mr. POMEROY. Thank you, Mr. Chairman.

I think there may have been value in the Medicare system in terms of trying private sector ways of getting the benefit out to achieve greater cost savings and efficiencies, but if that was the case, you would expect it to save money, not cost you more money.

If, on the other hand, the rationale for Medicare Advantage is we want to extend benefits, then you would think you would do it in more of a systemic way or systematic way than the randomness of just having various private sector plans right in various areas and you hope they get a little better benefit.

To me, it falls short on each point of analysis. It is not saving us money and it is not delivering in a broad based way extra benefits.

On the other hand, I feel badly about turning course again. For those people that are involved, including 4,000 in my district, and more than a million nationwide, they are about to see the world change again. This jacking around into a plan, out of a plan, into a plan under promises and having the promises be cut because of Congress's action, that is all very regrettable. For some that are

getting almost a Medicare supplement type benefit now with their Medicare Advantage, maybe my colleague Tubbs Jones's constituents that can't afford a Medicare supplement, they are going to be hurt. Again, that is terribly regrettable, too.

The prospects of taking maybe these extra benefits that some are benefiting from and trying to do it across the system would get quite expensive. Dr. Orszag, do you have any notions in terms of how increasing systemwide the payments to try and get those extra benefits out there to everybody, what the implications of that would be on a cost standpoint?

Dr. ORSZAG. Well, I guess you could take the cost numbers that I gave you for moving to 100 percent of fee-for-service and then recognize that Medicare Advantage even in the out years is only projected to be slightly over a quarter of all beneficiaries and see that it would be many multiples of the numbers that I gave you for moving in another direction.

Mr. POMEROY. Dr. Miller, do you have any?

Dr. MILLER. I don't have numbers, but, in terms of what that would cost, but it wouldn't necessarily be, if I am following the discussion here, it is not necessarily expanding the benefit to all beneficiaries. If you are trying to target low-income beneficiaries, then, there is a subset of beneficiaries that you would be going after.

Mr. POMEROY, but there are ways to target, if we make a policy decision to target and try and enhance the benefits for low-income beneficiaries that may not be able to afford Medicare supplement policies, we can do that in a program driven way that would be much more equitable across the country and probably effective at getting people into plans, than just slapping some money out there to plans and saying please go take this where you will?

Dr. MILLER. Yes, and there are examples of these things. What is referred to as the Medicare savings programs, which are the QMBs and SLMBs. So based on a certain income level, a beneficiary's premium and copayments are subsidized or just the premium is subsidized. There is also a low-income subsidy in the Part D benefit, which are much more—this is who is eligible for it, this is what they get, here is where the money comes from.

Mr. POMEROY. Your testimony reveals, and I don't know if you are reflecting the MedPAC board, a certain lack of enthusiasm for Medicare Advantage plans. Is that correct?

Dr. MILLER. No, that is not correct. I have to say this in response to that it is very important to know that first of all, the commission does support managed care plans and choice. I am going to say this, the commissioner, republican, comes from the managed care industry, feels very strong that managed care plans have the ability to innovate and to provide good, good services.

Even coming from that orientation, his view is that if you don't pay properly, you don't create the conditions for those plans to innovate. What he believes is that if we pay properly, the plans that will come to the table will have two characteristics. They will be efficient and able to provide additional benefits through that efficiency, and they will be there to stay because the business model is not built on excessive payments, it is built on efficiency.

Mr. POMEROY. I agree. I think that is a very interesting perspective, one we ought to pursue. If we want people in managed

care, because it is going to be cheaper, then we shouldn't pay more than fee-for-service for it. That seems kind of basic to me.

My time is up and our time is up.

Chairman STARK. We have a minute to the vote.

Mr. POMEROY. All right, thank you, Mr. Chairman.

Chairman STARK. I want to take part of that minute to thank both of you for your help. Believe me, we will be back to you often in the next couple of months. Thanks, both of you, very much. The meeting is adjourned.

[Whereupon, the at 5:01 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of Center on Budget and Policy Priorities

According to the Medicare Payment Advisory Commission (MedPAC), Medicare provides excessive payments to Medicare Advantage plans. MedPAC estimates, on average, that private plans are paid *12 percent* more than traditional fee-for-service for comparable beneficiaries.[1]

In testimony before Congress on March 1, MedPAC chairman Glenn Hackbarth stated that these overpayments are driving up Medicare payments and thereby making the task of sustaining Medicare more difficult. Hackbarth said Medicare faces "a very clear and imminent risk from this overpayment that will put this country in an untenable position."[2]

In fact, the Congressional Budget Office estimates that enactment of just one of the MedPAC recommendations related to Medicare Advantage payments to private plans—a proposal to "level the playing field," by adjusting the payment formula so that private plans essentially are paid the same amounts (rather than more than) it would cost to treat the same patients under Medicare fee-for-service—would save $65 billion over five years and $160 billion over 10 years.[3] Other Medicare Advantage payment changes recommended by MedPAC could save tens of billions more.

In response, the private plans argue that curbing these overpayments will harm low-income and minority Medicare beneficiaries because those beneficiaries disproportionately rely on Medicare Advantage plans for help with Medicare premiums and cost-sharing and for other supplemental benefits not covered by traditional Medicare fee-for-service.[4] As evidence, they cite a recent analysis issued by America's Health Insurance Plans (AHIP) analyzing 2004 data from the Medicare Current Beneficiary Survey.[5] Some members of Congress, including the ranking minority member of the House Ways and Means Committee, have also made these arguments.[6]

An analysis of AHIP's own data, however, reveals the following:

1. Medicaid, not Medicare Advantage, is the primary form of supplemental coverage for low-income and minority beneficiaries.

- Among *all* Medicare beneficiaries with annual incomes below $10,000, some 48 percent were covered by Medicaid. This is nearly five times the proportion enrolled in Medicare Advantage plans. In addition, slightly more beneficiaries with incomes below $10,000 rely on Medigap than on Medicare Advantage.
- [7] Because *minority* Medicare beneficiaries are disproportionately low-income, they, too, rely heavily on Medicaid for supplemental coverage. Some 42 percent

[1] See Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2007.

[2] BNA's Health Care Daily Report, "Growth of Managed Care Plans Threatens Program's Finances, MedPAC Chairman Says," March 2, 2007.

[3] Specifically, MedPAC has recommended that the benchmarks used to assess the bids that private plans submit, and to determine payments to the plans, be set at 100 percent of fee-for-service costs. See Congressional Budget Office, "Budget Options," February 2007.

[4] See, for example, America's Health Insurance Plans, "AHIP Raises Concerns about New MedPAC Report and its Potential Impact on Beneficiaries," March 1, 2007.

[5] America's Health Insurance Plans, "Low-Income and Minority Beneficiaries in Medicare Advantage Plans," February 2007. This report is similar in many respects to a prior analysis issued by the Blue Cross and Blue Shield Association. See Adam Atherly and Kenneth Thorpe, "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," Blue Cross and Blue Shield Association, September 20, 2005.

[6] BNA's Health Care Daily Report, "Medicare Advantage 'On the Table' for Democrats Seeking Budget Savings," March 7, 2007.

[7] Table 3A in AHIP, "Low-Income and Minority Beneficiaries in Medicare Advantage Plans," *op cit*. Among all beneficiaries with incomes between $10,000 and $20,000, 25 percent are en-

of African-American Medicare beneficiaries, half of Hispanic beneficiaries, and 42 percent of Asian-American beneficiaries have incomes of less than $10,000 and therefore may be eligible for Medicaid.[8] As a result, the majority of Asian-American Medicare beneficiaries (58 percent) and a plurality of African-American (30 percent) and Hispanics beneficiaries (34 percent) receive supplemental coverage through Medicaid. In comparison, much smaller percentages of minority beneficiaries—13 percent of African-Americans, 25 percent of Hispanics and 14 percent of Asians, respectively—are enrolled in Medicare Advantage.[9]

2. Low-income and minority beneficiaries enroll in Medicare Advantage plans to a lesser, rather than a greater, degree than other Medicare beneficiaries.

- Beneficiaries with incomes of less than $10,000 constitute 20 percent of all beneficiaries living in areas with access to a private plan but 16 percent of Medicare Advantage enrollees. (At the same time, as one would expect, they constitute 69 percent of Medicare beneficiaries who also receive coverage through Medicaid.)[10]
- [10] African-Americans represent 11 percent of all Medicare beneficiaries living in areas with access to a Medicare Advantage plan but 10 percent of all Medicare Advantage enrollees. They constitute 22 percent of Medicare enrollees who also receive Medicaid and 18 percent of those who rely on other forms of public coverage, including military or veteran's health care.
- Similarly, Asian-Americans constitute 2 percent of all beneficiaries with access to a private plan, and 1 percent of all Medicare Advantage enrollees. (Asian-Americans represent 9 percent of all dual eligibles.) Hispanics are slightly more likely to enroll in Medicare Advantage; they constitute 3 percent of Medicare beneficiaries with access to a private plan and 4 percent of Medicare Advantage enrollees.[11]

3. If Congress wishes to ensure that low-income, minority beneficiaries obtain assistance with paying their Medicare premiums and cost-sharing, and receive needed benefits, the best approach would be to strengthen aspects of the *Medicaid* program that assist low-income Medicare beneficiaries rather than to pay tens of billions of dollars in excess reimbursements to private plans so that a modest fraction of the excess payments trickle down to low-income and minority beneficiaries.

- Overpaying private plans in the hope that some of the overpayments may accrue to low-income and minority Medicare beneficiaries is not an efficient approach. It also is not equitable, in that it enables beneficiaries who do not have access to retiree coverage, Medigap, or Medicaid to obtain some help with their cost-sharing or benefits only if they switch from fee-for-service to Medicare Advantage and consequently may have to accept substantial restrictions on their choice of providers.
- MedPAC recommends that the overpayments to Medicare private plans be eliminated. MedPAC supports competition between fee-for-service and private plan alternatives, but calls for a level playing field where fee-for-service and Medicare Advantage compete fairly with each other. The overpayments skew the competitive landscape by allowing plans to use some lower cost-sharing and additional benefits to entice Medicare beneficiaries, particularly those who are healthier and thus less costly to treat.
- As MedPAC chairman Glenn Hackbarth has stated, these overpayments threaten the federal government's ability to sustain the Medicare program over time. As a result, these excessive overpayments are likely, if not rained in, to contribute to growing pressures to cut Medicare significantly over time. Such cuts could entail increased out-of-pocket costs and reduced benefits for Medicare beneficiaries. This could be particularly harmful for low-income and minority

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rolled in Medigap plans and 22 percent are in employer-based retiree health coverage but only 16 percent are in Medicare Advantage plans. 13 percent are in Medicaid.

[8] Table 1A.

[9] Table 5A.

[10] Table 7A. Beneficiaries with incomes between $10,000 and $20,000 constitute 27 percent of all Medicare beneficiaries living in areas with access to a Medicare Advantage plan. While they represent 33 percent of Medicare Advantage enrollees, such beneficiaries also constitute 56 percent of individuals with other forms of public coverage (like military or veteran's health care), 29 percent of individuals with Medigap coverage, and 28 percent of Medicaid beneficiaries.

[11] Table 8A.

[12] The Medicare Part D drug benefit includes a separate subsidy for low-income Medicare beneficiaries that pays for Part D premiums and/or Part D deductibles and cost-sharing. This low-income Part D subsidy could also be expanded to help low-income Medicare beneficiaries to a greater degree.

beneficiaries who can least afford to pay more of their health care costs on an out-of-pocket basis.

- A far superior, more targeted approach would be to expand and improve the existing QMB, SLMB and QI–1 programs in Medicaid that help low-income Medicare beneficiaries pay Medicare premiums and/or cost-sharing.[12] (The Qualified Medicare Beneficiary (QMB) program pays Medicare premiums and cost-sharing for poor Medicare beneficiaries, while the Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI–1) programs together pay for Medicare premiums for beneficiaries with incomes up to 135 percent of the poverty line.) Such improvements could be financed by using some of the savings from curbing the excessive overpayments to private plans. (Congress also could encourage states to use existing flexibility in making full Medicaid more available to low-income Medicare beneficiaries.)
- Alternatively (or in addition), because low-income and minority individuals and families disproportionately lack health insurance, savings from curbing the excessive payments also could be used to expand health insurance coverage more generally. As one immediate example, the resulting savings could be used to help offset the costs of legislation to reauthorize and expand the SCHIP program so that most or all low-income and minority children have coverage.[13] The Leadership Conference on Civil Rights and a host of other civil rights and religious organizations support providing $60 billion over five years in additional funding for SCHIP and Medicaid as part of SCHIP reauthorization, in order to move a long way toward this goal.

Those costs will need to be offset, however, if the SCHIP expansion is to become a reality. Savings from curbing overpayments to private plans, as MedPAC recommends, could provide some (or even all) of the offsetting savings.

Statement of National Center for Policy Analysis, Dallas, TX

Mr. Chairman and members of the Subcommittee, I am John Goodman, President of the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views in writing about the current state of Medicare, specifically how the Medicare Advantage plans are contributing to provide health coverage to senior citizens.

When Medicare began, the program copied the popular Blue Cross insurance plan. So for a while, seniors and non-seniors had basically the same health insurance. But since one plan was controlled by the marketplace and the other by politicians, the two plans diverged over time. Practically all of the structural problems of Medicare stem from this divergence.

Seniors are the only people in our society who must buy a second health plan (Medigap) to fill in holes in their primary plan (Medicare). Also, millions of seniors are paying a third premium to a third plan (Medicare Part D) to get the drug coverage non-seniors have. Even then, many face "donut hole" gaps that no one else faces.

Paying three premiums to three plans is extremely wasteful. In fact, two studies by Milliman & Robertson showed that if Medicare and Medigap funds alone were combined, seniors could have the same coverage non-seniors have—at least in principle.

This is where Medicare Advantage plans come in. They offer seniors comprehensive coverage, comparable to what the rest of America has.

In the early years, health economist Ken Thorpe found that these plans attracted low- and moderate-income seniors who did not have Medigap coverage. In return for a premium of about $250 a year or less, these enrollees got $1,034 worth of extra benefits, including drug coverage. A social problem solved, at minimal cost to taxpayers.

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[13] Edwin Park and Robert Greenstein, "Options Exist for Offsetting the Cost of Extending Health Coverage to More Low-Income Children," Center on Budget and Policy Priorities, March 8, 2007.

[1] The Passive Enrollment of Pennsylvania's dual eligibles was litigated in the Eastern District of Pennsylvania in the matter entitled Erb v. McClellan, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005). *Erb v. McClellan* alleged violations of the MMA, the Medicare Act, the Administrative Procedure Act, and constitutional due process requirements. The subject of the litigation, which was favorably settled in March 2006, was the agency's statutory authority and lack of due proc-

With the introduction of (subsidized) Part D coverage, this trend has continued. Medicare administrators report that:

- 86% of Medicare beneficiaries have the opportunity to join a Medicare Advantage plan with no premium charged for drug coverage.
- In addition to free drug coverage, enrollees often get such extra benefits as hearing aids, vision and preventive care.
- Half of Medicare Advantage enrollees have incomes below $20,000.
- About 27% of Medicare Advantage plan members are minority enrollees.

An AHIP study also found that these plans are especially beneficial for low-income and minority enrollees. In fact, almost 7 in 10 minority enrollees have incomes less than $20,000.

There are special needs Medicare Advantage plans (for those with several chronic illnesses) and medical savings account plans (for those who want to manage some of their own healthcare dollars). Also, several studies have found that Medicare Advantage enrollees get higher quality care than those in standard Medicare.

In all of its guises, Medicare Advantage plans take a rigid, inflexible Medicare benefit and use those same dollars to create more benefits better suited to senior citizen needs.

Given this success, we should build on it. Let the market for senior care be wide open, with the government offering premium support for seniors who choose from a much wider range of options—including remaining in, and paying premiums to, a former employer's plan.

Thank you for your consideration.

For CMS study: Medicare Advantage in 2007: http://www.cms.hhs.gov/HillNotifications/downloads/MedicareAdvantagein2007.pdf

For AHIP study: Low-Income and Minority Beneficiaries in Medicare Advantage Plans: http://www.ahip.org/content/fileviewer.aspx?docid=18974&linkid=162349

For Consensus Group/Galen Report: http://www.galen.org/medicare.asp?DocID=997

Statement of Pennsylvania Health Law Project, Philadelphia, PA

The Pennsylvania Health Law Project "PHLP" submits this testimony to be included in the record of the hearing on Medicare Advantage, held before the Health Subcommittee of the Committee on Ways and Means on Wednesday, March 21, 2007.

The Pennsylvania Health Law Project is a statewide, non-profit public interest law firm that provides free legal services, advice, information, and advocacy to lower-income individuals, persons with disabilities and seniors in accessing healthcare coverage and services through the publicly funded healthcare programs. Our website is www.phlp.org.

We write on behalf of our clients who are enrolled in Medicare Advantage Special Needs Plans (SNPs) and who have experienced, firsthand, problems accessing their medically necessary healthcare as SNP enrollees. We have substantial experience with Medicare Advantage SNPs and grave concerns about them. In late 2005, CMS allowed six Medicare Advantage SNPs in Pennsylvania to "passively enroll" over 110,000 of our poorest and most chronically ill individuals out of the Original Medicare benefit they had chosen and into the Medicare Advantage SNPs.[1] The result was a wholesale disruption in the access to critically needed healthcare coverage. Once the chaos of the abrupt shift to managed care settled and consumers began actually attempting to obtain necessary healthcare coverage, the issues surrounding SNPs' design and function came to the surface.

The MMA included a five year authorization of special Medicare Advantage plans that exclusively or disproportionately enroll "special needs" populations. SNPs can be designed to serve people who 1) are institutionalized; 2) are entitled to state medical assistance; or 3) have a severe or disabling chronic condition. For 2007, CMS has approved over 470 plans to be Medicare Advantage SNPs, most of which are focused specifically on the dual eligible population, although a significant proportion of persons who are institutionalized are or will become dual eligibles and, similarly, many individuals with chronic conditions may also be dual eligibles. The arrival of

[11] Table 8A.

SNPs on the market since the MMA has been swift; their numbers rapidly increasing each year.[2]

Our clients believe that dual eligibles, persons with chronic conditions, and institutionalized individuals could **potentially** benefit significantly from coordinated, integrated, and managed care from a plan specially designed to meet their needs, since they generally have substantial and complex healthcare needs. Accordingly, SNPs do present the possibility or opportunity for better care through coordination, integration, and targeted care management. Please note, however, that although plans may take steps to deliver these benefits to meet the special needs of their members, CMS imposes no formal requirements that a SNP actually take these or any other steps to deliver on the promise of better care.

We are particularly concerned that CMS has not promulgated regulations delineating either meaningful standards an MA plan must meet for initial approval as a SNP nor any requirements an approved SNP must follow to ensure that it coordinates the care and benefits or, in fact, meets the special needs of its enrollees. The failure by CMS to articulate meaningful requirements makes a difference for enrollees who are trying to access the medically necessary care they require. The MMA itself requires implementing regulations for SNPs.[3] Yet, to date, no substantive regulations have been promulgated.

It has quickly become clear to our clients in Pennsylvania that the Special Needs Plans, even those plans expressly for dual eligibles, which CMS has authorized as specially designed to meet their needs, are not obligated to require their providers to accept and bill Medicaid for any amounts unpaid by Medicare which are the responsibility of Medicaid. SNPs are not obligated to require, or even instruct, participating providers to comply with state and federal rules prohibiting them from billing Medicaid recipients for balances unpaid by Medicare. SNPs are not required to educate or maintain any accessible system for use by their participating providers to inquire whether those services that are not covered by the SNP are covered by Medicaid. SNPs are not obligated to inform their pharmacies of, or to require their pharmacies to bill, Medicaid programs for Part D excluded drugs that the state has elected to continue to cover under the state Medicaid plan. SNPs are not required to inform their enrollees that Medicaid may cover services or prescriptions not included in their SNP benefits, and they are not required to assist the enrollees in actually accessing these services. SNPs are not even required to insure the accuracy of the information they do publish about what a state Medicaid program covers or, in the institutional SNP realm, providers must furnish, and how the SNP coverage interacts with these.

Absent minimum standards for meeting the special needs of the populations they serve, labeling these plans as specially designed to do so is misleading. CMS needs to commit to ensuring that coordinated, integrated care is delivered. Beneficiaries need substantive regulations that establish minimum standards for what SNPs must do and how SNPs must function to meet their special needs. These regulations must clearly set forth the expectation that SNPs will take affirmative steps to assist enrollees with navigating both their Medicare and Medicaid coverage to ensure that they receive all needed covered services regardless of whether the SNPs themselves are responsible for covering the service. Only then will the potential benefits of specialized managed care actually inure to beneficiaries.At a minimum, SNPs serving dual eligibles must be required to:

1. Adopt minimum uniform standards for coordinating and integrating the Medicare and Medicaid benefits. These standards must be incorporated into the SNP contracts with CMS, and their compliance with these standards must be measured during site reviews and other CMS compliance evaluations.
2. Include in SNP summary of benefits documents accurate information, as confirmed and approved by the State's Medicaid agency, describing Medicaid's coverage of services not covered by the SNP as well as Medicaid's coverage of the beneficiary's cost-sharing obligations within the SNP.
3. Include as a SNP benefit "coordination of benefits" to include all services involved in coordination and integrating the enrollees' multiple insurances (primarily Medicare and Medicaid). Failure to provide these coordination and in-

[12] The Medicare Part D drug benefit includes a separate subsidy for low-income Medicare beneficiaries that pays for Part D premiums and/or Part D deductibles and cost-sharing. This low-income Part D subsidy could also be expanded to help low-income Medicare beneficiaries to a greater degree.

[13] Edwin Park and Robert Greenstein, "Options Exist for Offsetting the Cost of Extending Health Coverage to More Low-Income Children," Center on Budget and Policy Priorities, March 8, 2007.

tegration services should trigger beneficiary appeal rights through the Part C appeals process.

4. Include in SNP marketing materials explanations of the "coordination of care" and "coordination of benefits" benefits, in addition to Parts C and D covered benefits, which dual eligibles can obtain from their SNP.
5. Arrange for an evaluation of Medicaid coverage when a prescription is denied at the pharmacy, and, where applicable, direct the pharmacist to bill Medicaid. All SNPs should program their systems with medications Medicaid will and will not cover.
6. Require network providers to participate in Medicaid or accept the SNP's payment as payment in full.
7. Instruct all network providers on applicable state and federal prohibitions against billing Medicaid consumers for Medicare cost sharing that should be covered by Medicaid.
8. Design prescription drug or medical claims denial letters to state, "If you have Medicaid, note that this prescription medication or service may be covered by Medicaid. Please ask your provider to obtain this item through Medicaid. For any assistance with this, please call member services."
9. Train member services personnel regarding details of what Medicaid benefits are available and how to obtain them.
10. Make available special needs units and case management services, and publicize their availability to all enrollees for obtaining assistance in accessing referrals, understanding plan policies and procedures and coordinating challenging care needs.
11. Articulate precisely what benefits Institutional SNP enrollees get above and beyond what is already required by federal Nursing Home Reform and other laws and how benefits are limited, managed, and coordinated.
12. Make public exactly what expertise enabled them to qualify as a SNP.

On behalf of our clients, we thank the Committee for the opportunity to submit written testimony. We hope that this testimony will help inform the Committee's understanding of Medicare Advantage Special Needs Plans.

Statement of SCAN Health Plan

Overview

SCAN Health Plan is a geriatric-focused health plan that has been participating in the Medicare program for over 20 years. Currently serving approximately 100,000 beneficiaries in 7 Southern California counties, SCAN has grown to become one of the largest Medicare health plans in the State.

As a non-profit health plan, SCAN is committed to providing value to its members. While SCAN ensures that members receive the health care benefits to which they are entitled through the Medicare program, the health plan also provides additional programs and services to promote health and independence. Examples of some of the "extra benefits" offered by SCAN that are not otherwise available under the fee-for-service program include: vision and hearing benefits, and transportation services. Because SCAN is a geriatric-focused health plan, its programs and services are tailored to meet the needs of older adults. For example, the health plan provides chronic care management programs, a nurse advice line, and comprehensive prescription drug benefits.

Collectively, these benefits and services provide value to the Medicare program and to Medicare beneficiaries. In addition, they help to ensure that SCAN members have the resources they need to lead a healthy and independent life.

SCAN Health Plan

History

SCAN was founded in 1977 as the Senior Care Action Network by a group of twelve seniors in Long Beach, California. In 1984, after being awarded a contract to operate as a Social HMO demonstration project, the Senior Care Action Network established SCAN Health Plan as a 501(c)(3) not-for-profit Medicare managed care plan.

Since 1984, SCAN Health Plan has maintained the mission of the Senior Care Action Network—that of coordinating health and social services for frail older adults. SCAN aims to continue this mission by developing partnerships that allow the health plan to deliver the right health care, in the right setting, and at the right cost.

Today

Over the past 20 years, SCAN has become an increasingly popular choice for seniors in Southern California. Currently, the health plan serves almost 100,000 Medicare beneficiaries in seven counties that include Los Angeles, Orange, Riverside, San Bernardino, Kern, Ventura, and San Diego. In addition, SCAN recently expanded into the Phoenix, Arizona area. Demonstrating the success of the health plan, SCAN's membership has grown nearly 100% in the past 5 years.

Offering Additional Benefits and Services

To participate in the Medicare Advantage program, SCAN provides coverage for all of the services offered through the traditional Medicare program. This includes the full range of acute care benefits and Part D drugs. In addition, SCAN currently offers a number of health care related programs and services to meet the medical and functional needs of health plan members. The following is an overview of some of SCAN's geriatric-focused "extra benefits" that are not covered by the traditional Medicare fee-for-service program:

- Transportation—SCAN provides routine transportation to medical appointments. This benefit helps to ensure that frail members, such as those who are no longer able to drive, can access needed health care services.
- Nurse Advice Line—With access to registered nurses (RNs) to assist with medical questions 24 hours a day / 365 days a year, SCAN members can have their health care concerns addressed outside of traditional physician office hours.
- SCAN Family and Friends Program—This program gives SCAN Health Plan members the option of designating a friend or family member to receive non-confidential health plan material. These individuals can then review important information at the same time as the member to help ensure informed decision-making.
- Community Resource Centers—SCAN has built one community resource center in Ventura County, and is in the process of building a second resource center, to provide members of the health plan and the general community with health-related educational information and activities.
- Health Education Programs—SCAN helps members become active and engaged in the management of their own health. As such, the health plan distributes health information through newsletters, handbooks, and the Internet. Member Review Board—To ensure that health plan materials are sensitive to member needs, a peer review process is employed by which current members review current health plan activities and information.
- Chronic Care Management—Specially trained nurse or social worker case managers assist members from a patient-centric point of view. The health plan has designed programs for individuals with particular health needs such as *Chronic obstructive pulmonary disease (COPD), Congestive heart failure (CHF), and diabetes.*
- Senior Sensitivity—Each of SCAN's approximately 950 employees participate in the industry's foremost "Senior Sensitivity" training to help them be more attuned to the needs and challenges of health plan members.
- Continuing Medical Education—SCAN strongly believes that educating providers of care is a prerequisite for delivering good quality geriatric care. To this end, SCAN built its own continuing education capacity. The health plan offers geriatric education through Geriatric Symposiums as well as on—site trainings.
- Additional Drug Benefits—SCAN offers an expanded prescription drug formulary and a fill-in of the "doughnut hole" or coverage gap.
- Senior Friendly Focus—SCAN always has seniors in mind with every decision that the health plan makes. From the absence of automated phone systems to the distribution of pill holders, SCAN Health Plan promotes member health and well-being. In addition, SCAN's trained member services team provides personalized one-on-one assistance.

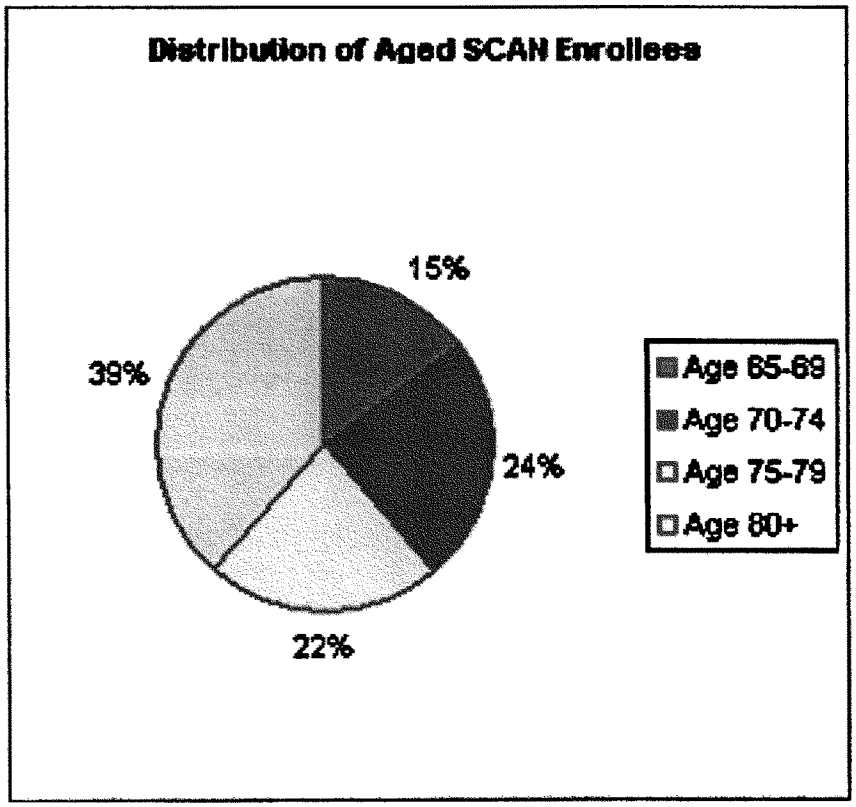
Serving Vulnerable Populations

With the provision of the additional benefits and services listed above, SCAN offers a health care delivery solution that is unrivaled by the fee-for-service Medicare program. The health plan provides these services because of its focus on serving the most vulnerable and frail Medicare members. The following table provides an overview of SCAN's membership.

Table 1. SCAN Health Plan

Member Statistics	
Average Age	Approximately 78 years
Male/Female Ratio	36%/64%
Marital Status	Married—46% Unmarried—54%
Highest Level of Education	High school graduate or less—57% Some college or higher—43%
Annual Income	Less than $20,000—38%
Medicare and Medicaid Enrollees—— Dual Eligibles	Approximately 7%

As illustrated in Table 1, SCAN's members are predominately female, unmarried, and have an average annual income of less than $20,000 per year. In addition, the average age of members in the health plan is approximately 78 years. As compared to the general Medicare population in the State of California, SCAN's membership is on average older.



SCAN vs. Other Medicare Advantage Plans

SCAN serves a population that is more frail and chronically ill than other Medicare managed plans[1] Specifically, SCAN members are:

More likely to be female and less likely to be male. Less likely to be married and more likely to be widowed. More likely to be over 80 years of age. Less likely to have 0 chronic conditions and more likely to have four or more chronic conditions. More likely to report having high blood pressure, angina, CHF, AMI, stroke, Crohn's disease, arthritis, and sciatica. More likely to report difficulty on each surveyed measure of Activities of Daily Living (ADLs) such as: bathing, dressing, eating, walking, using the toilet, and getting in or out of a chair.

The following table highlights some membership statistics from a recent HOS survey.

Table 2. SCAN Health Plan

Member Statistics	
Members with 0 Chronic Conditions	9%
Members with 4+ Chronic Conditions	40%
Percentage of Members Reporting Difficulty with ADLs:	Up to 44%

Providing Extra Value

SCAN offers considerable extra value to its enrollees by offering benefits and services, above and beyond those covered by the traditional Medicare program. Without this coverage, members would have to pay significantly more out-of-pocket for many of their health needs. This is a major reason why a significant percentage of SCAN's members are lower income seniors.

Generally, these are individuals whose incomes are not low enough to qualify for the Medicaid program but whose financial situation is such that they are extremely cost conscious. Having low out-of-pocket costs is also particularly important for members with considerable health needs who utilize more medical services.

Offering High Quality

SCAN offers multiple quality improvement activities geared to improve the health care delivery experience for Medicare members. These include:

A Geriatric Advisory Board—SCAN sponsors a Geriatric Advisory Board that brings together a group of the nation's foremost geriatric, clinical, and health policy experts to help guide the health plan in its offering of geriatric health management programs to seniors.

Coordination of Care—SCAN coaches members with high intensity and high cost needs through care transitions, or between care settings.

Focus on early identification of conditions, preventative services, and stratification of patient risks.

Monitoring of quality measurements that are not provided to Medicare members in the fee-for-service Medicare program.

Conclusion

Because SCAN is a geriatric-focused health plan, its membership is on average older and more frail than the general Medicare population, and than other Medicare managed care plans. The numerous additional benefits and services provided by SCAN Health Plan, above and beyond the fee-for-service Medicare program, help to ensure that members have the resources they need to lead a healthy and independent life.

Looking forward, SCAN intends on continuing to provide health care services to senior Medicare beneficiaries. For the past 20 years, SCAN's almost 100,000 members, 950 employees, and thousands of contracted providers have come to depend on us, and us on them. With your support, we can ensure that managed care plans remain a choice for Medicare beneficiaries.

[1] As indicated in the April 2006 Health Outcomes Survey (HOS), Cohort VIII, 2005.

The Center for Medicare Advocacy, Inc.

MedPAC has argued consistently for years that private plans could serve an important role within Medicare, but payments to plans must be financially neutral when compared to those in the traditional Medicare program. The Center agrees that financial neutrality would be a more appropriate position than the current scheme, nevertheless the Center urges Congress to consider adjusting payments to MA plans to less than traditional Medicare expenditures as a means to stimulate competition and efficiency among the private plans. Risk-based and coordinated care is important but not if it comes at the expense of a social insurance program that has been consistently successful for over 40 years.

Private Fee-For-Service

HMO's are not the only private plan options participating in Medicare. Other plan types include Local and Regional Preferred Provider Organizations (PPOs), Private Fee-for-Service plans (PFFS), and Special Needs Plans (SNPs). Insurance companies have continued to offer private plans in more areas and now at least one private plan alternative is available to every Medicare beneficiary.

PFFS is the fastest-growing plan type, accounting for 46% of total enrollment growth from December 2005 to July 2006. PFFS was available to 45% of beneficiaries in 2005 and is now available to almost 100% of beneficiaries. With payments to PFFS plans averaging 119% of the per capita traditional Medicare expenditures, it is no wonder that PFFS plans are growing at such a rapid rate.

Arguments from the Plans

Chairman Stark and other members of Congress have begun to seize on these overpayments to private plans as a significant source of potential savings for Medicare. Not surprisingly, the private insurance companies are very concerned that they might lose billions of dollars.

The plans have argued that cutting funding to the MA plans would disproportionately hurt low-income beneficiaries. We agree that low-income beneficiaries need extra help the most. For those who are most needy, the majority rely on Medicaid or Medigap policies, not MA plans, to cover what Medicare does not. Extra help is also available to low-income beneficiaries in the form of Medicare Savings Programs (MSPs). These programs reduce out-of-pocket expenses for individuals with incomes below 135% of the Federal Poverty Level ($18,482 for a couple and $27,878 for a family of four), but these programs could serve even more beneficiaries. The savings from eliminating the overpayment to MA plans could be used to provide more benefits to more low-income beneficiaries, not just those who choose to enroll in an MA plan.

Private plans have also pointed out that people who enroll in an MA plan receive more benefits than are offered by traditional Medicare. It is obvious that beneficiaries should receive as many benefits as possible, but those benefits should be distributed equitably. In the current system, the vast majority of beneficiaries—who choose traditional Medicare in the face of a marketing barrage from the private plans—pay premiums that are inflated by the overpayments made to MA plans. Why limit extra benefits to just the beneficiaries who enroll in MA plans at the expense of those who choose not to? How significant are these additional benefits, actually? The private plans cannot answer these questions. These additional services should, and could with efficient spending, be available to all Medicare beneficiaries.

The Reality of Medicare Advantage for Beneficiaries

Because Medicare Advantage plans, and in particular PFFS plans, are paid so well, they are engaged in an extensive marketing campaign to encourage, and sometimes coerce beneficiaries to join their plans. Indeed, 8.3 million beneficiaries, or 19% of the total number of beneficiaries, are currently enrolled in a Medicare Advantage plan, as compared to 7.6 million beneficiaries in 2006 [Medicare Advantage Fact Sheet, Kaiser Family Foundation (March 2007)]. In the Center's experience, not all Medicare beneficiaries understand the benefit structure of Medicare Advantage plans, know that they are enrolling in Medicare Advantage plans, or even reap "benefits" from the additional services these plans provide with the extra money they receive.

Marketing Practices

The Centers for Medicare & Medicaid Services (CMS) is supposed to monitor and approve all marketing materials. Nevertheless, these marketing materials often do not present Medicare Advantage plan structures in the most accurate light or provide all of the information a beneficiary needs to make an informed choice. A glossy, two-page advertisement inserted into the Montgomery County, Maryland, "Wash-

ington Post" in March 2007 provides an excellent example. The ad advised that someone who had chosen a Medicare plan with drug coverage still had time until March 31, 2007 to switch to an Aetna Medicare Advantage plan with drug coverage. A comparison chart showed that Medicare Parts A and B, Medicare Supplemental Plan, and Aetna Medicare Advantage Plan all have a "wide choice of local doctors/specialists," but only the Aetna Medicare Advantage Plan has preventive care with a $0 co-pay and an allowance for eyewear and hearing aids.

Despite being approved by CMS, the advertisement is not accurate. The "network" of doctors and specialists for Medicare Parts A and B and most Medicare Supplemental (Medigap) plans is widest because there actually is no network; beneficiaries can go to any doctor in the country who accepts Medicare, this includes almost all physicians, indeed almost all health care providers nationwide. Aetna Plans, on the other hand, restrict access. According to www.medicare.gov, Aetna offers four HMOs in Montgomery County, all of which require an enrollee to use plan doctors. Aetna also offers four PPOs (two local and two regional), that allow an enrollee to use any doctor, but the enrollee must pay higher cost sharing to go out of network. It is also inaccurate to say that only Aetna Medicare Advantage Plans have a $0 co-pay for preventive care. Beneficiaries with Medicare Parts A and B and a supplemental plan may also have a $0 co-pay if the Medigap plan covers Part B cost-sharing. Aetna Medicare Advantage Plans may indeed provide an "allowance" for eyewear and hearing aids that is not available under traditional Medicare, *but the allowance for eyewear under at least one of the Aetna plans is $100 every two years*. That allowance does not justify the premium for the Medicare Advantage Plan or the additional Medicare payments the plan receives from the Medicare program.

The advertisement, and most other educational information about Medicare Advantage plans, also does not adequately explain how Medicare Advantage plan cost-sharing may differ from the traditional Medicare cost-sharing structure, particularly for more costly services. For example, one of the Aetna plans available for beneficiaries who received the "Washington Post" ad, the Aetna Golden Choice Regional PPO plan, imposes a $150 yearly deductible for all out-of-network services. A beneficiary who is induced to enroll in this plan after seeing the ad and who believes she may use any provider will face a higher deductible than the current Part B deductible of $131. This out-of-network deductible applies to home health services, even though Medicare Parts A and B imposes no such cost-sharing. Beneficiaries who use an out-of-network hospital or skilled nursing facility must pay 20% of the entire hospital or skilled nursing facility stay; far in excess of the cost-sharing under traditional Medicare. Beneficiaries who use an in-network SNF start paying cost-sharing after day 7, rather than after day 20 in traditional Medicare. The plan imposes a $20 co-pay for each in-network home health visit and 20% cost-sharing for out-of-network care; traditional Medicare imposes no cost-sharing for home health services.

Individual Testimonials

Beneficiaries often do not learn about or understand these cost-sharing differences until after they have enrolled in a plan. For example, a Connecticut beneficiary required hospitalization each month to receive a blood transfusion. She paid the Part A deductible in January, but because she required monthly hospitalization she never entered a new benefit period and so paid no other cost-sharing for the rest of the year. The HMO she chose, like the Aetna PPO described above, imposed a co-pay for a Medicare-covered hospital stay that was substantially less than the Part A deductible. What the Connecticut woman did not understand until her second hospitalization was that the co-pay is required for each hospital stay, even if it falls within what would be the same benefit period under traditional Medicare. Thus, instead of saving money, she was required to pay substantially more for her hospital care than she would have paid if she was in traditional Medicare.

A beneficiary from Jasper, Florida enrolled in a PFFS plan at the beginning of 2007 because of his frustration with his prescription drug plan. Neither he nor the insurance agent understood the differences between traditional Medicare and a PFFS plan. The beneficiary expected only the prescription drug coverage to change. In February, three hours before a scheduled biopsy of a lump in his pectoral muscle, his doctor called to cancel the biopsy because the doctor would not accept the plan's terms and conditions. He was told by his primary care physician that the doctor would not accept the plan because the plan had not paid on time in the past. In early March the beneficiary finally received a welcome packet from the plan and saw for the first time the fine print explaining that coverage is contingent on his doctors' acceptance of the plan. He also found that the drug coverage was much more restrictive than under his previous Prescription Drug Plan (PDP). The beneficiary was able to get an "emergency" transfer back to his old PDP and original

Medicare, effective April 1, 2007. However, he will have gone more than a month without the needed biopsy and other medical services.

Special Needs Plans

In addition to marketing problems and cost-sharing issues, some Medicare Advantage plans may not be providing meaningful additional benefits to their enrollees. For example, beneficiary advocates have alerted the Center about SNPs for people with Medicare and Medicaid (dual eligibles) that do not contract with the largest Medicaid mental health provider in the community, that include in their networks doctors who do not accept Medicaid, that assess cost-sharing that should otherwise be covered by the state Medicaid program, or that do not inform their enrollees that the state Medicaid program will pay for some drugs such as benzodiazepines that are excluded from Medicare drug coverage. Some SNPs provide, as extra benefits, transportation and dental services that are already covered by Medicaid and thus provide their enrollees with no extra services for the extra payments the plans receive.

Conculsion

Private Medicare plans may offer some beneficiaries a useful Medicare coverage choice, but many beneficiaries find out that the coverage is not what they expected when they enrolled. The Medicare Trustees will soon issue their annual report, and will inevitably raise alarms that Medicare is in financial peril. The payments to these plans must be at least financially neutral when compared to those made for people in the traditional Medicare program. Eliminating overpayments to private plans is a clear way to save Medicare hundreds of billions of dollars while also making the program more equitable and cost-effective. Congress should prohibit overpayments and subsidies to private Medicare plans in order to ensure fair, affordable access to health care for older people and people with disabilities—now and in the future.

Statement of Visiting Nurse Associations of America, Boston, MA

The Visiting Nurse Associations of America (VNAA) is the official national association for non-profit, community-based Visiting Nurse Agencies (VNAs) across the country. For over one hundred years, VNAs have shared several common goals: to care for the sick and the disabled, to help people recover their strength and independence, to partner with their communities in improving public health care, and to assure that all people, rich or poor, have access to the home care they need.

VNAs created the profession of home care over one hundred years ago, and it is our hope and intention to provide high quality home care for at least the next one-hundred years. We are pleased to submit this statement for the record to highlight some of the experiences and concerns that VNAs have about the Medicare Advantage Program.

Medicare Advantage was implemented with the goal of providing enhanced benefits for beneficiaries, and intended to save the Medicare program money; however, VNAs' experience with the program indicates that this is not always the case.

Enrollment in the Medicare Advantage program accounts for 19% of all Medicare beneficiaries (8.3 million), and the Medicare Payment Advisory Commission (MedPAC) has shown that payments to the Medicare Advantage program are 112% of fee-for-service (FFS) Medicare expenditure levels, on average. Although the new MA programs are required to cover all benefits that are offered under FFS Medicare, and many plans offer enhanced benefits, they also impose additional cost-sharing requirements and limit beneficiaries to providers in their own networks.

VNAs from across the country have expressed concern that co-pays and deductibles on home care often cause patients to self-limit the care that they get and as a result, go without needed health care. In other instances, beneficiaries believe that Medicare will pay the cost of the deductible and do not pay their portion of the claim. For example, one plan in New Jersey imposed a $35 co-pay per visit on beneficiaries effective this year, which could be cost-prohibitive to a beneficiary who requires several visits in one week. As a result of the co-pay, all the members of that plan who the VNA has tried to set up services for have declined home health services that they needed. Another agency, located in Pennsylvania, has experienced problems collecting beneficiary co-pays/deductibles because beneficiaries think that Medicare will or should pay and do not understand how their Medicare Advantage plan works.

Many VNAs across the country are struggling to provide the same level of services to MA enrollees as enrollees ins traditional Medicare FFS receive, although VNAs

receive reduced payments from the MA plans that most often do not cover the cost of care. In some instances, there is a $1200 gap between the amount that a MA plan pays for care and the amount that FFS Medicare reimburses over a 60 day episode. In addition, quality information and processes required by traditional Medicare are often not valued or taken into account for reimbursement by MA plans and the plans impose additional administrative requirements that require increased employee resources for VNAs. One VNA in Omaha, Nebraska estimates that they could reduce their overhead by $45,000 a year if they did not have to use resources on authorization/verification of services, denial management and collections on incorrect payment, which they would prefer use to provide services.

For these reasons, we are concerned about the inevitable erosion of the Medicare program. For example, if Medicare Advantage plans do not cover the cost of care, then it is probable that beneficiaries over time will not receive equal care under the MA program as they would have if they had stayed with the traditional Medicare program. In some cases MA enrollees will not have access to home health care as agencies are forced to stop accepting MA patients for financial reasons.

To understand the difficult financial decisions that VNAs, for example, have to make when determining whether or not they can absorb the financial losses associated with many Medicare Advantage plans, it is important to know the average total operating margins of these providers. According to a 2006 data study by The Moran Company, 66% of VNA providers have total operating margins of less than 5% and 39% percent of VNA providers have negative total operating margin. Much of the financial difficulties that VNAs are experiencing are due to the revenue losses that they incur under managed care, including Medicare Advantage, Medicaid, and the recent sharp increases in the cost of recruiting and retaining clinicians.

Given this financial environment VNAA is concerned that increased market penetration of beneficiary enrollment into Medicare Advantage plans that do not cover the cost of care may financially cripple VNAs in certain geographic areas. Our greatest concern is that access to potentially the only "safety net" provider of home health services in a particular area will no longer be an option to many Medicare beneficiaries, which might be the outcome if those providers are forced to close or stop accepting MA beneficiaries.

We would like to offer some examples of how the home health benefit under fee-for-service Medicare generally differs from the home health services offered by many Medicare Advantage plans as well as information on some of the problems that VNAs have experienced with Medicare Advantage that we believe are typical for home health agencies nationwide.

Home Health under fee-for-Service Medicare

- Fee-for-service Medicare ensures continuous home health care for the entire 60-day episode of care and the episode is authorized and overseen by a physician.
- Episodic payments allow providers to follow evidence-based best practices for chronic care management, medication management, etc., which is difficult to do when visit authorizations are unpredictable and inadequate for the patient's specific diagnosis(es). Such comprehensive care management is essential to prevent hospitalizations. Medicare Home Health PPS has made it possible for providers to manage care for optimal outcomes, including avoidance of hospitalizations.
- Quality data (i.e. Outcome Based Quality Improvement (OBQI) data from the OASIS assessment instrument) provided to the home health agencies (HHAs) by CMS are used by the agencies to improve their quality processes and are used by state surveyors to ensure that HHAs are providing quality care.

Home Health under Medicare Advantage

- MA plans typically authorize only 2–3 visits at a time, complicating and often disrupting continuous chronic care management.
- Under MA, the plan's case manager typically manages the patient's plan of care and, therefore, clinical decisions are often made by MA staff whodo not have any clinical experience.
- In addition, MA plans typically have their own administrative paperwork requirements that must be completed in addition to Medicare's OASIS and other paperwork requirements even though OASIS data is often not used by MA plans. This over-abundance of paperwork is inefficient for Medicare, the provider, and the beneficiary.

General problems experienced by VNAs under Medicare Advantage:

- **Administrative Requirements—**MA plans require an extensive amount of paperwork and administrative time. The constant need to seek re-authorizations and check claim status is a drain on VNAs' resources; the amount of time

it takes to gain reauthorization for more visits could prevent patients from receiving medically-necessary services. However, VNAs will always provide the medically-necessary services if a patient is under their care, which may lead to claim denials because of the "unauthorized" status due to time lapses on the MA administrative side.

- **Reimbursement—**Reimbursement for Medicare Advantage plans is substantially below cost—on average about $50 less than the actual cost per visit, but in many cases much more.
- **Educating Beneficiaries About Their Plan—**With the numerous Medicare Advantage plans that are offered, it is vital that beneficiaries have adequate information about the plans in order to make an informed decision about their care. MA plans differ widely in the amount of home health services they cover. Typically, the only information provided by the plans simply states that all medically necessary services are covered, but each plan may have it's own definition of a "medically necessary service." Therefore, it can be extremely difficult for beneficiaries who need home health care to determine which plan will best meet their needs.
- **Beneficiaries Are Unaware of Enrollment—**As MA enrollment grows, there is an increasing need to coordinate the transition of patients from traditional Medicare to a MA plan. For example, with the advent of Part D, many dual-eligible beneficiaries were passively (i.e. automatically) enrolled into MA plans. Although information informing them of such enrollment must be sent to them, in reality many of these beneficiaries are unaware that they have been enrolled into a MA plan.

In addition, whether a beneficiary was passively enrolled into a MA plan or enrolled knowingly, he or she may not understand the implications of being enrolled. Consequently, beneficiaries fail to inform their home health provider of their change in enrollment status, either because they are not aware of their enrollment, have cognitive impairments, or do not realize that the MA plan is responsible for covering all Medicare health care services, including home health. Some beneficiaries believe that they signed up only for prescription drug coverage under a MA plan and don't realize that they no longer have traditional Medicare coverage for all other health care services.

- **HHAs Not Reimbursed for Services—**To avoid the enrollment problems detailed above, HHAs make every attempt to determine a patient's Medicare eligibility status during the initial patient visit or through Medicare's enrollment database, the Common Working File (CWF). If the patient believes he/she is still covered by traditional Medicare, and the CWF reflects traditional Medicare enrollment, the HHA has every reason to believe that the patient is covered by traditional Medicare but then later finds out this is not the case due to: 1) patient confusion about his/her coverage as mentioned above, 2) the patient's retroactive enrollment into a MA plan, and/or 3) delay of updated information in the CWF. In such situations, many MA plans have refused to cover services that HHAs have provided in good faith because the services were not "pre-authorized" by the MA plan, or the HHA did not have a contract.

VNAs across the country continue to experience problems with reimbursement due to delays in the information that is updated in the CWF. are refused reimbursement for services they provided in good faith. VNAs with a high census of Medicare Advantage patients must devote valuable staff resources to denial claims management, in addition to the staff resources who are devoted to obtaining pre-authorizations.

The Visiting Nurse Service of New York (VNSNY) provided the following example to illustrate their efforts to determine beneficiary enrollment status. As you will see from the example, the CWF did not accurately reflect the beneficiary's enrollment status, and as a result the VNSNY was denied reimbursement for the services they provided in good faith.

VNSNY Example VNS ID: H4186804

4/19/06: VNS insurance Fiscal Comments state the Medicare eligibility query shows the patient is enrolled in traditional Medicare.

4/20/06: Patient admitted

5/17/06: The Medicare batch query indicates the patient enrolled in Elderplan effective

5/1/06: The patient was not flagged as an Elderplan enrollee on two previous Medicare batch eligibility reports run in May 2006.

Elderplan denied VNS's request for authorization.

Dollar Amount at Risk: $810

Although this is just one example, this is a widespread issue for VNAs. Problems with reimbursement issues related to delayed updates to the CWF are the most common problem that VNAs experience with the Medicare Advantage program.

Data used by MedPAC and CMS and reports released by the Congressional Joint Economic Committee, as well as the Annual Statistical Supplement to the Social Security Bulletin have all shown that home health is a cost-effective alternative to other settings of care. Treating patients in the home health setting is significantly less costly than other settings of treatment such as hospitals, inpatient rehabilitation facilities, and skilled nursing facilities. Furthermore, for many patients, receiving the health care and skilled services that they need in their homes is preferable to receiving care in other settings that require them to receive care away from their homes and families. We would hope that Medicare Advantage plans would see the advantage to ensuring that beneficiaries receive adequate and appropriate home health care services. VNAA believes that by appropriately utilizing home health care services, Medicare Advantage plans will save money by keeping beneficiaries out of hospitals and other costly settings of care.

To address the issues with Medicare Advantage program that are detailed in this statement, VNAA offers the following recommendations, which we believe will ensure increased beneficiary access to comprehensive home health services:

Educating Beneficiaries About Their Plan

Recommendation: We urge Congress to require that all MA Plans provide beneficiaries

with specific details of what home health services they cover, including the average number of home health visits authorized per patient, if home health services require pre-authorization, and information about beneficiary cost-sharing requirements such as co-pays. This information must be available in all marketing materials used by MA plans. In order to ensure that beneficiaries make informed decisions, it is imperative that beneficiaries have access to information on the full scope of covered services, and receive updated information if the plan changes the services that are covered.

Home Health Agency (HHA) Reimbursement

Recommendation: During the initial month of any person's MA enrollment (or longer in the case of retroactive enrollment greater than a month), we urge Congress to require MA plans to waive the pre-authorization rule for home health services and any similar rule that would inhibit provider payment in situations where the HHA could not have reasonably been expected to know of the patient's MA enrollment status or to establish a hold harmless provision that would allow HHAs to receive reimbursement for services that they provided in good faith when they have made every effort to ascertain a beneficiary's enrollment status before providing services.

Medicare Advantage Should Use an Episodic Care Delivery System

Recommendation: Medicare Advantage plans should provide an episodic care management home health services benefit that would replace the current practice of authorizing and reimbursing for only a few visits at a time. The episodic payment plan in traditional Medicare allows VNAs to provide beneficiaries with cohesive and continuous care-management to achieve positive clinical outcomes, including reduced re-hospitalizations. An episodic delivery system would also ensure that beneficiaries in traditional Medicare and Medicare Advantage plans receive an equal home health care benefit.

VNAA is grateful for the opportunity to submit these comments to the Ways and Means Subcommittee on Health, and we look forward to working with the Committee on the issues surrounding the Medicare Advantage program to ensure that all Medicare beneficiaries receive equal home health benefits and have access to the high-quality, clinically effective and cost-efficient home health care that VNAs have provided for over a century.

For more information, please contact Kathy Thompson at 240–485–1856 or Ashley Groesbeck at 240–485–1857.