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May 5, 2008

The Honorable Pete Stark
Chairman, Subcommittee on Health
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

*Re: Questions for the record from the Ways and Means Subcommittee Hearing entitled:
“MedPAC’s Annual March Report”*

Dear Congressman Stark:

This letter is in response to the questions you sent us on March 25, 2008. Answers to the questions are as follows:

Replies to questions from Ranking Member David Camp

According to the March 2008 Med PAC report, approximately 80 percent of beneficiaries in Medicare Advantage (MA) are enrolled in a coordinated care plan. The same report also highlighted how the most popular form of coordinated care plan (HMO plans) submitted bids for the standard Part A and B benefit that were, on average, below the costs of traditional Medicare. Are HMO plans able to provide the standard Part A and B benefits at an amount lower than traditional Medicare, according to their average submitted bids?

As of March of 2008, 77 percent of enrollees in plans that participate in the MA bidding process are in coordinated care plans, a category that includes HMOs, local PPOs, and regional PPOs. HMOs have nearly 69 percent of the enrollment, and local or regional PPOs have nearly nine percent of the enrollment (with the two categories summing to 77 percent). The remaining 23 percent of MA enrollees are in private fee-for-service (PFFS) plans.

As of 2008, about 80 percent of Medicare beneficiaries have access to an MA HMO operating in their county. In rural areas, only about 44 percent of beneficiaries have access to an HMO. All residents of the United States have access to at least one PFFS plan in their county.

The average submitted bid for HMO plans indicates that they are able to provide Medicare's Part A and Part B benefit package for less than the cost to the traditional FFS program. In 2008, the enrollment-weighted average HMO bid is at 99 percent of average FFS spending. This is up from 97 percent of FFS in 2006.

If the majority of MA enrollees are in plans that, according to the plan bids, are able to provide the standard Part A and B benefits below the cost of traditional Medicare, what is the basis for your assertion that it would be more efficient to provide extra benefits through traditional Medicare?

What MedPAC has said about plan efficiency is that under the current MA payment policy, extra benefits are provided by efficient plans (with efficiency measured by a plan's ability to bid below 100 percent of FFS), as well as by inefficient plans. Inefficient plans require payments in excess of 100 percent of FFS to provide the Medicare benefit, and their sole source of funding for extra benefits are payments from the Medicare Trust Funds and beneficiary premiums. Whereas in the former case the extra benefits are (in part, at least) a signal that the plan is efficient, in the latter case the ability to provide extra benefits does not mean that the plan is efficient. In the latter case, payments to the health plan, because they are at a level above 100 percent of FFS, are an inefficient use of Medicare dollars and beneficiary premiums.

Another aspect of this question is whether MA plans could be efficient in all areas of the country (i.e., able to provide the A/B benefit package in all parts of the United States for less than FFS). As you point out, only HMOs are able to bid below FFS Medicare levels. Part of the reason HMOs are efficient in MA is that they are achieving economies of scale by operating in more densely populated areas. Almost half of HMO enrollment (49%) comes from 40 urban counties (out of the nearly 1100 urban counties, and 3200 total counties, in the United States). High levels of enrollment within a geographic area enable HMOs to achieve economies of scale—spreading fixed administrative costs over a larger enrollment—and they also allow plans to have better negotiating leverage with providers to secure favorable provider contracts and obtain discounts. However, HMOs still do not generally operate in certain areas, even where benchmarks are very high relative to FFS—that is, HMOs do not see the “business case” for operating in some counties (i.e., they cannot be efficient in some areas).

Has MedPAC identified any data that would indicate that coordinated care plans would be less efficient in the delivery of additional benefits, in contrast to their ability to provide standard Part A and B benefits at a cost lower than traditional Medicare?

MA HMO bids at an average level of 99 percent of Medicare FFS levels show that some plans, in some counties, can provide the traditional Medicare benefit package at a cost that is less than that of FFS Medicare in that particular county. It would be surprising if HMOs were not able to “compete” against FFS Medicare in the particular geographic areas where Medicare HMOs have been most successful. However, we also know that many plans—including the fast-growing PFFS plans—cannot provide traditional benefits more efficiently than FFS.

There are no data on the administrative costs of having the traditional FFS program offer extra benefits. So we do not know definitively whether the ability to be more efficient than FFS Medicare in some counties translates into an ability to provide benefits that are not part of the traditional Medicare benefit package more efficiently than the Medicare program. However, an important point is that the principal extra benefits that MA plans offer are the reduction in cost sharing for Medicare benefits and the reduction in plan premiums. According to CMS data for 2007, the buy-down of Medicare cost sharing represented \$67 out of \$86 in average net extra benefits for MA enrollees—over three quarters of the total dollars. As CMS noted, the MA buy-down of cost sharing has associated with it “allowed overhead costs for supplemental benefits...allocated to additional benefits and cost-sharing buy-down” (see CMS’s document, *Medicare Advantage in 2007*). That is, cost sharing buy-downs get a proportional allocation of the total plan administration and profit. For example, if a plan bid results in \$100 available as rebate dollars, and the plan decides to use all the rebate to reduce cost sharing, the value of cost sharing reduction for beneficiaries is \$85, if the plan administration and profit charge combined is 15 percent (which is a standard level of administration and profit). In other words, the most common additional benefit—reduced cost sharing—has an administrative “load” associated with the benefit, just as other extra benefits (eyeglasses, hearing aids) have loading for administration and profit.

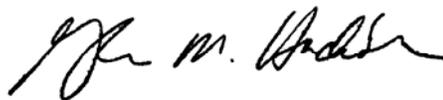
Has MedPAC estimated what it would cost to have the traditional Medicare program provide all of the extra benefits (reduced cost-sharing, reduced premiums, catastrophic cost protections, free preventive services, annual physicals, dental and vision coverage, disease management, etc.) that are currently being offered in the most popular coordinated care MA plans?

We have not specifically estimated the cost of having the Medicare program provide the kinds of additional benefits that many MA plans are offering. In MA, the current situation is one of many plans, small and large, across the country, providing a range of extra benefits and incurring administrative costs in providing those benefits. Generally, if Medicare were to provide a new benefit, such as the coverage of hearing aids, it could be provided in a way that capitalized on Medicare's large scale as a purchaser and its relatively low administrative costs (including the absence of profit as a component of such costs). However, private plans may be able to "manage" the provision of extra benefits and thereby reduce costs, with larger MA plans having an advantage over smaller plans in their incurred administrative costs.

HMOs are more efficient than other plan types in providing the Medicare A and B benefit, as indicated by the difference in bids between plan types. However, HMO enrollment is becoming a smaller proportion of total MA enrollment. Increasingly, enrollment in MA is coming from plans with bids for Medicare A/B services that are above Medicare FFS levels. Thus, it is becoming more expensive for the program to provide A/B benefits (as well as extra benefits) through the MA program than it has been in the past. To the extent that enrollment will continue to grow in areas and among plans with bids that are less efficient than the current HMO average, the extra cost to Medicare of providing the A/B benefit through MA plans has to be factored in when evaluating the question of what is the most efficient way of providing extra benefits to Medicare beneficiaries.

Please feel free to follow up with me or Mark Miller, MedPAC's Executive Director (202-220-3700) on any of these issues. Again, we appreciate the opportunity to testify on our March 2008 report and appreciate the Committee's interest in our work.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is written in a cursive style and is positioned above a thin vertical red line.

Glenn Hackbarth, J.D.
Chairman