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Testimony for Hearing on
Medicare Health Plans

Health Subcommittee
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U.S. House of Representatives

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Thank you, Chairman Herger, Ranking Member Stark, and members of the subcommittee for the opportunity to testify on Medicare health plans. As a senior fellow at Mathematica Policy Research during the past 20 years, I have tracked the history of private plans in Medicare; analyzed trends in plan participation, enrollment, and benefits; examined market dynamics; and studied the implications for beneficiaries. This body of work extends from the late 1990s, when Medicare+Choice replaced the Medicare risk-contracting (HMO) program, through today's mature Medicare Advantage (MA) program. I have written and presented extensively on this work and its implications for policy development.

Medicare is critical for the aged and disabled in this nation, many of whom have low to moderate incomes, complex health care needs, and characteristics that leave them disproportionately vulnerable to misleading information, confusion, or abusive practices (KFF 2011a). Private plan authority within Medicare, such as MA, has helped expand alternatives

available to Medicare beneficiaries, but controversies persist about what role such plans should play in Medicare. My testimony today focuses on the following assessments of the current MA program:

- Today, the MA program is strong, with rising enrollment and widespread plan availability expected to continue into 2013, despite concerns that cutbacks in payments would discourage plan participation or make plans less attractive to potential enrollees.
- MA plans are still paid considerably more for a similar beneficiary in the traditional program. In considering future policy changes, it is difficult to see the rationale on a national basis for paying private plans more than Medicare currently spends on the traditional program, particularly when there is so much concern about the federal deficit and debt.
- Although some may suggest otherwise, I have studied these plans in-depth for more than 20 years, and there is no strong or consistent evidence that private plans are better at cost control than traditional Medicare is or that health plan competition will produce enough savings to address current fiscal challenges.
- Traditional Medicare remains popular with beneficiaries (KFF 2012b), which means that paying more for private plans is effectively a tax on their choice because their Part B premiums will increase with no gain in benefits to them.
- As the Congressional Budget Office (2011) has concluded, premium-support programs that reduce government contributions to Medicare will shift costs to beneficiaries and limit the health and financial protection the program provides to vulnerable beneficiaries.
- Traditional Medicare, with its defined and nationally uniform benefits across the country, has served as a valuable protection to beneficiaries, particularly in times of fiscal stress.
- Evidence from MA and other programs shows that strong oversight and effective risk adjustment are necessary to prevent unfair marketing and enrollment practices.

MA Plan Enrollment Continues to Grow

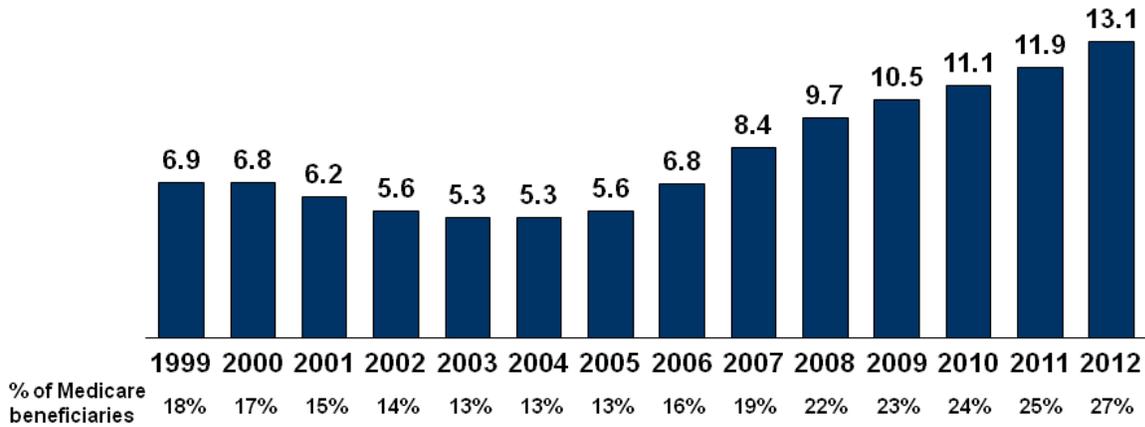
For many decades, Medicare has offered beneficiaries access to popular private-marketplace alternatives through a variety of legislative mechanisms, including cost contracts (1970s), the Medicare risk-contracting (HMO) program (1982), Medicare+Choice with additional private plan options (1997), and MA (2003), which expanded options and integrated the new Part D benefit for those choosing MA (Gold 2001, 2008). Enrollment in these plans has historically ebbed and flowed as payment levels have fluctuated. Over time, private Medicare plans have expanded offerings for beneficiaries and attracted a growing share of beneficiaries, even though over 70 percent are covered under traditional Medicare. However, private plans were never meant to replace the traditional program; rather, they were a voluntary option for beneficiaries (PL 105-33).

The Patient Protection and Affordable Care Act (ACA) (PL 111-148, Part III, Improving Payment Accuracy) sought to scale back payments to MA plans to achieve closer alignment between payments made for beneficiaries in MA versus in the traditional program. Because MA payments are drawn from both the Medicare Trust Fund and Part B, reducing MA payments also helped to extend the life of the Medicare Trust Fund and to slow increases in Part B premiums for all beneficiaries.

Despite concerns that payment cutbacks may hurt the program, MA enrollment has continued to grow. Currently, enrollment is at an all-time high of 27 percent of beneficiaries, and it continues to grow despite reductions in payments included in the ACA (Exhibit 1). The Obama Administration projects, based on its annual bidding process, that such growth will continue in 2013, with premiums rising only modestly in 2013 (around \$1.47 per month), assuming enrollees

do not change to a more attractive plan to get a lower premium (HHS 2012). Since the ACA was enacted, average premiums paid by enrollees have declined.

Exhibit 1: MA Enrollment in Millions, 1999-2012



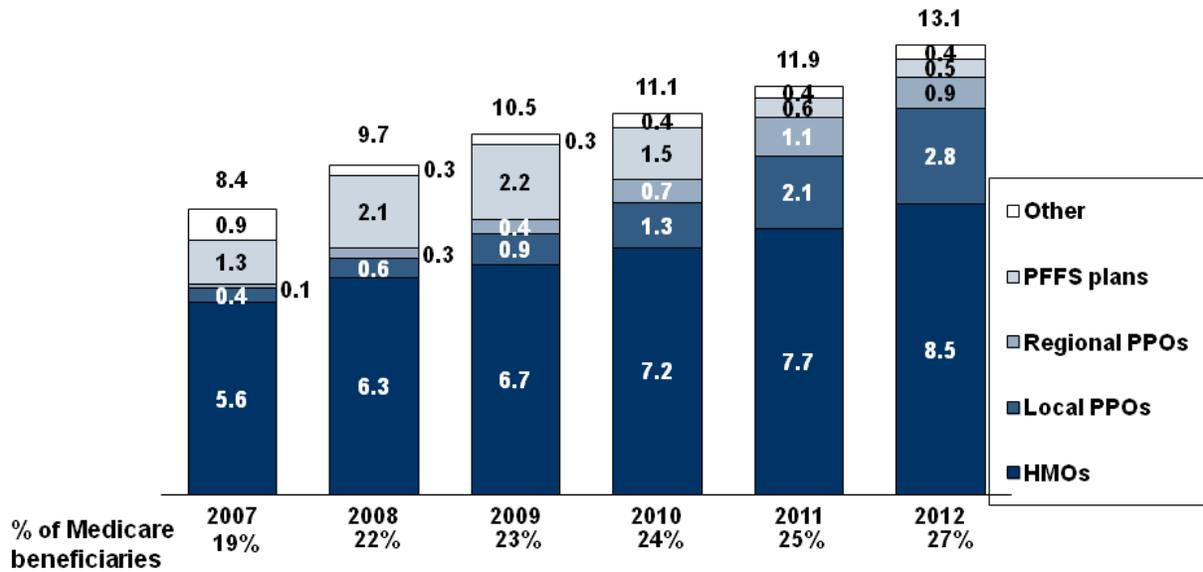
Source: Mathematica/Kaiser Family Foundation's analysis of CMS's Medicare Advantage enrollment files, 2008-2012, and Mathematica's "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2001-2007.

Notes: The data shown include cost and demonstration plans as well as enrollees in special-needs plans and other MA plans.

The enrollment numbers are from March of the respective year, with the exception of 2006 (from April).

New types of private plans, such as preferred provider organizations (PPOs)—which give beneficiaries broader access to providers and generally cost more—have accounted for a disproportionate share of recent growth, though the majority of MA enrollees remain in health maintenance organizations (HMOs), the core of the original Medicare program (Exhibit 2).

Exhibit 2: MA Enrollment (in Millions) by Plan Type, 2007-2012



Source: Mathematica/Kaiser Family Foundation's analysis of CMS's Medicare Advantage enrollment files, 2008-2012, and Mathematica's "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2007.

Notes: Enrollment numbers are from March of the respective year. Enrollment includes those in individual and group plans, including special-needs plans. "Other" includes cost and demonstration plans.

PFFS = private fee for service.

Recent Cutbacks in MA Payments Relative to Traditional Medicare Are Equitable

Medicare has historically aimed to set payments to private plans below or equal to what Medicare would pay in the traditional program for a similar beneficiary in the same county. Originally, payments in the Medicare risk-contracting program were set at 95 percent of traditional program payments; however, weaknesses in risk adjustment resulted in plans being paid considerably more (Brown et al. 1993). When the program evolved to the Medicare+Choice structure, the link between private-plan and traditional-program payments was modified in a subset of counties to support growth in areas with few, if any, private plans ("floor counties") and to address geographical differences in payment ("blend counties"). These changes did not have the intended effect of increasing program enrollment, in part because annual costs in the traditional program were growing more slowly during that period than in the past, contributing to

low rates of annual increases in premiums (Berenson 2008). As a result, many withdrew from the market (Gold 2001; Gold et al. 2004). In 2003, Congress sought to stabilize the MA program by setting minimum rates at 100 percent of fee for service (FFS) and, more critically, providing an option that allowed for substantially higher rates of annual increases (Gold 2008).

These cumulative policy changes, over time, led to plans being paid considerably more than Medicare would pay for a similar beneficiary in the traditional program. In 2009, for example, the Medicare Payment Advisory Commission (MedPAC), the nonpartisan adviser to Congress on Medicare payment issues, estimated that the MA payment benchmarks (the most Medicare would pay a plan), on average, were 118 percent of what Medicare would spend for a similar beneficiary in the traditional program. Furthermore, MA payments (set at 75 percent of benchmarks, up to the costs of the plan) were 114 percent of traditional Medicare spending. The data on which these estimates are based have not historically been available to the public, but recent analysis based on information made available as a result of a Freedom of Information Act request shows similar results and highlights the geographical variation in payments, relative to traditional Medicare (Biles et al. 2011).

Since 2005, MedPAC (2010) has recommended alignment of traditional Medicare and private-plan payments. Consistent with this recommendation, the ACA's legislative changes are gradually introducing more financial parity between traditional Medicare and MA. In 2012, average benchmarks declined to 112 percent of traditional program spending, and average payments to 107 percent (MedPAC 2012a). Average bids—that is, plan estimates of what it will cost the plan to provide the Medicare Part A and B benefit (which historically have been above 100 percent of costs in the traditional program)—have meanwhile fallen to 98 percent of traditional program spending, but this appears to be almost entirely a result of HMOs' experience. However, HMOs have not proven viable in all markets, with their growth also

constrained by many beneficiaries’ reluctance to limit their choice of provider. Local PPOs, which offer more provider choice but also cost more and represent a rapidly growing part of the program, had bids that were, on average, 108 percent of traditional program spending (Exhibit 3).

Exhibit 3: MA Payments Relative to Traditional Program Spending, 2012

	Benchmarks	Bids	Payments
All MA Plans	112%	98%	107%
HMO	112%	95%	106%
Local PPO	114%	108%	113%
Regional PPO	107%	100%	105%
Private fee-for-service	112%	106%	110%
Restricted Availability Plans			
Included in the Total			
Special-Needs Plans	114%	101%	110%
Employer Groups	114%	108%	113%

Source: MedPAC analysis of CMS data on plan bids from March 2012 Report to Congress, Table 12-3, p. 319.

Note: Benchmarks are computed for each county and reflect the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits. If a plan’s bid is above the benchmark, the plan’s MA payment rate is equal to the benchmark, with enrollees having to pay an additional premium equal to the difference. If a plan’s bid is below the benchmark, the plan’s MA payment rate is its bid plus 75 percent of the difference between the plan’s bid and its benchmark.

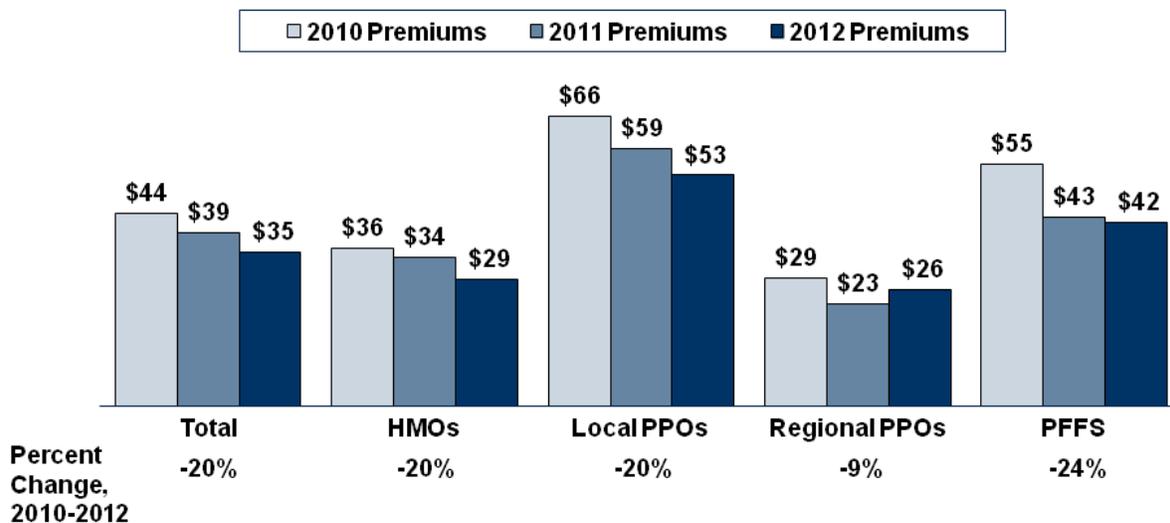
PFFS = private fee for service.

It is difficult to see the rationale on a national basis for paying private plans more than Medicare currently spends on the traditional program, particularly when there is so much concern about the federal deficit and debt. In fact, the original concept supporting risk-based plans was to pay them less, generating savings for Medicare and additional benefits (through efficiency) for beneficiaries.

Beneficiaries continue to have good access to private plans (Gold et al. 2012). In 2012, the average beneficiary could choose among 20 MA plans locally, excluding plans with specialized

enrollment requirements such as special-needs plans (SNPs). Plans also have been able to keep premiums down in order to attract enrollees (Exhibit 4). Benefits remain attractive, though out-of-pocket spending can be high given the limited incomes and assets of Medicare beneficiaries, particularly if they have extensive health needs that persist from year to year. In 2012, almost half of all beneficiaries in MA plans were in plans with premiums above CMS’s recommended \$3,400 limit, and 22 percent were in plans with out-of-pocket limits over \$5,000 (Gold et al. 2012). Common Medigap policies have higher premiums but provide better financial protection combined with traditional Medicare than do most MA plans. However, many beneficiaries do not understand the complex cost-sharing requirements and the trade-offs involved, making decisions based mainly on plan premiums, particularly if their incomes are modest.

Exhibit 4: Enrollment Weighted Average Monthly Premiums for MA Plans That Include Prescription Drug Coverage, Total and by Plan Type, 2010-2012



Source: Mathematica/Kaiser Family Foundation's analysis of CMS's Landscape Files for 2010-2012 and March enrollment files for 2010-2012.

Note: The premiums shown are weighted by enrollment. The data exclude SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). The data only include MA plans that offer Part D benefits. The total includes cost plans (not shown separately) as well as plans with zero premiums. The premiums for a subset of sanctioned plans were not available in 2011; these plans were therefore excluded from this analysis.

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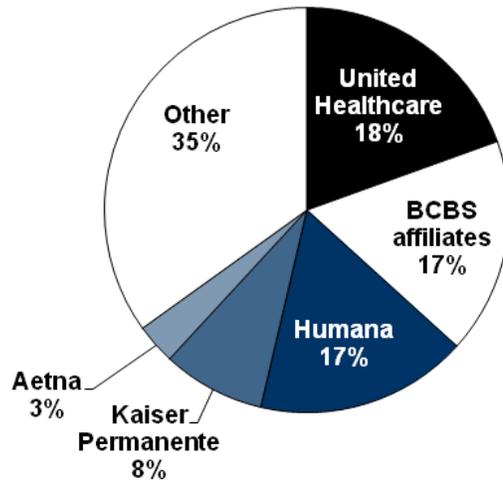
PFFS = private fee for service

Clearly, payment reductions can discourage plans from participating in MA, based on the history of private plans in Medicare (Gold et al. 2004, 2011a). Whether this is an issue depends on one's perspective on the desirability of choice, even if it costs (rather than saves) money. The evidence, however, suggests that firm participation and choice are not yet issues. They could become bigger issues in the future, but the erosion in commercial-coverage markets will make it harder for firms in the Medicare market to walk away because of the absence of good alternatives to make up that revenue (Gold et al. 2011). The introduction of Part D on a private-plan model also appears to have made MA more attractive because it familiarizes enrollees with choice and offers an integrated coverage option (traditional Medicare is precluded from offering such integrated coverage).

The crucial policy question is how much additional Medicare spending is warranted to maintain the private option—if the traditional program can provide benefits for less than private plans can and in a manner satisfactory to the vast majority of Medicare beneficiaries who continue to choose the traditional program? Paying more for beneficiaries who choose a private plan, as a matter of policy, implies that one program is better than another—perhaps offering better quality or more effective cost control. Unfortunately, the evidence has never consistently or strongly shown this to be the case, certainly not to the extent that would be warranted to justify substantially higher payments to private plans (Gold 2003, 2012). Such excess payments are particularly hard to justify in an environment where there is concern about growing Medicare spending and its effect on the deficit and national debt. Because MA enrollment is concentrated in a few firms, higher payments also involve a substantial transfer of funds from government to private firms, a few of whom dominate the market (Exhibit 5).

Further, traditional Medicare remains popular with beneficiaries, which means that paying more for private plans is effectively a tax on their choice because their Part B premiums will increase, with no gain in benefits to them.

Exhibit 5: MA Enrollment, by Firm or Affiliate, 2012



Total MA Enrollment, 2012 = 13.1 million

Source: Mathematica/Kaiser Family Foundation analysis of CMS enrollment files, 2012.

Note: "Other" includes firms with less than 3 percent of total enrollment.

BCBS affiliates = Blue Cross/Blue Shield affiliates, including Wellpoint BCBS plans, which comprise 4 percent of the total enrollment in MA plans.

Medicare Advantage Is Not Premium Support

MA (along with its precursor programs) created a role for private plans in Medicare, but it is not a voucher or premium-support plan (Gold 2012). The defined benefit Medicare provides differs fundamentally from a fixed-contribution plan. Under today's defined-benefit Medicare program, all beneficiaries, regardless of where they live or how they choose to receive their benefits, are guaranteed the same minimum benefits by Medicare today.

Geographic differences in care-seeking and care-providing patterns and costs affect the amounts of services beneficiaries actually *use*, the amounts plans are paid, and plans' flexibility

to make benefit packages more attractive, but they do not affect a beneficiary's guaranteed *benefits* or contribution to Part B and D premiums.

Private plans can modify cost sharing *if* the changes result in plans that are at least actuarially equivalent to traditional Medicare and do not discriminate against the sick. Oversight has been required to monitor benefit design and preclude practices, like high cost-sharing for selected services (such as chemotherapy) used by particularly ill enrollees. Furthermore, beneficiaries enrolled in MA plans retain the right to leave the plan and opt for the traditional program during the annual open-enrollment period. Although premium-support proposals vary, most would fundamentally change the traditional way the Medicare program operates or would eliminate it altogether. Those keeping it would break the national program up into local programs (KFF 2012).

Some proposals say they maintain a traditional Medicare plan option but do not appear to commit to finance it, as some might interpret recent proposals (Van de Water 2012). This arguably presents a false assurance about the future availability of traditional Medicare as we now know it. These proposals are not very detailed, but typically raise the possibility that beneficiaries seeking to remain in the traditional program would have to pay more for that opportunity.

Traditional Medicare and private plans alike face challenges in a health care system that is very inefficient. Fundamental reform of the system to reduce costs ultimately cannot be achieved without someone paying the price—whether that is the beneficiary, the plan, the provider, Medicare itself (that is, taxpayers), or some combination of these. Cost reduction means fewer services are used or lower payments are made for those services. Unfortunately, one person's wasteful spending is another person's reduced income. It also is not always easy to distinguish wasteful services from medically necessary care, especially as this relates to the care of specific

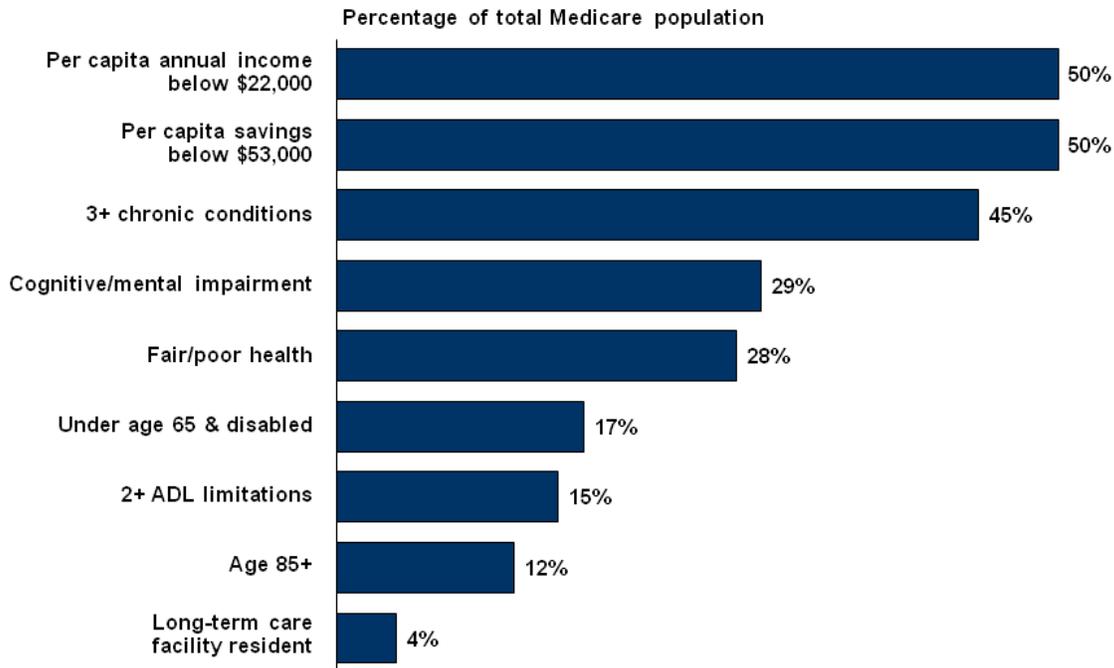
individuals. If the idea is to increase the out-of-pocket costs of beneficiaries and assume the financial pressure will make them advocates for more efficient, lower-cost care (despite their not generally having the knowledge to do that well), it seems that it would be important to tell them that is the plan. The managed-care backlash showed that policymakers should not expect the private sector—or beneficiaries—to engage in battles from which they themselves want distance (Gold 1999).

As these issues are debated, it is critical to place them within the current economic context facing beneficiaries today. Beneficiaries already pay a substantial share of their incomes for health care. For example, in 2006, median out-of-pocket spending as a share of income was 16 percent, with one in four Medicare beneficiaries spending 30 percent or more of their incomes on health expenses (KFF 2011b). As a result, Medicare beneficiaries are forced to make critical trade-offs in managing their household budgets (Cubanski et al. 2011).

Lessons for Premium Support

Medicare beneficiaries are a diverse group with complex health care needs, compared to the general population, and characteristics that make them vulnerable to abusive practices in a market environment, especially if appropriate regulatory protections are not in place (KFF 2011a). One-quarter have a cognitive or mental impairment, and about the same share report being in “fair” or “poor” health. Per capita annual incomes are low, as are assets (Exhibit 6). Research suggests that choice historically has not been very salient to most Medicare beneficiaries (Gold et al. 2004). Although the Part D benefit may make it more salient today, many choices can confuse beneficiaries (Ivengar et al. 2000; McWilliams et al. 2011). Once a choice is made, it is also “sticky,” with only annual opportunities to change plan choices (Polanski et al. 2010).

Exhibit 6: Characteristics of the Medicare Population



Source: Income and savings data from Urban Institute/Kaiser Family Foundation (KFF) analysis, 2011. All other data are from KFF's analysis of the CMS Medicare Current Beneficiary 2008 Access to Care file.

Note: ADL = activity of daily living.

History shows that strong system oversight is critical to the success of any private-plan offering. In the absence of protections against unfair marketing and enrollment practices, Medicare beneficiaries, many of whom have low levels of education and health literacy as well as physical or mental disabilities or cognitive impairments, are vulnerable to abuse by unscrupulous insurers, as evidenced by experience in various sectors of the Medicare supplemental market (GAO 1986; Borer 2008; Dallek 1997). While most in the industry may be ethical, there are always some who will be attracted by short-term gain and the available dollars, regardless of the consequences. An appropriate regulatory infrastructure can make it more likely that competition will be fair and focused on legitimate differences among plans as well as meaningful choice for beneficiaries. As the purchaser of health care, Medicare can help beneficiaries who need assistance in making a choice by providing neutral information, for

example, or counseling to lay out options and answer questions. Although regulatory requirements add to the administrative burden, and some regulatory features could be improved, problems tend to arise when oversight is either absent or unenforced.

Fixed payments give firms an incentive to avoid high-cost enrollees who use a disproportionate share of services. Data from beneficiaries in the traditional Medicare program show that the costliest 5 percent of beneficiaries account for 38 percent of annual Medicare spending, and the costliest quartile (top 25 percent) account for 81 percent (MedPAC 2012c). Research also underscores the importance of adequate risk adjustment in any arrangement that involves multiple competing plans. The highly skewed distribution of health care spending, combined with the fact that high needs may factor into the choices beneficiaries make, means that risk-adjusted payments are essential to an equitable private-plan offering. Although risk adjustment has been improved under MA, opportunities for gaming the system still exist, and plans that do well in serving those with the highest needs are not necessarily equitably compensated for their efforts (MedPAC 2012b).

Further, current risk-adjustment methods remain highly medically oriented. Risk adjustment based on medical diagnoses is particularly problematic for enrolling dual eligibles (those who qualify for both Medicare and Medicaid benefits) in private plans. Adjustors that work across Medicare and Medicaid, account for frailty, and take into account social circumstances that influence service costs, such as language barriers, low health literacy, or limited social support are essential to an equitable system of payment for private plans serving dual eligibles. Oversight is critical for programs serving these individuals, particularly when both payers and plans have limited experience in serving them, especially in an integrated way (Gold et al. 2012; Neuman et al. 2012).

Although decisions about the future of Medicare will inevitably reflect the values considered socially acceptable by a variety of stakeholders, the evidence suggests that there are no easy answers to the fiscal dilemmas facing our nation. There has been a long-standing hope that introducing private plans and competition into Medicare will help to control costs. The reality is that this goal has been elusive and that private plans generally cost Medicare more over their history compared to traditional Medicare. Proposals to use premium supports seem to continue to pursue this approach, with beneficiaries asked to have “more skin in the game,” in the hopes that they will choose more wisely and do what neither government nor the private sector has been able to do to date—control costs. Unfortunately, the available evidence provides little indication that this will occur. Premium support, particularly if it is not adequately financed, is likely to lead to higher costs for beneficiaries.

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