Hearing on the Future of Medicare Advantage Health Plans

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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Hearing on the Future of Medicare Advantage Health Plans

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

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

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*Mr. Brady. Good morning, everyone. The subcommittee will come to order.

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

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

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

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

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

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

Knowing just how unpopular these cuts were with the seniors that select these plans, the White House, acting through a new demonstration program and other regulatory actions, masked and delayed the impact of initial stages of the $300 billion in cuts through the November 2012 elections. Those political delays are over. The difficult reality is 2015 is now upon us, and millions of seniors who rely on the Medicare Advantage Program may be in jeopardy of losing their plan, their doctor, and the financial protection and benefits they have chosen.

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

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

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

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

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

And without objection, so ordered.

[The report of the American Action Network follows: The Honorable Kevin Brady]

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

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

Today you will hear from witnesses who will tell us the current picture of Medicare Advantage, the good, the bad and, yes, maybe even the ugly, and I am confident that as we look forward and work together we can break down barriers and improve Medicare Advantage for America's seniors who depend upon these critical plans.

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

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

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

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

Without objection, so ordered.

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

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

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

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

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

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

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

Independent analysis from the GAO, Medpac, and countless others point out that the wasteful spending was putting Medicare on an unsustainable course. To fix this, the ACA improved how we calculate payment rates. These reforms have brought payments to more in line with the costs of traditional Medicare, while emphasizing efficiency and quality.

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

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

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

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

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

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

And thank you, Mr. Chairman.

*Mr. Brady. Thank you.

Today we are joined by four witnesses:

Chris Wing, Chief Executive Officer at SCAN Health Plans;

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

And Joe Baker, President of the Medicare Rights Center.

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

*Mr. Wing. Thank you, Mr. Chairman.

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

I am happy to say that 37 years later we have the exact same mission statement. With our focus on our mission statement and the unique and disparate needs of seniors, since they are not a homogenous group, we have now emerged as one of the fastest growing MA plans in the Nation, and we are the fourth largest not-for-profit MAPD plan in the Nation.

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

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

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

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

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

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

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

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

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

Now plans of providers are adapting and evolving to these cuts. We have no choice, and it is good that we are doing it. Some of the larger plans are vertically integrating to create synergies in costs and care savings. SCAN is pursuing a more collaborative approach with the bigger systems in Arizona and California.

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

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

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

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

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

Dr. Burnich.

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

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

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

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

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

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

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

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

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

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

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

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

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

We go to the home, and we set goals with these patients. What is it that they want to accomplish? It can be as simple as a grandmother wanting to see her granddaughter graduate high school, and she is very ill and we need to manage her symptoms.

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

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

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

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

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

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

Thank you.

*Mr. Brady. Thank you, Doctor.

Mr. Book, you are recognized for five minutes.

*Dr. Book. Thank you, Chairman Brady and Ranking Member McDermott and members of the subcommittee.

*Mr. Brady. Can you get your microphone and just see if that is on?

*Dr. Book. I am sorry.

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

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

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

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

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

The bonus system based on the star rating system that Mr. McDermott referenced, I think everyone agrees that paying more for good performance is a good thing. However the star rating system does not necessarily accomplish that because CMS chooses the rating criteria after the period of performance. So, for example, in the first cycle, they measured performance between January 2010 and June 2011 and then October 2011 announced the criteria on which plans would be rated.

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

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

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

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

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

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

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

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

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

Mr. Baker, you are recognized.

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

Each year Medicare Rights Center counsels thousands of people with Medicare about topics ranging from enrolling in a plan to appealing a denied claim. For people with Medicare, we find there is no one size fits all choice. Medicare Advantage Plans are a good option for some, but for many original Medicare remains a better choice for them.

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

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

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

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

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

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

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

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

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

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

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

Even with this success, Congress can and should take steps to further improve Medicare Advantage, while also preserving and strengthening original Medicare, for example: By increasing support for the SHIP Programs, these are the State health insurance programs which provided free and unbiased counseling in each State to support seniors and people with disabilities in their decision making.

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

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

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

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

*Mr. Brady. Thank you, Mr. Baker, and thank you for the testimony from all four witnesses.

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

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

Mr. Book, as you describe in your testimony, the cuts to Medicare Advantage are becoming real for millions of seniors. There is no magic bean here. These cuts will land on them. Some suggest and your testimony said that you would be forced to spend $3,700 less per senior as a result of these cuts. Some suggest these simply eliminate inflated profits for Medicare Advantage Plans or have made them more efficient.

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

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

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

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

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

*Mr. Brady. They have to reduce the benefits.

*Dr. Book. Right.

*Mr. Brady. Or you have to increase the costs to seniors.

*Dr. Book. Right. There is no other room. That is correct.

*Mr. Brady. You do not have a magic bean that you will be using somehow --

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

*Mr. Brady. Yes, I would think so.

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

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

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

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

*Mr. Wing. I think the answer is yes. I cannot speak for the industry, but we submitted our bid for 2015 in the first week of June, and there will be withdrawals from markets. There will be withdrawals of products from certain markets.

*Mr. Brady. Withdrawals from markets means there will be fewer Medicare Advantage Plans offered to fewer seniors.

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

*Mr. Brady. Sure.

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

*Mr. Brady. They will be able to see fewer doctors, fewer hospitals, less choice.

*Mr. Wing. Yes.

*Mr. Brady. And that impact would not be occurring without these Affordable Care Act cuts?

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

*Mr. Brady. Negative margin means your profits are so large you are actually losing money?

*Mr. Wing. We are losing money.

*Mr. Brady. Yes. Dr. Burnich.

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

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

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

*Mr. Brady. So the plan that targets the most sick and chronically ill seniors would not have gotten off the ground?

*Dr. Burnich. No, and it will not be sustainable either.

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

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

*Mr. Brady. You think the impact on seniors will be the same or greater than the cuts in the Balanced Budget Agreement?

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

*Mr. Brady. Doing more things, seeking revenue from other sources?

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

*Mr. Brady. Can I finish with this?

*Dr. Burnich. I hate to say that, but I think --

*Mr. Brady. No, I know. Look. No magic bean here.

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

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

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

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

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

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

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

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

Dr. McDermott, you are recognized.

*Mr. McDermott. Thank you, Mr. Chairman.

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

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

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

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

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

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

The Ryan budget has had them in every single time.

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

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

*Mr. Brady. The Ryan budget is not the law today. These are people who are living under real cuts and real law.

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

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

*Mr. McDermott. Are they putting in bids?

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

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

These are private entities that make business decisions based upon reimbursement and a number of other factors about whether to enter a particular market or leave a particular market, and certainly BBA, other

reimbursement changes can affect that behavior, but there is a whole host of other issues that can be specific to particular plans that have nothing to do with reimbursement overall.

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

*Mr. Baker. Open how? I am sorry.

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

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

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

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

*Mr. McDermott. Thank you.

*Mr. Brady. Thank you.

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

Mr. Johnson is recognized.

*Mr. Johnson. Thank you, Mr. Chairman.

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

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

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

Mr. Wing.

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

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

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

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

*Mr. Johnson. Thank you.

Dr. Burnich.

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

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

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

*Dr. Burnich. Absolutely.

*Mr. Johnson. That is what I am seeing.

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

*Mr. Johnson. Yes. Mr. Book.

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

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

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

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

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

Mr. Chairman, I am ashamed that this Administration decimates Medicare, especially Medicare Advantage, to pay for Obamacare, and while they are playing political games and covering up these cuts until after the election, Medicare beneficiaries in my district and around the Nation are losing benefits and access to their preferred Medicare Advantage Plans.

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

*Mr. Brady. Thank you.

Mr. Gerlach, you are recognized.

*Mr. Gerlach. Thank you, Mr. Chairman.

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

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

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

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

And I would start with you, Mr. Wing.

*Mr. Wing. Well, thanks. It is a great question.

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

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

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

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

*Mr. Gerlach. Doctor.

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

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

So that is the concern I have.

*Mr. Gerlach. Dr. Book.

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

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

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

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

*Mr. Gerlach. Mr. Baker.

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

*Mr. Gerlach. Thank you all for your testimony.

Chairman.

*Mr. Brady. Thank you.

Mr. Blumenauer is recognized.

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

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

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

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

*Mrs. Black. Well, thank you, Mr. Blumenauer.

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

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

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

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

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

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

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

So I am looking forward to the rollout of the bill. I hope that this might be on the list that I have talked to the chairman about, but I think there are a variety of areas that we ought to be able to agree that have nothing to do with Obamacare. These are things that we can move forward on.

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

I would hope, Mr. Chairman, that there would be an opportunity for us to have hearings on things that we are not necessarily going to be hearing about on the Sunday talk shows, but could make a difference,

and I think this is an example. I look forward to working with my colleague, and I hope we can bring it back before the committee for further discussion.

Thank you, and I yield back.

*Mr. Brady. Thank you, Mr. Blumenauer.

Dr. Price is recognized.

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

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

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

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

*Dr. Book. Right. That is correct.

*Mr. Price. Does that make any sense at all?

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

That makes sense. I think that is fine.

*Mr. Price. That makes some sense.

*Dr. Book. But once you take that system and use it to make payments, you are adjusting the benefits that eh plans can offer, and you are saying to a senior whose criteria are different from that of the bureaucrats in CMS --

*Mr. Price. Right.

*Dr. Book. -- "If you like a different plan, you are going to have to pay more and accept lower benefits if your criteria are different from the bureaucrats' criteria."

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

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

*Dr. Book. Yes, exactly.

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

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

*Mr. Price. That is my understanding as well.

*Dr. Book. Yes.

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

Can you expand on that?

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

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

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

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

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

*Mr. Price. Yes.

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

*Mr. Price. Yes. It is again Washington knows best.

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

*Mr. Wing. I have no margin. I will lose money in 2014.

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

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

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

*Mr. Wing. No, not without extraneous changes.

*Mr. Price. Thank you.

*Mr. Wing. Thank you.

*Mr. Brady. Mr. Smith is recognized for five minutes.

*Mr. Smith. Thank you, Mr. Chairman.

And thank you to our witnesses as well.

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

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

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

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

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

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

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

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

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

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

My concern is overall that health care professionals are frustrated. They do not like the view of the future. It concerns me greatly, especially as a representative of a part of rural America, that health care providers, when I hear from them, they are just discouraging young people, especially family members, from going into health care, and this is because of the Federal Government making such a bureaucracy of health care.

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

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

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

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

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

*Mr. Smith. Okay. I would appreciate any further information on that.

*Dr. Book. I can do that, yes.

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

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

*Mr. Smith. Okay. Thank you, Mr. Chairman. I yield back.

*Mr. Brady. Thank you.

Mr. Thompson, you are recognized.

*Mr. Thompson. Thank you, Mr. Chairman.

Thank you to all of the witnesses for being here.

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

*Mr. Wing. Yes, sir.

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

*Mr. Wing. Thank you.

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

We bring these 14 groups together, and we do not hide the data. They have an economic incentive to group quality. They know who is best at each one of those 50 metrics, and then we have the physicians from those 14 groups share how do they get this best practice.

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

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

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

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

*Mr. Thompson. Mr. Baker, same question.

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

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

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

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

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

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

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

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

*Mr. Thompson. Thank you.

*Mr. Brady. Thank you.

Mr. Roskam.

*Mr. Roskam. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

*Dr. Burnich. Yes.

*Mr. Wing. Yes.

*Mr. Roskam. I yield back.

*Mr. Brady. Thank you.

Mr. Buchanan is recognized.

*Mr. Buchanan. Thank you, Mr. Chairman.

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

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

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

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

*Mr. Buchanan. Is there a percentage or a number?

*Dr. Book. I do not have that.

*Mr. Buchanan. Have you heard that number?

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

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

*Dr. Book. Right.

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

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

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

*Mr. Buchanan. Let me just move on.

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

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

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

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

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

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

*Mr. Buchanan. That is what I am hearing.

Thank you, and I yield back.

*Mr. Brady. Thank you.

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

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

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

So probably, Dr. Burnich, I would like to have you talk a little bit about what your thoughts are on such programs since you have had an innovation grant, which I understand was initiated under MA. So if you could talk a little bit about whether you think this is something that is important.

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

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

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

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

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

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

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

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

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

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

Mr. Wing.

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

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

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

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

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

*Mrs. Black. Doctor?

*Dr. Burnich. I would agree with those statements.

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

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

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

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

*Mrs. Black. Absolutely. Transparency is a big part of this.

Thank you again, Mr. Chairman.

*Mr. Brady. Thank you.

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

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

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

With that, this Subcommittee -- yes, sir.

*Mr. McDermott. May I ask unanimous consent to enter in the record a GAO study entitled "Medicare Advantage Specialty Needs Plans Are More Profitable on Average Than Plans Available to All Beneficiaries," an article from the paper which says, "Despite cuts, Medicare Advantage enrollment ensures stocks still surging," and three articles that say "Paul Ryan budget keeps Obama Medicare cuts Full Stop" from the Washington Post.

Thank you, Mr. Chairman.

*Mr. Brady. Since none of them relate to the issue, they will be inserted as submitted.

[The three articles provided by Mr. McDermott follow: The Honorable Jim McDermott 1, The Honorable Jim McDermott 2, The Honorable Jim McDermott 3]

*Mr. Brady. With that, the hearing is adjourned.

[Whereupon, at 11:35 a.m., the Subcommittee was adjourned.]

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