

MEDICARE HEALTH PLANS

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS
SECOND SESSION

SEPTEMBER 21, 2012

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MEDICARE HEALTH PLANS

FRIDAY, SEPTEMBER 21, 2012

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

The Subcommittee met, pursuant to call, at 9:32 a.m., in Room 1100, Longworth House Office Building, the Honorable Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

Chairman Herger Announces Hearing on Medicare Health Plans

Friday, September 14, 2012

House Ways and Means Health Subcommittee Chairman Wally Herger (R-CA) today announced that the Subcommittee on Health will hold a hearing to examine the current status of the Medicare Advantage (MA) program and other health plans. **The hearing will take place on Friday, September 21, 2012 in 1100 Longworth House Office Building, beginning at 9:30 A.M.**

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

BACKGROUND:

Private health plans have served Medicare beneficiaries from the early years of the program. With 2003 legislation that increased plan payments, beneficiaries were provided with more plan options and enhanced benefits, resulting in millions of seniors choosing to join private Medicare plans. Recent data from the Centers for Medicare and Medicaid Services (CMS) indicates that there are currently over 13.5 million beneficiaries enrolled in private health plans, representing more than one in four Medicare beneficiaries.

According to the Congressional Budget Office (CBO), the Democrats' health law will cut \$308 billion from the MA program over the next ten years. As a result of these cuts, the Medicare Trustees predict enrollment in MA will be cut in half by 2017 as compared to prior law. CBO estimates that those beneficiaries who remain in MA will lose \$816 worth of extra benefits they would have otherwise received in 2019 alone.

The statutory authority for one type of Medicare Advantage plan, MA Special Needs Plans (SNPs), expires at the end of 2013. SNPs were created in the Medicare Modernization Act of 2003 (P.L. 108-173) with the goal of better coordinating care for and tailoring benefits to higher-cost and vulnerable beneficiaries, including dual-eligibles, those with chronic diseases, and the institutionalized. Approximately 1.5 million beneficiaries are enrolled in SNP plans.

Another type of Medicare health plan, Medicare Cost Plans, are paid based on the costs of delivering Medicare-covered services, rather than on a capitated and risk-based basis like MA plans. Congress has repeatedly delayed enforcing a provision that requires cost plans to withdraw from areas that have competition from two or more MA plans. This moratorium expires on January 1, 2013, which would affect the 2014 plan year. There are approximately 400,000 beneficiaries enrolled in cost plans.

In announcing the hearing, Chairman Herger stated, **"More than one in four Medicare beneficiaries have chosen to receive their Medicare benefits through a private Medicare plan. Since 2003, enrollment in the Medicare Advantage program has tripled, which is a clear indication that many beneficiaries enjoy the additional benefits that are often provided by these private health plans. Unfortunately, the Democrats' health law slashed payments to the Medicare Advantage program by more than \$300 billion over the next 10 years to fund ObamaCare. These cuts will significantly alter the program and jeopardize seniors' access to the health plans they rely on. Understanding the successful structure of the current MA program, and the challenges the program will face because of the Democrats' health law,**

is key to ensuring Medicare meets the needs of seniors now and into the future.”

FOCUS OF THE HEARING:

The hearing will examine the current status of the MA program, including SNPs and Medicare Cost Plans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Friday, October 5, 2012**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman HERGER. The subcommittee will come to order. Today, we will hear testimony regarding the current role of Medicare health plans and, look to the future of how these plans can continue to effectively serve Medicare beneficiaries. As you know, we will be having votes earlier than expected. In the interest of time, and to ensure we hear the witnesses’ testimony, I ask unani-

mous consent that my opening statement be made part of the record. Without objection, so ordered.

The Honorable Wally Herger Opening Statement

**Health Subcommittee Hearing on
Medicare Advantage
September 21, 2012**

Chairman Herger Opening Statement

Today we will hear testimony regarding the current role of Medicare health plans, and look to the future of how these plans can continue to effectively serve Medicare beneficiaries.

Medicare has allowed private health care plans to deliver care to beneficiaries since the 1970s. Significant and numerous changes have been made to these plans over the years, some good and some bad, causing enrollment to fluctuate dramatically.

Through all of the changes over the last thirty years, one thing has been abundantly clear: a significant number of beneficiaries prefer to

receive their Medicare benefits from a private health plan.

Today, one-in-four Medicare beneficiaries have chosen a Medicare Advantage plan over the traditional program. Yet, many of these beneficiaries will lose access to the plans they have and like because of ObamaCare's \$300 billion in cuts to Medicare Advantage over the next decade.

In fact, in their original report on the law, the independent Medicare Actuaries reported that Medicare Advantage enrollment will be cut in half because of these cuts. And the non-partisan Congressional Budget Office reported that beneficiaries who remain in Medicare Advantage will lose \$816 per year worth of additional benefits or increased cost-sharing in 2019. Clearly the cuts in ObamaCare will significantly and negatively impact seniors.

In light of Wednesday's claims by the Obama Administration that Medicare Advantage is stronger than ever, it's important to keep in mind that less than four percent of these cuts have been enacted so far. Even more alarming, in what appears to be an attempt by the Obama Administration to mask the impact of the cuts before the election, CMS abused its demonstration authority to unilaterally increase payments to Medicare Advantage over the next three years. This \$8.3 billion demonstration program restored 70 percent of the funding that would have been cut from Medicare Advantage under the Democrats' health care law this year, according to the Government Accountability Office.

Clearly, beneficiaries and health plans have not seen the full impact of these cuts. Yet, millions

of seniors will be forced out of the plans they have and like once they are fully implemented.

We will also hear from two unique types of Medicare health plans: Special Needs Plans and Cost Plans.

Special Needs Plans are targeted to some of the sickest and most-difficult-to-reach Medicare beneficiaries: those dually-eligible for Medicare and Medicaid; those with chronic conditions; and those who are certified as being eligible for institutional care.

GAO recently examined Special Needs Plans for dual eligibles and found that these plans offered better care coordination and greater involvement of community resources than either standard Medicare Advantage plans or traditional Medicare. But GAO also found wide variety in what these plans submitted to CMS

and called for greater oversight by the agency to ensure these benefits are delivered.

These are important details to consider – how do we ensure that these vulnerable beneficiaries are receiving the high-quality care to which they are entitled, in the most effective manner. The authority for Special Needs Plans to continue serving vulnerable populations expires at the end of next year. As this Committee considers whether or not to extend authorization of this program, and how, testimony from today's witnesses will be valuable.

We will also hear testimony relating to Medicare Cost Plans, a type of Medicare plan that has served beneficiaries since the 1970s.

As part of the Medicare Modernization Act in 2003, Cost Plans were required to withdraw from a service area if there were at least two

Medicare Advantage plans in the same area. This “two plan” test has been extended several times, most recently as part of the Democrats’ health law. Unless Congress acts, the two-plan test will go into effect next year, with affected Cost Plans being forced to withdraw in 2014.

We must carefully examine the impact that changes to Medicare health plans will have on beneficiaries in these plans and the value these plans bring to beneficiaries, Medicare, and ultimately to taxpayers.

I want to thank all of our witnesses for their expert testimony today.

Today we heard a detailed discussion of the future of health plans in Medicare. Clearly, significant changes are coming to the Medicare Advantage program, and seniors are right to be

concerned about what will happen to the health plan they have and like.

As I conclude this hearing, likely my final one as a member of this Committee, I would like to highlight that this Subcommittee has some of the most challenging issues before it. I want to thank my colleagues for their thoughtful, and often spirited, discussion of those issues. We have debated these issues honestly and thoroughly, and have laid down the groundwork to address the issues important to the millions of current Medicare beneficiaries and those joining the program in the future.

I want to say it has been an honor and a privilege to work with all of my colleagues, and a blessing to represent my Northern California constituents. The work that we do is critical to maintaining a vibrant and thriving nation, and I have been proud to be part of it.



The Honorable Pete Stark Opening Statement

We're here today to look at the Medicare Advantage program. While it is important to get an update on the cost contract and special needs plans in light of their legislative needs, I know my colleagues on the other side of the aisle want to use today's forum to further demagogue the Affordable Care Act. Repealing ObamaCare appears to be their singular answer to any health question. Unfortunately for them -- but fortunately for Medicare beneficiaries -- the facts are with us on Medicare Advantage.

Just this week, CMS announced Medicare Advantage offerings for 2013. Virtually all (99.6 percent) beneficiaries have private plan options. Premiums for Medicare Advantage plans are down post-ACA enactment. Enrollment in private plans has increased substantially and is expected to increase another 11 percent next year. It is a positive report.

That shouldn't surprise us. In addition to improving Medicare's benefits, health reform is implementing long-overdue delivery system reforms; reducing waste, fraud and abuse; and greatly reducing overpayments to Medicare Advantage plans. These changes have substantially extended Medicare solvency, and are reducing beneficiary cost-sharing and premiums, too.

Private plans play a robust role in Medicare today, with approximately 25 percent of Medicare beneficiaries choosing to enroll in a Medicare Advantage plan.

In my district, more than 40 percent of beneficiaries opt for MA plans. I strongly support continuing private plans as an *option* in Medicare. I just don't want to pay more for the privilege.

Nationally, nearly 75 percent of beneficiaries *choose* to remain in traditional Medicare. That is also a choice we need to respect and an option we need to protect.

Unfortunately, my colleagues on the other side of the aisle don't agree. They support the Ryan voucher plan which has nothing to do with expanding "choices" for beneficiaries and everything to do with limiting government expenses by cost-shifting to seniors and their families.

The hallmark of Medicare -- its guarantee of defined benefits earned through years of work and contributions to the program -- is under all-out assault in the Ryan voucher. The Republican plan changes Medicare from a defined benefit plan to a defined contribution plan, using a voucher as its vehicle.

Moving to this scheme doesn't "reform" anything. It doesn't lead to a smarter, more efficient system. It doesn't incentivize higher quality. It actually turns back the clock as Medicare's power to innovate and drive delivery and payment system changes would be undermined.

And don't be fooled by assertions that Medicare "remains an option." You still have to use the voucher to get there – a voucher that in many cases won't cover the cost. So it may be "on the menu," but not everyone will be able to afford it.

According to CBO, the original Ryan Medicare voucher would actually INCREASE *national* health spending because tens of millions of people move out of Medicare, and into more costly private plans. It is hard to imagine a more misguided proposal.

Today's hearing is proof positive that we can preserve choices in Medicare while wringing fat out of the system and improving benefits. There is no need to end Medicare as we know it in order to save it.

With that, I look forward to the testimony of our witnesses today.



The Honorable Jim McDermott Opening Statement

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**Draft Statement of Congressman Jim McDermott, WA 7th
Congressional District
Ways and Means, Health Subcommittee
Hearing on Medicare Advantage
September 21, 2012, 9:30am**

You know, I have always heard that Republicans are the party of big business. So many of our best and brightest in this country go into corporate America to provide the United States and the entire world with the best goods and services, at the most competitive price. That is the nature of our dynamic free-market economy, which is the envy of the world. So I find it beyond strange that Mitt Romney, the standard bearer for the Republican Party and someone who touts his business experience as his primary qualification for the White House, is now out there talking about "restoring the cuts" to Medicare, including \$154 billion dollars to the Medicare Advantage program.

Did Mitt Romney forget what he did all those years as a turnaround specialist? I'm a medical doctor, but I understand that he bought companies, and found ways to make them more efficient and more profitable.

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I wonder how Mitt Romney would have reacted if one of his associates said to him: **“Hey—I’ve figured out that one of the companies in our portfolio has been overpaying for things, and we can cut that waste from its balance sheet. It will save the business 154 billion dollars over ten years, without compromising quality or customer service.”** Wow! Do you think he would be interested in that? Do you think his private-equity investors would want to capture that savings? The answer, I think, is obvious.

But instead the Republican nominee is out there saying—**“Repeal Obamacare!” “Restore the cuts to Medicare.”** That’s like saying—**“Let’s go flush \$154 billion dollars down the drain!”** This is not what gets you promoted at Bain Capital. Why would Mitt Romney squeeze all the savings possible out of Staples, or Domino’s Pizza, or Sports Authority—but not want to capture that savings for the American taxpayer? It just doesn’t make sense. And by the way, these savings help to stave off bankruptcy for Medicare for a decade. Anyone with a business mind ought to be interested in that proposition.

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But of course, the ultimate irony: the Paul Ryan Republican-endorsed Budget includes those same cuts! I can draw only one conclusion from that: the Republicans do indeed support conserving \$154 billion dollars for the taxpayer—as long as the Democrats can't get any credit for it!

Everyone knows that Medicare has been overpaying these plans. And the evidence now confirms that this was the case; as CMS announced earlier this week, the Medicare Advantage program remains very healthy in the age of Obamacare. Premiums are stable, and enrollment is up. More than 30 percent of Medicare beneficiaries in my district are in Medicare Advantage, so I am certainly concerned about whether these folks have appropriate choices and coverage.

A word about the Quality Bonus payments: Some of you may know that I am not a fan of our system of private insurance and for-profit health insurance in particular. I have advocated for a publicly financed single-payer health care system during my entire career here in Congress. But until we summon the will to change the role of private insurance in our system, I do think it makes sense to pay for quality, and I applaud the Administration for doing what it thinks is necessary to make the program work. This shouldn't be a partisan issue.

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There has to be a way for seniors to measure which are the best plans when they sign up. In my district of Seattle, Group Health--one of the most respected health systems in the country--also operates the largest Medicare Advantage plan in the state of Washington. It is also one of only nine plans in the country with a five-star rating, and this reflects the culture of Seattle, where the people believe in great health care as a human right. I am proud that seniors in my district have access to this level of care.

In any event, the politics around all of this continue to astound me. Dr. Bill Frist is now experiencing a public conversion, and is out there touting all of the innovations of Obamacare, now that he doesn't have to toe the party line. Mitt Romney has seemingly experienced a conversion in reverse--going from supporting health care as an entitlement to fighting so vigorously against it. Hopefully, one day we will see the Republican party get its act together and come up with a constructive, coherent position on how we as a nation are going to finally focus on the public good and solve our access and cost problems.

Chairman HERGER. I would also ask that if we do get interrupted by votes, I ask the members to return so we can finish questions. Also, before I recognize Ranking Member Stark for the purposes of an opening statement, I ask unanimous consent that all members' written statements be included in the record. Without objection, so ordered. I now recognize Ranking Member Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. Mr. Chairman, I ask that my opening statement be made part of the record, and yield back.

Chairman HERGER. Without objection, so ordered.

Chairman HERGER. Today, we are joined by six witnesses: James Cosgrove, director of the Health Care Group at the Government Accountability Office; Jim Capretta, fellow at the Ethics and Public Policy Center; Karen Ignagni, president and chief executive officer of America's Health Insurance Plans; Dr. Tim Schwab, medical director of SCAN Health Plan; John Tallent, chief executive officer of Medical Associates of Iowa; and Marcia Gold, senior fellow at Mathematica Policy Research.

Mr. Cosgrove, you are now recognized for 5 minutes.

**STATEMENT OF JAMES COSGROVE, DIRECTOR, HEALTH CARE,
U.S. GOVERNMENT ACCOUNTABILITY OFFICE**

Mr. COSGROVE. Good morning, Chairman Herger, Ranking Member Stark, Members of the Subcommittee. I am pleased to be here today as you discuss Medicare Advantage and Medicare cost plans, which offer Medicare beneficiaries an alternative to the fee-for-service program. For many years, private health plans have played an important role in caring for beneficiaries. Currently, about 13.6 million Medicare beneficiaries, more than one out of every four, receive their health care from such plans. Today, I would like to discuss our recent work in three areas related to Medicare health plans. And let me start by summarizing our work on quality payments for MA plans and CMS's demonstration.

PPACA sought to foster high quality health care by paying bonuses to MA plans that achieve the very highest quality ratings, four or more stars on CMS's five-star quality scale. However, instead of implementing these provisions CMS implemented the quality bonus payment demonstration. This 3-year demonstration makes plans of average quality eligible for bonuses, increased bonus amounts, and accelerates the phase-in of bonuses. The cost of the demonstration is expected to exceed \$8.3 billion, an amount that is at least seven times larger than that of any other Medicare demonstration conducted since 1995. The bonuses are expected to offset about 70 percent of PPACA payment reductions for MA plans this year, and about a third of the reductions next year. Due to the design of the demonstration, most of the bonuses are paid to plans of average quality. CMS's intention is to test whether the demonstration's approach would encourage plans to more rapidly adopt larger quality improvements. However, we believe that serious shortcomings in the demonstration's design cast doubt on its ability to produce meaningful results.

In March of this year, we recommended that HHS cancel the demonstration and allow PPACA's quality bonus payment system to take effect. HHS did not agree with our recommendation. Our findings also gave rise to concerns about the Agency's authority to conduct the demonstration under the Social Security Amendments of 1967. The statute does provide broad authority. However, in a July 2012 letter to the Secretary of HHS, we found that the Agency had not established that the demonstration meets the criteria set forth in the statute.

Next, I would like to discuss our most recent report, which examined MA plans designed for beneficiaries dually eligible for Medicare and Medicaid. These plans, known as D-SNPs, were originally envisioned as an option to help dually eligible beneficiaries navi-

gate the two very different health care programs and obtain care appropriate to their needs. It does appear that D-SNPs provide a benefit package that may be more tailored to the needs of duals, and that duals enrolled in D-SNPs have somewhat different characteristics relative to duals enrolled in other MA plans. However, CMS has not required D-SNPs to report information that could better hold plans accountable and help CMS determine whether D-SNPs are realizing their full potential. We found little available information on the amount and appropriateness of the care that these plans actually provide. Furthermore, we found that the plans did not use standardized performance measures when reporting information on outcomes to CMS, making it difficult to compare D-SNPs and hold them accountable for results.

We concluded that there was insufficient information on how well these plans are meeting the unique needs of dual-eligible beneficiaries. We made several recommendations to CMS intended to increase D-SNP accountability and ensure that CMS has the information it needs to systematically evaluate D-SNP performance. HHS concurred with these recommendations.

Finally, I would like to share some of our findings related to Medicare cost plans. These plans differ from MA plans in that they are paid based on their reasonable cost for delivering Medicare-covered services. Cost plans have been a part of the Medicare program since the 1970s. When we examined these plans in 2009, we found that they tended to have higher quality scores than MA plans operating in the same areas. Enrollment in cost plans has been fairly low, and is concentrated in a relatively small number of States. As of March, Medicare had 20 contracts with cost plans, and enrollment was just under 400,000. However, this represents a 36 percent enrollment increase since 2009.

While cost plan enrollment is small when compared to MA enrollment, industry representatives told us that cost plans provide a managed care option in areas traditionally that have had few or no MA plans. Over the last 3 years, the number of MA options available to beneficiaries enrolled in cost plans has declined. Nonetheless, we found that as of March, 99 percent of beneficiaries enrolled in cost plans had at least one MA option available, and that 80 percent had at least five MA options available. And this concludes my prepared remarks. I would be happy to respond to any questions.

Chairman HERGER. Thank you.

[The prepared statement of Mr. Cosgrove follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON FRIDAY,
SEPTEMBER 21, 2012***

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Health,
Committee on Ways and Means, House
of Representatives

For Release on Delivery
Expected at 9:30 a.m. EDT
Friday, September 21, 2012

MEDICARE PRIVATE HEALTH PLANS

Selected Current Issues

Statement of James Cosgrove
Director, Health Care

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GAO-12-1045T

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Highlights

Highlights of GAO-12-1045T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

As of August 2012, approximately 13.6 million Medicare beneficiaries were enrolled in MA plans or Medicare cost plans—two private health plan alternatives to the original Medicare fee-for-service program. This testimony discusses work GAO has done that may help inform the Congress as it examines the status of this MA program and the private health plans that serve Medicare beneficiaries. It is based on key background and findings from three previously issued GAO reports on (1) the MA quality bonus payment demonstration; (2) D-SNPs, and (3) Medicare cost plans. This information on cost plans was updated, based on information supplied by CMS, to reflect the status of cost plans in March 2012.

What GAO Recommends

In a March 2012 report on the MA quality bonus payment demonstration, GAO recommended that HHS cancel the MA quality bonus demonstration. HHS did not concur with this recommendation. In a September 2012 report on D-SNPs, GAO recommended that D-SNPs improve their reporting of services provided to beneficiaries and that this information be made public. HHS agreed with these recommendations.

View GAO-12-1045T. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

September 2012

MEDICARE PRIVATE HEALTH PLANS

Selected Current Issues

What GAO Found

In March 2012, GAO issued a report on the Centers for Medicare & Medicaid Services' (CMS) Medicare Advantage (MA) quality bonus payment demonstration—a demonstration CMS initiated rather than implementing the quality bonus program established under the Patient Protection and Affordable Care Act (PPACA). Compared to the PPACA quality bonus program, CMS's demonstration increases the number of plans eligible for a bonus, enlarges the size of payments for some plans, and accelerates payment phase-in. CMS stated that the demonstration's research goal is to test whether scaling bonus payments to quality scores MA plans receive increases the speed and degree of annual quality improvements for plans compared with what would have occurred under PPACA. GAO reported that CMS's Office of the Actuary estimated that the demonstration would cost \$8.35 billion over 10 years—an amount greater than the combined budgetary impact of all Medicare demonstrations conducted since 1995. In addition, GAO also found several shortcomings of the demonstration design that preclude a credible evaluation of its effectiveness in achieving CMS's stated research goal. In July 2012, GAO sent a letter to the Secretary of Health and Human Services (HHS), the head of the agency of which CMS is a part, stating that CMS had not established that its demonstration met the criteria in the Social Security Act of 1967, as amended, under which the demonstration is being performed.

In September 2012, GAO issued a report on Medicare dual-eligible special needs plans (D-SNP), a type of MA plan exclusively for beneficiaries that are eligible for Medicare and Medicaid. Dual-eligible beneficiaries are costly to Medicare and Medicaid in part because they are more likely than other beneficiaries to be disabled, report poor health status, and have limitations in activities of daily living. GAO found that two-thirds of 2012 D-SNP contracts with state Medicaid agencies that it reviewed did not expressly provide for the integration of Medicare and Medicaid benefits. Additionally, GAO found that compared to other MA plans, D-SNPs provided fewer, but more comprehensive supplemental benefits, such as vision, and were less likely to use rebates—additional Medicare payments received by many MA plans—for reducing beneficiary cost-sharing. GAO could not report on the extent to which benefits specific to D-SNPs were actually provided to beneficiaries because CMS did not collect the information. GAO also found that plans did not use standardized performance measures, limiting the amount of comparable information available to CMS.

In December 2009, GAO issued a report on Medicare cost plans, which, unlike MA plans, are paid based on their reasonable costs incurred delivering Medicare-covered services and allow beneficiaries to disenroll at any time. GAO found that the approximately 288,000 Medicare beneficiaries enrolled in cost plans as of June 2009 had multiple MA options available to them. GAO updated this work using March 2012 data and found that enrollment in cost plans had increased to approximately 392,000 and that 99 percent of Medicare beneficiaries enrolled in cost plans had at least one MA option available to them, although generally fewer options than in 2009.

Chairman Herger, Ranking Member Stark, and Members of the Subcommittee:

I appreciate the opportunity to participate in today's hearing on the status of the Medicare Advantage (MA) program and Medicare cost plans—two private health plan alternatives to the original Medicare fee-for-service (FFS) program.¹ As of August 2012, approximately 13.6 million Medicare beneficiaries—or about 1 of every 4—were enrolled in these Medicare private health plan options. Expenditures for Medicare private health plans reached approximately \$123.7 billion in 2011.

In an effort to contain costs and encourage Medicare private health plans to utilize resources effectively, the Patient Protection and Affordable Care Act (PPACA) made changes to how MA plans are paid and introduced bonus payments linked to the quality of care that they provide. In November 2010, the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, announced that instead of implementing the PPACA quality bonus payment provisions, it would conduct a demonstration of an alternative bonus payment system from 2012 through 2014 in which all plans would participate unless they affirmatively opt out.

PPACA also included provisions that extended the availability of certain types of Medicare private health plan options for beneficiaries. Specifically, PPACA extended the authorization of special needs plans (SNP)—a type of MA plan intended for beneficiaries with special needs, such as those dually eligible for Medicare and Medicaid—through December 31, 2013. PPACA also extended until January 1, 2013, the deadline after which Medicare cost plans in service areas with sufficient MA competition may no longer be renewed. Medicare cost plans differ from MA plans in that they are paid on the basis of their reasonable costs incurred delivering Medicare-covered services. In comparison, MA plans are paid a fixed monthly payment per beneficiary and bear financial risk if their costs exceed Medicare payments.

¹Both MA plans and Medicare cost plans—the term we use to refer to Social Security Act §1976 Medicare cost contracts—are generally required to provide the same benefits as Medicare FFS. In addition, MA plans may offer benefits not provided under Medicare FFS, such as reduced cost sharing or vision and dental coverage. Medicare cost plans may also offer optional additional benefits to beneficiaries, but beneficiaries who opt for these additional benefits would be responsible for their entire cost.

We have conducted several analyses that may help inform the Congress as it examines the status of the MA program and the private health plans that serve Medicare beneficiaries. My remarks today will focus on three of these analyses. Specifically, I will discuss key background information and findings from our recent work on (1) the MA quality bonus payment demonstration, (2) SNPs for dual-eligible beneficiaries, and (3) Medicare cost plans. My remarks are based largely on our previously issued work.² We updated our prior work on Medicare cost plans by including more recent data supplied by CMS on the number of Medicare cost contracts, enrollment in cost plans, and the number of MA options available to beneficiaries enrolled in cost plans. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. In addition to these three reports, my statement includes information from a legal analysis we recently issued on the MA Quality Bonus Payment Demonstration.³

MA Quality Bonus Payment Demonstration

CMS's quality bonus payment demonstration includes several key changes from the quality bonus system established by PPACA. Specifically, PPACA required CMS to provide quality bonus payments to MA plans that achieve 4, 4.5, or 5 stars on a 5-star quality rating system developed by CMS.⁴ In contrast, the demonstration significantly increases the number of plans eligible for a bonus, enlarges the size of payments for some plans, and accelerates payment phase-in. In announcing the

²See GAO, *Medicare Managed Care: Observations about Medicare Cost Plans*, GAO-10-185 (Washington, D.C.: Dec. 28, 2009); *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, GAO-12-409R (Washington, D.C.: Mar. 21, 2012); and *Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance*, GAO-12-864 (Washington, D.C.: Sept. 14, 2012). See individual reports for details on the objectives, scopes, and methodologies.

³See GAO, *Medicare Advantage Quality Bonus Payment Demonstration*, B-323170, July 11, 2012.

⁴Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3201-02, 124 Stat. 119, 442, 454 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (Mar. 30, 2010) (hereafter, "PPACA").

demonstration, CMS stated that the demonstration's research goal is to test whether scaling bonus payments to the number of stars MA plans receive under the quality rating system leads to larger and faster annual quality improvement for plans at various star rating levels compared with what would have occurred under PPACA.

In March 2012, we reported that CMS's Office of the Actuary (OACT) estimated that the demonstration would cost \$8.35 billion over 10 years—an amount that is at least seven times larger than that of any other Medicare demonstration conducted since 1995 and greater than the combined budgetary effect of all those demonstrations.⁵ The cost is largely for quality bonus payments more generous than those prescribed in PPACA. Plans are required to use these payments to provide their enrollees enhanced benefits, lower premiums, or reduced cost-sharing.⁶ We also found that the additional Medicare spending will mainly benefit average-performing plans—those receiving 3 and 3.5-star ratings—and that about 90 percent of MA enrollees in 2012 and 2013 would be in plans eligible for a bonus payment. As we noted in our report, while a reduction in MA payments was projected to occur as a result of PPACA's payment reforms, OACT estimated that the demonstration would offset more than 70 percent of these payment reductions projected for 2012 alone and more than one-third of the reductions for 2012 through 2014.

Our March 2012 report also identified several shortcomings of the demonstration's design that preclude a credible evaluation of its effectiveness in achieving CMS's stated research goal. Notably, the bonus payments are based largely on plan performance that predates the demonstration. In particular, all of the performance data used to determine the 2012 bonus payments and nearly all of the data used to determine the 2013 bonus payments were collected before the demonstration's final specifications were published. In addition, under the demonstration's design, the bonus percentages are not continuously scaled. For example, in 2014, plans with 4, 4.5, and 5 stars will all receive the same bonus percentage. Finally, since all plans may participate in the demonstration, there is no adequate comparison group for determining whether the demonstration's bonus structure provided better incentives

⁵GAO-12-409R.

⁶Bonuses under the demonstration increase the size of plan rebates, which are additional payments received by many plans.

for improving quality than PPACA's bonus structure. We therefore concluded that it is unlikely that the demonstration will produce meaningful results.

Given the findings from our program review of the demonstration's features, we recommended in our March 2012 report that the Secretary of Health and Human Services (HHS), who heads the agency of which CMS is a part, cancel the demonstration and allow the MA quality bonus payment system authorized by PPACA to take effect. We further recommended that if that bonus payment system does not adequately promote quality improvement, HHS should determine ways to modify it, which could include conducting an appropriately designed demonstration. HHS did not agree. It stated that, in contrast to PPACA, the demonstration establishes immediate incentives for quality improvement throughout the range of quality ratings. Regarding their proposed evaluation of the demonstration, HHS did not consider the timing of data collection to be a problem and said that the comparison group it would use would enable them to determine the demonstration's impact. We continue to believe that, given the problems we cited, the demonstration should be canceled.

In addition to our March 2012 report, we sent a letter on July 11, 2012, to HHS regarding CMS's authority to conduct the demonstration.⁷ In our letter, we stated that CMS had not established that the demonstration met the criteria set forth in the Social Security Amendments of 1967, as amended—the statute under which CMS is conducting the demonstration. Specifically, the statute authorizes the Secretary to conduct demonstration projects to determine whether changes in payment methods would increase the efficiency and economy of Medicare services through the creation of additional incentives, without adversely affecting quality.⁸ However, features of the demonstration, particularly those

⁷GAO, *Medicare Advantage Quality Bonus Payment Demonstration*.

⁸Section 402(a)(1)(A) authorizes the Secretary to develop and engage in experiments and demonstration projects "to determine whether, and if so which, changes in methods of payment or reimbursement for health care and services under health programs established by the Social Security Act ... would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services." Relatedly, section 402(b) authorizes the Secretary to waive Medicare payment requirements to carry out such demonstrations.

regarding the timing of data collection for plan star ratings, call into question whether the demonstration includes additional incentives to increase the efficiency and economy of Medicare services and raise concerns about the agency's ability to determine whether the payment changes under the demonstration result in increased efficiency and economy compared to the payment methods in place under PPACA.

SNPs for Dual-Eligible Beneficiaries

In 2003, Congress authorized the establishment of three types of MA coordinated care plans for individuals with special needs: dual-eligible special needs plans (D-SNP), which are exclusively for beneficiaries eligible for both Medicare and Medicaid; institutional special needs plans for individuals in nursing homes, and chronic condition special needs plans for individuals with severe or disabling chronic conditions. Of the three types of SNPs, D-SNPs are by far the most common, accounting for about 80 percent of SNP enrollment as of September 2012.

The approximately 9 million dual-eligible beneficiaries are particularly costly to both Medicare and Medicaid in part because they are more likely than other Medicare beneficiaries to be disabled, report poor health status, and have limitations in activities of daily living. Furthermore, their care must be coordinated across Medicare and Medicaid, and each program has its own set of covered services and requirements.

In September 2012, we reported that the 2012 D-SNP contracts with state Medicaid agencies that we reviewed varied considerably in their provisions for integration of benefits.⁹ Two-thirds of the 124 contracts between D-SNPs and state Medicaid agencies that were submitted to CMS for 2012 did not expressly provide for the integration of any benefits. To carry out the requirement in the Medicare Improvements for Patients and Providers Act of 2008 that each D-SNP contract provide or arrange for Medicaid benefits to be provided,¹⁰ CMS guidance required that, at a minimum, contracts list the Medicaid benefits that dual-eligible

⁹GAO-12-864

¹⁰Pub. L. No. 110-275, §164, 122 Stat. 2494, 2571.

beneficiaries could receive directly from the state Medicaid agency or the state's Medicaid managed care contractor(s).¹¹

Like other MA plans, D-SNPs must cover all the benefits of fee-for-service, with the exception of hospice, and may offer supplemental benefits, such as vision and dental care. In addition, they must develop a model of care that describes their approach to caring for their enrollees. The model of care describes how the plan will address 11 elements, including tracking measureable goals, performing health risk assessments, providing care management for the most vulnerable beneficiaries, and measuring plan performance and outcomes; and D-SNPs must offer the benefits that allow them to actualize these elements.

In our September 2012 report, we examined the supplemental benefits offered by D-SNPs and found that D-SNPs provided fewer supplemental benefits than other MA plans. However, the individual services covered under vision and dental benefits were generally more comprehensive than in other MA plans. Despite offering these supplemental benefits somewhat less often than other MA plans, D-SNPs allocated a larger percentage of their rebates—additional Medicare payments received by many plans—to these benefits than other MA plans. They were able to do so largely because they allocated a smaller percentage of rebates to reducing cost-sharing.

We could not report on the extent to which benefits specific to D-SNPs and described in the model of care were actually provided to beneficiaries because CMS did not collect the information. For the 15 models of care we reviewed, most did not report—and were not required by CMS to report—the number of beneficiaries who received a risk assessment, for example, or the number or proportion of beneficiaries who would be targeted as “most vulnerable.” However, of the models of care we reviewed, past completion rates for risk assessment varied widely among the 4 plans that provided this information. None of the models of care we reviewed reported the number of beneficiaries that were expected to receive add-on services, such as social support services, that were intended for the most-vulnerable beneficiaries.

¹¹Only new and expanding D-SNPs are required to contract with state Medicaid agencies in 2012. Beginning in 2013, all D-SNPs must contract with state Medicaid agencies. CMS stated in its 2013 training materials that contracts must specify how Medicare and Medicaid benefits are integrated and coordinated.

We found that plans do not use standardized performance measures in their models of care, limiting the amount of comparable information available to CMS. Although the D-SNPs are required to report how they intend to evaluate their performance and measure outcomes, CMS does not stipulate the use of standard outcome or performance measures, making it difficult to use any data it might collect to compare D-SNPs' effectiveness or evaluate how well they have done in meeting their goals. Furthermore, without standard measures, it would not be possible for CMS to fully evaluate the relative performance of D-SNPs.

We concluded that there was little evidence available on how well D-SNPs are meeting their goals of helping dual-eligible beneficiaries to navigate two different health care systems and receive services that meet their individual needs. Consequently, we recommended in our September 2012 report that CMS require D-SNPs to state explicitly in their models of care the extent of services they expect to provide, require D-SNPs to collect and report to CMS standard performance and outcome measures, systematically analyze these data and make the results routinely available to the public, and conduct an evaluation of the extent to which D-SNPs have provided sufficient and appropriate care to their enrollees. HHS agreed with our recommendations and in its comments on a draft of our report, said that it plans to obtain more information from D-SNPs.

CMS is embarking on a new demonstration in up to 26 states with as many as 2 million beneficiaries to financially realign Medicare and Medicaid services so as to serve dual-eligible beneficiaries more effectively. CMS has approved one state demonstration—Massachusetts—and continues to work with other states. If CMS systematically evaluates D-SNP performance, it can use information from the evaluation to inform the implementation and reporting requirements of this major new initiative.

Medicare Cost Plans

In contrast to MA plans, which have a financial incentive to control their costs, a small number of Medicare private health plans—called cost plans—are paid on the basis of their reasonable costs incurred delivering Medicare-covered services. Medicare cost plans also differ structurally from MA plans in several ways. For example, cost plans, unlike MA plans, allow beneficiaries to disenroll at any time. Despite their enrollment only totaling under 3 percent of Medicare private health plan enrollment, industry representatives stated that cost plans fill a unique niche by providing a Medicare private health plan option in rural and other areas that traditionally have had few or no MA plans. Under current law, new

cost contracts are not being entered into and contracts with existing cost plans cannot be extended or renewed after January 1, 2013 if sufficient MA competition exists in the service area.¹² Additionally, in general, organizations that offer cost plans and MA plans in the same area must close their cost plan to new enrollment.

In our December 2009 report on cost plans, we examined the MA options available to beneficiaries in these plans and found that all of the approximately 288,000 Medicare beneficiaries enrolled in cost plans as of June 2009 had multiple MA options available to them.¹³ We also found that, of the 22 cost plan contracts, 7 were closed to new enrollment in 2009. We recently updated this work with March 2012 data and found that the number of cost plan contracts decreased from 22 in 2009 to 20 in 2012, with 6 of the 20 contracts being closed to enrollment.¹⁴ Despite this slight reduction in the number of contracts, enrollment in cost plans increased by 36 percent during this time.¹⁵ Of the approximately 392,000 Medicare beneficiaries enrolled in cost plans in March 2012, we found that over 99 percent of cost plan enrollees continue to have at least one MA option in March 2012; however, they generally have fewer MA options than in June 2009 (see table 1).¹⁶ This decrease in MA options for beneficiaries enrolled in cost plans is consistent with the overall decrease in MA plans over this period, as well as with CMS's efforts to simplify MA

¹²Social Security Act, §1876(h)(5).

¹³GAO-10-185

¹⁴Between 2009 and March 2012, 1 new cost contract was closed to new enrollment. Of the 7 cost plan contracts that were closed to enrollment in 2009, 5 remain closed to enrollment, 1 contract is no longer in operation, and 1 has since become open to new enrollment. All 7 of the cost plan contracts that were closed to enrollment in 2009—including 1 contract that has since become open to enrollment—had lower enrollment in March 2012 than they did at the end of 2009.

¹⁵This increase in enrollment was primarily due to increases in two plans in the Midwest—one operated by Blue Cross Blue Shield of Minnesota, which exclusively serves enrollees in Minnesota and gained over 65,000 enrollees, and another operated by Medica Insurance Company, which primarily serves enrollees in Minnesota, North Dakota, South Dakota, and Wisconsin and gained 54,000 enrollees.

¹⁶We conducted our analysis of MA options at the contract level. Within each contract, an organization may offer one or more plans with different benefit packages. The percentage of beneficiaries enrolled in cost plans with access to a given number of MA options would be greater if we conducted the analysis at the plan level.

plan offerings by eliminating potentially duplicative plans and those with low enrollment.

Table 1: Medicare Cost Plan Summary Statistics, June 2009 and March 2012

	June 2009	March 2012
Number of contracts	22	20
Enrollment	287,796	392,048
Number of contracts closed to new enrollment	7	6
Percentage of beneficiaries enrolled in cost plans with access to at least		
1 Medicare Advantage (MA) option	100%	99%
5 MA options	99%	80%
10 MA options	89%	25%
15 MA options	57%	1%

Source: GAO analysis of CMS data.

Note: We conducted our analysis of MA options at the contract level. Within each contract, an organization may offer one or more plans with different benefit packages. The percentage of beneficiaries enrolled in cost plans with access to a given number of MA options would be greater if we conducted the analysis at the plan level.

As part of our 2009 report on cost plans we also described the concerns of officials from Medicare cost plans about converting to MA plans. We found that the most-common concerns cited by these officials from organizations that offered Medicare cost plans were potential future changes to MA payments that may then necessitate closing the plan, difficulty assuming financial risk given their small enrollment, and potential disruption to beneficiaries during the transition.

Contact and Acknowledgments

For future contacts regarding this testimony, please call James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions include Phyllis Thorburn, Assistant Director; Alison Binkowski; Krister Friday; Gregory Giusto; and Eric Wedum.

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Chairman HERGER. Mr. Capretta, you are recognized for 5 minutes.

STATEMENT OF JAMES CAPRETTA, FELLOW, ETHICS AND PUBLIC POLICY CENTER

Mr. CAPRETTA. Thank you. Mr. Chairman, Ranking Member Stark, Members of the Subcommittee, I really appreciate the opportunity to be here at this important hearing. I want to make just a couple of points today. First, contrary to what is often stated, Medicare Advantage plans are not less efficient than the traditional Medicare fee-for-service program. Data from the Medicare

Payment Advisory Commission confirms this fact. Comparing apples to apples, MA plans, and especially MA HMOs, can provide the Medicare benefit package to seniors at a cost well below that of fee-for-service. In 2012, based on bids for the plans, MedPAC reports that the average MA plan provides Medicare benefits at 98 percent of fee-for-services costs, and the MA HMO plans did so at just 95 percent of fee-for-service costs. It is clear from this data that MA HMOs, which have by far the largest enrollment numbers—11.4 million as of February 2012—have built the capacity over many years to deliver care more efficiently than fee-for-service. This should not be surprising, however. Medicare fee-for-service is an extremely inefficient model. It breeds fragmentation and undermines coordination, leading to low quality care for too many seniors. The emphasis from the Center for Medicare and Medicaid Services on quality in the MA program is admirable, but it would be even more effective if fee-for-service were rated on the same metrics. There is ample evidence that the United States continues to experience much waste in the health care delivery system. Recent Institute of Medicine studies left little doubt about this fact. But what is often not stated is Medicare fee-for-service's role in the problem. Medicare fee-for-service is the dominant payer in many markets, and its rate setting regulations become the default option for other payers too.

The sheer size of Medicare fee-for-service ensures that the entire delivery system is organized around its incentives. For those looking for the reasons that we have too much fragmentation, lack of coordination, and low quality care in too many settings, they should look no further than the incentives that are embedded in Medicare fee-for-service.

My second point is that the reductions in MA payments contained in the 2012 health care law will raise costs for seniors and force many of them out of their MA plans. The cuts are very deep. According to the Congressional Budget Office, the total 10-year cut in MA payments now estimated at \$308; \$156 billion in direct MA payment cuts; and \$152 billion in indirect MA reductions from the interactions fee-for-service cuts contained in the law. That these cuts will directly impact the beneficiaries is indisputable. According to the most recent trustees' report, enrollment in MA will peak in 2013 at 13.7 million people, and then fall to 9.7 million in 2017.

Further, by law, MA plans must provide some percentage of the difference between their bids and the benchmark to the beneficiaries in the form of expanded benefits. Thus, reducing MA payments will, by definition, reduce benefits provided through MA plans to current enrollees. In a study I co-authored with Robert Book for the Heritage Foundation, we estimated that this would be about \$3,700 per MA enrollee by 2017.

Why, if these cuts are so deep, has MA enrollment grown in 2012 and 2013? The answer is relatively simple. For starters, the cuts are back-loaded. Through 2013, less than 10 percent of the scheduled Medicare reductions will have gone into effect, and costs have risen modestly in recent years because of the slow economy. More importantly, CMS has sent an unprecedented, and perhaps unlawful, \$8.3 billion to MA plans, filling in over 70 percent of the cuts in 2012 alone, quite plainly because the agency wants to mitigate

the impacts of the cuts required by the 2010 law. There is no real other explanation for what they are doing in this particular demonstration program. Certainly there is no public policy rationale that would justify it, as the testimony from various government agencies have indicated.

Once the artificial and temporary bump up in payments is terminated, as it inevitably will be, MA plans will be forced to pare back benefits, and enrollment in the plans will drop.

My third point is that MA plans are particularly important for lower income seniors, and cuts in MA payments will hit this population the hardest. Lower income seniors are disproportionately represented in MA plans because they find the reduced cost sharing in these plans attractive, especially at premiums that are usually well below the cost of Medigap coverage.

In the 2010 study I co-authored, which I previously mentioned, we used earlier findings from an AHIP study to estimate that beneficiaries with incomes between \$10,800 and \$21,600 were 19 percent more likely than the average beneficiary to enroll in an MA plan. The MA program has important features for the future of the Medicare program. MA can provide innovations in ways that Medicare fee-for-service cannot. Moreover, the presence of the MA program ensures some level of choice for the beneficiaries, which is important for program accountability. If we want delivery system reform, and I think we do, the MA program is something to be built upon, not discarded. Thank you.

Chairman HERGER. Thank you.

[The prepared statement of Mr. Capretta follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON
FRIDAY, SEPTEMBER 21, 2012***

Testimony Presented to the House Ways and Means Committee:

“The Status of the Medicare Advantage Program”

James C. Capretta
Fellow, Ethics and Public Policy Center
and Visiting Fellow, American Enterprise Institute

September 21, 2012

Mr. Chairman, Ranking Member Stark, and members of the subcommittee, thank you for the opportunity to participate in this very important hearing on “The Status of the Medicare Advantage Program.”

I want to make a few points with my testimony today.

First, contrary to what is often stated, Medicare Advantage (MA) plans *are not* less efficient than the traditional Medicare fee-for-service (FFS) program. Data from the Medicare Payment Advisory Commission (MedPAC) confirms this fact. Comparing apples to apples, MA plans, and especially MA HMOs, can provide the Medicare benefit package to seniors at a cost well below that of FFS. In 2012, based on bids from the plans, MedPAC reports that the average MA plan provides Medicare benefits at 98 percent of FFS costs. And the MA HMO plans did so at just 95 percent of FFS costs.¹

¹ *Healthcare Spending and the Medicare Program: A Data Book*, Medicare Payment Advisory Commission, June 2012, p. 146 (<http://www.medpac.gov/chapters/Jun12DataBookSec9.pdf>).

It's clear from this data that MA HMOs, which have, by far, the largest enrollment numbers — 11.4 million as of February 2012, according to MedPAC — have built the capacity over many years to deliver care more efficiently than FFS. This should not be surprising. Medicare FFS is an extremely inefficient model. It breeds fragmentation and undermines coordination, leading to low-quality care for many seniors. The emphasis from the Centers for Medicare and Medicaid Services (CMS) on quality in the MA program is admirable. It would be even more effective if FFS were rated on the same metrics.

There is ample evidence that the United States continues to experience much waste in the health care delivery system, and shockingly low quality too. Recent Institute of Medicine studies leave little doubt about that.² But what is often not stated is Medicare FFS's role in the problem. Medicare FFS is the dominant payer in many markets, and its rate setting regulations become the default option for other payers too. The sheer size of Medicare FFS ensures that the entire delivery system is organized around its incentives. For those looking for the reasons American health care continues to perform poorly in important ways, they need look no further than Medicare FFS and its influence on how care is delivered for everyone.

My second point is that the reductions in MA payments contained in the 2010 health care law will raise costs for seniors and force many of them out of their MA plans. The cuts are very deep. According to the Congressional Budget Office (CBO), the total

² See, for instance, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Institute of Medicine, September 6, 2012 (<http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx>).

ten-year cut in MA payments is now estimated at \$308 billion: \$156 billion in direct MA payment cuts and \$152 billion in indirect MA reductions from the interactions with the other FFS cuts contained in the law.³ That these cuts will directly impact the beneficiaries is indisputable. According to the most recent Trustees' Report, enrollment in MA will peak in 2013 at 13.7 million and then fall to 9.7 million in 2017.⁴ Further, by law, MA plans must provide some percentage of the difference between their bids and the benchmark to the beneficiaries in the form of expanded benefits. Thus, reducing MA payments will, by definition, reduce benefits provided through MA plans to current enrollees. I co-authored a study with Robert Book in which we estimated that the average cut per MA enrollee would reach \$3,700 by 2017.⁵

Why, if these cuts are so deep, has MA enrollment grown in 2012 and 2013? The answer is simple. For starters, the cuts are back-loaded. Through 2013, less than 10 percent of the scheduled Medicare reductions will have gone into effect, and costs have risen modestly in recent years because of the slow economy. More importantly, CMS has sent an unprecedented, and perhaps unlawful, \$8.3 billion to MA plans, filling in over 70 percent of the cuts in 2012 alone — quite plainly because the agency wants to mitigate the impact of the cuts required by the 2010 law. There is no other way to explain what they are doing. Certainly there is no public policy rationale for the payments, as the

³ Senate Finance Committee Minority Staff Press Release, September 19, 2012 (<http://www.finance.senate.gov/newsroom/record/recordings?id=9d69a54a-9a59-42b0-a1d4-5676c824440e>).

⁴ *2012 Annual Report of the Board of Trustees of the Federal Hospital Insurance and the Supplementary Medical Insurance Trust Funds*, April 2012, Table IV.C1, p. 180 (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf>).

⁵ "Reductions in Medicare Advantage Payments: The Impact on Seniors by Region," Robert A. Book, Ph.D. and James C. Capretta, The Heritage Foundation, Background #2464, September 14, 2010 (<http://thf-media.s3.amazonaws.com/2010/pdf/bg2464.pdf>).

Government Accountability Office (GAO) has indicated.⁶ Once the artificial and temporary bump-up in payments is terminated, as it inevitably will be, MA plans will be forced to pare back benefits, and enrollment in the plans will drop.

My third point is that MA plans are particularly important for lower-income seniors, and cuts in MA payments will hit this population hardest. Lower-income seniors are disproportionately represented in MA plans because they find the reduced cost-sharing in these plans attractive, especially at premiums that are usually well below the cost of Medigap coverage. In the 2010 study I co-authored with Robert Book, we used earlier findings from AHIP to estimate that beneficiaries with incomes between \$10,800 and \$21,600 were 19 percent more likely than the average beneficiary to enroll in an MA plan.⁷

The MA program has important features for the future of the Medicare program. MA plans can provide innovations in ways that Medicare FFS cannot because MA is not bound by FFS's payment structures. Moreover, the presence of the MA program ensures some level of choice for the beneficiaries, which is important for program accountability.

In recent years, there's been a lot of discussion of "delivery system reform." MA HMOs have proven that they can, in many parts of the country, deliver Medicare benefits

⁶ Testimony presented to the House Oversight Committee, James Cosgrove, Ph.D., U.S. Government Accountability Office, July 25, 2012 (<http://oversight.house.gov/wp-content/uploads/2012/07/GAO-Cosgrove-Emmanuel-Perez-Testimony-Medicare-Advantage-7-25-COMPLET1.pdf>).

⁷ Book and Capretta, September 2012 (<http://thf.media.s3.amazonaws.com/2010/pdf/bg2464.pdf>). See also "Low-Income and Minority Beneficiaries in Medicare Advantage Plans, 2006," America's Health Insurance Plans (AHIP), Center for Policy and Research, September 2008 (<http://www.ahipresearch.org/pdfs/MA1owIncomeReport2008.pdf>).

at less cost than FFS, and many plans have developed innovative tools to improve the quality of care for their patients. That is something that should be built upon, not discarded.

Chairman HERGER. Ms. Ignagni is recognized for 5 minutes.

**STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF
EXECUTIVE OFFICER, AMERICA'S HEALTH INSURANCE PLANS**

Ms. IGNAGNI. Thank you Mr. Chairman, Ranking Member Stark. We appreciate the opportunity to testify today on behalf of

a program that serves 27 percent of Medicare beneficiaries. Our testimony focuses on three things: First, the specific programs our members have implemented to improve the effectiveness of care; second, the value Medicare Advantage plans bring to beneficiaries; and third, the impact of future cuts to the program, and a new premium tax that begins in 2014.

Health plans in Medicare Advantage, as well as those serving employers and individual purchasers of coverage, are partnering with doctors and hospitals to change the way care is paid, by paying for the effectiveness of care provided rather than the volume of services delivered. We are working to change what is purchased by rewarding successful outcomes and employing other strategies to ensure that patients receive the right care in the right setting. For example, health plans offer customized programs and support services that are integral to avoiding hospital readmissions and reducing emergency room visits, while also addressing health care disparities, providing nurse hotlines, and offering personal health records. These programs and tools have been validated in peer-reviewed journals. Health plans also help patients receive the appropriate level of services post-discharge. These include follow-up calls from nurses to ensure that patients understand their drug therapy, their rehabilitation needs, and when they need to follow up with their physician.

This follow-up also includes home health visits and instructions on how to use any medical equipment necessary at home. Health plans also are coordinating care to help patients with multiple chronic conditions navigate an increasingly complicated delivery system, as well as partnering with clinicians by supporting their ability to do complicated case management and improve quality of care by providing data about variations in care, best practices, and efficiency and effectiveness of treatment.

Health plans also provide value to beneficiaries by providing strong consumer protections which are identified in our testimony, by protecting beneficiaries against unpredictable out-of-pocket costs, and by establishing care plans for beneficiaries which encourage them to get the preventive care they need, and providing a more organized support system for those with chronic illness.

CMS is partnering with our plans in a variety of initiatives to expand these tools into the traditional program, and we believe these partnerships hold great promise.

Two days ago, the Centers for Medicare and Medicaid Services announced information about the high quality affordable health plan choices that will be available in 2013 in the Medicare Advantage program. This announcement is good news, and clearly demonstrates that Medicare Advantage plans have been successful in delivering value to beneficiaries. Looking forward, however, we are concerned about the impact of ACA's future cuts to the Medicare Advantage program.

Our written testimony presented data from the Congressional Budget Office. Mr. Capretta just referred to those data, I won't repeat it. But given the scale and scope of these reductions over the next few years, and since the majority of the reductions haven't taken effect, we are seriously concerned about their potential impact.

In addition, another element to this and to scaling the impact of potential reductions is it is going to be compounded by a new premium tax scheduled to begin in 2014 which will amount to \$220 per beneficiary in 2014. For Medicare Part D plans, the tax will increase premiums by an estimated \$9. Given the size of the Medicare Advantage funding cuts and the new premium tax, if across-the-board sequestration cuts are triggered under the Budget Control Act of 2011, it could have serious impact on Medicare beneficiaries, and, place a financial burden on clinicians participating in the program.

As the payment cuts take effect, Medicare health plans will continue to do everything they can to preserve benefits and keep coverage as affordable as possible for the millions of seniors and people with disabilities they serve. However, given the size of these cuts, along with the impact of the premium tax, we are concerned in the coming years about the potential for Medicare Advantage beneficiaries to face higher costs and coverage disruptions.

We look forward to working with the committee to address these concerns and preserve Medicare Advantage as a choice for current and future generations of beneficiaries. Thank you very much.

Chairman HERGER. Thank you.

[The prepared statement of Ms. Ignagni follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON FRIDAY,
SEPTEMBER 21, 2012***



**The Medicare Advantage Program and the
Role of Private Health Plans in Serving Medicare Beneficiaries**

by

**Karen Ignagni
President and CEO
America's Health Insurance Plans**

**for the
House Ways and Means Committee
Subcommittee on Health**

September 21, 2012

I. Introduction

Chairman Herger, Ranking Member Stark, and members of the subcommittee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP). AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

Our members are strongly committed to continuing to offer high quality coverage options to meet the health care needs of Medicare beneficiaries, and we appreciate this opportunity to testify on the Medicare Advantage program.

Our plans have played an important role in serving Medicare beneficiaries. Currently, more than 13 millions seniors and people with disabilities have chosen to enroll in Medicare Advantage plans because they value the improved quality of care, additional benefits, and innovative services these plans provide. In addition, our community is working closely with policymakers to improve care for beneficiaries who are dually eligible for both Medicare and Medicaid, with the goal of ensuring that these individuals with special needs receive the preventive care they need, along with coordinated care for their multiple chronic conditions and the services and support that will allow them to stay in their homes if they wish and are able to do so.

Our testimony focuses on four broad topics:

- The leadership private plans are demonstrating in advancing delivery system reforms to improve quality and contain costs for Medicare beneficiaries;
- The value offered by private health plans participating in the Medicare Advantage program;
- The impact of the Affordable Care Act (ACA) on Medicare Advantage enrollees; and
- The need for congressional action to reauthorize Medicare Advantage Special Needs Plans (SNPs).

II. What Health Plans Are Contributing to Delivery System Reform

As policymakers consider how to sustain Medicare for generations to come, there are three areas where there is widespread agreement: (1) that health care costs are rising at unsustainable rates; (2) that doctors and hospitals should be paid for the effectiveness of the care they provide, rather than the volume of services they deliver; and (3) that more can and should be done to ensure that patients are receiving the right care in the right setting.

Private sector health plans – serving Medicare beneficiaries, as well as those under age 65 and enrollees in Medicaid – are demonstrating strong leadership in addressing these goals through innovative payment and delivery system reforms. These efforts are a critically important component of ensuring that our nation’s public safety net continues to protect patients and is sustainable in the long run.

While there is no magic bullet for reforming the payment system and bringing costs under control, health plans have developed a roadmap for the system-wide changes that are needed. Through a variety of partnerships with providers and other stakeholders, health plans are transforming the health care system and bringing the following tools and programs to Medicare Advantage enrollees:

- Helping patients navigate an increasingly complicated health care system through innovative care coordination programs;
- Changing how they pay for care through the introduction of prospective, risk-based payment systems;
- Working to change what we purchase by rewarding successful outcomes and high quality care to ensure that patients receive the right care at the right time in the right setting;
- Working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- Linking payment changes to new benefit designs that provide information on high performing clinicians and hospitals and encourage patients to use them;

- Connecting clinicians with health plans' disease and case management services, embedding nurse case managers in provider practices, and offering clinical decision-support with the latest science and tools to inform the treatment decisions of providers;
- Offering intensive case management to help patients who are at high risk of hospitalization and providing them expanded access to urgent care centers, after-hours care and nurse help lines;
- Arranging for regular phone calls and in-home visits for patients discharged from the hospital to ensure that they keep their follow-up appointments, take their medications, and receive needed home care;
- Utilizing the latest technology to identify gaps in care, target potentially at-risk patients for support and intervention, and give physicians real-time data on how their patients are doing.

As a result of these efforts, health plans are now reporting tangible results in several key areas: improvements on quality metrics; reductions in unnecessary hospital admissions, readmissions, and emergency room visits; and reductions in health care cost growth. Building upon existing private sector initiatives, health plans also have developed important partnerships with the Centers for Medicare & Medicaid Services (CMS) in primary care, and are actively working to coordinate on comprehensive payment alternatives and to partner on standardizing performance metrics used in the private and public sectors.

Recognizing the importance of these public-private partnerships, our members appreciate that CMS has adopted an open process for collaborating and communicating with health plans to advance our shared goal of serving the best interests of Medicare beneficiaries.

III. The Value Offered by Health Plans Participating in the Medicare Advantage Program

Private health plans and insurers have a strong track record of offering high quality coverage options, with innovative programs and services to serve the Medicare population. In addition, plans are participating in innovative programs to meet the needs of dual eligibles and other beneficiaries with complex needs, using individualized care plans and care management, facilitating transitions between care settings, and employing other strategies to improve care and services for these vulnerable populations.

The Role of Medicare Advantage Plans as a Health Care Safety Net

More than 13 million Medicare beneficiaries – accounting for roughly 27 percent of all beneficiaries nationwide – currently are enrolled in Medicare Advantage plans and are receiving comprehensive, high quality, affordable coverage with benefits and innovative services that go well beyond the coverage offered by the Medicare fee-for-service (FFS) program. Survey findings¹ show that 88 percent of Medicare Advantage enrollees are satisfied with their coverage overall and 92 percent are satisfied with their doctor.

1. **MA Enrollees Receive Coordinated Care.** Seniors and people with disabilities are choosing Medicare Advantage plans because they have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious level.

Medicare Advantage plans also help to reduce emergency room visits for routine care, and ensure prompt access to primary care physicians and specialists when care is needed. In addition, they promote communication among treating physicians about the various treatments and medications a patient needs.

2. **Medicare Advantage Enrollees Have Strong Consumer Protections.** By law, coverage is guaranteed issue and Medicare Advantage plans offer coverage to all beneficiaries regardless of age or health status, although Special Needs Plans enroll only beneficiaries who meet criteria for the SNP type (e.g., dual eligibles, eligible for an institutional level of care, specified chronic conditions). All beneficiaries who choose a plan pay the same premium as all other plan enrollees. CMS performs annual reviews of Medicare Advantage plan benefit packages to ensure they are appropriate to beneficiaries with all health conditions. In

¹ Survey by Ayres, McHenry & Associates and the Feldman Group on behalf of AHIP, June 11-15, 2008

addition, nearly 90 percent of all Medicare Advantage enrollees are enrolled in Medicare Advantage plans that offer Part D prescription drug benefits, which allows beneficiaries to receive medical and prescription drug coverage from the same health plan — similar to how people receive coverage in the commercial market. Medicare Advantage plans typically redesign and reduce the cost sharing that applies under Medicare FFS. They may offer lower cost sharing as an additional benefit and typically eliminate deductibles and establish copayments rather than coinsurance.

Further, a Medicare Advantage enrollee who is not satisfied with a plan's decision about providing or paying for covered services may exercise appeal rights through an internal plan appeals process, as well as automatic external review if the plan's decision is not wholly in the beneficiary's favor. Beneficiaries who choose to join Medicare Advantage plans also benefit from plan compliance with detailed requirements associated with CMS oversight activities that include operational and financial audits, evaluation of quality improvement projects, validation and evaluation of data on a broad spectrum of operational activities (e.g., customer service, resolution of appeals, and provider network adequacy), review and approval of plan marketing materials, and strong standards for the conduct of marketing activities.

3. **MA Enrollees Are Protected Against Unpredictable Out-of-Pocket Costs.** Medicare Advantage plans also protect beneficiaries from catastrophic health care costs. In 2012, all Medicare Advantage plans offer an out-of-pocket maximum limit for beneficiary costs, and about 78 percent of Medicare Advantage enrollees are in plans that have annual out-of-pocket maximums of \$5,000 or less, providing greater protection than the maximum \$6,700 cap that is required by law. These out-of-pocket maximums — which are not offered by the Medicare FFS program — help protect Medicare beneficiaries from catastrophic health care expenses that otherwise might pose a serious threat to their financial security.

Medicare Advantage plans also help reduce out-of-pocket costs for enrollees by reducing premiums for Part B and Part D, and by limiting cost-sharing for Medicare-covered services, including primary care physician visits and inpatient hospital stays.

4. **MA Enrollees Receive Additional Services.** Medicare Advantage plans offer a range of additional services that build upon the coordination of care, consumer protections, and protection against high out-of-pocket costs that are available to their enrollees. These

features of the program, combined with the innovative services offered by plans, are integral to improving the efficiency and effectiveness of health care for beneficiaries. The following are additional specific examples of the extra benefits and services that are not included in the Medicare FFS program, but are offered by Medicare Advantage plans to improve enrollees' coverage and manage their overall health and well-being on an ongoing basis:

- Case management services
- Disease management programs
- Coordinated care programs
- Prescription drug management tools integrated with medical benefits
- Tools and data collection to address disparities in care for racial and ethnic minorities
- Nurse help hotlines
- Enhanced coverage of home infusion, personal care and durable medical equipment
- Personal health records to offer beneficiaries greater control over their health information and to coordinate information better
- Vision, hearing, and dental benefits coordinated with medical services

5. **Peer Reviewed Studies Show the Value of Medicare Advantage.** As a direct result of these additional benefits and services, peer reviewed research has demonstrated that Medicare Advantage plans are more effective than the Medicare FFS program at addressing crucial patient care issues facing the nation, including reducing preventable hospital readmissions, increasing primary care visits, and managing chronic illnesses. The following are several examples:

One recent study published in the *American Journal of Managed Care* (AJMC) found that the Medicare Advantage readmission rate was about 13 percent to 20 percent lower than that in the Medicare FFS program.² In addition, a study published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a Medicare Advantage special needs plan (SNP) had "seven percent more primary care physician office visits; nine percent lower

² Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104. This study was preceded by a series of working papers and reports published by AHIP's Center for Policy and Research. One earlier study based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in Medicare Advantage than in Medicare FFS among patients with at least one admission. See: <http://www.ahip.org/Hospital-Readmissions/>

hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare.”³

Additional research co-authored by researchers affiliated with The Brookings Institution concluded that Medicare Advantage plans outperformed the Medicare FFS program in 9 out of 11 clinical quality measures.⁴ This means that Medicare Advantage enrollees received the level of effective care recommended by a doctor with greater frequency than patients in Medicare FFS, for 9 of the 11 procedures studied. These findings confirm that Medicare Advantage plans deliver effective and consistent care for a number of important procedures at higher rates compared to the Medicare FFS program. This added value is a factor in improving the health and well-being of Medicare Advantage enrollees — especially those with high-risk conditions, such as diabetes, heart disease, breast cancer, and depression.

Another recent study, conducted by researchers at the HHS Agency for Healthcare Research and Quality (AHRQ) and the Research Triangle Institute (RTI) and published by the *Medicare and Medicaid Research Review* (a CMS journal), demonstrates the positive impacts of Medicare Advantage compared to the Medicare FFS program in terms of improving quality primary care by reducing preventable hospital admissions.⁵ The three states examined in this study (New York, California, and Florida) were chosen due to historically high rates of Medicare managed care enrollment. Researchers used 2004 hospital discharge data from the Healthcare Cost and Utilization Project (HCUP). This year was chosen because HMOs were most prevalent in the market at that time, providing an opportune time to test the impact of Medicare Advantage on preventable hospitalizations. The study found that preventable admissions, relative to the control group, were lower for Medicare Advantage enrollees than Medicare FFS enrollees in all three states. The study concluded that “MA plans have added value to the quality of primary care for the elderly by reducing preventable hospitalizations.”

³ Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. “Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients.” *Health Affairs*. January 2012. Vol. 31, no. 1, p. 110-119.

⁴ Brennan, Niall MPP & Shepard, Mark BA. *Comparing Quality of Care in the Medicare Program*. The American Journal of Managed Care, November 2010. Vol. 16 No. 11, p. 841-848. (www.ajmc.com)

⁵ Medicare Managed Care Plan Performance: A Comparison across Hospitalization Type. Jayasree Basu & Lee Rivers Mobley. *Medicare & Medicaid Research Review*, 2012: Volume 2, Number 1

The value of Medicare Advantage is further demonstrated by another study⁶, also conducted by an AHRQ researcher, showing that enrollment in Medicare Advantage plans was associated with significant reductions in racial and ethnic differences in preventable hospitalization rates and improved quality primary care. Since access to quality primary care can help avoid preventable hospitalizations, this finding suggests that Medicare Advantage plans may improve the quality of primary care and reduce current disparities in this area of health care.

Leaders in the policy and scientific communities have clearly indicated that meeting these challenges is the key to improving the efficiency and effectiveness of the health care system. Private health plans already have a strong track record in these areas and are continuing to advance these reforms in the Medicare Advantage program and throughout the broader health care system.

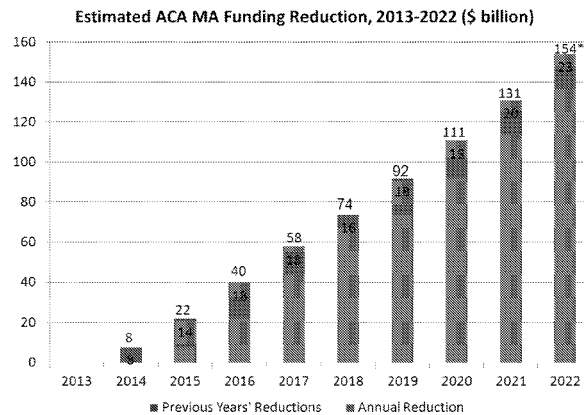
IV. Assessing the Impact of Future ACA Cuts on Medicare Advantage Enrollees

Plan sponsors are doing everything they can to offer coverage options that meet the needs of Medicare beneficiaries. The good news in recent days about the continued availability of high quality, affordable health plan choices in the Medicare Advantage program demonstrates that our members have been successful in delivering value to the beneficiaries they serve through systems of coordinated care and innovative services that improve the efficiency and effectiveness of health care. Looking forward, however, we continue to be concerned about the impact of the ACA's future cuts on Medicare Advantage enrollees, as well as the premium tax that begins in 2014.

⁶ Jayaree Basu. "Medicare managed care and primary care quality: Examining racial/ethnic effects across states." Health Care Management Science. September 2011

Cuts in Medicare Advantage Funding

According to the 2010 estimates from the Congressional Budget Office (CBO)⁷, the ACA will reduce funding for the benefits of Medicare Advantage enrollees by more than \$200 billion over ten years (2010-2019). CBO estimated that the law will *directly* reduce funding for the Medicare Advantage program by an estimated \$136 billion in this timeframe. CBO further estimated that, because of the linkage between Medicare Advantage payment benchmarks and Medicare FFS spending, the ACA's other Medicare FFS reimbursement changes will *indirectly* reduce funding for Medicare Advantage by an additional \$70 billion over ten years. More recently, in July of this year, CBO issued revised estimates⁸ indicating that the ACA would *directly* reduce Medicare Advantage funding by \$156 billion in the current ten-year budget window (2013-2022). This estimate did not include information on the ACA's *indirect* cuts to the Medicare Advantage program.



Source: CBO Letter to the Honorable John Boehner (July 24, 2012)

*NOTE – Rounding Effect: CBO reports total 10-yr funding cut = \$156 billion

⁷ CBO, Selected CBO Publications Related to Health Care Legislation (2009-2010), December 2010, pages 29-34

⁸ CBO, Letter to House Speaker John Boehner, July 24, 2012

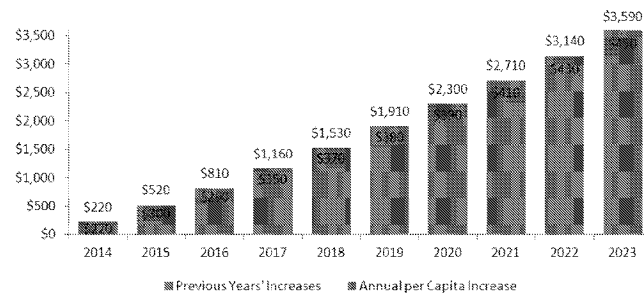
Given the scope and scale of these funding cuts, we have serious concerns about their likely impact. Because the vast majority of the ACA's cuts to the Medicare Advantage program have not yet taken effect, beneficiaries have not yet felt their full impact. This impact will be heightened by a new premium tax scheduled to begin in 2014.

Premium Tax on MA and Part D Programs

Medicare Advantage enrollees also will be impacted by the new health insurance premium tax established by the ACA. An actuarial study⁹ by the Oliver Wyman firm, commissioned by AHIP, found that the new premium tax is likely to increase costs – through higher premiums or higher cost-sharing – for beneficiaries enrolled in Medicare Advantage plans and Medicare Part D prescription drug plans.

According to the Oliver Wyman study, Medicare Advantage plans will pay \$220 per member in 2014 and \$450 per member in 2023 as a result of this tax, for a total tax burden of \$3,590 per member over ten years. For Medicare Part D plans, the tax will increase premiums by an estimated \$9 in 2014 and \$20 in 2023, for a total increase of \$161 over 10 years.

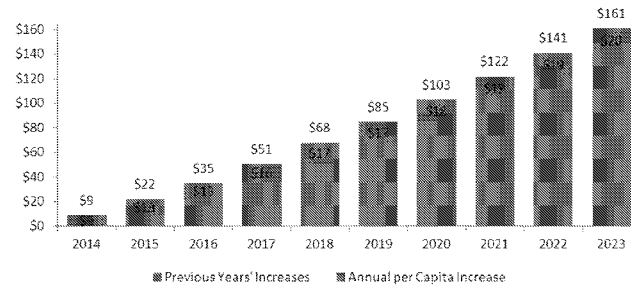
Cost Increase for Medicare Advantage Enrollees Due to ACA Premium Tax



Source: Oliver Wyman study, October 2011

⁹ Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. 31 October 2011.

Cost Increase for Medicare Part D Enrollees Due to ACA Premium Tax



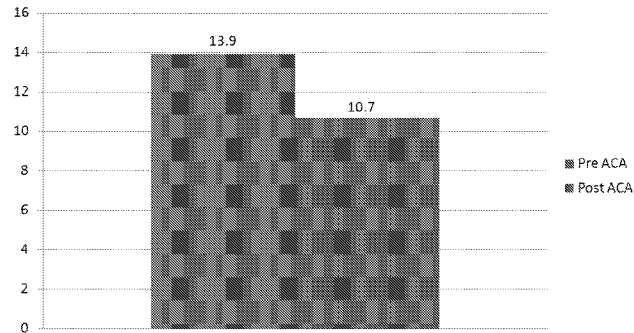
Source: Oliver Wyman study, October 2011

In addition to the ACA's Medicare Advantage funding cuts and the new premium tax, another serious concern is that across-the-board sequestration cuts, triggered under the Budget Control Act of 2011, would further limit the resources available to support the benefits of Medicare Advantage enrollees. These additional cuts – if they are implemented – could further disrupt coverage for Medicare Advantage beneficiaries and place a financial burden on providers participating in the program.

Enrollment Impact

The ACA's likely impact on the Medicare Advantage program is highlighted by CBO projections showing that the ACA will adversely impact enrollment in the Medicare Advantage program. In its March 2012 baseline, CBO projected that the ACA's funding cuts will cause Medicare Advantage enrollment to decline to 10.7 million in 2019. This decline represents a 23 percent reduction from the pre-ACA enrollment level of 13.9 million that was anticipated for 2019 according to CBO estimates issued in 2010.

**2019 MA Enrollment Estimates, Pre and Post ACA
(millions)**



Sources: Pre-ACA estimate: CBO, Selected CBO Publications Related to Health Care Legislation (2009-2010), December 2010
Post-ACA estimate: CBO, March 2012 Baseline

Impact on Vulnerable Beneficiaries

In evaluating the impact of the ACA's funding cuts, it is important to recognize the crucial role the Medicare Advantage program plays as a health care safety net for many low-income beneficiaries and other vulnerable populations.

For years, AHIP has been tracking government data that show how valuable Medicare Advantage plans are for vulnerable beneficiaries, particularly those who are not eligible for Medicaid and do not have employer-sponsored retiree benefits. For many of these individuals, Medicare Advantage may be their only option for comprehensive, affordable coverage.

Key findings of our most recent analysis¹⁰, based on 2010 data and published in May 2012, show that:

¹⁰ AHIP Center for Policy and Research, Low-Income & Minority Beneficiaries in Medicare Advantage Plans, May 2012

- Thirty-nine percent of all Medicare beneficiaries had incomes below \$20,000. By comparison, 43 percent of Medicare Advantage enrollees had incomes below \$20,000.
- Sixty-four percent of African-American Medicare Advantage enrollees and 82 percent of Hispanic Medicare Advantage enrollees had incomes below \$20,000.

These findings demonstrate that Medicare Advantage plans are important to many beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare FFS program. These vulnerable beneficiaries will pay a heavy price if the ACA's Medicare Advantage funding cuts are fully implemented.

Recent data clearly demonstrate that Medicare Advantage plans will continue to do their best to mitigate the impact of these funding cuts in the future. However, past history¹¹ suggests it is likely that the continued erosion of Medicare Advantage funding eventually would lead to increased costs for beneficiaries and reduced access to health plans that are demonstrating better performance on quality than Medicare FFS. We look forward to working with the Committee to mitigating the impact of these future cuts on beneficiaries.

V. Reauthorization of Medicare Advantage Special Needs Plans

Medicare Advantage Special Needs Plans (SNPs) have played an important role in meeting the health care needs of Medicare beneficiaries. SNPs serve as a crucial safety net for approximately 1.5 million of our nation's most vulnerable seniors, many of whom have disabilities and chronic conditions. Enrollees in SNPs benefit from the coordinated care, disease management, and other initiatives our members have pioneered to ensure that they receive high quality health care across the entire continuum of services they need.

SNPs were authorized by the Medicare Modernization Act of 2003 to provide new coverage options to beneficiaries with specific health care challenges. Three categories of SNPs are authorized under current law: (1) Dual Eligible SNPs serve beneficiaries who are dually eligible for both Medicare and Medicaid; (2) Chronic Care SNPs serve beneficiaries with severe or disabling chronic conditions; and (3) Institutional SNPs serve beneficiaries who live in skilled

¹¹ According to an analysis of CMS data from 1999 to 2003, after enactment of the Balanced Budget Act of 1997, nearly 2.4 million Medicare beneficiaries were affected by plan withdrawals and benefit reductions.

nursing facilities or other long-term care institutions or who qualify for an institutional level of care and live in the community. All three types of SNPs tailor their benefits and services to address the unique needs of the specific populations they serve, and a number of studies indicate that SNPs are providing a high level of value to both beneficiaries and taxpayers.

- **Dual Eligible SNPs:** Dual Eligible SNPs are at the forefront of providing cost effective, quality care to vulnerable populations. Several studies¹² have documented their success in achieving cost savings for state Medicaid programs by reducing inpatient hospital admissions and institutionalization for their dually eligible members while providing patient-centered, coordinated care. By targeting programs to meet the distinct needs of special populations of beneficiaries, Dual Eligible SNPs are demonstrating that they provide high quality care to beneficiaries with unique needs.
- **Chronic Care SNPs:** Nearly 25 percent of Medicare beneficiaries have five or more chronic conditions and account for 68 percent of Medicare spending.¹³ Tailored programs that address these conditions better coordinate and manage care and may improve quality of life and reduce long-term costs for the Medicare program by preventing unnecessary hospitalizations. Examples of activities typically undertaken by Chronic Care SNPs include engaging care coordinators with expertise in the specific condition addressed by the plan, developing provider networks that specialize in the condition targeted by the plan, and providing extended drug coverage through the Part D coverage gap for medications important to treating the condition that is the focus of the SNP.
- **Institutional SNPs:** Beneficiaries who qualify for an institutional level of care can particularly benefit from the special attention that Institutional SNPs can provide. These plans typically link beneficiaries with care coordinators – generally nurse practitioners – who manage teams of health care providers to ensure that the needs of beneficiaries are being met. These teams also include social workers, behavioral health specialists, and pharmacists who educate beneficiaries about their conditions, monitor health status, and identify health care and other needs. Independent studies have demonstrated that the model of care used by Institutional SNPs improves health outcomes. A 2003 University of Minnesota study found that enrollees in an Institutional SNP experienced fewer hospitalizations, reduced emergency department visits, and decreased hospital length of stay in comparison to other nursing home patients.¹⁴

¹² See for example “MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons,” JEN Associates Incorporated and The Lewin Group, “Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities,” (November 2008)

¹³ Anderson, G.F., “Medicare and Chronic Conditions”, New England Journal of Medicine, Vol. 353(3):305-309, 2005.

¹⁴ Kane, RL et al. “The Effect of Evercare on Hospital Use.” *Journal of American Geriatrics Society*, 2003;51(10):1247-1434

Under current law, the authorization for SNPs ends on December 31, 2013. It is important for Congress to take action promptly to reauthorize this program to ensure that SNP enrollees can continue to benefit from plans tailored to address their unique needs. Moreover, a longer term reauthorization covering several years is crucial to ensuring that SNP enrollees who benefit most from these plans have the peace of mind in knowing that they will continue to have access to them.

VI. Conclusion

Thank you again for this opportunity to testify. Our members are strongly committed to working with Congress to strengthen the coverage options that are available to meet the health care needs of our nation's Medicare beneficiaries, and will continue to focus on developing innovative solutions and new tools and techniques to help sustain Medicare into the future.

Chairman HERGER. Dr. Schwab is recognized for 5 minutes.

STATEMENT OF TIM SCHWAB, M.D., CHIEF MEDICAL OFFICER, SCAN HEALTH PLAN

Mr. SCHWAB. Thank you, Chairman Herger, Ranking Member Stark, and members of the Health Subcommittee. My name is Tim Schwab. I am chief medical officer of SCAN Health Plan in Long Beach, California. I am board certified in internal medicine, and have been working at SCAN for nearly 25 years. I appreciate the opportunity to appear before you today to discuss the innovative

programs that SCAN has put in place to meet the needs of our most vulnerable and frail members.

My testimony will focus on SCAN's Special Needs Plans, or SNPs. SNPs serve Medicare beneficiaries with highly complex health needs. There are three types of SNPs. First, institutional SNPs, or I-SNPs, serve individuals who reside in institutional settings or who live in the community but require an institutional level of care. SCAN is the Nation's largest community-based I-SNP.

Second, chronic or C-SNPs, which serve individuals living with multiple chronic conditions. SCAN has a C-SNP that focuses on end-stage renal disease.

And third, dual eligible SNPs, or D-SNPs, which serve dual eligible beneficiaries. SCAN runs California's only fully integrated dual eligible SNP.

All in all, SCAN serves 16,000 individuals in Special Needs Plans. In addition, SCAN Health Plan is the Nation's third largest not-for-profit Medicare Advantage plan. We were founded in 1977 by senior citizens in Long Beach who worried about the prospect of declining health and loss of autonomy. These citizen activists helped design a program of extra services and supports to keep them living in their own homes and not in a nursing home. Since then, SCAN has helped nearly 100,000 individuals avoid or postpone a nursing home stay. When Special Needs Plans came along in 2006, they reflected SCAN's mission to help seniors maintain their health and independence through specialized care and attention. Ideally, the SNP model was the same as SCAN's, placing the beneficiary at the center of care. It was a natural transition to move our beneficiaries to SNPs and continue with their personal care plans, care transitions assistance, disease management, and medication therapy management.

Well done, this model can significantly improve health outcomes and bring down the cost of care. Let me give you an example. An April 2012 study by Avalere Health found that SCAN's dual eligible members had a hospital readmission rate that was 25 percent lower than dual eligibles in Medicare fee-for-service with identical risk profiles. The study also found that SCAN performed 14 percent better than fee-for-service on Prevention Quality Indicator, or PQI's, overall composite, keeping people out of the hospital to begin with. Keeping people out of the hospital saves money. Based on results of a matched cohort analysis, if California fee-for-service duals had the same hospitalizations and readmission rates as SCAN's duals, this would result in at least \$50 million in annual savings to Medicare fee-for-service in California. Studies are useful, but let me give you a real example. Mr. A, a native Spanish speaker, recently enrolled in a SCAN D-SNP. Like all SCAN enrollees, he filled out an initial health assessment. In it, he revealed that over the last few weeks he felt down, depressed, or hopeless more than half the days. A SCAN case manager was able to reach Mr. A and perform an assessment.

The manager identified three concerns: Depression and suicidal ideation, poor relationship with his primary care physician, and inadequate access to needed psychiatric care. The assessments were shared with the PCP, and a behavioral health specialist rec-

ommended partial hospitalization. The team partnered with the medical group to coordinate services and address language-related barriers.

And they connected him with a Spanish-speaking psychiatrist and new PCP. Today, Mr. A has that new PCP, and is visiting his psychiatrist regularly, and is no longer having the suicidal ideations. The SNP model of providing patient-centered coordinated care to vulnerable populations has been a success. Unfortunately, the authorization is set to expire at the end of 2013. Congress should act as soon as possible to extend SNPs for a period of at least 5 years. Moving quickly is imperative. Plans must file their notices to offer these plans for 2014 by November of this year. A multi-year extension would provide stability to beneficiaries, States, and health plans to ensure beneficiaries do not experience a dangerous lapse in their care. In addition, my written testimony includes a number of other recommendations to strengthen SNPs to give beneficiaries better care. People who are frail, disabled, and chronically ill——

Chairman HERGER. Dr. Schwab, if you could conclude.

Mr. SCHWAB [continuing]. Are poorly served by fragmented models. They deserve the specialized treatments. SNPs are working, and we ask that you let them continue to work. Thank you.

Chairman HERGER. Thank you very much.

[The prepared statement of Mr. Schwab follows:]

*****TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON
FRIDAY, SEPTEMBER 21, 2012*****

Testimony

for

**House Ways & Means Committee
Subcommittee on Health**

Medicare Advantage Special Needs Plans

**by
Timothy Schwab, MD, FACP, MHA
Chief Medical Officer
SCAN Health Plan**

September 21, 2012

I. Introduction

Chairman Herger, Ranking Member Stark, and members of the subcommittee, I am Dr. Tim Schwab, Chief Medical Officer at SCAN Health Plan (SCAN). SCAN is the third largest not-for-profit Medicare Advantage Prescription Drug (MAPD) plan in the United States, serving approximately 130,000 members in California and Arizona. While most of SCAN's members are over the age of 65, we also provide care to some younger, disabled individuals who are dually-eligible for Medicare and Medicaid benefits ("dual eligibles").

We appreciate this opportunity to testify on the innovative programs that SCAN has put in place to meet the needs of our most vulnerable and frail members. In particular, my testimony will focus on SCAN's Special Needs Plans (SNPs). These Medicare Advantage (MA) plans serve members who reside in institutional settings, or who reside in the community but require an equivalent level of care; manage multiple chronic conditions; and/or are dual eligibles. Since the program's inception, SNPs have pioneered successful strategies to manage the care of Medicare beneficiaries with complex health needs. Our testimony includes the following:

- An introduction to SCAN and the people that we serve;
- A brief background on SNPs, and the added value that they provide to the Medicare program;
- The successful health outcomes and cost savings that SCAN's SNPs have produced; and
- Recommendations for strengthening SNPs for Medicare beneficiaries going forward.

II. SCAN Health Plan

SCAN has a long history of serving older adults with complex health situations. SCAN was founded in 1977 by a group of Long Beach, California senior citizen activists who were frustrated by a lack of access to health and social services that addressed their specific needs. They specifically wanted assurance that they could continue living in their own homes even if their declining health qualified them for a nursing home. SCAN's mission today is the same as it was then: to develop innovative ways to help our members manage their health and live independently. For more than two decades, SCAN participated in Medicare's Social HMO Demonstration, incorporating long-term services and supports (LTSS) with a comprehensive program of assessment and care management. It was through our experience as a Social HMO that SCAN developed an expertise in crafting benefits and services of unique importance to persons with special care requirements.

Because of the complex nature of our members' health conditions, SCAN has created a care management model that emphasizes prevention and early intervention, with a keen focus on medication management. Our model spans the continuum of a beneficiary's health status. Our disease management programs focus on recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, nutrition, self-management and healthy behaviors, advance care planning and medication management. Highly-trained care teams address the complex needs of the chronically ill population, and each program is

coordinated with all others to ensure safe and effective care transitions between all levels of care and providers. All those involved work together in offering a person-centered, holistic approach for persons with multiple, complex, and ongoing care needs. The *New England Journal of Medicine* has cited SCAN's model as an example of a successful investment in primary care to provide better care at reduced costs through reductions in the use of hospitals and emergency rooms.¹

III. Background and Value-Add of SNPs to the Medicare Program

The bipartisan Medicare Modernization Act of 2003 (MMA) established a new type of MA plan that focused on providing coordinated care to individuals with particularly complex health conditions. Congress intended these "Special Needs Plans" (SNPs) to exclusively serve one of three types of special needs individuals: (1) institutionalized beneficiaries, or individuals living in the community who require an equivalent level of care (I-SNP); (2) dual eligibles (D-SNP); and/or (3) beneficiaries with severe chronic conditions (C-SNP).² Because SNPs target their enrollments to particular patient populations, they can design programs that meet a group's unique health care needs and successfully reduce hospitalizations and institutionalizations.

All SNPs must offer Medicare Parts A, B, and D benefits, and must function under most of the same rules governing MA plans, including payment methodology. Additionally, SNPs are statutorily and administratively required to tailor benefits and services to their unique targeted populations. One difference is that Medicare enrollees may not have to wait until a new plan year to join SNPs. A person who reaches institutional or dual eligible status may enroll in a SNP at any point throughout the year. Beneficiaries with chronic conditions have a one-time special election period, based upon the time at which they are diagnosed with the chronic condition.³

Since 2003, Congress has enacted additional requirements for SNPs aimed at improving SNP performance and quality. These include:

- National Committee on Quality Assurance (NCQA) approval by 2012
- Individual care plans developed with input from beneficiaries and, if desired, families
- Annual comprehensive assessment of enrollee's physical, functional, and psychosocial health
- Interdisciplinary care teams with composition based on special needs of targeted enrollees
- Third party validation of institutional level of care equivalence

¹ Bodenheimer T., Berry-Millet R. (2009) Follow the Money – Controlling Expenditures by Improving Care for Patients Needing Costly Services. *New England Journal of Medicine*, 361:1521-1523.

² Special Needs Plans – Fact Sheet & Data Summary. Centers for Medicare and Medicaid Services. Available at <http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/FSNPFACI.pdf>.

³ The Basics About Special Needs Plans. National Health Policy Group. Available at <http://www.nhpg.org/about-snps.aspx>.

- Mandatory contracts with state Medicaid agencies for contract year 2013 and beyond which require D-SNPs, at a minimum, to:
 - Coordinate Medicare and Medicaid benefits and services;
 - Provide or arrange for the provision of Medicaid services;
 - Ensure that beneficiaries are not being charged higher cost sharing than Medicaid fee-for-service;
 - Include prohibitions in provider contracts against balance billing; and
 - Include in their summary of benefits a list of all Medicaid benefits to which the beneficiary is entitled in his or her state of residence, and which of these services are covered by the plan.

In addition, CMS rules require all SNPs to provide additional benefits and services of unique importance to their targeted populations – in addition to all those provided by standard MA plans – without additional payment. They must also attest to hundreds of SNP-specific requirements for staffing, health risk assessment, individual care plans, interdisciplinary care teams, provider networks, quality, etc. as a requirement for licensure. Further, to receive NCQA approval, SNPs must provide an extensive narrative description of their Model of Care (MOC), and supportive documentation, for the 11 MOC domains.

As of September 2012, over 500 SNPs are serving 1,530,935 beneficiaries across the United States. Of the total SNP enrollment, 1,259,446 beneficiaries are enrolled in a D-SNP.⁴ SCAN runs the nation's largest non-institutional I-SNP and one of the few CMS-certified fully-integrated D-SNPs (FIDESNPs) that provides extensive integration of Medicare and Medicaid benefits and services under a single program. In addition, SCAN provides specialty care for persons with end-stage renal disease through a C-SNP.

The advantages of SNPs to beneficiaries and public payors alike are clearly evident in the results of the SNP Alliance's 2010 Annual Member Profile. The SNP Alliance represents 30 organizations serving over 650,000 beneficiaries in more than 250 SNPs. The most recent profile shows that SNP Alliance members serve significantly more complex, high-need beneficiaries than those in Medicare fee-for-service (FFS). For example, while the average risk score for FFS beneficiaries living in institutions was 1.84, SNP Alliance members' median risk score for I-SNPs was 2.14, with an upper range of 2.27. The average risk score for SNP Alliance fully-integrated FIDESNPs was 1.49 compared to 1.27 for dual eligibles in FFS. SNP Alliance enrollees also had, on average, twice as many HCC conditions as beneficiaries in FFS. Despite these significantly higher risk levels, SNP Alliance members have been highly effective in reducing hospital utilization, readmissions, and emergency room visits.

⁴ Special Needs Plan Comprehensive Report. CMS Health Plan Management System. September 2012. Available at http://www.nhpg.org/media/15488/snp_2012_09.pdf.

IV. SCAN's SNP Experience Shows Improved Health Outcomes and Potential for Significant Cost Savings

Because SCAN's members are, overall, older and frailer than the average Medicare beneficiary, the availability of targeted, coordinated care options is particularly important. SCAN offers I-SNPs, D-SNPs, and C-SNPs to our members, with a total SNP enrollment of approximately 16,000 individuals. The full host of case management services is available to enrollees in a SCAN SNP, including the creation of a personal care plan, care transitions assistance, disease management, and medication therapy management. Approximately 8,000 of our members are dual eligibles enrolled in one of SCAN's D-SNPs. In addition to the case management services available to other SNP members, D-SNP enrollees have access to a Personal Assistance Line (PAL) Unit. SCAN provides these members with a "PAL," a member services representative who speaks their language and provides additional assistance in navigating the complexities of the Medicare and Medicaid programs. PALs act as liaisons between the member and SCAN staff, medical groups, providers, and community-based organizations, ensuring that the member has access to the services and supports that he or she needs.

Recent analyses of this unique care management model demonstrate its effectiveness in improving patient health outcomes. A March 2012 study conducted by Avalere Health found:

- Comparing HEDIS 30-day All-Cause Readmissions Rates between dual eligibles enrolled in a SCAN Health Plan D-SNP versus Medicare fee-for-service (FFS) dual eligibles, SCAN's dual eligibles had a **hospital readmission rate** that was **25 percent lower** than a similar cohort of California FFS dual eligibles.
- SCAN also scored better than Medicare FFS on ARHQ's Prevention Quality Indicator (PQI) Overall Composite, demonstrating a **14 percent lower hospital inpatient admission rate** for conditions that compose the composite measure, including chronic obstructive pulmonary disease (COPD), congestive heart failure, and bacterial pneumonia.

The study also found a potential for significant cost savings tied to the improvement in health status of SCAN's D-SNP enrollees. Based on the results of a matched cohort analysis, if California FFS duals had the same hospitalizations and readmissions rates as SCAN's duals, this would result in at least \$50 million in annual savings to Medicare FFS in California.⁵ Avalere based the calculation on expected reduced hospitalizations and re-hospitalizations for the 5,500 FFS dual members it examined in the CMS 5% sample, multiplied by 20 to approximate the impact to the full California FFS duals population. Avalere has said that savings could be greater across the entire California duals population if additional FFS duals matched the SCAN members' conditions.

⁵ Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions. Avalere Health LLC. March 2012.

V. Recommendations for Strengthening SNPs to Ensure the Continuous Availability of High-Quality Care for Medicare Beneficiaries

The SNP model of providing patient-centered, coordinated care to vulnerable populations has been a success. Unfortunately, current SNP authorization is set to expire at the end of 2013. Congress should act as soon as possible to extend SNPs for a period of at least five years. Moving quickly is imperative, given that health plans must file their notices of intent to offer these plans for the 2014 year by November 2012 and meet a series of other requirements by next August that assume contract renewal for 2014.

A multi-year extension would:

- Stabilize specialty care for the 1.5 million current special needs beneficiaries and provide them peace of mind regarding their existing care plans
- Continue the progress SNPs are making in reducing ER visits, hospitalizations, re-hospitalizations and nursing home stays
- Allow states, if they choose, to construct their duals demonstration on a SNP framework
- Allow SNPs to be a Medicare-based alternative to the duals demonstration in other states to see which model works best for beneficiaries
- Allow time to gather experience and evaluate findings from SNPs, ACOs, PACE and the Duals Demonstration so that CMS may work with Congress to enact a permanent program going forward

In addition, Congress should consider:

1. Allowing long-term services and supports (LTSS) to be offered through all SNPs. Under current law, only D-SNPs are authorized to provide these supplemental benefits. Avalere's study of SCAN's D-SNP shows the importance of LTSS to the health of individuals with complex health conditions, as well as to controlling costs within the Medicare program. Extending the availability of these services to all SNPs would amplify these results and improve the care available to Medicare beneficiaries.
2. Reducing financial barriers to specialization by directing the Secretary of Health & Human Services to improve the accuracy of the MA risk adjustment methodology to more fully account for cost differences associated with plans specializing in care of high-risk/high-need beneficiaries. This could be accomplished by: (1) adding new risk factors for frailty, dementia, and number of chronic conditions; (2) extending the new enrollee factor for C-SNPs to include D-SNPs; and (3) permitting all SNPs to offer expanded supplemental benefits, not just FIDESNPs.
3. Ensuring that SNPs are evaluated based on their performance in relation to their specialty care mandate. Congress should require CMS to establish population-based performance evaluation measures and methods, in collaboration with the National Quality Forum (NQF) and NCQA. This would ensure that SNPs are assessed based on measures that are sensitive to the unique but diverse needs of SNP beneficiaries, rather than standard

measures for general Medicare enrollees. A good starting point would be to require NQF to develop recommendations regarding measures for plans serving high-risk/high-need beneficiaries, after reviewing the appropriateness of existing measures and Star ratings. In addition, NQF should assess the need for new measures; the validity and reliability of self-report surveys for beneficiaries with mental illness, cognitive impairment, and behavioral problems; and opportunities for streamlining and consolidating current measures for SNPs -- including Medicare and Medicaid reporting requirements -- without jeopardizing SNP quality and risk-adjusting and benchmarking SNP performance against FFS.

VI. Conclusion

Persons who are poor, frail, disabled, and chronically ill are among healthcare's most vulnerable, high-cost, and fast growing care segments. Their multiple, complex, and ongoing care needs are poorly served by fragmented care models. Unless we promulgate specialty care arrangements for these high-cost/high-need beneficiaries, we will not be able to stem the tide of cost escalation, nor maintain our commitment to service for our most needy citizens.

As it stands, SNPs are the only managed care entity, other than PACE, able to exclusively serve persons who are dually eligible for Medicare and Medicaid -- critical to the advancement of dual integration programs. SNPs are also the only managed care platform required to offer a model of care of unique importance to frail, disabled, and seriously ill persons, with CMS using a commensurate set of oversight and reporting requirements, also not required of other managed care entities. If states and local communities are empowered to build upon programs like SCAN's, with proper refinement of program, payment, and oversight requirements, a timely new generation of specialized care can emerge for bending the cost curve while actually improving care for our most needy citizens.

Chairman HERGER. Mr. Tallent is recognized for 5 minutes.

STATEMENT OF JOHN TALLENT, CHIEF EXECUTIVE OFFICER, MEDICAL ASSOCIATES CLINIC & HEALTH PLANS

Mr. TALLENT. Chairman Herger, Ranking Member Stark, and distinguished Members of the Subcommittee, my name is John Tallent. I am the chief executive officer of Medical Associates Health Plans in Dubuque, Iowa. I am here today testifying on behalf of the Medicare Cost Contractors Alliance, a coalition of 15 Medicare cost plans that currently serve over 400,000 Medicare beneficiaries enrolled in plans in 14 States and the District of Co-

lumbia. Since 1972, they have proven to be a stable, quality alternative to Medicare fee-for-service, particularly for beneficiaries living in rural areas and areas in which risk-based plans have encountered challenges. We firmly believe that Medicare cost plans should remain available as a coverage option, and are grateful for the bipartisan support that the program has enjoyed. We want to thank Representative Paulsen and Representative Kind for introducing legislation to preserve this important program.

There are 19 Medicare cost plans across the U.S., located principally in rural areas, or areas with comparatively low Medicare Advantage rates. Ninety percent of cost plans are nonprofit organizations. A large portion of Medicare cost plans are either owned by or affiliated with well regarded medical groups. The average Medicare cost plan has been providing high quality, cost-effective services to Medicare beneficiaries for over 20 years. For nearly three decades, Medical Associates Health Plans has been serving Medicare beneficiaries under a cost-based contract in five counties in Iowa, four counties in Wisconsin, and one county in Illinois. Like most cost plans, our members are elderly. Their average age is almost 76. And one third of our members are 80 years of age or older. In fact, many of our members have been with us for 20 years or more. Our members like our plan, and we have a less than 1 percent voluntary disenrollment rate. Medical Associates Health Plans is owned by Medical Associates Clinic, which is the oldest multi-specialty group practice clinic in Iowa.

Medical Associates Health Plans is proud of the quality of services it offers to its cost plan members. In 2012, Medical Associates Health Plan was one of 12 CMS contracts out of 569 that received a 5-star rating. Our Wisconsin plan received a 4.5-star rating. If current law is not changed, over 230,000 beneficiaries will lose their cost plan coverage in 10 States on January 1, 2014. Medical Associates would be forced to withdraw from four of the five counties in its Iowa service area. This is despite the fact that Medical Associates is overwhelmingly the most popular Medicare health plan in our service area, and has the highest quality rating as well. In States like Texas and South Dakota, cost plans will have to withdraw from rural areas despite very low Medicare Advantage penetration. Cost plan members throughout Minnesota and portions of Colorado, Wisconsin, and Ohio will also lose their plans.

Because of the cost plan withdrawals, these vulnerable beneficiaries will face higher costs. They could also face disruptions in long-standing provider relationships, since many of them have been Medicare cost members for many years. As you know, Medicare Advantage rates are scheduled to decline under current law. History shows that when payments to Medicare risk-based plans have decreased, plans have withdrawn from the program or reduced their service areas, resulting in many beneficiaries losing their Medicare health plan choices, particularly in rural areas.

In order to prevent 230,000 Medicare beneficiaries from losing their Medicare cost plan choice in 2014, and to ensure that beneficiaries have an ongoing choice of quality Medicare managed care plans, it is imperative that Congress pass legislation this year. We very much appreciate the opportunity to testify before the sub-

committee, and look forward to continuing to work with members of this committee. Thank you.

Chairman HERGER. Thank you.

[The prepared statement of Mr. Tallent follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON FRIDAY,
SEPTEMBER 21, 2012***

Testimony of John Tallent

CEO, Medical Associates Health Plans, Dubuque, Iowa

On behalf of the Medicare Cost Contractors Alliance

Before the Subcommittee on Health

House Committee on Ways and Means

on

The Medicare Advantage Program

September 21, 2012

I. INTRODUCTION

Chairman Herger, Ranking Member Stark and distinguished members of the Subcommittee, my name is John Tallent. I am the Chief Executive Officer of Medical Associates Health Plans, headquartered in Dubuque, Iowa. I am here today testifying on behalf of the Medicare Cost Contractors Alliance, a coalition of 15 Medicare cost plans that currently serve over 400,000 Medicare beneficiaries enrolled in plans in 14 states and the District of Columbia.

Congress authorized Medicare cost plans in 1972 under section 1876 of the Social Security Act. Since then, they have proven to be a stable, cost-effective alternative to Medicare fee-for-service, particularly for beneficiaries living in rural areas and areas in which risk-based plans have encountered challenges. As a result, Congress has worked on a bipartisan basis to maintain this important program.

We appreciate this opportunity to testify on Medicare cost plans. We firmly believe that cost plans should remain available as a coverage option for beneficiaries and are grateful for the bipartisan support that the program has enjoyed. The Alliance also appreciates the efforts of two members of this Committee—Representative Paulsen (R-MN) and Representative Kind (D-WI)—who have introduced H.R. 2770, the Medicare Cost

Contract Extension Act of 2011. I also want to recognize the work of Senator Klobuchar (D-MN) and Senator Grassley (R-IA), who have introduced a companion bill in the United States Senate.

My testimony today will focus on three main areas: first, I'll provide some background information on cost plans in general and discuss Medical Associates Health Plans as an example of the types organizations that have Medicare cost contracts; second, I'll explain the status of cost plans under current law and the need for changes to current law that will ensure that beneficiaries—many of whom have been members for more than a decade – can continue to receive care through their plans. Finally, I will present some policy options to achieve that objective.

II. BACKGROUND

A. Medicare Cost Plans

Like Medicare Advantage plans, Medicare cost plans cover Part A and Part B services, as well as any optional supplemental benefits. In addition, they can choose to offer Part D coverage. The principal difference between Medicare cost plans and Medicare Advantage plans is that the Centers for Medicare and Medicaid Services (CMS) reimburses cost plans based on their reasonable costs, rather than through a risk-based capitated payment.

There are 19 Section 1876 Medicare cost plans across the U.S., located principally in rural areas or areas of comparatively low Medicare Advantage rates. Ninety percent of cost plans are nonprofit organizations. A large portion of Medicare cost plans are either owned or affiliated with well-regarded medical groups. The average Medicare cost plan has been providing high quality, cost-effective services to Medicare beneficiaries for over 20 years.

In fact, although Section 1876 cost plans only represent 19 of the 569 Medicare health plan contracts, in 2012, 25 percent of all five star Medicare health plans are cost plans. All cost plans have a star rating of 3.5 or higher; however, only half of Medicare Advantage plans have a star rating 3.5 or higher.

B. Medical Associates Health Plans

Medical Associates Health Plans is a provider-owned health plan located in Dubuque, Iowa. Established in 1982, the Plan operates within a 60-mile radius of Dubuque in Iowa, Wisconsin and Illinois. The organization operates two health plans—Medical Associates Health Plan, Inc. operating in Iowa and Illinois, and Medical Associates Health Plan operating in Wisconsin—collectively doing business as Medical Associates Health Plans. Their overall membership, including both commercial and Medicare members, is just over 30,000 members with an additional 12,000 members managed by the organization under a related company.

Medical Associates Clinic, the owner of Medical Associates Health Plans, was established in 1924, and is the oldest multispecialty group practice clinic in Iowa. With over 170 providers serving Dubuque and the Tri-State area, Medical Associates Clinic and Health Plans have a staff of over 1,000 health care professionals and support personnel. The clinic has two campuses in Dubuque and nine satellite clinics throughout the Plans' service area. They have been designated a Better Performing Practice by the Medical Group Management Association for over ten consecutive years. Medical Associates Clinic was awarded the Physician Practice Connections®-Patient Centered Medical Home™ by NCQA, and is ranked among the top recognized practices in the nation by scoring a Level 3, the highest recognition status obtainable.

The clinic has made a significant investment in quality, technology and service. In the area of quality, this includes NCQA recognition for Diabetes Education as well as Heart/Stroke care. The Clinic implemented use of an Electronic Medical Record in 1993, the first in the region to adopt this technology.

Medical Associates Health Plan has had a Medicare cost-based contract since 1984—converting from a Health Care Prepayment Plan, another form of cost contract, to a Section 1876 Cost Contract in 1996. We operate our Medicare cost contracts in five counties in Iowa—Dubuque, Jones, Jackson, Delaware and Clayton; four counties in Wisconsin—Grant, Iowa, Crawford & La Fayette; and one county in Illinois—Jo Daviess.

Our current Medicare cost plan enrollment is 12,290 and our Medicare members like our plan – our voluntary disenrollment rate is 1 percent or less. Our members are elderly. Their average age is almost 76 and one third of our members are 80 years of age or older.

Medical Associates Health Plans is proud of the quality of services it offers to its cost plan members. In 2012, Medical Associates Health Plan was one of twelve CMS contracts out of 569 (2.11%) that received a five star rating. Our Wisconsin plan received a 4.5 star rating. In addition, Medical Associates Health Plans have had an NCQA “Excellent” accreditation since 2002.

III. THE WITHDRAWAL REQUIREMENT

The Balanced Budget Act of 1997 amended the Social Security Act to provide for a sunset of all Medicare cost plans in 1999. This provision was subsequently amended and in 2003 under the Medicare Modernization Act, the so-called “two plan test” was created. The test has been subsequently refined in an effort to ensure that beneficiaries will continue to have health plan choices.

Under current law, after January 1, 2013, Medicare cost plans must withdraw from any portion of their service area if there are two local or two regional Medicare Advantage (MA) plans that overlap that portion of the cost plan’s service area and that have met minimum enrollment requirements for the previous year. If the test is met, the affected cost plan will have to withdraw effective on January 1, 2014. The enrollment thresholds are determined by segments of the Medicare Advantage plans’ service areas. For Metropolitan Statistical Areas (MSAs) with a population of 250,000 or more, the test is met if the two Medicare Advantage plans have 5,000 enrollees in the MSA and its contiguous counties. For all other areas, the test is met if the two Medicare Advantage plans have 1,500 enrollees in areas outside of MSAs and their contiguous counties.

If current law is not changed, about 230,000 beneficiaries will lose their cost plan coverage in 10 states on January 1, 2014. Medical Associates Health Plan would be forced to withdraw from four of the five counties in its Iowa service area, affecting almost 1,400 members.

In states like Texas and South Dakota, cost plans will have to withdraw from rural areas despite very low Medicare Advantage penetration in the affected counties because the area over which the “all other area” test is measured is so large. In Minnesota, cost plans would be required to withdraw from their entire Minnesota service areas with the exception of the Duluth MSA and its contiguous counties. Additionally, cost plans will be required to withdraw from counties in Colorado, Wisconsin and Ohio.

IV. MEDICARE COST PLANS SHOULD REMAIN A COVERAGE OPTION FOR BENEFICIARIES

A. Effect of Withdrawals; Cost Plan Enrollees Will Face Higher-Out of Pocket Costs

The withdrawals required under current law will become effective on January 1, 2014. Thus, beneficiaries would have to pay the deductibles and coinsurance amounts under Original Medicare, move to a Medigap plan or choose a Medicare Advantage plan during the 2013 open enrollment season. Medigap plans will be particularly expensive for older cost plan members because they are age rated. Moreover, a 2009 study by the General Accounting Office found that cost plan benefit packages tend to attract less healthy beneficiaries.¹ The GAO report found that beneficiaries 80 to 84 years old who reported poor health had lower average out-of-pocket costs than competing Medicare Advantage plans or Medicare fee-for-service. Thus, these vulnerable beneficiaries will have higher out of pocket costs because of the cost plan withdrawals. They also could face disruptions in long-standing provider relationships, since many of them have been Medicare cost members for many years.

¹ United States General Accounting Office, Report to Congressional Committees, MEDICARE MANAGED CARE: Observations about Medicare Cost Plans, GAO-10-185 (December 2009).

The elderly and less healthy beneficiaries who tend to be enrolled in Medicare cost plans will not receive the care management and coordination offered by Medicare cost plans if they go to Medicare fee-for-service. Moreover, studies have shown that Medicare cost plans offer higher quality of care than fee-for-service Medicare.²

One purpose of moving from a defined sunset date to the two plan test was to ensure that beneficiaries affected by cost plan withdrawals would continue to have Medicare managed care choices. However, because the effective date of withdrawals (beginning 2014) takes place during a period of decreasing Medicare Advantage rates, this will not be ensured. The Medicare Advantage payment changes authorized by the Affordable Care Act will be fully implemented over a six year period beginning in 2012. Full implementation will occur at the end of 2017. In the past, when payments to Medicare risk-based plans have decreased or have been uncertain, plans have been forced to make the difficult decision of withdrawing from the program or reducing their service areas, resulting in many beneficiaries losing their Medicare health plan choices. For example, in the period from 1999-2002 severe payment reductions went into effect and the regulatory environment presented additional challenges to plans. As a result, 374 Medicare+Choice organizations either ended their contracts or reduced a portion of their service areas, resulting in 2,205,000 beneficiaries losing their plans. A GAO analysis of the withdrawals and service area reductions noted that by 2001 almost 75 percent of counties that had a Medicare+Choice plan in 1999 were affected by service area reductions or withdrawals.³

The same GAO analysis explained that Medicare+Choice plans tended to withdraw from more difficult to serve rural counties or large urban areas that they had entered more recently or where

² This conclusion is supported by two separate research findings: (1) that Medicare Advantage plans scored higher than Medicare FFS on the vast majority of HEDIS measures (*See Niall Brennan and Mark Shepard, Comparing Quality of Care in the Medicare Program, VOL. 16, NO. 11, THE AMERICAN JOURNAL OF MANAGED CARE, 841 (November 2010)*) and (2) that correspondingly, Medicare cost plans scored higher than Medicare Advantage plans on HEDIS measures (*See MedPAC, Report to the Congress. Medicare Payment Policy (March 2011)* and *United States Government Accountability Office, Report to Congressional Committees, MEDICARE MANAGED CARE: Observations about Medicare Cost Plans, GAO-10-185 (December 2009)*).

³ United States General Accounting Office, Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings, GAO/HEHS-00-183 (September 2000).

they failed to attract sufficient enrollment. Many Medicare cost plans serve predominately rural areas.

B. Policy Options To Preserve Beneficiary Access to Cost Plans

In order to prevent 230,000 Medicare beneficiaries from losing their Medicare cost plan choice in 2014 and to ensure that beneficiaries have a choice of quality Medicare Managed care plans, it is imperative that Congress pass legislation. Such legislation could take the form of a straight extension, under which the date the withdrawal obligation becomes effective is pushed back for three years. In the alternative, Congress could modify the current two plan test to require, as a condition of a cost plan needing to exit a market, that the two competing MA plans must both have minimum enrollment levels (as currently required) and also have a star rating equal to or greater than the star rating of the Medicare cost plan that would be required to withdraw.

Such changes could be enacted in conjunction with policy changes that would more closely align the Medicare cost plan requirements with those under the Medicare Advantage program and promote value-based purchasing, for example, by:

- Augmenting cost plans' current quality assurance program requirements by adding the Medicare Advantage requirements to have a chronic care improvement program and to conduct quality improvement projects;
- Allowing cost plans to be accredited by private accreditation agencies for certain quality requirements, as currently permitted for Medicare Advantage plans;
- Allowing cost plans to offer mandatory supplemental health care benefits in the same manner as Medicare Advantage plans;
- Applying the Medicare Advantage preemption of state law provisions (except licensure and solvency requirements) to cost plans;
- Applying the restrictions on imposing premium taxes on cost plans in the same manner that they apply to Medicare Advantage plans; and
- Permitting CMS to promote the offering of employer group health plans by approving waivers of requirements that would hinder the design of, offering of, or enrollment in cost plans.

V. CONCLUSION

In closing, we once again appreciate the opportunity to testify before the Subcommittee. As we discussed, cost plans have a long history of providing high quality, affordable care to Medicare beneficiaries. In addition, cost plans have been an extremely stable plan offering for beneficiaries. It is imperative that Congress enact legislation this year necessary to prevent 230,000 beneficiaries from losing their Medicare cost plans on January 1, 2014 when there is no assurance that those beneficiaries will have ongoing access to high quality plan choices. We look forward to continuing to work with members of this Committee in meeting that important objective.

Chairman HERGER. Ms. Gold, you are recognized for 5 minutes.

**STATEMENT OF MARSHA GOLD, SENIOR FELLOW,
MATHEMATICA POLICY RESEARCH**

Ms. GOLD. Thank you. Chairman Herger, Ranking Member Stark, and Members of the Subcommittee, I am a senior fellow at Mathematica Policy Research, an independent, nonpartisan public policy organization. I want to make seven points today that I elaborate on in my written remarks.

First, the MA program today is strong, with rising enrollment that is expected to continue into 2013. While the ACA sought to

scale back payments to MA plans to achieve closer alignment between payments made for beneficiaries in MA versus the traditional program, it was acting in line with the origins of the program, and consistent with the recommendations of Congress's non-partisan adviser MedPAC. The ACA changes also served to extend the life of the Medicare Trust Fund and to slow increases in Part B premiums for all beneficiaries. Second, MA plans are still paid considerably more for a similar beneficiary in the traditional program.

In considering future policy change, it is difficult to see 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 with the Federal deficit and debt. Third, although some suggest otherwise, I have studied these plans in depth for more than 20 years, and there was no strong and consistent evidence that private plans in general are better at cost control than traditional Medicare is, or that health plan competition will produce enough savings to address current fiscal concerns.

Fourth, polls show traditional Medicare remains popular with beneficiaries. That means that paying more for private plans is effectively a tax on their choice. The Part B premiums will increase, with no gain in benefits to them. Clearly, payment reductions at some point can discourage plans from participating in MA, but we are not there now. Even if we were, the question is how much payment is warranted to preserve choice, especially if it costs rather than saves money.

Overpayments also involve a substantial transfer of funds from government to private firms, a few of whom dominate the market. Fifth, as the Congressional Budget Office has concluded, Medicare premium support programs that reduce government contributions to Medicare will shift costs to beneficiaries and limit the health and financial protection the program provides vulnerable beneficiaries. MA has a role for private plans in Medicare, but it is not a voucher or premium support program. The defined benefit Medicare provides differs fundamentally from a fixed contribution plan.

Although premium support proposals vary, most would fundamentally change the traditional way the Medicare program operates, and some would eliminate traditional Medicare altogether.

Sixth, traditional Medicare, with its defined and nationally uniform benefits across the country, has served as a valuable protection to beneficiaries. It provides defined and nationally uniform benefits to all Medicare beneficiaries. Some proposals say that they maintain the traditional Medicare plan option, but they do not appear to finance it. This arguably presents a false assurance about the future availability of traditional Medicare as we know it now. The program would be different, and beneficiaries would pay more. Our health care system is very inefficient. Both traditional Medicare and private plans alike face challenges in containing costs. 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, or some combination.

One person's waste is another's income. It also is not that easy to define medically necessary care, especially at an individual level.

The 1990s managed care backlash showed that policymakers should not expect the private sector or beneficiaries to engage in battles from which they themselves want distance. Medicare beneficiaries already pay a considerable amount out-of-pocket for health care, as my written testimony indicates.

Seven, other programs show that strong oversight and risk adjustment are important to prevent unfair marketing practices, enrollment abuse, and protecting vulnerable Medicare beneficiaries. When they are absent, scandals occur and people are hurt. Appropriate risk adjustment is critical, and all of these will be more important if dual eligibles enter the program.

In closing, although decisions about the future of Medicare will inevitably reflect the values considered socially acceptable by a variety of stakeholders, the evidence suggests there are no easy answers to the fiscal dilemmas facing our Nation. Thank you.

Chairman HERGER. Thank you.

[The prepared statement of Ms. Gold follows:]

***TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON FRIDAY,
SEPTEMBER 21, 2012***

MATHEMATICA
Policy Research

Marsha R. Gold
Senior Fellow
Mathematica Policy Research

**Testimony for Hearing on
Medicare Health Plans**

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

September 21, 2012

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

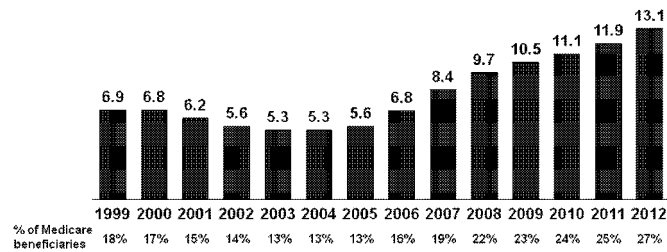
For many decades, Medicare has offered beneficiaries access to popular private-marketplace alternatives through a variety of legislative mechanisms, including cost contracts (1970s), the Medicare risk-contracting (HMO) program (1982), Medicare+Choice with additional private plan options (1997), and MA (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



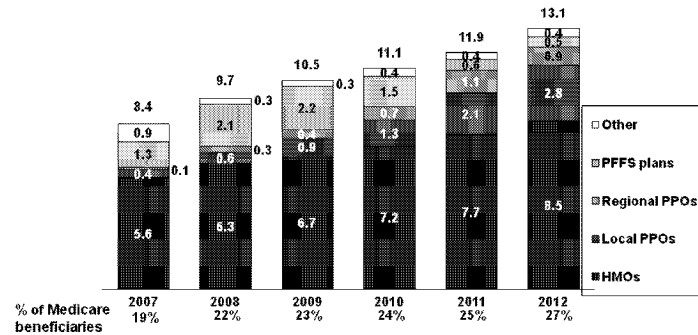
Source: Mathematica/Kaiser Family Foundation's analysis of CMS's Medicare Advantage enrollment files, 2008-2012, and Mathematica's "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2001-2007.

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%	106%
Private fee-for-service	112%	106%	110%
Restricted Availability Plans			
Included in the Total			
Special Needs Plans	114%	101%	110%
Employer Groups	114%	105%	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.

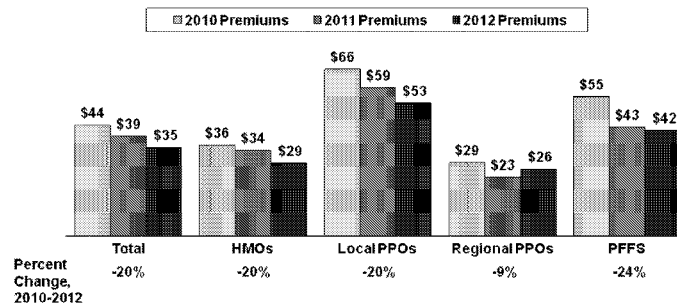
PFFS = private fee for service.

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, HCFPs, 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.

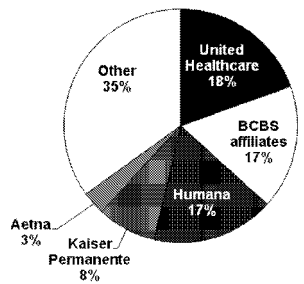
PFFS = private fee for service

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.

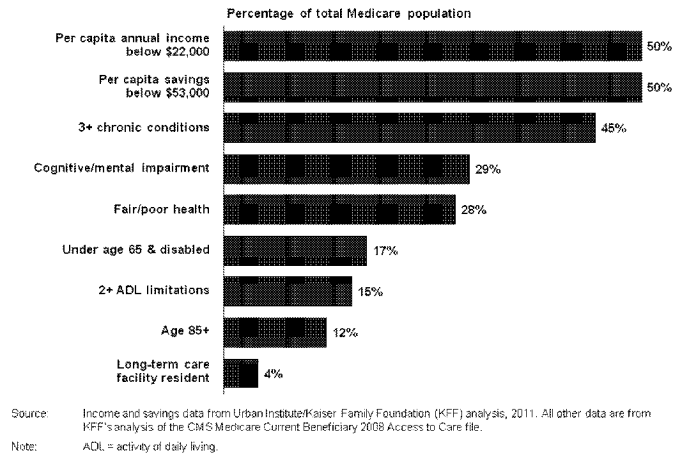
Traditional Medicare and private plans alike face challenges in a health care system that is very inefficient. Fundamental reform of the system to reduce costs ultimately cannot be achieved without someone paying the price—whether that is the beneficiary, the plan, the provider, Medicare itself (that 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

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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Chairman HERGER. Mr. Cosgrove, I read in your report that the CMS MA quality bonus payment demonstration would cover up nearly one third of the ObamaCare cuts to MA plans over the life of the demonstration. Is this correct?

Mr. COSGROVE. The demonstration would offset about one third of the cuts, yes.

Chairman HERGER. Can you please break down your estimate of how much of the cuts will be offset each year?

Mr. COSGROVE. This year, in 2012, just over 70 percent. Next year, in 2013, about a third. And then the final year about 16 percent, I believe.

Chairman HERGER. It seems to me the administration is trying their hardest, and using any means necessary to hide these cuts until after this election.

Ms. Ignagni, as you well know, ObamaCare's cuts to Medicare Advantage are real, especially to the beneficiaries that are enrolled in these plans. In fact, not too long ago, cuts to the Medicare health plans which were far less than those in ObamaCare resulted in millions of seniors losing access to their health plans. In fact, in some counties in the Northern California district I represent, seniors lost all choice of private health plans after the 1997 cuts.

Even the Medicare actuaries highlight this fact in this year's report which stated that "As a direct consequence of the plan terminations, the percentage of Medicare beneficiaries who enrolled in private health plans declined each year from 2000 through 2004."

Won't the cuts to Medicare Advantage in ObamaCare have a real and lasting impact on seniors' access to the MA plan they have and like?

Ms. IGNAGNI. Two comments, sir. One, with respect to the past, which I remember very vividly, I think the lesson there was that Congress responded by putting additional resources and targeted towards specific counties, Northern California as an example, in the upper northwest, in the middle part of the country, Michigan, Ohio, Illinois, Upstate New York, et cetera. And that had a very positive effect. It was a bipartisan action.

With respect to what is going to happen as a result of the cuts that we see in the ACA, and also the premium tax, which hasn't been much focused on but I think needs to be because it begins in 2014 and compounds this, I can't tell you exactly what would happen, but I think the CBO estimates provide a window into that. And we provided that in our testimony.

Chairman HERGER. Thank you. Dr. Schwab, I understand that SCAN Health has had a fully integrated health plan for beneficiaries, many of them dual eligible for over the last 20 years. Can you describe how the plan integrates benefits between Medicare and Medicaid? What are the benefits to this type of integration?

Mr. SCHWAB. Yes. SCAN has had a program that for some of our members, we had a contract with the State of California to provide all Medicaid or Medi-Cal services. So from a member standpoint, all benefits are arranged through the health plan, whether it is a Medicare benefit, a Medi-Cal benefit. And included in the Medi-Cal benefits are the home and community-based services and nursing home care as per the Medi-Cal program. The way we integrate that primarily is through our case management program, a one-on-one relationship with the member, working in conjunction with the primary care physician and the medical group we contract with.

Chairman HERGER. Thank you. Mr. Stark is recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman. I thank the panel for their testimony. Ms. Gold, my Republican colleagues would like us to believe that the sky is falling in terms of enrollment, benefits, premiums. But these projections have turned out to be incorrect. And since the passage of the ACA, Medicare Advantage enrollment

has increased, and the premiums have decreased. Is that not correct?

Ms. GOLD. That is correct.

Mr. STARK. And I am sure that this happened last year, so that it isn't just a one-time event, this is a trend. Could you just discuss for a moment the distinctions between Medicare Advantage and the Romney-Ryan voucher, or premium support program that the Republicans would have us—how do they differ?

Ms. GOLD. Well, there are so many plans floating around that I will answer generally. But basically, under Medicare Advantage, beneficiaries always have the option to return to Medicare, traditional Medicare. They get the same benefits in Medicare Advantage whether—you know, whether they are in Medicare Advantage or traditional Medicare. And plans are required to pay those. They have a national Medicare program and strong oversight. Under a premium support program, most of them—and again, they all differ—but they don't guarantee a certain amount of money. There is more wiggle room in the benefits. And a lot of them would seem to dismantle the traditional Medicare program into a bunch of littler programs or changes that make its bargaining power nationally much more limited with providers, and might hurt it from controlling health care costs.

Mr. STARK. Also, there are some that would like you to believe that the only reason that plans are still in MA is because of the quality bonus program. And I think most of our estimates show that the Affordable Care Act has reduced Medicare Advantage overpayments by, I think, \$156 billion, which is listed in the Ryan budget, over 10 years. And the quality bonus payment demonstration is a total of what, \$8.5 billion over 10 years. So isn't it also true that the underlying quality program will continue in perpetuity under the law?

Ms. GOLD. Yes, it is in the law.

Mr. STARK. So, it is possible that the demo is being targeted at the mid-level plans to help them improve before this bonus plan takes over.

Ms. GOLD. Yes.

Mr. STARK. Thank you very much.

Chairman HERGER. Thank you. Mr. Buchanan is recognized for 5 minutes.

Mr. BUCHANAN. Thank you, Chairman, for holding this important hearing today. And I would like to thank all our witnesses for taking the time to do this. I represent in my district in Florida about 200,000 seniors who rely, obviously, heavily on Medicare. About 40,000 of those seniors are on Medicare Advantage. And I want to make sure they have quality health care. Millions of Americans are struggling, especially those living on fixed incomes. I read a new study in terms of the cuts they are talking about, the \$716 billion in cuts in the new health care law, that \$2.2 billion will be in the two counties I represent in my congressional district. The question I have for the panel, really, how big of an impact in terms of our congressional area?

Mr. Tallent, can you maybe express your concerns on this or your thoughts on it?

Mr. TALLENT. I apologize, but I don't understand the particulars of Florida and your situation.

Mr. BUCHANAN. Well, just look at the \$716 billion in cuts. Of that, it will be applicable in a lot of different congressional districts around the country. But I have 200,000 seniors 65 and older; \$2.2 billion of those cuts are going to be in my immediate area, the area I represent. And I was just wondering do you have a thought on the impact of those cuts?

Mr. TALLENT. Specifically, I am focusing this morning, I have been asked to focus on the effect of—

Mr. BUCHANAN. Medicare Advantage?

Mr. TALLENT. Well, of the cost contracts and the situation that we are in.

Mr. BUCHANAN. Dr. Schwab, do you have any comments on that in terms of the cuts?

Mr. SCHWAB. Well, the cuts are going to force all plans to operate more efficiently and effectively. I think some of the things that the plans are looking at are how do you use technology to more efficiently care for people. Ultimately, cuts will potentially reduce the amount of benefits if the cuts are deep enough. But the other thing that helps is as we have moved more towards a risk adjustment system so that you pay appropriately for the appropriate needs of that individual, that can help offset some of the impact of the cuts.

Mr. BUCHANAN. Ms. Ignagni, do you have any comments on that?

Ms. IGNAGNI. There is no way to know with precision exactly what will happen in any particular area. But I do think that looking at what happened in the past post the Balanced Budget Act of 1997, there is reason for caution and deliberation. In particular, I think that as we see the cuts have not—they are back loaded. So we haven't seen the impact yet. But number one. Number two, the premium tax is going to be hitting in 2014 as these cuts ramp up. And I think that is a place to start for real deliberation in terms of the impact of all of these things.

So without a doubt, I think that our plans, what I can tell you, our plans are going to do everything they can to maintain benefits and service seniors who are depending upon them. But the scale and scope of the cuts that have yet to come is something that we are concerned about.

Mr. BUCHANAN. Thank you. And I yield back.

Chairman HERGER. Thank you. Mr. Kind is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman. I want to thank our panelists for the testimony today. And this is yet another hearing that we are having on what is happening within health care reform, which I think is totally necessary, totally appropriate that we have these conversations, we find out what is working and what isn't working. And then hopefully have the ability as a Congress to continue to make adjustments as we learn more. I don't think anyone going into health care reform, certainly those of us who supported the Affordable Care Act, thought it was going to be easy or that it was going to happen overnight. It is going to require a lot of hard work. It is quite frankly going to take the effort of a Nation, not just one party, to try to reform a health care system that is in des-

perate need of reform. I have been one of the leading voices of trying to do what we can to reform the way health care is delivered in our country so it is more integrated, coordinated, patient-centered. But especially we have to change the way we pay for health care so it is value- or outcome-based, and no longer volume-based payments.

And Ms. Ignagni, I know you and the plans that you represent and that have been at the forefront when it comes to a lot of these changes and a lot of these reforms. I think we need to be doing it on a parallel path between Medicare and the private plans that are out there. I don't think doing it in isolation is going to work. Could you give us a quick update on what you are seeing happening, especially in the private sector right now, with these type of delivery and payment reforms that are happening?

Ms. IGNAGNI. I really appreciate the opportunity to do that. A couple of points. One, there are very significant changes going on all across the country that are very exciting. And the story is about collaboration, health plans and clinicians collaborating in patient-centered medical homes to bring more value and case management to those with chronic illnesses. And baking those strategies into the Medicare Advantage, Medicaid plans, SNPs, and so on and so forth, I think that shows real promise.

Two, bundling, which you have talked about a quite lot, really changing, moving to a prospective payment as opposed to retrospective and more of a piece rate. And we are beginning to see real traction as a result of that all over the country. And I think that holds real promise. The third point, I had mentioned in my oral remarks that we are partnering with CMS on a number of these initiatives. And I think that too holds promise in terms of getting more traction and getting more pickup across the country in a synergistic way.

And I think you will be hearing more about that. But without a doubt, what is very significant now, as a result of these strategies, health plans are showing in peer-reviewed journal data that they are working with respect to readmissions, emergency room.

So we are not finished by any means. I don't want to leave you with that impression. But we have taken a major step. And it clearly has to be the future, more coordinated care, more prospective payment and partnerships between plans and clinicians and hospitals.

Mr. KIND. Mr. Cosgrove, let's back up here a little bit. You testified about how the bonus payment plans are going to be phasing out over the next few years as far as the bonus payments are concerned and that. But what I don't understand is there are two different competing visions of where health care reform needs to go. Under the Romney-Ryan plan, the changes they are advocating under Medicare won't happen until 10 years from now, the year 11, 12. I am sorry, but that is just not good enough. We can't sit around and wait 10 years to start making important changes within the health care system, especially in a program as important and as vital as Medicare.

Now, there is some criticism up here from the dais today about how these bonus payment incentives for quality plans are going to be reduced, and the impact it is going to have on Medicare Advan-

tage plans. But weren't the MA plans created to begin with back in 2003 and actually passed in 2004 as part of the Medicare Modernization Act and also the new prescription drug plan? Is that right? Is that where the MA plans came from?

Mr. COSGROVE. Yes. But there was a predecessor program, commonly referred to as the risk program, that went back to the 1980s. But the MA program built upon that, yes.

Mr. KIND. And do you recall, sitting here today, whether or not that legislation that passed, that also called for higher reimbursement levels for MA plans, whether any of that was paid for in the 2004 bill?

Mr. COSGROVE. I do not.

Mr. KIND. Well, the answer, and I think everyone up here on the dais understands, that it wasn't. That was a major piece of legislation, the largest expansion of entitlement spending since Medicare was first created in 1965, and not a nickel of it was paid for. Many of us at the time who voted against it didn't think it was fiscally responsible to be offering these higher reimbursement payments to the MA plans without any ability to pay for it to begin with. And now we are hearing some criticism when we are trying to reform that to find some cost savings. Cost savings, by the way, that was completely adopted in the Ryan budget that virtually every one of my colleagues on the other side supported and voted for. And now they are trying to have it both ways up here, which is inexplicable to me.

And Ms. Gold, I think you testified about the differences that there is between their plan that would privatize, in essence, through a voucher or premium support, whatever you want to call it, with the existing Medicare program. Is there an important distinction to be made there?

Ms. GOLD. Extremely important decision. Right now Medicare is a national——

Chairman HERGER. The gentleman's time has expired. Maybe you could respond in writing, please.

Ms. GOLD. Yes, it is in my testimony. Thank you.

Mr. KIND. Thank you.

Chairman HERGER. Mr. Roskam is recognized for 5 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman. Mr. Cosgrove, in your testimony before the Government Reform Committee in July, and again before us today, you note that CMS enacted a demonstration that was seven times larger than any since 1995. It was greater than the combined budgetary effects of the demonstration, has no control group or way to judge the outcomes of the demonstration program, and went so far as to suggest that the demonstration should be canceled. Is that right?

Mr. COSGROVE. We did recommend that the Secretary cancel the demonstration, yes.

Mr. ROSKAM. Ms. Ignagni, you know, President Obama during the large discussions around the passage of the new health care law made much of the argument that if you like your plan you are going to be able to keep it. Can you reflect on sort of how the reality is of what your members are dealing with and their ability to offer products that existed before the enactment of the health care law and what they are dealing with now?

Ms. IGNAGNI. Well, first of all, in the Medicare Advantage arena as well as the commercial arena, we are doing everything we can to bring costs down and to improve quality. That is what beneficiaries want, and that is what purchasers want. As we look at the cuts with respect to ACA in Medicare, we are very concerned about the future impacts. We are going to continue to do everything we can to bring costs down and improve quality. But if you look at the scale and the size of these, plus the premium tax, that compounds the impact. We are very concerned. The data that we provided in our testimony from CBO, that gives you a window, I think into the potential effect. And so the honest answer is we don't know what the future will hold. And we are going to work very, very hard to do our part. But as we see the size of all of this that will come into effect, we are very concerned.

Mr. ROSKAM. So I think you said concerned either two or three times. And so let me focus on Mr. Capretta. If you are advising Ms. Ignagni on the nature of her concern, if you are her consigliere and you are there looking out over a spreadsheet and making some predictions, what are the things that she needs to be concerned about if the stated goal of the President of the United States is to be able to offer a program—to continue to offer a program that somebody currently enjoyed? What would you advise about the nature of the concern going forward?

Mr. CAPRETTA. Well, she needs no advice from me, first of all. But—

Mr. ROSKAM. Well played. Well done.

Mr. CAPRETTA. It is quite clear from the trustees' projections that the program is going to shrink. The question is degree and magnitude. If you make these reductions, the law requires that any payments above a bid but below the benchmark are returned, essentially, to the beneficiary in the form of higher benefits. So when you reduce the MA payments, by definition, they are going to be scaling back what they can offer to the beneficiaries to enroll in the program.

Mr. ROSKAM. That is a truism, right? That is not a revelation.

Mr. CAPRETTA. No.

Mr. ROSKAM. That is not a subject of dispute. That is a truism.

Mr. CAPRETTA. Absolutely.

Mr. ROSKAM. All right. Go on.

Mr. CAPRETTA. The trustees project that about one third of the program is going to disenroll one way or the other. Either the plan plans are going to close down some of the counties they are operating in, or some of the beneficiaries will disenroll voluntarily because the benefits will be less attractive. So in about 6 years' time, 5 years' time, the trustees, based on the actuary's projections, assume the program will be basically one third smaller than it is today.

So for the Congressman from Florida, he has 200,000 beneficiaries, 40,000 of them in Medicare Advantage, you know, 10,000, 12,000, 15,000 beneficiaries probably will lose the plan they have today and move back into the traditional program. I don't view that as a very positive development. Fee-for-service has its advantages; it is an important program. But one has to recognize it is not co-

ordinated care. It is very fragmented care. It doesn't necessarily deliver higher quality care. There is no metric to prove that.

Mr. ROSKAM. So your testimony today is that the trustees, the people that are calling balls and strikes on this, are saying that in a period of 6 years, a third of the beneficiaries are going to be out of the system. And it is your conclusion that that one third leaves because of the downward pressure on reimbursements. Either they take themselves out, the beneficiaries do, or the carriers no longer are participating in the program. Is that right?

Mr. CAPRETTA. That is correct. It is slightly less than one third, but it is just below that end, yes. And those are the reasons why.

Mr. ROSKAM. I yield back.

Chairman HERGER. The gentleman yields back. Mr. Reichert is recognized for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman.

I am going to continue the line of questioning that Mr. Roskam was pursuing with Mr. Capretta. Just to clarify, when the bill was first drafted and passed, we were looking at a \$523 billion cut to Medicare. About \$200 billion of that was Medicare Advantage. Today, CBO has upped that figure to \$700 billion and \$308 billion in Medicare Advantage; is that correct?

Mr. CAPRETTA. That is correct.

Mr. REICHERT. I am really confused as to what we are supposed to believe, because the other question is, and Mr. Roskam touched on it, the President of the United States has said if you like your health care plan, you can keep it. But I was at an event where the President actually came back and said, when he was asked that question, well, there may have been some language inserted in that bill that runs contrary to that premise. That is a paraphrase of his comment.

What are we supposed to believe is still my question. So to follow up, your testimony suggests that the cuts to Medicare Advantage may force seniors out of the plan that they like and that they currently have; is that true?

Mr. CAPRETTA. Yes, that is true.

Mr. REICHERT. And they are forced into less preferred options like fee-for-services or less generous Medicare Advantage plans; is that correct?

Mr. CAPRETTA. That is true, yes.

Mr. REICHERT. So let's talk about those seniors who lose their plan. Isn't it true that Medicare trustees expect million of seniors to lose access to Medicare Advantage altogether?

Mr. CAPRETTA. I haven't seen them specify exactly how it is likely to fall out, but one can surmise. There are about 4 million beneficiaries, fewer beneficiaries, enrolled in Medicare Advantage in 2017 than there will be in 2013. Of those 4 million, one might surmise that some of them are in counties where the plans have pulled out. Some are in counties where the plans are still there operating, but perhaps offering less generous benefits, so they don't find it as attractive and they move back into fee-for-service. So the reasons for the disenrollment and the shrinkage is not all that clear yet.

Mr. REICHERT. But there will be disenrollment?

Mr. CAPRETTA. Yes, there will be.

Mr. REICHERT. And so they won't be able to keep their health care if they like it, obviously?

Mr. CAPRETTA. That's correct.

Mr. REICHERT. And seniors who stay in that program are going to lose benefits, as you just mentioned?

Mr. CAPRETTA. Yes, they will.

Mr. REICHERT. So really these seniors will be forced back in the traditional fee-for-service Medicare, which is not coordinated, does not have the additional benefits that seniors are used to, and lacks any type of out-of-pocket maximum; is that correct?

Mr. CAPRETTA. That is correct. Many of them may end up trying to buy Medigap insurance, which the average premium is \$150 or \$200 a month, something like that.

Mr. REICHERT. So that was my next question. As you know, Chairman Herger and I have been doing a little bit of investigation into AARP and its relationship to, its involvement in helping to negotiate this Obama health care plan. I find it interesting that the promises made—you can keep your health care if you like it—AARP benefits from this. As seniors leave Medicare Advantage and they are forced into Medigap, what happens is, for AARP, they end up with a \$1 billion windfall over 10 years. They increase their revenue by \$1 billion in 10 years as a result of that change because AARP gets a flat rate fee for seniors who are on Medicare Advantage, and they get a percentage of every senior enrolled in Medigap.

I also find it curious that in this bill what we are going to do is we are going to tax people who don't buy insurance. We are going to tax medical devices. We are going to tax businesses who don't provide enough insurance with a penalty. We are also going to add a \$3,000 tax penalty if you provide too much insurance. And then we are going to tax 40 percent on Cadillac health. We are going to tax American citizens over and over and over and again. But AARP, with a \$1 billion increase in revenue in 10 years, is a tax-free organization that will not be taxed one cent on that \$1 billion. And I don't expect you to respond to that. I appreciate the time, and I yield, Mr. Chairman.

Chairman HERGER. Thank you.

Mrs. Black is recognized for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman.

I appreciate the panel being here today and helping us to look at what the future of these programs might be for especially the very frail population. And given my health care background and having worked in long term care, I am certainly acutely aware of what their needs are. One of the things that I know as I worked with patients over the years is that they still want choice. They still want to make some of those decisions and not feel like they will be told about everything that is going to be done for them.

So I want to turn to you, Dr. Schwab, because I believe this is an area that we really need to take a look at. You have both the clinical background and also the background on the economics side of SCAN which has been the special needs programs for many years. And so in your testimony on page 6, you talk about the special needs model providing patient-centered, coordinated care to

vulnerable populations having been a success. You say: Unfortunately, as we all know, the current special needs program authorization is set to expire in 2013, which is great concern to me.

If you could just briefly talk about what you see, if you were going to sell this program to the policymakers who are going to make that decision, tell me what you see as being the benefits, and then also, I want to know from you what do you see as a possibility of working within the environment, the cost, but yet the patient-centered care and the quality, what kind of things could you do to make the program better and make it more effective?

Mr. SCHWAB. Well, to start with, what can you do to make it better, and there are three different types of SNPs and so the answers depends on which SNPs you are talking about. The dual SNPs, one of the things that could be improved is better coordinating and reducing overlap of regulatory issues between the State and the Federal Government. Not that one is wrong or one is right, it is just that there is confliction and there is duplicative work.

What you can do for the overall programs I think is recognize that all SNPs are people that are very different. Whether it is the duals or whether it is the chronic or whether it is institutional, and measuring quality specifically for that population would be a big help. The five-star system is a great step forward in measuring quality in plans. But, unfortunately, it doesn't always apply to some of the unique populations within there. What is good for a person on dialysis may not be same quality metric you want to measure for a person who is dual eligible and not on dialysis.

The other thing is we have shown that providing home and community-based services is very valuable in keeping people in their home, which is where they want to stay, and out of a nursing home. Allowing plans, other plans other than just the D-SNPs to provide the supplemental benefits would go a long way to, especially in the I-SNPs, preventing people who are low income but not yet on Medicaid, to prevent their spend down and going into a nursing home and then ending up on the Medicaid program.

Mrs. BLACK. Thank you.

Mr. Cosgrove, I want to turn to you because I know the GAO examined the requirements from the Medicare improvements for Patients and Providers Act of 2008, which established the contracting requirements for the dual Special Needs Program. Can you discuss some of the challenges identified by the States in implementing these contracts?

Mr. COSGROVE. Yes. We met with, I think, five States to talk about some of the challenges that they face. And part of it they just explained to us, one of the terms they used was bandwidth. It is just the number of organizations that they would have to contract with, and it is the State having the resources to be able to do it. They could see that it is more valuable for plans that are larger. Some of the SNPs are fairly small and—but still, it takes the contracting effort.

And they also brought up some other issues as well in terms of the State's fiscal year may not coincide with the contracting year for the SNP which causes difficulty for them entering into contracts as well.

Mrs. BLACK. Dr. Schwab, you have experience in this particular issue. Do you have any comments regarding this report?

Chairman HERGER. The gentlelady's time has expired. If you can answer that in writing.

Mrs. BLACK. Thank you, Mr. Chairman, that went quickly.

Chairman HERGER. Mr. McDermott is recognized for 5 minutes.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

As I sit here and listen to this, I think about the fact that dust is the best political defense you have—make people confused. And I think there are a lot of people watching this who don't understand that everyone who is speaking on the other side talking about these awful cuts, voted for them. Every single one of them voted twice for them. So they are trying to have it both ways because isn't it true that the ACA actually eliminated costs and gave new benefits to people that are in place now? Is that true, Ms. Gold?

Ms. GOLD. Yes.

Mr. MCDERMOTT. So what is the difference between this voucher plan that the Ryan budget wants, and this medical plan? What does it mean to patients? Because I sit up here as a doctor and I think about patients rather than product and numbers and trends and graphs. I think what it does to patients. So tell me what is going to be the difference for a patient if they are forced into a voucher plan by Ryan or remain in the regular Medicare program?

Ms. GOLD. Well, I think it is going to be a lot more confusing and probably a lot more expensive, depending upon how much money Congress puts in.

Right now, beneficiaries know there is Medicare. Medicare is very popular. 70 percent of beneficiaries remain in the traditional program, and like it.

If this goes forward, beneficiaries probably will not necessarily have the same benefits across the country. Some may have less. We will get into more fights about what areas have more money or less money. They will have to figure out whether they pay more money, how these benefits compare to one another, and it is likely to be relatively confusing. Also, I think underappreciated is that your plan may affect what doctor you can go to, and if every year these plans switch, and especially if there are different bids and different plans come in and out, it means that beneficiary's care may not be stable over time and that they may find that even if they stay in the same plan, they don't have the same doctor or they could lose their doctor.

Mr. MCDERMOTT. When we talk about cuts, everybody here thinks they know what we are talking about, but I have no idea what the average American thinks when we say we are making cuts in Medicare. Does that mean that they won't take my blood pressure anymore? Or does that mean they won't take my blood sugar? Or does that mean I won't get physical therapy with my aching bones? What are these cuts?

Ms. GOLD. Do you mean under the current program?

Mr. MCDERMOTT. Well, they are making all of these cuts to Medicare.

Ms. GOLD. Every day Congress decides how much money it is going to spend. It pays providers. It decides how much to update

this provider's rate and that provider's rate. As I understand the cuts in the ACA, most of the general cuts involve those kind of decisions as to what an equitable payment for a hospital was, or another provider. So they are changes in provider payments. There was no change made except improvements in benefits for cost sharing for beneficiaries.

So presumably, and there always is a problem. If you cut providers too far, you could have a problem getting access to them. But I think most of these cuts are probably invisible to beneficiaries right now.

Mr. MCDERMOTT. When somebody said, I forgot which one of the witness, that this pressure on Medicare with the cuts is going to make them more efficient, does that mean you won't get good medical care, if it is efficient?

Ms. GOLD. You know, what is efficiency?

Mr. MCDERMOTT. Let me ask Dr. Schwab or Dr. Tallent, what do you intend to cut because of these changes in Medicare that will make people get out of your program or leave? Or is it just that the rural areas are too far away so we are not going to give that coverage? We are going to drop that county? What does it mean?

Mr. SCHWAB. Well, because I was the one that used the term "efficiency," I think the first focus is on how do you become more efficient and not reduce quality. The quality comes first in all plans. And efficiency means you are going to be cutting administrative overhead that you can find better ways to do things more efficiently and more effectively. That can only go so far, but that is clearly the first area that we are looking at of cutting, how do we work more efficiently without impacting beneficiary experience.

Chairman HERGER. The gentleman's time has expired. If there is any further response, if you could respond in writing, please. Thank you.

Mr. Paulsen is recognized for 5 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman, and also for holding this very important hearing. Like many of my colleagues, I am concerned about the pending cuts to the Medicare Advantage program and the likelihood that millions of seniors will be pushed out of their health care plans in the coming years, even though they may like those health care plans.

Mr. Tallent, in your testimony, you pointed out that about 250,000 Medicare beneficiaries could lose access to their cost contract plan unless Congress takes some action or steps this year to extend the program or make modifications to the so-called two-plan test. A substantial number of those affected beneficiaries, about 200,000 of them, are in my home State of Minnesota. And when cuts have been made in the past to the Medicare risk program, plans have been forced to either scale back offerings or even withdraw from certain areas of the country altogether. So Mr. Tallent, from your experience, do you agree that it is even more important now to extend cost contract, that program, the cost contract program given the cuts to the MA program that are slated to take effect now over the next few years?

Mr. TALLENT. Well, yes. We think it is very important because we are entering another period, it would appear, of instability, of unknown rates, for the MA plans. And over history, which has been

mentioned a number of times by the panel, we have observed these plans, MA plans, making decisions to pull out of certain markets. And that is what we are experiencing.

In my testimony, I discussed specifically in Iowa that we are concerned that we will be displaced next year and there could be a very high probability that in the near future, that the plans that are displacing us will also leave and the result will be many beneficiaries without appropriate high-quality options for plans.

Mr. PAULSEN. Okay. I think you also mentioned that many cost plans enrollees at Medical Associates, health plans and at other cost contract plans are older than the average of Medicare beneficiaries in general, and they have been members for a decade or longer, for a long period of time. So to me, this seems like a potentially vulnerable group to disrupt care for. I imagine you would agree with that. What would it mean to these beneficiaries if they could no longer choose to enroll in the plan that they had come to rely upon? You talked about the high probability of disruption, and losing out to—if other competitors pull out down the road as well?

Mr. TALLENT. Well, certainly for many of our members, I think it would be very disruptive. In my testimony, I mentioned that 30 percent of our membership is over the age of 80. And also that many of these members have been with us for very lengthy periods of time, have been with the same doctor or sets of doctors, many of them have multiple issues, for lengthy periods of time. If we were to have to be displaced, this vulnerable population would definitely be affected.

Mr. PAULSEN. Thank you, Mr. Chairman. I yield back the time, and I appreciate the testimony.

Chairman HERGER. Thank you. I want to thank each of our witnesses for your expert testimony today.

Today we heard a detailed discussion of the future of health plans and Medicare. Clearly, significant changes are coming to the Medicare Advantage program, and seniors are right to be concerned about what will happen to the health plan they have and like.

As I conclude this hearing, likely my final one as a member of this committee, I would like to highlight that this committee has some of the most challenging issues before it. I want to thank my colleagues for their thoughtful and often spirited discussion of those issues. We have debated these issues honestly and thoroughly, and I have laid down the groundwork to address the issues important to the millions of current Medicare beneficiaries, and those joining the program in the future.

I want to say, it has been an honor and a privilege to work with all of my colleagues, and a blessing to represent my northern California constituents. The work that we do is critical to maintaining a vibrant and thriving Nation, and I have been proud to be a part of it.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask that the witnesses respond in a timely manner.

Mr. MCDERMOTT. Mr. Chairman.

Chairman HERGER. Yes.

Mr. MCDERMOTT. May I have a point of personal privilege?

Chairman HERGER. You may. Mr. McDermott is recognized.

Mr. MCDERMOTT. It is typical of you that you would put this announcement of your leaving at the end when there is nobody here except me. We are going to miss you. You have done a good job for your people in California and for the committee. I think that it should be acknowledged publicly. Good Members retire sometimes before they are thrown out, and it is good to see you going to retirement. I hope you enjoy it. You have done a great service to our country. Thank you.

Chairman HERGER. I thank my good friend for those comments. With that, this subcommittee stands adjourned.

[Whereupon, at 10:48 a.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]



Association for Community Affiliated Plans



ACAP
Association for Community
Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7506 | Fax 202.204.7517 | www.communityplans.net
Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

October 5, 2012

The Honorable Wally Herger
Chairman
House Ways and Means Health Subcommittee
1102 Longworth House Office Building
Washington, DC 20515

submitted electronically

Dear Representative Herger and Members of the Subcommittee:

The Association for Community Affiliated Plans (ACAP) submits the attached paper on Special Needs Plans as part of the record for the Committee's hearing on Medicare Health Plans held on September 21. We strongly urge re-authorization of Duals Special Needs Plans (D-SNPs) to allow stability for beneficiaries, health plans and states while more permanent options for duals are developed based on learning from the Duals Financial Alignment Demonstrations which will begin during 2013. It is imperative that D-SNPs remain an option to provide integrated care to a highly vulnerable population.

ACAP is a national association representing 58 not-for-profit Safety Net Health Plans that serve nearly 10 million individuals on Medicare, Medicaid, Children's Health Insurance Program (CHIP) and other public health programs in 28 states. Approximately half of ACAP plans operate D-SNPs; even more will serve dually eligible beneficiaries in the upcoming demonstrations.

We appreciate the opportunity to submit this statement. Questions may be addressed to Mary Kennedy, Vice President for Medicare and Managed Long Term Care at: mkennedy@communityplans.net or 202-701-4749.

Sincerely,

Margaret A. Murray
Chief Executive Officer



Congress Should Reauthorize the Medicare Advantage Special Needs Plan Program Before the End of the Year

Request

ACAP urges the House and Senate to reauthorize the Medicare Advantage (MA) Special Needs Plan (SNP) Program by the end of 2012 to provide certainty for health plans and continuity of care for dual eligibles and other vulnerable Medicare beneficiaries, and to improve the SNP program by enacting policies that assure actuarially sound payment, fair comparison to other MA plans, and support the critical role that Safety Net Health Plans play in the SNP program.

Background

People enrolled in both Medicare and Medicaid, or “dual eligibles,” tend to be among the poorest, most frail, most medically needy Americans. But because Medicare and Medicaid are separately administered, these beneficiaries are often poorly served. Strong incentives for cost-shifting between the two programs lead to unnecessarily high spending across *both* programs.

The *Medicare Modernization Act* established SNPs, which provide an integrated care setting for dual eligibles. Fully-integrated care management for dual eligibles is the best way to improve care coordination and reduce unnecessary barriers to care, supports and services.

The *Affordable Care Act* renewed focus on dual eligibles with the establishment of the Federal Office of Medicare-Medicaid Integration. Several states are implementing shared savings demonstrations in 2013. Others are planning for 2014. But successful movement to a fully-integrated risk-based model requires stability, long-term planning and thoughtful implementation. Given uncertainty around the timing, location and populations included in these demonstrations, SNPs remain essential to coordinating care for many dual eligibles. We expect discussions on a more permanent setting for integrated care to begin in 2014.

Policy Requests

As it looks forward to legislative action before the end of the year, ACAP calls on Congress to pass legislative language to:

1. **Reauthorize the MA Special Needs Plan Program for a period of no less than five years.** Current authorization ends in January 2014, and CMS requires that SNPs submit notices of intent to operate in 2014 before the end of this year. Until a new permanent integrated program emerges for dual eligibles, Congress must provide greater certainty to health plans and Medicare beneficiaries by reauthorizing the SNP program for no less than five years. The uncertainty caused by short-term reauthorization periods is a continuous threat to the quality and continuity of care provided to SNP enrollees.
2. **Provide accurate payment to SNP Plans by improving the risk adjustment process to reflect the actual health care needs of the enrolled population.** With respect to risk adjustment for MA, Congress should (1) expand the types of health conditions considered when calculating risk adjustment, such as mental health and substance abuse; (2) require CMS to use the prior two years of patient health data, as supported by MedPAC; (3)



include a greater number of conditions for each person to assure more accurate payment for people who have more complex care needs, also recommended by MedPAC; and (4) require the use of an enrollee's health status in calculation of the risk score during the first year of Medicare eligibility using either a risk assessment or through claims obtained through Medicaid or private health coverage.

3. **Adjust all SNP payments to recognize the frailty of individual dual eligibles enrolled in the plan.** The current risk adjustment model provides a frailty adjuster only to those SNPs that provide Medicaid managed long-term care services for high concentrations of individuals at a nursing home level of care. ACAP recommends the frailty factor be paid to a SNP serving a person who has been certified as needing a nursing home level of care and resides in the community. Both PACE programs and the early integrated demonstrations recognized this institutional bias and paid a "frailty factor" to support community-based care. Current statutory language on the frailty adjuster is limited to those plans with a high concentration of these members. The adjuster should be paid for each person who is frail.
4. **Stars Quality Ratings and the related Bonus Payments should more accurately reward plans serving Duals. The quality of care among plans serving higher-need populations should be compared with similar SNP plans and not with regular MA plans serving a healthier population.** In the absence of a unique quality measurement system for SNP plans, Congress should require CMS to attribute three stars as a baseline for a SNP plan *if* the SNP plan meets all the SNP Structure and Process measures. Comparisons should also be made with Medicare Fee-for-Service for a similar population.
5. **Maintain the integrity of the CMS demonstration process by prohibiting the marketing of plans that are not participating in the demonstrations to dual eligibles within the demonstration.** The purpose of the demonstration process at CMS is to test and analyze best practices for the service of dual eligibles in a coordinated care environment. The only way that the analysis can be successful is if there is integrity in the demonstration. Actively marketing non-demonstration Medicare Advantage products to beneficiaries within the demonstration should be prohibited and broker fees should be limited for any plan switches that do occur.
6. **Ensure that safety net health plans remain a viable option for beneficiaries in public programs including D-SNPs, dual demonstrations, the Exchange and the 2014 Medicaid market by improving access to capital for safety net health plans.** As Medicare and Medicaid increasingly turn to health plans to serve dual eligibles, Congress should seek ways to increase access to local coordinated care plans. Safety Net Health Plans have specific expertise in serving Medicare and Medicaid beneficiaries, currently serving one-third of all Medicaid managed care enrollees in capitated plans and over 10% of all D-SNP enrollees. Non-profit plans have limited access to capital needed to expand their plans and meet insurance reserve requirements. In 1996, Congress created a loan guarantee program to help in the creation of plans operated by Community Health Centers to bring a local-focus to the delivery and coordination of care. Congress should now create a similar loan guarantee program building off the definition of safety net health plan created under the *Affordable Care Act*.

