MEDICARE ADVANTAGE AND THE FEDERAL BUDGET

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HOUSE OF REPRESENTATIVES

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MEDICARE ADVANTAGE AND THE FEDERAL BUDGET

THURSDAY, JUNE 28, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:10 a.m. in room 210, Cannon House Office Building, Hon. John Spratt [chairman of the committee] presiding.

Present: Representatives Spratt, DeLauro, Edwards, Cooper, Schwartz, Doggett, Blumenauer, Berry, McGovern, Scott, Etheridge, Moore of Kansas, Bishop, Moore of Wisconsin, Ryan, Bonner, Hensarling, Lungren, Conaway, Tiberi, Porter, Alexander, and Smith.

Chairman SPRATT. Good morning, and welcome to the House Budget Committee's hearing on Medicare Advantage. We have an outstanding lineup of witnesses today. I am pleased that all of you could join us, and I appreciate your taking the time to testify.

As the Budget Committee, we have a serious obligation to continually review the scarce resources available to the Federal Government and how those resources are allocated. We are here today to look at one particular program, the Medicare Advantage program, partly based upon the recent testimony of the Congressional Budget Office estimating that, if these plans providing for Medicare services were paid for at rates equivalent to fee-for-service Medicare, we could save nearly $150 billion over 10 years.

Now, this is a program within Medicare, which everyone tells us faces insolvency sometime in the foreseeable future. When we see something that might save as much as $150 billion, it is our obligation to take a close and serious look at the alternatives. I would emphasize we are not here to demonize anybody. We are not here to claim that the insurance companies, HMOs, PPOs or whoever participates in these programs is making profits that are unconscionable or are not anything other than taking advantage of a government program which we put in place. We are going back and looking at the terms of that program and asking ourselves does it need to be adjusted for a number of different reasons, not the least of which is budget resources.

The current payment structure was put in place in the 2003 Medicare Modernization Act. Even Tom Scully, who was the former administrator of the Center on Medicare and Medicaid Services and who played a serious and significant role in the 2003 legislation, even he now says that there appears to be overfunding. In reference to the subsidies that insurance companies receive and who

participate in Medicare Advantage, Tom Scully told the St. Petersburg Times at a recent conference that there has been a huge overfunding, and he also said, "Some of the excess payments exceed what was intended for sure, and I think Congress should take some of it away." That was Tom Scully speaking.

Private plans operating within Medicare Advantage are paid, on average, 12 percent more than the cost for regular fee-for-service Medicare. While it is true that some of that payment is returned to beneficiaries in the form of additional benefits, it is not exactly clear how much is, and there are, in any event, some significant additional issues at stake.

First of all, there is the issue of equity. Should we be paying as much as 15-20 percent more for some beneficiaries than for other beneficiaries? Is that an equitable administration of this program which is supposed to provide, basically, equal benefits for every beneficiary?

Secondly, what are the benefits of the Medicare Advantage plan? Are a plan's participants achieving higher and healthier outcomes than other participants? We do not really know because we do not have the feedback of information that one would want in order to make an honest judgment of this system.

Third, is it time to take a look at something that was put in place several years ago on the grounds that it needs adjustment at the present time? The whole point of providing private plans was that competition for enrollment would lead to better services, more choices, lower cost. Paying for these plans more than for fee-for-service permanently, forever, seems to defy that logic.

The Medicare Payment Advisory Commission, or MedPAC, has argued that beneficiaries should have a choice of a private managed plan or a fee-for-service plan but that these plans should play on a level playing field in the competition for Medicare enrollees.

We have got a significant number of witnesses today. We are going to start with Dr. Peter Orszag, who is the director of the Congressional Budget Office, and with Dr. Mark E. Miller, who is the executive director of the Medicare Payment Advisory Commission.

I would like to note at this point that your testimony will be made part of the record, and you can both summarize it and take as much time as you need to explain it. If you wish, we have got the facilities here that are available to display any slides you have brought with you.

Before proceeding with your testimony, however, let us hear from the Ranking Member, Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman. I want to thank you for holding today's hearing.

Also, I want to welcome our witnesses. And in particular, Dr. Orszag, I would like to welcome your two children, Leila and Joshua. It is nice to have them here with us today, and I hope they get some good coloring done during this hearing. At least I can see she is well on her way.

This is an appropriate hearing. It is a timely hearing, too. We need to be discussing our Nation's health care entitlements in the Federal budget. In particular, today's hearing is appropriate on the Medicare Advantage program.

Private health plans are not new to the Medicare program. They have been available since the early 1970s, and their goal then was the same as it is now, to offer beneficiaries choices that will improve their health and will reduce their out-of-pocket costs while saving Medicare money.

Over the years, we realized that some seniors had more choices than others. We understood that rural populations were not as well served as urban, and that low-income beneficiaries had unique problems in need of specific solutions. So we made adjustments. The Balanced Budget Act of 1997 expanded the range of private Medicare plans available, and the Medicare Modernization Act of 2003 created additional options, further strengthening the program.

Today, 1 in 5 Medicare beneficiaries is enrolled in a Medicare Advantage plan, and a vast majority of them are receiving coverage, such as dental, vision, caps on out-of-pocket costs, that they would not have had otherwise. In addition, Medicare Advantage is saving beneficiaries and taxpayers money. Beneficiaries enrolled in a Medicare Advantage plan see an average savings of more than $1,000 a year. These plans also return an average of $3 billion annually to the U.S. Treasury.

Now, all of that said, I appreciate any ideas on health care entitlement reform that my friends on either side of the aisle would bring to the table. We should take a hard look at whether all private plans are fulfilling the goals of the Medicare Advantage program and whether we can improve some areas of the program to save beneficiaries and taxpayers even more money.

The unfunded liability of Medicare is currently standing at $32 trillion over the next 75 years. That is the amount by which benefits promised by Medicare exceed the projected financial resources. This translates to more than $282,000 per household, and that figure is growing at an alarming rate. When Leila is 10 years old—because I believe—no. She is 7 now, right? When she is 12 years old, that figure is going to get us to $54 trillion. So, if we do nothing for the next 5 years, the unfunded liability of Medicare will go from $32 trillion to $54 trillion. This is why some of us keep saying that the current path of Medicare is unsustainable.

Yet no one is talking about cutting Medicare Advantage payments to make entitlements more sustainable or to reduce the deficit. And given that this is the Budget Committee, I think we ought to at least entertain the notion that if we are going to create savings in some program, we ought to actually save the money.

To the contrary, the majority is talking about reducing these payments just to use that money for more entitlement spending in another part of the government. No matter where you stand on those issues, taking from one entitlement just to expand another one will not address any budgetary concerns.

The recently passed budget, which is the incumbent budget resolution we are now operating on, does not offer any entitlement reforms, not for health care, not for anything else. So, not surprisingly, this subject became the primary focus of the committee's Tuesday hearing on the Federal deficit and the debt. Once again, we were warned, this time by some of our Nation's leading financial experts, that the chief threat to our Nation's long-term fiscal

and economic health is the unsustainable growth of our health care entitlements, with Medicare and Medicaid leading the way. In urging Congress to act, our witnesses argued that the benefits of doing what was needed would far outweigh the perceived short-term gains from putting it off, and I agree with that.

Again, I want to thank the Chairman for calling today's hearing. We have excellent witnesses, and I look forward to their testimony.

I yield.

Chairman SPRATT. I thank the gentleman.

Let me say again that this is about entitlement reform. This is about savings which should equal as much as $150 billion were we to reduce Medicare Advantage payment rates to the rates that are paid for traditional fee-for-service Medicare, according to CBO. What we do with those funds would then be up to Congress' determination. They could be used for SCHIP expansion, for example, or they could be applied to the reduction of the budget deficit, or both.

In any event, this is about entitlement reform. It is certainly about the entitlement overview of a program that is costing a substantial sum of money.

STATEMENTS OF PETER R. ORSZAG, DIRECTOR, CONGRESSIONAL BUDGET OFFICE; AND MARK E. MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Chairman SPRATT. Dr. Orszag, we are glad to have you. We appreciate your testimony. As I said earlier, your full statement will be made part of the record, and you are free to summarize in any way you see fit. Thank you very much for coming.

STATEMENT OF PETER R. ORSZAG

Dr. ORSZAG. Thank you for having me back this morning.

As you know, the central long-term fiscal challenge facing the Nation involves health care, and the focus of this morning's hearing is Medicare Advantage. In addition to my written testimony on the topic, CBO is releasing an issue brief this morning on Medicare Advantage plans. My testimony makes four points.

First, Medicare Advantage has been growing rapidly. Payments to Medicare Advantage plans increased from $36 billion in 2004 to an estimated $77 billion this year. Reflecting that cost growth, enrollment has been rising rapidly.

As the first table shows, enrollment growth during 2006 amounted to almost 1.5 million beneficiaries. In 2007 alone, there has also been almost another 1 million beneficiaries added. Disproportionately, the growth has been occurring in a subcomponent of Medicare Advantage plans called "private fee-for-service plans," which do not have as much case management and utilization management as the other types of Medicare Advantage plans—HMOs and PPOs in particular. It is striking that enrollment in private fee-for-service plans increased by over 700,000 beneficiaries during this year so far alone.

The next figure shows that CBO projects continued rapid growth in Medicare Advantage, mostly due to private fee-for-service plans. In particular, CBO projects that private fee-for-service plans will reach 5 million members by 2017. As a result of that growth, Medicare Advantage enrollees are projected to rise from about 18 per-

cent of all Medicare enrollment today to more than a quarter by 2017. The result of such continued rapid growth—and I would note that it is possible that it will, under current law, be even more rapid than we currently project—would likely be a significant change in the fundamental nature of the Medicare program.

The second point of my testimony is that Medicare's payments for beneficiaries enrolled in Medicare Advantage plans are higher on average than what the program would spend if those beneficiaries were in the traditional fee-for-service program. In particular, the CBO estimates net payments to plans will be approximately 12 percent higher this year than per capita fee-for-service costs. The differential is more pronounced for private fee-for-service plans. I understand that some industry claims have suggested that these figures are significantly biased. Such claims are simply inaccurate. As a result of this cost differential, shifts in enrollment out of the fee-for-service program and into private plans increase net Medicare spending. The cost differential raises overall Medicare costs and, as a result, slightly increases Part B premiums and accelerates the date of exhaustion of the Part A trust fund.

The third point of my testimony is that these additional costs to the government for Medicare Advantage plans subsidize additional benefits and reduce premiums for the beneficiaries who enroll in the Medicare Advantage plans. In particular, the payments that plans receive in excess of their bids for providing the service are required to be returned to beneficiaries as additional benefits or as a rebate of their Part B or Part D premiums. Those extra benefits and reduced premiums are a significant motivation for enrollees to join the plans.

It is also noteworthy that, at least outside of private fee-for-service plans, many Medicare Advantage plans undertake various efforts at disease management, care coordination and preventative care. Thus, one possible benefit of the Medicare Advantage program is the higher quality of care beneficiaries may receive through these programs than they would receive in the Medicare fee-for-service program. The extent to which such services lead to improved health outcomes, however, is difficult to assess with the currently available data.

Policymakers may, therefore, want to explore options for the expanded reporting of outcomes and other measures within the Medicare Advantage program. In particular, I would note private fee-for-service plans are exempt from many of the reporting requirements that apply to other types of Medicare Advantage plans.

My final point is that a number of policy options exist that would reduce spending on Medicare Advantage. For example, one policy would reduce the county level benchmarks under Medicare Advantage to the level of local per capita fee-for-service spending.

Relative to spending under current law, as the next table shows, that policy would reduce spending by $54 billion over the next 5 years and $150 billion over the next 10 years. Such policy changes would also reduce Part B premiums and improve the actuarial soundness of the Part A trust fund.

Reducing benchmarks, however, would leave less money for health plans to offer reduced premiums or supplemental benefits. That change, in turn, would make the program less attractive to

beneficiaries and lead some to return to the traditional fee-for-service program.

Indeed, by CBO's estimates, enacting that policy which I just mentioned would reduce enrollment in Medicare Advantage by about 6 million beneficiaries in 2012 relative to projected levels. That is a decline of about 50 percent, leaving total enrollment at a little over 6 million in that year, which is roughly 1.7 million enrollees fewer than today.

Potential policy changes could also be limited to private fee-for-service plans. For example, limiting benchmarks to 100 percent of fee-for-service costs for private fee-for-service plans alone and maintaining current law benchmarks for other plans would reduce spending by about $14 billion over the next 5 years. Similarly, requiring private fee-for-service plans to negotiate their own terms with participating doctors rather than automatically gaining access to Medicare's payment rates to doctors would save roughly $13 billion over the next 5 years.

Each policy would also have some impact on enrollment, we estimate, roughly a reduction of 3 million beneficiaries in 2012 from either of those private fee-for-service plan options which I just mentioned.

In conclusion, the Medicare Advantage program has been growing rapidly and is projected to continue to do so. Such growth under current policy increases net costs to Medicare. Policymakers evaluating options for reducing payments to Medicare Advantage plans need to weigh the cost savings against benefits that the plans provide in managing care, the effect on overall health care costs and the impact on beneficiaries.

Finally, regardless of what happens to payments, expanded reporting on health outcomes may help policymakers better evaluate the overall effects and specific care management approaches of Medicare Advantage plans.

Thank you very much.

Chairman SPRATT. Thank you, Dr. Orszag.

[The prepared statement of Peter R. Orszag follows:]

CBO TESTIMONY

Statement of
Peter R. Orszag
Director

The Medicare Advantage Program

before the
Committee on the Budget
U.S. House of Representatives

June 28, 2007

This document is embargoed until it is delivered at 10:00 a.m. (EDT) on Thursday, June 28, 2007. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, Representative Ryan, and Members of the Committee, I am pleased to appear before you today to discuss the Medicare Advantage program. My testimony focuses on several themes:

- Unexpectedly strong growth in enrollment in the Medicare Advantage program during 2006 and the beginning of 2007 led the Congressional Budget Office (CBO) to increase its projections for both enrollment in and spending on the program.

- Medicare's payments for beneficiaries enrolled in Medicare Advantage plans are higher, on average, than what the program would spend if those beneficiaries were in the traditional fee-for-service (FFS) sector. As a result, shifts in enrollment out of the FFS program and into private plans increase net Medicare spending. Policymakers need to weigh that additional cost against the benefits provided by Medicare Advantage plans.

- The additional cost to the government for Medicare Advantage plans subsidizes the beneficiaries who enroll in such plans, which fuels the plans' growth in enrollment, but also raises costs for the rest of the Medicare program and for beneficiaries who are not in Medicare Advantage.

- The rate of growth in enrollment and the cost differential with the traditional FFS sector are particularly large in private fee-for-service (PFFS) plans, which draw significant enrollment from rural areas.

- Reducing the payment differential between Medicare Advantage and the FFS program could result in substantial savings to the Medicare program but also in a decline in the supplemental benefits and cash rebates that Medicare Advantage plans can offer to enrollees and reduced enrollment in those plans. Lowering payments to those plans would slightly reduce the standard premiums for Part B (Supplementary Medical Insurance) and delay the exhaustion of the trust fund that supports Part A (Hospital Insurance).

- Many Medicare Advantage plans offer disease management, care coordination, and preventive care programs, but little information is available on the degree to which the plans generate better health outcomes than the traditional Medicare program. Expanded reporting of health outcomes would be helpful in assessing the value of the care management services provided by the plans.

- The central long-term fiscal challenge facing the nation involves health care costs. Over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private-sector health markets. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing overall cost growth for health care. A variety of evidence suggests opportunities to constrain health care costs without harming incentives for innovation or Americans' health (and perhaps even improving it). Moving the nation toward that possibility—which will inevitably be an iterative process in which policy steps are tried, evaluated, and reconsidered—is essential to putting the country on a sounder long-term fiscal path. Changes to the Medicare program should be evaluated with that broader perspective in mind.

Background on Medicare Advantage Plans

Medicare provides federal health insurance for 43 million people who are aged or disabled or who have end-stage renal disease. Part A of Medicare covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B of Medicare covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. Home health care is covered by Part A and Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit beginning in 2006 under Part D.

The majority of Medicare beneficiaries receive services through the traditional fee-for-service part of the program, which compensates providers using a set fee for each service or bundle of services. In nearly all areas of the country, however, Medicare beneficiaries have the option of enrolling in Medicare Advantage—the program through which private plans participate in Medicare—rather than receiving their care through the FFS program.[1] As of June 2007, about 18 percent of beneficiaries are enrolled in Medicare Advantage plans, which accept the responsibility and financial risk for providing Medicare benefits.[2] Although the payment system for private plans has been modified several times during the more than 20 years that they have participated in Medicare, a key feature of the system has remained intact: Plans that offer Medicare benefits for less than the amount of their payment from the government are required to return the difference to beneficiaries in the form of additional benefits or, in an option that became available

1. The program through which private plans participate in Medicare is also called Part C. Previously, the Medicare Advantage program was called Medicare+Choice.

2. That figure excludes about 1 percent of beneficiaries who are enrolled in group plans besides Medicare Advantage plans (which include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans).

recently, rebates on their Part B or Part D premiums.[3] Those additional benefits and rebates of premiums are a major incentive for beneficiaries to enroll in Medicare Advantage plans and are particularly attractive to people without Medicaid or employer-sponsored supplemental health insurance.

About 80 percent of the Medicare beneficiaries enrolled in Medicare Advantage are in health maintenance organizations (HMOs) or preferred provider organizations (PPOs).[4] Both HMOs and PPOs have comprehensive networks of providers, but PPOs allow beneficiaries to obtain care outside the network if they pay higher amounts. Some HMOs offer coverage for services received outside their network (and thus resemble PPOs), while others require that their enrollees receive all of their nonemergency care within the network. A key feature of many HMO and PPO plans is the use of care management services that are intended to promote better coordination and more effective use of health care.

The other main type of Medicare Advantage plan is private fee for service. Such plans allow their enrollees to obtain care from any provider who will furnish it and are not required to maintain networks of providers. In contrast to the FFS system, which requires participating providers to accept Medicare's rates for all covered services and all beneficiaries, providers in a private fee-for-service plan can decide each time they see a patient whether to accept the plan's terms of participation and payment rates, which are usually those of Medicare's FFS program. Beneficiaries' copayments and deductibles are generally lower than those in the FFS program, and private fee-for-service plans typically provide significantly less care management and utilization control than do HMOs and PPOs.

In 2007, 82 percent of beneficiaries live in a county served by an HMO or a local PPO, up from 67 percent in 2005.[5] Nearly all beneficiaries who do not have access to a local HMO or PPO have access to a regional PPO (and 99 percent have access to one of the three). All beneficiaries have access to a PFFS plan in 2007, up from 80 percent in 2006 and only 45 percent in 2005.

The Payment System for Medicare Advantage Plans

The latest legislative changes to the payment system for private health plans were enacted in 2003 in the Medicare Modernization Act. The modified payment system is analogous to the previous system, and the incentives facing plans and beneficiaries are similar.

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3. Plans have had the option of giving their enrollees rebates on their Part B premiums since 2003. Since 2006, plans can also offer rebates on the Part D premiums.

4. PPOs in the Medicare Advantage program are either local or regional; regional PPOs, an option that became available in 2006, are required to serve broad regions of the country rather than defining their service areas on a county-by-county basis. About 2 percent of Medicare Advantage beneficiaries are enrolled in regional PPOs.

5. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2007), Chapter 4, "Update on Medicare Private Plans," pp. 237–266.

Since 2006, private plans wanting to participate in Medicare must submit bids indicating the per capita payment for which they are willing to provide Medicare's Part A and Part B benefits.[6] The government compares those bids with county-level benchmarks that are determined in advance through statutory rules. The benchmarks are the maximum payments that the government will make for enrollees in private plans, though bids by and net payments to plans are usually lower than the benchmarks.[7,8]

Under current law, benchmarks are required to be at least as great as per capita FFS expenditures in every county and are higher than FFS expenditures in many counties. For 2007, CBO calculates that benchmarks are 17 percent higher, on average, than projected per capita FFS expenditures nationwide. Net payments to plans will be approximately 12 percent higher than per capita FFS costs. The differential is more pronounced for private fee-for-service plans: According to estimates by the Medicare Payment Advisory Commission (MedPAC), the payments to those plans in 2006 averaged 19 percent above FFS costs.[9] Of that difference, 10 percentage points' worth went to beneficiaries in the form of extra benefits or rebates. In contrast, payments to HMOs averaged 10 percent above FFS costs, MedPAC estimates. On average, HMOs offered extra benefits and rebates equal to 13 percent of FFS costs; those additional benefits reflected the difference between the benchmarks (which averaged 10 percent above FFS costs) and plans' bids (which averaged 3 percent below FFS costs).

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

7. The description of the MMA payment mechanism in this section pertains to plans that participate in Medicare on a county-by-county basis (or local plans). The payment mechanism for regional PPOs is analogous to the mechanism described here for local plans but uses a modified approach to compute benchmarks. See Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (June 2005), pp. 59–81.

8. The benchmark for a plan that serves more than one county is a weighted average of the county-level benchmarks in its service area (using the plan's expected enrollment in every county as weights). Plans are paid their bid (up to the benchmark) plus 75 percent of the amount by which the benchmark exceeds their bid. Plans must return that 75 percent to beneficiaries as additional benefits or as rebates of their Part B or Part D premiums. Plans whose bid is above the benchmark are required to charge enrollees the full difference between the two as an additional premium for the Medicare benefit package. For 2007, the Medicare Payment Advisory Commission reports that nearly all (99 percent) of beneficiaries have access to Medicare Advantage plans that do not require an additional premium for Parts A and B benefits and any supplemental benefits offered by the plans but not offered by Medicare. See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 248.

9. See Statement of Glen M. Hackbarth, Chairman, Medicare Payment Advisory Commission, *The Medicare Advantage Program and MedPAC Recommendations*, before the Senate Committee on Finance (April 11, 2007), p. 5.

Benchmarks are updated each year by either the growth in national per capita Medicare spending or 2 percent, whichever is greater.[10,11] For 2008, the Centers for Medicare & Medicaid Services (CMS) announced that benchmarks will increase by 3.5 percent.

Medicare also adjusts payments to Medicare Advantage plans to reflect their enrollees' health status. That "risk adjustment" is meant to encourage plans to compete on the basis of efficient delivery of services rather than selective enrollment of healthier beneficiaries. To that end, CMS collects information on the medical diagnoses of every beneficiary and uses it to calculate the relationship between individuals' health and subsequent spending on their behalf for Medicare services and to thereby adjust payments to plans (upward for those with sicker beneficiaries and downward for those with healthier beneficiaries).

In managing the risk adjustment system, CMS has to confront difficult issues of data collection and validity, statistical complexity, and potentially different coding practices between plans and the fee-for-service sector. Each judgment the agency makes for each of those aspects of risk adjustment can increase or decrease payments to Medicare Advantage plans.

Geographic Patterns of Enrollment

The relationship between the cost of offering Medicare benefits and the benchmarks is an important determinant of the types of plans that are available in various areas of the country. To offer a product that is attractive to beneficiaries, a plan

10. The benchmarks for 2007 were updated from the payment rates for private plans that were established by the Balanced Budget Act of 1997 (BBA) and modified through subsequent legislation. Before the enactment of the BBA, plans were generally paid 95 percent of the local per capita FFS costs. Under the BBA, the payment rate in each county was the greatest of three amounts: a minimum, or "floor," rate; a blend of a local rate and the national average rate; and a minimum increase from the previous year's rate (which was equal to 2 percent in most years). The floor amount established in 1998 ($367 a month that year) was increased each year by the national rate of increase in per capita Medicare spending. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 increased that floor amount to $475 for 2001 and established a $525 floor for metropolitan areas with at least 250,000 residents. Those amounts also were increased each year by the national rate of increase in per capita Medicare spending.

11. The BBA's rules resulted in rates in some counties that were higher—in some cases, by a substantial amount—than local per capita spending in the FFS program. In other counties, however, the update mechanism resulted in payment rates that were lower than local per capita FFS spending. The MMA modified the benchmarks to be the higher of the BBA benchmarks or local per capita spending. The MMA also requires that the government "rebase," or reestimate, per capita FFS expenditures in each county at least once every three years using the most current data available. In those years in which rebasing occurs, the benchmark for each county will be the greater of the rebased per capita FFS expenditures or the update from the previous year's rate. The Centers for Medicare & Medicaid Services rebased the FFS rates in 2004, 2005, and 2007.

must have a cost of offering Medicare benefits that is low enough, relative to the benchmarks, to enable it to provide some combination of additional benefits and cash rebates. Those additional benefits—which are similar to the supplemental benefits offered by private supplemental insurance policies—often include reduced cost sharing for medical services or prescription drugs. They may also include coverage of services that are not covered by Medicare, such as dental care, and they often include disease management, care coordination, and preventive care programs to promote better use of services.

Both the cost of providing benefits, as reflected in plan bids, and the maximum amount Medicare will pay for those benefits, as reflected in the benchmarks, vary greatly among communities. That variation, in combination with characteristics of plans themselves, results in distinctive patterns of enrollment in Medicare Advantage as a whole and among the various types of plans.

Until recently, HMOs and PPOs accounted for nearly all enrollment in Medicare Advantage, and most of that was concentrated in urban and suburban areas. Those plans incur substantial administrative costs to establish and maintain networks of providers, to acquire and maintain enrollment, and to manage utilization. To the extent that they negotiate payment rates with providers that are higher than Medicare's payment rates for services furnished in the fee-for-service sector, those plans may also incur higher costs for medical services. They also have higher administrative costs per enrollee than the traditional Medicare program does because of their smaller scale of operations and their costs associated with network development and retention, care management, marketing, and reinsurance. As a result, private plans must offset their higher costs of operations with savings from lower utilization or reductions in payment rates for providers. The ability of plans to achieve such savings varies greatly among geographic areas.

Previous work by CBO has shown that plans' bids for operating Medicare Advantage plans vary less from county to county than per capita FFS spending does (see Table 1). As a result, in areas with high FFS costs per capita, Medicare Advantage plans' bids are relatively low in comparison with FFS spending, and vice versa. In particular, in areas with the highest per capita FFS spending, health plans' bids are about 9 percent below FFS spending. By contrast, in the lowest-cost FFS areas, health plans' bids are about 16 percent above FFS spending. Benchmark rates in those areas vary in similar fashion, from an average of about 4 percent above FFS costs in high-cost FFS areas to an average of about 26 percent above in low-cost areas.

Most enrollment in HMOs and PPOs tends to be in relatively densely populated urban and suburban areas (where it is easier to establish provider networks) with

Table 1.

Private Plans' Bids for Providing Medicare Benefits Relative to Costs in the FFS Program, 2007

Average per Capita FFS Expenditures in Plans' Service Areas (Dollars)	Difference Between Plans' Bids and per Capita FFS Expenditures (Percent)	Plans' Projected 2007 Enrollment in Category (Percent)
More Than 750	-9	26
700 to 749	1	19
650 to 699	3	25
600 to 649	9	17
Less Than 600	16	13
National Average	2	100

Source: Congressional Budget Office based on data submitted by private plans to the Medicare program for 2007.

Note: FFS = fee for service.

relatively high benchmarks and generally high per capita FFS spending.[12] Because private plans try to restrain medical costs by managing the level and intensity of service utilization, they have greater potential to achieve savings relative to the FFS program in geographic areas where FFS practice involves relatively high utilization of costly services—which also tend to be areas with high per capita FFS expenditures. Private plans have much less opportunity to achieve such savings in areas where utilization rates for expensive services in the FFS sector are already relatively low.

In contrast to HMOs and PPOs, private fee-for-service plans generally do not incur the costs of establishing and maintaining networks of providers or managing utilization, and the payment rates PFFS plans pay to providers often are the same as Medicare rates. However, PFFS plans incur administrative costs for acquiring and maintaining enrollment, and they do not realize comparable savings from utilization management, which is often cited by supporters as an important public policy benefit from other types of Medicare Advantage plans.[13]

Private fee-for service plans have enrollment that is far more dispersed than that of local HMOs and PPOs, including significant enrollment in rural areas. The rapid growth of those plans increased the market share of private plans in rural areas

12. It is easier for a plan to establish a network in a relatively densely populated area that has a relatively large number of providers than in a more sparsely populated area because the plan's leverage in negotiations with providers (to get them to accept relatively low payment rates and to cooperate with the plan's efforts to manage utilization) is to promise them some volume of business by diverting to them patients from providers who do not participate in the network.

13. Some PFFS plans employ certain utilization controls, such as counseling and monitoring of patients with phone calls from nurses.

from about 4 percent in 2005 to about 7 percent in 2006, and CBO expects that share to continue to grow under current law as private fee-for-service plans play an increasingly large role in Medicare Advantage. They are able to grow in rural areas, first, because they face little competition from other types of private plans there; unlike HMOs and PPOs, they do not require networks of providers, which are difficult to establish in those areas. Second, the rules enabling plans to pay the same rates to providers as Medicare does give them a competitive advantage against HMOs and PPOs, which often pay higher rates than that program does. Finally, benchmarks in rural areas are sufficiently high that private fee-for-service plans are able to offer extra benefits or rebates to attract members even without the cost-reducing tools available to other types of plans (that phenomenon is particularly notable in the rural counties with benchmarks at the floor amounts).[14]

Care Management in Medicare Advantage

Medicare's FFS program provides a generally unmanaged approach to the delivery of medicine because providers are paid for the number and types of services they deliver and not for the quality of the outcomes they bring about.[15] Health plans may be more able to manage care through their knowledge of members' health conditions, contact with providers, and centralized administrative arrangements. Medicare Advantage plans also have a strong incentive to manage care to reduce costs, as any savings that they can generate accrue directly to them and their members. Health plans' various efforts at disease management, care coordination, and preventive care often include:

- Phone calls from nurses or caseworkers to provide reminders and periodic health assessments,
- Health coaches to encourage healthy behaviors,
- Educational programs to teach members and physicians about guidelines for effective treatment, and
- Efforts to connect members with resources in the community.[16]

14. In 2006, the average benchmark in urban counties with benchmarks at the floor amounts was 121 percent of per capita FFS spending, the benchmark in other "floor counties" (largely rural) was 134 percent, and the benchmark in other counties was 111 percent. (A floor county is paid at one of the two minimum rates established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 and updated each year.) See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 244.

15. See Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (June 2006), Chapter 2, "Care Coordination in Fee-for-Service Medicare," pp. 53–80.

16. See Blue Cross and Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management* (February 2007); and America's Health Insurance Plans, *Innovations in Chronic Care* (March 2007).

Some plans also employ more intensive case management services targeted to their most medically complex members. Such programs have the potential to reduce plans' costs to the extent that they eliminate unnecessary services or manage chronic conditions so as to avoid relatively costly episodes, such as extended hospital stays. (Each of the techniques described above can also result in increased costs to plans if they are ineffective.)

Initially, any cost savings that health plans realize (after bids and premiums are set) from such activities accrue entirely to the plans, not to the government. Medicare spending would not be reduced, for instance, if inpatient admissions in Medicare Advantage plans declined in 2007. Plans (except for regional PPOs for a limited period of time) accept the full risk for their beneficiaries, so, within the payment period, they also realize all gains from their medical management strategies.

In the long run, any reductions in cost achieved by health plans should be passed back to the beneficiaries (75 percent) and the government (25 percent) through the operation of the bidding mechanism. If a plan can provide services for a lower cost, it has a strong incentive to reduce its bid in order to increase the extra benefits and rebates that it can use to attract members. Similarly, any care management technologies that cause plans to increase their bids will result in reduced benefits and rebates for beneficiaries and increased costs to the government. Even if improvements in care management yielded significant improvements in efficiency in Medicare Advantage, the government would realize, at most, 25 percent of those savings.

Reporting on Measures of Health Plans' Quality

One possible benefit of the Medicare Advantage program is the higher quality of care beneficiaries may receive through more disease management, care coordination, and preventive care than they would receive in the Medicare fee-for-service program. But the extent to which such services lead to improved health outcomes is difficult to assess with the currently available data. Policymakers may therefore want to explore options for expanded reporting of outcomes.

Some Medicare Advantage plans are required to report on the quality of care they provide, as measured by several surveys administered by the National Committee for Quality Assurance:

- The Health Plan Employer Data and Information Set (HEDIS), which collects information on the quality of care delivered by plans and their affiliated providers;
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS), which collects information on members' experience in interacting with plans and their affiliated providers; and

- The Health Outcomes Survey (HOS), which collects information on the overall mental and physical health of plans' populations.

Some of the information collected is made available to the public through Medicare's "plan finder" Web site and other distribution channels.

The current data sources and reporting requirements, however, do not provide sufficient information to assess whether health plans produce better health outcomes or deliver more cost-effective care than the FFS sector (as indicated by the quality of care per dollar of federal spending). PFFS plans, the fastest growing component of Medicare Advantage, are exempt from many of the reporting requirements, including all HEDIS measures.[17] Furthermore, the measures collected by the HEDIS and CAHPS surveys largely measure the quality of the process of delivering health care rather than the outcomes of that care. Plans are surveyed about their adherence to medical recommendations (for instance, treatment of heart attack patients with beta blockers and management of antidepressants), ability to deliver preventive health services and screenings (for instance, controlling high blood pressure and providing breast cancer screenings), availability of care, and members' perceptions of their responsiveness and accessibility. The HOS collects population-level health information on each plan but does not provide insight into the plans' efficiency of operations.

Though Medicare Advantage plans cost more than care under the FFS program does, on average, they would be more cost-effective if they delivered a sufficiently higher quality of care. The limited measures available suggest that Medicare Advantage plans are no more cost-effective than the FFS program.[18] In addition, the quality measures reported for HMOs and PPOs show dramatic variation in performance between the best- and worst-performing plans.[19] Developing reporting systems to comprehensively measure health outcomes in the Medicare Advantage and FFS programs would be helpful in assessing the value of care management techniques employed by Medicare Advantage plans. Expanded reporting on outcomes would also allow analysis of varying approaches adopted by different plans, which could be a valuable tool in the search for ways to restrain the cost of health care in the United States while maintaining or improving the quality.

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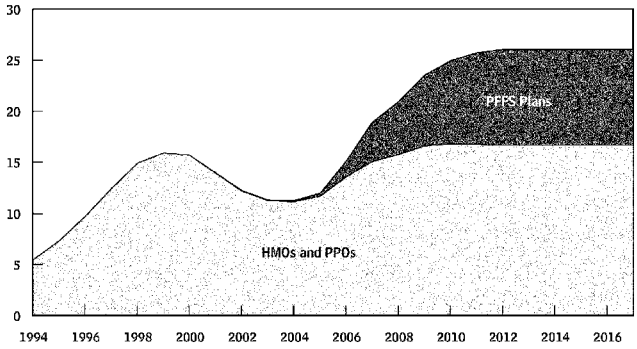
17. PPO plans are also exempt from some reporting requirements. In comparison to HMOs, both PFFS and PPO plans have less access to medical records, making some reporting requirements more difficult for them. All plans are required to report on only a subset of the measures in HEDIS; in particular, plans are not required to report on the cost-of-care measures implemented in recent versions of the survey.

18. See Medicare Payment Advisory Commission, *Issues in a Modernized Medicare Program*, p. 70.

19. See Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 67.

Figure 1.

Enrollment in Medicare Advantage as a Percentage of Enrollment in Medicare



Source: Congressional Budget Office.

Notes: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee for service.

For the purpose of this figure, enrollment in Medicare is considered to be that in Part A (Hospital Insurance).

by 2017, accounting for one-third of all Medicare Advantage enrollment at that time, up from about one-sixth now.

HMOs and local PPOs grew strongly in 2006 as well, adding approximately 1 million members from the end of 2005 to June 2007. Membership in such plans now numbers approximately 6.2 million. Growth in 2007 for those types of Medicare Advantage plans was slower than that for 2006, however, and, according to CBO's projections, that portion of the program will grow more slowly than the PFFS portion over the next several years. In addition, the expiration of the authorization for a special needs program after December 31, 2008, will eliminate one of the fastest-growing components of local HMOs and PPOs, limiting the future growth of such plans under current law.[23]

23. Special needs plans were authorized by section 231 of the Medicare Modernization Act. As of May 2007, about 900,000 beneficiaries were enrolled in such plans, the majority of whom were in HMOs. Those plans are permitted to market to and restrict enrollment to specific subgroups of beneficiaries, including people who are dually eligible for Medicare and Medicaid, who have chronic conditions, and who reside in institutions.

Table 2.

Recent Enrollment in Medicare Advantage and Other Group Health Plans

(Thousands of people)

	Total, December 2005	Additions: During 2006	Additions: During 2007	Total, June 2007
Medicare Advantage				
Local HMOs and PPOs	5,160	840	190	6,190
Private fee for service	210	660	720	1,590
Regional PPOs	0	100	60	160
Subtotal, Medicare Advantage	5,370	1,600	970	7,940
Other Group Health Plans[a]	760	-130	-10	620
Total, All Group Health Plans	6,120	1,470	960	8,560

Source: Congressional Budget Office based on data from the Centers for Medicare & Medicaid Services.

Notes: HMO = health maintenance organization; PPO = preferred provider organization.

Figures do not add up to totals because of rounding.

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

Rising Costs for Medicare Advantage

CBO projects that payments to Medicare Advantage plans will rise from an estimated $60 billion in calendar year 2006 to $196 billion in 2017, an annual average growth rate of 11 percent (see Table 3). Much of that increase will result from growing enrollment (about 7 percent per year); the rest from increasing payments per enrollee (about 4 percent per year). By comparison, CBO estimates that total enrollment in Medicare will grow much more slowly and that total spending will increase by an average of 6.5 percent per year. Spending for Medicare Advantage is projected to total approximately $1.5 trillion over that 11-year period.

Because beneficiaries can be enrolled in only the Medicare Advantage program or the FFS program, increasing enrollment in the former leads to partially offsetting decreasing spending in the latter. However, because payments to Medicare Advantage plans are higher, on average, than costs in the FFS sector, shifts in enrollment out of the FFS program and into private plans increase net Medicare spending.

CBO projects that private fee-for-service plans will account for a rapidly growing share of Medicare Advantage spending, with payments to them increasing from approximately $5 billion in calendar year 2006 to $13 billion in 2007 and $59 billion in 2017. That increase represents an annual average nominal growth rate of 25 percent over the 11-year period and reflects a 20 percent average rate of growth

Table 3.

CBO's Baseline Estimates for Medicare Advantage

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017	2006-2017
							Enrollment (Calendar year average, in thousands)								
Local HMOs and PPOs	5,740	6,400	6,790	7,230	7,380	7,460	7,560	7,720	7,920	8,120	8,320	8,530			
PFFS	650	1,670	2,290	3,120	3,720	4,170	4,490	4,680	4,770	4,840	4,900	4,960			
Regional PPOs	70	140	180	240	290	350	420	490	570	650	730	810			
Subtotal, Medicare Advantage	**6,460**	**8,210**	**9,260**	**10,590**	**11,390**	**11,980**	**12,470**	**12,890**	**13,260**	**13,610**	**13,950**	**14,300**			
Other Group Plans[a]	640	590	520	310	160	160	150	150	150	150	150	140			
Total, Medicare Group Plans[b]	7,100	8,800	9,780	10,900	11,550	12,140	12,620	13,040	13,410	13,760	14,100	14,440			
Medicare Advantage Enrollment as a Percentage of Hospital Insurance Enrollment	15	19	21	23	25	25	26	26	26	26	26	26			
							Spending (Calendar year incurred, in billions of dollars)								
Local HMOs and PPOs	54	63	70	78	83	87	92	97	103	110	118	127	411	965	
PFFS	5	13	19	27	33	39	44	47	50	52	55	59	162	424	
Regional PPOs	1	1	2	2	3	4	4	5	6	8	9	10	15	53	
Subtotal, Medicare Advantage	**60**	**77**	**91**	**107**	**119**	**130**	**140**	**149**	**159**	**169**	**182**	**196**	**587**	**1,442**	
Other Group Plans[a]	4	4	4	2	1	1	1	1	1	1	1	1	8	13	
Total, Medicare Group Plans[b]	64	81	95	109	120	131	141	150	160	170	183	197	596	1,455	
Fiscal Year Outlays[c,d]	56	75	91	106	117	140	128	150	158	167	195	194	582	1,446	
Number of Capitation Payments[d]	11	12	12	12	12	13	11	12	12	12	13	12	60	121	
							Enrollment Growth (Percent)								
Local HMOs and PPOs	16	11	6	6	2	1	1	2	3	2	3	3	3	3	4
PFFS	435	156	37	36	19	12	8	4	2	1	1	1	22	12	20
Regional PPOs	n.a.	98	30	36	23	21	19	16	16	14	12	11	25	19	25
Subtotal, Medicare Advantage	**27**	**27**	**13**	**14**	**8**	**5**	**4**	**3**	**3**	**3**	**3**	**3**	**9**	**6**	**7**
Other Group Plans[a]	-13	-8	-11	-41	-48	-1	-1	-1	-1	-1	-1	-1	-24	-13	-13
Total, Medicare Group Plans[b]	22	24	11	11	6	5	4	3	3	3	3	3	7	5	7

Continued

Table 3.

Continued

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

Source: Congressional Budget Office.

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

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

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

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

d. In general, capitation payments to group health plans and prescription drug plans for the month of October are accelerated into the preceding fiscal year when October 1st falls on a weekend. However, the Balanced Budget Act of 1997 required that the October payment in 2006 be made on October 2 instead of September 29.

in enrollment and a 4 percent average annual rate of growth in net payments per enrollee. In 2006, PFFS plans accounted for approximately 8 percent of Medicare Advantage spending; CBO anticipates that those plans will account for 17 percent of that spending in 2007 and 29 percent in 2017.

Despite the rapid projected growth in PFFS plans, local HMOs and PPOs are projected to continue to account for the largest portion of spending throughout the projection window. According to CBO's estimates, payments to those organizations will increase from approximately $54 billion in calendar year 2006 to approximately $63 billion in 2007 and $127 billion in 2017, reflecting an annual average nominal growth rate of 8 percent. That increase results from projected annual average growth of 4 percent in enrollment and 4 percent in net per capita payments.

Regional PPOs are projected to grow from the current 160,000 members to about 800,000 in 2017 (under an assumption that current law remains in place). Payments to such plans were approximately $1 billion in 2006 and, by CBO's projections, will be $1 billion in 2007 and $10 billion in 2017—representing an annual growth rate of 31 percent, 25 percent from enrollment and 4 percent from growth in net per capita payments.

CBO's baseline projections also include approximately $3.5 billion in spending in 2012 and 2013 from the "stabilization fund" established under the Medicare Modernization Act to encourage regional PPOs' participation in the Medicare Advantage program.

Estimated Spending Reductions from Alternative Policies

A number of policy options exist that would reduce spending on Medicare Advantage. This testimony presents three options drawn from CBO's February 2007 *Budget Options* report.[24]

Pay Plans at Local FFS Rates

The first policy would reduce the county-level benchmarks under Medicare Advantage to the level of local per capita FFS spending. Relative to spending under current law, CBO estimates, this policy would save $9.5 billion in 2009, $54 billion over the 2009–2012 period, and $149 billion over the 2009–2017 period (see Table 4).[25] Limiting benchmarks to 100 percent of FFS costs for private fee-for-service plans and maintaining current-law benchmarks for other plans

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

25. The county-level benchmarks for 2008 have been announced, and the bid approval process is under way. The estimates assume that the policies under discussion would take effect in 2009 to avoid interrupting that process for 2008.

Table 4.

Estimated Budgetary Effects of Alternative Policies

(Billions of dollars, by fiscal year)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
Pay Plans at Local FFS Rates	0	-9.5	-13.7	-16.2	-14.6	-16.8	-17.7	-18.6	-21.2	-20.8	-54.0	-149.1
Eliminate Double Payments for Indirect Medical Education	0	-0.8	-1.1	-1.3	-1.1	-1.3	-1.4	-1.6	-1.8	-1.7	-4.2	-12.0
Eliminate the Remainder of the Regional PPO Stabilization Fund	0	0	0	0	-1.6	-1.6	-0.4	0	0	0	-1.6	-3.5

Source: Congressional Budget Office.

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

The estimates are net of changes in premium receipts resulting from policy changes.

would reduce federal spending by about $14 billion over the 2009–2012 period and $43 billion over the 2009–2017 period. Requiring PFFS plans to maintain networks similar to local PPOs would have similar effects, saving $13 billion over the 2009–2012 period and $40 billion over the 2009–2017 period, if implemented in 2009. Each policy would, however, have a considerable impact on both plans and their participants.

All counties have benchmarks set at or above local FFS rates. Many counties have rates well above local per capita FFS costs, particularly counties where the floor payment rates were in effect before the enactment of the Medicare Modernization Act. Reducing benchmarks to FFS levels would result in a significant reduction in benchmarks in most counties. CBO estimates that in 2007, the average payment will be 12 percent above FFS rates; that difference will be greater for PFFS plans and lower for HMOs and PPOs. One force pushing that payment difference still higher in the future is the continuing growth of PFFS plans, although other forces could offset or reinforce that increase (such as changes to the calculations of county benchmarks and changes in the reported health status of enrollees).

Reducing benchmarks would leave less money for health plans to offer reduced premiums or supplemental benefits. That change, in turn, would make the program less attractive to beneficiaries and lead some to return to the traditional fee-for-service program. Others who would have joined Medicare Advantage plans would remain in the fee-for-service program. The change also would make the Medicare Advantage program less attractive for health plans and cause some to leave the program, as they did after the Congress restrained growth in payment rates in the Balanced Budget Act of 1997. By CBO's estimates, enacting this policy would reduce enrollment in Medicare Advantage by about 6.2 million beneficiaries in 2012 relative to the baseline projection, a decline of about 50 percent—leaving

Table 5.

Estimated Budgetary Effects of Policies Capping the Benchmarks under Medicare Advantage

(Billions of dollars, by fiscal year)

Limit on MA Benchmarks as a Percentage of FFS Costs	Change in Direct Spending	
	2008–2012	2008–2017
100	-54	-149
105	-43	-120
110	-32	-90
115	-23	-64
120	-15	-42
125	-10	-28
130	-6	-18
135	-4	-10
140	-2	-7
145	-2	-5
150	-2	-4

Source: Congressional Budget Office.

Notes: MA = Medicare Advantage; FFS = fee for service.

The estimates are net of changes in premium receipts resulting from policy changes. Each policy would limit the Medicare Advantage program's county benchmarks to some level above local per capita FFS costs.

total Medicare Advantage enrollment at about 6.3 million (and the program's share of total enrollment in Medicare at 13 percent), which is roughly 1.7 million enrollees fewer than there are today. Limiting the policy change to private fee-for-service plans would result in a smaller reduction in enrollment, approximately 3.3 million beneficiaries in 2012. Requiring PFFS plans to have PPO-like networks would have approximately the same effect.

CBO also has estimated the budgetary effect of variations on this option that would limit the benchmarks to certain levels above local FFS costs (see Table 5). For example, the Congress could limit all local benchmarks to 110 percent or 120 percent of local per capita FFS spending. Such policies would have similar, but smaller, effects on payments to plans and enrollment. CBO estimates that capping benchmarks at 110 percent of local per capita FFS costs would reduce spending by $32 billion over the 2009–2012 period and $90 billion over the 2009–2017 period ($12 billion and $38 billion, respectively, for the PFFS-only option). Capping rates at 120 percent of FFS costs would save $15 billion from 2009 to 2012 and $42 billion from 2009 to 2017 ($7 billion and $22 billion, respectively, for the PFFS-only option).

In general, those spending reductions mirror the spending distribution of Medicare Advantage payments. About 52 percent of Medicare Advantage spending is in counties where the benchmark is greater than 110 percent of local FFS costs,

Table 6.

Distribution of Medicare Advantage Spending, by the Percentage by Which County Benchmarks Exceed Local FFS per Capita Costs

(Percent)

Percentage by Which Benchmark Exceeds FFS Costs	Portion of Medicare Advantage Spending	
	Within Category	Within or Above Category
0	10	100
Greater Than 0 to 9.9	38	90
10 to 19.9	31	52
20 to 29.9	12	21
30 to 39.9	5	9
40 to 49.9	1	4
50 and Higher	3	3

Source: Congressional Budget Office.

Note: Categories are based on the Medicare Advantage program's local county benchmarks and local fee-for-service (FFS) rates. The total spending is calculated as if all bids were equal to the benchmark and all beneficiaries had average expected costs. The analysis includes all counties with reported FFS spending for 2007 (as well as Puerto Rico).

meaning that about one-half of spending would be affected (see Table 6). (That fact does not mean, however, that one-half of spending would be cut from the program, because the portion of spending below 110 percent of local FFS costs in those counties would be unaffected by the change.)

Because the payment reduction is largest in counties with the highest benchmarks relative to local FFS costs, the reductions in extra benefits and declines in enrollment under the policy would be largest in those areas. Plans in counties paid at one of the two floor rates would experience the largest payment cuts and enrollment reductions; those counties generally have low FFS costs. Plans in counties with benchmarks nearest FFS costs would see the smallest payment and enrollment reductions; those counties are generally urban and suburban counties with relatively high FFS costs. In virtually no county would plans avoid a payment reduction if benchmarks were set at FFS rates, however; the minimum update requirement has kept the rates for counties where payments were at FFS rates in 2004 (the first year plans were paid at the local FFS level) above FFS costs subsequently in the majority of cases.

Eliminate Double Payments for Indirect Medical Education

Medicare's payments to teaching hospitals for inpatient services in the traditional fee-for-service sector include an "indirect medical education" (IME) adjustment. That adjustment is intended to account for the fact that teaching hospitals tend to have greater expenses than other hospitals. Teaching hospitals, for example, typi-

cally offer more technically sophisticated services than other hospitals do and treat patients who have more-complex conditions.

Those IME payments are included in the benchmarks in counties where the benchmark has been tied to FFS spending. Nevertheless, Medicare also pays the IME amount to teaching hospitals that treat patients enrolled in Medicare Advantage plans.

This policy would eliminate that double payments by removing IME payments from the benchmarks in counties where the benchmark has been associated with per capita spending in the fee-for-service sector. By CBO's estimates, such a change would save $1 billion in 2009, $4.5 billion over the 2009–2012 period, and $12 billion over the 2009–2017 period (compared with spending under current law).

This option is only one method of implementing such a payment reduction. The Administration's budget for fiscal year 2008 proposed an alternative approach: remove the double payments for IME in all counties (not just the FFS-based counties) by eliminating the separate IME payments for Medicare Advantage enrollees treated in teaching hospitals. The Administration's proposal would phase in that change over the 2008–2016 period. According to CBO's estimates, that provision would save $500 million in 2008, $5 billion over the 2008–2012 period and $19 billion over the 2008–2017 period (this policy generates savings in 2008 because payments to hospitals can be changed more quickly than payments to plans made through the bidding system). The choice of whether to eliminate the double payments from the health plan side or from the hospital side could have important financial consequences for health plans and teaching hospitals.

Eliminate the Remainder of the Regional PPO Stabilization Fund
The stabilization fund established by the MMA was authorized to spend $10 billion over the 2007–2013 period to encourage the participation of regional PPOs in the Medicare Advantage program. The Tax Relief and Health Care Act of 2006 repealed $6.5 billion of that amount and prohibited spending the remainder until 2012. This option would eliminate that fund and would save an estimated $1.6 billion in 2012 and $3.5 billion over the 2008–2017 period.

Conclusion

The Medicare Advantage program has been growing rapidly and is projected to continue to do so. Such growth, under current payment policies, increases net costs to Medicare because payments made to Medicare Advantage plans exceed costs under the traditional fee-for-service program. Policymakers evaluating options for reducing payments to Medicare Advantage plans need to weigh the cost savings against benefits that the plans provide in managing care, the effect on health care costs overall, and the impact on beneficiaries. Finally, expanded reporting on health outcomes may help policymakers better evaluate both the overall effects and specific care management approaches of Medicare Advantage plans.

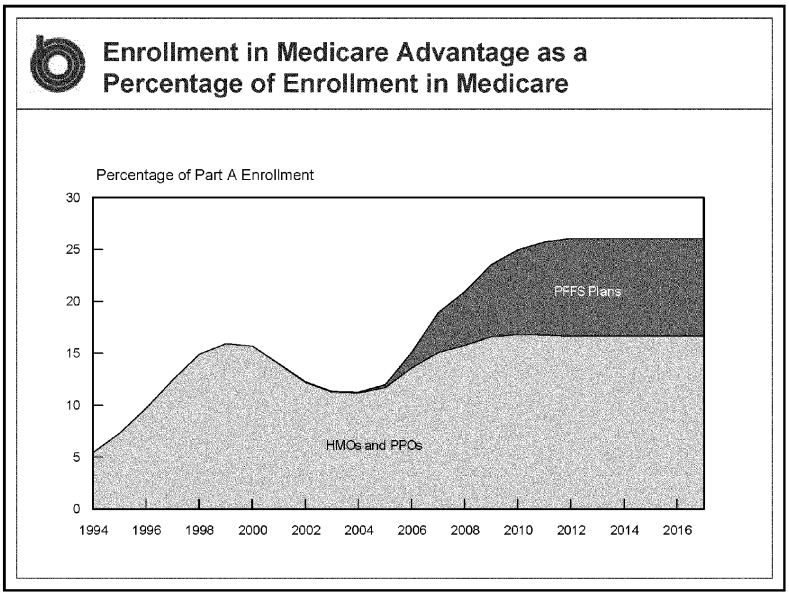
Congressional Budget Office

The Medicare Advantage Program

June 28, 2007

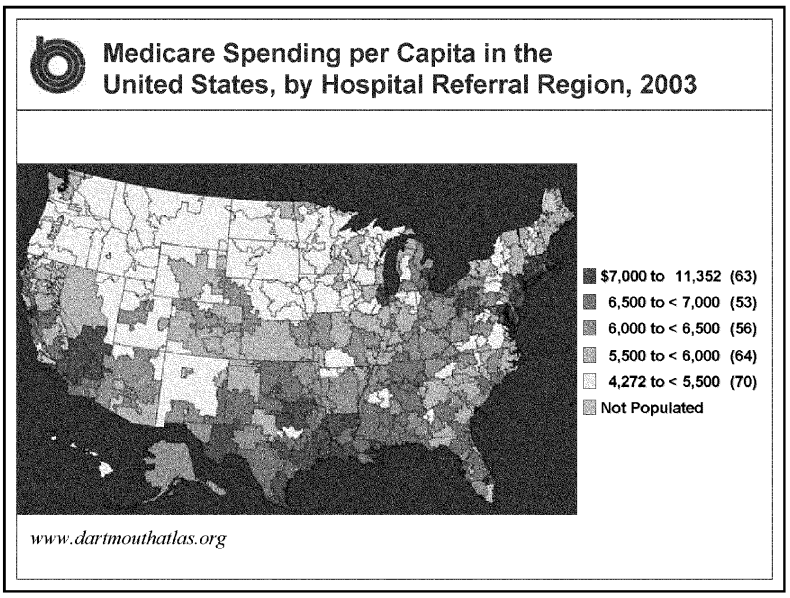
Recent Enrollment in Medicare Advantage and Other Group Health Plans

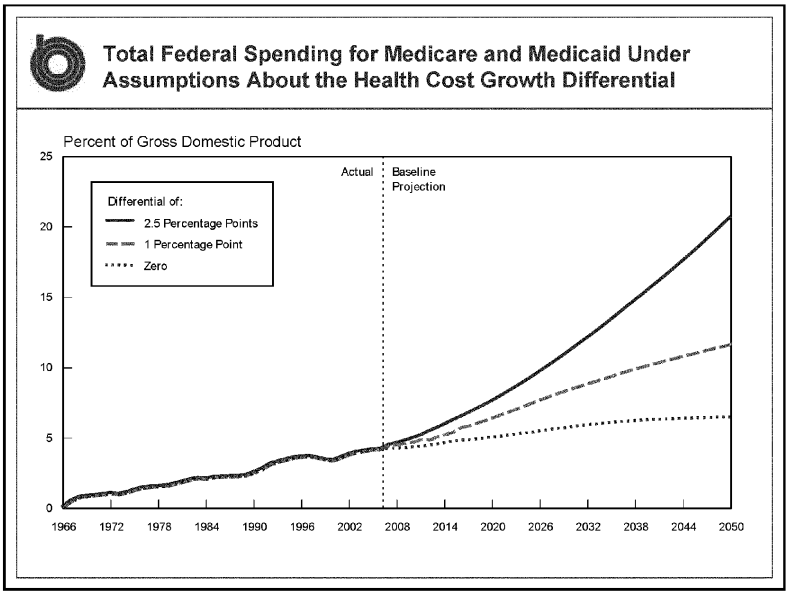
		Additions		
	Total, Dec. 2005	During 2006	During 2007	Total, June 2007
Medicare Advantage				
Local HMOs and PPOs	5,160	840	190	6,190
Private fee for service	210	660	720	1,590
Regional PPOs	0	100	60	160
Total for All Group Health Plans	6,120	1,470	960	8,560



Estimated Budgetary Effects of Policies Capping the Benchmarks under the Medicare Advantage Program

Limit on MA Benchmarks as a Percentage of FFS Costs	Change in Direct Spending (Billions of dollars)	
	2008–2012	2008–2017
100	-54	-149
110	-32	-90
120	-15	-42
130	-6	-18
140	-2	-7
150	-2	-4





Chairman SPRATT. Dr. Miller, the executive director of MedPAC, thank you for coming. And we would now like to hear your testi-

mony. We will make the full statement part of the record. You can summarize it as you see fit.

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

Mr. MILLER. Chairman Spratt, Ranking Member Ryan and distinguished members of the committee, I appreciate your asking for MedPAC's views on Medicare's managed care payments. MedPAC is an independent congressional support agency created by the Congress to provide analysis and recommendations regarding Medicare policy. Much of our work focuses on payment issues, and I would stress that we make many payment recommendations on the fee-for-service side that involve reducing payments, much as the recommendations we are going to discuss today for managed care.

In our recommendations, the Commission tries to assure that beneficiaries have access to quality care, to assure that tax dollars are well spent and to assure that payments to providers are fair and adequate. Furthermore, the Commission believes that all providers in Medicare, whether fee-for-service or managed care, should be under some degree of fiscal pressure, to motivate the continuous search for efficiency and quality improvement. The Commission is also acutely aware of the long-run sustainability problems facing Medicare. These problems are reviewed in my testimony, and I am sure Peter has gone through them with this committee many times.

The Commission has long supported managed care plans as a choice in Medicare. Managed care plans have the potential to be efficient, and they have greater flexibility in innovating care delivery. Indeed, the original concept of the managed care plans was that they would be more efficient than fee-for-service and, through these efficiencies, offer extra benefits such as lower cost sharing, and that in turn would attract beneficiaries.

Regarding payment, for many years the Commission has recommended that Medicare payments should be neutral to the beneficiary's choice. We should not have payments that favor either fee-for-service or managed care plans, and of course, as has been mentioned, they should encourage efficiency. The current Medicare managed care payment system is flawed. It is not neutral, and it does not encourage efficiency. It draws beneficiaries to enroll in managed care, and as Peter indicated, every beneficiary enrolled is an increased cost to the Medicare program. This is largely because the plans bid against legislatively set benchmarks that are, on average, 16 percent above traditional fee-for-service payments. These benchmarks vary across the country. They can be as high as 30 and 40 percent above fee-for-service in the Continental U.S.

The current bidding system, which I can explain in questions, results in payments that, on average, are 12 percent above traditional fee-for-service. Plans are required to use part of their total payment to give extra benefits to beneficiaries. And of course, this is attractive to beneficiaries, and there has been a large increase in plan offerings and enrollment. There are now an average of 20 plan options offered per county, and enrollment is at 18 percent, the highest it has ever been in Medicare.

Note that these extra benefits are paid for by taxpayers through the Part A trust fund and general revenues. Further note that it increases the Part B premium that is paid by all beneficiaries whether they are in managed care plans or not. It is also alarming to note that the most rapid growth is in the private fee-for-service plans. These plans operate largely like traditional fee-for-service. They do not put together networks of providers to manage care. They do not negotiate fees. In fact, they use the same fees as traditional fee-for-service, and they are highly inefficient based on the analysis that we have done. On average, Medicare pays them 9 percent more than fee-for-service to deliver the traditional fee-for-service benefit, and then because of our current payment system, these plans, on average, are paid 19 percent more than fee-for-service after all is said and done.

Furthermore, these plans have very few requirements. Peter referred to the fact that they have very minimal quality data reporting requirements, and there is less oversight exercised by the agency on these plans. The current Medicare managed care payment mechanism sends signals inviting and rewarding inefficient plans, and the private fee-for-service plans may be the most striking example of what is wrong with the system.

As you know, the Commission has recommended reducing the benchmarks to pay managed care plans to 100 percent of fee-for-service. We acknowledge and realize that this creates concern that in some markets there will be fewer plan offerings and benefit packages will be less generous. Our most recent report explains some methods of transitioning to these lowered benchmarks. And we also note that there are plans that are efficient and that can provide additional benefits through those efficiencies, but we do recognize that there will be less plans and less generous offerings, as Peter indicated.

In closing, I would make these points. The Commission supports the role of managed care plans in Medicare. There is evidence that plans, particularly certain types of plans, can be efficient, but the current system is costly and rewards inefficient plans. Reducing the benchmarks will have the effect of focusing our resources on plans that can provide extra benefits through savings and return to the original intent of the program. There will be resistance from plans enjoying the extra payments and from beneficiaries enjoying the extra benefits, but the problems will be more costly and more difficult to address given the current enrollment trends.

I look forward to your questions.

[The prepared statement of Mark E. Miller follows:]

TESTIMONY

The Medicare Advantage Program and MedPAC Recommendations

June 28, 2007

Statement of
Mark E. Miller, PhD.

Executive Director
Medicare Payment Advisory Commission

Before the
Committee on the Budget
U.S. House of Representatives

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Chairman Spratt, Ranking Member Ryan, distinguished Committee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss the Medicare Advantage program and recommendations that the Commission has made for the program.

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the Congress on issues affecting the Medicare program. MedPAC makes recommendations on payment policy for providers in Medicare's traditional fee-for-service program and for Medicare Advantage organizations. MedPAC also analyzes beneficiary access to care, quality of care, and other issues affecting Medicare.

The Commission's 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. The Commission is supported by a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

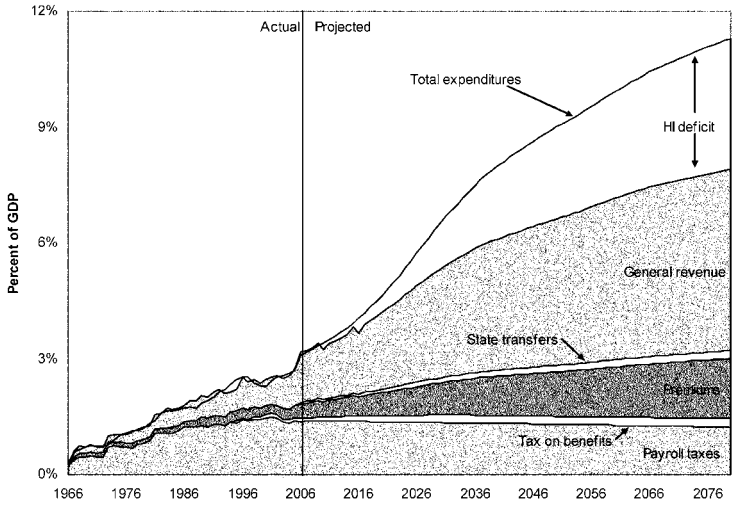
Several principles guide the Commission's work. First, Medicare beneficiaries need to have access to high quality care. Second, taxpayer dollars should be spent wisely. Third, providers should be paid fairly to serve Medicare beneficiaries and those payments should encourage efficiency and quality. In short, the Commission strives to make Medicare a more efficient program while at the same time improving the quality of care beneficiaries receive.

The Commission believes that greater efficiency is achieved when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional fee-for-service (FFS) program and the Medicare Advantage (MA) program. This financial pressure, coupled with meaningful measurement of quality and

resource use in order to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program.

The Commission is acutely aware of the long-run sustainability issues facing Medicare. Figure 1 shows the Medicare trustees' view of the future of Medicare financing. Total expenditures for Medicare will take up an increasing share of the nation's gross domestic product (GDP) and quickly exceed dedicated financing. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the hospital insurance (HI) trust fund (which finances Part A of Medicare) will be exhausted in 2019. There is no provision to use general revenues to cover Part A services once the HI trust fund is exhausted. Consequently, either those expenditures will have to cease or some new source of financing will have to be found. For other parts of Medicare (Part B and Part D), general tax revenues and premiums automatically increase with expenditures. Those automatic increases will impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing, and on taxpayers in general. For example, if income taxes remain at their historical average share of the economy, the Medicare trustees estimate that the program's share of personal and corporate income tax revenue would rise from 10 percent today to 24 percent by 2030.

Figure 1. Medicare faces serious challenges with long-term financing

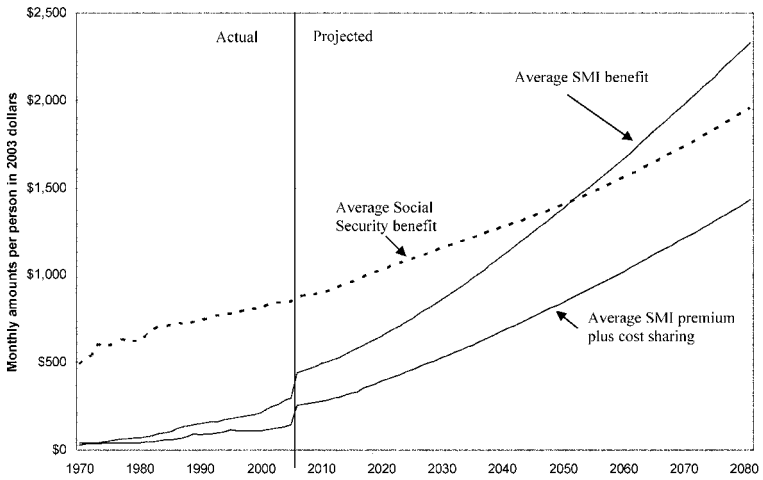


Note: GDP (gross domestic product), HI (Hospital Insurance). Tax on benefits refers to income taxes that higher income individuals pay on Social Security benefits that are designated for Medicare. State transfers (often called the Part D "clawback") refer to payments from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2007 annual report of the Boards of Trustees of the Medicare trust funds.

Figure 2 shows that between 1970 and 2005, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average supplementary medical insurance (SMI) premiums plus cost sharing and average SMI benefits grew by annual averages of 4.5 percent and 5.9 percent, respectively. In the 2003–2006 period, Part B premium increases offset 20 percent to 40 percent of the dollar increase in the average Social Security benefit. For 2007, the increase in the Part B premium offsets 13 percent of the Social Security benefit increase. Medicare trustees project that between 2006 and 2036, the average Social Security benefit will grow by just over 1 percent annually (after adjusting for inflation), compared with 3 percent annual growth in average SMI premiums plus cost sharing.

Figure 2. Average monthly SMI benefits, premiums, and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs prior to 2006 is not included.

Source: 2007 annual report of the Board of Trustees of the Medicare trust funds.

Medicare's private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Through the use of coordinated care techniques, selected provider networks and negotiated fees, plans would be more efficient than the traditional FFS program. Efficient plans would be able to provide extra benefits to enrollees choosing to enroll in such plans, and this in turn would lead to higher plan enrollment. Unfortunately, MA has instead become a program in which there are few incentives for efficiency. Although MA uses "bidding" as the means of determining plan payments and beneficiary premiums, the bids are against administratively-set benchmarks. Setting benchmarks well above the cost of traditional Medicare signals that

the program welcomes plans that are more costly than traditional Medicare. Put differently, inefficient plans—as well as efficient plans—are able to provide the kind of enhanced coverage that attracts beneficiaries to private plans because of generous MA program payments. These additional payments are funded by all taxpayers. Furthermore, all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—pay higher Part B premiums to fund these payments in excess of Medicare FFS levels.

MedPAC's recommendations on private plans in Medicare and transition approaches

MedPAC has a long history of supporting private plans in the Medicare program. The Commission believes that Medicare beneficiaries should be able to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans may have greater flexibility in developing innovative approaches to care, and these plans can more readily use tools such as negotiated prices, provider networks, care coordination and other health care management techniques to improve the efficiency and quality of health care services.

The Commission believes that payment policy in the MA program should be built on a foundation of financial neutrality between payments in the traditional FFS program and payments to private plans. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. This approach underpins many of the recommendations that the Commission has made to improve the MA program, which are shown in the text box, p. 15.

Current MA program payment rates reflect previous statutory changes that provided for minimum payment levels in certain counties, which were often well above FFS levels. These inflated benchmarks, coupled with the distribution of MA enrollment across the country, undermine the goal of financial neutrality. Currently, program payments for MA plan enrollees are well above 100 percent of FFS expenditure levels: on average, MA program payments are at 112 percent of Medicare FFS levels. Note that benchmarks vary

by county, and so payment levels to plans vary among plan types, based on where their enrollment is concentrated. In 2006, payment levels ranged from 110 percent of FFS for HMOs to 119 percent of FFS for private fee-for-service (PFFS) plans.

To pay MA plans appropriately, the Commission recommends that benchmarks—the basis of plan payments in MA—should be set at 100 percent of Medicare FFS expenditures. The Commission first made this financial neutrality recommendation in March 2001. For the past several years, we have analyzed payments to private plans compared to FFS and have found consistently that plan payments exceed FFS expenditure levels.

The excess payments to private plans allow them to be less efficient than they would otherwise have to be, because inefficient plans can use the excess payments—rather than savings from efficiencies—to finance extra benefits that in turn attract enrollees to such plans. As shown in Table 1, enrollment has grown substantially in MA as result of this situation.

Table 1. Enrollment has grown substantially in the Medicare Advantage program in the last two years

Plan type	Enrollment			Net enrollment growth	
	December 2005	July 2006	February 2007	Dec. 2005 to July 2006	July 2006 to Feb. 2007
Local HMOs and PPOs	5,157,627	5,479,630	6,064,666	6%	11%
PFFS	208,990	773,553	1,327,826	270%	72%
Regional PPOs	None available	81,785	120,770	N/A	48%

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). Table does not include special needs plans or employer-only plans.

Reducing benchmarks would mean that plans could only provide benefits through their efficiencies relative to FFS. This would result in fewer plan offerings and less generous benefits. Because of the impact on plan enrollees, the Congress may wish to employ a transition approach in implementing the Commission's recommendation on payment rates. Possible approaches might be to (a) freeze all county rates at their current levels

until each county's rate is at the FFS level, with a possible minimum yearly update; (b) cap the percentage by which county rates can exceed FFS levels and then gradually lower the cap; (c) use a blend of 100 percent of FFS levels and Medicare Advantage county rates and gradually over time increase the portion attributable to 100 percent of FFS in the blend; or, (d) use competitive bidding to set rates, using plan bids as a factor in determining county rates.

Efficiency in Medicare Advantage and extra benefits

Historically, policymakers have tried to structure the Medicare private plan program so that efficient plans could provide extra benefits to plan enrollees. To the extent that a private plan could provide care more efficiently than FFS Medicare, the plan could use its efficiency gains to finance extra benefits—reduced out-of-pocket costs, and coverage of services Medicare did not cover, such as dental, hearing, vision services, and (most importantly before the advent of Part D) outpatient prescription drugs. The ability to offer extra benefits would attract beneficiaries to enroll in these plans. Having plans compete against each other would also promote efficiency. In a system in which plan payments are appropriately risk-adjusted, a richer benefit package would generally signal that one plan was more efficient than another competing plan—and that a private plan offering extra benefits was more efficient than the traditional Medicare FFS program in the plan's market area.

There are efficient plans operating in the MA program. Such plans are able to provide the traditional Medicare Part A and Part B benefit at a lower cost than the FFS program. As shown in Table 2, on average in 2006, HMO plans were able to provide the traditional Medicare benefit for 97 percent of Medicare FFS expenditure levels. Because, in 2006, HMOs had such a large share of the overall enrollment, on average across all plan types, the "bid" for traditional Medicare services was 99 percent of Medicare FFS expenditures.

Table 2. MA plan payments relative to Medicare FFS spending by plan type, weighted by enrollment, and plan enrollment, July 2006

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Bid (for Medicare A/B benefit) in relation to FFS	99	97	108	103	109
Rebate as percent of FFS	13	13	9	7	10
Payment (bid + rebates)/FFS	112	110	117	110	119
Enrollment (in thousands) as of July 2006	6,877	5,195	285	82	774

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Special needs plans and employer-only plans are included in all-plan total but plan data not shown.

Table 2 indicates the level of "rebates" or extra benefits that plans provide at no charge to the enrollee, expressed as a percent of Medicare FFS expenditures for the geographic areas from which plans draw their enrollment. These rebate amounts are determined based on the plan bid and its relation to the area "benchmark," which is the maximum program payment to an MA plan in a given county or geographic area and which is often well above the FFS level. If a plan is able to provide the traditional Medicare benefit package for less than the benchmark level, enrollees receive extra benefits valued at 75 percent of the difference between the benchmark and the plan bid for the Medicare package (with 25 percent of the difference retained by the Medicare Trust Funds). (Plans may also provide extra benefits that enrollees pay for through an additional premium to the plan.)

Except in the case of regional PPO plans, benchmarks are set at the county level. The benchmarks vary significantly from county to county, and the difference between a given county's benchmark and FFS expenditure levels in the county can also vary significantly, although in no case is the FFS level above the MA benchmark. Table 3 shows the ratio of benchmarks to FFS expenditure levels for the different plan types in July of 2006, based on the counties from which the plans drew their enrollment.

Table 3. MA benchmarks by plan type, compared to Medicare fee-for-service expenditure levels, weighted by enrollment, July 2007

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Benchmark/FFS expenditures	116	115	120	112	122

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service).

PFFS plans, for example, are primarily drawing their enrollment from higher-benchmark counties—specifically counties that were historically "floor" counties. MA benchmarks in these counties are established by statutory formula, resulting in benchmarks far above FFS expenditure levels in most cases. While PFFS plans are drawing enrollment from floor counties, HMOs are drawing their enrollment from counties where benchmarks are closer to Medicare FFS expenditure levels.

Enrollment trends in relation to payment

Within MA, PFFS is by far the fastest growing type of plan (see Table 1). If current enrollment patterns continue—with PFFS growing more rapidly than other plans and continuing to draw enrollment from higher-benchmark counties—the difference between Medicare FFS expenditure levels and MA payment rates will widen further. More enrollees will come from counties with very high benchmarks in relation to FFS. If continued, this enrollment trend will counteract the phase-out of the "hold-harmless" provision, which would otherwise narrow the difference between FFS and MA payment levels.

The hold-harmless provision affects risk-adjusted payments to MA plans. Plan enrollees, on average, are healthier than beneficiaries in FFS Medicare. Under the current system, though payments at the individual beneficiary level are fully risk adjusted for health status as of 2007, plans receive an additional payment during a phase-out period. During the phase-out period, plans are paid a portion of the difference between risk-adjusted payments and the payment that would have been made without the health status risk adjustment. This approach is being phased out over the next few years to move towards payments solely at the risk-adjusted level. The net result of phasing out the hold-

harmless provision would have been an overall reduction in average plan payments. However, we are concerned that the opposing MA enrollment trend could potentially eclipse the effect of the phase-out of the hold-harmless provision, and thus continue higher overall MA payments.

Varying efficiency among different types of plans

Table 2 also illustrates that there is varying efficiency among plan types in MA. While HMOs can provide the Medicare benefit at 97 percent of Medicare FFS costs, as noted above, not all plans achieve the same level of efficiency. At the other end of the scale from HMOs are PFFS plans. From a taxpayer point of view, PFFS plans are paid 9 percent more than Medicare FFS, on average, to provide the traditional Medicare FFS benefit package. Although PFFS plans provide enrollees with rebates valued at about 10 percent of Medicare FFS expenditures, program payments on behalf of PFFS enrollees are 19 percent above FFS expenditure levels—so only about half of the excess amount is used to finance extra benefits for enrollees. More over, all of the extra benefits provided by PFFS plans are financed by the overpayments.

For HMOs, what the 97 percent means is that, on average across HMO plans, some of the extra benefits are financed by rebate dollars that are generated because these plans can provide the Medicare benefit package more efficiently than the Medicare FFS program in the counties where HMOs have their enrollees. This also means is that, if benchmarks are reduced, there could still be extra benefits provided to enrollees in the MA program. It is not the case that, if benchmarks were reduced to 100 percent of FFS, no plans would be able to provide extra benefits. But as we pointed out above, there would likely be fewer plan choices and less generous plans in some markets.

Equity between sectors and among plan types

The Commission supports equity between the two sectors—the Medicare private plan sector and traditional Medicare. Supporting the principle of equity between the sectors takes many forms. For example, most of the private plans participating in Medicare are required to report various types of quality measures. The Commission believes that the same approach should apply in the traditional FFS program. That is, there should be

quality information reported for FFS Medicare that allows Medicare beneficiaries to compare FFS Medicare with private plans in terms of their performance on quality measures. To that end, the Commission has specifically recommended that the Secretary of Health and Human Services should calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans.

The Commission also supports the concept of equity in the treatment of different plan types. For example, the Commission recommended that the Congress eliminate the benefit stabilization fund, which provided an unfair advantage to the regional preferred provider organizations introduced in the Medicare Modernization Act (see text box, p. 15). Similarly, the Commission finds that, relative to other plans, there are advantages currently in place for special needs plans, PFFS plans, and medical savings account (MSA) plans in the MA program.

Table 4 illustrates the ways in which different requirements apply to different plan types in MA. In general, the Commission favors a level playing field for all plan types, with no plan type having an advantage over another plan type. The Commission believes, for example, that PFFS plans and MSA plans should be required to report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging these plans. Payment rules that give one plan an advantage over another—as described above with regard to regional PPO plans—should be eliminated. The MSA plan option raises this question: why are these plans not required to have 25 percent of the difference between the MSA plan bid and the benchmark retained in the Trust Funds, as is the case for other plan types?

Table 4. Different requirements and provisions apply to different types of Medicare Advantage plans

	PFFS	MSA	HMO/Local PPO	Regional PPO	SNP
Must build networks of providers			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have CMS review and approve bids			✓	✓	✓
Must return to the Trust Funds 25 percent of the difference between bid and benchmark	✓		✓	✓	✓
Must offer individual MA plan if offering employer group plan*			✓	✓	✓
Must offer Part D coverage			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries					✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), MSA (medical savings account), PPO (preferred provider organization), SNP (special needs plan).
*Effective as of 2008 contract year; requirement does not apply to PFFS and MSA plans.

Source: MedPAC analysis of MA statutory and regulatory requirements.

Efficiency in MA and broader equity issues

Some argue that paying plans more than FFS is a worthwhile expenditure because plans provide extra benefits to enrollees. While it is true that plans provide extra benefits, some equity and efficiency issues need to be considered. The overarching equity issue is that all beneficiaries and all taxpayers are paying the cost in excess of Medicare FFS when payments to plans exceed 100 percent of Medicare FFS expenditure levels. When MA rebate dollars exist only because MA program payments are far higher than expenditures in the FFS program—not because plans are being efficient—then the extra benefits are being funded through taxes from all taxpayers, and Medicare Part B premiums from all Medicare beneficiaries, not just those enrolled in these plans. Only

some Medicare beneficiaries, therefore, derive a benefit from the way in which the MA program is financed, while the majority of Medicare beneficiaries are paying for the benefits that only some beneficiaries receive. To quantify what this means, the Medicare actuary recently testified in front of the House Ways and Means Committee that on average every Medicare beneficiary is paying about $2.00 more per month in his or her Medicare Part B premium to finance the payments being made in MA that exceed Medicare FFS expenditure levels.

If the justification for higher payments to plans is that extra benefits are being provided to low-income beneficiaries who choose these plans, there are less more targeted ways to achieve this result—the Medicare savings program, for example, or the approach used for low-income subsidies in Part D. What is occurring now is that the most inefficient plans are expanding their enrollment, and providing extra benefits only with taxpayer dollars. In fact, these plans need additional taxpayer dollars just to provide the Part A and B benefit. The longer the current situation continues, the more difficult it will be to reform the program to restore the right incentives in the MA program to promote efficiency and improved quality. As millions of beneficiaries enroll in products shaped by the current policy, it will become ever more difficult to change direction. Put differently, a major expansion of Medicare benefits will have occurred without a discussion of who is eligible, what benefits to provider, and how to pay for them. As difficult as it seems today, it will be even more difficult next year or the year after. The constituency with a stake in the current policy, both plans and beneficiaries, will be that much larger. This is especially worrisome given that the most heavily subsidized and fastest growing plans are the least efficient ones.

If beneficiaries are able to choose between Medicare FFS and an array of private plans—and if the Medicare program pays the same on behalf of the beneficiaries making the choice—then over time, beneficiaries will gravitate either to the FFS system or to the plan that provides the best value in terms of efficiency and quality. The Medicare program would not subsidize one choice more than another. The Medicare program should be financially neutral regarding whether the beneficiary chooses to remain in the

FFS system or enroll in a plan. This neutrality provides beneficiaries with the incentive to select the system that they perceive as having the highest value.

The equity and efficiency issues that we have described here are of particular concern in an era in which Medicare is facing long-run sustainability issues. We should take all steps possible to promote efficiency in both FFS Medicare and in MA. The Medicare program should strive towards improving plan efficiency by paying appropriately, by ensuring a level playing field between FFS and MA plans and among MA plans. The basic question for us is, "What kind of plans do we need to participate in Medicare?" Given Medicare's sustainability issues, the obvious answer is more efficient plans. However, the current benchmarks are sending the opposite signal to plans and beneficiaries. Overpaying in the short run is never a strategy for achieving long-run efficiency.

Medicare Advantage recommendations from MedPAC's June 2005 Report to the Congress

MA recommendations from the June 2005 Report to the Congress are summarized below:

- A number of MMA provisions give the new regional PPOs a competitive edge over other plans, as well as added funding. One provision is the regional stabilization fund, initially funded at $10 billion. The Commission recommended that the Congress eliminate the stabilization fund for regional PPOs.

- Regional PPOs can have an advantage over local plans as a result of the MA bidding process. Because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans, and because of the bidding approach used for regional plans, there can be distortions in competition between regional and local plans. The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population.

- MA rates include medical education payments, but at the same time Medicare makes separate indirect medical education payments to hospitals treating MA enrollees. The Commission recommended that the Congress remove the effect of payments for indirect medical education from the MA plan benchmarks.

- The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans, with equitable payments among private plans. The Commission recommended that the Congress set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of fee-for-service costs. However, the Commission recognizes that higher MA rates reflect the desire of Congress to expand the availability of plans and that payment reductions may result in disruptions for beneficiaries and for plans, so that benchmarks may need to be adjusted differentially across the country.

- The Commission believes that pay-for-performance should apply in MA to reward plans that provide higher quality care. Funding can come from the amounts that are retained in the Trust Funds when plans bid below benchmarks, as recommended by the Commission in stating that the Congress redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.

- The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system. The Commission therefore recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans.

Another recommendation the Commission made in 2005 was a provision of the Deficit Reduction Act. This specified in statute the time line for phasing out the hold-harmless policy that offsets the impact of risk adjustment on aggregate plan payments through 2010.

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Chairman SPRATT. Let us explore for the record, first, exactly how the benchmarks are determined and why it is they differ from place to place and throughout the country, which is a great part of the source of inequity, or unevenness, in the payment scheme here.

Dr. Orszag.

Dr. ORSZAG. Sure. The existing benchmarks come from or are sort of the legacy of congressional changes that were made at various different points in 1997 and in 2000 and as part of the Medicare Modernization Act.

One of the things that happened was that Congress decided that there should be floors put in in particular counties, particularly and often disproportionately in rural areas, so that plans would have more ability to operate in those areas.

So the result today is that you have the legacy of that history embedded in benchmarks which are then updated from year to year, basically, by the national average growth rate in Medicare costs.

If Mark wants to add anything——

Chairman SPRATT. Is it correct to say that the benchmarks are set above FFS, fee-for-service?

Dr. ORSZAG. Yes.

Chairman SPRATT. In all cases?

Dr. ORSZAG. Yes.

Chairman SPRATT. So, to the extent that FFS already from county to county is uneven, the unevenness is exaggerated by adding benchmarks that differ from place to place on top of these uneven payments?

Dr. ORSZAG. Not quite, because relative to local fee-for-service costs, the benchmarks tend to be higher in the low fee-for-service cost areas than in the high fee-for-service cost areas.

Chairman SPRATT. Dr. Miller, would you like to comment on that?

Mr. MILLER. There is nothing really to add, and this was addressed, I think, some by Mr. Ryan's comments.

I mean, the benchmarks were created because the business case for managed care to go to rural areas was difficult to make when you have sparse beneficiaries. Your marketing costs are higher, and it is harder to create networks. And I think the original intent was, "Well, if we put these higher payments in these areas, will we draw plans?" then you have got something of a ripple effect as other areas wanted to get the higher benchmarks and try and draw plans to those areas, and then you basically would have a legislative history, as Peter laid out.

Chairman SPRATT. But the original idea was that more competition for enrollment would lead to better services, better choices, better outcomes, one would hope, and lower costs.

Mr. MILLER. Yes, and I tried to address this a little bit in my 5 minutes.

I think the original intent of the managed care plan—and you know, I will actually take this opportunity to make this point. We are saying that the benchmarks should be tied to fee-for-service, and I want to be clear. We do not think that fee-for-service is a highly effective, well-functioning system. Much of the work that we engage in at MedPAC is directed towards trying to make that system more efficient and more effective.

Chairman SPRATT. And this was one way that we sought to make it more efficient and more effective.

Mr. MILLER. Exactly. So I think the original intent of managed care was that I could come in as a managed care plan and do better

than this uncoordinated, duplicative system that does not focus on the patient. By managing care, putting together a network of providers who are oriented towards quality and lower resources, I will produce savings. Those savings, in turn, can be used to provide additional benefits. That was the original intent.

Chairman SPRATT. To the extent that the objective was to produce savings or to create efficiency and lower costs, does it make sense to have this incremental payment for the Medicare Advantage plans permanently paying more than fee-for-service Medicare? If so, does the program, the system, ever realize the savings?

Mr. MILLER. There are two comments from me on that.

The Commission's position is that the benchmarks need to come down to fee-for-service, and so our point is, no, they should not be above it.

Secondly, the Commission—and again, I tried to reference this—feels that all providers, not just managed care plans but that those on the fee-for-service side as well, should be under some degree of fiscal pressure so that they are always searching for efficiencies, improved quality. To the extent that any payment system—fee-for-service or managed care—does not put that kind of pressure on a provider, the Commission thinks it is not achieving the objectives in Medicare that it should be.

Dr. ORSZAG. Mr. Spratt, if I could just add: From the perspective of the Federal budget, given the current law system of financing Medicare Advantage plans and in order for the current system to actually save money for Medicare, the efficiency improvements that Medicare Advantage plans would have to achieve relative to local fee-for-service are so large that they are implausible.

So, in particular, Medicare Advantage plans would have to come in with bids that were on the order of magnitude of one half of local fee-for-service costs in order for the net costs to the Federal Government to be reduced as a result of Medicare Advantage plans. There are other dimensions along which you can evaluate Medicare Advantage in terms of quality of care, in terms of overall efficiency of the health care system, but for the Federal budget by itself, the result is that we are providing a benefit that raises net costs to a particular set of beneficiaries.

Chairman SPRATT. Dr. Miller, let me ask you.

Both of you mentioned the criticisms of your argument, that there is a differential here that is more than what was really intended. AHIP and the other insurance companies that are providers say that you have overestimated the differences between Medicare Advantage payments and fee-for-service medicine.

Would you take those points one by one and defend, both of you, the analyses you have made?

Dr. ORSZAG. Who would like to go first? All right. I will do it briefly. I think for us it is pretty straightforward.

There are a variety of assertions that are made. You can see them there. The first is that the bottom part, actually, that Congress raised rural and urban floor rates above fee-for-service, is what we were just discussing, and it does not reflect the accuracy of our analysis. It reflects an underlying reality that one of the things going on here is that you had various kinds of statutory interventions.

Chairman SPRATT. In other words, it is not, in fact, an additional cost, but it was one that was warranted from outside the program?

Dr. ORSZAG. That does not affect the analytical integrity of the comparison that is being made. There are other assertions that are made, for example, that CBO's numbers do not take into account the changes that were made with regard to the risk adjustment system or with regard to the physician payment fix.

With regard to the risk adjustment system, that is not correct. CBO's estimates reflect our March 2007 baseline, which incorporates the changes from the Deficit Reduction Act and the Tax Relief and Health Care Act.

With regard to the doctors' fix that was enacted, the SGR override, that override does not affect our numbers for 2008 forward, which is again the key thing for determining the budget numbers that I gave you.

So, as we go down the list one by one of the assertions that are made, they are either just wrong or disingenuous.

Chairman SPRATT. Dr. Miller.

Mr. MILLER. I agree with that characterization. There are just a couple of things that I want to add.

I mean this was used extensively in hearings and by the press to discredit our numbers, and I want to be really clear for the record that we stand by our numbers. We believe that the "112 percent" is correct, and I just want to add a couple of things to what Peter said.

The basic argument on the budget neutrality adjustment, the assertion of the industry, is "do not do anything because, over time, my payments will come down."

Chairman SPRATT. Let me stop you here because this assumes a knowledge that a lot of us do not have.

Mr. MILLER. Oh.

Chairman SPRATT. You might start with the Deficit Reduction Act, risk adjustment of payments and things of that nature.

Mr. MILLER. I am happy to hit it. I just did not want to take up a lot of your time, and I will keep this as brief as I can. So where this came from worked like this:

Whenever you have enrollment in a managed care plan, you can get different types of patients or beneficiaries, say a very healthy 65-year-old or somebody with multiple conditions and complications. And so what the payment system is designed to do is to adjust for the relative risk of a patient who gets enrolled.

There was an implementation of a new risk adjustment system, and it would have had the effect of lowering overall payments for the industry as a whole because, on average, enrollment was tilted towards healthier beneficiaries. There was a decision made not to allow the payments to come down.

You know, we analyze things like this, and we went through it and said, no, if the risk adjustment says that the beneficiaries are less sick or more healthy, the payments should come down. We made that recommendation. Congress took it up as part of the DRA. So, all things being equal, this might lower the payments. So the industry's point is it is going to go down, do not take the benchmarks down. But there are also trends that are counteracting this.

Enrollment is moving into high-payment areas, which has the effect of increasing payments over time. So our point is that this is not necessarily going to play out the way people thought it would, and I would offer one piece of evidence. We did the analysis on 2006 data, and we got 12 percent above fee-for-service. The CBO folks did the analysis on 2007 data, so you would expect it to come down. It did not come down. They also arrived at 12 percent, and I think I am characterizing that fairly.

Dr. ORSZAG. Yes.

Mr. MILLER. I also want to say—is that what you needed before I go on?

Chairman SPRATT. Absolutely. Go ahead.

Mr. MILLER. Okay. All right.

Chairman SPRATT. By "12 percent," we are talking about 12 percent above fee-for-service?

Mr. MILLER. Above fee-for-service, absolutely, this 1 percent underestimate from the change in the doc payment, that was taken into account in our number.

I would also point to the floor. He is absolutely correct that that is a question: Does Congress want to put those floors in place? But we also think that that number on the table is wrong, that those floors account for much more of the overpayment than is represented on that chart.

Chairman SPRATT. Thank you very much.

One final question, Dr. Orszag. If we could, put back up in closing—not "closing" because others have questions, but just to wrap up with me—the chart estimating the cost differential over a period of 10 years equaling, eventually, $149 billion cumulative. Do we have that chart?

Dr. ORSZAG. Yes, chart 3. Yes, that one.

Chairman SPRATT. Would you walk us through that again?

Dr. ORSZAG. Sure.

What this shows you is you currently have this wide variety of benchmarks relative to fee-for-service costs. If you limited the benchmarks to different ratios relative to local fee-for-service, what would the reduction be compared to current law?

So, if you said in every area the benchmark is no more than 100 percent of local fee-for-service, the reduction in the budget savings basically over the next 5 years would be $54 billion, and over the next 10 years it would be $150 billion.

What is noteworthy about this table is—and it is in addition to those sets of numbers—if you look down, other highlighted figures show you that even at ratios of 130, 140, and 150 percent limits, if you put in a 150 percent limit, you are still saving money, which tells you that there are some areas of the country in which the benchmarks are more than 50 percent above local fee-for-service costs, which was the purpose of highlighting that bottom row.

Chairman SPRATT. Now, does this assume the expansion of enrollment in Medicare Advantage programs that you outlined earlier going to 26 percent?

Dr. ORSZAG. These figures assume our baseline. And just to underscore what Dr. Miller said, one of the reasons that even with the phase-out of the "hold harmless" provisions on the risk adjustment that you still get numbers like this is that enrollment is

growing very rapidly, and my other chart showed you disproportionately in private fee-for-service areas which tend to have higher ratios of benchmarks to fee-for-service costs than other types of Medicare Advantage plans.

Chairman SPRATT. Okay. Thank you both very much.

I have one question for the record, Dr. Miller, that the Energy and Commerce Committee has asked to submit:

Has MedPAC looked into the physician access problems in the Northwest? If so, have you found that these problems are specifically related to Medicare patients or do they impact both Medicare and privately insured patients?

Mr. MILLER. MedPAC does a couple of things—and I am going to answer your question—but we do an annual survey of beneficiary access across the country, and just recently we did a survey of physicians to look at access for Medicare beneficiaries. And we generally find across the country that access has remained stable and comparable to the privately insured. And I can go through more details if anyone cares.

We do not have a strong ability to go in market by market, and we know that there are markets where there are concerns about access to physicians. However, other analysts—and I have in mind right at the moment Health Systems Change, the group that is run by Paul Ginsburg—have looked at some of this; and some of their conclusions were that markets like the ones you are talking about are really the effect of broader demographic changes. These markets are often experiencing very rapid increases in population. Sometimes it is retirees moving to the areas. And so the general access to physicians is compromised, not as a specific result of Medicare policy, but I want to underscore this is based on analysis that other organizations have done. We have not directly looked at that area of the country.

Chairman SPRATT. Thank you very much. Others now may have questions.

First, Mr. Ryan.

Mr. RYAN. Thank you, Chairman.

I remember this vividly. I serve on Ways and Means as well, and we went through all of this, back and forth, as to how to make these payments rates. If you remember from, you know, a 1997 law, we had this Medicare Plus Choice program, and all of us probably had a county where plans came in, where people were pretty happy, payments changed; you had, you know, one county with this number and another county with that number, one State with this, one State with that. And then plans left, and our constituents were very upset.

So we had this huge rocky road of private plans coming in and out because you had this uncertain payment system. So that was then.

What we have now is—the idea was a more certain payment system. Then the rural Members of Congress—and this was a bipartisan thing. The Rural Health Care Coalition, I think it is called, really wanted to get these plans into the rural areas. And because I do not have my glasses, I could not see your second to the last chart, and we do not have a hard copy of it.

So, really, Dr. Miller and Peter, because your numbers are very similar, I am trying to get a handle on how much of the 12 percent overpayment, or whatever we want to call this—12 percent additional—is attributable to the rural enhancements that were a conscious decision by Congress to enact.

Mr. MILLER. I am not sure I am able to quantify that on the spot for you. I would say that it is a function of a couple of things. It is definitely true—and Peter made this point early on—that the benchmarks, the floor, are the results of the floors, and the floors and the benchmarks tended to be higher in rural areas. How much ends up being actually attributed to the rural areas is dependent on how much enrollment occurs in the rural areas and then how the plans bid relative to those benchmarks in rural areas. I cannot toss off a number.

Mr. RYAN. It would be helpful to get that because that was a conscious decision by Congress in 2003, and I would just like to know what the price of that policy preference was with respect to these overpayments.

Peter, did you want to add to that?

Dr. ORSZAG. I would just add again, if you look at the benchmark relative to fee-for-service costs, in high-cost fee-for-service areas, that difference is about 4 percent. In low-cost fee-for-service areas, mostly because of the policy interventions that Congress adopted, it is 26 percent.

Mr. RYAN. Oh, really?

Dr. ORSZAG. So you can see that there are very significant differences in that differential across the country, and the low-cost areas have a higher differential, and actually we have data on where the low-cost areas are, so you can start to——

Mr. RYAN. That would be interesting to get a handle on, because then we would know what this conscious decision—and I think these numbers have exceeded what people expected, to be sure, but it would be interesting to know how much is attributable—thank you, I finally got a hard copy of this—how much would be attributable to that.

Another question for both of you, but for particularly Dr. Miller. CMS has 22,000 employees who run Medicare and Medicaid. Last year, we provided CMS with $3.2 billion for their administrative costs to run these programs. The Medicare Advantage plans do not receive additional subsidies for administrative costs, and so they have to embed those administrative costs within their plan bids.

When calculating these payment differentials between traditional Medicare and Medicare Advantage, does MedPAC, and CBO for that matter, include the CMS costs, administrative costs, so we sort of have an apples-to-apples comparison on that?

Mr. MILLER. Yes, we do.

Mr. RYAN. You do.

You do as well?

Dr. ORSZAG. Yes, and I would just note—I mean, to the extent that there are administrative cost differentials, that does not undermine the fact that these plans cost the government more than the traditional fee-for-service program.

Mr. RYAN. Right. I am just trying to see if we have disaggregated these things. So to me that is pretty significant.

What would be the difference between Medicare Advantage and fee-for-service if the traditional program—the government program—had disease management, coordinated care, mandatory quality reporting and improvement, and out-of-pocket caps, as are found in many Medicare Advantage plans? That is, how much would the difference be reduced if traditional Medicare did all of the things that Medicare Advantage does?

The key thing I am trying to understand here is apples to apples. With Medicare Advantage, the beneficiary kind of gets it all in one plan, meaning they get their Medigap insurance or the equivalent of that. They get their Part D plan in all but the fee-for-service ones, and they get a part A and a Part B. So that is the one comprehensive plan.

You know, what would be the cost differential if we assumed apples to apples over on the traditional program, including all of those other things—the supplementals, the part Ds and the As and the Bs?

Mr. MILLER. All right. There are a couple of things that I think—and actually, let me be very direct.

I cannot quantify that, but I think there are some things that we should talk out in thinking about that. I mean, first of all, some of the argument of managed care plans are that they engage in these types of activities, because over the long haul, it is supposed to produce savings. So if you manage disease and you coordinate care, the whole idea is that, actually, costs would be lower over time. That is kind of what the business—that is kind of what the business model is about.

The other thing I would say is that you are saying, at least on the quality front, well, what if fee-for-service were required to do this? More and more, fee-for-service providers are being required in Medicare to do it. For example, in hospitals, if they do not report—I cannot remember whether it is 22 or 24 health/clinical process measures—their update is lowered by a certain percentage. So some of this is going on. Incidentally, our work——

Mr. RYAN. That cost is not being borne in the traditional fee-for-service program as we measure it to Medicare Advantage, though. I mean the 24 is a cost that is borne by the hospitals.

Mr. MILLER. It is borne by the hospital, right; and just like we are saying that the quality metrics that the health plans have to provide are borne by the health plan, and that is part of their administrative structure.

I am just trying to say that while it is not a uniform requirement in fee-for-service—and on that point, you are absolutely right—more and more, there is a push to require quality reporting on the fee-for-service side, and as a Commission, we have been arguing strenuously that that needs to happen, which I know does not give you the quantitative answer that you want.

One other thing I would say is that you are right, that a lot of plans have, say, out-of-pocket caps and that type of thing, catastrophic caps. But the other thing that is somewhat concerning about this is you can find also plans where we are paying this additional amount, and the beneficiary ends up, depending on their health path, being exposed to higher cost-sharing than they would actually experience under traditional fee-for-service. There is no

guarantee that when you walk in with these plans, even with the higher payments, that you are, you know, protected—I am sorry—from the additional out of pocket. I am sorry.

Dr. ORSZAG. That is okay. I would just add two things quickly.

One, it is clear that a lot of plans are doing a lot of these activities, and effectively we are sort of running a public experiment. We are providing them Federal Government money, and then the plans are going off and doing things, some of which may actually work. But we do not have sufficient reporting requirements, given the amount of Federal money that is going into these experiments, if you will, to see what works and what does not, and it seems like that may be something worth exploring.

The second point I would note is the evidence that we do have that some of these programs—for example, the coordinated care demonstration project that was conducted under Medicare—actually reduce costs as opposed to improve quality still remains to be seen. The evidence from that demonstration project is suggesting that the programs, for example, on coordinating care do not, on net, reduce the cost of care delivered even when you have a nurse kind of centralizing your care and keeping track of things. So I would just sort of be waiting for more empirical data, which the plans, if they were required to report more, could basically serve as little laboratories for it.

Mr. RYAN. That is kind of where we are with this.

You know, the idea here is comprehensive care where you have your care coordinated within your plan, and you have the right kinds of incentives—disease management, you know, preventative medicine—and that, over time, this is good for the beneficiary and good for the taxpayer. The traditional program, you know, is sort of silos. You have got to go out and buy your supplemental; then you have to go out and buy your Part D; and then you have your Part B premiums and this and that. So it seems like we still have not gotten our quantitative tools available yet that will really give us a good measuring of this.

One of the reasons I think you were selected to be the director of CBO, Peter, is you are an expert on health care, and this is an area where I think we all—and we are encouraged and are looking forward to the modeling that you are working on with respect to health care modeling.

Give us an idea of where you think you are on better quantifying these things like disease management, preventative medicine and risk management. Where are we in getting a better idea on how to measure these things, which are kind of an intangible, but we know intuitively that these things are good things? How is it that we can get to the point as policymakers where we can make good judgments on good health care policy, and we can see the kinds of savings that we think we would get?

Dr. ORSZAG. Well, first, let me just say there are many mornings when I wake up wondering precisely why I was selected to be the CBO director and why I thought that was a wise move. But in any case, let me just say that I think that there is progress being made, but there is substantially more that could be done.

I think, perhaps, on Tuesday I mentioned vastly expanded comparative effectiveness research where you are examining outcomes

and what works and what does not, provides a significant step forward that Congress could be exploring and expanding upon.

With regard to CBO's own internal efforts, we are increasingly moving towards becoming the Congressional Health Office, as you know——

Mr. RYAN. Right.

Dr. ORSZAG [continuing]. And shifting staff into the area and doing more modeling. We are, though, dependent on in many cases the outside empirical knowledge, and we have not yet moved to a state of the world where there is enough data available at a finely disaggregated level to be examining all of the questions that need to be examined.

So there is progress, but we are still pretty far from where we should be.

Mr. RYAN. Dr. Miller.

Mr. MILLER. Yes, if I could just say a couple of other things on this front, and I just want to reinforce a couple of points that were just made.

You know, the notion of collecting quality data uniformly across plans—which does not happen—and uniformly between fee-for-service and managed care is part of what needs to happen here so that we know, and we have made recommendations along those lines.

Another way to think about it is trying to have the payments vary to the plans—and by the way, we have made recommendations on the fee-for-service side—but to the plans based on their quality outcomes. If you want to pay a plan more, how about a plan that produces a higher quality outcome—and we have made recommendations along those lines—which then may also drive some evidence. If you find a plan with higher quality metrics and you are paying them more, you can look at what they are doing.

Finally, I just want to also strongly make the point on the comparative effectiveness. We just in our recent report have made a recommendation to move forward on comparative effectiveness. And I just want to be sure that I endorse that, because I think that is a direction we need to go.

Mr. RYAN. Great. Thank you. That is very helpful. Thank you very much.

Chairman SPRATT. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Mr. Chairman, under the Republican leadership in the House for the last 12 years, we have had a number of economic theories passed into law, and it is interesting to look at the difference between the theory and the reality. One theory was that we could pass trillion-dollar tax cuts, fight a war on terrorism, and balance the budget. That theory proved to be absolutely wrong, and we ended up turning the largest surpluses in American history into the largest deficits in American history.

Then in 2003 at 3:00 o'clock in the morning, with 3 hours of arm-twisting, after the vote should have ended—arm-twisting by Mr. DeLay—we passed into law the largest increase in entitlement spending for Medicare in the history of that program, based on the theory that tax subsidies for Medicare Advantage would somehow save taxpayers money.

Then, I think, just a few minutes ago, I heard my colleague Mr. Ryan refer to Medicare Advantage—and I put this in direct quotes—"while saving Medicare money and saving taxpayers' money." That was the theory in 2003 and apparently the theory this morning.

Dr. Orszag, I want to ask you: On average—not theory, but fact. On average, how much extra tax-funded subsidy is there per Medicare recipient under Medicare Advantage versus fee-for-service per person on average?

Dr. ORSZAG. Again, roughly, 12 percent.

Mr. EDWARDS. How about dollars, actual tax dollars per person? An average, ballpark.

Dr. ORSZAG. I am told about $1,000.

Mr. EDWARDS. So $1,000 more cost per taxpayer in America today for every person who—under this theoretical program that was going to save taxpayers money, it is $1,000 per Medicare recipient as an extra cost to the taxpayer.

How much is the total cost to taxpayers for the Medicare Advantage program as compared to the fee-for-service are we talking about in fiscal year 2007?

Dr. ORSZAG. This year—I will give you the calendar year number. We can get the fiscal year number. The total payments are about $75 billion. I think I said $77 billion.

Mr. EDWARDS. But the extra cost compared to if we had everyone under fee-for-service. What is the extra cost this year in fiscal year 2007?

Dr. ORSZAG. Something like $10 billion.

Mr. EDWARDS. Somewhere around $10 billion.

Am I correct that you both testified that over 5 years, Medicare Advantage is an additional $54 billion cost to taxpayers—is that correct—compared to fee-for-service?

Dr. ORSZAG. That is correct.

Mr. EDWARDS. Am I correct that the number—let me just get the facts on the table here.

Are we correct that your testimony today says that, over 10 years, Medicare Advantage will cost $149 billion more relative to if we had a fee-for-service for all Medicare recipients? Is that correct?

Dr. ORSZAG. That is correct.

Mr. EDWARDS. One hundred forty-nine billion dollars.

So, rather than the theory of saving taxpayers money and, quote, "saving Medicare money," the data prove that it is actually costing more than $10 billion more to taxpayers this year, $149 billion over the next 10 years.

Mr. RYAN. Would the gentleman yield for a friendly clarification?

Mr. EDWARDS. In just a moment. If I can just finish. The gentleman has had two opportunities——

Mr. RYAN. Well, you invoked my speech.

Mr. EDWARDS. All right. I would be glad to give you 30 seconds, and then I am going to continue. Yes.

Mr. RYAN. What I was talking about in the $3 billion savings number is the bid system where 75 percent of the savings goes to the beneficiary, that was about $1,000 in benefit and premium reductions, and 25 percent goes to the taxpayer. That is the $3 billion

figure I am saying. I am not suggesting that, net, the program is $3 billion lower. I am saying that the system——

Mr. EDWARDS. Okay. So, when you said "saving taxpayers money" in your testimony and "saving Medicare money," you were talking about savings within one part of the program.

Mr. RYAN. That is right. That is what I was talking about. When you are under the benchmark, the 25 percent goes to the taxpayer, and the 75 percent goes to the beneficiary. It is that part of——

Mr. EDWARDS. I understand that. So then you would agree with the data that has been presented here today that, overall, the plan that was passed in 2003—largely on a partisan basis—is costing taxpayers $1,000 per Medicare beneficiary more per person.

Could I ask one other question? I do not know how you define it—"administrative costs"—and compare that in profits within the public versus private sector.

Is there some kind of comparison—we are all together, on a bipartisan basis, looking for efficiencies. Can you tell me what the administrative costs are for the Medicare program fee-for-service versus the administrative costs for the Medicare Advantage program? Is it more efficient? Do we have lower administrative costs, including profits, under the private part of the system compared to the publicly managed part of the system?

Mr. MILLER. I think—and I do not have a lot of precision on what the profit margins—in fact, I do not have any precision on the profit margins on the private side, but it is generally understood that the administrative costs—you know, overhead, marketing and profits in the managed care plans—are higher than the costs of administering the Medicare program.

Mr. EDWARDS. Do you know how much higher? A ballpark, either in percentages or numbers?

Mr. MILLER. I really do not. The plans submit bids, and I believe that there is data that it has on medical cost ratios that—or medical loss ratios that are submitted as part of the bid that CMS reviews, but that information is not publicly available.

Mr. EDWARDS. Okay. I thank you.

Chairman SPRATT. Mr. Hensarling.

Mr. HENSARLING. Thank you, Mr. Chairman.

One, let me sincerely thank you for holding this hearing. As I see Dr. Orszag's child over there, she looks roughly to be the age of my own daughter. And I have been very, very concerned about the impact that runaway entitlement spending is going to have on future generations, and I know we all care deeply about our children and our grandchildren. We just perceive their interests, obviously, in varied ways.

So, since the budget that was passed out of this committee was stone-cold silent on the subject of doing anything to reform entitlement spending, I welcome this hearing, and I welcome the opportunity to learn more about the subject matter at hand.

I must admit, in listening to my good friend from Texas here and his statement, I was interested to hear about the sensitivity on the vote for the prescription drug benefit in 2003, since yesterday we had a vote left open on the Udall amendment in order to persuade people to change their opinions. So I am glad to see that that continues.

Ms. DELAURO. Five minutes versus 3 hours.

Mr. HENSARLING. I am sorry. I thought the time was mine, Mr. Chairman.

The purpose was the same. So, if there is a difference in the time, I am just appreciative of the sensitivity of my friends on the other side of the aisle. And although certainly this prescription drug benefit program is of massive cost for those who criticize it, I at least remember looking at the CBO scores at the time of the Democrat alternative, and was interested to discover that it cost even more. So I would invite my friend from Texas and other friends on the other side of the aisle to look into that.

Dr. Orszag, the question that I have here for you—I understand there is insufficient data as of today, and I certainly am interested in receiving more information from you and Dr. Miller on perhaps legislative incentives to ensure that we have, I believe, uniformity and quality of data in order to judge some of these policy options, but at least in the time that I have been a Member of the House of Representatives, every medical professional with whom I speak all believe that the long-term solution to the health care crisis is to be found somewhere in preventative care and incentives for wellness, which, according to your testimony, is what we see in a number of the Medicare Advantage plans—disease management, care coordination and preventative care programs. At least to those who know more about the subject than I do, they claim that is the long-term solution.

So, number one, is it a possibility that the program is working and we just do not understand it is working because we have insufficient data? I guess the other part of the question is: Could it be that we have a very good model, and we have just overpaid for the model?

Dr. Orszag.

Dr. ORSZAG. I am not going to comment on the structure. That is obviously up to you. Again, my job is just to tell you what the budgetary implications and other implications are without the normative term of "good" or "bad."

With regard to preventative medicine, I would say a couple of things. One is—and we could provide more information to you on this topic. I hold out a lot of hope for prevention and healthy living to ultimately improve health. The impact on health care costs, at least to date from existing programs, is much more ambiguous than we would like. In part, the reason is that you first need to have an intervention actually work for a particular subset of the population. Often when you are doing preventative medicine steps, you are finding things that require additional health care costs because you screen people for something and then realize they actually require something more, and that can offset it. Then you are often applying the screen or the test, or what have you, across a wide variety of the population, not just the subset of the population for which it will make a difference. And that entails cost, too.

When you incorporate all of those effects, the evidence on preventative medicine's actually reducing costs as opposed to improving quality is not as hard as we would like, and we are constantly looking for better information.

So, again, I want to hold it out as a possibility and just say CBO is constantly monitoring developments.

Mr. HENSARLING. If I could, also in your testimony you talk about, over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in the private sector health market. When I looked at the size of Medicare, Medicaid, the VA health care system, isn't this possibly a case where the tail is wagging the dog, that government is so involved in our health care system that they are driving the cost trend?

Mr. ORSZAG. The point of that sentence was to say the two systems are so integrated it is not plausible to me that you are going to reduce Medicare and Medicaid costs sustainably over a long period of time unless you are affecting overall health care costs.

And I would agree, in many situations the public programs are large enough to affect how medicine is practiced. So, for example in Medicare, moving to the DRG system, that is, a fixed payment per episode for inpatient hospitalizations, created incentives to shorten hospital stays for Medicare patients; it wound up shortening hospital stays not just for Medicaid patients, but for everyone because it affected how hospitals operated.

Chairman SPRATT. Mr. Cooper.

Mr. COOPER. I want to thank both witnesses for the excellent work of their groups, both CBO and MedPAC are essential for our understanding of these entitlement programs.

I would like to focus first on Dr. Orszag's slide No. 2, if that could be put up there. It seems like the core abuse are these private fee-for-service plans that receive the higher reimbursement, and in return, don't really offer any of the managed care improvements that we thought we were paying for.

So I would like to ask if we can quantify how much savings it would be if we eliminated the excess reimbursement for these private fee-for-service plans.

Mr. ORSZAG. Yes.

For example, if you took private fee-for-service plans and you paid them at 100 percent of local fee-for-service costs, we estimate that the budget savings over 5 years would be $14 billion and the budget savings over 10 years would be $43 billion.

And as I mentioned in my oral, and it is also in my written testimony, one gets almost as much as those numbers by changing the way that private fee-for-service is allowed to operate and not allowing the so-called deeming provisions where private fee-for-service plans automatically get access to the payment rates that have already been negotiated by Medicare itself in the traditional fee-for-service part of the program.

Mr. COOPER. So if we were to eliminate the worst abusers of the system, the savings would be a fraction of the overall savings that you have listed in your Chart 3?

Mr. ORSZAG. That is correct.

And part of the reason there again is, even though private fee-for-service is growing really rapidly, it is still the case even in 2017, under our projections, that HMO and PPO-type plans account for more people than private fee-for-service plans, even in 2017, as I think you can see from the chart.

Mr. COOPER. I was just looking at the chart. It looks like a larger piece of the puzzle than the numbers suggest.

Mr. ORSZAG. Well, again, one way of—sorry, if you go back to that, again, if you are looking at, let's call it—$43 billion compared to roughly $150 billion for the 10-year figures overall, is, you know, a little under a third. It is not that disproportionate from the relative enrollment rates.

Mr. COOPER. Is there a way to distinguish between managed care Advantage plans that are appropriate and fee-for-service plans that are inappropriate? Do they declare themselves and say, hey, I am committing fraud on the system? I don't think so.

What other disguises could these private fee-for-service plans use in order to gain the extra reimbursement without doing the work?

Mr. ORSZAG. Well, again, one of the things that is interesting about this option that I mentioned in my testimony: By taking away this deeming provision, by necessity, the private fee-for-service plans or whatever they would then be called would have to negotiate—basically create their own network. So they would effectively become something akin to a PPO-type of organization.

So the distinction between private fee-for-service and other types of Medicare Advantage plans has a nontrivial amount to do with the fact that the private fee-for-service plans can just piggyback off of the rates that Medicare has already negotiated.

Mr. COOPER. In earlier versions of Medicare managed care, we only reimbursed at roughly the level of 95 percent of fee-for-service.

Mr. ORSZAG. Correct.

Mr. COOPER. How much would the savings be if we took it back to that level? They would be larger than the numbers you have on the chart.

Mr. ORSZAG. We have not estimated that, but we could provide an estimate of that for you.

Mr. COOPER. That would be very helpful.

You referred to the overall Medicare price structure, and that is on your Slide 4, which you did not use in your testimony. I think members of the committee should focus on that, if you would put up the slide.

I think members should find this chart very instructive because some areas of the country are reimbursed at much higher levels than others. This isn't a recent phenomenon. This has existed for the entire history of the Medicare program. This is fundamental to all the costs of the program, and if better health was correlated with higher reimbursement, that might not be a problem, but oftentimes it is an inverse correlation.

The white areas on the chart with the lowest reimbursement have the healthiest populations. So that is a fundamental entitlement problem that this committee and others should be addressing.

But obviously with our friend from Texas and Florida and other areas of the country that are the darker colored on the chart—and Tennessee is somewhat darkly colored—we have problems in adjusting this formula, the basic formula, to achieve better health outcomes for our people.

Mr. ORSZAG. I think that the variation that you can see in this chart, which is very substantial and which does not—cannot be explained by the underlying riskiness of the patients in the different

areas and which does not translate into better health outcomes in the darker regions than the lighter regions, presents the most substantial opportunity to reduce health care costs without harming health outcomes. It is, I think, very compelling evidence in favor of that perspective.

So it is stunning that embedded in the long-term fiscal challenge facing the country is an opportunity like that one.

Mr. COOPER. Let me say, "amen," Mr. Chairman.

Mr. MILLER. The only thing I would say, this is not a managed care point. At the Commission, we try to focus on—we do a lot of focus on fee-for-service, and we are trying to move the Medicare system to payment mechanisms that are sensitive to these differences that would reward those areas of the country that have high quality outcomes and low resource use under the fee-for-service system so that you would see some of this change and then would also make the case for—I have to raise these—take away the need to raise some of these floors on the managed care side.

Chairman SPRATT. Mr. Conaway of Texas.

Mr. CONAWAY. Thank you, Mr. Chairman.

Dr. Miller, you have in your testimony, as well as in the written information, used the word "efficiency." It seems to be related directly to cost.

Can you flesh that out for me a little bit.

Mr. MILLER. Efficiency—and you are correct, I have been using it in this instance to refer to cost.

In a perfect world, and in most of our work, we use "efficiency" to refer to high quality, low cost. What I am specifically referring to when I say that is, in the bids that plans submit, they say how much they would charge or they want to be paid to deliver the traditional fee-for-service benefit.

And, for example, in the private fee-for-service plans, the reason I said they are inefficient and definitely a cost concept—you are very clear on this—is because we have to pay so much more to them to deliver the traditional fee-for-service. So I think that was the point.

Mr. CONAWAY. So you are not saying that the highest efficiency plan would be one that costs zero but provides the best care. I mean, that is irrational, the highest efficiency plan would be one that costs nothing, but provides the best care possible.

Mr. MILLER. I would just say it a little bit differently. The highest quality with the lowest cost would be the best efficiency.

Mr. CONAWAY. On Chart 2, it flattens out. There is a big jump. Can you tell us why that happened? And why does it go flat?

Mr. ORSZAG. One of the explanations is that private fee-for-service plans currently have a variety of opportunities that could be taken advantage of in moving into various different areas, and we project that as they exhaust those easier opportunities, the growth tapers off.

I would note, however, that I think there is significant potential for our projections to be too low on the projected growth, including especially in private fee-for-service plans. There is very significant potential for it to be higher than that.

Mr. CONAWAY. My colleague from Tennessee said that dark blue area was fraud; is that right?

Mr. ORSZAG. I am not going to use terms like that.

Mr. CONAWAY. These are folks who are playing by the rules we put in place. We have got bad rules in place to allow them to manage or orchestrate their business models to take advantage of it; but under our current system, that is not fraud is it, Jim?

Mr. COOPER. I think these plans acknowledge that they are not even intending to offer the additional services that would be offered by an HMO.

Mr. CONAWAY. Fraud is a term of art that you as a lawyer understand, and it was subject to being reined in by existing issues.

This chart, now, we talk about—this goes from the $32 trillion for today's unfunded mandates to 54 trillion in 5 years. Most of our conversations talk about 30 or 40 years out.

Either of you have recommendations that we could not let that happen over the next 5 years?

Mr. ORSZAG. I will say the following, and I think this is obviously a much broader topic; but CBO is increasingly focusing on providing options for you that may help bend that curve.

We do not—over the long term in terms of health care cost growth, we do not know enough today to know what would reliably help bend that curve, but there are several things that seem auspicious that need to be tried and could be tried and then examined, including on both the provider and the consumer side.

On the provider side we are currently paying for Medicare on a fee-for-service basis. We don't know whether we are always getting the highest value for that payment. Expanded comparative effectiveness research tied to changes in incentives for providers could help move towards a higher value-lower cost combination.

On the consumer side, one of the striking things that has happened over the past three decades is, out-of-pocket expenses as a share of total health care spending have plummeted and they are now about 15 percent, under half of what they were a couple of decades ago. The evidence suggests that has driven up health care costs. So reversing that would also help to bring down health care costs.

Mr. CONAWAY. Take one for the record, because I am going to run out of time before you can answer it; and that is, physician access across time as baby boomers qualify for Medicare, one of the concerns is, there are going to be fewer and fewer physicians available who will continue to leave their practices open.

Can you get some information back to the committee about your projections, based on the number of folks in school, the doctors and all of that stuff—in terms of access when the baby boomer bulge hits the 65 bracket?

Mr. ORSZAG. We know that the flow of people going through medical schools has been pretty flat and the share of general practitioners, in particular, coming out is down.

Mr. CONAWAY. I yield back.

Thank you, Mr. Chairman.

Chairman SPRATT. Mrs. Schwartz.

Ms. SCHWARTZ. I want to follow up on some of the other points that were made and see if we can—I will ask a few questions.

You have made the point there are 35 million beneficiaries in fee-for-service Medicare, traditional Medicare, and about 8 million,

about 18 percent in this special managed—well, it has been called managed care, but Medicare Advantage.

Isn't it true that the greatest growth in this Medicare Advantage is actually in the private fee-for-service?

Mr. ORSZAG. Even during this year, as one of my charts showed, that subcomponent of Medicare Advantage plans added more than 700,000 beneficiaries. So they are growing; they started small, but relative to that small base, they are growing at a very rapid rate.

Ms. SCHWARTZ. That is a group that is not claiming to do any managed care or coordinated care, but not only that, has the least oversight or the least rules and least accountability back to Medicare, to CMS, to be sure that they are giving anything extra to their beneficiaries.

Is it true that we don't know whether they are in fact providing either additional benefits or better outcomes?

Mr. MILLER. I think there are a couple of things.

They don't have the same data requirements on quality of care. CMS is not—cannot do the same oversight to the bids that they submit. They don't have to establish networks. And actually there is a provision in law that they are not allowed to link provider incentives to managing care.

So—I mean, they are really structured not to be managed care plans and their reporting requirements are different. So it will be, as you say, hard to know what they are, but they are required by law to provide additional benefits. They do submit a bid. They say how much in the actuary value of the benefits that are provided. And so I believe benefits are being provided.

Ms. SCHWARTZ. We just don't know what they are.

Mr. MILLER. They vary significantly across plans. You don't necessarily know what is being used by beneficiaries.

Ms. SCHWARTZ. Is it also true that the physicians—we have heard the physicians don't know what they are going to be paid by these private fee-for-service plans, so when they accept a patient, they have no idea.

Mr. MILLER. I think the phenomenon is more this: When the patient presents, the patient says I have a—the beneficiary has a private fee-for-service plan. At that point, the physician has to determine what this plan is paying, which is the private—which is the regular fee-for-service rate, and they may not know that and they have to sort of search and figure out whether they are going to accept the patient at that point.

Ms. SCHWARTZ. A previous question asked about access for Medicare recipients and whether, in fact, we have enough physicians to provide and accept Medicare patients and accept the benefits. I think that is a concern for all of us.

I assume what we are not getting is—we are paying for for these private fee-for-service plans; physicians don't know what they are going to get reimbursed; patients—we don't know, certainly, how much patients are getting—whether beneficiaries are getting more and whether, in fact, there are any better outcomes, and it is costing us all more money.

Could you say also that the amount of money that we are spending, that additional $1,000 a person, or the additional $10 billion a year, is really coming out of the pockets of other Medicare bene-

ficiaries? You pointed out that we really don't have enough money today to pay—to meet all of our obligations under Medicare. We are now spending $10 billion more a year, $1,000 more per Medicare beneficiary, that in some ways is coming out of the pocket of the 80 percent of Medicare beneficiaries—in order to get a few beneficiaries who are the healthier and younger beneficiaries, potentially more benefits; and we are not even sure of that.

Would that be the right framework for the way this is working?

Mr. MILLER. We both have testified to the fact that all beneficiaries, the other 80 percent who are not enrolled in the plans, are paying a Part B premium—a higher Part B premium.

A different way to say what you are saying is, in a sense, what we are watching here is, in this context of the sustainability issues that this committee is well aware of, we are watching a benefit expansion in progress. And it is not targeted; it is whoever presents at the plan. It is not——

Ms. SCHWARTZ. It is not targeted to the most elderly or sickest.

Mr. MILLER. Or the lowest income. The benefits that are actually being offered through this expansion are determined by the specific plan, and as both of us have said, we don't have a consistent data set to know what we are getting out of that.

Ms. SCHWARTZ. So we are spending a whole lot more money, and we are not sure what we are getting.

Thank you.

Chairman SPRATT. Mr. Bonner.

Mr. BONNER. I know this hearing was called to focus on Medicare Advantage. I want to ask one question that is germane to the hearing, but I want to take advantage of your broad expertise on health care.

Consider the following statement: Government health plans aim to make sure that everyone who is eligible gets a benefit. Private health plans make sure that everyone who gets a benefit is eligible.

Does that strike you as an accurate distinction?

Mr. ORSZAG. I don't necessarily have any objection to it. I think there are many dimensions along which public programs may vary from private insurance plans.

Mr. BONNER. I don't know if this hearing is being broadcast outside of the House, but in the event C-SPAN picks it up and someone is stumbling—by chance, they flip from Oprah to Judge Judy and they end up with the Budget Committee, they probably won't stay for long, but I would like to broaden the question a little bit outside of just Medicare Advantage.

I had a telephone town hall meeting night before last with about 10,000 constituents from my district. I was surprised that many stayed on the line. And one of the questions that came to me, which I think is very appropriate is, why is our health care—Medicare and other, why is it so complicated, especially the reimbursement aspect of it; and does it have to be?

Because at the end of the day, that is one of the challenges we have: How are we going to pay—I think most everyone, Democrat and Republican, would agree that we have got the best health care system in the world, or most of us believe that, but it is certainly not as accessible or as affordable to all Americans.

Does it have to be this complicated? And is there a better way to do it?

Mr. ORSZAG. I would just say that part of the complexity of our current system comes from choices that we have made, in particular, to have an employer-based health care system in which that is the primary mechanism for the nonelderly to obtain health insurance and then to layer on public programs around that system.

There is a lot of fragmentation in our system, and one of that may have—that system may have benefits and costs. One of the costs is that it is more fragmented, and complexity is necessarily sort of part of that framework.

Mr. MILLER. And I think on the public side, the programs in Medicare grew up based on the public—or, sorry, the private models. Many of them came on at different points in time; different benefits arrived at different points in time in the program, incremental changes where people who saw an inequity stepped in and said, I am going to make that change. And that compounds over time, and that is certainly why you have the complexity.

We do think that there are better and, hopefully, clearer ways to reimburse, such as having the payments be sensitive to the quality outcomes in the use of services that we try to push. Hopefully, that is at least clearer incentive-wise. Whether it is less complex, you know, those raise issues about measures and mechanisms as well.

Mr. BONNER. If someone from Arkansas or Ohio or Tennessee or Alabama or South Carolina has switched from Oprah to this hearing and is curious as to where we are going with this—I guess the other question I have got is, we have got a Presidential election coming up next year. Some of the candidates running for President are calling for some type of universal coverage for those who don't have health insurance.

Is there any reason to believe that, as expensive and as complicated as this current system is, if we were to have some type of universal health care plan to cover all Americans, that it would cost us less money than what we are currently arguing about that we are spending too much money on?

Mr. ORSZAG. I guess I would just say that the net impact of just adding people who are currently uninsured into the insured population would be a net increase in costs.

There may well be other changes that could be made to reduce costs. But the uninsured currently, on average, spend less even—despite the fact that they often wind up in extremes with very high-cost situations, they often spend less than the insured. Adding them to the pool of the insured would on net increase costs.

Chairman SPRATT. Mr. Doggett.

Mr. DOGGETT. Thank you very much for your testimony.

I would like to return to the comments to which our chairman referred at the opening.

The official President Bush selected to run Medicare from 2001 to 2003, Tom Scully, said of these Medicare Advantage plans, quote, "There has been huge overfunding," and I ask you if you are able to quantify the amount of "overfunding," to use his euphemistic term, that has occurred with Medicare Advantage.

Mr. ORSZAG. Well, I guess you could do that historically or prospectively. One way of——

Mr. DOGGETT. I am asking, first, historically. Since this program was set up, do you have an estimate of how much overfunding there has been of Medicare Advantage?

Mr. ORSZAG. I don't believe we have done that analysis.

Mr. DOGGETT. And looking at it prospectively, given the fact that even the Bush official who ran the program describes it as huge overfunding, what is a reasonable amount of savings?

I realize it depends on the policy choices that are made, but what is a reasonable amount of savings to expect we might be able to achieve over a 5-year period?

Mr. ORSZAG. Well, again, that depends on your policy intervention. If you reduce the payments to plans, the benchmarks in particular, to 100 percent of local fee-for-service costs, we estimate budget savings of $54 billion over 5 years.

Mr. DOGGETT. $54 billion over 5 years. And there would be a variety of other choices that could be made that might be less than that, but that would be kind of the ceiling of reducing it to that level.

Now, having created this huge amount of what his own officials call "overfunding" and what some of us would call "gross waste," did President Bush, in his proposal to Congress this year, propose to achieve a dollar of savings from these Medicare Advantage plans?

Mr. MILLER. I don't believe——

Mr. DOGGETT. Not a dollar. Not a penny.

Did the budget proposal that our Republican colleagues submitted to the Congress propose to save a dollar or a penny for Medicare Advantage? No. It did not.

Did President Bush's budget proposal propose to save, through its inaction, money by cutting the payments that physicians will receive on January 1st of next year? To be more specific, if nothing is done, will physicians next year face a cut in their reimbursement rates of about 10 percent?

Mr. ORSZAG. Yes, sir.

Mr. DOGGETT. And there is nothing in the President's budget to stop—to fund any change in that?

Mr. ORSZAG. I don't believe that the President's budget—I am just looking at that.

Mr. DOGGETT. Not a penny, not a dollar taken away from these insurance companies that his own officials say have received huge overfunding where there has been gross waste and unnecessary spending, but a 10 percent cut to every physician who provides services to seniors and people with disabilities and relies on Medicare across this country.

Now, I agree fully with the point Mr. Conaway made that this is not the result of fraud; and I also agree with my other Texas colleague that what it does result from is the clash between Republican theory and Republican reality. Let me give you—some might call it bad judgment.

Let me give you one example of the way the waste and abuse—the term we usually hear at election time in talking about the mythical welfare Cadillac. You could imagine what would happen,

if you were talking about an extra $100 that one of these recipients got versus $100 million. Let me talk about $100 million example of what has actually occurred.

The General Accountability Office determined this spring that Medicare, the Bush administration, paid out $100 million for benefits to insurance companies for poor and disabled seniors, when the—this was for retroactive coverage for 5 months. The only thing is, they never required the insurance companies to tell the seniors and the disabled people that they were entitled to any coverage, and they didn't get around to telling anyone to change their practices until March of this year.

The General Accountability Office estimates $100 million of money paid out to these Medicare Advantage plans, to these insurance companies, for which little or no service was rendered. And that is the kind of example of mismanagement of this program which goes right back to its origin of favoring, as you put it so well, Mr. Edwards, the conflict between theory, between ideology and between reality.

And we are paying a big price for it.

Mr. ORSZAG. Could I offer one small clarification?

The President's budget did not directly make any changes to Medicare Advantage plans, but because of the other changes that you mentioned—for example, the update factors, et cetera—there would be implications for the benchmarks that Medicare Advantage plans payments are based off of and, therefore, some implications for Medicare Advantage plans.

Chairman SPRATT. Thank you.

Mr. Tiberi.

Mr. TIBERI. Thank you.

Dr. Miller, speaking of realities, let me try to get you to answer a question here. In my district, I was visited by a nonprofit hospital that set up a Medicare Advantage program. And they have seen an incredible boom in that program, just incredible growth in enrollment. And part of that enrollment, a large part of that enrollment actually they have seen is in an urban area of my district—a number of African Americans have enrolled in their program and have been very pleased with the program, which goes along with something I think you said earlier about growth in the Medicare Advantage program; they've seen incredible growth, people choosing to go into the program.

And I met with some of the African American leaders in that part of my community, and they are very happy with that nonprofit hospital's Medicare Advantage program.

Why do you think there has been so much growth in the Medicare Advantage program since its inception? Why are seniors switching to it?

Mr. MILLER. I think that at least part of the reason is that because of these payments, plans are able to offer additional benefits. We talk about benefits, and benefits can mean lower out-of-pocket. And so I think that that, plus the benefits that Medicare doesn't offer, is very attractive to a beneficiary. And that is urban, rural, you know, high income, low income; any beneficiary would find additional benefits on top of traditional Medicare attractive and——

Mr. TIBERI. The CMS study that you provided that said there was a 12 percent gap, or differential, between Medicare Advantage——

Mr. MILLER. That is analysis that both of our shops have done.

Mr. TIBERI [continuing]. If you factored in those "extra benefits" you just talked about, whether it is disease management, whatever it might be, that attracts people to Medicare Advantage from their own personal experiences, if you factored that in, could that be part of the 12 percent?

Mr. ORSZAG. That is what the 12 percent is supposed to be.

DCMN NORMAN

Mr. MILLER. Absolutely. It is supposed to be that, and I want to clarify something, though.

You know, this kind of gets missed in the debate occasionally. People often come back and say, but I know it is more payment but people are getting extra benefits so that is a good thing. And I think there is some of that. But remember, each one of these benefits is a fully loaded benefit. They don't administer themselves.

So those dollars, the plan gets paid what they bid. They retain that part of the additional payment that they use for additional benefits. But part of those dollars go to admin, marketing, and profit. And so each one of those dollars doesn't necessarily travel to the beneficiary in terms of the benefit.

But having said that, and as Peter just said, yes, part of it are those additional benefits.

Mr. TIBERI. How do you factor in when a nonprofit Medicare Advantage program tells me there are larger upfront costs to implementing this program that will see a decrease over time to Medicare?

Mr. ORSZAG. Could I comment on that?

In order to get a decrease in Medicare costs, okay, you can evaluate this along other dimensions. But a decrease in Medicare costs, given the current structure of the payment systems, one would need the bids that the plans are submitting to be roughly one half of local fee-for-service costs in order for the net payment from the Federal Government to be lower than it would be for someone in traditional fee-for-service. That seems to me implausible.

So there may be some potential longer-term effects or some systemwide effects, but from the narrow perspective of the Federal budget, the story that the plans will develop enough internal efficiencies to actually generate a net reduction in budget outlays for the Federal Government, given the current structure, seems very difficult to see.

Mr. MILLER. To add to the implausibility part, what you are basically saying is that the beneficiaries will have more benefits, the current payments don't put pressure——

Mr. TIBERI. I understand. I am running out of time.

How do you mirror or how do you merge both of you gentlemen's concern about the cost of Medicare Advantage? Because I know where you both are, versus, at least in my district, constituents who have long complained about Medicare fee-for-service, including my mom and dad, long complained about it with an incredible liking of Medicare Advantage and what Medicare Advantage is providing them. How do you mirror those two things?

Mr. ORSZAG. I want to just clarify. I hope I am not betraying concern. I am just trying to communicate our analysis to you.

I think the real question that one needs to ask is I have no doubt that many Medicare Advantage beneficiaries enjoy or like the plans that they are in. Those plans do cost the Federal Government more than traditional fee-for-service, and so there is this question of there is a subset of beneficiaries who are getting expanded benefits and reduced premiums that are being financed by the rest of the beneficiaries and by taxpayers. And that is a trade-off that, you know, is for you to evaluate.

Mr. MILLER. I agree with all of that. I would go at the question a little bit differently.

First of all, I believe that there are plans who can provide additional benefits through their efficiencies. And in fact, you know, one way to look at this is that if I am an HMO and I have to create a network and report quality data, and then the private fee-for-service plan shows up and it doesn't have to do any of that, it is like I have been working to dig out these efficiencies in order to offer these benefits, and this other competitor has a much easier time of it.

So my first answer is I believe this model has the potential, and there actually are plans who can do it; maybe not as generous as when there is a subsidy present, but can still do it.

Then on the fee-for-service side, which you are absolutely right about, it is a system that is in need of repair. I will say we have made recommendations, which I won't go through now, but to make the payments reward high quality and low utilization so that the same kinds of incentives are being driven on that side as well.

Chairman SPRATT. Let me tell everyone that we have about 13 votes coming up at 1 o'clock. So what I would like to do is try to finish this up as soon around 12 o'clock as possible, then move to the second panel.

I would ask our remaining members to limit their questions to 3 minutes, if you could. I will recognize you first for the additional panel. Won't apply to Mr. Blumenauer, since I am sure he has got more to ask. But it is simply precatory. If you can do it, fine.

Mr. BLUMENAUER. I come at this from a slightly different perspective.

I voted against both Medicare prescription drug programs because I didn't think that they were focused and thought they were too expensive. But I represent a State that I think has the highest market penetration, and I think I have the legislative district that probably has more in the State. I think it is over 50 percent in the places that I represent.

Part of it gets to what Mr. Cooper was talking about a moment ago. In fact, I look around the room and other than the Texans, we are all States where our people are paying the same Medicare taxes as everybody else in the country and they are getting back a much reduced amount. We are being penalized—some of us are being penalized for being low-cost States.

Mr. Ryan, I think you are the only State on the list here of anybody represented that is actually getting back less in the fee-for-service.

So I am having people that are being driven to these programs because we have such a low reimbursement rate that physicians are feeling very uncomfortable with it.

And I get a little nervous when I hear people talking about substituting the average benchmark fee-for-service, just sort of plugging that in, when we have wild areas of differential in terms of the local costs.

What would be the impact if we substituted the average fee-for-service nationally for everybody? You have got a range here where people in Louisiana are getting $950 a month, on average. Why should—if we are going to drive the market for efficiencies and if we really care about entitlements, if we care about entitlements, why don't we do something that starts driving average reimbursement towards a national level that is lower, rather than keep piling it on the expensive States because—and where I disagree with Mr. Barrett, there is no evidence that we have the best health care system in the world; if we had lower child mortality; if we lived long. We are right in the middle of the pack.

So can we kind of not come back here and whack low-cost States, Arkansas, North Carolina, Tennessee, Kansas, Wisconsin? If we are going to be adjusting Medicare Advantage, why can't we just come back and do a little adjustment with the national average, which would seem to be to be much more fair, and then see what the market can do?

Mr. MILLER. I am not sure I follow your point on the national average, but I do want to say something about what you have said.

I absolutely——

Mr. BLUMENAUER. Let me clarify it, because I think it is important.

You are talking about the local average benchmark and so adjusting, you would adjust the $950 that Louisianians get and then you are trying to whack Oregonians at 750 when we are only getting 582 right now. So why not whack everybody the same?

Mr. MILLER. When we have talked about transitions to the benchmarks, there are different ways that you can do this, and there are different ways that you can achieve the 100 percent of the—of fee-for-service across the country.

And so ideas like that and options like that are possibilities, and we do talk about them.

And I also want to address your underlying concern because I think your point is really well taken.

Peter put the map up showing the dramatic geographic variations.

We are well aware of these things, and I don't think this fits entirely in a managed care issue. We have fee-for-service inequities across the countries that our payment systems continue to perpetuate, and we have made recommendations that would drive fee-for-service dollars into areas that have low utilization and high quality. If that is your area, you would benefit from that.

Mr. BLUMENAUER. But why couldn't—it is going to take a while to get to where you are going.

Mr. MILLER. I have acknowledged the other point.

Mr. BLUMENAUER. Why isn't the simplest way to start moving towards equity and efficiency to just benchmark the average fee-for-

service and make that the cost for Medicare Advantage and get us moving in both areas?

Mr. MILLER. Because part of the response, I think, is also these underlying differences in the country should probably be addressed as well; as Peter said, they represent an opportunity for the entire health care—or at least all of Medicare to run in a much more efficient way.

Mr. BLUMENAUER. Can we have a number from you about what it would be if we benchmarked to the national average, what the savings would be for fee-for-service?

Mr. ORSZAG. I believe we can do that.

Chairman SPRATT. If we could get that, we would like it for the record. But let's move on.

Mr. Moore, Dennis Moore.

Mr. MOORE OF KANSAS. We are getting the number that was just asked for; is that correct?

Mr. ORSZAG. We will do that.

Let me note, one of the things about putting in a national average given these patterns without affecting these underlying patterns is that, of course, you would create a strong incentive for Medicare Advantage plans to enter into the lower-cost areas and drive enrollment growth there, which I am not saying is a good or bad thing but, I am saying is a consequence.

And the result would be that if you are paying the national average in those lower-cost areas, that does drive—given this underlying existing pattern of enrollment and costs, does drive up cost for the system.

In other words, if what you did was—you only moved the lighter regions towards the average and didn't do anything else, you wind up raising cost.

Mr. BLUMENAUER. But you are driving the darker regions down.

Mr. ORSZAG. Right. But part of the response will depend on exactly the distribution of beneficiaries and the response of the plans to that kind of incentive. I can't give you an answer right now, but I will get back to you with one.

Mr. MOORE OF KANSAS. The number of enrollment, persons enrolled in traditional Medicare, is about 35 million nationwide.

The number of enrollees in traditional Medicare is about 35 million nationwide; is that correct?

Mr. ORSZAG. That is approximately correct.

Mr. MOORE OF KANSAS. And the number in Medicare Advantage is about 8.7 million; is that correct?

Mr. MILLER. That is right.

Mr. MOORE OF KANSAS. And the cost of the Medicare Advantage far exceeds the cost per person of traditional Medicare, correct?

Mr. ORSZAG. Correct.

Mr. MOORE OF KANSAS. And how much is that cost per person in excess?

Mr. ORSZAG. As we said earlier, something like $1,000 per beneficiary.

Mr. MOORE OF KANSAS. Who do you suspect would object if we were to say we are going to have everybody enrolled in traditional Medicare and discontinue Medicare Advantage?

Mr. ORSZAG. Well, obviously, the people who are beneficiaries today under Medicare Advantage would, by observation, prefer that to traditional fee-for-service. So they presumably would object.

Mr. MOORE OF KANSAS. But there is, I think, general consensus here that a lot of money is being wasted; not fraud, but wasted on this Medicare Advantage program.

Mr. ORSZAG. I would say that the program is increasing Federal costs.

Mr. MILLER. I think it is a judgment of what you call "waste," and I think the objections would come from the beneficiaries enrolled, the plans that are providing the service. And I would say as an organization, we think there should be an option. So we don't think that—we are not saying that the managed care option should be eliminated.

Mr. MOORE OF KANSAS. All right. Thank you.

Chairman SPRATT. Mr. Etheridge.

Mr. ETHERIDGE. Thank you, Mr. Chairman, and let me thank you both for staying.

Let me follow up on that question just a minute, if I may, because I think that is the heart of it.

If Congress put Medicare Advantage on a level financial playing field with fee-for-service as MedPAC recommends, what will happened to Medicare Advantage's market? Will Medicare Advantage plans and the extra benefits they provide disappear? Do you think it will? Or will beneficiaries still have the opportunity to receive some extra benefits?

As has been stated here this morning, or alluded to, that there would still be some money within that system, and how can we minimize the disruption of how—to the Medicare Advantage enrollees if the plan should disappear.

Mr. ORSZAG. Let me say first, under our estimates, moving to 100 percent of local fee-for-service would not eliminate the Medicare Advantage program. It would in 2012 reduce enrollment by about half. So there would still be roughly 6 million or so beneficiaries in Medicare Advantage plans. And the reason, presumably, that they were in those plans is that somehow the plans offered some combination of supplemental benefits or reduced premiums to them that made it attractive for them to be in that plan, as opposed to traditional fee-for-service, despite the fact that the benchmarks were set at 100 percent of local fee-for-service.

Mr. MILLER. And just to back right into that, too. I mean, in our analysis that we present in the June chapter, we have evidence that we think that certain plan types, on average, the HMO plans, deliver the traditional fee-for-service benefit at below what the traditional fee-for-service benefit costs Medicare. That represents the opportunity for the plan to provide additional benefits, and that is why I think you still would see enrollment in these plans and still have some additional benefits, but not as many plans as now and not as generous a benefit package as you are seeing now.

I want to acknowledge that.

Mr. ETHERIDGE. So in effect what you are saying is we would start to level the playing field.

Mr. MILLER. The payments would level—you would level the playing field between fee-for-service payments and the managed care payments, yes.

Mr. ETHERIDGE. Thank you. I yield back.

Chairman SPRATT. Mr. Berry.

Mr. BERRY. Thank you, Mr. Chairman. I think that it should be said that this Medicare Advantage part of the Medicare Modernization Act of 2003 was written by

the insurance companies. And I served on that conference committee; and the insurance companies—it turned out just exactly just like they wanted it to, and we should not be surprised at the result.

Having said that, my question is, and it was mentioned earlier, I think by the Ranking Member, that there is some advantage to having all of your coverage in one place, with one Medicare Advantage plan, where you get your drug plan and all of that.

Have you done any analysis of the cost of whether or not we could lower the cost of the Part D program if we had Medicare, offer a Medicare-only plan as part of the A and B and make it a Medicare Part D, where one card served all of those purposes, and negotiated the prices for the people that would receive the medicine?

Mr. ORSZAG. There would be a variety of ways of doing that. CBO has spoken, I guess at some length, about the role of the Medicare program, or the Secretary of HHS, in obtaining price discounts, for example, within Part D.

But the details matter here. It depends on exactly how it is structured.

I would also note with regard to benefits from that integration within Medicare Advantage plans that you referred to, again we need more data. CBO has been asking for and I would welcome evidence from the Medicare Advantage plans on the degree to which that integration is actually generating internal efficiencies and cost savings.

Mr. BERRY. Thank you, Mr. Chairman. I yield back.

Chairman SPRATT. Thank you.

Thank you for your excellent testimony and for the fine work each of you does at your respective agencies, CBO and MedPAC. We very much appreciate your service and your contribution made today in understanding this complex problem.

Thank you.

We now have the second panel, which consists of Dr. Mark McClellan, former director of CMS, now at AIE Brookings; Barbara Kennelly, who is the chief executive officer of the National Committee to Preserve Social Security and a former Member of the House; Patricia Newman who is the director of Medicare Policy, the Henry J. Kaiser Family Foundation; Ardis Hoven of the AMA, the American Medical Association; and Catherine Schmitt of Blue Cross Blue Shield of Michigan.

STATEMENTS OF MARK McCLELLAN, M.D., AIE BROOKINGS; BARBARA KENNELLY, CHIEF EXECUTIVE OFFICER OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY, AND FORMER MEMBER OF CONGRESS; PATRICIA NEUMAN, DIRECTOR OF MEDICARE POLICY, THE HENRY J. KAISER FAMILY FOUNDATION; ARDIS HOVEN OF THE AMERICAN MEDICAL ASSOCIATION; AND CATHERINE SCHMITT, BLUE CROSS/BLUE SHIELD OF MICHIGAN

Chairman SPRATT. Dr. McClellan, do you have a time constraint?

Mr. MCCLELLAN. I do, but I will push it back.

Chairman SPRATT. Some time the bell is going to ring around 1 o'clock.

I tell you what we will do. To accommodate your situation, we will let you go first. Thank you for coming. We look forward to your testimony, and I will say to all of the witnesses, the statements you filed will be made part of the record, and you can summarize them as you see fit.

Thank you very much again, and Dr. McClellan.

STATEMENT OF MARK McCLELLAN, M.D.

Dr. MCCLELLAN. Mr. Chairman, thank you very much, Mr. Ranking Member, for the opportunity to be here. It is a real privilege to be back with many of you on this important issue of Medicare Advantage and the Federal budget.

As you know, how Medicare pays for health care not only has important implications for the Federal budget, it has a major impact on how quickly and how effectively we can create a health care system that fulfills the promise of modern medicine: more prevention, better health at the lowest possible cost.

In fulfilling this goal, Medicare Advantage Health plans pay a critical role. They bring greater value to our overall health care system in terms of enabling beneficiaries to get more up-to-date, higher quality care at a lower total cost. They are achieving higher rates of use of preventative services, they are providing greater access to care coordination services, improving compliance to prevent complications of chronic diseases, keeping beneficiaries healthier.

This adds up, as we talked about earlier today, to $86 a month in savings for beneficiaries. That is more than $1,000 a year. And it is particularly important for beneficiaries with limited means who have no options, who aren't eligible for Medicaid, who don't have employer-provided retiree coverage, and who are facing out-of-pocket costs that exceed $3,000 a year.

As Ken Thorpe at Emory University and other experts have noted, the average savings from the Medicare Advantage plans exceed reasonable estimates of the higher Government payments.

There are also a number of reasons why the payment differences that we have been discussing today for most Medicare Advantage plans may not be as large in 2008 and beyond as the recent CBO, MedPAC, and other estimates would suggest, or at least why these—the reasons for the differences may change.

These estimates only look at Part A and Part B costs in Medicare, not the Part D drug costs. And Part D costs are much less expensive in Medicare Advantage and these differences seem to be increasing over time.

Also, I am not sure that all of these estimates fully incorporate traditional Medicare administrative costs, including the higher cost of preventing fraud and abuse, because of the very detailed administration of the program. Many of these estimates are based off what are called APCC costs which include most of the costs within a particular county of the Medicare benefits themselves, but not some of these other administrative costs that I mentioned.

Also the estimates, looking forward, tend to understate the expenses in traditional Medicare that will be associated with physician payments. As we talked about this, we are scheduled for a 10 percent reduction next year. If Congress acts to address that—and they should to provide adequate access for seniors—then the payments in fee-for-service will be higher relative to Medicare Advantage and that is not taken account of yet in the projection.

Also, the budget neutrality phase-out which was mentioned before is going to be a less important component of payment differences going forward. And, finally, there are a lot of studies that health economists have done showing there are spillover effects of health plans that provide coordinated care on the rest of the health care system, and in particular on Medicare fee-for-service, by promoting preventative care, by promoting care coordination that make it easier for providers to change their practice in that direction overall, leading to health care savings as well.

So if you add all of this up, what looks like is going to happen in the years ahead is that the main factor accounting for payment differences in 2008 and beyond will be the higher payments in counties that historically have had low access to coordinated care and innovative benefits, that have had lower fee-for-service costs and were the subject of explicit decisions by Congress—not in the Medicare Modernization Act but in the Balanced Budget Act of 1997, BIPA 2000 and beyond, bipartisan decisions by Congress to increase payments to Medicare Advantage plans to improve access to these kinds of coordinated care benefits and more extensive benefit plans.

So reducing Medicare Advantage payments further than what is already scheduled to happen in the next couple of years—and the payment updates for Medicare Advantage are going to be well below the rate of medical inflation next year, just like they were this year—may go too far to restrict access to savings and, importantly, to up-to-date health benefits that keep beneficiaries healthier and enable them to survive their chronic diseases more effectively.

It would leave many beneficiaries not only with much higher out-of-pocket costs but also with no better alternative to either traditional Medicare, with all of its gaps, or to having to sign up for a very inefficient Medigap plan where beneficiaries pay much more in premiums than they get out in benefits.

Seniors, I think, deserve better than that. They deserve more up-to-date options than that, and so policy reforms to address this looming Federal entitlement crisis should not start with shifting costs from the Federal Government to Medicare beneficiaries, who disproportionately have limited means and don't have access to Medicaid or employer or retiree coverage. Those are the people who primarily enroll in Medicare Advantage.

Now, while finding ways to reduce costs and improve value in the overall health care system is very important, so, obviously, is finding ways to reduce Medicare spending growth. The best policy reforms will cause both Medicare expenditures and total health care expenditures to go down without compromising beneficiary health. And while some of the proposed payment reductions from Medicare Advantage don't meet that test, there are promising approaches to improve the performance of Medicare Advantage and also of traditional fee-for-service Medicare.

Effective marketing and oversight, improving the availability of information on planned quality and costs, including better measures for traditional fee-for-service Medicare and Medigap as well, and providing more support to beneficiaries to use this information to make informed decisions about their coverage and their care can all help.

In addition, adjusting the rules affecting the private fee-for-service plans has been the subject of so much discussion this morning to limit the use of physician deeming, perhaps after an initial start-up period or when a range of options of plans that do not significantly restrict access if treatments are available in an area, that can achieve significant savings, according to Peter Orszag's testimony just a little while ago.

Similarly, there are many opportunities to improve the efficiency of payments in fee-for-service Medicare you have all already discussed this morning. All of these steps can help achieve greater savings in Medicare with budgetary reductions, without raising beneficiary costs substantially.

The best solution to Medicare's financing problems isn't to take away innovative coverage options and to shift costs to beneficiaries, particularly those with limited means who are struggling with out-of-pocket costs today.

The main opportunities for improving care, as Representative Cooper pointed out, is the huge overuse, underuse, and misuse of treatments that is occurring around the country in the Medicare program overall today.

As Peter Orszag said, this is the most substantial opportunity to reduce health care costs without compromising quality.

So there are better ways to address the long-term sustainability of the Medicare program, or at least better places to start, while promoting more efficient health care. And I look forward to supporting this committee's continuing efforts to achieve this absolutely critical public health goal.

Thank you very much, Mr. Chairman.

Chairman SPRATT. Thank you very much.

[The prepared statement of Mark McClellan follows:]

PREPARED STATEMENT OF MARK MCCLELLAN, M.D., PH.D., AIE BROOKINGS

Chairman Spratt, Ranking Member Ryan, and distinguished members of the Committee, thank you for the opportunity to testify today on Medicare Advantage and the Federal Budget.

My testimony makes a number of points. First, Medicare Advantage (MA) health plans play a critical role in bringing greater value to our overall health care system, in terms of enabling beneficiaries to get more up-to-date, higher-quality care at a lower cost. Second, policy reforms to address the looming Federal government entitlement crisis should not start with shifting costs from the Federal government to Medicare beneficiaries with limited means, and they should seek to avoid reducing

access to benefits like preventive services, more comprehensive drug coverage, and care coordination services that both reduce costly complications and help beneficiaries lead healthier lives. In fact, such changes may meet the definition of reduced efficiency, properly defined from the standpoint of the overall value of the care provided in our health care system. Third, any differential payments for most types of MA plans may well be smaller in 2008 and beyond than some recent estimates based on 2007 data would suggest. As a result of recent changes in law and regulation, MA plans overall will have relatively modest payment increases in 2008 and possibly in subsequent years. Remaining differences in payment rates are largely the direct result of bipartisan Congressional action to address concerns about reduced access to up-to-date coverage options in rural and certain urban areas. Thus, any changes should be approached cautiously. Fourth, while the MA program is a key element in achieving the overall policy goal of improving the quality and efficiency of Medicare and our health care system, there are some important opportunities to improve it and help reduce Federal costs.

THE VALUE OF THE MEDICARE ADVANTAGE PROGRAM

Before discussing the efficiency of Medicare Advantage plans, I would like to start with a comment on the importance of considering value—which is the way economists define efficiency—in the context of our health care system. Economic efficiency is not simply reducing costs to the government. For example, consider two kinds of health care coverage. One kind generally pays for complications of health problems after they happen, but limits coverage of preventive care, services to help people with chronic disease stay well, and other benefits that improve health, resulting in higher costs to patients. The other kind of coverage is more in line with 21st-century health care: it provides more personalized medical services, such as helping people understand their risk factors, comply with drug therapies and other treatments to prevent complications, avoid duplicative services, and as a result it achieves better health outcomes. Even if these two kinds of coverage cost the same amount to the government, they are by no means equally efficient. Because the latter type of coverage achieves better quality for the same amount of government payment—because it delivers greater value—it is the more efficient approach. In fact, even if the more up-to-date coverage were somewhat more costly, because it delivers better health, it may still be the more efficient plan. Moreover, economic efficiency cannot be determined simply by looking at costs to the government. Efficiency depends on overall costs, including costs paid by beneficiaries as well as the government. Coverage that shifts costs to beneficiaries without lowering overall costs—or perhaps increasing them—does not increase efficiency.

If we want to achieve a high-value, efficient health care system, then Federal policies must encourage high-value health care. With this background in mind, I would like to describe how the Medicare Advantage program overall is performing.

Overall, compared to fee-for-service Medicare, beneficiaries in Medicare Advantage plans have much lower out-of-pocket costs; they receive significantly more preventive benefits, drug coverage, and services to help them better manage their chronic diseases; they have very high satisfaction rates; and in most cases, their overall care costs (Medicare plus beneficiary) are lower.

For example, Medicare Advantage beneficiaries receive preventive services like mammograms, colorectal cancer screening, prostate screening, and immunizations at significantly higher rates than beneficiaries in traditional fee-for-service (FFS) Medicare. In addition, compared to other Medicare beneficiaries without supplemental "Medigap" coverage, MA beneficiaries are only one-third as likely (6 percent versus 17 percent) to report delaying the use of needed care due to cost.[1]

MA beneficiaries also receive higher quality of care in many areas; for example, a study in the Journal of the American Medical Association found that beneficiaries in MA plans received higher quality of care than beneficiaries in traditional FFS Medicare in five of seven HEDIS quality measures studied.[2] Quality is reflected in overall high beneficiary satisfaction rates with their coverage: Consumer Assessment of Health Plans Surveys (CAHPS) generally rate MA plans highest among a range of types of health plans.[3]

These quality of care results are the consequence of how most MA plans provide coverage. Plans receive a single, risk-adjusted payment from Medicare, and they compete to attract and keep beneficiaries by using this subsidy to provide the most attractive benefits at the lowest overall cost. In contrast, in traditional FFS Medicare, benefits are determined by statute and cannot easily include many innovative approaches to benefit design, provider payment, care coordination services, and personalized support for beneficiaries. Through MA plans, beneficiaries across the country have access to plans with lower or zero copays for preventive services; they have

widespread access to wellness programs; they have access to dental and vision services that not only reduce costs but also help beneficiaries live better and improve their overall health.

Importantly, MA plans are also providing drug coverage that is more extensive and much less costly than in traditional FFS Medicare. This difference in generosity and cost, which increased between 2006 and 2007 and may continue to increase in the future, is likely the result of several factors. First, most MA plans can manage the use of prescription drugs more effectively, as part of their efforts to support the overall coordination of care for a patient's health. Second, higher compliance with drugs has been shown to reduce other health care costs,[4] and because MA plans have incentives to keep overall costs down that do not exist in traditional FFS, they can capture the savings in hospital, physician, and other costs from the greater compliance that comes with more comprehensive drug coverage. Again, this is a more efficient approach to health care coverage.

Finally, most MA plans provide much more support for patients with chronic diseases than is available in traditional FFS Medicare. This is critically important, since the vast majority of costs in Medicare—and most of the cost growth in Medicare—relates to treating the complications of a limited number of serious chronic diseases. Our health care system has huge and persisting quality gaps in the prevention and treatment of chronic diseases. There is no population in this country that needs such personalized services to improve coordination and prevent complications from chronic diseases more than Medicare beneficiaries.

All of these features—better preventive care, lower out-of-pocket costs, better drug coverage, better support for quality care for chronic diseases—are signs of more efficient health care. Not surprisingly, they add up to very large savings for beneficiaries—on average, out-of-pocket costs are $86 a month less in MA, compared to traditional FFS Medicare with Medigap (counting beneficiary premiums) or no supplemental coverage. That's more than $1000 a year in savings. This is why a recent analysis by Adam Atherly and Ken Thorpe of Emory University concluded that even though MA payments increase Medicare costs, "the size of the increase in costs will be less than the value of the supplemental benefits provided to beneficiaries"—that is, overall costs to beneficiaries and the Federal government are lower in the MA plans.[5] (Similarly, according to MedPAC testimony before the Ways and Means Committee in May, average bids across all Medicare Advantage plans for Part A and B services are lower than the average cost of traditional FFS Medicare[6]—and when Part D benefits are included, the cost differences are larger.)

To achieve the goal of reducing overall health care costs while improving quality—that is, to improve efficiency from the standpoint of our overall health care system, and to spend beneficiary as well as tax dollars more effectively—Medicare Advantage is providing very important options to Medicare beneficiaries.

ESTIMATED PAYMENT DIFFERENCES BETWEEN MA AND TRADITIONAL MEDICARE, AND IMPLICATIONS FOR PAYMENT REFORMS

While finding ways to reduce costs and improve value of the overall health care system is very important, so is finding ways to reduce Medicare spending growth. The best policy reforms will cause both Medicare expenditures and total health care expenditures to go down, without compromising beneficiary health. With all the overuse, underuse, and misuse of medical care in our health care system, there are plenty of opportunities to do this. But reductions in MA payment rates would not do it: they reduce Medicare spending by reducing the benefits and the beneficiary savings just described. So an important question is: what is the likely impact of reducing MA payments?

As a preliminary step, it's important to review what the overall Medicare payment differences are between MA plans and traditional Medicare. There are some reasons why the 12 percent estimate of cost differences from CBO and MedPAC may not be indicative the payment differences in 2008 and beyond, and thus the impact of payment reforms to "equalize" payments, especially for the coordinated care plans (HMOs and PPOs) that continue to make up the vast majority of MA enrollment. First, the estimated payment differences do not include a number of factors that affect the overall cost comparisons:

- The analyses generally focus on Part A and B benefits only.[7] But MA plans are providing Part D coverage at substantially lower costs than in traditional Medicare, for the reasons described above, and these cost differences are increasing. As a result, MA plans are likely to exert a growing impact on holding down the Part D "benchmark" and thus holding down Part D costs for the entire Medicare program. Accounting for the complete costs of A, B, and D benefits results in a significantly smaller difference in total Medicare costs.

• The analyses include the administrative costs of MA plans (these costs, along with care coordination and other patient management costs, are included in the MA bids) but the administrative costs (including the administrative costs to combat fraud and abuse) of traditional FFS Medicare are not included. These costs likely amount to 2 percent or more in additional traditional FFS costs.

• The forecasts of spending differences and savings for 2008 and beyond do not account for the artificially low forecasts for physician spending in traditional Medicare. The large spending reductions required under current law, including a 10 percent cut in payment rates for 2008, are not sustainable. Physicians cannot provide adequate services for beneficiaries with these payment reductions. When Congress addresses the physician payment reduction for 2008, payments in traditional Medicare will go up significantly, and would not be accounted for in the MA rates until 2009 (by which time Congress may have enacted another one-year physician payment "fix" that increases traditional FFS costs again).

• An important source of additional payments to MA plans right now, the so-called "budget neutrality" adjustment to the risk-adjusted payments to MA plans, is being phased out. Other things equal, it will be substantially smaller in 2008 and beyond, particularly if MA plans continue to increase their efforts to design benefits that attract chronically ill beneficiaries.

In addition to these four factors, some reports have also pointed out other potential factors that may incrementally affect the estimated differences, such as costs not included in the county "AAPCC" amounts behind the traditional FFS payment estimates, and the way that payments for medical education are counted.[8]

From the standpoint of overall health care efficiency, another important factor to consider in evaluating the cost impact of the MA program is known as the "spillover effect" of a growing presence of plans that emphasize prevention and coordinated care. As every health care provider knows, how traditional Medicare pays is an important influence on how overall health care is delivered. For example, when providers are paid more when patients have more duplicative tests and more preventable complications—as is the case in fee-for-service payment systems—it is more challenging to take steps like adopting health IT or reorganizing practices in other ways to deliver care more efficiently. In reviewing a broad range of studies of the impact of managed care plans on overall health care spending in different regions of the country, Laurence Baker of Stanford University concluded that "despite some, generally early, studies that do not find strong effects, this literature as a whole suggests that managed care is capable of having broad influences on the health care delivery system, and that these effects have been in the direction of driving down health care costs. Some of this evidence, particularly that focused on traditional Medicare enrollees, clearly indicates the ability of managed care activity to influence spending patterns for patients well outside the boundaries of managed care plans."[9] Thus, increasing access to coordinated care plans through higher payments is an important policy lever for the Federal government to help influence the overall efficiency of the health care system, with potentially important "external" efficiency benefits in traditional FFS Medicare and even beyond the Medicare program.

Similarly, the estimate of a $2 higher Part B beneficiary premium resulting from MA payments is offset by the lower average Part D premiums resulting from MA plans. Indeed, reducing enrollment in MA plans would exacerbate another kind of inefficency that increases overall Medicare spending and total beneficiary premiums. Most beneficiaries in traditional Medicare are also enrolled in "Medigap" supplemental coverage. This coverage, particularly the individual Medigap plans, is quite inefficient: not only does it have a high "load factor"—meaning beneficiaries have to pay much more in premiums than they get out in benefits—but the Medigap options are also designed in a way that encourages "first dollar" coverage that, according to the CMS Actuaries and CBO analysts, adds billions to Medicare costs each year.[10] Such Medigap plans not only promote inefficient spending; Medigap premiums have been rising rapidly, and are much higher than Part B and Part D premiums combined. Yet except for MA plans, the Medicare program gives beneficiaries in traditional FFS Medicare few options besides this costly and inefficient approach for lowering their out-of-pocket medical costs and protecting themselves against devastatingly high expenditures.

Finally, the principal MA payment policy associated with this year's increase in CBO's forecast of cost savings from revising MA payment rates is the higher payment rates in rural and urban "floor" counties. These payment rates were the result of explicit, bipartisan policy decisions in several Medicare laws preceding the Medicare Modernization Act. The stated goal of the Congress in creating and increasing the floor county payment rates was to promote access to more comprehensive health plan choices, and a broader range of choices, in areas that might not otherwise have MA plan availability. With the competitive reforms enacted in the MMA, these law

changes are finally having that effect: for the first time ever, virtually all Medicare beneficiaries have a choice of health plans, including HMO and/or PPO plans and private FFS plans, and access to other options like MSA plans is increasing as well.

REDUCTIONS IN MA PAYMENT RATES WILL INCREASE BENEFICIARY COSTS AND REDUCE THE OVERALL EFFICIENCY OF THE HEALTH CARE SYSTEM

Reductions in payments to the MA plans would increase beneficiary health care costs, reduce the overall availability and use of preventive services and care coordination services in Medicare (and likely in the overall health care system), and reduce many aspects of the quality of care received by millions of Medicare beneficiaries. According to estimates by Adam Atherly and Ken Thorpe,[11] these impacts may be large: limiting MA payment increases to 1 percent would increase MA beneficiary costs by $412 by 2009, and approximately 1.8 million beneficiaries would lose HMO/PPO coverage and face out-of-pocket cost increases of $825 per year. In considering these impact analyses, it is important to note that statutory and regulatory changes in MA payment rates are already holding down MA payment increases. For 2007, the relatively small payment increases accounted for a negligible share of the increase in the Part B premium, and for 2008, plan payment increases will generally be well under the rate of overall medical inflation and Medicare FFS spending growth.

Moreover, the beneficiaries who enroll in Medicare Advantage plans are those who most need lower-cost, efficient coverage options. According to another analysis by Ken Thorpe,[12] as well as other studies, MA enrollees are more likely to have limited means (i.e., incomes under $20,000 to $30,000), are much less likely to have employer-provided supplemental coverage, and are more likely to be racial and ethnic minorities. For these beneficiaries, the alternative choices of the gaps and financial exposure of traditional FFS Medicare alone or of the high costs of traditional Medicare plus Medigap are not good choices.

If our nation is going to close the huge gap in prevention and in quality of care for chronic diseases, it is essential that we promote access to coverage like that available in most MA plans, which emphasizes preventing illness in the first place, avoiding preventable complications of chronic diseases, and using health services more efficiently. As Administrator of CMS, I was a strong supporter of greater prevention and greater focus on prevention and improving care for chronic diseases within the traditional Medicare program as well. Over the past several years, CMS has implemented many steps in traditional FFS Medicare to improve quality and efficiency. These steps include a major "My Health, My Medicare" prevention initiative to encourage beneficiaries take advantage of the expanded coverage of preventive services, the Medicare Health Support program to pilot the availability of disease and care management programs in traditional FFS Medicare, and initial steps toward providing better information on quality and efficiency and paying more for better care not just more care, to encourage better health and greater efficiency. But progress has been slow, because it is challenging to encourage the kinds of care coordination and integration that promote quality and efficiency, and that get the right care to the right patient at the right time, in a FFS payment system. In contrast, as described above, most MA plans have clearly demonstrated the capacity to achieve higher levels of quality without increasing overall health care costs, and in many cases reducing overall costs.

I am particularly concerned that, in the current policy debate about MA plans, there has been little discussion of alternative policies that can improve prevention, care coordination, and overall health care costs and that could achieve similar savings for Medicare beneficiaries. For example, some have proposed using MA payment reductions to "pay for" increased Part B payments to physicians. If Congress took this step, Medicare beneficiaries would face a "double hit" on their out-of-pocket costs, first from their loss of MA benefits and savings and second from the higher copays and premiums for Part B services. Medicare physician payment needs to be addressed, but there are better alternatives than taking away benefits and savings from seniors, particularly the many beneficiaries with limited means who can least afford this kind of Medicare reform.

PRIVATE FEE-FOR-SERVICE PLANS

Understandably, Members of the Committee and many other Members of Congress have been particularly concerned about trends in private fee-for-service (PFFS) enrollment. PFFS plans were created by Congress in the Balanced Budget Act of 1997 to fulfill an important role: giving beneficiaries access to coverage that would not impose substantial utilization review or other regulatory restrictions on access to care. PFFS plans are the least efficient kind of MA plans and they are

now growing rapidly, spurred by selectively entering "floor" counties with very favorable reimbursement rates and offering essentially the same fee-for-service payment schedule as traditional Medicare, plus some additional benefits and cost sharing reductions. Some of these plans have claimed that they are implementing a multi-year strategy to serve beneficiaries effectively in areas that previously have not had much if any private plan participation. That is, when they have started enrolling beneficiaries, they look very similar to traditional FFS Medicare; but over time, they expect to build beneficiary familiarity, provider networks, and other features that will enable them to increase the quality and efficiency of care. Other plans appear simply to be mimicking traditional FFS Medicare with some additional cost savings, which does not create the same kind of quality improvements and overall efficiency gains as other types of MA plans and is not what extra Federal spending should be supporting in the years ahead.

Some policy reforms have been discussed which might address concerns about the impact of PFFS growth on program efficiency without eliminating access to this option, and reduce Medicare costs without undermining the positive features of the MA program. One step, which CMS has already initiated, is aggressive enforcement of proper marketing practices. Satisfaction rates overall in MA remain high, but keeping them high will require ongoing, effective Federal oversight and responses to beneficiary complaints, especially when patterns of abuse are apparent. The AMA and other physician organizations have also criticized the availability of "physician deeming" to PFFS plans. While new PFFS plans may need this authority to establish a market presence and "get off the ground" with beneficiaries and health care providers, the long-term use of deeming authority may not be necessary for a well-run PFFS plan. To address this, deeming authority for a PFFS plan might end after an initial plan startup period, perhaps several years, or after a substantial presence of PFFS, PPO, MSA, and other plans that do not impose strict utilization management techniques has been established in an area. Similarly, PFFS plans might be required to establish contracts with providers and post the resulting provider lists after a reasonable time period. Finally, PFFS plans might be required to undertake steps that go beyond simply replicating traditional FFS benefits with lower cost-sharing, such as providing wellness services or support services for beneficiaries with chronic diseases. Properly implemented, steps like these would help avoid excess Medicare costs and assure that PFFS plans are both available to beneficiaries who want them and are a good investment for the Federal government.

SPECIAL NEEDS PLANS

Another rapidly growing component of the MA program is Special Needs Plans (SNPs), which are MA plans that target beneficiaries with particular, distinctive health needs that offer services tailored to those needs. Today, the largest number of such plans are designed for "dual eligible" Medicare-Medicaid beneficiaries, who have much to gain from care coordination services. However, plans for beneficiaries with institutional levels of care needs and for beneficiaries with particular kinds of chronic diseases are also growing rapidly; for example, 23 organizations are offering 83 chronic-disease SNPs this year.

Clearly, these plans create important opportunities to customize services, improve care, and reduce costs for beneficiaries who have the most to gain from such services. SNPs for dual-eligible and institutionalized patients have enabled beneficiaries to simplify their medication regimens and avoid costly, preventable hospitalizations, while reducing costs and improving quality in state Medicaid programs. Chronic-care SNPs help beneficiaries with chronic illnesses manage their conditions more effectively, through more generous drug coverage and assistance with medication compliance, diet and behavior changes, information technology (IT) support for care coordination, and other steps intended to prevent costly complications and disease progression. None of these benefits and services is available in traditional FFS Medicare, and many states have turned to SNPs to provide these services to their dually eligible beneficiaries. By focusing on high-cost, complex patients, SNPs show that—with proper payment incentives and oversight that promotes effective competition to serve even the most vulnerable Medicare beneficiaries—the traditional criticism that private plans only want healthy patients is being turned on its head. Because the beneficiaries served by these plans account for a large share of Medicare spending, the SNP program can have an important impact on the overall quality and efficiency of Medicare and our health care system's ability to serve those who need the most help.

While the initial experience with SNPs has had many positive features, indicating that the program should be reauthorized, the proliferation of a diverse range of SNP plans is beginning to provide a richer basis for evaluating the SNP program and

improving it. For example, CMS is working with outside expert groups to develop improved performance measures for the various types of SNPs. In addition, some SNPs may be targeting conditions like high cholesterol that, by themselves, may not represent a truly distinct cluster of patient health needs where specialized benefits and management can achieve significant improvements in quality and efficiency. And some of these plans may not offer many specialized, targeted services compared to typical MA plans that must market and provide appropriate services for the general Medicare population. CMS or Congress should consider minimum standards for the conditions and types of beneficiaries treated by SNP plans. In particular, the plans should be targeted to beneficiaries where distinctive, complex health care needs create a real opportunity to achieve significant overall cost savings and quality improvement, and the plans should be expected to provide significant specialized benefits and services. Conditions like congestive heart failure, diabetes, chronic lung disease, HIV/AIDS, and certain cancers, as well as high-cost combinations of such conditions, are examples of clinical areas where targeted, specialized services and expertise are likely to be appropriate.

CONCLUSION

Mr. Chairman, Mr. Ranking Member, and Distinguished Members, we are living in era when the opportunities for preventing diseases and their complications have never been greater, and at the same time, when the challenge of promoting effective and efficient use of all of the increasingly diverse and sophisticated treatments available has never been greater. Increasingly, efficient health care is about prevention, personalization, and coordination of services around the needs of each individual patient. How we pay for health care has an important impact on how quickly and effectively we can create a health care system that fulfills the promise of modern medicine at the lowest possible overall cost. With Americans generally and Medicare beneficiaries in particular getting only about half of the preventive care they need, and with poor care coordination and preventable complications accounting for more and more spending in the Medicare program, it is more urgent than ever for Medicare payment policies to promote high-value, personalized care. To achieve a high-value health care system—the most important kind of "efficiency" in health care—Congress should continue to support the Medicare Advantage program, which is our best, proven avenue for improving prevention and chronic disease management in Medicare.

At the same time, there are promising approaches to improve the performance of Medicare Advantage, and of traditional FFS Medicare as well. Effective marketing enforcement and oversight, improving the availability of information on plan quality and costs (including better measures for traditional FFS Medicare and Medigap, as well as all types of MA plans, to help beneficiaries make more informed choices about their coverage), providing more support for beneficiaries to use this information to make informed decisions about their coverage and their care, and adjusting the rules affecting PFFS plans and SNPs are all examples of such policies. Similarly, there are many opportunities to improve the efficiency of payments in traditional FFS Medicare. All of these steps can help achieve greater efficiency in Medicare, leading to budgetary savings without raising beneficiary costs substantially.

The best solution to Medicare's financing problems isn't to take away innovative coverage options and shift costs to beneficiaries—particularly those with limited means who are struggling with out-of-pocket costs today. There are better ways to address the long-term sustainability of the Medicare program while promoting more efficient health care, and I look forward to supporting the Committee's efforts to achieve this critical public health and fiscal goal.

ENDNOTES

[1] Centers for Medicare and Medicaid Services, Overview of the Medicare Advantage Program, May 2007.

[2] Jencks, SF, et al., Journal of the American Medical Association, 289: 305-312, Jan. 15, 2003.

[3] CMS, op. cit.

[4] Sokol, MC, McGuigan, KA, Verbugge, RR, Epstein, RS. Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost. Medical Care 2005; 43: 521-530.

[5] Atherly, A, and Thorpe, KE, The Impact of Reductions in Medicare Advantage Funding on Beneficiaries. Atlanta, GA: Emory University Rollins School of Public Health, April 2007.

[6] Miller M, Private Fee-for-Service Plans in Medicare Advantage. Statement on behalf of MedPAC before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 22, 2007.

[7] MedPAC, Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending, June 2006.

[8] See, e.g., the detailed report in Centers for Medicare and Medicaid Services, Medicare Advantage in 2007. Baltimore, MD: May 2007, *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/MedicareAdvantageIn2007.zip.*

[9] Baker L, "Managed Care Spillover Effects," Annual Review of Public Health 24: 435-56, 2003.

[10] According to CBO's Budget Options (February 2007), replacing the current first-dollar Medigap coverage options with supplemental coverage that required limited cost sharing (with an out-of-pocket spending limit) to levels more like that seen in MA plans would save over $14 billion.

[11] Thorpe, op. cit

[12] Atherly, A, and Thorpe. KE, Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries. Atlanta, GA: Emory University Rollins School of Public Health, 2005.

Chairman SPRATT. Before turning to Barbara Kennelly, let me recognize Dr. Robert M. Wah who is taking the place of Ardis Hoven of the American Medical Association. I am sorry for the initial mistake I made.

Ms. Kennelly, you are welcome any time. Good to see you again. Thank you for coming to testify.

STATEMENT OF BARBARA KENNELLY

Ms. KENNELLY. Thank you, Chairman Spratt, and thank you Ranking Member, Mr. Ryan. And thank you members of the committee for inviting me to testify today on this important issue of the impact of Medicare Advantage overpayments on the Medicare program.

As President of the National Committee to Preserve Social Security and Medicare, I represent 4 million members and supporters who are vitally committed to the preservation of Social Security and Medicare, programs that are crucial to our Nation's retirement security.

Mr. Chairman, while the groups like us, like the National Committee, were concentrating on stopping the privatization of Social Security, Medicare was already undergoing a transformation into a privatized program, thanks to the Medicare Modernization Act.

I listened very carefully to Dr. Orszag this morning and Dr. Miller, and I certainly appreciate what they were saying: that there are managed care plans that before this bill was passed, did a very good job and will continue to do a very good job. In fact, people on this panel represent some of those proposals.

But I truly feel that the way the bill was designed that it is truly a—it is looking right at the heart of Medicare—to do away with Medicare as we know it. In fact, I will go so far as to say this morning that it was designed to accomplish the goal expressed by our former Speaker, Mr. Gingrich, to lure seniors voluntarily out of Medicare so that it would eventually—Medicare would eventually wither on the vine.

Now, I know much time has been spent debating the long-term affordability of both Social Security and Medicare. In fact, the administration has people on the Hill almost weekly telling us that we can't afford these entitlements. We can't afford Medicare. And this committee has spent—and I know how much time it has spent, considering these situations and looking at Medicare very seriously, and they certainly will do that again next year because of the 45 percent trigger.

We know that many of Medicare's costs are not unique to Medicare. They reflect the same factors that are causing skyrocketing increases in health care costs for the under-65 population. Many

experts continue to struggle with ways to solve these problems. But unlike these complex technical challenges, overpayments to Medicare Advantage plans are much more straightforward. They are also one cost that you can control.

Congress created the expanded subsidies in the MMA. Congress can vote to eliminate them or at least reduce them to a certain extent.

I cannot overstate the damage these Medicare Advantage overpayments will cause to the traditional Medicare program if they are not addressed.

Ultimately, overpaying Medicare Advantage plans will shatter the risk pool that made Medicare work. Medicare Advantage plans tend to attract healthier seniors because of their benefits.

As more of these seniors are lured out of the traditional Medicare, they leave behind the frailest and most vulnerable to pay higher and higher premiums. Also, as Medicare Advantage enrollments grow, so do taxpayer subsidies. Over time, this cycle will cause Medicare to become unaffordable for both taxpayers and beneficiaries. Eventually, political support for the program will shift.

Today's social insurance concept of shared risk will be replaced by the ownership society, a concept of individual risk, a concept that has been already pushed very hard by our President, and hand-in-hand with individual risk will come an individual payment system called vouchers.

We know that vouchers save money for healthy beneficiaries and shift the burden of health care to the frailest and sickest among us, and they also provide no containment for health care costs. Eventually, we will find ourselves in a world much like it was before Medicare was created, and health care will be unaffordable for the average senior.

At a time when our Nation is struggling with how to create affordable health care coverage for all Americans, it is simply incomprehensible to me why we would destroy the one affordable, universal health care system that already exists, known as Medicare. Now, I know that you will hear arguments that the Medicare Advantage overpayments are necessary to provide improved health care services to groups such as those with multiple and chronic conditions, minorities, those living in rural areas, and the poor.

Of course, we do not always know whether the Medicare Advantage plans actually provide significant benefits to these groups because of lack of reporting and claims of proprietary information, but if Congress believes higher payments are needed to improve the health of beneficiaries in these groups, it would be much more simple and it certainly would be less expensive to increase resources targeted to the groups that we are talking about by expanding and improving low-income programs.

Mr. Chairman, the vast majority of Medicare beneficiaries remain in the traditional program. You may not hear their voices as loudly as you hear the insurance industry's, but believe me when I tell you they will be seriously hurt if Congress does not eliminate Medicare Advantage subsidies. The decision you make this year will be impacting on the people of this country for decades to come.

Thank you for inviting me here today, and thank you very much for listening to me, and I look forward to working with you.

[The prepared statement of Barbara Kennelly follows:]

PREPARED STATEMENT OF HON. BARBARA B. KENNELLY, PRESIDENT AND CEO, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, FORMER MEMBER OF CONGRESS

Mr. Chairman and Members of the Committee: Thank you for inviting me to testify this morning on the important issue of the impact of Medicare Advantage overpayments on the Medicare program. As President of the National Committee to Preserve Social Security and Medicare, I represent 4 million members and supporters who are vitally committed to the preservation of Social Security and Medicare—programs that are critical to our nation's retirement security.

The National Committee advocated in favor of adding a prescription drug benefit to the Medicare program for many years. We shared many seniors' expectations that a drug benefit would take the form of a simple expansion of the traditional Medicare program. Providing prescription drug coverage through traditional Medicare would have given beneficiaries a simple, standardized benefit, and allowed the federal government to leverage the purchasing power of millions of beneficiaries to lower drug prices.

As you know, this benefit structure is not what seniors received. The current Medicare Part D benefit is complicated, confusing and fragmented, and whatever competition exists between private plans has not been sufficient to slow the continued upward spiral of prescription drug prices. Because the drug benefit is provided entirely through private plans, it also represents the first major step toward the full privatization of the Medicare program.

The Medicare Modernization Act (MMA) is not only a mechanism for enacting a drug program that provides considerable financial benefit to the drug and insurance industries. For many, offering seniors prescription drug coverage for the first time was the "sweetener" intended to mask the taste of the medicine of privatization. As it has turned out, the drug benefit itself was a bitter pill for many seniors. But for the designers of the MMA, it was conceived as a way to smooth the passage of massive long-term changes leading to the privatization of the Medicare program. This was done despite the success and popularity of the traditional fee-for-service Medicare program, and despite the failure of past privatization efforts such as Medicare+Choice.

Mr. Chairman, the Medicare Modernization Act is a weapon aimed at the heart of the traditional Medicare program. It was designed to accomplish the goal expressed by former Speaker Newt Gingrich—to lure seniors voluntarily out of Medicare so that it would eventually wither on the vine. The overpayments to Medicare Advantage plans that you are exploring today represent one of the tools by which to achieve this end.

The National Committee believes that privatizing Medicare is just as likely to ultimately destroy the health care safety net for seniors as privatizing Social Security is to dismantle the foundation of retirees' income security. Through much hard work and education, groups such as ours have been able to temporarily halt the march of Social Security privatization. Unfortunately, we were not similarly successful with Medicare, so our efforts must be concentrated on reversing the most egregious provisions of the Medicare Modernization Act.

Privatization in the MMA takes a number of forms. First, there is the privatized nature of the drug benefit itself, which is only available through private plans and not through traditional Medicare. In addition, the MMA provided massive subsidies to the private sector, most of them in the form of the overpayments to private Medicare Advantage plans that the Committee is exploring today. Finally, we would note some of the lesser understood elements of privatization such as the 45% limit on federal funding, the privatization demonstration project known as the "comparative cost adjustment demonstration project" or "premium support", and the new provision means-testing the Medicare Part B program for the first time in the history of Medicare. All of these provisions collectively undermine the traditional Medicare program.

Private health plans, now called Medicare Advantage plans, were first allowed to participate in Medicare because some policymakers believed they could provide better services at a lower cost than traditional Medicare. In fact, because it was anticipated private plans would be so efficient, the government initially paid them 5 percent less for each beneficiary they enrolled than it would have cost to cover that same beneficiary in traditional Medicare.

In 25 years time, the powerful health insurance industry lobby has been extremely successful in turning this rationalization on its head. Instead of paying private plans less to reflect the efficiencies they argued would save the government money, Medicare now pays them significantly more than it would cost to cover the same beneficiaries through traditional fee-for-service Medicare. In fact, today the government pays an average of 12 percent more to cover a beneficiary in a private Medicare Advantage plan than it would cost to cover that same beneficiary in traditional Medicare. And some types of private plans can receive much larger payments. For example, Private Fee-For-Service plans are paid about 19 percent more than traditional Medicare and plans in some localities are paid 50 percent more than traditional Medicare. In simple dollar terms, Medicare pays about $1,000 more a year to cover a beneficiary in a private plan than it would cost to provide care to that same beneficiary under traditional Medicare.

All beneficiaries, whether they enroll in a private plan or not, subsidize payments to private companies by paying higher Part B premiums. Today, these premiums are almost $50 per year higher per couple than they should be because of overpayments to private plans. This number will clearly continue to grow exponentially in future years. These increases are in addition to the record-setting increases in Part B premiums beneficiaries have already experienced—and which are expected to continue—as a result of increases in the cost of health care.

In addition to adding costs for individual beneficiaries, overpayments to Medicare Advantage plans result in higher costs to the federal government. Medicare's Actuaries estimate that eliminating these overpayments would add two years of solvency to Medicare's hospital insurance trust fund. These additional costs are absorbed by the Medicare program at a time when health care costs are growing dramatically, both for the federal government and for beneficiaries. In fact, President Bush and some others have insisted that the federal government cannot afford to continue supporting entitlement programs such as Medicare over the long-term. President Bush has included deep cuts to Medicare in his past two budgets, and many of his supporters in Congress have pushed to include sizeable Medicare cuts in the budget process this year. In addition, the automatic triggering mechanism included in the Medicare Modernization Act of 2003 has initiated a process designed to result in significant cuts in Medicare as early as 2009.

Many of the causes of increased Medicare costs are difficult to tackle—they reflect the same factors that have resulted in skyrocketing increases in health care costs for the under-65 population that have proven so intractable. Many experts continue to struggle with ways to solve this problem.

But I can point out one cost reduction that is obvious and can be addressed by this Congress quite simply—the overpayments to Medicare Advantage plans. Overpaying private plans adds to the cost of the Medicare program for both beneficiaries and for taxpayers. Unlike the more complex challenges of curbing the overall growth of health care, it is the one cost that is easiest to control. Congress created the expanded subsidies in the Medicare Modernization Act. Congress can vote to eliminate them.

The National Committee believes that Medicare should equalize payments between the traditional program and private plans. We support the Medicare Payment Advisory Commission's (MedPAC) recommendation of financial neutrality between payments in the traditional fee-for-service program and payments to private plans. Equalized payments would level the playing field and remove private plans' unfair advantage in attracting beneficiaries.

Continuing to overpay private insurance companies to provide services that could be more affordably and efficiently provided by the traditional Medicare program is unconscionable. According to the Congressional Budget Office (CBO), leveling the playing field could save taxpayers $149 billion over the next ten years. Congress should remove these unwarranted subsidies and use a portion of the savings to improve benefits for low-income Medicare beneficiaries.

I cannot overstate the damage these Medicare Advantage overpayments will cause to the traditional Medicare program if they are not eliminated. Medicare Advantage plans tend to attract healthier seniors because of their benefit structures. As more of these seniors are lured out of traditional Medicare, overpayments to the private plans will continue to grow dramatically. That will result in even higher costs for taxpayers, and increasing premiums paid by those remaining in the traditional program. Over time, this cycle of higher payments and growing costs will simply become unaffordable—for both taxpayers and beneficiaries.

Ultimately, this cycle will shatter the risk pool that makes Medicare work. Increasing numbers of healthier seniors will abandon traditional Medicare for the private sector, leaving the frailest and most vulnerable to pay the price not only for their own care, but also for the growing subsidies to the private plans. Over time,

political support for the program will shift. Today's social insurance concept of shared risk will be replaced by the ownership society's concept of individual risk. And hand-in-hand with individual risk will come an individualized payment system such as vouchers.

Vouchers save money for healthy beneficiaries and shift the burden of health care to the frailest and sickest among us. They shift risk from shared pools to individuals. And they provide no containment for health care costs. Eventually we will find ourselves in a world much like that before Medicare was created, and health care will be unaffordable for the average senior. At a time when our nation is struggling with how to create affordable, universal health care coverage for our workers and their families, it is simply incomprehensible to me why we would destroy the one affordable, universal health care system that already exists in Medicare.

You will hear arguments that the Medicare Advantage overpayments are necessary to provide improved health care services to groups such as beneficiaries with multiple, chronic conditions, minorities, those living in rural areas or the poor. Of course, we don't really know whether Medicare Advantage plans actually provide any significant benefits to these groups because of the lack of reporting and claims of proprietary information. What we do know is that the numbers the insurance industry is using about the impact of Medicare Advantage plans on these vulnerable groups are misleading. We also know that private industry is insisting on being overpaid to provide these services—clear proof that this is not the most efficient way to deliver benefits.

If Congress believes higher payments are needed to improve the health of beneficiaries in these groups, it would be much simpler and less expensive to increase resources targeted to the groups directly, by expanding low-income programs. Instead of giving private plans extra money and simply hoping some if it finds its way to these vulnerable populations, Congress should improve the Medicare Savings Programs or the low-income prescription drug subsidy.

Mr. Chairman, the vast majority of Medicare beneficiaries remain in the traditional program. You may not hear their voices as loudly as you do the insurance industry's but believe me when I tell you they will be seriously hurt if Congress does not eliminate Medicare Advantage subsidies immediately. The decisions you make this year will impact the Medicare program for decades to come.

BACKGROUND

Overpayments to private plans increase Part B premiums for all Medicare beneficiaries. The Medicare program finances overpayments to private plans with money collected by general revenues and beneficiary premiums. MedPAC has estimated that every Medicare beneficiary pays $24 a year in higher Part B premiums just to fund excess payments to private plans. In other words, the majority of Medicare beneficiaries—the 81 percent of beneficiaries choosing to remain in traditional Medicare—are paying to subsidize the private plans that provide benefits to the remaining 19 percent of beneficiaries. Because subsidies are projected to continue rising, all Medicare beneficiaries can expect to pay dramatically higher premiums in the future, and can expect increasing portions of those premiums to be diverted to private plan subsidies.

Eliminating overpayments would save billions of dollars and improve Medicare's financial outlook. The Congressional Budget Office (CBO) projects that Medicare will pay $75 billion to private plans in 2007 and $1.31 trillion to private plans over the next ten years. Federal spending on Medicare Advantage plans will continue to grow as more beneficiaries are lured out of traditional Medicare as a result of the excessive payments made to private plans. According to CBO, paying private plans at the same rate as traditional Medicare would save $54 billion over the next five years and $149 billion over the next ten years. Not only would eliminating these large overpayments save billions of dollars, it would also add two years of solvency to Medicare's hospital insurance trust fund.

Overpayments are used to improve insurance industry profits and are not completely passed along to beneficiaries. When Congress approved the system which overpays private plans, policymakers intended that the excess payments be returned to beneficiaries in the form of additional benefits or reduced cost-sharing. It is not at all clear to what extent this is occurring. Private plans are subject to few public reporting requirements, so it has been extremely difficult to determine what percentage of the overpayments has inflated the profit margins of the private insurance companies offering the plans, or has been used for marketing, rather than being returned to beneficiaries. In the case of Private Fee-For-Service plans, MedPAC found that only about half of the excess payment is used to deliver extra benefits for en-

rollees. The remainder of the payment is used to finance the administrative costs, marketing, and profits of private plans.

Overpayments are driving unscrupulous agents and private plans to use aggressive sales tactics and misrepresentations to sell their products to beneficiaries. A recent survey of state insurance departments found that 39 of 43 states had received complaints about misrepresentations and inappropriate marketing practices of Medicare Advantage plans. In most cases, these practices led to Medicare beneficiaries enrolling in a private plan without adequate understanding of the plan or their ability to stay in traditional Medicare. The inflated payments to private plans allow them to offer exceedingly large commissions to agents who enroll beneficiaries into Medicare Advantage plans, regardless of whether the plan meets their needs. To receive their commissions, some insurance agents have engaged in fraudulent activities including: forging signatures on enrollment documents; mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities; and enrolling beneficiaries with dementia into inappropriate plans. Removing overpayments, increasing oversight and regulation, and limiting large commissions would help to prevent beneficiaries from falling victim to unethical and illegal sales tactics.

Eliminating overpayments would not adversely affect low-income and minority beneficiaries. Contrary to insurance industry claims, private plans do not attract a disproportionate number of low-income and minority beneficiaries. A recent analysis by the Center on Budget and Policy Priorities found that these Medicare beneficiaries are far more likely to receive supplemental coverage through Medicaid than to be enrolled in Medicare Advantage. The Center found that nearly half (48 percent) of all Medicare beneficiaries with incomes under $10,000 receive Medicaid, compared to only 10 percent who are enrolled in private plans. Similarly, they found that most Asian American Medicare beneficiaries (58 percent), and a plurality of African American (30 percent) and Hispanic beneficiaries (34 percent) receive Medicaid, compared to the 14 percent of Asian Americans, 13 percent of African Americans, and 25 percent of Hispanics enrolled in private plans. If Congress believes higher payments are needed to improve the health of beneficiaries in these groups, it would be much simpler and less expensive to increase federal resources targeted to these groups directly by expanding low-income programs. Instead of giving private plans extra money and simply hoping some of the funds find their way to these vulnerable populations, Congress could improve the Medicare Savings Programs or the low-income prescription drug subsidy.

Eliminating overpayments would not adversely affect beneficiaries living in rural areas or inner cities. Proponents of private plans have argued that beneficiaries living in areas that are difficult or expensive to serve need an expanded and overpaid Medicare Advantage program to continue receiving services. In fact, in many rural and low-income inner cities exactly the opposite is true: the expansion of bloated private plans accelerates the deterioration of traditional fee-for-service providers, and undermines the ability of hospitals and other providers to continue operating. Medicare payments to hospitals, doctors and other providers who care for beneficiaries in traditional Medicare today are partly based on geographic differences in the cost of providing health care. If Congress believes even higher payments are necessary to ensure beneficiaries in some parts of the country receive adequate services, it would be much more efficient to modify Medicare's geographic cost adjustment or provide additional payments to areas where Medicare providers are particularly scarce or have costlier expenses. This way plans in counties with greater need could receive higher payments without harming the traditional Medicare system in those areas or the beneficiaries who chose to remain in it.

Despite receiving inflated payments, Medicare Advantage plans can provide inferior health coverage compared to traditional Medicare. Private plans do not necessarily provide benefits that are fully equivalent to traditional Medicare. They are required to cover everything that Medicare covers, but they do not have to cover every benefit in the same way. For example, private plans may create financial barriers to care by imposing higher cost-sharing requirements for benefits such as home health services, hospitalization, skilled nursing facilities, inpatient mental health services, and durable medical equipment that protect the sickest and most vulnerable beneficiaries. In many cases, beneficiaries are lured into the private plans based on improved coverage of relatively inexpensive services such as expanded dental or vision care, only to discover after it is too late that their plans shift significantly more of the higher costs of major illnesses onto their shoulders. Preventing private plans from imposing greater cost-sharing requirements than traditional Medicare would better protect beneficiaries from high out-of-pocket costs.

Failure to rein in overpayments to private plans will lead to the privatization of Medicare. Continuing to dole out excessive and unwarranted payments to private

plans will undermine traditional Medicare. Private plans use these overpayments to offer additional benefits like gym memberships that attract healthier enrollees. They can also discourage sicker beneficiaries from joining their plan by charging higher cost-sharing for hospitalization and home health benefits. Eventually, Medicare's risk pool will be shattered as those with greater health care needs remain in the traditional program, paying increased taxes and higher Part B premiums to subsidize overpayments to private plans. Eliminating overpayments would allow traditional Medicare to provide efficient and affordable health coverage to all beneficiaries for generations to come.

NATIONAL COMMITTEE POSITION

Medicare should equalize payments between the traditional program and private plans. The nonpartisan Medicare Payment Advisory Commission (MedPAC) has recommended that Medicare pay the same amount regardless of whether a beneficiary enrolls in traditional Medicare or Medicare Advantage. Instead of being paid up to 50 percent more than traditional Medicare, private plans should be paid at a rate equal to the costs of traditional Medicare in every part of country. Equalized payments would level the playing field and remove private plan's unfair advantage in attracting beneficiaries.

Savings from eliminating overpayments should be used to help low-income Medicare beneficiaries. The most cost-effective and efficient way to help low-income and minority beneficiaries is to use a portion of the savings collected from eliminating Medicare Advantage overpayments to strengthen the Medicare Savings Programs and improve Medicare Part D's Low-Income Subsidy program.

Private plans should be prohibited from charging higher out-of-pocket costs for benefits than traditional Medicare. It is particularly egregious for private plans to receive excess payments while providing lesser coverage. To better protect Medicare Advantage beneficiaries from high out-of-pocket costs, policymakers should prevent private plans from imposing higher cost-sharing requirements than traditional Medicare.

Traditional Medicare is an option that must be preserved. The vast majority (81 percent) of Medicare beneficiaries choose to remain in the traditional program. The special treatment of Medicare Advantage plans allows them to receive higher payments than traditional Medicare and allows them to impose higher cost-sharing on beneficiaries. This treatment is particularly unwarranted because there is no available data to suggest that private health plans deliver any better health outcomes than traditional Medicare. If Medicare continues to fund large overpayments to private plans, the program will face growing fiscal pressure to cut benefits or increase beneficiary cost-sharing.

Thank you for inviting me to testify today, Mr. Chairman. I look forward to working with you and the other members of this Committee to reverse the privatization of Medicare that has been imposed through the Medicare Modernization Act. Eliminating overpayments to Medicare Advantage Plans is the first important step toward achieving that goal.

Chairman SPRATT. Thank you very much for your excellent statement.

Dr. Neuman.

STATEMENT OF PATRICIA NEUMAN, SC.D.

Ms. NEUMAN. Thank you, Chairman Spratt, Mr. Ryan, and distinguished members of the committee. It is an honor to be here to talk about the Medicare Advantage program. I am Patricia Neuman. I am a Vice President of the Kaiser Family Foundation.

The proliferation of private health plans under Medicare is fundamentally changing the coverage landscape for the 44 million people on Medicare.

If I could have slide 1. Enrollment in Medicare Advantage plans is at an all-time high and is projected to rise rapidly, as you have heard already this morning.

Slide 2. Enrollment today is highly concentrated among a small number of organizations. UnitedHealth leads other firms, covering 1 in 6 Medicare Advantage enrollees nationwide. Together,

UnitedHealth, the Blue Cross/Blue Shield affiliates, Humana, and Kaiser Permanente account for more than half of the total enrollment today.

Medicare Advantage has emerged as a front burner issue for many reasons, not the least of which is that MedPAC, the Congressional Budget Office, and the HHS Office of the Actuary report that the shift in beneficiaries from traditional Medicare to Medicare Advantage plans has the effect of increasing Medicare spending.

Recent discussions have focused on whether Medicare Advantage plans serve a disproportionate share of people who are among the most vulnerable on Medicare, focusing on income, race and ethnicity, and rural locations.

Our analysis of the most recent data available from the Center for Medicare and Medicaid Services finds first, if I could have slide 5, Medicare Advantage enrollees are neither disproportionately low-income nor high-income. Roughly the same share of beneficiaries in traditional Medicare and in Medicare Advantage plans, about half, live on incomes below $20,000. This is not surprising. The Medicare Advantage program was not designed as a program for people with low incomes.

For these beneficiaries—and if I could have slide 6—Medicaid has been and continues to be the primary source of supplemental assistance. So the extra benefits that you have heard about today, this morning, do not just go to those with modest incomes. They are distributed to people with low incomes and higher incomes who are in Medicare Advantage plans.

Second, slide 7, enrollment rates are actually similar for white and African American people on Medicare. Thirteen percent of white and 15 percent of black beneficiaries were enrolled in the Medicare Advantage plan, again using the most recent data we have available, which is 2005. Rates are higher among Hispanic beneficiaries at 25 percent, and that is because they tend to live in areas of the country, like Florida and California, with a relatively high concentration of Medicare Advantage plans. Clearly, as you can see, the majority of all beneficiaries, regardless of race or ethnicity, are in traditional Medicare.

Third, just 7 percent of all beneficiaries living in rural areas are now on a Medicare Advantage plan although access to Medicare Advantage plans has clearly increased in rural areas over the past few years.

Fourth, slide 9, Medicare Advantage enrollees tend to be healthier than their counterparts in traditional Medicare, and you can see this is true across a number of measures—looking at self-assessed health status, looking at the rates of people who are under 65 with permanent disabilities in Medicare Advantage plans and the percent living in institutions.

Now, while Medicare Advantage enrollees are generally healthier than those in traditional Medicare, 24 percent do say their health status is fair or poor, and a concern for this group is likely to be the adequacy of their plan's coverage and the out-of-pocket costs associated with their medical care. Out-of-pocket costs depend on many factors, including an individual's medical needs and the particular plan they choose. On the one hand, as you have heard this morning, Medicare Advantage plans often waive deductibles. They

reduce cost-sharing requirements. They offer additional benefits and sometimes include a valuable stop-loss limit on catastrophic spending. On the other hand, some Medicare Advantage plans impose daily hospital copays, daily copays for home health visits and daily copayments for the first several days in a skilled nursing facility, unlike traditional Medicare. Of course, extra benefits help to reduce out-of-pocket costs for many beneficiaries in Medicare Advantage plans. Yet, even with these extra benefits, some enrollees could end up paying more in a Medicare Advantage plan than they would pay under traditional Medicare, and that probably sounds a little counterintuitive to you.

If you would look at slide 10, my written testimony illustrates how a hypothetical senior using inpatient and post-acute care could end up with higher out-of-pocket costs under a Medicare Advantage plan than under traditional Medicare.

In Oakland, for example, our illustrative senior could spend between about $2,500 and $5,200 under an Advantage plan and about $3,000 in traditional Medicare. She would definitely spend less in five of the Medicare Advantage plans than under traditional Medicare but more, and in some cases substantially more, under the majority of Medicare plans in her areas.

For seniors living on fixed incomes, the difference between the highest and the lowest plans, $2,700 in this example, is not trivial. In the current system, it is clearly up to the individual beneficiary, the senior, to choose which plan is going to end up saving them the most money, and given the number of plans that are in their area and the wide variety of benefits, that can sometimes be a tall order.

The current payment system translates into extra benefits for up to 1 in 5 beneficiaries in Medicare Advantage, and some of these benefits, as we have noted, are highly valued, but the allocation of resources raises questions about whether Medicare is distributing benefits equitably across the entire population, including the 4 out of 5 beneficiaries who are in traditional Medicare.

A second equity issue relates to financing. The current payment system results in higher part B premiums paid by beneficiaries to help fund higher payments to Medicare Advantage plans. This is according to the HHS Office of the Actuary. As a result, the majority of beneficiaries who are in traditional Medicare are asked to pay higher monthly premiums to help support this system for Medicare Advantage plans, but of course they do not receive the extra benefits that are provided to the enrollees of Advantage plans.

A third issue concerns future generations. Again, according to the Office of the Actuary, the current payment system cuts short by 2 years the life of the part A trust fund, potentially affecting coverage for future generations of beneficiaries who are looking forward to having Medicare and its benefits when they retire.

In summary, Mr. Chairman, Medicare Advantage plans do play an important role as an alternative to traditional Medicare. However, the on-budget costs associated with the current payment policies coupled with rapid enrollment growth in relatively high-payment areas underscore a number of important policy considerations. Clearly, critical questions relate to whether the positive at-

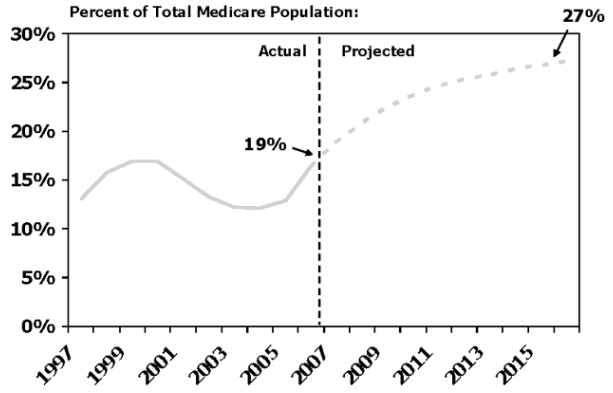
tributes of the Medicare Advantage program are balanced by the higher costs associated with the current payment system and whether the current payment system is affordable for beneficiaries and taxpayers in light of the long-term fiscal challenges facing Medicare and in light of competing national priorities.

Thank you very much, and I look forward to your questions.

[The prepared statement of Patricia Neuman follows:]

Exhibit 1

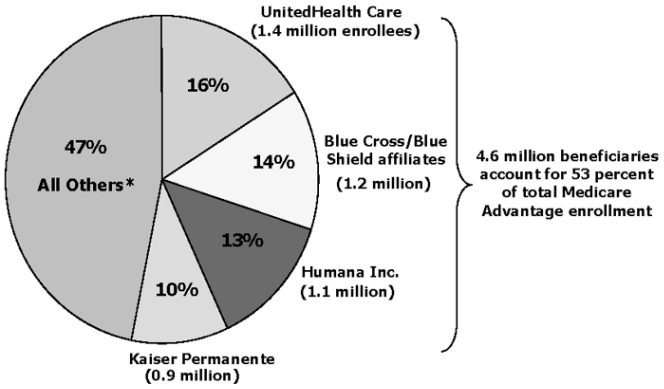
Actual and Projected Medicare Advantage Enrollment, 1997-2016



SOURCE: Centers for Medicare and Medicaid Services, 2007 Medicare Trustees Report Table IV.B6.

Exhibit 2

Enrollment in Medicare Advantage plans is highly concentrated

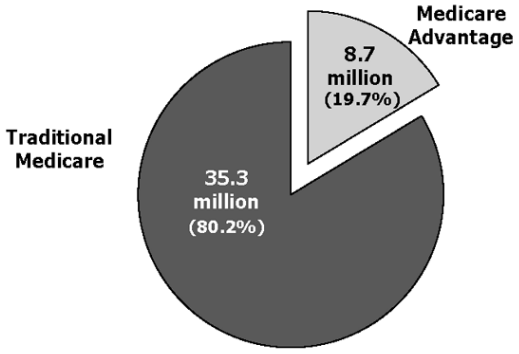


Total Medicare Advantage Enrollment= 8.7 million

NOTE: All Other Medicare Advantage Plans includes plans with enrollment less than 230,000 beneficiaries. Total for Blue Cross/Blue Shield affiliates provided by Blue Cross/Blue Shield. Numbers rounded. Data as of May 15, 2007. SOURCE: Centers for Medicare and Medicaid Services (CMS), June 2007 Monthly Summary.

Exhibit 3

Medicare Advantage Enrollment, June 2007



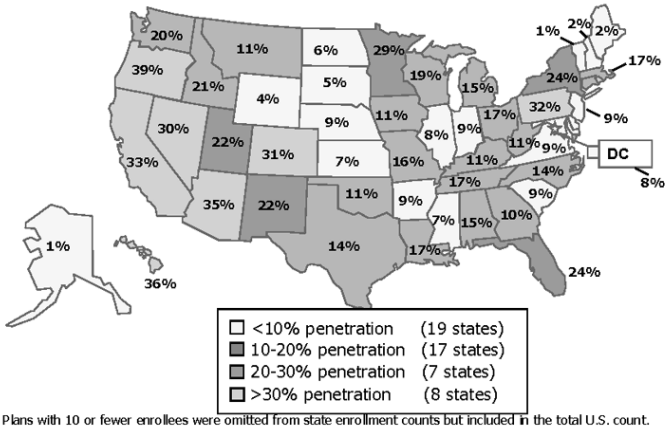
Total Medicare Beneficiaries = 44 million

Source: Centers for Medicare and Medicaid Services (CMS), Monthly Tracking Report, June 2007.

Exhibit 4

Medicare Advantage penetration varies by state

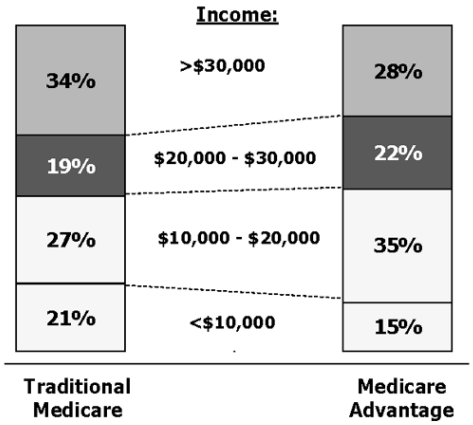
U.S. Penetration, June 2007*: 19.7%



NOTE: Plans with 10 or fewer enrollees were omitted from state enrollment counts but included in the total U.S. count.
Source: Centers for Medicare and Medicaid Services (CMS), June 2007.

Exhibit 5

About half of all beneficiaries in traditional Medicare and in Medicare Advantage plans live on incomes below $20,000

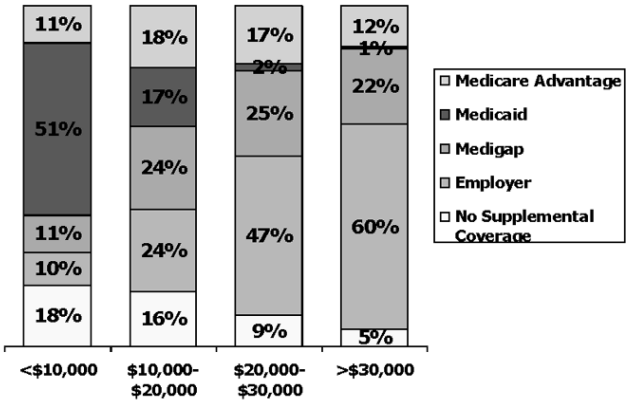


NOTES: Numbers do not add to 100% due to rounding. Data exclude 3.6 million beneficiaries due to missing income data.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 6

Across all income groups, most are in traditional Medicare

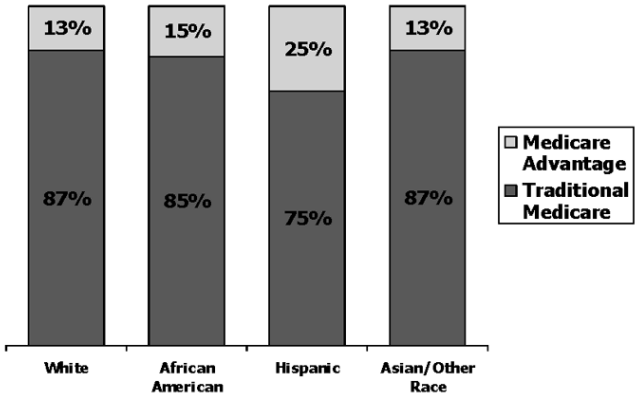
Medicaid is the primary supplement for low-income beneficiaries



NOTES: Numbers do not add to 100% due to rounding. Excludes beneficiaries with "other" public sources and those with missing income data. Employer includes those with TriCARE/Military coverage.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 7

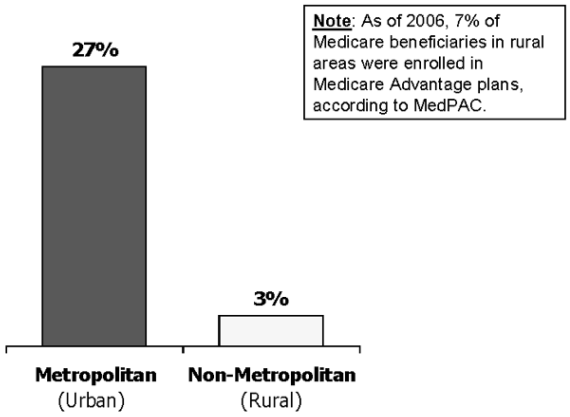
Medicare Advantage enrollment rates are similar for White and African American beneficiaries; enrollment rates are higher among Hispanic beneficiaries



NOTES: Numbers do not add to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 8

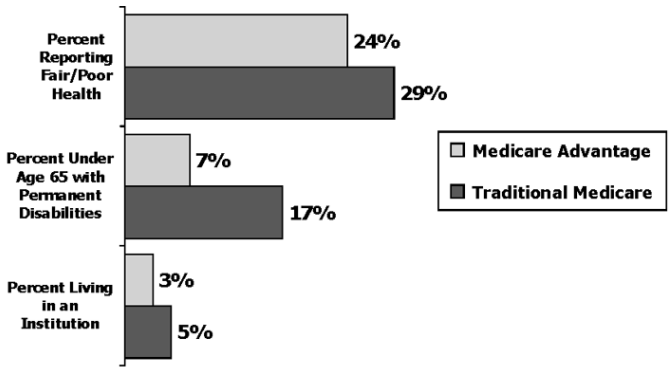
A small but growing share of beneficiaries in rural areas are enrolled in a Medicare Advantage plan



SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 9

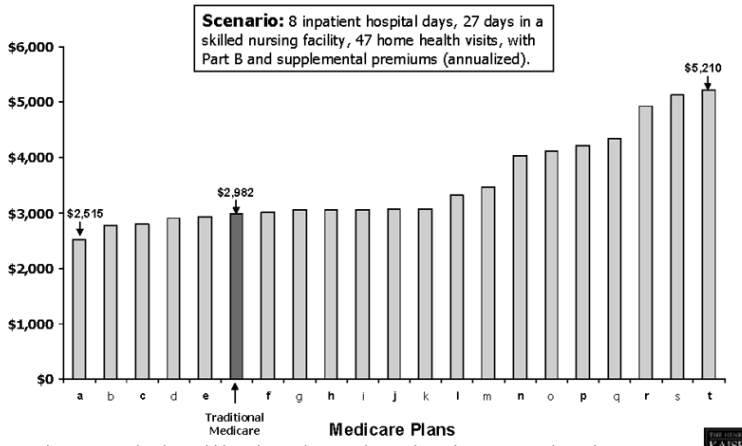
Medicare Advantage enrollees are generally in better health than beneficiaries in traditional Medicare



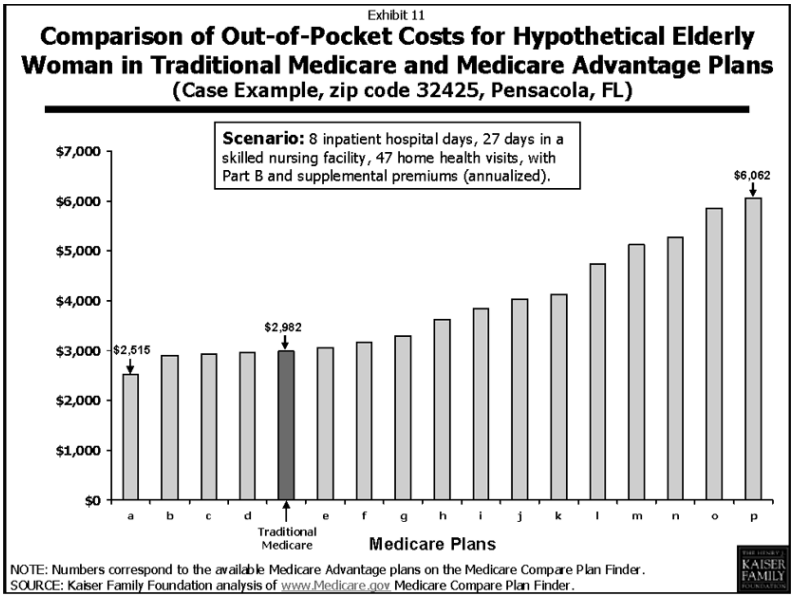
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

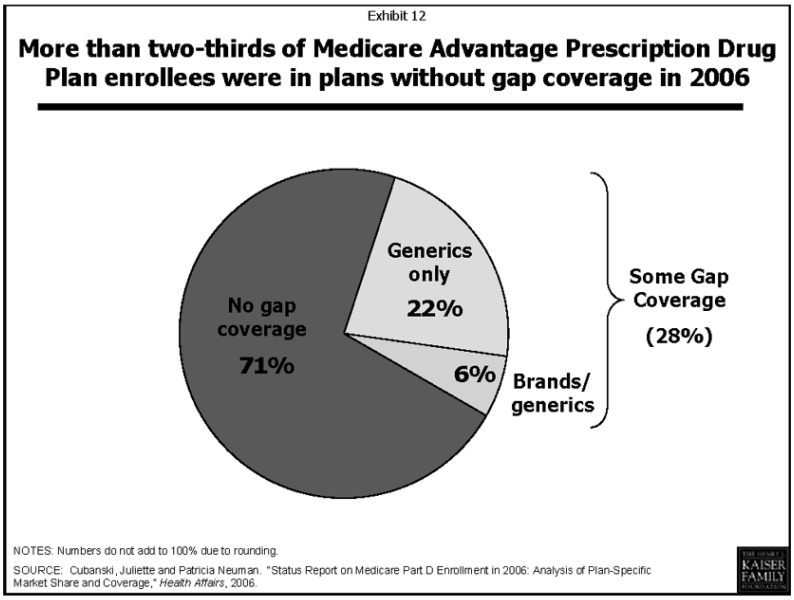
Exhibit 10

Comparison of Out-of-Pocket Costs for Hypothetical Elderly Woman in Traditional Medicare and Medicare Advantage Plans
(Case Example, zip code 94601, Oakland, CA)



NOTE: Numbers correspond to the available Medicare Advantage plans on the Medicare Compare Plan Finder.
SOURCE: Kaiser Family Foundation analysis of www.Medicare.gov Medicare Compare Plan Finder.





Chairman SPRATT. Thank you, and thank you in particular for the points you have made.

Dr. Wah.

STATEMENT OF ROBERT M. WAH, M.D.

Dr. WAH. Thank you, Chairman Spratt, Mr. Ryan, and members of the committee. Thank you for inviting the AMA to speak with you regarding the impact of the Medicare Advantage program on Medicare's financial viability and the delivery of quality care for Medicare patients. I am Robert Wah. I am a practicing physician and a member of the Board of Trustees of the American Medical Association.

The AMA supports competition in the Medicare program. Real competition would increase patient choice and Medicare's financial sustainability. Seniors should be able to choose from Medicare options based on their health care needs and with accurate information on each option. The AMA staunchly supports fiscal neutrality between Medicare Advantage plans and regular Medicare.

Currently, there is not fiscal neutrality between them because the government provides Medicare Advantage plans, as we heard this morning, with an average 12 percent subsidy per enrollee. Instead of making Medicare more sustainable as the baby boom generation reaches the age of Medicare eligibility, this subsidy will have the opposite effect. The Medicare actuary has stated—and we have heard it again this morning—that the Medicare Advantage subsidies will shorten the solvency of the hospital insurance trust fund. However, adopting fiscal neutrality between Medicare Advantage and regular Medicare would extend that insolvency date by about 2 years.

The Medicare Advantage add-ons averages almost $1,000 per Medicare Advantage enrollee, and the CBO reports this amount is only expected to climb. So Medicare Advantage costs taxpayers more. In addition, all seniors, not just those in Medicare Advantage, are paying about $2 a month in higher premiums to help fund these subsidies.

There are real trade-offs involved in public policy choices that face Congress today. The government here is providing billions of dollars in subsidies to Medicare Advantage plans that only serve 1 in 5 beneficiaries. At the same time, physicians in the regular Medicare plan, which serves 80 percent of seniors and disabled beneficiaries, are facing a 10 percent cut. There are also questions about the access to health care provided by Medicare Advantage. Patients and physicians are being shortchanged by a significant number of Medicare Advantage plans that are luring their enrollees in with false promises, then skimping on coverage and payments and using the subsidies primarily to increase profits.

The picture painted by responses of an AMA survey of our physicians who have treated Medicare Advantage patients is startling. An overwhelming number of physicians—8 out of 10—reported that their patients have difficulty understanding how Medicare Advantage plans work. As for the physicians who deal with multiple health plans every day, 6 out of 10 of those physicians reported that they also have a hard time understanding how Medicare Advantage plans work. Clear information on the plans is scarce and often inaccessible to both patients and their physicians. About half of the physicians reported that Medicare Advantage plans have denied services that are typically covered by regular Medicare, and half also indicated that they have received payments from Medi-

care Advantage plans that were lower than regular Medicare. These survey results corroborate reports by the Medicare Rights Center, the State insurance commissioners and others.

Furthermore, all Medicare Advantage beneficiaries—minority, low-income and rural beneficiaries—face the same problems. For example, the National Rural Health Association reported that Medicare Advantage private fee-for-service plans often pay rural health clinics at a rate far below regular Medicare rates and, quote, "have the potential to destabilize the existing rural safety net." So the government is paying more for Medicare Advantage plans, but there is mounting evidence that these subsidies in many cases are not buying better health care coverage for our patients and for your constituents.

Until Medicare Advantage is placed on equal footing with regular Medicare, the market distortions will continue to encourage inefficient behavior by Medicare Advantage plans. Patients and physicians will face additional financial risks. The delivery of health care will be compromised, and taxpayers will pay more and get less. Clearly, these Medicare Advantage subsidies do not advantage patients or physicians.

The AMA looks forward to working with the committee to achieve our shared goals of strengthening the Medicare program and providing quality care to patients.

Thank you for the opportunity to be here today.

Chairman SPRATT. Thank you for coming and testifying.

Now, Ms. Schmitt, we left you a little piece of the table back there. Can you pull the microphone up? That is good. Thank you for coming. We look forward to your testimony.

STATEMENT OF CATHERINE SCHMITT

Ms. SCHMITT. Thank you, Mr. Chairman, Representative Ryan, and members of the committee. My name is Catherine Schmitt, and I am Vice President of Federal Programs at Blue Cross and Blue Shield of Michigan. I appreciate the opportunity to testify on the Medicare Advantage program.

Blue Cross/Blue Shield of Michigan is a nonprofit health plan that serves nearly 5 million members, of which 440,000 are Medicare beneficiaries. We offer government contracted MA, private fee-for-service, part D, and supplemental products in every county in Michigan. My testimony today focuses on the importance of the private fee-for-service option in meeting the needs of employer and union retirees.

We believe that it is critical to preserve the viability of the private fee-for-service option because it is the only Medicare Advantage product available today for bringing uniform integrated health benefits to the retirees of major employers and unions nationwide. This option allows employers to provide nationwide retiree health care plans that are identical to the benefit programs they offer for their other group members, incorporating the same care management features through a single plan. There are three key reasons why it is important to preserve this product.

First, care coordination. There is a common misperception that these plans cannot provide any advantages with regard to improving member health. In fact, this is one of the key reasons why em-

ployers are interested in this product. Our plans offer care coordination and management for diseases that commonly afflict the elderly through an integrated benefit package. For example, we provide access to 24x7 nurse consultants, personal health care coaches for chronic conditions, as well as complex case management programs.

The second key reason is that these products provide access in rural areas. For the first time, all Medicare beneficiaries have access to private Medicare plans.

Third, private fee-for-service plans offer members enhanced benefits. In addition to filling gaps in traditional Medicare, with these benefits customized, care management plans can be developed for the most complex cases. The comprehensive benefits offered by MA plans are very important to lower income individuals who make too much to qualify for Medicaid but who cannot afford Medigap.

I would also like to address some of the criticisms of private fee-for-service plans, starting with the most discerning, unscrupulous and even fraudulent sales tactics. I can only imagine the trauma to victimized beneficiaries. We commend CMS for taking decisive actions to strengthening the enforcement of marketing standards to address these problems. We have a zero tolerance policy for agents who do not follow the rules, but please note that these sales problems are not an issue with employer and union accounts.

Some have questioned the care management exemption private fee-for-service plans have from requirements that do apply to HMOs and to PPOs. We believe that private fee-for-service plans should be required to report quality data to enable Medicare beneficiaries to make informed health plan choices. Plans should be required to establish chronic care improvement programs with participation voluntary by members.

Others have indicated a lack of provider acceptance and satisfaction as an issue. Our experience has been that, through education on both the provider fee-for-service option and how, in fact, one I.D. card and a single check from one payor benefits the provider, there has been generally very widespread acceptance. These are also advantages to the beneficiaries.

Another concern identified by MedPAC is that the average payments for private fee-for-service plans are 19 percent more than traditional Medicare compared to 12 percent more for all MA plans. Our actuaries have found that payments for our employer and union products are not higher than the average. For groups, all retirees, regardless of the county-specific reimbursement, are enrolled. Many of the members are in urban areas, but the very reason that the program works for employers is that retirees in rural areas also have access to care. I urge you to reject further cuts in funding for this program.

Congress improved payments under the Medicare Modernization Act to ensure broader access in rural areas and to stabilize the program. Achievement of these goals will pave the way for following the industry movement towards more integration and coordination of care in order to improve quality and member health outcomes. Yet, every time the Federal Government makes a significant investment in these programs in a meaningful way, the funding is threatened, and the momentum is lost.

I can assure you that members whose care we are coordinating would have been far less likely to participate with an unknown care management vendor than with the local Blue plan that has been their health carrier their entire lives. They know the Blues when they call.

The $6.5 billion in cuts already enacted under the Deficit Reduction Act has resulted in MA rates that are rising significantly below the growth in medical costs. If Congress cuts MA funding, the private fee-for-service product is unlikely to remain a sustainable product in many areas. The result may well be that most, if not all, of the 1.3 million enrollees in this product will have a disruption in care, lose access to the enhanced benefit, and lose the opportunity for care coordination.

What would the loss of the private fee-for-service mean for beneficiaries? It will mean that beneficiaries who do not qualify for Medicaid and who cannot afford a Medigap policy will be left without supplemental coverage. It will mean that employers and unions will be forced to make hard choices about reducing benefits, and it will mean that beneficiaries lose confidence in Congress, CMS and their health plans to ensure continuity of care and to help them maintain predictable coverage and premiums.

Thank you for considering my perspective on the MA program and the private fee-for-service option.

[The prepared statement of Catherine Schmitt follows:]

PREPARED STATEMENT OF CATHERINE SCHMITT, VICE PRESIDENT, FEDERAL PROGRAMS, BLUE CROSS BLUE SHIELD OF MICHIGAN

I. INTRODUCTION

Mr. Chairman, Representative Ryan, and members of the committee, my name is Catherine Schmitt and I am Vice President of Federal Programs at Blue Cross and Blue Shield of Michigan. I appreciate this opportunity to testify on the Medicare Advantage program.

Blue Cross and Blue Shield of Michigan (BCBSM) is a non-profit health plan that serves nearly five million members, of which 440,000 are enrolled in government contracted Medicare or supplemental programs. Nearly 70 years ago, Blue Cross Blue Shield of Michigan started with a purpose to provide people with the security of knowing they have health care when they need it. Today, we're accomplishing that mission in many ways, including offering access to health care coverage for everyone, regardless of circumstances, as the insurer of last resort.

Blue Cross Blue Shield of Michigan is committed to offering Medicare products that meet the needs of the individual members, employers and unions that we serve. We offer a range of plans to Medicare beneficiaries in every county of the State of Michigan, including Medicare Advantage (MA) Private Fee-For-Service (PFFS) plans, Medicare Part D coverage, and supplemental coverage. The BCBSM enterprise also offers a MA HMO product in counties where an adequate network could be developed. Our Medicare Advantage plans play an important role in providing comprehensive, coordinated benefits for seniors and disabled members who might not otherwise have affordable options for supplemental benefits.

In my testimony today, I will provide an overview of the importance of Medicare Advantage with a primary focus on the role of the PFFS plan in meeting the needs of Medicare eligible beneficiaries who are retirees of employers and unions. We believe that it is critical to preserve the PFFS option because it is the only product available today for bringing integrated health benefits to the retirees of employers and unions nationwide under Medicare Advantage.

II. WHY DID BCBSM OFFER A PRIVATE FEE-FOR-SERVICE PLAN?

BCBSM has traditionally served the Medicare population through Medicare supplemental plans, or Medigap. However, with the passage of the Medicare Modernization Act (MMA), which addressed inadequate payment levels in Michigan that had made Medicare+Choice plans unsustainable, we saw an opportunity to make

comprehensive coverage through Medicare Advantage and Part D plans available to our customers.

We chose the private fee-for-service plan for a number of reasons. In the individual market, we needed a less costly alternative to Medigap, which had become too expensive for many of our customers. Even with a dedicated contracting team, network health plans take years to develop as health care providers will not contract initially for the Medicare allowable amounts. They want higher payments and re-contracting would have taken considerable lead time. So, we found ourselves with Medicare members who have been with Blue Cross and Blue Shield their whole life and we wanted to continue to serve them if they were interested in Medicare Advantage.

At the same time, employers were asking for alternatives to their current arrangements which supplement Medicare but do not coordinate care or focus on health improvement. Our employer and union customers needed a solution for serving retirees all over the country and using a state-wide PPO would leave no choices for the group with retirees residing in different parts of the country like Arizona, California, Florida and New Mexico. Due to a combination of regulations that prevent PPOs and HMOs from offering coverage to retirees outside of their state and the lack of nationwide acceptance by providers to participate in networks for Medicare Advantage products, PFFS is the only option available for serving these members.

Medicare Advantage private fee-for-service plans allow our employers to provide retiree health care plans identical to the benefit programs they offer active and non-Medicare eligible retirees nationwide incorporating the same care management features such as care coordination and disease management programs through a single Plan, eliminating the need to stitch together multiple HMOs or PPOs that would cover only a portion of their retirees nationwide.

I would like to share with you an example of our largest group account enrolled in PFFS and explain why this coverage is so valuable to them. The Michigan Public School Employees Retirement System (MPSERS) implemented a Medicare Part D Prescription Drug Plan in 2006 and a Medicare Advantage private fee-for-service plan in 2007 in order to lower health care costs and improve health care management and outcomes for their Medicare eligible retirees.

There are more than 115,000 MPSERS members in the Medicare Advantage private fee-for-service plan. Many include lower-income retired clerical staff, bus drivers, janitors and cafeteria workers. Medicare Advantage provided MPSERS with an opportunity to reduce the System's cost and integrate coordinated medical and drug management programs. This option also allows them to manage health care costs without reducing school programs for the students.

III. THE IMPORTANCE OF MAINTAINING MEDICARE ADVANTAGE

I would like to stress three reasons why it is important for Congress to maintain funding for the Medicare Advantage program and preserve the private fee-for-service product: enhanced benefits and cost savings for beneficiaries, opportunities for care coordination, and providing access in rural areas.

ENHANCED BENEFITS AND COST SAVINGS FOR BENEFICIARIES

Medicare Advantage plans provide beneficiaries with substantial protection from the high cost-sharing in traditional Medicare plus additional benefits not offered under Medicare. According to CMS, Medicare beneficiaries receive an average additional value of $86 per month—or $1,032 per year—from enrolling in an MA Plan. The majority of that value comes from reduced out-of pocket costs because plans generally fill deductibles and co-payments in original Medicare and provide protection against catastrophic costs.

Our PFFS plans offer members benefits that are more generous than Medicare alone, especially in the group market. We estimate that the value of benefits offered among our plans is 21-33 percent more generous than original Medicare. This is because our employer and union accounts generally want to offer their retirees the same benefits they provide to their active workers and are willing to subsidize the group product. We also offer individual products with an actuarial value of up to 27 percent more than traditional Medicare.

Our lowest cost plan (with premiums of $0-$61 per month depending on one's area) offers a number of additional benefits not available in traditional Medicare. This plan has an annual out-of-pocket limit of $5,000 that offers the peace of mind that an unexpected illness won't result in bankruptcy. This is a benefit that is not available in traditional Medicare as FFS cost sharing on one significant hospital or skilled nursing admission can easily exceed $5000. Our plan has a $20 copay for

doctor visits instead of the 20% coinsurance in FFS Medicare. In order to foster good preventive care, our plan has no cost sharing for services such as bone mass measurement, mammograms, prostate and colorectal cancer screenings and immunizations. We also provide much more generous benefits for inpatient and outpatient mental health care.

Another advantage is that MA plans have flexibility to offer innovative benefits that are not permitted under the Medicare program and that better meet the needs and preferences of beneficiaries. For example, we can offer the member the option of obtaining care in the setting of their choice following a hospitalization, when traditional Medicare might only have provided the payment for care in a skilled nursing facility.

All of our individual plans are comprehensive MA-PD plans and groups can select either an MA-PD plan or an MA plan with the Retiree Drug Subsidy. In either case, we can provide comprehensive, fully integrated programs. Additionally, members like the fact that, as Medicare Advantage members, they can continue to carry a single Blue card for their Medicare A and B benefits, supplemental and drug coverage.

If Congress cuts MA funding, plans will be forced to increase cost-sharing for these services, cut benefits, or increase premiums. This will most affect those seniors who are living on lower-to-modest incomes who may lack affordable alternatives. The average premium for Medigap Plan C in Michigan is $2,355 annually (or nearly $200 a month) and the average premium for Medigap Plan C nationally is $1,766 annually (nearly $150 a month). These premiums may be out of the reach of many seniors who have purchased Medicare Advantage products.

CARE COORDINATION

Medicare Advantage holds promise for meeting one of the biggest challenges facing Medicare: coordinating care for those with chronic illnesses. Today, 82% of Medicare beneficiaries have at least one chronic condition, with 65% having multiple chronic conditions. However, according to a report by the Institute of Medicine, FFS Medicare does little to encourage coordinated, preventive and primary care that could produce better outcomes for beneficiaries.

Medicare Advantage plans can play a critical role in addressing this challenge through offering care coordination and management for diseases that commonly afflict the elderly through an integrated benefit package. Employers are turning to our PFFS product because they can provide the same care coordination programs that are available to their active and non-Medicare eligible retirees. The importance of the integrated benefits available under Medicare Advantage plans cannot be understated. With a Medicare supplemental plan, inadequate and untimely claim information does not allow for meaningful coordination. By the time information is received, it may be too long after a major event to reach out to a member, their family or providers.

Our Medicare Advantage members benefit from a variety of voluntary, patient-centered programs designed to improve their health through our BlueHealthConnection(r) program. BlueHealthConnection provides a spectrum of wellness, disease and symptom management, and case management opportunities for PFFS Medicare Advantage beneficiaries to take an active role in improving their health.

For example, we provide access to personal health care coaches to assist members in the management of chronic conditions, such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disorder, cancer, benign uterine conditions, and back pain. The program is focused on building self-reliance and seeks to inform members by providing a range of information, transferring skills, building confidence, and enabling members to take action to improve their health.

We also provide access to a case management program that focuses on members with multiple co-morbidities, those who are the most difficult to care for. These initiatives provide telephonic and face-to-face assessments, develop collaborative care plans with both physicians and members, and use evidence-based guidelines to measure success. Through this program, we also provide telemonitoring devices to assist health care professionals in the management of complex conditions, such as congestive heart failure.

We believe that programs offered by the plan a member has selected, such as BCBSM, and is familiar with, will be far more successful than efforts by other third-party companies contracted by CMS where the beneficiary does not know or trust the party contacting them about their health care needs.

ACCESS FOR RURAL BENEFICIARIES

Historically, the existence of private plan options in rural America has been virtually non-existent with the benefits of private plans only available to beneficiaries in urban cities. Congress sought to reverse this trend by raising rates in rural areas over the past decade. The intent was to increase payments so plans could operate more viably in rural America so that all Medicare beneficiaries would have access to a private plan option.

Network-based products are difficult to construct in rural areas with sparse populations and limited provider availability. In rural areas of the country, where traditional Medicare rates are very low, providers often refuse to join a plan's network unless reimbursement from the plan far exceeds what the Medicare rate would be. Unless plans can meet the network adequacy requirements of CMS, they will not be approved to participate in the MA program.

Due to the availability of PFFS plans in 2007, for the first time all Medicare beneficiaries in the country have the choice of a private Medicare plan option: a significant increase from 2004 when one-quarter of beneficiaries did not have that option. Between 2005 and 2006, enrollment in PFFS plans by rural beneficiaries accounted for 39 percent of total MA enrollment growth.

If Congress equalizes MA and traditional Medicare payments, this would have a disproportionate impact on rural areas by eliminating the increased payments in rural areas. Some rural states would have no access to MA options at all if these cuts were enacted.

IV. RESPONDING TO CRITICISMS OF MEDICARE ADVANTAGE PLANS

A number of criticisms have been raised regarding the Medicare Advantage program over the last few months. I would like to respond to several of the issues you may hear today.

• Comprehensiveness of coverage relative to traditional Medicare. Some have argued that MA plans modify benefits in traditional Medicare and create financial barriers for high cost beneficiaries. We use the flexibility we have to tailor our plans to meet the preferences of our members for predictable cost-sharing, protection from catastrophic expenses, and benefits not covered under FFS Medicare. MA plans return an additional $6.8 billion dollars in supplemental benefits, according to CMS. Those who consume more services will generally benefit more from the financial protections in our MA plans.

A recent analysis published in Health Affairs found that the average out-of-pocket cost for all MA plans was $268 (Gold, 2007). Average out-of-pocket costs for members in poor health were estimated at $1,656 for all MA plans. The Blue Cross and Blue Shield Association applied the same methodology to spending under traditional Medicare with prescription drug plan coverage and found the costs for those in poor health was $5,408—more than three times the estimate for all MA plans in the Health Affairs article.

While it may be theoretically possible to choose selected services for which an individual could pay more under an MA plan, this would generally not be the case if one looked at the total distribution of claims for an individual over an entire year that includes all doctor, hospital and other services. Thus, I would caution against looking at outliers and focus instead on the vast majority of beneficiaries who see better value under MA.

• Specific issues with private fee-for-service plans. Over the past couple of months, a number of criticisms have been leveled against PFFS plans. Some of these concerns involve legitimate issues that industry and regulators are working to address to ensure confidence in this product. My message is simple: let's stop vilifying PFFS plans and instead focus on correcting the legitimate issues and improving the program.

The most troubling concerns leveled against PFFS plans involve instances of unscrupulous and even fraudulent sales tactics involving sales of individual PFFS plans. Some of the incidents were appalling and should never have happened. CMS has acted decisively to strengthen enforcement of marketing standards to address these problems. We continue to strengthen our agent training requirements and have a zero tolerance policy for agents that do not follow the rules. Our complaint ratio regarding agents is less than 1 for every 2,000 enrollees. It is important to note that these sales problems simply are not an issue with employer and union accounts. Group PFFS products do not involve the use of agents or brokers for individual sales to their members. Employers and unions work with us to ensure that retirees understand these products.

Some have questioned the value of PFFS plans, given the exemptions that they have from certain requirements that apply to Medicare HMOs and PPOs. Some of

the current PFFS exemptions make sense, given the very different nature of PFFS plans as compared to HMO and PPO plans. However, we recommend ending three exemptions to inject more accountability and provide increased value to beneficiaries. We should require PFFS plans to report quality data, establish chronic care improvement programs (which would remain voluntary on the part of beneficiaries), and allow CMS to review PFFS bids.

Some have also raised questions about provider acceptance of PFFS plans. The PFFS product is unique in that it does not require use of a defined network of providers like a PPO or HMO. While this enables us to serve retirees in every area of the country, it also means that there is no guarantee that a given provider will see a patient. Our rate of provider acceptance is very high. We respond to these incidents by working to educate providers on the benefits of participation, including receipt of a single payment from the health plan for all services rather than waiting for transfer, processing and payment of the supplemental claim after the Medicare claim is paid. We have found that physician offices we contact almost always decide to accept our PFFS patients once they understand our products. When a provider still refuses to participate, we make every effort to locate an alternative provider for the member.

• Risk selection in MA and the traditional program. Some have suggested that MA plans are eroding the risk pool in traditional Medicare by attracting healthier seniors through benefit design. While there may have been some evidence of this in the early years of this program, the reality today is that health plan enrollees have similar health status to the overall Medicare population. MA payments are also fully risk adjusted which removes any incentive to enroll healthy beneficiaries. Risk adjustment pays plans more for enrolling sicker individuals and less for healthy ones, providing an incentive to enroll the sickest beneficiaries and manage their care appropriately. Moreover, there is significant growth in MA Special Needs Plans that are specifically designed to allow a plan to enroll those who are institutionalized or have specific chronic conditions. These tend to be the sickest and most costly beneficiaries in Medicare.

• Arguments that MA plans are "overpaid". One concern leveled at MA plans is that their average payments are 12% more than claims costs under traditional Medicare (19% more for PFFS plans) according to MedPAC. In reality, comparing MA and FFS costs is an apples to oranges comparison that fails to take into account the significant differences between the two programs. Traditional Medicare pays claims for an uncoordinated package of benefits that includes high beneficiary cost-sharing. Medicare Advantage plans provide a more comprehensive package of benefits with care coordination, disease management, quality accountability, and usually with integrated drug coverage.

The question that continues to go unanswered in the current Congressional debate is what type of Medicare program do we want over the long-term? On an industry-wide basis, there is a clear movement toward more integration and coordination of care in order to improve quality and member health outcomes. Yet every time the federal government invests in these programs for Medicare in a meaningful way the funding is threatened.

Congress has already cut MA base funding by $6.5 billion in the Deficit Reduction Act (cuts that will be phased in through 2010). This is having an impact on our payments in Michigan, which are rising at a rate that is below growth in medical costs, which over time will result in increased year-to-year costs or reduced benefits for our members.

This is exactly what happened in the years prior to the MMA, when Medicare+Choice became unsustainable in many counties after years of medical cost increases outstripped growth in plan payments. The result was widespread loss of coverage for Medicare beneficiaries. Congress should not backtrack on its promise of broader access to health plan options for beneficiaries.

If Congress adopts MedPAC's recommendations for cutting MA funding, the PFFS product is unlikely to be viable in many states. The result may well be that most, if not all, of the 1.3 million enrollees in this product will lose access to the enhanced benefits and opportunities for care coordination that come with these products. According to a study by Professors Ken Thorpe and Adam Atherly at Emory University, adopting MedPAC's recommendations could result in 3 million people losing their MA coverage, including more than 180,000 in Michigan.

What would the loss of the PFFS option mean for Michigan? It will mean that many Medicare beneficiaries who make too much to qualify for Medicaid, but cannot afford a Medigap policy, will be left without an option for obtaining affordable supplemental coverage. It will mean the loss of care coordination and health improvement opportunities. It will mean that employers and unions struggling to maintain retiree benefits in light of new accounting rules will be forced to make hard choices

about reducing or even eliminating retiree benefits. It will mean more confusion for beneficiaries who will lose trust in Congress, CMS and plan sponsors.

V. CONCLUSION

Thank you for considering my perspectives on the Medicare Advantage program. I appreciate this opportunity to testify about the importance of the private fee-for-service product. Medicare beneficiaries need stable options for supplemental benefits and PFFS plans are a major source of that coverage in many areas of the country. We urge the committee to ensure the continued viability of this product and to support adequate funding for the Medicare Advantage program.

Chairman SPRATT. Thank you very much for participating and for the contribution you have made. We greatly appreciate it. I have one question in the interest of allowing others to ask questions.

One question, Dr. McClellan. Your predecessor, Tom Scully—maybe he was caught off guard—said there has been huge overfunding in this program and Congress ought to take some of it back.

Would you agree that, when you created it, you did not foresee excess payments to this extent and that your objective originally was more competition, better services, better plans, and lower costs as well and at least that part of the quest in creating these plans has not been achieved and should be reconsidered?

Dr. MCCLELLAN. Well, Mr. Chairman, Tom says a lot of things, and I think if we put it in a little bit broader context and, if you look at my written testimony, I did talk about some ways to reduce the costs both in the Medicare Advantage program and, more generally, in Medicare without starting by taking away benefits from people who do not have any good alternatives, and my own preference would be to try to take steps like many of the members here have discussed—to address the overuse and underuse and misuse of treatments, to promote more prevention, to promote better quality of care for chronic diseases. We do a lousy job overall in many respects in this country, and we do a not very good job in the traditional Medicare program of providing support for efforts to get better quality care at a lower cost.

I also made the point in my testimony that, while it is important to get budget costs down, it is also important to get overall health care costs down. If we are just shifting costs from the Federal Government to beneficiaries, disproportionately with limited means, who have no better alternatives than a traditional Medicare plan with many gaps in it or a Medigap insurance plan that is very costly and very inefficient, well, I think we can do better than that.

So that is why, hopefully, just as the payment reforms that got us to this point had a lot of bipartisan support, looking ahead, it is those floor county payment rates, those higher payment rates for private plans in counties with low fee-for-service costs that did not historically have access to these plans, and there is bipartisan effort that——

Chairman SPRATT. In setting up the original benchmarks, you were giving incentives to certain areas, in sparsely populated areas, for example, where it was difficult to build a comprehensive medical care network, but did you intend that to be a permanent and even widening differential?

Dr. MCCLELLAN. I think the goal ought to be getting overall costs in our health care system down while improving quality. There are

plenty of opportunities to do that. Some of those opportunities involve reforms in the Medicare Advantage plans like the ones that I talked about in my testimony. I do not think I would start by cutting payments that are going to have a direct effect on reduced access to up-to-date benefits like prevention, like better care for chronic diseases for seniors with limited incomes.

Chairman SPRATT. Mr. Ryan.

Mr. RYAN. Thank you, and I will try and be brief as well because I want to get to everybody before votes happen.

This is a strange conversation because, every time we have this conversation, we just think about it within the context of just this program, just Medicare, and we simply cannot ignore the underlying premise of the issue, which is health care inflation, itself, is running at about triple the rate of regular inflation.

Mr. Blumenauer expressed a lot of the frustration that a lot of us have from these lower cost States. You know, we always point to Louisiana—I guess they must be the highest cost—and it is important that we address the root cause of health care inflation first and foremost.

Also, as we take a look at, you know, payments and things like this, how do we get best practices out there? How do we get transparency in the metrics on cost and quality and best practices so that providers—hospitals and doctors—gravitate towards those norms and get to those best practices so that we can wrench out those inefficiencies, those overpayments so that the Louisiana model where the quality is no better than, say, it is in Wisconsin—I think, statistically speaking, it is not as good; the cost inefficiencies are there. So we have to go at that which is outside of Medicare, and that is probably more important than anything we could do to save money for the taxpayer here.

Dr. McClellan, you just ran this agency until recently, so I want to direct most of my questions to you. You know, we can come through all of these different statistical contortions. We can say it is 12 percent over. It may be. I just do not know. When you take a look at the fact that the doc fix is not put on that baseline—and that is $22 billion just this year to stop the doctors from getting cut, which we should do, what would be the 10-year cost of freezing the doc payment, and preventing the cuts would be far, far more than the $150 billion we would save from freezing, you know, the private fee-for-service or all of the Medicare Advantage plans at 100 percent of fee-for-service.

So, when we see the fact that there are just glaring anomalies or glaring missing links in these statistics, we need to proceed with caution on this, and the reason we need to proceed with caution is I think it is important we go toward a comprehensive care model where we know intuitively that getting people into preventative medicine, getting people into disease management, continuation of care, and comprehensive care, we know it works. The problem is we do not have the statistics, the models, the measuring sticks to prove that it works, and the problem with legislating—and we do this in Ways and Means every day—is the only numbers we can use are what the scorekeepers give us. So, therefore, we legislate based on the stuff we get on paper from CBO and Joint Tax regardless of whether it is really good policy or not. Regardless of whether

or not we really think it is going to save money in the long run or not, that is what we do.

So, Dr. McClellan, you have been on all sides of this issue. Where are we missing in this conversation? What are the key elements we need to bring into this conversation so that we get to this $32 trillion unfunded liability and make sure we are not overpaying for things that a taxpayer should not be overpaying for?

Dr. MCCLELLAN. Congressman Ryan, I think you start by asking the question of:

Are the policy reforms that we are considering going to get at those underlying fundamental drivers of low-quality and high-excess cost in our health care system?

There are things that can be done in both traditional Medicare and in supporting a Medicare Advantage program more effectively to drive out inefficient practices to do something about these huge variations in costs across areas. Unfortunately, I do not think the solution is simply cutting the Medicare Advantage payment rates across the board. That is going to result in more beneficiaries ending up in the traditional fee-for-service plan, which is an incredibly important plan that most seniors depend on and that we need to keep strengthening.

In fact, a lot of the attention in the last few years has been on these competitive reforms, and we have put a lot of effort into strengthening traditional Medicare as well: bringing in more preventative benefits and making seniors aware of them, trying to take steps to not simply pay more for more care but pay more for better care and better results and better use of preventative services and better outcomes for patients with chronic diseases.

So I would start with the reforms that help accomplish that goal, and while there are some changes in Medicare Advantage that can move in that direction, the Medicare Advantage program itself has taken some important steps to make available preventative care and disease management and all of the kinds of services that you were just describing for beneficiaries who otherwise would have no access to those kinds of services. More and more people in the Medicare program with chronic diseases who are frail are enrolling in Medicare Advantage plans, including special needs plans, that turn the criticism of attracting only healthier beneficiaries on its head. These are plans that only enroll people with institutional levels of care or who are also in Medicaid or who have serious chronic diseases, and they are offering a lot of this kind of support to help reduce those overall variations in quality and those missed opportunities to improve care while keeping costs down.

Mr. RYAN. Yes, that is my concern that we are going to cut off our noses and spite our face, because we can get a good score from CBO that says "you are going to save this much if you do that" without thinking into terms the comprehension of care that is beginning to evolve, without integrating these benefits and incentivizing preventative medicine and disease management. We know that most of the costs in Medicare and in health care itself are chronic care, when a person is in the hospital, in-patient stuff. If we can keep them out of the hospital and keep them off of the operating table, we are going to improve their lives and save taxpayer money and society money.

So when we sort of arbitrarily use statistics that are not comprehensive, you know, I worry that we are going to go down the wrong path and send people into plans that just do not give them that kind of preventative medicine, that kind of disease management, and so that is just something where I think we need to proceed with caution as we move down this road.

I thank the chairman for his indulgence, and I yield.

Chairman SPRATT. Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

I appreciate all of our witnesses being with us today.

There is one question that I thought I heard that had occurred to me when the previous panel was testifying that I did not get a chance to ask, and that is they said if the Advantage plans could use the Medicare provider reimbursement rate, that they could save money. Did I hear that right? Do the Medicare Advantage programs reimburse physicians at the same rate that Medicare reimburses them at?

Dr. MCCLELLAN. I think it may have been around the discussion with the private fee-for-service plans which have this authority, as I mentioned, called "physician deeming," where basically if the physician sees the patient and could have found out about the plan's terms, then the plan can bill that physician at the traditional Medicare rate, and that has been a source of some confusion, and it is an area where you all may look at potential changes, but as a general matter the Medicare Advantage plans do not use the—at least the HMO plans and the PPO plans and so forth, do not use the traditional Medicare rates. In fact, they have often very different benefit designs with things like pay for performance and wellness benefits and things like that.

Mr. SCOTT. Do they get paid more or less than Medicare?

Dr. MCCLELLAN. I think they get paid differently. You heard from Dr. Wah. In some areas for some services physicians get paid less, but many plans have started care coordination programs, medical home pay-for-performance models where they pay physicians significantly more for providing better care and for preventing complications of diseases.

Mr. SCOTT. Could you provide these medical delivery options without privatization?

Dr. MCCLELLAN. Well, I hope so. Over the last few years, we took a lot of steps in traditional Medicare to create care management programs and things like that. Peter Orszag mentioned earlier the Medicare Health Support program, which was a pilot effort to bring disease management services into traditional Medicare.

Mr. SCOTT. Well, we are spending $150 billion to get these options available to people. Could we do it cheaper if Medicare just did it?

Dr. MCCLELLAN. Well, the challenge in traditional Medicare is that it is hard to put an emphasis on keeping people well and coordinating care in a purely fee-for-service payment system where, you know, the doctors and providers——

Mr. SCOTT. The question is could we have the different delivery options under Medicare without privatization and without the subsidies?

Dr. MCCLELLAN. I think the others may have different views, but my own view is that we ought to try as hard as we can to put the emphasis on prevention and better quality through the Medicare Advantage program and also to try as hard as we can through the fee-for-service program, but the fee-for-service program does present some different challenges in promoting coordination and integration——

Mr. SCOTT. You are comparing apples and oranges.

What I am suggesting is what is the barrier to Medicare's running a prevention-type service rather than just a fee-for-service program, and we are spending $150 billion to get these services. For the same amount of money, could the beneficiaries of Medicare get the same benefit if Medicare did it rather than through somebody else?

Ms. KENNELLY. Yes, Congressman, you could. I think that is the point.

Mr. SCOTT. Are we getting $150 billion worth?

Ms. KENNELLY. You are getting many more people involved in spending those dollars. The problem with—Mark and I have talked about this many times. We talk about improving the traditional Medicare program. You can only spend a dollar once, and if you put all of the available dollars into the Medicare Advantage program, all of these wonderful things we could do in the traditional program will not be done.

Mr. SCOTT. The problem is that, with Medicare, you do not have all of the commissions, fees, profits, advertising, and everything else, and the money would go just to the service.

Dr. Neuman.

Ms. NEUMAN. Yes, that is right. I mean it could well be that the private fee-for-service plans—now, while all of them do not provide care coordination and they are not required to provide care coordination, maybe there are some lessons that can be learned from those plans that do that could be applied to traditional Medicare so that traditional Medicare has the benefit of care coordination models to the extent that they seem to be working.

You know, I just want to amplify the broader issue here of the question that you face of whether you want to invest resources to provide preventative benefits and care management to the minority of people on Medicare who are choosing Medicare Advantage plans, really leaving the majority, the 4 out of 5, without the same set of benefits, and many of these people are low-income, have modest incomes, and are paying higher premiums as a result of the system.

Mr. SCOTT. Well, the choice is whether we could do—you have got $150 billion leaving the system, and whether you could get that done within the system for $150 billion is the question.

Dr. WAH. Yes. I think the other speakers pointed out that not every dollar is traveling to the beneficiary here. There is load, there is admin, there is marketing, and there is profit involved, and that is one of the things we are talking about. If there were a more level playing field here between Medicare Advantage and regular Medicare, the competitive marketplace would drive those players to squeeze those loads down, but right now they are able to just load them on without the competitive forces to drive them down.

Dr. MCCLELLAN. If I could make two more points on this.

One is that, if you look at the total savings that beneficiaries in Medicare Advantage are getting, they exceed these total overall payments. Why? Because in a coordinated care program, it is easier to target the beneficiaries, to target the benefits of people who need them the most. It is hard to do in a fee-for-service system.

Second, I think your emphasis on finding ways to spend dollars better and maybe more dollars in fee-for-service on prevention and care coordination is great. Unfortunately, there has been very little discussion of that around this Medicare Advantage payment reform debate. Most of the money in the proposals would go to things like paying more for physician services in the existing program. That is a very important goal, but it amounts to a double hit on beneficiaries in terms of increased payments, and it does not, by itself, do anything about these variations in practices or about the problems with access to preventative and coordinated care benefits.

Mr. SCOTT. Mr. Chairman, can I ask one other question that they could respond to in writing? Because I know my time is up.

Chairman SPRATT. Sure.

Mr. SCOTT. That is that I understand that the risk pool in the Advantage plans is healthier than the others. How does that calculate into all of this? Because that should be where they get their profits from, not from the subsidies. If I could get that in writing because I am way over my time, I would appreciate it, Mr. Chairman.

Chairman SPRATT. If those of you who are able to respond to that question would supply us an answer for the record, we would appreciate it.

Now, Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

I know time is limited, so I just wanted to stress one point. I thought it was the most interesting thing in any of the testimony we received, and that is Dr. McClellan is opening a new front in the debate on how to improve health insurance. These are his comments, and let me quote.

"most beneficiaries in traditional Medicare are also enrolled in Medigap supplemental coverage. This coverage, particularly the individual Medigap plans, is quite inefficient. Not only does it have a high load factor, meaning that beneficiaries have to pay much more in premiums than they get out in benefits, but the Medigap options are also designed in a way that encourages first dollar coverage that, according to CMS actuaries and CBO analysis, adds billions of Medicare costs each year. Such Medigap plans not only promote inefficient spending, but Medigap premiums have been rising rapidly and are much higher than part B and part D premiums combined."

That is the most direct frontal attack on Medigap coverage I have ever seen or read. I congratulate you, personally. I was curious if you did anything about this while you were CMS Director.

Dr. MCCLELLAN. We did, and thank you for highlighting that point.

With the Medicare Modernization Act, some other Medigap plans became available that did have more reasonable copay limits and designs, but the way that Medigap is set up—I think it is implicit

in your comment—is that seniors often have very little alternative between the traditional Medicare program with all of its gaps and going into a Medigap plan that might provide first dollar coverage, and seniors are risk-adverse. They do not like to be looking at a lot of potentially unlimited out-of-pocket spending. That is what you get in the traditional Medicare plan. So because they have no better alternative, they will spend hundreds of dollars a month out of their limited incomes to get into these plans that are costing a lot more than they are paying out and that are promoting this kind of inefficient delivery of health care that you were talking about. So we took some limited steps, but the Medigap plans are there by statutory design. It would take legislation to change that.

Mr. COOPER. Did the administration propose any fundamental adjustment of the Medicare-Medigap coverage while you were at CMS?

Dr. MCCLELLAN. I believe they have proposed—there were a lot of proposals in the past, but I believe in the past the administration has proposed reforms in Medigap coverage to get rid of or at least require higher payments for those who sign up for the first dollar plans and to try to encourage the availability of some reasonable plans that provide real protection but that do it at a lower cost.

Dr. WAH. Could I just add also, though, that sometimes these Medicare Advantage plans are, in fact, billed as a replacement for a regular Medicare plus a Medigap plan, and there is so much variation in the Medicare Advantage plans. For instance, the Blue Cross private fee-for-service in South Carolina, for instance, provides no more coverage for drugs or for home care than if you had Medigap and regular Medicare. In fact, it provides less. So it looks attractive for some features of the Medicare Advantage plan, but in fact if you get really sick, when the high-dollar amounts start kicking in, it actually pays less, and so I just want to make sure it is clear that Medigap plus regular Medicare, as we have said, is not always optimal. These Medicare Advantage plans are not always a perfect replacement for those either.

Ms. SCHMITT. What we find is that what beneficiaries particularly like is where you can give them fixed cost-sharing because they want to know that, instead of having some percentage of something that is going to cost them, if they know that they are selecting this plan and know that they have a set stop-loss and an office visit is going to cost them $10, they consider that a strong advantage because their costs are then predictable.

Mr. COOPER. Ms. Schmitt, in your testimony, you also decry fraudulent marketing practices that are employed on behalf of some private fee-for-service Medicare Advantage plans.

I thank the Chair. I see that my time has expired.

Mr. SCOTT. Mr. Chairman.

Chairman SPRATT. Mr. Scott.

Mr. SCOTT. Could I ask unanimous consent that a statement from AFSCME be entered into the record of the hearing?

Chairman SPRATT. Without objection.

Mr. SCOTT. Thank you.

[The information follows:]

PREPARED STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES (AFSCME)

The American Federation of State, County and Municipal Employees (AFSCME) represents 1.4 million employees who work for federal, state, and local governments, health care institutions and non-profit agencies, and an additional 230,000 retiree members. AFSCME and its members are proud of labor's historic role in the creation of Medicare and we remain strong defenders of the Medicare program from those who would undermine its foundations.

When President Johnson signed Medicare into law on July 30, 1965, he spoke of the profound promise of Medicare to our nation and its citizens:

"No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 42 million Medicare beneficiaries and our nation, the need for Medicare to remain a sanctuary against financial ruin caused by the vicissitudes of illness and disability rings as true in 2007 as it did nearly 42 years ago.

Today, the financial security of Medicare is threatened by the drive to privatize the program. Overpayments to Medicare Advantage plans are causing a shift of beneficiaries out of the more efficient government-administered program into more costly private plans. Overpayments to these private plans may make them highly profitable, but they also have a deleterious impact on the federal budget, the Medicare program and the Medicare benificiaries.

OVERPAYMENTS TO PRIVATE MEDICARE ADVANTAGE PLANS THREATEN MEDICARE'S FINANCIAL SOLVENCY

When Congress opened up Medicare to private plans, it was based on the claim that the private health insurance industry would be more efficient, provide more coordinated care for seniors and the disabled, and do so with less cost to the taxpayers and beneficiaries than the traditional Medicare program. The promises of efficiencies and lower costs have been illusory; Medicare now pays private Medicare Advantage plans more than it would cost to cover the same beneficiaries through the traditional Medicare program. According to the Medicare Payment Advisory Commission (MedPAC), these private plans are paid an average of 12 percent, or $1,000 per year, more to cover a Medicare beneficiary than the cost of traditional Medicare to cover the same beneficiary. Private Medicare Advantage fee-for-service plans are paid on average 19 percent more than the traditional Medicare fee-for service program.

Overpayments to the private insurance industry are worsening Medicare's financial health. Enrollment in the private plans is growing rapidly and enrollment is growing the fastest among plans receiving the largest overpayments. Over the next 10 years, these overpayments to insurance companies will cost an additional $160 billion. These overpayments shave two years off the financial solvency of Medicare's hospital insurance trust fund. The ballooning growth in overpayments to private plans will drive premiums even higher for beneficiaries, erode Medicare's financial solvency and ultimately force major changes in the Medicare program, including substantial cuts in benefits. If left unchecked these overpayments will ultimately lead our nation backwards to a time when seniors were one illness away from poverty and were denied reasonable and necessary medical care because they could not afford to pay doctors or hospitals.

OVERPAYMENTS TO PRIVATE MEDICARE ADVANTAGE PLANS ARE INCREASING STATE MEDICAID COSTS

The overpayments to private plans come out of the Medicare hospital trust fund, Part B premiums and general revenues. Medicaid, which is jointly funded by states and the federal government, subsidizes Part B premiums for low-income Medicare beneficiaries. Because the overpayments push Part B premiums higher, states are forced to pay more for Part B premiums to subsidize these overpayments to private plans. Nationally, states and the federal government will be forced to pay an extra $168 million in FY 2007 in Part B monthly premiums for all low-income Medicare beneficiaries as result of the overpayments to private Medicare plans. Attached is

a table showing the additional cost to Medicaid, by state, to subsidize overpayments to private Medicare plans.

ALL MEDICARE BENEFICIARIES ARE ALREADY PAYING MORE

Because Medicare Advantage overpayments drive up premiums paid by Medicare beneficiaries, all seniors, not just those in the private plans, are paying more now. In 2007, each beneficiary in traditional Medicare paid an extra $24 per year for the Part B premium to subsidize the overpayments to the private plans.

MEDICARE DISADVANTAGE PLANS

Advocates for Medicare beneficiaries, beneficiaries and state insurance commissioners have been reporting that private plans have used abusive, misleading and fraudulent sales tactics to shift seniors out of Medicare and into their private insurance policies. The billions and billions in extra costs coming out of the pockets of taxpayers, states and beneficiaries to fund overpayments to Medicare Advantage plans explains the gold rush fever of health insurance companies to sign up seniors, even if it means these companies step far over the line in their sales and marketing practices. With 27 percent of all Medicare beneficiaries having cognitive or mental impairments, these elderly and disabled beneficiaries are a vulnerable target of abusive, confusing, misleading and fraudulent sales tactics. According to press reports, beneficiaries are told that "Medicare is going private" or that they will lose their Medicare or Medicaid unless they sign up for a particular plan. Insurance company agents show beneficiaries business cards which suggest that they are from Medicare, Social Security, or other trusted government agencies. Many beneficiaries do not realize that when they sign up for Medicare Advantage plans they will lose their Medicare coverage and terminate or jeopardize eligibility for existing retiree or Medicare supplemental plans.

Once beneficiaries are in private Medicare Advantage plans they may be forced to pay higher co-payments than they would under traditional Medicare. Traditional Medicare does not require any co-payments for home health care services but many Medicare Advantage plans do. Many plans have higher out-of-pocket costs for hospitalization, chemotherapy, and services needed for those who are chronically ill. Medicare Advantage beneficiaries also find they have fewer rights than traditional Medicare beneficiaries when things go wrong with their health insurance.

The dizzying array of complex benefits packages and out-of-pocket rules vary from plan to plan and can change every year in a Medicare Advantage plan. While current law requires these plans to offer at least the actuarial equivalent level of benefits as provided in traditional Medicare, plans can and do change their benefit and cost-sharing rules to keep the healthiest, and least costly, beneficiaries in their plans. MedPAC reports that Medicare Advantage plans are enrolling beneficiaries who are healthier than average. By targeting healthier beneficiaries through marketing or winnowing out sicker, and more costly, beneficiaries through increased costs and changes in benefits, Medicare Advantage plans raise their own profit margins at the expense of beneficiaries and the Medicare program.

It is not at all clear that the additional payments made to Medicare Advantage plans are indeed being returned to beneficiaries in the form of additional benefits or reduced cost-sharing. With little accountability and reporting requirements it has been extremely difficult to identify what percentage of the overpayments are being used to boost profits of the private insurance companies, to pay insurance commissions, marketing or administrative costs, rather than improve benefits.

Medicare Advantage fee-for-service plans are the least efficient private plans and receive the highest overpayments from Medicare. Because these types of private plans are exempt from most quality measurements, taxpayers have no assurance that these excessively costly plans are truly protecting the health of beneficiaries. For example, these plans are not required to coordinate care of enrollees with complex or serious medical conditions. These plans are not required to work with community and social service programs to ensure continuity of care and integration of services.

In sum, taxpayers have little to no assurance that the billons in extra payments to private insurance companies are actually providing meaningful benefits to the sickest and frailest beneficiaries. It would be more accurate to call many of these private insurance plans Medicare Disadvantage Plans.

CONGRESS MUST STOP THE INSURANCE INDUSTRY'S FLEECING OF MEDICARE

Overpayments to insurance companies prime the Medicare privatization pump and put the security of the Medicare program at risk. Congress must act to secure Medicare by reining in the runaway overpayments to Medicare Advantage plans.

Recalibrating Medicare Advantage overpayments will improve the efficiency of the program, reduce incentives for abusive tactics and strengthen the financial health of Medicare. The savings realized from reducing these escalating overpayments can be used to improve the prescription drug benefit, improve health services for low- and moderate-income beneficiaries, prevent a cut in the Medicare reimbursement to physicians and help pay to cover more children under the State Children's Health Insurance Program (SCHIP). Congress must act now to stop the insurance industry's fleecing of Medicare.

AMOUNT OF EXTRA PART B MONTHLY PREMIUMS MEDICAID MUST PAY IN 2007 AS A RESULT OF OVERPAYMENTS TO MEDICARE ADVANTAGE PRIVATE PLANS
(Based upon CMS Part A and Part B state buy-in data for April 2007 billing cycle)

Alabama	$4,291,296
Alaska	$283,032
Arizona	$2,878,824
Arkansas	$2,367,336
California	$25,669,416
Colorado	$1,618,200
Connecticut	$1,624,440
Delaware	$474,456
District of Columbia	$375,744
Florida	$11,185,992
Georgia	$5,217,192
Hawaii	$619,752
Idaho	$618,360
Illinois	$5,327,688
Indiana	$2,871,144
Iowa	$1,569,024
Kansas	$1,220,520
Kentucky	$3,276,744
Louisiana	$3,349,296
Maine	$1,353,312
Maryland	$2,035,992
Massachusetts	$4,549,560
Michigan	$4,423,368
Minnesota	$1,984,248
Mississippi	$3,275,712
Missouri	$2,720,832
Montana	$369,504
Nebraska	$613,296
Nevada	$712,824
New Hampshire	$316,992
New Jersey	$4,071,888
New Mexico	$1,280,256
New York	$11,919,048
North Carolina	$6,238,728
North Dakota	$180,072
Ohio	$5,570,664
Oklahoma	$1,970,544
Oregon	$1,785,216
Pennsylvania	$6,365,112
Rhode Island	$655,080
South Carolina	$2,974,632
South Dakota	$367,824
Tennessee	$5,549,664
Texas	$11,299,296
Utah	$588,312
Vermont	$516,000
Virginia	$3,349,392
Washington	$2,913,624
West Virginia	$1,398,744
Wisconsin	$2,090,064
Wyoming	$193,392

Chairman SPRATT. Mr. Doggett.

Mr. DOGGETT. Thank you.

Dr. Wah, I certainly agree with your concluding comment in your earlier testimony that what we have here is a pay-more-and-get-less system.

As it relates to the health of your patients, did I understand your testimony to be that there is mounting evidence that this excessive payment to Medicare Advantage is not producing better health care outcomes?

Dr. WAH. Well, I think that there are concerns.

For instance, like I mentioned, the Rural Health Association noted that because of the lower payment rates that the safety net for rural health care is likely to be put at risk because of that. I would be happy to, in written testimony, provide more detail about actual outcomes as I do not have those details in front of me, but there is a concern that—and it is partly because of the confusion of just this blizzard of different terms and conditions that are out there in the Medicare Advantage programs. They have all of the shortcomings of the commercial products that are out there, and physicians and patients are literally just besieged by these little fine print details that make it very hard to understand what they are signing up for or what they are being involved in, and so that can lead to patients who think they signed up for something good, and then the fine print comes around at the end and gets them because it turns out, like I said before, they actually do not get coverage for home health care when they get really sick. If they get cancer, their chemotherapy drugs are only covered up to 80 percent, and they have to come up with the other 20 percent. They did not read that fine print. They read that, oh, they get dental; they get vision, all of the things that were in bold print that sounded really good.

So it is hard to articulate or to actually quantify whether the health is better or worse because of that, but I am concerned that they end up paying more overall because of these expenses that they did not see in the fine print.

Mr. DOGGETT. Exactly, and I note in your written testimony—and I welcome any supplementation that you might want to do—that you report or say that there has been rampant Medicare Advantage plan marketing abuse reported by physicians all over the country and that there is mounting evidence that the billions of dollars poured into Medicare Advantage are not buying better health coverage.

Let me ask you: If we continue pouring the money there and we cut physician reimbursement by 10 percent as a New Year's Day present to seniors and to individuals with disabilities across this country, what will the impact be?

Dr. WAH. Well, I appreciate your bringing this up, and I appreciate Mr. Ryan's saying the Medicare physician payment problem does need to be fixed. I think, obviously, we are concerned about that. In polling our physicians, a high percentage—60 to 80 percent—will find it very difficult to continue to care for their existing Medicare patients, but more importantly, it is going to be financially very difficult for them to accept new patients, and I think there have been numerous studies that have shown that new patients coming into the Medicare system are having a great deal of difficulty finding physicians to take care of them because it is just

fiscally difficult for them to accept new patients at this time, and with these impending cuts that we have talked about coming in 2008, that will only get much worse in terms of patients being able to find the care they need, and that is our concern, is making sure that the patients can get the care they need that is out there.

Mr. DOGGETT. Well, thank you very much for your comments.

Ms. Kennelly, I appreciate so much your efforts overall to prevent those who are determined to let Medicare wither on the vine, and that was not a very hidden agenda in promoting this form of the prescription drug plan. Just as there is a limited amount of money to decide how much is wasted in Medicare Advantage and how much is available to meet the cost of health care provided by physicians and other health care providers, there is also a question about what our priorities will be in monies available to the poorest of our seniors, and I know some of these insurance companies have been rounding up poor people to say how much they will be disadvantaged if the insurance companies do not get the advantage in Medicare Advantage. I believe Dr. Neuman's testimony pointed to some of that.

Wouldn't we be better off if we used some of the money that we can save in these excessive payments to address the Medicare savings program and the prescription coverage now, the improvements in extra help in the legislation that I know you have endorsed and that I have offered?

Ms. KENNELLY. Absolutely, Congressman. Yes, you are absolutely right about the Medicare savings program. It is perfectly set up just for this, and we absolutely should have more subsidy for the part D prescription drug, but I sit here, and it washes over me, my history.

I was born and brought up in Hartford, Connecticut, and then I represented Hartford, Connecticut in the Congress, the capital, the insurance capital of the world.

And I just ask you Congressmen that are here to remember, that before 1965 there was no Medicare, and then all of a sudden it was realized, if you put all of the people over 65 in a pool, it works, and they will be covered, and since 1965, the demographic for those people who are 65 and over, having health insurance is the highest. Before 1965, it was the lowest. So I know absolutely that we should have managed plans, and we should have competition, but what has happened in the 2003 bill—and you know, Mark, and I know, and we know people who saw the prescription part D as a sweetener, and these are things that they wanted to do over the years. It is a philosophical thing, but I just absolutely urge you do not just look at the arcane things that we talk about today. Look at the traditional program. Any country like the United States has to have that program. Then go on and have the competition. But these robust, absolutely almost unbelievable subsidies, with the deficit situation we have today, we are just going down a road where we will not have Medicare, and I will tell you that one of your predecessors, Bruce Platek, he taught me a lot about insurance, and he said, "Barbara, as long as those insurance companies have subsidies, they will play the game, but as soon as they do not have subsidies, for those over 65, they will not," and we should remember that.

Mr. DOGGETT. Thank you.

Thank you, Mr. Chairman.

Chairman SPRATT. Thank you.

Mr. Berry.

Mr. BERRY. Ms. Neuman, do you have something you wanted to say?

Ms. NEUMAN. Thank you so much.

I wanted to respond to Mr. Doggett a little bit on the question about ways to help low-income beneficiaries because, if you look back on one of the slides I presented, there are more than 1 million Medicare beneficiaries with incomes below $10,000 who have no supplemental insurance. They do not have Medicaid; they are not in the Medicare Advantage plans.

One of the options for assisting these beneficiaries is to, one, inform them and get them covered under the programs that are out there, but many people may not qualify for these programs because the asset requirements, the asset tests, have not been indexed over time, and so people may have very low incomes, but they could have $6,000 in life savings and not get help with their Medicare premiums and cost-sharings. So there are other strategies the committee could consider if the goal were to improve coverage for people with very low incomes.

Mr. DOGGETT. Thank you.

Mr. BERRY. Thank you, Mr. Chairman.

My question is for Ms. Schmitt. I believe you mentioned, when you have unscrupulous marketing abuse and things like that, that CMS is doing a good job of regulating that.

Ms. SCHMITT. I indicated that they have added some new requirements as of the last week or two.

Mr. BERRY. The reason I raise that is I thought that maybe you were getting something in Michigan that we surely are not getting in Arkansas. They are completely without any kind of oversight at all, and even when we repeatedly report the same companies doing the same abusive things to senior citizens who basically have no way to protect themselves, over and over again, they do nothing, and I thought maybe you had found a way to get CMS off the dime and make them actually do something. We are completely frustrated with CMS at the moment.

Ms. SCHMITT. Well, actually, there are requirements that we oversee the agents and make sure that they follow all of the policies.

Mr. BERRY. And maybe you do that, but I assure you that there are insurance companies that do not, and I was trying to find an easy way to accomplish this. What we are looking at is having the State Insurance Commission have oversight responsibility over those companies because right now there is nobody who has the authority to regulate them but CMS, and they are not doing it.

Ms. SCHMITT. I would expect that CMS' requiring that they cease selling and marketing their programs until they begin this oversight is probably going to have some response from those places.

Mr. BERRY. Has CMS done that?

Ms. SCHMITT. Yes.

Mr. BERRY. Okay. I had not realized that. I think some of those companies that they told to cease, there are still some of them out

there, some companies that should have been on that list that were not.

Ms. SCHMITT. I cannot respond to that.

Mr. BERRY. Right, I am sure you cannot.

Ms. SCHMITT. May I make a comment on a couple of other things that have been said?

Mr. BERRY. Yes, ma'am.

Ms. SCHMITT. Okay. One thing is there was a question of whether or not CMS could do the same type of care management. I think one of the big components is having all of the data in order to be able to look at a person's drug coverage and their medical, and I think the entities that are in the best position to do that is an MAPD plan that has all of the data in order to do that.

There was also a comment about rural health clinics, and under Medicare private fee-for-service, you are required to pay the exact same amount as traditional Medicare. So these clinics should either be receiving the exact amount as traditional Medicare or they have agreed to and have contracted with these plans. So I am not exactly sure what it is that they are not receiving the plan on.

Lack of education. Certainly, any new program takes a while for people to become familiar with that, and when I say "people," I am referring to both the providers and the beneficiaries, but I think we have certainly gone out of our way to have that type of education, and I think that the knowledge in that is going to continue to grow so that many of those issues will be eliminated fairly quickly.

So thank you.

Dr. WAH. Can I just add to that?

You were talking about the marketing practices and the really egregious things have been pointed out. I think that is just the tip of the iceberg. Below that is this myriad of different terms and conditions that people are trying to sort through, and you know, we talk about the really egregious things, and we see the headlines in that, but the really day-to-day problem is a patient will think, looking at the big print, like I said before, that this is an appealing program, and then one of the things it will say is this is a fee-for-service, a private fee-for-service; you can go see anybody because it is a fee-for-service system, and then they will find out that their physician is not part of that, and they can no longer see their physician without being charged out-of-network charges, and so they end up having to change physicians because their current physician does not accept their, quote/unquote, private fee-for-service plan.

So there are a lot of things below the surface that these egregious things are just beginning to show, but there is much more below the surface that we are not seeing. I just wanted to point that out.

Mr. BERRY. When those things happen, they come to us, and we are beginning to see an awful lot of that, too, and I do not know if you would agree, but there is what I consider to be massive confusion between the part D plans and the Medicare Advantage plans and managed care plans and fee-for-service plans and traditional Medicare. Traditional Medicare is one of the few things that pretty well everybody understood and knew where they stood with it, knew what it did and what it did not do. With all of these other things that have been added through the private sector, as much

as I am able to determine, great confusion has come about because every plan is different. In fact, some plans change almost on a monthly basis.

So we have created a situation which, quite honestly, I cannot keep up with. We run into situations like that in our office that will just make you want to cry. In fact, some of our caseworkers in the district office, you go in there sometimes, you want to take them for treatment because they are so frustrated with trying to work these constituents through these problems, and then you call CMS, and you know, you just might as well be calling the railroad station, which actually does not exist in my State.

If you disagree with that, I would sure like to know about it, but whatever we do—and we can talk about how much it costs and all of that. Whatever we do, there has got to be a better way than what we are doing right now.

Dr. WAH. Yes, sir. I agree. I mean, like I said, the frustration you are seeing with your patients and your constituents is exactly what our physicians and our patients are seeing out there as well, and that is why, to see that in a plan where you are already pouring extra money into the system, you have got to wonder where all of that extra money is going.

Mr. BERRY. I am convinced that the insurance companies wrote this stuff, and this is the way they intended it to be. They didn't want people to be able to understand it very well. That is why they shouldn't write laws. That should be left up to the Congress.

Ms. SCHMITT. We brought up a large group this year. It is the Michigan public school retirees, cafeteria workers, janitors, as well as the teachers, and our experience was that we set up a separate phone bank for people when this program first went up, and when they called and said their physician would not see them, we made an outreach to the physician's office and very frequently, you are correct in that physicians did not even—some of them didn't even know that private fee-for-service existed or thought it was the same as an HMO or PPO.

So we went through the education process with the physicians and most of—the vast majority, once they understood it, there was acceptance. There were some that would not, at which point we then made outreach to other physicians in the area and did what we could and probably 99 point some percent, we were able to locate alternative providers for the members.

Mr. BERRY. Well, I applaud that, but I am here to tell you that doesn't happen very many places. I would say places where that happens are a lot less than the places where it does. And like I say and it comes back to us, and it comes back to the providers. And that is fine. That is my job, and I don't mind dealing with it at all, but the problem that is hard to deal with is the fact that these people are not getting the care that they think they have paid for, and it is because they have largely been deceived by hotdog salesmen somewhere. And I wish that wasn't the case.

I know we have already had a discussion about whether or not—that was that argument, a while ago—fraud, whether this was fraud or not. If it's not fraud, I don't ever want to run into fraud because it is as close as you can get without being there.

But—and I do—I applaud you and your company for doing good, and I hope you all keep doing it.

Thank you.

Mr. SPRATT. Thank you. Let me thank each of our witnesses for bringing us the knowledge and perspective you provided on what is a very complex but vitally important matter. We appreciate your participation. Thank you very much.

I would ask unanimous consent that members who did not have the opportunity to ask questions of our witnesses be given 7 days to submit questions for the record.

Without objection, so ordered.

[The prepared statement of Ardis Hoven follows:]

PREPARED STATEMENT OF ARDIS D. HOVEN, M.D., AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding Medicare Advantage (MA) plans and their impact on the Federal Budget. We commend Chairman Spratt and the Members of the Budget Committee for your leadership in recognizing the need to examine the impact of the MA plans on Medicare patients and the long-term financial viability of the Medicare program.

The AMA supports providing Medicare beneficiaries with coverage options so that they are able to select the health insurance plan that is tailored to meet their specific needs. The MA option was originally conceived as a strategy to promote efficiency, provide enhanced patient care through care coordination, and promote private competition. MA plans were also devised to increase diverse plan offerings that would dovetail with the varied needs of beneficiaries. The AMA has been and continues to be a strong proponent of greater competition in the Medicare program to help strengthen patient choice and the program's long-term financial sustainability. However, seniors' choices should be based on their health care needs and not influenced by preferential government subsidies to highly profitable insurance companies. The average reimbursement to MA plans—112 percent of regular Medicare expenditures—has created significant market distortions and undermined competition by providing large subsidies to the MA plans at the expense of regular Medicare.

SUBSTANTIAL SUBSIDIES TO MA PLANS

The Congressional Budget Office (CBO) estimates that Medicare spending would be reduced by $65 billion from 2008-2012 if the MA benchmarks were decreased to the Medicare fee-for-service level. CBO estimates that 21 percent of MA spending goes to private plans that receive between 120 percent and more than 150 percent of regular Medicare rates. The large disparity in payment between MA plans and regular Medicare is a particularly troubling development because it is difficult to detect enough additional meaningful benefits to patients to justify these enormous government subsidies. In fact, there is mounting evidence that a significant number of MA plans are luring their enrollees with false promises, skimping on benefits and reimbursement, and using their government subsidies primarily to increase profits for their shareholders.

There are real tradeoffs involved in the public policy choices that Congress currently faces. An average 12 percent add-on payment is being provided to plans in which only 19 percent of Medicare beneficiaries are enrolled, while the physicians who care for all Medicare beneficiaries face a 10 percent cut next year. The Medicare Payment Advisory Commission (MedPAC) estimates that all seniors, not just those in MA plans, are paying two dollars a month in higher premiums to help fund the subsidies being paid to managed care companies. The CBO and the Medicare Actuary have noted that Medicare cost growth, which was already a cause of major concern, is now projected to rise even more rapidly due to its projections of increasing enrollment in MA plans. The Medicare Actuary also has stated that overpayments to MA plans shorten the solvency of the Part A Trust Fund and concluded that setting the benchmarks for MA plans at the regular Medicare fee-for-service level would extend the insolvency date by about two years. In other words, instead of making Medicare more sustainable as the baby-boom generation reaches the age of Medicare eligibility, the MA subsidies are having the opposite effect. The additional payment to MA plans averages about $1,000 per beneficiary and the CBO reports that the MA overpayment per beneficiary is only expected to climb.

In addition to subsidizing MA plans by paying more per enrollee in MA than for beneficiaries in regular Medicare, Congress established a further MA subsidy through the creation of the MA preferred provider organization (PPO) stabilization fund (the fund). The fund was designed to provide additional financial incentives to insurance companies that offer regional PPO plans in areas where regional PPOs would not have otherwise been established. (This additional subsidy was not necessary to encourage regional PPO participation given that there were such plans in 21 of the 26 regions in 2006.) Originally, $10 billion was placed in the fund, but Congress has already reduced the fund by $6.5 billion. If this fund were completely eliminated, the CBO estimates that it would save $3.5 billion over a ten year period. Furthermore, the CBO Budget options provided to Congress show that MA plans receive an additional financial subsidy through a duplicate payment to MA plans for Indirect Medical Education (IME). (The MA benchmarks include an IME payment even though these payments are already made directly to teaching hospitals that treat MA beneficiaries.) The CBO estimates that if the IME payments were removed from MA payments, approximately $12.9 billion would be saved over ten years.

The AMA joins other health care stakeholders, including the AARP and the Medicare Rights Center, as staunch supporters of financial neutrality between the regular Medicare program and the MA program. The AMA urges Congress to adopt the MedPAC recommendation that "the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses." We concur with MedPAC's goal of "having Medicare payments cover the costs that efficient providers incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and beneficiaries have access to the care they need."

MEDICARE FFS REMAINS THE PRIMARY MEDICARE OPTION AND IT MUST BE SOLIDIFIED AND IMPROVED

Although many physicians provide health care to MA patients, they have many more patients—81 percent—who are in regular Medicare. Huge subsidies are being paid to MA plans that serve 19 percent of Medicare beneficiaries, while physicians who take care of all senior and disabled patients face cuts of 10 percent in 2008 and about 40 percent over the next decade.

If Congress does not take action to provide Medicare physician payment updates that keep up with practice cost increases, then physicians will not be able to sustain their practices, resulting in significant access problems for all Medicare patients, not just those in regular Medicare. In a recent AMA survey of 8,955 physicians, 60 percent reported that they plan to limit the number of new Medicare patients they treat if payment rates are cut 10 percent in 2008. Only 17 percent of the surveyed physicians said that the MA subsidy should continue, while most of the remaining respondents said the subsidy would be better spent on preventing physician pay cuts and/or helping all low-income patients with their out-of-pocket costs, not just those in MA plans. These survey results demonstrate that there is a tradeoff in a tight budget environment between adequate payment updates for physicians and government subsidies for health insurance plans.

AMA SURVEYED PHYSICIANS AND PATIENTS REPORT PROBLEMS WITH MA PLANS

Adding to these concerns, there is mounting evidence that calls into serious question whether the extra billions of dollars being poured into MA are buying better health care coverage for seniors. An April 2007 report from the Medicare Rights Center grouped problems with MA plans coverage into nine different categories:

- Care can cost more than it would under original Medicare;
- Private plans are not stable;
- Getting emergency or urgent care is difficult;
- Continuity of care is broken;
- Members have to follow plan rules to get covered care;
- Choice of doctor, hospital and other providers is restricted;
- Getting care away from home is difficult;
- Promised extra benefits can be very limited; and,
- People with both Medicare and Medicaid can encounter higher costs.

A recurring theme throughout this report and its major conclusion is that, "[e]ven with enhanced payments, private health plans often fail to deliver coverage that a patient could obtain from Original Medicare."

In March 2007, AMA surveyed 2,202 physicians about their experience with MA plans. The findings corroborated that patients and their physicians are being shortchanged by MA plans. About half of the physicians who had patients in MA reported that they have experienced denial of services that are typically covered in

the regular Medicare program. In addition, about half responded that they have received payments from the MA plans that were below the regular Medicare rate. Contrary to industry claims that MA plans provide more benefits to patients, physicians are telling us that their patients who have enrolled in MA plans may be getting even fewer benefits than they receive in regular Medicare.

The AMA survey results also lend credence to the reports from beneficiary advocates that marketing by MA plan representatives is often confusing to beneficiaries or misleading. An overwhelming number of physicians—eight out of ten—who treated MA plan patients stated that their patients have difficulty understanding how the MA plan works. Choice is an important element of a market-driven health care system, but patients must have accurate information if they are to make decisions that best meet their health care needs. MA plans have failed in their obligation to provide patients accurate information in an accessible and comprehensible fashion. This failure has real consequences for seniors who may have their health care services interrupted or incur significant unanticipated costs when they are least able to afford it.

Good information about MA plans is also inaccessible to physicians. Six out of ten physicians reported that they have had difficulty understanding how the MA plans work. This problem is particularly pronounced for PFFS plans. In the AMA survey, over half of the physicians treating PFFS patients stated that they did not have access to or knowledge of the PFFS plans' Terms and Conditions, even though ready access to plans' Terms and Conditions is a cornerstone of the PFFS plan design. It should be no surprise that patients have had difficulty finding physicians who will accept PFFS plans, despite the promises made by sales representatives that patients would be able to go to any doctor. The recent action by CMS and several health plans to suspend marketing of PFFS plans underscores the validity of these complaints. Before the suspension can be lifted, plans will need to have a provider outreach and education program in place to ensure that physicians have reasonable access to the plan Terms and Conditions of payment, and that provider relations staff are readily accessible to assist physicians with questions concerning the plan.

Physicians report a number of additional problems with MA plans, including having to overcome additional financial and administrative burdens when accepting MA beneficiaries. Nearly six out of ten physicians indicated that they had experienced excessive hold times when attempting to contact MA plans. The same number reported that MA plans have requested excessive or additional documentation for payment of claims. Finally, about a third report that MA plans have used proprietary claims editing software to down code or bundle claims—administrative billing practices that Medicare has not approved for use in regular Medicare. These responses demonstrate that MA plans have not enhanced, but instead have hampered operational efficiency on the front lines of health care delivery in physician offices, to the detriment of physicians and their patients.

Surveyed physicians also reported that they have had experience with their patients being switched to a MA plan from regular Medicare without the beneficiary's knowledge, very restrictive formularies with MA prescription drug plans, and customer service outsourced to a foreign country.

MINORITY AND RURAL PATIENTS

Although the insurance industry has issued reports touting the benefits of the MA program to minority and rural beneficiaries, an even-handed look at the data and related analysis paints a different picture. The Center for Budget and Policy Priorities (CBPP) pointed out that Medicaid, not MA, is the main form of supplemental coverage for low-income and minority Medicare beneficiaries. It noted that 58 percent of Asian Americans, 30 percent of African Americans, and 34 percent of Hispanics receive supplemental coverage through Medicaid. In addition, the CBPP analyzed the data offered by America's Health Insurance Plans (AHIP) in a report outlining the benefits of MA. The CBPP concluded based on the AHIP data that low-income and minority beneficiaries participate in MA plans less than other Medicare beneficiaries. In 2004, the Center for Policy Analysis and Research of the Congressional Black Caucus Foundation reported that the "unprecedented amount of financial assistance" to MA plans will divert "precious resources away" from regular Medicare. Even then the CBC Foundation argued that "unfair subsidies and other advantages" provided to MA plans should be eliminated "so that traditional Medicare can compete on a level basis."

Another AHIP report concluded that the supplemental coverage offered by Medigap plans is "particularly important to low- and moderate-income beneficiaries, especially those living in rural areas." As PFFS plans are the most common MA plan for patients in rural areas—the patients who are most reliant on Medigap for

their supplemental coverage according to AHIP—it is important to note that Medigap plans are not allowed to provide coverage for MA services. In some cases, therefore, MA plans may actually put patients at higher risk for out-of-pocket costs than they would face if they had remained in the regular Medicare program and kept their Medigap policy.

Some of the services where these extra costs are especially problematic are cancer care, home health care, and other services provided to patients with potentially terminal diseases. For example, for a low-income cancer patient with Medicare coverage and a Medigap supplemental policy, Medicare would pay 80 percent of their chemotherapy costs and Medigap would pay the remaining 20 percent. However, many MA plans do not provide more than the 80 percent coverage of chemotherapy drug costs that is provided in the regular Medicare program and, because these patients are not allowed to purchase Medigap policies, cancer patients in these plans must pay the 20 percent coinsurance out of their own pockets.

The National Rural Health Association (NHRA) testified to the House Ways and Means Health Subcommittee that while currently only 5.6 percent of rural Medicare beneficiaries have joined a MA plan, left on its current course MA has the "potential to destabilize the existing rural safety net." For example, NHRA stated that there was an open question as to whether MA plans will honor existing rural add-on payments that safety net providers receive under regular Medicare. Related to the foregoing, a Texas nurse wrote to the AMA about her experience as the practice manager of a rural health clinic (RHC). She stated that the RHC received a per visit rate from regular Medicare of $68.13—this amount covers everything provided by the RHC and all codes. However, an administrative and financial nightmare has ensued because while MA plans have informed patients that they can see any physician in the clinic, some of the plans have been unwilling to pay the RHC at the higher rates that it is entitled to receive because it serves a rural community. In fact, the nurse manager wrote that one MA plan is paying a rate that is less than half the clinic's RHC rate under regular Medicare. Far from increasing access to rural beneficiaries, MA plans could well result in fewer rural physicians being able to accept Medicare patients.

MA PLANS HAVE INCREASED COSTS TO ALL BENEFICIARIES

MA has resulted in higher premiums across the board for all beneficiaries. MedPAC has estimated that on average every Medicare beneficiary pays approximately two dollars per month extra to finance the higher MA payments that only benefit 19 percent of beneficiaries. For example, only 8 percent of Medicare beneficiaries in South Carolina are enrolled in Medicare Advantage plans, but all seniors in South Carolina are paying higher Medicare premiums every month so that the government can provide subsidies to health plans that serve only 8 percent of the state's Medicare beneficiaries. This is true across the country—a majority of Medicare beneficiaries in all states are forced to pay higher premiums to fund overpayments to plans that enroll a select subset of beneficiaries.

MA MARKETING ABUSES

There have been rampant MA plan marketing abuses reported by physicians and other health care stakeholders. In testimony to the Senate's Special Committee on Aging, Wisconsin Insurance Commissioner Sean Dilweg reported that, in a survey by the National Association of Insurance Commissioners, 37 out of 43 states reported receiving complaints about inappropriate or confusing marketing practices leading Medicare beneficiaries to enroll in a Medicare Advantage plan without adequately understanding their choice to remain in regular Medicare or without adequate understanding of the consequences of their decision.

Many reports of marketing abuses focus on PFFS plans, including a common practice of signing up patients for plans that end up costing the beneficiary more in out-of-pocket expenses and misleading patients regarding which physicians accept the PFFS plans. Reportedly, many PFFS plans market themselves as providing patients the "freedom" to choose any provider that accepts Medicare. As a result, regular Medicare patients sign-up for PFFS with the expectation that they will be able to continue receiving their health care from the same physician they have always had. Although CMS allows patients who have been misled to drop the PFFS plan and re-enroll in regular Medicare and supplemental Medigap plans, this is a difficult, time-consuming process and can impact the delivery of health care services. In addition, once patients willingly drop supplemental Medigap, they are not able to obtain that supplemental coverage if they elect to re-enroll in regular Medicare until and unless they demonstrate that they meet a host of criteria. Even after meeting these requirements the Medigap plan may have less favorable terms. Previously, neither

Congress nor CMS have addressed these patient burdens. These abuses have both short-term and long-term consequences to patients. We hope that the recently announced voluntary effort to suspend PFFS plan marketing will lead to more responsible behavior in the future.

MA PLANS HAVE GENERATED LARGE PROFITS FOR PRIVATE INSURANCE COMPANIES

When Congress set up the payment system for MA plans, it may have intended for the extra payments to support health care services. In the AMA physician survey and reports by patient advocates, MA plans are not delivering on this promise. The subsidies to MA plans are substantial, create market distortions by creating a preferred government Medicare option, and are inefficient. Who then benefits from the subsidies? As of November 2006, the MA market was dominated by four firms that accounted for 58 percent of all MA enrollment. There have been reports that private insurance companies have reaped substantial profits from the Medicare program. For example, in February 2007 the Associated Press reported that one of the companies "fourth-quarter profit more than doubled on the strength of its burgeoning Medicare business" and the company had "a record year in revenue and profit." Recently, Goldman Sachs reported that the same company "will earn 66 percent of its net income from Medicare Advantage this year * * * which comes to between $670 million and $705 million."

Until MA plans are placed on equal footing with regular Medicare, the market distortions will continue to encourage inefficient behavior by MA plans, patients and physicians will face added financial risks, delivery of health care will be compromised, and taxpayers will pay more (seemingly for less). Clearly, the status quo does not advantage patients and physicians.

The AMA appreciates the opportunity to provide our views to the Budget Committee concerning MA and the Budget. We look forward to working with the Committee and Congress to preserve patient access to high quality, cost-effective health care and to find solutions to address the long-term financial sustainability of the Medicare program.

[The prepared statement of Mr. McGovern follows:]

PREPARED STATEMENT OF HON. JAMES P. MCGOVERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. Chairman: About one million people of Massachusetts are enrolled in Medicare. Of these, about 16.7% are enrolled in Medicare Advantage plans—or 168,000 Massachusetts seniors.

838,000 are enrolled in traditional Medicare programs—or 84%.

This is very similar to the national average (80/20 split of traditional Medicare/Medicare Advantage).

I believe there are a few "bottom line" problems with Medicare Advantage.

As members of the Budget Committee, we need to be good stewards of how our federal dollars are dedicated and spent.

We need to be promoting economic efficiency——

The most cost-effective health care——

And accountability.

Medicare Advantage appears to be failing us on all three of these priorities.

It fails the efficiency test—because the additional benefits it allegedly provides for about 16-20 percent of Medicare seniors are being paid for—literally subsidized—by the 80 percent of the elderly who are enrolled in traditional Medicare programs.

It fails the cost-effective test because it's already costing about $1,000 more per beneficiary than traditional Medicare.

And it doesn't even pass the sniff test on accountability because the insurance companies won't tell us how much they're skimming off the top of Medicare Advantage as profit; and they don't have to comply with any of the reporting, monitoring, data collection, or quality measures required of all other Medicare plans.

Finally, CBO projects that Medicare Advantage has actually moved up by two whole years the date when Medicare will reach insolvency!

Mr. Chairman, I ask you, what's wrong with this picture? Everything!

We could save about $140-to-$150 billion over the next 10 years, either by returning all beneficiaries to traditional Medicare programs—or by leveling the playing field and equalizing the payment structure between all Medicare program choices, including Medicare Advantage.

Those funds could ensure that our hospital and physician reimbursements were adequately adjusted; and that health insurance coverage could be provided to all of America's children; with tens of billions of taxpayer dollars to spare.

And if private plans that now make up Medicare Advantage withdraw from the program because they don't want to operate on a level playing field—well, that's just fine with me. The efficient programs will remain—the inefficient and corrupt will withdraw. It's called market efficiency—something I know my Republican colleagues stand fully behind.

I don't have a question—I just wanted to state my concerns on behalf of the seniors of Massachusetts—especially when we're struggling in Massachusetts to implement our own health-care-for-all state plan.

I'd like to associate myself with much of the testimony provided to us today and the previous statements of my Democratic colleagues.

We have to be better stewards of our federal dollars than this.

Medicare is supposed to be a not-for-profit, federally-provided health care program where every American senior is part of the risk pool that allows all of our seniors to receive basic, quality medical care and health insurance.

Medicare Advantage is a wrecking ball undermining the basic structure of Medicare.

We have to do better.

[Whereupon, at 1:15 p.m., the committee was adjourned.]