

# **MATHEMATICA** **Policy Research**

**Marsha R. Gold**  
**Senior Fellow**  
**Mathematica Policy Research**

**Testimony for Hearing on**  
**Medicare Advantage**

**Health Subcommittee**  
**Committee on Energy and Commerce**  
**U.S. House of Representatives**

December 4, 2013

Thank you, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee for the opportunity to testify on Medicare Advantage. As a senior fellow at Mathematica Policy Research for the past 20+ years, I have tracked the history of managed care plans in Medicare; analyzed trends in plan participation, enrollment, and benefits; examined market dynamics in Medicare Advantage (MA); and studied the implications of MA for beneficiaries. This body of work extends from the late 1990s, when Medicare+Choice replaced the Medicare risk contracting (HMO) program, through today's mature Medicare Advantage (MA) program which I have been tracking with staff at the Kaiser Family Foundation as well as others. I have written and presented extensively on this work and its implications for policy development.

Medicare is critical to the well-being of the nation's seniors and people with disabilities, many of whom have low to moderate incomes, complex health care needs, and other characteristics that leave them disproportionately vulnerable. (The Henry J. Kaiser Family

Foundation 2011). The participation of private plans in Medicare, such as MA, has expanded the coverage alternatives available to Medicare beneficiaries, but the role that such plans should play remains controversial. My testimony today makes three key points about today's MA program that I hope will inform congressional debate on Medicare Advantage today.

First, the MA program is strong. Rising enrollment and widespread plan availability are expected to continue into 2014 despite concerns that cutbacks in payments to plans would discourage them from participating or make them less attractive to potential enrollees.

Second, MA plans are still paid more for an enrollee than a similar beneficiary would cost in the traditional Medicare program.. In considering future policy changes, it is difficult to see the rationale on a national basis for paying private plans more than Medicare now spends on the traditional program, particularly when there is so much concern about the federal deficit and debt.

Third, while some argue that changes in the MA market in 2014 should raise policy concerns, my recent analysis of offerings suggests that the market remains attractive to those sponsoring health plans and beneficiaries enrolling in them.. From my perspective, many of the concerns raised about 2014 offerings, which are either inconsistent with the evidence or an inherent part of the way competitive markets work, are already addressed by protections in place in the Medicare program.

In its March 2013 Report to Congress, the Medicare Payment Advisory Commission (MedPAC), a nonpartisan commission established in 1997 to advise Congress on Medicare, concluded that payment changes under the Patient Protection and Affordable Care Act of 2010 (ACA) have improved the efficiency of the program and may have encouraged plans to enhance quality—all while continuing to increase MA enrollment through plans and benefit packages that

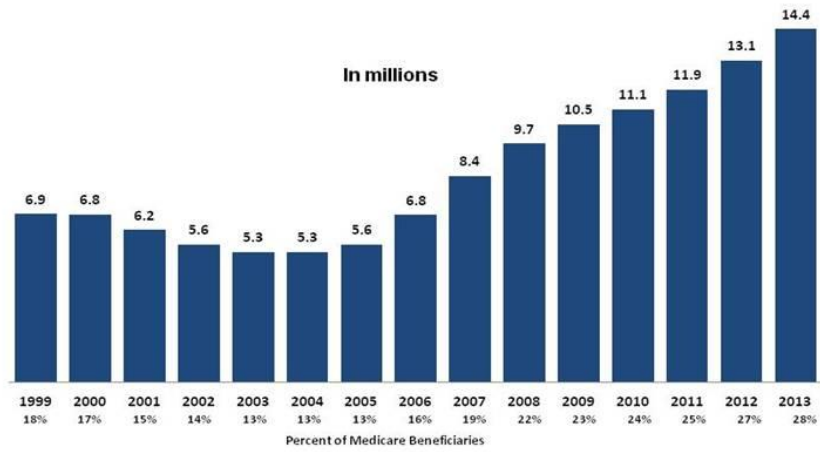
beneficiaries find attractive. I believe my analysis and testimony are fully consistent with the thrust of MedPAC's conclusions and its advice to Congress.

### **MA Enrollment Continues to Grow**

For many decades, Medicare has offered beneficiaries access to popular private plans through a variety of legislative mechanisms including cost contracts (1970s); the Medicare risk contracting (HMO) program (1982); Medicare+Choice, which added even more private options (1997), and Medicare Advantage (2003), which expanded these options and integrated the new Part D benefit (Gold 2001, 2008). Enrollment in these plans has historically ebbed and flowed as payment levels have fluctuated, but they were never meant to replace traditional Medicare (PL 105-33). In fact, more than 70 percent of beneficiaries are covered under traditional Medicare.

The ACA (PL 111 148 PART III) sought to scale back payments to MA plans in order to more closely align them with payments made for beneficiaries in the traditional program—as long changes like this were recommended by MedPAC (MedPAC 2009). Because MA payments are drawn from both the Medicare Trust Fund and Part B, reducing these payments also helped to extend the life of the Medicare Trust Fund and slowed increases in Part B premiums for all beneficiaries. Despite concerns that the cutbacks (which began in 2012) could hurt the MA program, enrollment has continued to grow (Exhibit 1). More than 15 million Medicare beneficiaries were enrolled in MA as of November 2013—an all-time high of 29 percent of all Medicare beneficiaries (CMS 2013). And despite concerns that MA plans would leave the market in 2014, there are almost as many new plans entering as leaving (Exhibit 2). Since the ACA was enacted, average premiums paid by enrollees have declined and will be even lower in 2014 than they were in 2010, as discussed later.

## Exhibit 1: Total Medicare Private Health Plan Enrollment, 1999-2013

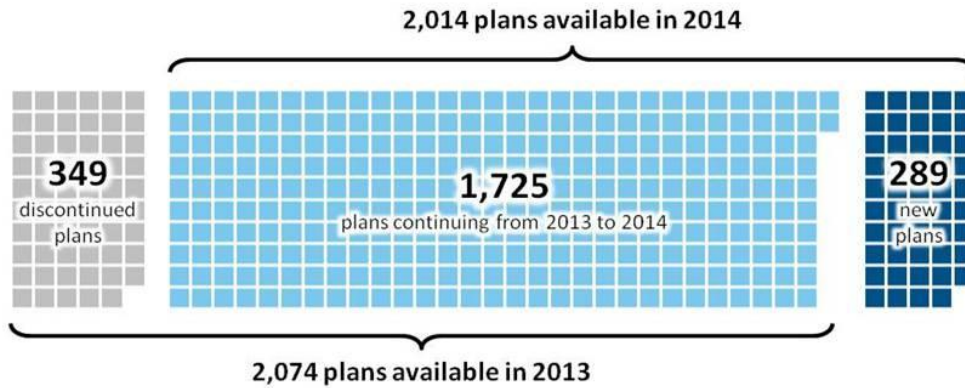


Note: Includes cost and demonstration plans, and enrollees in SNPs as well as other MA plans.

Source: Mathematica/Kaiser Family Foundation analysis of CMS MA enrollment files, 2000-2013; Mathematica, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2001-2007; enrollment numbers from March of the respective year, except for 2006, which is from April.

## Exhibit 2: Number of Medicare Advantage Plans Available, by Plan Availability Status, 2013 and 2014

Each  is equivalent to about 6 plans

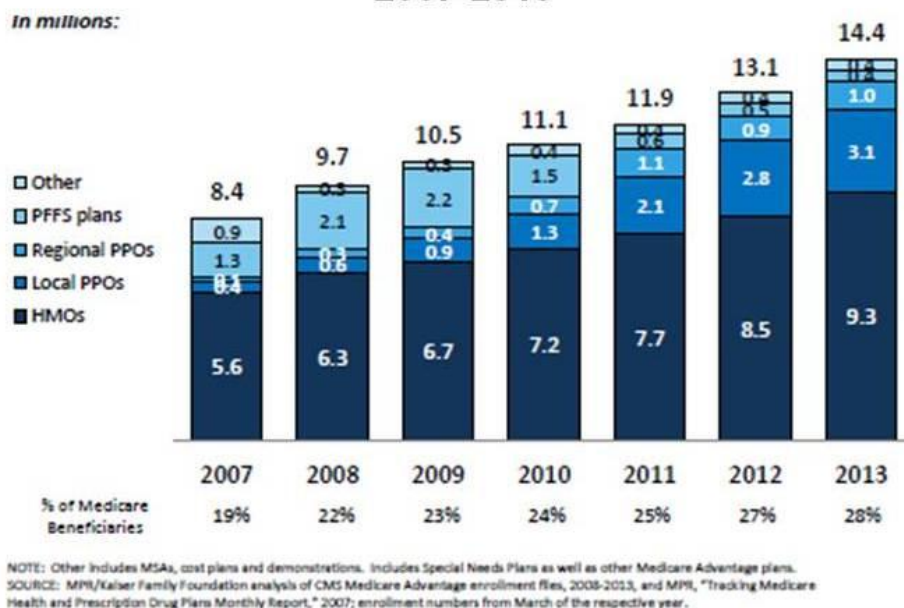


NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites).

SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2013 – 2014.

New types of private plans, such as preferred provider organizations (PPOs)—which give beneficiaries broader access to providers and generally cost more than HMOs—have accounted for a disproportionate share of recent growth, although the majority of enrollees have remained in HMOs, the core of the original predecessor programs to Medicare Advantage. (Exhibit 3).

**Exhibit 3: Total Medicare Advantage Plan Enrollment, 2007-2013**



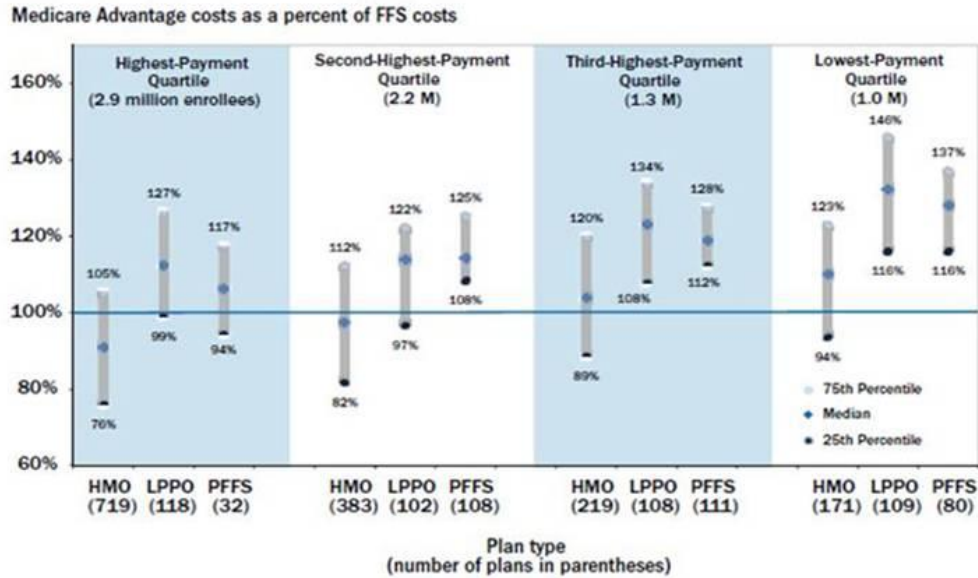
**Recent Cutbacks in MA Payments Relative to Traditional Medicare Are Equitable**

Medicare has historically aimed to set payments to private plans below or equal to what it paid in the traditional program for a similar beneficiary in the same county as the MA beneficiary. Payments in the Medicare risk-contracting program were originally set at 95 percent of traditional program payments, but weaknesses in the risk adjustment method—which have since been fixed—pushed the payments considerably higher (Brown et al. 1993). When the risk program evolved into Medicare+Choice, the link between private-plan and traditional-program payments was modified in a subset of counties for two reasons: to support growth in areas with few, if any, private plans (“floor counties”) and to address geographical differences in payment

(“blend counties”). These changes did not have the intended effect of growing the program enrollment, in part because annual costs in the traditional program were growing more slowly during that period than in the past, which contributed to low rates of annual increases in premiums (Berenson 2008). As a result, many private plans withdrew from the market (Gold 2001; Gold et al. 2004). In 2003, Congress sought to stabilize the program—now termed “Medicare Advantage—by setting the minimum payment rate at 100 percent of fee for service (FFS) and, more critically, by providing an option that allowed annual premiums to increase at a substantially higher rate (Gold 2008).

Over time, these cumulative policy changes led to MA plans being paid considerably more than Medicare would pay for a similar beneficiary in the traditional program, despite the improvement in risk adjustment to account for favorable selection. In 2009, for example, MedPAC estimated that the MA payment benchmark (the most Medicare would pay a plan), was, on average, 118 percent of what Medicare would spend for a similar beneficiary in the traditional program. Furthermore, MA payments (legislatively set at 75 percent of MA benchmarks, up to plan costs) were 114 percent of traditional Medicare spending. Thus, MA has been paid considerably more than Medicare pays for similar beneficiaries in the traditional program.

## Exhibit 4: Comparison of Medicare Advantage Plan Bid Costs to Medicare Fee-for-Service Costs, by Geographic Payment Quartiles, High to low, 2009



Notes: FFS = fee-for-service; HMO = health maintenance organization; LPPO = local preferred provider organization; PFFS = private fee-for-service. Source: Mathematica analysis of publicly available Medicare Advantage data.

The data on which these estimates are based have not historically been available to the public, but a recent analysis based on information made available through a Freedom of Information Act request produced similar results and highlights the geographical variation in payments relative to traditional Medicare (Biles et al. 2011). My own analysis of these data points to wide variation in MA costs relative to traditional Medicare both within and across the two types of plans even controlling for payment levels (Exhibit 4), suggesting that there is room for greater efficiency in how care is delivered (Gold 2013; Gold and Hudson 2013).

For many years, MedPAC (2010) has recommended that Congress align payments to MA plans with payments to traditional Medicare, and the ACA's provisions are gradually working toward this goal. MedPAC (2013) found that the average benchmark for payments to MA plans dropped to 110 percent of traditional program spending, down 8 percent from the 2009 level, and

## Exhibit 5: Projected Payments Exceed FFS Spending for all Plan Types in 2013

Plan type	Percent of PFFS spending in 2013		
	Benchmarks	Bids	Payments
All MA plans	110%	96%	104%
HMO	110	92	103
Local PPO	111	107	108
Regional PPO	106	97	102
PFFS	110	105	107
Reached availability plans included in totals above			
SNP*	111	96	105
Employer groups*	111	106	108

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider fee-for-service), SNAP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. We estimate FFS spending by county using the 2013 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made at teaching hospitals

\*SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type. We have broken them out separately to provide a more complete picture of the MA programs.

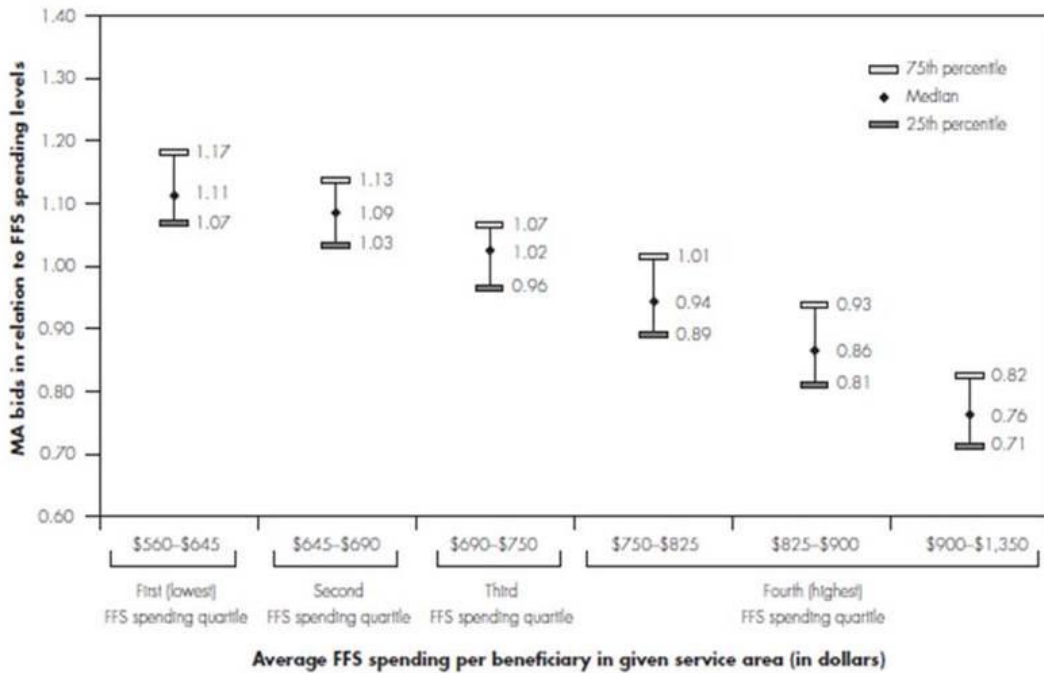
Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and FFS expenditures.

the average payments themselves dropped to 104 percent (Exhibit 5). Meanwhile, average bids—that is, what MA plans estimate it will cost them to provide the Medicare Part A and B benefit (which were historically above 100 percent of costs in the traditional program)—have fallen to 96 percent of traditional program spending. However, this average is due to HMO experience (They are the only plan type that averages below traditional program spending.) There also is considerable variation across plans and geographic locales. HMOs have not, however, proven viable in all markets, as their growth has been constrained by the reluctance of many beneficiaries’ to have a limited choice of providers. Local PPOs, which offer more provider choice but also cost more and represent a rapidly growing part of the program, had bids that were, on average, 108 percent of traditional program spending. In examining these data, MedPAC (2013, p. 298) found that even if there were no quality bonuses or favorable selection, plans in 2013 would still have received about 101 percent of the amount Medicare spends on similar beneficiaries in the traditional program. MedPAC also found that the efficiency of MA



plans has continued to vary, although MA spending perhaps did not vary as much across geographic areas as it did in the traditional program (Exhibit 6).

### Exhibit 6: Medicare Advantage Bids in Relation to FFS Spending Levels, 2013



Source: Medicare Payment Advisory Commission "Chapter 13: The Medicare Advantage Program: Status Report," in Report to the Congress: Medicare Payment Policy, March 2013.

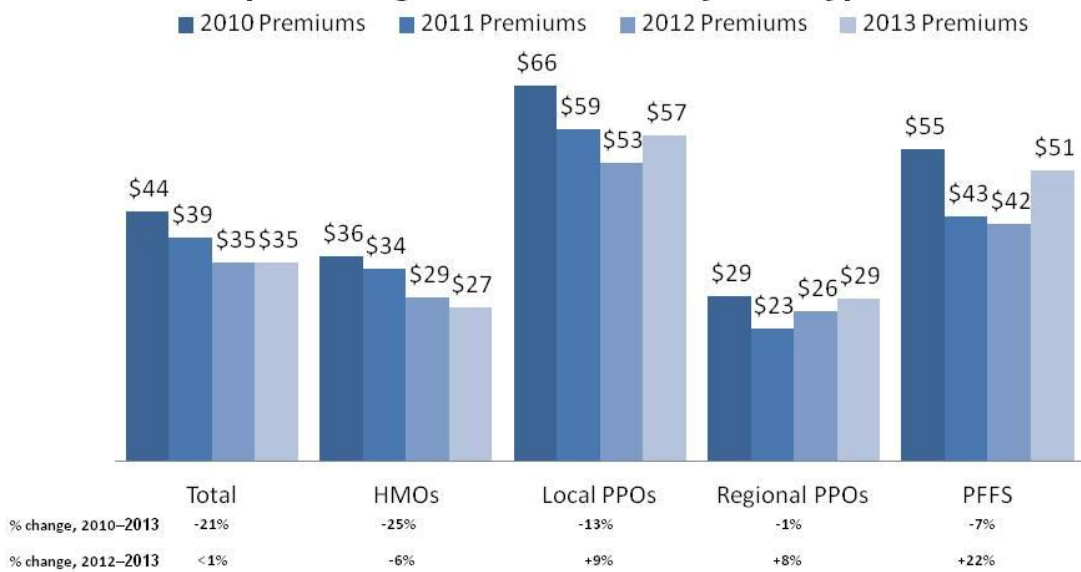
### Implications for Beneficiaries

Beneficiaries continue to have good access to private MA plans (Gold et al. 2013b). In 2012, the average beneficiary could choose from among 18 local MA plans (This estimate excludes plans with unique enrollment requirements such as special-needs plans (SNPs)). Companies that are terminating plans often are adding other plans in that same market (Exhibit 2). Plans leaving the market are disproportionately private fee-for-service plans, a trend based on changes predating the ACA. Only five percent of MA enrollees in 2013 will have to switch plans for 2014 because their plans will no longer be available. However, most who do will be able to enroll in the same type of plan, often offered by the same company.

Despite the decline over the past few years in MA payments relative to costs under traditional Medicare, plans also have been able to keep premiums down in order to attract enrollees (Exhibit 7). From 2010 through 2013, the average MA enrollee’s premium dropped by 21 percent—25 percent if they were in an HMO (Gold et al 2013a). Average plan premiums will be stable in 2014, although once current enrollment patterns are factored in, enrollees will see their premiums rise by an average of 5 percent, assuming that they stay in the same plan in 2014 (Gold et al 2013b). If historical patterns hold, some enrollees may decide switch plans to keep premiums down. However, even if they stay put, MA enrollees will be paying less, on average, in 2014 than they did in 2010.

Benefits also remain attractive, even though out-of-pocket spending can be high, given the limited income and assets of Medicare beneficiaries, particularly if they have complex health needs that persist from year to year (Cubanski et al 2011). In 2013, 47 percent of all MA

**Exhibit 7: Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2010-2013**



Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only MA plans that offer Part D benefits. The total includes cost plans (not shown separately). The premiums for a subset of sanctioned plans were not available in 2011. These plans were excluded from this analysis.

Source: Mathematica/Kaiser Family Foundation analysis of CMS Landscape Files for 2010–2013 and March Enrollment Files for 2010–2013.

enrollees were in plans in which the out-of-pocket limit was above CMS's recommended \$3,400 limit, and 24 percent were in plans with out-of-pocket limits over \$5,000 (Gold et al. 2013a). Such limits attract beneficiaries because they provide more financial protection but the amount of the limit rose from 2012 to 2013 and appears to be poised to rise again in 2014 (Gold et al 2013b). In a competitive market, it is important for beneficiaries to carefully examine differences in cost sharing across plans and how they change from year to year if they are to choose a plan that is best for them whether that be a Medicare Advantage plan or traditional Medicare, with or without a Medigap supplement.

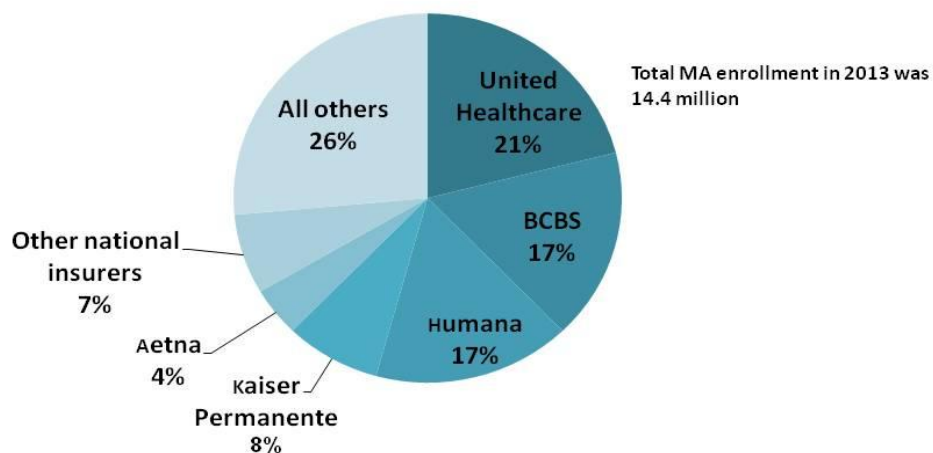
### **Implications for Policy**

The history of private plans in Medicare makes it clear that payment reductions can discourage plans from participating in MA (Gold et al 2004, 2011a), but this does not yet appear to be an issue. Whether it should be--if circumstances change--depends on one's perspective on the desirability of choice, even if it costs (rather than saves) money. MedPAC (2013) sees signs that payment changes are encouraging plans to take steps to become more efficient. The downside, of course, is that some of these changes may not always be popular with beneficiaries or with providers (Gold 1999). Medicare seeks to protect beneficiaries from the adverse effects of such changes through mechanisms like network adequacy and quality standards, requirements about notifying beneficiaries of change in their plan and provider networks, and other means. And because enrolling in MA is voluntary, there also is the option to return to traditional Medicare during the annual open enrollment period (more often if they are dually eligible for Medicare and Medicaid).

The crucial policy question is how much additional Medicare spending to maintain the private option is justified if the traditional program can provide benefits for less than private plans can and if they can do so in a manner that is satisfactory to the vast majority of Medicare

beneficiaries who continue to choose the traditional program? Paying more for beneficiaries who choose a private plan, as a matter of policy, implies that one program is better than another—perhaps by offering better quality or more effective cost control. Unfortunately, the evidence has never consistently or strongly shown this to be the case, certainly not to the extent that would justify substantially higher payments to private plans (Gold 2003, 2012). It is particularly hard to justify excess payments in today’s environment, in which there is concern about growing Medicare spending and its effect on the deficit and the national debt. Because MA enrollment is concentrated in a few firms, higher payments also involve a substantial transfer of public funds to these firms (Exhibit 8). Under the ACA, both traditional Medicare and MA are encouraged to take steps to become more efficient. Further, traditional Medicare remains popular with beneficiaries, which means that paying more for private plans is effectively a tax on their choice because their Part B premiums will increase, with no gain in benefits to them.

**Exhibit 8: Medicare Advantage Enrollment, by Firm or Affiliate, 2013**



Note: Other includes firms with less than 3% of total enrollment. BCBS are Blue Cross/Blue Shield affiliates and include Wellpoint BCBS plans that make up 4% of all enrollment (558,833 enrollees) in MA plans; approximately 47,000 beneficiaries are enrolled in other Wellpoint plans. Other national insurers includes 1,228,443 enrollees across the following firms: Cigna (438,252), Coventry (305,584), Wellcare (252,563), Universal American (127,340), Munich American Holding Corporation (57,697), and Wellpoint non-BCBS plans (47,007).

Source: Mathematica/Kaiser Family Foundation analysis of CMS Enrollment Files, 2013.

## **Conclusion**

My independent research and analysis are consistent with MedPAC's conclusions in its March 2013 Report to Congress, in which it concluded that payment changes under the ACA have improved the efficiency of the Medicare Advantage program and may have encouraged plans to enhance quality—all while continuing to increase MA enrollment through plans and benefit packages that beneficiaries find attractive.

## REFERENCES

- Berenson, Robert A. "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field'." *Health Affairs*. Web exclusive, December 15, 2004. Available at <http://content.healthaffairs.org/content/early/2004/12/15/hlthaff.w4.572.citation>. Accessed December 3, 2013
- Biles, Brian, Grace Arnold, and Stuart Guterman. "Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field." Issue Brief #1491. New York: The Commonwealth Fund, March 2011.
- Brown, Randall, Dolores Gurnick Clement, Jerrold W. Hill, Sheldon M. Retchin, and Jeanette W. Bergeron. "Do Health Maintenance Organizations Work for Medicare?" *Health Care Financing Review*, vol. 15, no. 1, fall 1993.
- Centers for Medicare and Medicaid Services "11.04.13 Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Organizations—Monthly Summary Report. Available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/>). Accessed November 23, 2013.
- Cubanski, Juliette, and Adrienne Dulio. "Living Close to the Edge: Financial Challenges and Trade-Offs for People on Medicare." The Henry J. Kaiser Family Foundation, June 2011. Available at <http://kff.org/medicare/report/living-close-to-the-edge/>. Accessed December 3, 2013.
- Gold, Marsha. "Making Sense of the Change in How Medicare Advantage Plans are Paid." Issue Brief. New York: The Commonwealth Fund, May 2013.
- Gold, Marsha. "Medicare Advantage—Lessons for Medicare's Future." *New England Journal of Medicine*, vol. 366, March 29, 2012, pp. 1174–1177.
- Gold, Marsha. "Medicare's Private Plans: A Report Card on Medicare Advantage." *Health Affairs*. Web exclusive, November 24, 2008. Available at <http://content.healthaffairs.org/content/28/1/w41>. Accessed December 3, 2013
- Gold, Marsha. "The Medicare+Choice Program: An Interim Report Card." *Health Affairs*, vol. 20, no. 4, July-August 2001.
- Gold, Marsha. "ISO Quick Fix, Free Lunch and Share of Pie." *Journal of Health Politics, Policy and Law*, vol. 24, no. 5, 1999. Special issue: The Managed Care Backlash.
- Gold, Marsha, Lori Achman, Jessica Mittler, and Beth Stevens. "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage." Washington, DC: Mathematica Policy Research, August 2004.
- Gold, Marsha, and Maria Cupples Hudson. "Analysis of the Variation in Efficiency of Medicare Advantage Plans." Washington DC: Mathematica Policy Research, May 2013.

- Gold, Marsha, Gretchen Jacobson, Anthony Damico, and Tricia Neuman. “Medicare Advantage 2013 Data Spotlight: Enrollment Market Update.” The Henry J. Kaiser Family Foundation, June 2013a. Available at <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/>. Accessed December 2, 2013.
- Gold, Marsha, Gretchen Jacobson, Anthony Damico, and Tricia Neuman. “Medicare Advantage 2013: Plan Availability and Premiums.” The Henry J. Kaiser Family Foundation, November 2013b. Available at <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/>. Accessed December 2, 2012.
- The Henry J. Kaiser Family Foundation. “How Much “Skin in the Game” Is Enough: The Financial Burden of Health Spending for People on Medicare: An Updated Analysis of Out-of-Pocket Spending as a Share of Income.” June 2011. Available at <http://kff.org/medicare/report/how-much-skin-in-the-game-is-enough-the-financial-burden-of-health-spending-for-people-on-medicare/>. Accessed December 3, 2013.
- Medicare Payment Advisory Commission. “The Medicare Advantage Program: Status Report.” *Report to the Congress: Medicare Payment Policy*. Chapter 13. Washington, DC: March 2013.
- Medicare Payment Advisory Commission. “The Medicare Advantage Program.” *Report to Congress: Medicare Payment Policy*. Chapter 4. Washington, DC: March 2010
- Medicare Payment Advisory Commission “The Medicare Advantage Program,” in *Report to the Congress: Medicare Payment Policy*. Chapter 3. Washington, DC: March 2009.
- Public Law 111-148 PART III—Improving Payment Accuracy of the Patient Protection and Affordable Care Act.
- Public Law 105-33—The Balanced Budget Act of 1997. Part C: Medicare+Choice Program: Eligibility, Enrollment and Enrollment.