Statement of

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"Effects of the Affordable Care Act's Changes to the Medicare Advantage Program"

*The views expressed here are my own and not those of either the Health Systems Innovation Network, LLC, or the American Action Forum.

Chairman Brady, Ranking Member McDermott, and members of the Subcommittee:

Thank you for the opportunity to share my research regarding the impact of the Affordable Care Act on the seniors and disabled Americans enrolled in the Medicare Advantage program.

Since its inception, Medicare Advantage (MA) has proved to be one of the most popular and successful components of Medicare, with enrollment steadily increasing over time. Every Medicare beneficiary has the right to choose a Medicare Advantage plan, but no one is required to participate. If a beneficiary is unsatisfied with the chosen plan, he or she has the right to switch to another plan at least once a year, or swit`ch to the original Medicare fee-for-service plan at least twice a year.

As of March 2014, 30 percent of Medicare beneficiaries have chosen Medicare Advantage plans. This is estimated to include almost 44 percent of those who do not have access to a retiree supplemental plan from a former employer. Medicare Advantage is even more popular among beneficiaries who have lower incomes, or who are African-American or Hispanic. Hispanics, in particular, have historically been more than twice as likely to choose Medicare Advantage, compared to the average Medicare beneficiary.

Despite this success, both changes mandated by the Affordable Care Act (ACA), and various regulations enacted or proposed by the Administration, will impose substantial cuts to the Medicare Advantage program – both in dollars and in patient choice – that will reduce the health care benefits and options available to seniors and the disabled.

ACA Changes

The Congressional Budget Office (CBO) estimates that ACA cuts to Medicare Advantage will total $308 billion by 2023, which would be approximately 43 percent of the ACA's total cuts to Medicare.

MA payments are tied to a “benchmark” monthly payment set individually for each county (or similar jurisdiction) in the United States.

The ACA made several changes to the calculation of the benchmarks:

- Benchmarks are now specifically tied to average spending in the fee-for-service (FFS) program in every county, and based on the quartile rank of FFS spending in each county.

  This will have the effect of locking in geographical variation in Medicare spending that is difficult to explain based on costs or health status, and that many experts believe is irrational.[1]

- Changes to the FFS program will result in lower payments, which will be passed through to the MA program and will result in lower MA benchmarks, and thus lower benefits or higher premiums for patients.

1 Elliott Fisher, David Goodman, Jonathan Skinner, and Kristen Bronner, “Health Care Spending, Quality, and Outcomes: More Isn’t Always Better,” Dartmouth Atlas Project Topic Brief, February 27, 2009, at http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf.

- A bonus system is established based on a plan's "star rating" on a five-star scale using criteria developed by the Centers for Medicare and Medicaid Services (CMS).

This rating system, originally developed only to assist beneficiaries in selecting a plan, is now being used to determine payment. However, because the rating criteria are chosen ***after*** the time period being rated, the rating system cannot incentivize quality performance, since the rules are not written until after the game is played. It could, however, be used as a way to reward favored plan sponsors by choosing criteria that make them appear to offer higher quality plans and therefore entitle them to higher payments.

> In addition, because plans with higher ratings will be paid more, they will be able to offer more benefits. Because the ratings are based on *ex post* criteria determined by bureaucrats rather than by the health outcomes or satisfaction of patients, bureaucrats would have the ability to "herd" patients into favored plans by enabling them to offer more benefits and lower costs. Instead of allowing plans to compete on a level playing field, the rating system could be used to tilt the field in favor of particular plans, and drive some patients away from the plans they would normally prefer. This represents a substantial diversion from the original goal of patient choice to meet each individual's particular needs.[2]

- The bonus will be doubled in certain "qualifying counties" based on demographic criteria that are unrelated to costs, performance, or patient satisfaction.

The ACA called for these changes to be phased in, with the effect that every county in the country would experience a cut relative to its pre-ACA baseline by 2017; in fact, 97.9 percent of counties will experience a cut by 2015. At the state level, every state is already experiencing a reduction in average benchmarks.

Regulatory Changes

CMS also periodically uses its regulatory authority to make adjustments to certain factors that affect MA payments. These adjustments include, for example, the formulas for risk-adjusting plan payments based on each MA enrollee's individual health status. The ACA made only relatively minor changes to this authority.

However, after the ACA was passed, CMS used its regulatory authority in a new way, which had the effect of masking the first few years of ACA cuts to the Medicare Advantage program.

The ACA specified that the new county benchmarks are to be phased in over six years, beginning in 2012. However, from 2012 to 2014, CMS used its pilot program authority to implement incremental bonuses for star ratings of 3 and 3.5 stars in addition to the 4-and-above bonuses mandated in the ACA. Very few MA plans have ratings of less than 3 stars, so nearly all plans got a "bonus" under this system.

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2 Douglas Holtz-Eakin, Robert A. Book, and Michael Ramlet, "Medicare Advantage Star Ratings: Detaching Pay from Performance," American Action Forum, May 2012, at http://americanactionforum.org/uploads/files/research/Medicare_Star_Ratings_Detaching_Pay_from_Performance.pdf.

The payment increases as a result of this program had the effect of mostly offsetting the cuts in benchmarks mandated by Congress. Because of this CMS-initiated regulatory program, many of the expected cuts in benefits and in plan choices did not occur, simply because the cuts mandated by Congress have not yet been felt by patients or plan sponsors.

However, now that the pilot program has ended, we will see substantial cuts in average payments for 2015 relative to 2014, and these cuts will continue until 2017 if current law remains in place.

Magnitude of Benefit Cuts

Based on published rates for each county, as well as enrollment data reported by CMS, I have calculated that the average MA enrollee will face a reduction in benefits in 2015 of about $317, or about 3 percent, compared to the year before.[3]

However, the total cut for 2015 relative to the pre-ACA baseline is estimated to be in excess of $1,530, or more than 13 percent. This demonstrates the extent to which CMS regulatory action offset the ACA's cuts for 2014.

Because the ACA calls for the new rates to be phased in through 2017, there are more cuts to come. The average reduction in benefits for 2017, relative to the pre-ACA baseline, is over $3,700 per beneficiary, per year, or nearly 27 percent.[4]

Impact of Benefit Cuts on Beneficiaries

Medicare beneficiaries – both seniors and the disabled – will experience these benefit reductions in a variety of ways, depending on the plan they select. Every beneficiary will experience some combination of higher copayments, higher deductibles, a higher premium in excess of the Part B premium, reduced benefits or plan services, and/or smaller provider networks. These are real impacts that will affect not only seniors' financial stability, but also their access to health care itself.

Disparate Impact

The ACA's reductions in MA benefits will have different impacts geographically and demographically. Because of geographic disparities in payment rates, the cuts will hit seniors in Louisiana the hardest, almost twice as hard as seniors in Montana.

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3 Robert Book, "Medicare Advantage Cuts in the Affordable Care Act: April 2014 Update," American Action Forum, April 17, 2014, at http://americanactionforum.org/research/medicare-advantage-cuts-in-the-affordable-care-act-april-2014-update.

4 Robert A. Book and Michael Ramlet, "What Changes will Health Reform Bring to Medicare Advantage Plan Benefits and Enrollment?" Medical Industry Leadership Institute, Carlson School of Management, University of Minnesota, October 2011, at http://www.carlsonschool.umn.edu/medical-industry-leadership-institute/publications/documents/Book_RamletFinal_10-13-2011.pdf.

Because of enrollment patterns, the cuts will hit those in lower-income groups nearly twice as hard as those in higher-income groups. For example, the ACA will cut benefits by almost twice as much on average, per Medicare beneficiary, from those with incomes just above the eligibility limit for Medicaid, as compared to those with incomes over $54,000.[5]

In addition, the Affordable Care Act's cuts to Medicare Advantage will hit Hispanic Medicare beneficiaries harder than those of any other ethnic group. CMS data indicates that Hispanics are more than twice as likely as the average Medicare beneficiary to enroll in Medicare Advantage.[6] This takes into account only the 50 states and DC. If Puerto Rico were included, the disparate impact on Hispanics would be even stronger, since about 70 percent of Puerto Rico's beneficiaries enroll in Medicare Advantage, higher than the enrollment rate in any state.[7]

Conclusion

For the last three years, Medicare beneficiaries have been shielded from the benefit reductions and cost increases imposed by the Affordable Care Act through the Administration's use of pilot program dollars to partially offset the first phases of benefit cuts imposed by law. Now that the pilot program is ending, Medicare beneficiaries will feel the full impact of the Affordable Care Act's benefit cuts over the next three years.

If current law remains in force, senior citizens and disabled Americans enrolled in the Medicare Advantage program will experience reductions in benefits and increases in out-of-pocket expenses at least through 2017 due to provisions in the Affordable Care Act. These reductions in benefits and increases in out-of-pocket spending will disproportionately harm those in the lower income ranges, particularly those just above the threshold for Medicaid eligibility. It will also disproportionately harm Hispanic seniors, who depend on Medicare Advantage at much higher rates than the rest of the Medicare-eligible population.

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5 Robert A. Book and James. C. Capretta, “Reductions in Medicare Advantage Payments: The Impact on Seniors by Region,” Heritage Foundation Backgrounder No. 2464, September 14, 2010, at http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf; based on data from AHIP Center for Policy and Research, “Low-Income and Minority Beneficiaries in Medicare Advantage Plans, 2006,” September 2008, at http://www.ahip.org/MA-Low-Income-Report-2008, and additional data from the CMS Medicare Current Beneficiary Survey and the Bureau of Labor Statistics.

6 *Ibid.*

7 Kaiser Family Foundation, http://kff.org/other/state-indicator/medicare-advantage-penetration, based on CMS data.