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Committee on Energy and Commerce
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Medicare Advantage

Mr. Chairman, Ranking Member Pallone, and members of the subcommittee, I appreciate the invitation to appear before you today. My statement reviews the role of private health plans in Medicare, identifies the factors that will hold down payments to Medicare Advantage (MA) plans in 2015, and explains why the Administration and Congress should reject demands to freeze MA payment rates in 2015 at their 2014 level.

The Role of Private Plans in Medicare

For 40 years, Medicare beneficiaries have been able to receive their benefits through private health plans, although the arrangements have evolved significantly over that time. In 2014, 29 percent of beneficiaries are enrolled in a private health plan through the Medicare Advantage program, and virtually all beneficiaries have access to a private plan.[1] The remaining 70 percent or so of Medicare beneficiaries are in traditional fee-for-service (FFS) Medicare, which allows them to receive care from virtually any licensed health care provider and to receive any covered service that they and their provider consider appropriate.

The Medicare Payment Advisory Commission (MedPAC) has long recommended that Medicare's payment system be neutral, favoring neither MA plans nor the traditional FFS system.[2] But in recent years, the system has been substantially tilted in favor of private plans — the result of a large increase in MA payments in the 2003 Medicare prescription drug law. In 2009 Medicare paid MA plans 14 percent more per enrollee than what it would have cost traditional Medicare to cover comparable enrollees. The Affordable Care Act (ACA) is gradually reducing MA payment rates to

[1] Secretary Kathleen Sibelius, Letter to the Honorable John Boehner, February 21, 2014; Scott Harrison, Kim Neuman, and Carlos Zarabozo, "Medicare Advantage program: Status update, and employer bid and hospice policies," Medicare Payment Advisory Commission, January 16, 2014.

[2] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 287, http://www.medpac.gov/chapters/Mar13_Ch13.pdf.

bring them more in line with payments in traditional Medicare, although some overpayments will continue in certain geographic areas. In 2014, MA payments average 6 percent higher than FFS levels.[3] These overpayments drive up premiums for beneficiaries and weaken Medicare's finances.

Most elderly people are covered by the Hospital Insurance portion of Medicare (Part A) because they or their spouse have paid Medicare payroll taxes into the Medicare Hospital Insurance trust fund for at least ten years. Enrollment in Supplementary Medical Insurance (Part B, which pays for physician and other services) and outpatient prescription drug coverage (Part D) each requires payment of a monthly premium that covers about 25 percent of the cost of the insurance. General revenues cover the other three-quarters of the cost.

The Part B premium is a uniform national amount (in 2014, $104.90 a month) that does not vary with a beneficiary's age or place of residence. Low-income beneficiaries are eligible for extra assistance to help pay their premiums and cost-sharing, and high-income people pay additional income-tested premiums. Under Part D, Medicare delivers prescription drug coverage exclusively through private insurance plans that contract with the program: either stand-alone drug plans or Medicare Advantage plans that package drug coverage with the rest of Medicare coverage. Almost 90 percent of Medicare beneficiaries also have some type of supplemental insurance that fills in part of Medicare's cost-sharing requirements and protects beneficiaries against catastrophic health care costs, which Medicare (unlike most employer-sponsored health plans) does not fully cover.

Beneficiaries enrolled in an MA plan must pay the Part B premium (less any rebate that the private plan provides), and they often pay an additional premium specific to the MA plan for prescription drug coverage and supplemental benefits. Medicare payments to MA plans are generally tied to local per capita expenditures in traditional fee-for-service Medicare and to the plans' "bids" (their estimated cost of providing Part A and B benefits to an average enrollee). Medicare also adjusts its payments to MA plans to reflect the health status of each plan's enrollees.[4]

Federal law requires Medicare Advantage plans to offer the same basic benefits as traditional Medicare and prohibits them from charging higher cost sharing. To the extent that MA plans have been overpaid or can deliver care more efficiently, they can offer benefits beyond those that traditional Medicare provides. The most common enhancements are reductions in cost sharing and additional services such as dental and eye care and wellness benefits. Since 2011, all MA plans must limit in-network out-of-pocket costs (excluding premiums) to $6,700 a year; traditional Medicare has no limit on out-of-pocket costs.

Preliminary 2015 Payment Policies for Medicare Advantage

The Centers for Medicare & Medicaid Services (CMS) recently announced preliminary 2015 payment policies for Medicare Advantage plans.[5] Although the health insurance industry's trade association, America's Health Insurance Plans (AHIP), says that the CMS announcement includes

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[3] Harrison and others, "Medicare Advantage program."

[4] For an explanation of how MA plans are paid, see MedPAC, *Medicare Advantage Program Payment System: Payment Basics,*October 2013, http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.

[5] Centers for Medicare & Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter," February 21, 2014, http://cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf.

"new proposed cuts," the agency is simply applying current law.[6] The announced payment policies reflect four factors that will hold down MA payments in 2015.[7]

- **Curbing excessive payments.** CMS continues to phase in the payment reductions that health reform requires, which curb some (but not all) of the excessive payments to MA plans. Depending on the county in which an MA plan operates, some of these reductions have already been fully implemented, some will be fully implemented in 2015, and some won't be in full effect until 2017.
- **Slowdown in cost growth.** Under the Affordable Care Act, payments to MA plans are tied in part to the cost per beneficiary in traditional fee-for-service Medicare. With Medicare per-beneficiary spending continuing to grow at historically low rates, CMS has again revised downward its cost assumptions, which lowers MA payment rates.
- **More accurate risk adjustment.** As health reform requires, CMS will modestly reduce MA payments to address the problem of "upcoding," under which the diagnosis codes that plans assign to their enrollees to report their health status make the enrollees appear to be sicker than they actually are — which, in turn, causes Medicare to overpay the plans. Also, CMS will no longer include diagnoses identified during a home assessment visit (rather than in a clinical encounter) in determining an enrollee's health status, since they also tend to make enrollees appear sicker than comparable enrollees in traditional Medicare.
- **Ending a demonstration project.** CMS awards quality and performance ratings to MA plans — with ratings from one star (worst) to five stars (best) — based on enrollee satisfaction, access to care, and other measures. A demonstration project that runs from 2012 through 2014 allows plans with a three-star quality rating to receive bonus payments otherwise available only to four- or five-star plans and allows five-star plans to receive enhanced bonuses. CMS is ending the demonstration project on schedule, which effectively lowers payments to three- and five-star plans in 2015, relative to 2014.

Assessing Medicare Advantage Payments

AHIP and other interest groups charge that the preliminary 2015 payment rates will substantially increase costs to MA participants and will reduce the choice of plans. They ask that MA payment rates be frozen in 2015 at their 2014 level. The Administration and Congress should reject these demands.

The predictions of doom and gloom are greatly exaggerated. AHIP issued the same warnings about the MA payment cuts made in 2014, but MA enrollment has nonetheless reached record levels. The Congressional Budget Office projects that MA plans will continue to thrive, despite further payment cuts.[8] Nationwide, the number of plans available dropped by only 3 percent in

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[6] America's Health Insurance Plans, "Statement on New Proposed Cuts to Medicare Advantage," February 21, 2014, http://www.ahipcoverage.com/2014/02/21/ahip-statement-on-new-proposed-cuts-to-medicare-advantage/.

[7] Edwin Park, "As Expected, No New Medicare Advantage Cuts," *Off the Charts* blog, February 24, 2014, http://www.offthechartsblog.org/as-expected-no-new-medicare-advantage-cuts/.

[8] Edwin Park, "Health Reform Won't Cripple Medicare Advantage, Latest CBO Estimates Show," *Off the Charts* blog, May 23, 2013, http://www.offthechartsblog.org/health-reform-wont-cripple-medicare-advantage-latest-cbo-estimates-show/.

2014, a small change that reflects the offsetting effects of newly entering and departing plans. Plans also responded to the payment reductions by becoming more efficient. The unweighted average monthly premium for MA plans with prescription drug coverage fell from 2013 to 2014 and is lower today than in 2011 or 2012.[9]

Wall Street certainly isn't pessimistic about Medicare Advantage. In the wake of the CMS announcement, shares of Humana, the second largest insurer in the MA market, recorded their biggest single-day gain in four years and reached their highest value in more than 33 years. Standard & Poor's composite Managed Health Care Index also climbed.[10]

Moreover, preventing overpayments to Medicare Advantage plans is sound policy. Along with the other cost-saving provisions in the Affordable Care Act, eliminating overpayments reduces premiums for all beneficiaries, including the large majority who are not enrolled in MA plans, and extends the solvency of Medicare's Hospital Insurance trust fund. If Medicare's benefits are to be improved, equity requires that they be improved for all beneficiaries — not just the minority who are enrolled in MA plans. That's the approach taken in the ACA, which has added coverage of preventive health services without cost sharing and is gradually closing Medicare's prescription drug "donut hole."

Because both Medicare Advantage plans and traditional Medicare have their own unique strengths, they should compete on a level playing field. Traditional Medicare, in particular, has been the leader in instituting reforms in the health care payment system to improve efficiency and constrain costs. Because of its large buying power, traditional Medicare can implement payment and delivery system reforms that private insurance companies cannot. To assure that traditional Medicare can continue to play this crucial role, Medicare's payment and other policies should not be tilted in favor of Medicare Advantage plans.

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[9] Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, *Medicare Advantage 2014 Spotlight: Plan Availability and Premiums*, Kaiser Family Foundation, December 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8520-medicare-advantage-2014-spotlight2.pdf.

[10] Caroline Chen, "Humana Leads Insurer Gains on Proposed Medicare Payments," *Bloomberg*, February 24, 2014, http://www.bloomberg.com/news/2014-02-24/humana-leads-insurer-gains-on-proposed-medicare-payments.html.