

The Medicare Advantage Program and MedPAC Recommendations

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

MedPAC is charged by the Congress with making recommendations on payment policy both for providers in Medicare's traditional fee-for-service program and for Medicare Advantage organizations. The Commission's goal is for Medicare payments to cover the costs that efficient providers and organizations incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and that beneficiaries have access to the care they need. MedPAC focuses on ensuring that Medicare program dollars are spent wisely—ensuring that beneficiaries are getting efficient, high-quality care, and that beneficiaries and taxpayers are getting maximum value for each dollar spent in the program. We are striving 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.

Medicare's private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Efficient plans could be able to provide extra benefits to enrollees choosing to enroll in such plans, and better efficiency 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 benchmarks which are often legislatively set. Setting benchmarks well above the cost of traditional

Medicare signals that the program welcomes plans that are more costly than traditional Medicare. 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 that are in excess of Medicare FFS payment levels. All taxpayers, and all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—are funding the payments in excess of Medicare FFS levels.

MedPAC's recommendations on private plans in Medicare

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. 12.

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 based on where plans tend to operate, the payments vary among plan types, ranging from 110 percent of

FFS for HMOs, for example, 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	August 2006	February 2007	Dec. 2005 to Aug. 2006	Aug. 2006 to Feb. 2007
Local HMOs and PPOs	5,157,627	5,921,837	6,064,666	15%	2%
PFFS	208,990	802,068	1,327,826	284%	66%
Regional PPOs	None available	89,492	120,770	N/A	35%

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable).

Because of the impact on beneficiaries enrolled in plans with extra benefits, 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; (b) differentially reduce MA rates, with counties in which payments are highest in relation to Medicare FFS facing a larger reduction to more rapidly arrive at FFS rates in each county; or (c)

reduce rates in all counties at the same percentage each year until arriving at FFS rates in each county. Other transition strategies are also possible.

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 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 Medicare Part A and Part B 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. If a plan is able to provide the Medicare Part A and Part B 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. Table 3 shows the relationship between benchmarks and 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).

The ratio of benchmarks to FFS expenditures differs by plan type because of the counties that plans choose to serve and where they attract enrollees (Table 3). 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 reflect a minimum payment level established by statute, 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 in which 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. 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, thus producing higher overall MA payments.

Varying efficiency among different types of plans

Table 2, p.5, 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 the Medicare program, 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.

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.

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 within the private plan sector. 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. 12). Similarly, the Commission is exploring whether there are unwarranted 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 unless special circumstances dictate otherwise. 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 ^a			✓	✓	✓
Must report quality measures			✓	✓	✓
Protected from some risk through risk corridors				✓	
Must return to the Trust Funds 25 percent of the difference between bid and benchmark ^b	✓		✓	✓	✓
Must offer Part D coverage ^c			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures				✓	
Can limit enrollment to targeted beneficiaries ^d					✓

Note: PFFS (private fee for service), MSA (medical savings account), PPO (preferred provider organization), SNP (special needs plan).

^aPFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare FFS rates.

^bThis provision applies when bids are under the benchmark. For regional PPO plans, one-half of the 25 percent amount is retained, and the remainder is included in the stabilization fund that, as of 2012, may be used to retain or attract such plans.

^cMSA plans are prohibited from offering Part D coverage. PFFS plans may offer Part D coverage, but special rules apply to such plans (e.g., it is not required that receive drugs at a discounted rate when the deductible applies or the person is in the Part D coverage gap).

^dMA plans must allow all Medicare beneficiaries in their service area to enroll with few exceptions, e.g. beneficiaries with end stage renal disease. Other exceptions apply to MSA plans (e.g., Medicaid beneficiaries may not enroll in an MSA). SNPs are permitted to limit their enrollment to their targeted beneficiary population, i.e. dual eligibles, beneficiaries who reside in an institution, or those with a chronic or disabling condition. SNPs can be local or regional coordinated care plans. They cannot be MSAs or PFFS plans.

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, there are some equity and efficiency issues that 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, our preliminary estimate is that on average every Medicare beneficiary is paying in the range of \$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; and only some of that money is being used to provide extra benefits to beneficiaries who choose to enroll in these plans.

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 costly and more efficient 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 with taxpayer dollars in an inefficient manner. 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. 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 among plans and across the sectors, and by promoting fair competition among plans and across sectors to induce greater efficiency. 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—especially overpaying indiscriminately without requirements—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 set at 100 percent of FFS 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.