**Testimony of**
**Kerry Weems**
**Acting Administrator**
**Centers for Medicare & Medicaid Services**
**Before the**
**House Ways & Means Subcommittee on Health**
**On**
**The Structure and Costs of the Medicare Advantage Program**
**February 28, 2008**

Good morning Chairman Stark, Ranking Member Camp and distinguished members of the Subcommittee. I am pleased to be here today to discuss the Medicare Advantage (MA) program.

MA is providing an affordable, high-value choice for all Medicare beneficiaries. Currently, MA enrollment is at an all-time high, with roughly one-in-five (9 million) Medicare beneficiaries enrolled in a MA plan. MA plans are available in every State across the country and, in large part due to improvements enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), MA plans are now serving a significant number of beneficiaries in rural areas. In 2008, MA plans are offering an average of over $1100 in additional annual value to enrollees in terms of cost savings and added benefits beyond original fee-for-service (FFS) Medicare.

## Medicare Advantage Payment Overview

Under the revised payment methodology included in the MMA, plans submit bids for their projected costs to deliver Part A and Part B services in the coming year. The bids are compared to county-specific benchmarks, and adjusted to reflect the health risk characteristics of their enrollees, to determine the total payment to plans.

Benchmarks are the maximum amount Medicare will pay a particular type of plan for delivering Part A and B benefits in a specific geographic area. They are determined by the Secretary each year under a methodology provided in the Medicare law. For most plans, benchmarks are based on the county capitation rates that were used for payment purposes before the bidding system for MA plans began in 2006. Plan benchmarks are averages of county rates weighted based on projected plan enrollment in each county in a plan's service area.

The vast majority of plan bids are below their respective benchmarks. If a plan bid is above the benchmark, an enrollee must pay the difference in the form of a premium, referred to as the "basic beneficiary premium." If a plan bid is less than its benchmark, 75 percent of the difference, termed the "rebate," must be provided to enrollees as extra benefits (in the form of cost-sharing reductions, premium reductions for Part B or Part D, or additional covered services). For local plans, the remaining 25 percent of the difference is retained by the Federal Treasury. For regional preferred provider organization (PPOs), 12.5 percent of the difference is retained by the federal treasury and the remaining 12.5 percent is directed to the MA Regional Plan Stabilization Fund.

In March 2007 MedPAC reported that payments to MA plans in 2006 were on average 12 percent higher than estimated federal costs if the MA enrollees were still in FFS Medicare.[1] As CMS testified in 2007, there are a number of important factors to keep in mind when considering the payment differential presented by such analyses. These differentials exist because of an interest by policymakers to ensure that payments were high enough in low per-capita-cost areas to provide beneficiaries in those areas with private plan options. Representatives of regions with low per-capita costs argued that otherwise the beneficiaries in their areas were being disadvantaged just because their areas were low cost. The policies in place now have achieved the goal of broad access to private plans, and have also resulted in lessening the variation between the high and low-cost regions. The ratio between the highest and lowest county payment rate was 3.47 in 1997 and is now 2.29 (for 2008).

Focusing on aggregate MA payment differentials over-simplifies the issue by not acknowledging regional variations in FFS costs. We know that there is wide geographic variation in average FFS costs. While average MA payments nationwide may exceed average nationwide FFS costs by 12 or 13 percent, the actual differential varies considerably across the country. Differentials tend to be highest in areas where average FFS costs and MA payments are the lowest – often rural areas. Differentials are lowest, or close to zero, in areas where average FFS costs and MA

[1] MedPAC will issue an update on March 1, 2008. Based on the December 2007 MedPAC meeting, the new projected differential is expected to be 13 percent for 2008.

payments are the highest. For example, in 2007, average MA plan payments in La Crosse, WI, exceeded average FFS costs in the area by 41 percent. In the higher-cost Dade, FL area, however, the average MA plan payments was actually 2 percent less than average FFS costs. Looking at the differences in payment between La Cross and Dade counties alone (41 percent and -2 percent, respectively), might lead someone to conclude that plans in Dade are far more efficient than plans in La Crosse. In La Crosse, the average risk-adjusted FFS cost is just $412. In Dade it is more than double, at $1062. It is incorrect to suggest that plans in La Crosse are less efficient based on a comparison of their payment rates to dramatically lower risk-adjusted FFS costs.

**The Value of Medicare Advantage**

Competition in the MA program has created significant value for beneficiaries. For example, MA enrollees typically benefit from reduced cost-sharing relative to FFS Medicare; all regional PPO enrollees have the protection of a required catastrophic spending cap and a combined Part A and B deductible. In addition:

- 67 percent of plans have coverage for eye glasses;
- 83 percent have coverage for routine eye exams;
- 86 percent cover additional inpatient acute care stay days; and
- 90 percent waive the 3-day hospital stay requirement for Skilled Nursing Facility care.

In 2008, enrollees in MA plans are receiving, on average, additional benefits, including lower cost-sharing, with a value of $96 per month. MA plans restructure and reduce average cost-sharing relative to FFS Medicare. Many MA plan enrollees also receive basic Part D prescription drug coverage at a lower cost than stand-alone Part D plans (PDPs) can provide. Enrollees in MA plans that include Part D coverage (MA-PDs) save money on drug coverage in two ways. First, MA plan drug premiums for basic coverage in 2008 were, on average, about six dollars less than average PDP premiums for basic coverage. Second, the MA payment structure allows MA-PDs to use rebates to further reduce Part D premiums. On average, Part D premium savings from rebates was more than $16 per month in 2008.

Additionally, unlike with FFS Medicare, MA enrollees do not face the physician and ancillary services cost-sharing associated with a hospital stay separately. These costs are bundled with the hospital out-of-pocket cost-sharing. What is more, many plans have additional coverage in the form of maximum out-of-pocket limits for inpatient stays.

We do acknowledge the Subcommittee's previously expressed interest in data regarding the utilization of additional benefits by plan enrollees. We do not currently collect comprehensive utilization data on all MA benefits. However, MA enrollees do report on their perception of the experience in MA plans through the Consumer Assessment of Health Plan Survey (CAHPS). Scores from CAHPS are consistently high. Eighty-six percent of respondents give their plan a rating of 7 or higher (on a scale of 10). Ninety percent of respondents indicated that they usually or always received needed care. Eighty-eight percent of respondents indicated that they usually or always received care quickly.

**Oversight of MA Plans**

With respect to CMS oversight of MA plans, I want to indicate my unequivocal commitment to protecting people with Medicare from potential marketing abuses and to ensuring that beneficiaries have the information they need to make informed choices about their health care. Since September 2007, when I began my tenure as Acting Administrator, I have made it a top priority for CMS to be more proactive and transparent than ever before in overseeing the MA program, and we have made significant strides in strengthening program oversight.

Greater transparency allows beneficiaries, you in the Congress, and all interested parties to have a clearer awareness of our ongoing oversight activities, the nature of any plan violations, and the actions we take to remedy them. In November 2007, for example, we implemented a star-rating system for MA plans that expanded on the existing rating system for prescription drug plans. This Web-based tool provided the public with a powerful new way to comparison shop MA plans during the 2007 open enrollment period. In the past month, we refined our approach to posting Corrective Action Plans (CAPs) on the CMS Web site, making the information on CAPs more accessible and understandable for beneficiaries and others.[2] CMS has posted summary

[2] http://www.cms.hhs.gov/MCRAdvPartDEnrolData/CAP/.

enforcement action information to the Web as well, such as information on intermediate sanctions and civil monetary penalties (CMPs) levied against plans.[3] We believe that all of these efforts toward increased transparency are shaping MA plan behavior in the ways that we had hoped. For example, in a recent meeting with a sanctioned MA plan, the plan's senior officials cited the public posting of CMPs as a significant concern due to its impact on how existing and potential enrollees, view the plan. In other words, plans are taking CMS oversight very seriously.

We have strengthened our oversight and enforcement tools through a variety of measures aimed at holding MA plans – and, because of the relative "newness" and rapid growth of this option, private-fee-for-service (PFFS) plans in particular – responsible for their marketing practices and the conduct of their agents and brokers. In December 2007 we published a Final Rule clarifying and modifying compliance requirements for MA and prescription drug plans.[4] For example, under the new Final Rule, we are streamlining the process of imposing intermediate sanctions and CMPs, by eliminating the informal reconsideration process that had significantly delayed CMS action and our ability to make compliance actions public in the past, among other actions. We also have made clear in the Final Rule that appealing plans bear the burden of proof when challenging an adverse contract determination.

Furthermore, CMS continues to seek ways to address concerns related to marketing of MA plans , including PFFS and SNPs, that limit the ability of plans to pressure beneficiaries into certain products (in addition to the special enrollment period for beneficiaries who have been pressured or deceived into enrolling in a plan). We also hope to improve information sharing between MA organizations and State Medicaid agencies and have stepped up our routine communication with our Office of Inspector General and the Department of Justice to ensure coordination on matters that ultimately may require law enforcement oversight or investigation.

[3] http://www.cms.hhs.gov/MCRAdvPArtDEnrolData/Downloads/Enforcement_Actions_Web.pdf.
[4] CMS-4124-FC, 72 Fed. Reg. 68700, Dec. 5, 2007.

I intend to continue using all of the enforcement tools at my disposal, along with continued transparency, to protect beneficiaries from harmful marketing practices and other program violations to the best of our ability for the remainder of my tenure as Acting Administrator.

Finally, we are aware of Government Accountability Office's ongoing work to examine additional benefits in the MA program, and would like to highlight some methodological concerns with their analysis. The draft report shared with CMS describes the type and value of additional benefits, including lower cost-sharing that beneficiaries receive when they choose a Medicare Advantage plan. It compares the level of additional value that health maintenance organizations (HMOs), PPOs, and PFFS, plans offer beneficiaries. Instead of highlighting the value of these additional benefits, and how they vary by plan type, the authors chose to highlight that some MA enrollees are exposed to higher inpatient hospitalization cost sharing. The methodology used to determine inpatient cost sharing was flawed in that it did not include Part B services, consider longer term hospitalizations, or address effective out-of-pocket maximums. This finding was then used to create a general impression that MA plans do not usually reduce all types of out-of-pocket costs for beneficiaries with their rebate dollars. Overall, CMS finds the information in the GAO report confirms that the MA program is working as Congress intended. It is providing broad access to a valuable alternative to FFS Medicare.

**Conclusion**

Mr. Chairman, thank you again for this opportunity to speak with you today. We look forward to working with Congress to further strengthen the MA program, which is offers important choices to all beneficiaries, including those in rural areas who historically have not had choices. The system offers, enhanced benefits and access to high quality care for approximately 20 percent of the Medicare population, and is a particularly important option for those who lack access to retiree coverage or other supplemental coverage through Medicaid or a private supplement policy. I would be happy to answer any of your questions.