Medicare Advantage in a Changing Health System
DaVita Healthcare Partners
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name is Ed Howard. I'm with the Alliance for Health Reform. On behalf of Senator Rockefeller, Senator Blunt, and our Board of Directors I want to welcome you to this program examining the basis, I'm sorry, the basics, as well as the basis of a program we know as Medicare Advantage, or MA as it's called. Now, by one name or another, there's been an option for Medicare beneficiaries to get their healthcare through private health plans, mainly HMO's, since the 1970s. But never have these plans been more prominent than they are today. You're going to probably hear numbers like this throughout the conversation: 3 in 10 beneficiaries are in Medicare Advantage plans. More than 15 million of the 50 plus million Medicare beneficiaries overall, and triple the number that there were just a decade ago. So it's a growth industry, and it's particularly apt that we focus today on MA because it's a program that beneficiaries can opt into and out of each year in an open season, and the open season is about to close. That is, it ends this Sunday, December 7th. So, choices remain to be made by beneficiaries and helped along by many of those who are advising them, and maybe we can, today, help some of them anyway make better choices. And that's what we're here for.

Medicare pays for care for beneficiaries in MA plans differently from the payments for those in traditional fee for service Medicare. A lot of what you're going to hear today describes the payment arrangements, which are pretty complicated sometimes. You're also going to hear about changes that are being made now to payment methods and amounts and other changes that are being proposed. They're substantial. Some of them are controversial and they deserve the effort that you are going to have to put out to understand them.

We're pleased to have, as a partner in today's program, Davita Healthcare Partners, which is the product of a merger between Healthcare Partners, which manages and operates medical groups and affiliated physician networks in half a dozen states, and Davita, a leading provider of kidney dialysis services in the U.S. We're going to hear from their board co-chairman in a few minutes.

If I can, I'd like to do a little housekeeping. You'll find a lot of information, including better biographical information about our speakers than I'll have time to give them. There are articles that will fill out a little bit of your knowledge beyond the announcement that sketches the topic of the briefing. There's a green card you can use for questions at the time when we get to Q&A. There's a blue evaluation sheet that I would implore you to fill out to help us improve these briefings and be responsive. If you're communicating with the world through Twitter you can use the hash tag Medicare Advantage. WiFi is available. I believe you can see the credentials on the screen and that's it. We can get to the program. I think we have a terrific lineup of panelists to give you some brief presentations and then we're saving the bulk of the time for interchange among those speakers and your questions.

So, we're going to start with Arielle Mir, who is the Assistant Director of MedPAC, the Medicare Payment Advisory Commission, which makes thoughtful recommendations to congress about the Medicare program including Medicare Advantage. Arielle has experience both on the Hill and in the Executive Branch and she's agreed to give us an overview of the MA program, including the basics of financing, the system for rating the quality of plans, risk adjustment, and some recent policy changes. Arielle, thanks for being with us.

ARIELLE MIR: So let's dive right into the nuts and bolts of how the Medicare Advantage payment system works. So, as you know, the Medicare Advantage program is an alternative to traditional Medicare, or fee for service Medicare, which allows beneficiaries to receive their Medicare benefits through a private plan. The plans are paid on monthly capitated amount to finance the care of their enrollees, and usually plans are able to offer extra benefits over and above what's offered in traditional Medicare, and plans sometimes charge a premium to their enrollees in addition to the standard per fee premium that most enrollees continue to pay when they're enrolled in Medicare Advantage.

So, in the next slide you see the types of plans that participate in Medicare Advantage. So, on the left you have Coordinated Care Plans, which is just another word for managed care plans. And you have HMOs and PPOs, and HMOs and PPOs are similar in that they both create networks of physicians and hospitals and other providers to provide care to their enrollees. The difference between the HMOs and PPOs is that typically HMOs have narrower networks and often enrollees in HMOs need a referral from a primary care doctor to see a specialist. In contrast, PPOs tend to have wider networks.

Then moving along the slide, the next bucket is Private Fee for Service Plans and, in contrast to the Coordinated Care Plans, Private Fee for Service Plans traditional haven't had networks of providers and haven't used the same sorts of tools that CCP's have to coordinate or manage care for their enrollees.

And then, all the way on the right, you have a list of a few of the restrict plan designations that exist in Medicare Advantage, so these are plans that could be HMOs, PPOs, or Private Fee for Service, and they're permitted to limit their enrollment to certain populations. So, for example, within special needs plans, there are plans that can limit their enrollment to the dual eligibles, those eligible for Medicare and Medicaid, or to beneficiaries that have certain chronic or disabling conditions.

You also have Employer Group Plans which are offered to the retirees of certain employers or unions, and those former employers or unions supplement the coverage for those enrollees.

So, since 2010, virtually all Medicare beneficiaries have at least one MA plan available in their county, and in 2014 the average was about 10 plan choices per county. But there's a

lot of variation there. In a county like Miami-Dade you have upwards of 40 plan choices available to beneficiaries, and the vast majority, almost 85% of beneficiaries have access to at least 1 plan with drug coverage at no additional premium over and above the Part B premium.

So, you can see on the next slide the trends in enrollment since 2006. Currently about 28% of beneficiaries are enrolled in private plans, and enrollment is now at an all time high of, at the end of this year, nearing 16 million. And you can see the blue bars, at the bottom of the chart, are the growth in HMO enrollments. You'll see that enrollment in HMOs continues to make up the larger share of enrollment with local PPOs growing in popularity. And then I'd also point out the gray bars at the top is Private Fee for Service plans, and so those plans grew considerably through the 2000's and then, subsequent to a law change in 2008 that limited their ability to operate, enrollment in those plans has gone down.

So, how are they paid? So, unlike in Fee for Service where Medicare has sort of a price list for various services, the MA plans are paid based on bids and benchmarks. So, the plan comes forward in June of each year and offers to CMS, to Medicare, the amount that it would cost them to provide the standard A and B benefit to their enrollees. And then, that bid is compared to a benchmark and the benchmark is a dollar amount set in advance by county that is loosely based on historical fee for service spending in that county. And so, if the bid is above the benchmark, Medicare pays only the benchmark and the enrollee pays the difference as a premium. In contrast, if the bid is below the benchmark, Medicare pays to the plan the bid plus a portion of the difference between the bid and the benchmark. And the portion of the difference that the plan gets is often referred to as the rebate dollars, and those rebate dollars are often used to offer extra benefits to enrollees, services that aren't covered through traditional Medicare, or reducing beneficiaries' cost sharing. And then, the remainder that doesn't come out in rebate dollars to the plans remains with the treasury.

So, the next slide, you can see what the benchmarks, bids, and payments look like for fee for service relative, like for 2014, relative to fee for service. So, looking at the top row of the table, across all MA plans, the average benchmark in the country is about 12% higher than average fee for service spending in the average county in the country. In contrast, in the next column you see what the average bid is and so you can see that, on average, plans are actually able to come in and say that they can offer care—provide the A and B benefit—for about 2% less than average fee for service spending. And, if you look down that column, you can see that varies considerably based on plan types with HMOs being able to offer the A and B benefit for considerably less than fee for service, and local PPOs and Private Fee for Service well above.

And then, the last column shows the payments relative to Fee for Service, and so, what we would say, you know, the way to interpret that, the top line is that on average

Medicare pays about 6% more for an enrollee in the Medicare Advantage than they would if a comparable enrollee were in Fee for Service.

So, the payments that the plans receive are further adjusted based on the risk profiles of the enrollees that join the plans, and so plans receive higher payments for sicker enrollees and slightly lower payments for healthy enrollees, and basically, the Medicare program uses a multiplier, an index, to determine how that risk adjustment affects the payment. The average risk score for the country is 1.0. That represents the risk of the average beneficiary and a risk score higher than 1 would be a beneficiary that is sicker or more aged and, in contrast, lower than 1 would be healthy or younger, etcetera. And the data that make up those risk scores include demographic data, conditions, and a few other factors.

For several years now, the Medicare program has used information about plan quality that they've aggregated up into a star rating system to give Medicare beneficiaries information about plans when they're making their decisions during the open enrollment period as Ed said. And you can see the elements, the domains of that system listed here on the slide.

The data that populates the star rating system, it comes from a number of different data sets so, for example, plans report data from the HEDIS set on things like whether the plan provided recommended screenings of blood sugar for diabetics. Data also comes from beneficiary surveys, enrollee surveys, like the CAP survey that asks enrollees if they got access to care when they needed it. And then the last two domains are populated a lot by data that CMS gathers, for example, on beneficiary complaints.

We'll talk more on the next slide, CMS now uses the star rating system subsequent to the Affordable Care Act to adjust payments to plans. So it's not just to give beneficiaries information but actually impacts the resources that they have available to them. So that happens in a few different ways. So, actually plans that perform better on the star rating system have their benchmarks increased and so they have more room to offer extra benefits. In addition, better performing plans get to keep a greater share of that difference between the bid and the benchmark as rebate dollars. You can see the breakdown on the slide. And then, the highest rated plans, the 5-star plans, also have the added benefit of being able to enroll beneficiaries throughout the year, so not just during that open enrollment period.

And the last slide shows you that from 2014 to 2015 an increasing share of beneficiaries are actually in higher rated plans and a smaller share of beneficiaries are in lower performing plans.

So, I'll stop there and then I'll turn it to Mark, who's going to tell you a little bit about some of the issues and questions that the Commission has raised about the Medicare Advantage program over the years.

MARK MILLER: Okay, so, I'd like to thank the organizers for giving us two slots, and, most importantly, to thank Arielle for going through all of the nuts and bolts because that will allow me to talk kind of conceptually about what the underlying tension has been in MA policy over the last several years and for people who are either on Hill staff or new to the issue, hopefully it'll give you some sense of the back and forth here.

So, actually, I should say before I get going, the Commission strongly supports the presence of a private plan option in Medicare. Some beneficiaries like this kind of delivery system, the certainty of their out of pocket, and we also think that managed care plans have the tools that traditional fee for service doesn't have, the ability to form networks, to negotiate rates in some instances, prior authorization, the constructure, cost sharing ways to kind of incent the beneficiaries or relieve them of cost sharing. And when you think about the proposition of managed care at least, you know, people who have been around as long as I have, you know, the proposition was look at fee for service. It's uncoordinated. It's volume driven. It's not focused on quality. You give us the average payment, we'll come in, save money relative to fee for service, use that money to offer extra benefits which really mostly means relieving cost sharing, and people will want to enroll in managed care. And that was kind of the notion of the underlying proposition of managed care. And it certainly, in some parts of the country, plans were able to do that and you might imagine, you know, Miami, McAllen, Texas where you have a lot of fee for service utilization, managed care plan could come in, do that , make a profit, and offer extra benefits. But that led to kind of an alternative way to view managed care plans which was, well, if managed care plans are a choice, should they be a choice for everybody and should extra benefits be available for everybody? Now, the issue there would be that you could do that but that might mean that managed care plans have to be subsidized in some parts of the country because they may not be more efficient than fee for service. And so that is kind of the underlying tension of is the managed care plan about reducing spending relative to fee for service and hopefully improving quality, or is it about availability to everyone and extra benefits for everyone? And let me kind of put this across to you.

Now, if you look at the data, the data will show this kind of a picture, but this picture is simplified to make the point here. So, the 45 degree line there is, think of every county, as Arielle said, there's a payment rate, or a benchmark for every county, but think of this 45 degree line as fee for service utilization in the country from lowest to highest. So, on the right-hand side of the 45 degree line you have Miami, McAllen, Texas where lots of utilization. Left-hand side of the line you have middle of the country, northwest, where utilization in the fee for service world tends to be lower. And then, again, stylized, think of the broken line as the managed care proposition. Managed care plans have overhead. They have 10%-15% overheads for enrollment, marketing, forming networks, managing care, etcetera. And if they can reduce utilization in the high utilization side of that chart, the right-hand side of the chart, they can undercut Medicare, deliver savings, deliver benefits. On the left-hand side it might be more difficult.

Now, some people could stop a policy thought at this point and say, well, that's what the proposition is, where managed care can undercut fee for service it should do so; and where it can't it doesn't. But, over time, there was this desire to have extra benefits, as you might imagine, and there were some accretion in policy over many years, and we're whipping through many years in this conversation, by the way. And really, where we ended up was here. And again, this is a stylized chart. The data would show this, too, but for simplicity reasons I've just burned it down to the concept. So, you still have your 45 degree fee for service line there, and then you have that yellow kinked line at the top. That's what the legislated benchmarks look like and so the benchmarks were set way above fee for service in the low utilization parts of the country because the managed care plans had a difficult time competing against fee for service. And then, through some other legislative changes, they ended up being above fee for service throughout the entire country. And then if you remember, Arielle said people bid against the benchmarks and then they kept the difference and that's the broken line. But what happened was they were bidding below the benchmark using the difference to offer extra benefits, but on average, they were bidding above fee for service. Or, going back to that original proposition, managed care plans, before 2010, were basically saying I can deliver the traditional Medicare benefit at more cost than fee for service. And at its most extreme it was like 15% and 16%. And a way to think about it, it was every time someone was enrolled in managed care it cost the trust fund money.

The other thing that was happening is, it was growing an incredibly inefficient set of plans, plans that didn't even purport to manage care. They were literally processing claims, paying Medicare rates, and basically taking a higher payment for it, and offering the beneficiary extra benefits, but these benefits were, of course, taxpayer subsidized rather than subsidized through plan efficiency.

As you can imagine, people like the Commission were a little bit concerned, both from a spending point of view, and are we growing an industry that was not focused on efficiency. So, we made recommendations saying that payments should be more closely reconciled to fee for service. There's a couple of ways to do that, but that's beyond this talk right at the moment, and said that we should get our payments to be more aligned with fee for service and then pay extra when a plan has better quality versus a plan that has poor quality.

And what the Congress did in 2010 was, they did do that, but they sort of did it in a particular way. Now, in this slide, the red line—broken line—is the fee for service line that I've been using throughout the conversation. What Congress said is, okay, on average the benchmarks will be close to fee for service, but they will be set below average in the high expenditure parts of the country—the right-hand side of your chart—and, as you can see, go to the extreme left, the benchmarks are still well above fee for service in the low expenditure parts of the country. And so, they're saying on average it'll be about fee for service but it will be set below fee for service in the Miami-McAllen and

actually it's almost 36% of the enrollment on the right-hand side of the chart. But it will still be above average in those parts of the country where fee for service utilization is low.

These benchmarks are being transitioned to. This is what it will look like in 2017. We're not quite there yet. We're about two-thirds of the way to the transition. And they also implemented the notion of higher payments if the quality is better and Arielle walked you through all of that.

Okay. So then, I'll wrap up here and so, there was lots of consternation and concern—excuse me. Told you there was consternation. [Laughter.] So I wanted to illustrate it for you. I apologize for that. There was lots of consternation when this policy was being put into effect. Lots of resistance from, you know, organized associations. There was great concern that plans would leave the program and enrollment would fall. That has not come to pass. And as I said, about two-thirds of the transition has occurred. Again, Arielle pointed out that we are at the highest enrollment levels. We're up to about 30% enrollment. There has been 9% annual growth since the passage of this legislation so enrollment has continued to grow. Plan availability continues at about 100%. It's like 99.6% or something like that, but virtually at 100%. And then, what's not on the slide, and I should have put on the slide, but Arielle made this point, so I want to track you back to that, the average bid now from managed care plans are below fee for service. And we think that that's because they're now responding to the fact that the benchmarks are more aggressive and that they need to figure out how to manage their costs and so now, actually on average, managed care plans do deliver the traditional benefit for less than fee for service. But, keep in mind, from Arielle's slide, that's highly variable. HMOs seem to be really able to do that. Other plans in certain parts of the country haven't been able to kind of hit that point.

I'm done now. The only think I'll say, by way of closing, is there is this inherent tension. What is the purpose of managed care? And I would just kind of re-raise that in your mind. I imagine that when questions come up on managed care inherently these will be the questions. And also point out to you that in our public meeting on the 18th and the 19th we will be updating the information that Arielle has presented and bringing some new information on plan profitability, coding for risk adjustment, and some discussion of quality and, in particular, the notion of SES and what role that's playing.

ED HOWARD: Terrific. Thank you, Mark. And I'm going to rely on the biographical information sheet because I didn't want to interrupt the flow between Arielle's and Mark's presentations but I will just say a word about Marsha Gold who is the Senior Fellow Emeritus at Mathematica Policy Research. She's also, fortunately for us, one of the country's leading Medicare experts, and Marsha is going to report to us on a summary that she's compiled of research on the quality of Medicare Advantage plans. And I should say you have the executive summary of that report in your packets. There are a limited

number of full report copies at the registration desk and otherwise there's a reference to it online and you can print out whatever you need from it.

Marsha, thanks for being with us.

MARSHA GOLD: Thank you. I want to note that this is work that Kaiser Family Foundation commissioned and Giselle Cassalenas [Phonetic] is over there and has worked on it with me as did a lot of other people there. So, why did we get into this project? So, basically, you've just heard. There's a lot of interest in Medicare Advantage and it's fine to talk about the numbers and the costs and all the rest. But this is a program about beneficiaries and Medicare is very important to beneficiaries. So there's a lot of interest in understanding, whether from beneficiary perspective, it makes a difference if you're in Medicare Advantage or if you're in traditional Medicare. And one of the ways it could make a difference is on your access to services and the quality of care you receive.

And so, a lot of these fiscal issues have brought to the fore, well, is one better? Isn't it better than all the rest? Unfortunately, it's very hard to study this issue, as you'll see, and the prior reviews of the studies, they were really well done, but they were over 10 years old and they didn't focus specifically on Medicare. So, and the market's changed a lot since then anyway. There's a lot more, as MedPAC staff said, and as my presentation has, there's a chart, too, there's a lot more non-HMOs in it, and the market's different even within that. So there's a real interest in understanding what it is that we do know about this. So that's what we started to do and what we looked at was, we said let's find the studies that are out there, and we may have missed one or two, but I think we got a lot of them. We were looking at research that was published from 2000 to 2014. We found 45 studies, including 40 that had direct comparisons between Medicare Advantage and traditional Medicare. We didn't restrict them in terms of quality but we did look at they had to have a written description of methods, they had to have some formal comparison group, and they had to have some outcomes relevant to access and quality. So that let us look around that. And we excluded, because we were looking at plans available for the general population. We didn't get into special needs plans, PACE, social HMOs, etcetera.

We found that, when we looked at the studies that were there, they used what we could put in about 5 different buckets. One were the HETIS effectiveness measures and those, the ones that we used in the studies, were mainly based on prevention. HETIS has some other kinds of measures but, for a variety of reasons that are too complicated to get into here, those are hard to construct from fee for service data and so the studies focus mainly on the HETIS preventive care measures, use the CAPS beneficiaries and other beneficiary surveys, use quality metrics around hospitalizations—does it prevent people from going in, what's the quality when you're there, readmission rates—looked at other utilization metrics and there's a real caveat there, I should mention, because we were looking at quality and access and it's hard to know whether more or less is better or worse. And so, these measures, I think, are a lot weaker in terms of what they can tell you

on quality and access, they're really measures of resource use which is important but a different question. And finally, we looked at healthcare outcomes and mortality in terms of—most of those studies were in the cancer area.

So what did we find? Well, first thing, and I know, as a researcher, people always hate it when you say we found there's a lot of limitations. But, in fact, one of the most important findings is that even though this is such an important question, there are a lot of limitations. None of the studies, with one minor exception that looked at Medicare Advantage versus fee for service, were, in 2010 and on, that is in the post-ACA era, and a lot of them were before 2006 when the Medicare, you know, Medicare Modernization Act and when a lot of other changes happened. Some of them were in the '90s. So, it takes a long time to get these studies out and that limits what we can know.

Second, they were mainly reflecting HMO experience, either directly or because they were for a time period that that wasn't there. So it doesn't talk about that whole new sector of the plans that's maybe a third of the market right now. There are surprisingly a number of Medicare national studies, 17 of the 40, but they're based on where you have data, so those are mainly ones based on CAPS and other surveys and some HETIS measures. And finally, there's limitations, because people join these plans on a voluntary basis there's always differences in the people in traditional Medicare and fee for services, in managed care advantage and there's differences across the plans and who's in them, and the ability to control for risks. I think I was impressed that the researchers tried to do this but some of them did that better than others and there were real data limitations that they faced.

So what did the evidence show that we did get? One, on the HETIS effectiveness measures, again, largely based on preventive care, Medicare Advantage, HMOs generally scored better. This was a period before traditional Medicare had improved coverage for preventive services and also that the plans varied across the HMOs with plan characteristics, so the older established HMOs tended to perform better than the newer ones and we're not sure how much this carries over into PPOs. There's some evidence on some measures that maybe PPOs do better than traditional Medicare but not as good as HMOs, but there's really not a lot known there.

On CAPS, Medicare beneficiaries generally rated Medicare Advantage lower on questions related to access and however, they preferred the traditional Medicare program, especially if they had chronic illness or were sick. But again, there's a lot of variability across plans and higher scores for the newer plans.

Potentially avoidable hospitalizations—those studies can't be done nationally because the data don't exist, but they seem to agree, the ones that are done in states. They are that, in those states, or in the health plans that were studied, beneficiaries were less likely to be hospitalized for conditions that could be potentially benefited, which is a good thing.

Readmission rates—there's been a lot of focus on the literature there but I think our conclusion was that the evidence really is inconclusive. The studies don't agree with one another and there's a lot of limitations in their ability to address important differences across the populations.

On other utilization metrics, Medicare HMOs, especially older established ones, generally used fewer resources, especially hospital resources in caring for Medicare beneficiaries. But again, as I mentioned, some of these studies, which use things like end of life care, hospital visits, and use of certain procedures, they could affect both. We don't know what's needed and what's not needed. But also, it could be a sorting effect because we don't know which beneficiaries want to go into a managed care advantage plan and it may be that those who want to go in want to use less resources, so we just don't know.

On health outcomes we really don't know very much from the existing literature. There was a number of studies done with some of the cancer registries, a number of them are quite old. They suggest that good coverage, whether it's either Medicare Advantage or it's a Medicare traditional plan with a Medicare supplement which pays for cost sharing, results in earlier detection of cancer but the data have a number of limitations.

So what can we conclude? I think the bottom line is that, you know, there's a lot of need for information but the studies are quite limited in what they can say. They do, you know, provide some general conclusions. I don't think those are terribly inconsistent with the conclusions that were in some of the earlier studies. The evidence suggests that, on average, Medicare HMOs perform better than traditional Medicare in providing preventive services and using resources more conservatively, at least through 2009. But Medicare beneficiaries continue to rate Medicare higher, especially if they sick, and we really don't have any findings on a number of measures that would be important. We also—and I think this is very important from a policy perspective—you can talk of averages but people enroll in specific plans. And, in fact, there's considerable variability even within the HMO sector across HMOs, across different locales and all the rest. So, if you're looking at what people get there's a lot of differences across them and, of course, we don't know much more about the newer plans.

In terms of the policy implications, you know, I think it's outrageous there's not better information around that costs money, but I shouldn't say that here. But, you know, improvements would include—one of the things that's hardest is, because these sectors are different there's differences in the available data and metrics about them to support research and some of that's hard to mix. But until you can get some comparable data across the sectors it's hard to study, especially nationally. We need to get more timely data and we need to get more timely information out there. MedPAC does a good job of providing the most timely information but they don't have the ability to do some of the in depth studies that some of this requires. And we need, I think, results. Again, because the

program is serving people, we need results that better differentiate by beneficiary group, by subgroup, and characteristics, and by geography.

So, with that, I'll end. Thanks.

ED HOWARD: Terrific. Thank you, Marsha. Would you pass the clicker to Dr. Margolis. We are going to hear now from Dr. Robert Margolis. Who is CEO Emeritus of Healthcare Partners and Co-Chairman of the Davita Healthcare Partners board now. He's going to provide us with a perspective on Medicare Advantage, a provider group that has implemented delivery system reforms geared toward providing better coordinated care, integrated care, for many years and we're very pleased to have you with us.

ROBERT MARGOLIS: Thank you, Ed, and thank you all for your interest in this very important federal program. It's actually in an era when, as you've heard from the other panelists, we're working on how to improve care for seniors both in quality and cost. It's truly one of the only federal programs that supports moving from volume to value, which in most of our experiences, including mine, is absolutely the critical movement in healthcare that will improve care for all Americans.

I will try to illustrate in this next few minutes how the program actually works within an organized delivery system and why coordination of care is absolutely the critical element of team-based care to support the complicated and multi needs of a senior population and, as you'll see also, it's a population that, in its demographics, supports primarily low income and minority seniors in a greater proportion than Medicare itself.

I personally have had the privilege of working as a physician with seniors for many decades and Healthcare Partners has been in the program since its inception on January 1st 1985. So, how does the program work from a delivery system perspective and what are some of the advantages of the program vis-à-vis Medicare Fee for Service which many of us practiced in for years. I appreciate the important academic review and skepticism from Marsha, but I think this slide illustrates exactly her point.

While there is growing evidence on Medicare Advantage because of the star program, because of the 40 some elements of quality measurement, because of the CAPS surveys and so on, there's really very little on the Medicare Fee for Service side to compare that to and so one of the important, I think, aspects of improving this program over time is to actually try to implement those kinds of same standardized measurements on the Fee for Service side so that we can actually do the kind of comparisons that Mathematica and others need to do to assist policy makers in making good decisions on how to improve what some of us believe is a really important and great plan for seniors.

You saw how Medicare Advantage is growing. It's growing very rapidly, especially in areas where there are good benefits and now, as Mark pointed out, those benefits are in most of the big metropolitan areas at or below the fee for service benchmark. As you'll

see here, there's double the number of Hispanic beneficiaries than there is in Fee for Service, and almost half of Medicare Advantage members are in the income brackets that you see there, which is lower as well than the average for Medicare.

The big changes over the last couple of years has been the implementation of the star system which you saw some of the basics earlier, and as I said, the actual distinct measurement of quality in this program is really very important to driving quality and value as well as the economic efficiencies that Mark and Arielle pointed out, that MedPAC has shown are actually improving as Congress has changed the benchmarking.

What happens? It leads to better health outcomes. I've chosen here to show national studies as opposed to Healthcare Partners, but I can tell you, as you'll see in a few moments, that within an organized coordinated system you can predictably reduce readmission rates and improve patient satisfaction some 30% in a coordinated care program and, in a few moments, I'll try to show you how some of that is achieved.

So, what is the difference and, again, I'll use the experience that we've had at Healthcare Partners. A brief overview: we operate in these half a dozen or so states. We've been in the program since its inception, as I said. We have over 300,000 Medicare Advantage patients that we care for, and we care for them under a global risk arrangement in coordination with essentially all the health plans in those states. It's a model of both employed physicians and affiliated physicians, as you can see there, and we work with hundreds of hospitals as well in partnership across those states. So, it's a complex system but there are elements of it that I think are very transferrable and translatable across delivery systems in the United States and we're seeing more and more of that as delivery systems throughout the country recognize that these kinds of programs, as well as the Medicare ACOs, as well as commercial ACOs and other things that aren't on the agenda today, start to drive the delivery system into coordination for patients' measurement of improved quality and improved outcomes and improved access and satisfaction, all of which are trending towards, if they're not already there, better than the Medicare Fee for Service alternative.

How is this done? It's really a question of creating, under these risk arrangements, the savings that are generated by lower admissions and lower readmissions that are quality driven and outcome driven into reinvestment back into patient-centered care. And that patient-centered care requires a great emphasis, because now an organization like ours or any of these others that are described, are actually responsible for the care of a defined population of seniors. And those seniors, now, are going to be an expense to the delivery system if you don't keep them well. If you don't improve their care. If you don't improve their management of chronic disease and the like. So this patient centeredness is absolutely critical to the delivery of the program and you do that through focusing on health and wellness and prevention. Marsha showed that preventive care usually is somewhat better in Medicare Advantage plans within an organized system. It's an absolutely critical piece for the 80% or so of those patients that you might call worried

well, that have some disease, some chronic illnesses, some problems, but they're not acutely in jeopardy.

But, as you develop these programs, you start to segment this population and you start to realize there are certain patients who have certain diseases, you know, chronic heart failure or diabetes, chronic pulmonary disease and the like, that need specialized programs and there are folks that are towards the end of life and advanced illness that need very intensive programs and so you start to develop the kind of infrastructure that's denoted here on this slide of The Right Care at the Right Place for the Right Patient. You certainly concentrate on those folks that end up in the hospital with very intense teams of hospitalists and care managers and this is all driven by an important investment in information technology, not just electronic health records but data information warehouses that allow you then to do both analysis of your current population and ultimately predictively model through the use of services who may be at jeopardy and you need to apply greater resources into the future to prevent more acute disease.

So, that kind of collaboration is really what the care team is. It's all about investment in care management and social workers and coordinators and outreach, which as you may know, is very different than a fee for service world where the docs are doing everything they can through the patient that presents him or herself, but not necessarily reaching out in between visits to make sure the patients are compliant with their medications, that they're on the right clinical delivery process, and that they actually have their home situation, which is often the reason that they're having medical problems, assessed in social work with better mental health intervention where necessary and all the elements of coordinated care. That accountability for that population really drives the kind of incentives that you see, and ultimately and finally what you've done now is you've taken a distinct population of patients, in our case over 300,000, and you've managed, through your technology platform, to divide into subsegments of need those patients at the bottom of this triangle that need this kind of health education, of patient connectedness, of social groups, of group therapy, meaning group collegiality, to learn from each other. You then get into complex care management where you start to have disease management programs that actually reach out and manage specific illnesses and diseases, and you ultimately start to see, now that that 5% of patients that, believe it or not, eat up 52% of the entire healthcare dollar, are really in an intense set of focus for a delivery system on creating these care teams of need, usually geriatric driven with social work, with rehab, with mental health support, and the like. And then there are those folks in that last 1% that have advanced illness that are maybe home bound, where you have home programs and ultimately you have great palliative care and great compassionate end-of-life care for the fact that you do have an important segment of your patients.

Just one last factoid before I finish. I believe 42% of people on Medicare die within the hospital setting. Less than 5% of patients and families, when asked how they would like to be dealt with in acute end-of-life care, wish that we have the ability, through

compassionate, organized, systematic, and supportive home and affiliated end-of-life care to actually make great impacts in that important aspect of dealing with Medicare patients.

With that, I'll end and say pleased to be here and happy to answer any questions. Thank you.

ED HOWARD: That's terrific. Thanks very much, Bob. We have microphones where you can ask questions. We have green cards that you can write your question on and hold up so that we can get it up here at the front.

Let me just start, Dr. Margolis, you mentioned in one of your first slides, the higher proportion of low income and minority beneficiaries that are enrolled in Medicare Advantage plans, and I wonder if there is an accepted reason for that or do you have some informed speculation—why is that the case?

BOB MARGOLIS: I believe it's because folks that don't have medical supplemental plans through their employer and are not eligible for dual Medicare-Medicaid are in that place where they'd have to pay significant out of pocket Medicare deductibles and these plans have greater benefits and lower out of pocket expenses. So that would be my expectation. That's a personal view. I don't have an academic study to suggest that's true.

ED HOWARD: Do any of our academics want to supplement that? Is there a rural/urban factor at work here, too?

MARSHA GOLD: I mean, I think that generally that what you're describing is right. It's a price sensitivity issue. It's, you know, the issue is that there's some out of pocket costs in Medicare and Medigap looks expensive because you're paying a high premium per time and the Medicare Advantage plans are less expensive so sometimes people will—a lot of times people may join them instead. I'm not sure people quite understand healthcare costs and out of pocket costs at the time of service versus premiums when they're making those tradeoffs but that's the issue and there are limitations in the Medicare benefit package. One of the policy issues, I think, is one can always fix Medicare as well.

MARK MILLER: You know, just to sweep across a few comments. I think there is probably an out of pocket issue that explains some of the income. As Arielle was pointing out to me, the higher Hispanic representation also is probably something of a function of what markets managed care plans happen to be concentrated in at the moment, which is just an outcome that has occurred. I'll also just say a few other things. On your last point, on the hospice and palliative care, the Commission made a recommendation to include the hospice benefit in the managed care package. Right now it's not included in the managed care set of benefits that are required to be provided and paid as such and a lot of the beneficiaries, and actually managed care plans, use hospice more than fee for service and the beneficiary kind of rolls back out into fee for service, as it were. And we've recommended that we build that back into the managed care plan so they have a clear line

of sight in providing that complete continuum of care. And I don't want to speak for anybody at the table, but when we talk to the industry, the industry's view was, yeah, this made a lot of sense. And so, that was one change we made.

I also want to comment on the quality stuff. In our last June report we talked about this notion of the need to move to being able to measure fee for service, managed care, and ACOs, because you now have this other delivery system out there as well, on a comparable basis in a marketplace for the beneficiary to both—both the program and the beneficiary to see the differences. There are huge sets of problems. A lot of it has to do with data. One of the things we need is encounter data from the managed care plans so we can see things like readmission rates and so forth and be able to measure them relatively more directly than we do out of the current payment systems. But those are just a couple of comments on some things that were said.

ED HOWARD: Very good. Thanks very much. Yes. And I'd ask the folks that line up to ask questions orally to identify themselves and keep their questions as brief as they can.

AUDIENCE MEMBER: Stuart Gordon with the National Association of State Mental Health Program Directors. So, we're not measuring plans by outcomes and that's a very good thing to the extent that plans that don't do well in the star measures I consecutive years risk being excluded from the program. I know that a number of the plans and the associations representing those plans that do the special needs plans that care for the individuals with low income and other impediments to care, have been urging CMS for a number of years to take into account in the risk adjustment and in the scores of the star measures social determinance and socioeconomic status. And CMS has resisted that. Dr. Miller, I heard you say that you're taking up socioeconomic status this month and I was wondering what context you're taking it up in. Are you looking at whether or not that should be a factor in modifying risk adjustment and star measure scores?

MARK MILLER: So, there's a few things going on here. The first thing I would say about socioeconomic, you know, like a lot of issues, it's not, you know, the fix is not real straightforward. But the Commission spent a bunch of time thinking about socioeconomic status and doing it in the context of the readmissions penalty, which is in the fee for service world, and I'm just bringing this up because this is where the Commission did a lot of its work. And there were a couple of takeaways from that conversation that we had for the policy world.

The first thing is, there is a lot of rush to saying, oh, well, it's SES, so adjust it and, you know, move on from there. Now there's a whole bunch of information packed into that statement which is what does SES mean? Is it measurable—because when people get into this they start throwing things in, like people will say, well homelessness has a big effect on how our ability is to deliver care. But the ability, for example, to measure and adjust for homelessness is pretty distant. There are also big methodological arguments about how to adjust for SES and I think you could put yourself in for a lot of years of research

and letting people kind of crank through things before you got to a place of some resolution.

So, what the Commission said, at least with respect to readmissions, and I think some of this philosophically transfers to this conversation, is this. One, the Commission is uncomfortable with the notion of simply adjusting it away. So if you have some kind of variation on a quality metric and some of that is SES and if you adjust for it, the distribution gets compressed. And what that actually means from a consumer's point of view is this hospital or this plan or whatever, which has a poor score because it's got lots of, let's call it – let's just say, low income folks, suddenly doesn't look like its score is as poor. And we think the transparency should be maintained. People should be able to see that a plan or a hospital or whatever performs better or worse, as the case may be. However, when it's about quality payment or penalties, what you might do is relieve some of the impact of that in trying to recognize that the actor is dealing with a more difficult population. And so what we said is organize, and in this instance it was hospitals into lots of poor folks, not so many poor folks, set the same standard but keep in mind that that standard will be more aggressive for the hospitals with few poor people and less aggressive for the hospitals that have more poor people. And then you keep a pressure on that hospital to improve its performance but you relieve, let's say in this instance, the impact of the penalty. And I think some of that same thinking transports over to the kinds of conversations that we're talking about here. And I know this is long, but there are just a couple—well, he asked.

ED HOWARD: That's why we're here.

MARK MILLER: And you asked me. So, you know. [Laughter.] So, that is kind of our take on sort of how to think about the SES problem. It sort of splits the difference between no adjustment and just adjust it away and then you're not able to see it. So there's that point.

I also think, and would urge people who think about this, think about what is within reach. So we think, and at least in our research, a lot of the driver here is income. And you can go off and look for other types of measures, but your ability to bring them to bear on policy in the short run is going to be difficult. And so, if you want a solution soon focus on measures that probably are moving the needle a lot and are within reach to get. And I'll stop there.

ED HOWARD: Okay. Very good. Thank you.

AUDIENCE MEMBER: Thank you. My name is Stacy Sanders. I'm with the Medicare Rights Center. And earlier this year CMS released a number of audit findings. We know the agency is limited in its capacity to audit plans. It only audits about 10% each year. But it's consistently found, over the last several years, that an area where plans have been, or plan sponsors have been noncompliant and who really have sort of fallen short,

is in the area of coverage determinations, appeals, and grievances. So, for instance, you know, CMS found inappropriate communication to beneficiaries about the reason for denials, inappropriate use of utilization management tools, and I'm sort of, you know, this is interesting to my organization. We directly serve Medicare beneficiaries and while we know Medicare Advantage is a great option for some, the top consistent concern that we hear from beneficiaries has to do with denials of coverage and appeals. So, my question is whether MedPAC, or Marsha, for you and other independent researchers, whether you think these audit findings really warrant additional scrutiny, and whether there needs to be some sort of additional spotlight shown on how well Medicare Advantages are managing appeals and grievances.

MARK MILLER: So, the first thing I would say is we actually did some work on this, and I'm going to say a year ago? A year, year and a half ago, and I think in some ways, you know, it brought—I hope that it doesn't happen it really brought some attention to this. I don't, you know, we have a lot of stuff going on. I don't have it immediately on the agenda to appear again, but we did some work on this about a year and a half ago. At the time, you know, there were portion s of—I'm not very good at this, in particular, but there were portions of data on the process that weren't particularly transparent. We could see this part of the process, this part of the process, but not this part of the process and don't ask me what any of those this's are. But you get the idea. And so we did what we could with what we had and that's kind of what I've got for the moment anyway.

AUDIENCE MEMBER: I'm Dr. Caroline Poplin. I'm a primary care physician. My question is actually very closely related to the one that was just asked. It seems to me, at the beginning of Medicare Advantage or in the early days, there were studies, especially by Mathematica, showing that Medicare Advantage ended up with a healthier population than the average population. And my sense, as a clinician, is there are two groups of people. There's a large group of predominantly healthy people and there's a small group of very sick people, especially older people. And I was wondering, given that, if that's still true and if the risk adjustment that the government is making seems to be working, and then I would've asked about people who are dissatisfied and what have you found about them, but that's sort of the last question.

MARSHA GOLD: Let me start, and I'm sure Mark will want to add some other things. In terms of that Mathematica study, that was done by my colleague, Randy Brown, a long time ago, and it did find what you said. The issue then, and since then they have improved the risk adjuster, and Mark may comment more on this, but it has improved the selection. There still may be selection which is why, when we looked at the studies, it's very important to look at the, you know, adjust them as you could for it. And the researchers are trying to. Some of them, as I said, did it better than others.

That was actually one of the most important reasons. I think it would be very useful from a policy perspective to look at performance not just for the average beneficiary but for subgroups of beneficiaries because we looked at how many studies looked at sort of the

chronically ill or very sick, or just across the board at them, not at a particular condition but just in general how did people who had a lot of needs do. And we didn't find many studies like that, especially outside of the beneficiary survey ones. So, that, I think, is an important point to take care of in monitoring, regardless of how well the risk adjustment system works in terms of payment.

ARIELLE MIR: I couldn't agree more. Those are the people healthcare is for. The healthy people are going to do well no matter what the system is.

BOB MARGOLIS: A very important question. Those of us have been watching this program for decades agree with you. The early days of Medicare Advantage, I think, the expectation that there was potentially, is what we called cherry picking going on, is probably not too far off. The advent of risk adjustment, in my view, is one of the most important things that ever happened to this program and I think we can all urge CMS to continue to study it, to stabilize it, and to improve it so that risk adjustment for the sicker patients continues to incentivize those folks to be appropriately resourced so that these kinds of organized coordinated care systems, which can take care of sicker patients, in our view much more efficiently than the average individual doctor can by having the care teams and the systems, is actually the most important part of risk adjustment. So, risk adjustment is imperfect but it needs to, in my view, be constantly improved and improved to actually appropriately both on fee for service and on Medicare Advantage, monitor the sicker patients as the more important aspect of risk adjustment.

MARK MILLER: So, we agree that the level of selection, you know, from back in the day, is less than it is now. I think that that probably has to do with three things. As everybody has said, the risk adjustment system has gotten more accurate, and I think everybody gets this, it's just you blow past it. We're up to 30% enrollment so, you know, as you move further into the distribution your ability to pick becomes less. And then, third, annual open enrollment I think has also contributed to this, so the ability to turn the patient immediately is not present, as present for the plan.

The risk adjustment system does need constant monitoring and improvement like everything else. We made a couple of – we did some work, and I'm forgetting what year. Sometimes you remember this sometimes I don't. I always don't. But we did some work, I'm going to say about a year, a year and a half ago, maybe 2 where we said, alright, here's the risk adjustment system. Generally it's accurate if you're represented across the various risk categories, types of patients. But if you look at the healthy we probably overpay and if you look at multiple chronic conditions we under pay. And we made a set of three relatively simple, when you think of the methodology involved in these things, adjustments to this that we've asked CMS to consider. And we think it would help those plans that really go and kind of focus on the multiple chronic condition crowd, it would help those kinds of plans out. Now, this is just a redistribution of money but it would help them out. But the other thing we're keeping an eye on is there has also been, and in some ways there's a selection issue, but related to the selection issue is the coding issue. So,

plan can increase at the payments depending on how many codes it puts in, and we'll be presenting some work on the 18th or the 19th, whichever day it turns out to be, on sort of looking at the coding patterns. And you definitely see more coding in the managed care environment than you do on the fee for service environment. That tangles up the issue a bit.

DR. CAROLINE POPLIN: Where is that presentation going to be?

ED HOWARD: I'm sorry. Would you repeat your question, Doctor.

DR. CAROLINE POPLIN: Where is the presenta—you said there was going to be a presentation on the 18th and 19th on coding?

ARIELLE MIR: When the Commission meets for its December public meeting there'll be a variety of sessions including a session on Medicare Advantage, and that'll be discussed then.

DR. CAROLINE POPLIN: Okay. Thank you.

ED HOWARD: I've got a fairly straightforward question here, and I think it refers back to one of Dr. Margolis's slides. Are the number of beneficiaries in high quality Medicare Advantage plans increasing because there are more high quality plans or because beneficiaries are choosing the high quality plans that already exist? Or do we know?

ROBERT MARGOLIS: I think there's evidence of both. There's been a rapid and highly incentivized reason for plans to become 4-star or better, in that, as someone else pointed out, if you retain a low star rating you'll actually be excluded, so I think the plans are much more focused on measuring and reporting their quality and incenting the provider networks to do that. And I think patients are starting to have access to the transparency related to the star programs so that they're starting to make those choices actively.

MARSHA GOLD: I think that we really – it's clear that the plans, there are more plans with higher star ratings. I'm not sure which changes that reflects. It may be some metrics over other metrics and I hope that people will be looking at this over time so that that star rating can be improved and we know that improvements really mean quality is improving. The research so far, I think, and it isn't just for Medicare but it's across other programs, is that so far quality doesn't seem, at least as it's reflected in people using stars on charts, to drive a lot of the decision making people are looking at benefits, they're looking at premiums. Partly, that's historically the stars didn't show much differentiation across the plan so it was hard to know. Sometimes the information wasn't presented well and I know that there have been some people arguing that the information needs to be presented well. So I think so far we're probably dealing with things that reflect plan behavior as it relates to the measures that are there over time, whether that can drive performance may be different. The highest rated plans, and there are so few of them that

capture the 5 star, do have an ability to enroll throughout the year so they have some advantage that year and that may drive some things.

ED HOWARD: Arielle, you had a slide that listed the domains on which the ratings are based. Are those weighted in a particular way that it would be useful to know? Are they all weighted the same?

ARIELLE MIR: No, they're not all weighted the same, so there is some greater weight placed on outcome measures. And the weighting changes from year to year so CMS proposes their methodology for the different weights of the star measures and has responded in the last couple of years to a lot of comments about the distribution of the measures and the weights within the system.

ED HOWARD: Thank you. Yes, ma'am, go ahead.

AUDIENCE MEMBER: Hi, thank you. Camille Banta, and I'm here on behalf of the American Society for Retina Specialists. On the issue of the star ratings and going back to the question that the woman from the Medicare Rights Center had stated, so we see the star ratings going up for plans but yet, you know, with the audits that were conducted that she referenced, and there was a good summary article in the New York Times about that, a recent article in the Wall Street Journal about provider directories being out of date. I think we're all familiar with the issues regarding terminations of providers from MA plans and narrow networks, and so my question is do we think that there are shortcomings potentially in the star rating system and that there should be a reexamination of the metrics that are used to evaluate the plans?

MARK MILLER: Well, this keeps going back to me. [Laughter.] Okay. I think, I guess the way I would start to parse this in my mind, and I'm not saying that this is the right thing because I'm thinking about it as I'm doing it, and I'm certainly not saying that this is a Commission view or anything like that. I would tend to think of the difference between those two things as network adequacy and access and then quality, and so I would think that if you're concerned about—and I read the same articles; I know the concerns you're expressing—you would be thinking about the requirements on the network adequacy side and so, for example, the Commission does think that plans need to have the flexibility to alter their networks, but it should be—and if it's narrow it's narrow and if it's broad it's broad—it should be transparent to the beneficiary and it shouldn't change without long lead time. And so, you know, we made comments along those lines and this wasn't in our report, this was more in a comment letter to the secretary. So, I'm not saying no, it's not part of the star process but I tend to think of them as, you know, trying to push the star process towards outcomes, comparability between fee for service, you know, some of the things that Marsha was saying, fee for service, managed care, ACOs, and how you're handling a patient and that this notion falls more in the network adequacy world of are you meeting the requirements that when you bark it to the beneficiary they know what they're getting into. This is a narrow network, or this

network is changing. Now, and then your next question might be well, what would you suggest? And I think there is where I think we're still, you know, in the back room kind of figuring out what's going on. I also think there's some other entities out in the environment who are starting to look at this issue, oversight entities, that type of thing. So there may be some more information coming out on this.

ED HOWARD: Yes, Dr. Margolis.

BOB MARGOLIS: Just one additional comment to Mark's. The star rating is measured at the health plan level. In most parts of the world the health plan doesn't actually deliver the care, the physician networks that they contract with deliver the care. And, as in any system, you'll have a bell shaped curve of how the different parts of the network are delivering relative to the star system. So, as the health plans are measured for stars they have a strong incentive to start to narrow their networks around those physician networks that are actually producing higher quality star information, and so you're seeing that weight-counterweight between the fact that in some of our views the stars are being measured at the wrong place. They should be ultimately measured at the provider level not necessarily at the plan level. Certainly the administrative complexity of doing that is understood.

MARK MILLER: Wait a minute, I want to – no, no. Because I want to agree with some of it but I do want to also draw one distinction because I think it is unfair to say to the plans, you know, I demand quality, I demand this focus but, by the way, you have to include, you know, everybody in the network. So, your point about giving the plans the flexibility to say I want to narrow my network to the people who I think are doing the right thing and practicing judiciously and focused on quality is on – is on point. There should be transparency, as I said. The only thing I would say, and we might agree, but I just wanted to get this out. I don't know that Medicare should go in and say, okay, I'm going to measure all of the individual delivery networks. What I would say is, is that Medicare would say to the plan you're who's being paid, you're responsible. You should measure those networks and make sure that it all feeds in. And I don't know whether you meant Medicare should be out doing it or whether you meant that would be a plan responsibility. I would tend to see it as you pay the plan, let the plan manage its actors.

BOB MARGOLIS: I don't think we ultimately – I mentioned the administrative complexity of doing it any other way, but I think your point is right, is that ultimately provider organizations, and this is a little bit self promoting, that actually have higher stars get dragged down by the average of whatever the entire delivery network of the health plan is, and so I think rewarding we're actually incenting the health plans to reward based on the individual network actors as opposed to across the average, it might be a good thing to think about.

MARSHA GOLD: Yeah. I've looked at this a lot over the years as I've watched the industry change and all the rest. And you're from California. California has a bunch of

really big plans and there's a lot of lumpy stuff there. That doesn't exist in a lot of other places in the country and, from an accountability point of view, I've sort of always been with Mark and the Commission if he's saying that's the Commission view as well, that you have to hold the health plan responsible. If the health plan is going to work they have to make sure that their delivery system, at least on average, is doing well and that they're getting rid of the lower hanging fruit. But it's hard to run from up here as to how you change the system there, and we have to recognize that, at least so far, the system is very different in different parts of the country and also just from a research point of view some measures are really hard to do with small providers. You don't have enough patients, especially patients who are sick, to come up with any kind of measures that make sense, and that's a limitation that I think you meant to include in one of your caveats. But, realistically, I think that's why people say, okay, health plan, you've taken responsibility from this. You're close to the ground. You know all these providers. Make sure it's good care. The issue may not always be in getting rid of certain providers. The issue may be in complementing things with other methods of coordinating care that go over what the provider's done. It may be supporting the provider. It may be a lot of other things. But that's the whole concept. It doesn't work a lot of the time which is why there's been problems of performance not being as good as people would hope it would be.

ED HOWARD: Let me just add also that we've gone through a series of events in the Alliance schedule focusing on narrow networks, not particularly in the Medicare Advantage context, but in the context of the consideration, among other things, consideration by the National Association of Insurance Commissioners of a model stage regulatory measure directed at precisely this question. And I wonder if our panelists think that there is merit in having two or three different kinds of scrutiny in the area of narrow networks or quality based networks, one based on insurance for people over 65 and those with disabilities, the other one with people in marketplaces and employer based plans—is there a way to sort of synergize those kinds of efforts into better data collection at the level that our panelists seem to agree we need it? There's another research question, Marsha.

MARSHA GOLD: For Mark it's very different and I think your question is interesting. I was just trying to sort out how it would all work. I think Medicare is ahead of the game. Medicare has had a lot more experience with this and there are differences in the population in different areas. Certainly people should be looking at what other people are doing but I think it's hard enough to get each program to work well and I doubt that trying to figure out how to get them all integrated would necessarily improve care. It would probably make it more complex. That's a personal opinion.

ED HOWARD: Mark, are you going to give classes to NAIC Commissioners?

MARK MILLER: No, I am not.

ED HOWARD: I recommend to you the background materials that are on our website: allhealth.org, from those various narrow network events. I think you can find a fair amount of good information about this issue there.

I've got a couple of related questions that refer to what you have heard here today which is that Medicare Advantage enrollment continues to grow. One questioner points out that CBO and others projected decreased enrollment and spending on MA, but of course, it's been increased and fee for service differences and payment have remained between the two. And the other questioner points out that as the Medicare population is becoming more, or those who age into Medicare age, are more comfortable with HMOs and PPO models, is enrollment going to continue to rise? And both questioners are concerned about the fiscal implications of that potential movement. Comments? Challenges?

BOB MARGOLIS: There was a really cool myth going around for a while until somebody actually did the data, so thank you, Marsha, for folks like you—that people that were used to commercial managed care or coordinated care as they aged in that over 50% of those folks were choosing Medicare Advantage. The number turned out to be more like 25% or 28%, I think. It came out of your data? But, nevertheless, I think that premise and that question is accurate is that there is a greater comfort with coordinated care in the younger seniors than there are in the historical ones that went through the Medicare and PPO-HMO backlash of the 80s and 90s.

MARSHA GOLD: A couple of things from things I've looked at over time. In fact, the growth in managed care really, I think reflects a number of things. It is true. People are more used to it although I wish we had data that let us look at new entrance versus others. Those are hard data to get to do those analyses. But I think the other thing is that people are—it became a one-stop shop and I wanted to say, CBO changed its analysis. I mean they've updated their projections and I think they now agree that there's going to be more growth. It's very hard to project into the future and one of the things I think that people underestimated was the sort of attractiveness of one-stop shopping. I mean, once you had to pick a Part D plan you already had to pick a plan. And so, then picking a Part D plan and picking a Medigap plan, it became a lot easier to say, oh, I'll just do a Medicare Advantage plan, and we had it for a while. A lot of these private fee for service plans that Mark described that we're marketing would give you everything Medicare gives plus more, and they were essentially arbitraging the Medicare program and so that got people comfortable. They now, thanks to some legislation in Congress, are a less smaller part of the program but, in fact, I don't know – they've managed to keep the sector of the economy growing, and it has grown a lot. I don't know how much it will grow in the future.

ED HOWARD: Mark?

MARK MILLER: I tend to think that people are getting more comfortable so a few things. We also go out and we do site visits and focus groups with beneficiaries and

providers and people actually using the services and providing them, and you do hear—and I don't want to put too much weight in this—this is not science. This is, you know, focus group type stuff. You do hear a certain amount of greater comfort with understanding the tradeoffs and the choices between managed care. This might mean I have a narrower network but my out of pocket is more controlled.

But that 50% and what turned out to be either 24% or 25%, you know, that came out of us, the phenomenon that you see is the beneficiary hits Medicare is in for a year or two, then moves to a managed care plan, and so there's some kind of education, and I use that broadly, process that occurs where they must see the plans present information and their neighbors join or whatever the case may be. And so, whether they are more prone to it or not, there does seem to be something that happens. They hit the program, then a few years later they jump into a managed care plan, because you're getting rapid growth there.

There was another thing I was going to say but now I've completely forgotten it.

ED HOWARD: And you don't have much more time to remember and say it because we have just a few minutes left and I'd ask you to multi task. While you listen to these last questions and answers, if you would pull out that blue evaluation form and fill it out for us we'd very much appreciate it.

And this is a tough question and I probably shouldn't have saved it for this long. It appears in several different cards that have been passed forward, and it all has to do with the data you saw in the initial presentations that show that the benchmarks are 12% above the fee for service benchmarks, and then there are adjustments that make the payments different from 12% above. But the question is: why is the benchmark different from the fee for service spending level, and to ask a question posed by this card writer, why don't we move to a benchmark that is not tied to fee for service at all but as the fiscal year '11 budget proposed by President Obama would have done, moved it to the average plan bid, which is something that's fairly common in state regulation? Talk about the phenomenon or the policy implications of either of those things, but there is a great deal of discussion about where the bids and the payments come out.

MARK MILLER: Okay. To the first question, I think the first question is why was the benchmark higher.

ED HOWARD: Yes.

MARK MILLER: Apparently I didn't do a good job. [Laughter.] So, I want to know who this person is. [Laughter.] I want them to identify themselves and I'm going to take them outside. No. I – I think the way – it's simplistic, but just to cut to the chase, I think you had certain parts of the country where plans were growing and providing extra benefits and people were like, you know, politically that raises a question of why not

extra benefits for everybody? And so, policy kind of – and I blew through this, accreted over many years to end up in this situation where the benchmark ended up above fee for service. It wasn't something that happened over night. It happened over, you know, small change – why don't you just change this and just change this and help my plan in this part of the country and then you ended up where you were.

The second plan is sort of saying, well, I'm going to define it this way. The second question is this. Our view is there should be a financially neutral choice to the beneficiary. So, if the beneficiary wants fee for service you shouldn't pay more for them over there, and if they want managed care you shouldn't pay more over there. There should be a financial neutral transaction. They choose, the trust fund pays accordingly. You can get there a couple of different ways. You can link it to fee for service, which is historically what's been going on, and we said if you're going to link it to fee for service don't pay more, set it to fee for service and then adjust on the basis of quality. You could say I'm going to do it on a more competitive basis. Someone will walk into a given market and say I'm going to look at plan bids. I'm going to look at fee for service as if it's a bid, and then I'm going to set some rate, you know, 85% or whatever the case may be, and you could pay it at that point. That's what goes on in Part D. Those are different ways of getting neutrality. And so.

ED HOWARD: And it is still factually correct that even with the changes that are on the books but not yet implemented as they're phased in, we don't necessarily get to complete neutrality, is that right?

MARK MILLER: Yes, but our estimate is, when you're talking about base payment, it gets down to about within 1%. One, one and a half percent but not quite.

ED HOWARD: Okay. One last quick question and it's directed to Marsha, since so much of the message you were trying to get out is that we need more research. What is the source of the research that's now being done, in other words, who's paying for it, how much of it is federal government; is there any private sector research into the comparative effectiveness of MA and traditional Medicare? If you had a policy recommendation specifically who would you make it to?

MARSHA GOLD: I think we need good quality research no matter who's going to pay for it, but right now the government, in general, has been the biggest source of payments for a lot of research. Some of the work that I cited was funded by CMS. Some of it was funded by NIH under grants. So there's some different funders. The amount of funds available has gone down in all those cases. Not too much, I don't think, has been funded by foundations. The Robert Wood Johnson Foundation has historically funded some things. I'm not sure they're funding as much in the future. Some of it is funded by delivery systems. There's some that's been funded by trade associations. Sometimes, you know, that can be fine research, it can be messy research. I think there's more questions

asked when it's funded by someone with a stake in it to make sure that the research is up to snuff and not designed to prove a point.

So, basically it's a federal program. My own sense is that there should be incentives and there should be availability to study it with federal funds because it's a federal program and the decisions of federal funders. I would encourage any other private sector group that wants to study that these are important public policy issues and could definitely benefit from support. And whatever it's done it should be with a good methodology and people who know what they're doing.

ED HOWARD: Okay. That is the word we're leaving you with. One final word, if you haven't done the blue evaluation form, I'd appreciate it if you would. A quick plug for the briefing that we're going to be doing in this very room on Monday on the subject of Digital Health, and if you've missed that announcement take a look at it. I think you will profit from being in the room to listen to that conversation.

And finally, I'd ask you to join me in thanking our panel for an incredibly useful conversation about an incredibly difficult topic.

[Applause.]