



**The Future of Medicare Advantage: Are We on the Right Path?
Alliance for Health Reform
June 10, 2013**

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ED HOWARD: Good afternoon. My name is Ed Howard, I'm with the Alliance for Health Reform, and on behalf of Senator Rockefeller, Senator Blunt, and our Board of directors, I want to welcome you to this program on a growing part of Medicare, The Medicare Advantage Program, that enrolls more than one-fourth of the entire population of Medicare beneficiaries, 14 million or so of them, in a private health plan. That plan's then responsible for delivering all the traditional benefits and they sometimes deliver more services than those in the traditional Medicare package. If you're on Medicare and not in a Medicare Advantage plan, you are in a traditional fee-for-service Medicare arrangement and very likely to have a Medigap policy to help you with cost-sharing, very likely to have a prescription drug policy that's separate from that. Did I mention that this was kind of confusing? Medicare Advantage plans have been around with one name or another for a better part of 40 years. In recent years, they have grown in enrollment and also they've grown as a source of policy issues. Are the payments at appropriate levels, how well did they serve the needs of minority and low-income beneficiaries? What does the future hold for the program?

Today, we're going to look at those questions. What changes are coming for the plans and for beneficiaries'

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enrolled in them? What impact the changes might have on those two groups? We are going to look at the future of the program. How much gets paid to them and how that it is determined, which is itself, a granular process that we all need to learn more about.

Our partner and our co-sponsor in this briefing, the Kaiser Family Foundation, has been cranking out some of the best analysis of Medicare including Medicare Advantage that you're ever going to see. Tricia Neuman, who is in the audience today, heads up the Foundation's Medicare Policy Project; and along with her colleagues, they have produced some great analysis many of which you'll find in your packets. One of which was just published today, so you won't find it in your packets; but if you go to our website at allhealth.org or presumably kff.org, you will be able to find today's version of their update on Medicare Enrollment. Is that what we are talking about? Medicare Advantage Enrollment?

So, we're very pleased to have the Kaiser Family Foundation involved and we're especially pleased to have co-moderating today's discussion the foundation's executive vice president, Diane Rowland. Diane?

DIANE ROWLAND: Thank you Ed and thank you all for joining us today on the topic of Medicare Advantage. I really appreciate the fact that today we were able to pull together

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such an incredible panel to really look at the various aspects of how Medicare Advantage is working. Who enrolls in it? How it's paid? But especially because not only are there are implications from the Medicare Advantage Program for the medical program itself and for Medicare beneficiaries, but also as we increasingly are looking through the implementation of the ACA and through the changes going on in Medicaid and in private insurance at a growing role for managed care, and what are some of the lessons that we can take away from today's discussion that might help us as we move forward to try across the board to improve the way health care services are paid for and delivered in this country. So I am very pleased that we have such a good panel to start off our discussion and such a great audience that I know will put a really good questions to them as we move forward. Thank you Ed.

ED HOWARD: Great. Thanks Diane. If you are a member of the twitterverse, or whatever one might call it, you will notice that there is a hash tag MA future that you can make use of in the course of the briefing. In your packets, you'll find a lot of information. Some even not produced by the Kaiser Family Foundation including some speaker bios that are more extensive than you will get from us as moderators. There is one page materials list in your kits in the PowerPoint presentations that we received in advance. There'll be lot more

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of background information available at our website of allhealth.org via video recording of this briefing available in the next couple of days. Thanks to the Kaiser Family Foundation on their website. You can get there through our website as well. There will be a transcript few days after that on allhealth.org. If you are watching now on C-SPAN and have accessed to the internet, you can call up the slides from our speakers as we go along by going to our websites, allhealth.org, clicking on the info link for today's briefing and then on the panelists' name under speaker presentation.

At the appropriate time, those of you in the room can ask our panel a question as Diane has encouraged you to do by filling out one of the green question cards in your packets or by going to one of the microphones, one on each side of the room; and at the end of the briefing, we would appreciate if you would fill out the blue evaluation form so that we can improve these briefings to respond to your needs as well.

So let's get to the program, we have—as Diane alluded—four terrific panelists today. They're going to give us brief presentations and then you'll have a chance to get in the conversation.

We're going to lead off with Gretchen Jacobson, who is the associate director of the Kaiser's Medicare Policy Program, who came to the foundation from the staff of the Congressional

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Research Service where she specialized in health care financing. For the foundation, she carries out projects and directs others that shed light on Medicare and the people it serves, and we are pleased to have you back on our panel.

Gretchen?

GRETCHEN JACOBSON, PhD: Thank you Ed. So I will provide a bird's eye view of the Medicare Advantage Program and how it currently works for the people on Medicare. For decades now, Medicare beneficiaries have had a choice between receiving their medical benefits from either traditional fee-for-service Medicare or through a private managed care plan known as a Medicare Advantage plan now. Today, they are 51 million Medicare beneficiaries, 28-percent of whom are enrolled in the Medicare Advantage plan. Medicare Advantage enrollees can select from different types of plans. In 2013, most people in Medicare Advantage plans, 65-percent, are enrolled in HMOs; about 30-percent are enrolled in local PPOs or regional PPOs; 3-percent are in private fee-for-service plans; and 3-percent are in other types of plans such as demonstrations or medical saving accounts.

When we look at the demographics of people enrolled in Medicare Advantage versus traditional Medicare, we do see some subtle differences. Starting from with the orange set of bars, you can see that a smaller share of people who're under the age

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of 65 and disabled and a smaller share of people who are ages 85 and older are enrolled in Medicare Advantage. In the blue middle bars, you can see that a smaller share of white beneficiaries and a larger share of Hispanic beneficiaries are enrolled in a Medicare Advantage, and while there appears to be a slightly larger share of black beneficiaries in Medicare Advantage, this difference is not statistically significant. All other differences shown here are statistically significant. Finally, in the green set of bars on the right, you can see that the incomes are slightly lower among people on Medicare Advantage. So changes in Medicare Advantage Plans will affect some groups of beneficiaries more than the others.

Earlier, we saw that 28-percent of the beneficiaries are enrolled in the Medicare Advantage, but this has not always been the case. Enrollment in private plans has increased over the past couple of decades. Many of these changes in enrollment coincided with changes and policy. Initially, enrollment in private plans was relatively low. Then starting in the early 1990s, there was some increased in enrollment in private plans. Then in 1997, the Balanced Budget Act named the private the plan program Medicare+Choice and reduced payments for many plans. In the years following BBA, enrollment decreased. Then in 2003, the Medicare Modernization Act renamed the program Medicare Advantage, increased payments for all plans and

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established the Part D prescription drug program which was subsequently integrated into most Medicare Advantage plans. Since then, enrollment has continued to steadily increase. In 2010, the Affordable Care Act reduced payments to plans and established a new quality-based bonus system for the plans that was subsequently expanded by a CMS demonstration for 2012 to 2014 and partly offset the reduction in payments that were implemented in the ACA. Since the ACA, enrollment has continued to increase; and in 2013, more than 14 million beneficiaries are enrolled in Medicare Advantage plans.

While nationally, 28-percent of beneficiaries are enrolled in Medicare Advantage, this varies greatly across the country, ranging from less than 1-percent in Alaska to 49-percent in Minnesota. In 15 states, which are shown here in orange, you can see that more than 30-percent of beneficiaries are enrolled Medicare Advantage plans compared to less than 10-percent of beneficiaries in the six states shown here in dark blue. Enrollment also significantly varies within a state. So changes in policy that affect Medicare Advantage play out differently across states, but they also play out differently within states.

From the prospective of the beneficiary, Medicare beneficiaries can choose for among 20 Medicare Advantage plans on average in 2013. There are a lot of differences across the

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plans but there are also some minimum requirements that all plans must meet. All plans are required to cover Medicare Part A and Part B benefits and have cost-sharing that is at least actuarially equivalent to the cost-sharing in traditional Medicare. Plans can also cover Part D prescription drugs; and in 2013, most Medicare Advantage plans do. Unlike traditional Medicare, all Medicare Advantage plans are required to limit enrollees' out-of-pocket expenses to \$6,700 or less and this limit varies greatly across the plans. Finally, most plans provide extra benefits, such as lower cost-sharing or benefits that are not covered by traditional Medicare, which beneficiaries may value and which may factor into their plan choices.

Familiarity with the company, or brand loyalty, is another factor that may factor into beneficiaries' plan enrollment decisions. Most Medicare Advantage enrollees are in plans operated by one of five firms or affiliates, which you can see here, and this is similarly true at the state and county level, albeit at slightly different companies. So there are really a select number of companies that drive the local and national Medical Advantage markets and have most of the enrollment.

Another factor that may have influence beneficiaries' plan choices is the plans' quality ratings. The left side of

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bars here shows the distributions of ratings among plans. The right side of bars shows the distribution of ratings by enrollment. If you compare the orange set of bars on the left to the orange set of bars on the right, you can see that while a quarter of all plans received four or more stars, about 40-percent of enrollment is in plans with four more stars. While beneficiaries seem to be disproportionately enrolling in plans with higher quality ratings, it remains to be seen to what extent the ratings are influencing beneficiaries' plan enrollment decisions.

And another factor that may influence the beneficiaries' plan selection is the plan premium. On average in 2013, beneficiaries enrolled in a Medicare Advantage plan with prescription drug coverage paid \$35 per month in premiums, in addition to their Part B premium. This is about the same amount that they paid in 2012 and is a decrease from the \$44 per month that they paid in 2010. Premiums, as you can see, vary across plan types and they also vary from one county to the next. There are many other factors that may influence beneficiaries' plan choices that vary across plans, including things such as provider networks or plans' cost-sharing.

Looking forward, the outlook for the Medicare Advantage Program is not entirely clear. Although most expect enrollment to continue to increase after 2014, which you can see here in

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red, the projections differ. Some say enrollment will continue to increase while others say enrollment will decrease. It remains to be seen how policy changes from the ACA and the CMS bonus demonstration will change the landscape of the Medicare Advantage Program in the coming years, and for more information about Medicare Advantage, you can see our resources on kff.org. Thank you.

ED HOWARD: Thanks very much Gretchen. We're gonna hear next from Mark Miller, who is the executive director of the Medicare Payment Advisory Commission (MedPAC). Most of you know that MedPAC advises Congress on all things Medicare including payment, access, and quality; and this is a nonpartisan as you can get at this time. Mark, himself, has held senior positions and CBO, OMB, and at the Centers for Medicare and Medicaid services within HHS and in the nonprofit sector, and I am pleased to say he is a frequent flyer on our panels or at least not as frequently as we would like but we are happy to have you back.

MARK E. MILLER, PhD: Thank you and nice job Gretchen. I think it sets us up really well. I assure you my talk will not be as smooth as Gretchen was. What they asked me to do here is to take you through the payment policy and sort of the evolution of payment policy and what's coming, and that's what I am going to try and do here. As Ed said I am from the

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Medicare Payment Advisory Commission. The commission's position is that the beneficiary should have the choice of managed care plans or private plans and traditional fee-for-service. We think that private plans have tools that fee-for-service does not necessarily have to coordinate care and to keep a necessary volume down. But on the other hand, like every other payment, whether it is hospitals or physicians or otherwise, we think the payments have to be done carefully to be fair to the providers, but also to be fair to the taxpayer and the beneficiary, and there've been some issues with respect to private plans.

But just to jump right into it, the first thing I want you to get into your head is that managed care's propositions sort of works like this: fee-for-service is high cost because it is volume-driven and uncoordinated and the proposition of managed care is we'll come in, do a better job; and with that savings, we can offer the beneficiary extra benefits. So the extra benefits were usually less cost-sharing and that will attract beneficiaries to go to managed care and you will have this cycle of under bidding fee-for-service and drawing beneficiaries in. And let me give you a sense of how that might work and this is how the old payment system works and how the new payment system works; but of course, it is obviously much more complicated than this because it always is.

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Okay, but just to work our way through this slide, on your left-hand side of the slide, let's imagine that there's a county with an \$800 monthly benchmark. The government says this is its benchmark. Let's say Plan A bids \$700. There's \$100 below it. Under the old system, they would keep 75 of those dollars and Medicare would pay 775—I'm just working my way down the slide here. The beneficiaries would pay nothing else beyond their Part B premium and there would be \$75 of extra benefits. Now, also on the same county Plan B comes in and bids \$840. In that instance, there is no rebate—there is no extra dollar because they did not bid below the benchmark. The government pays \$800. The beneficiary has to pay \$40 to join that plan and there are no extra benefits. Then, you see the economics here—the beneficiary should want to choose Plan A unless there's some superior quality gained on Plan B, but for the moment, assuming the quality is the same, they should want to pick Plan A because their premium will be zero and they'll get extra benefits. The sixty-four-thousand-dollar question there is where is the benchmark set?

Now to get this concept into your head, I want you to get this picture. What's happening in this picture is that you take the counties of the United States and you array them from the low fee-for-service counties to high fee-for-service counties and basically what's happening up at the far right-

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hand side is you have Miami and McAllen, Texas—everybody's going to hospital, everybody's getting an MRI—and on down. On the left-hand side of that line, you have the North West and the Upper Midwest where utilization is lower. Now again, this is the stylized picture but this is the managed care proposition. They have a cost function. It's not flat like that. It follows the line a little bit more; but to dramatize it a little bit, I want to make it flat and the point here is—in high fee-for-service areas of the country, managed care can beat fee-for-service. But in low fee-for-service areas of the country, managed care may not be able to compete against fee-for-service. So I want you to imprint this picture in your head because it is going to come up again. The proposition this creates with the Congress is where do you set your payments? Do you set your payments to maximize the savings on your right-hand side of the picture or do you set your payment in such a way that you have plans in all parts of the country? In other words, maybe you have to pay more than fee-for-service to get plans in the low fee-for-service parts of the country.

Well, the Congress decided over many years in over many pieces of legislation to actually set those benchmarks well above fee-for-service in the low-cost fee-for-service parts of the country—as you can see the yellow line at the top; and even in other parts of the country, the benchmarks were above fee-

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for-service and you see the problem from the payment point of view. If the plans bid below that benchmark, they get to keep some of those payments but those payments are in fact above fee-for-service, and so what we had for many years is the situation in which given the payments—the way plans were paid—every time a beneficiary, at least on average, was enrolled into managed care, it cost the program money. So pulling people out of fee-for-service into managed care, cost the Trust Fund, cost the taxpayer. Now, of course, plans offered extra benefits and so this was very attractive to beneficiaries but those extra benefits didn't come from the efficiency of that plan relative to fee-for-service. The extra benefits came from the fact that we were paying above fee-for-service and the plans were able to get the dollars and offer extra benefits. This caused the rapid growth in the industry—as you've see in Gretchen's slides—and lots of enrollment in the managed care and our concern is that also stimulated low value plans; and we mean two things: plans that were bidding well above fee-for-service - they were entering the program and saying I can't provide these benefits more efficiently, but I'm going to enter the program anyway - and plans who set out and said I'm not even going to manage care, such as private fee-for-service plans, which I'll leave with that thought and we can take on questions.

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So we recommended that the payment system shouldn't do this. That the payment system should be more neutral between fee-for-service and managed care. We should say the beneficiary should look at these two choices and not be sent one signal or another that steered them to managed care or fee-for-service. It should be an equal signal for either managed care or fee-for-service. Now, I want to be clear about something, we don't think fee-for-service is a well-functioning system but what we want is managed care plans to come in and do a better job both in cost and in quality, and so we made a recommendation to change the payment system and Congress took some action—I'll show you that in a second—and we also said within managed care system, if a plan does better on quality, it should be paid more than a plan that does worse on quality. So those plans have more money to offer extra benefits and attract beneficiaries to the higher quality plans and Congress also acted on done that.

So this slide is the most complicated slide, I apologize for that, but this is why I set up the original one. The Congress has divided the counties of the country into four quartiles and they have set the benchmark at different levels in those four quartiles. I'm going to illustrate just two of them for you. So on your right, in the light blue shaded area, these are the high-cost areas of fee-for-service in the

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country—Miami and McAllen, Texas places like that. The benchmark is now transitioning until 2017 to a benchmark that is 95-percent of fee-for-service. In these parts of the country, managed care plans to be competitive have to bid below that in order to offer the beneficiary extra benefits, and the program will save money and beneficiary will get their extra benefits from the efficiency of the plan. However, look on the far left—the dark blue—the benchmark there in 2017 will be transitioned to 15-percent above fee-for-service. So the Congress has made this decision that says in the low fee-for-service parts of the country, we will continue to allow plans to pay or to be paid above fee-for-service and so in a sense, they're getting savings from the part of the country that has high fee-for-service and then they're using some those to subsidize plans in the low fee-for-service parts of the country. If this is painful, we're almost done so just hang on. I'm not enjoying this anymore than you are [laughter] so just be clear about this.

So that's what Congress did on the benchmarks and the payments, and then on quality, what they did is that they said okay if you are a high a quality plan—by the way there is five-star system that works on intermediate outcomes, patients experience, some process measures, and one other I forgot. There's about 50 measures between MA and the Part D part of the

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program, and they get stars, and a couple of things happen, if you are a high-star plan, you get a bid of a higher benchmark, which means if you come further below it you get more money to provide benefits, and if you are a high-star plan, you get a greater percentage of that difference. So if you are five-star plan, you keep 70-percent of the difference. If you are a three-and-half-star plan, you keep 50-percent of the difference and that means that the high quality plans have more dollars to offer extra benefits to try and attract beneficiaries to them. There are some issues here with the way this has been executed. Gretchen mentioned that demonstration. We decidedly—I have issues with that but I will stop here and take that on question. Thank you.

ED HOWARD: Thank you very much Mark. It was a lot less painful than it seems to you on the inside [laughter]. Next up, we have Alissa Fox, who is the senior vice president in the Office of Policy and Representation for the Blue Cross and Blue Shield Association. The 38 member health plans in that association cover almost 100 million Americans including tons of Medicare beneficiaries under Medicare Advantage plans. Alissa has been one of Washington's premiere health policy analysts for 25 years or so. She's been at OMB. She's been at HHS. She's run her own firm. She understands how health programs work and she's going to tell us how Medicare Advantage

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works from the standpoint of the plans. Thanks for being with us, Alissa.

ALISSA FOX: Thank you so much Ed for that lovely introduction and thanks so much Diane. I appreciate the invitation to be here today to talk about Medicare Advantage. The Blue Cross and Blue Shield Association as Ed mentioned is comprised of 38 independent companies across the country. Plans offer coverage to individual small groups and large groups in every zip code in this country. Plans also participate extensively in the government programs including Medicare Advantage, Medicaid as well as the Federal Employees Health Benefit Programs. In addition, all Blue plans offer Medigap coverage, Medicare supplemental coverage. Gretchen did a great job in telling you who is in the program. Blue plans enrolled about 2 1/2 million people about 17-percent of all Medicare Advantage beneficiaries. Blue plans offer HMO coverage, PPOs, special needs plans and we also have one MSA option.

There is great value in the Medicare Advantage Program and I would like to outline some of that value. First of all, it is really important to understand that Medicare Advantage enrollees receive comprehensive high quality coverage in benefits and services that go far beyond what people get in the traditional program. In 2013, our survey found that nine out of 10 Medicare Advantage beneficiaries are satisfied with their

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coverage and 94-percent believed that they received very high quality of care. A key feature of Medicare Advantage plans is the coordinated care and that is what is so important to ensure people are receiving the right care at the right time with the greatest efficiency and with fewer return visits to the hospital and doctor. I will give a few examples from our own experience in Blue plans in Medicare Advantage. People want to make sure they're getting the appropriate preventive care and using the best practices to both treat medical conditions and manage chronic illnesses. Medicare Advantage plans offer a range of benefits, not covered in Medicare fee-for-service. A key one as Gretchen mentioned was that out-of-pocket cap which is really a great value to make sure that you know that your out-of-pocket spending is capped and you don't get that in the traditional program as well. But Medicare Advantage plans also offer many other additional services to improve enrollees' coverage including medication management, nurse help lines, hearing and vision care, just to name a few. Finally, it is really important to know that Medicare Advantage serves many low-income and minority individuals. The 41-percent of beneficiaries in Medicare Advantage make under \$20,000 a year compared to 37-percent in the traditional program, and there is a very high percentage of minorities also receiving care in Medicare Advantage.

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As a result of the coordinated care and its additional services and benefits, peer review research has demonstrated the high value of Medicare Advantage. I have several of the studies listed on the chart. I will just highlight a few of them. Key findings include lower hospital readmissions, better performance on clinical quality measures, and the last study here by the National Bureau of Economic Research showed a spill-over effect to the community. So where you see high penetration of Medicare Advantage, you can actually see lower hospital cost in the community, both to the traditional Medicare program and to the under 65 populations. So you are seeing better savings as a result of this care. And finally not listed on this page but a study that I just became aware of a few days ago, was a study by the Boston Consulting Group, which found shorter hospital stays and better preventive care and that was just released a few weeks ago.

Blue plans are seeing very, very impressive results. For example, Blue Cross Blue Shields in Massachusetts is ensuring that their knee and hip replacement members are returning home safely through home visits and phone calls to ensure they're getting the proper follow-up care. They're also seeing significantly lower readmission rates in both their HMOs and PPOs compared to the traditional program. WellPoint who has 14 Blue Cross Blue Shield plans across the country has a

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comprehensive program, that identifies high risk members, provides them with specialized services to ensure they get the care they need to prevent hospitalizations and keep them as healthy as possible. For example, congestive heart failure patients are equipped with wireless scale that sets off alerts if the patient gains too much weight overnight. If so, that patient is seen by clinician in the next day to monitor and take care of that patient.

Mark did a great job talking about how Medicare Advantage payments are being calculated. What I'd like to highlight are the cuts that are ahead. They are: the Accountable Care Act included direct funding cuts of over \$150 billion of the next 10 years. As you can see from the slide, the cuts are being phased in with the largest cuts yet to come. In addition to the ACA direct cuts, the ACA includes a new health insurance tax that is supplied to Medicare Advantage enrollees. The tax begins in 2014 at \$8 billion. It grows significantly each year and totals of over \$100 billion over the next 10 years.

The actuarial firm, Oliver Wyman—it's not a person, a lot of people think that's a person, it's a firm—estimated that the tax will add \$220 per beneficiary a year in 2014 growing to \$450 by 2023. We think the tax is also unfair. HMOs, nonprofit HMOs pay 50-percent of the tax while PPOs even nonprofit PPOs

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pay 100-percent of the tax, so there's a difference in the tax which we think is unfair as well.

In addition to the direct cuts that I mentioned, there's a lot of other cuts that are being phased in. The ACA also included billions of dollars in cuts to other providers because the benchmarks are tied to fee-for-service spending. That means there is an indirect cut being phased in to Medicare Advantage as well. CBO estimated that it would be \$70 billion over 10 years in additional indirect cuts because of this linkage. Second New Year's Eve also brought in an additional \$2 billion in cuts in a fiscal cliff package and Medicare Advantage has also been subject to the additional 2-percent because of sequestration. And while not a funding reduction starting next year, Medicare Advantage plans are subject to new requirements for a minimum medical loss ratio subject to 85-percent which is restricting how much can be spent on administrative cost. The bottom line, there is very sizable cuts that are ahead of us. And I just want to mention to you something that gets lost sometimes too. Medicare Advantage is a very highly regulated product. I'll just give you some examples. All the marketing materials are scrutinized by CMS. How quickly phones are answered or set and monitored by the government. Language lines, you know, how you are answering lines, being sure that you have the right people behind

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different people's language skills and being sure you have the appropriate staff monitored. How agents' and brokers' pay is set? There's 53 performance measures that are set and reviewed and overseen by the government and on top of that, there are regular financial and performance audits. So, there's a lot of oversight to make sure the government is getting what it's paid for and we just want make sure people understand that there's a lot of oversight here as well.

I'd like to leave you with two points. First, Medicare Advantage plans are very committed to continuing to serve Medicare beneficiaries and to build upon the current innovations to improve quality and rein in cost. We're very proud of the job we're doing but we always think we can do better than we've done and we're striving to do that. We are concerned, however, that already scheduled funding cuts are likely to lead to increased cost and reduced benefits and access for beneficiaries. I'll look forward to talking about that. Thank you.

ED HOWARD: Terrific. Thank you very much Alissa. As Alissa was saying, the Medicare Advantage Program is operated in the private sector and part of the answer to the question that's posted in the title of our briefing about the future of Medicare Advantage has to do with how the private shareholders and the markets in America perceive that future and fortunately

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we have—in my note somewhere—a perfect addition to this panel. Our final speaker is Carl McDonald. Carl is a director and a senior analyst for Citi Investment Research and Analysis. He's followed the managed care industry for a decade or more for several leading firms and we've asked him to take a sort of clear-eyed look at the future of Medicare Advantage from a business standpoint. Carl.

CARL MCDONALD: Great. Thanks Ed. So, I was tasked with the question of whether or not Medicare Advantage is viable over the long-term so we need to take the payment policies that Mark talked about and some of the funding challenges that Alissa just walked through. Is this program going to be around for five or 10 years? Continue to thrive? And I think the answer absolutely is yes and I think the key factor to think about here is that Medicare Advantage plans are competing against the completely inefficient fee-for-service program. So in other words, these companies have the ability to actually save cost versus the fee-for-service program and I know medical management is sort of a vague term. Some specific example—so Medicare Advantage can try to make sure if its seniors have a primary care physician, somebody that they can go to for care relatively inexpensively as oppose to showing up in emergency room. A separate example would be the Medicare Advantage plans, what they'd try to do in terms of fraud and abuse, something

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that the federal government or fee-for-service program attempts to do but with very limited success. A final example that I'll give you is that Medicare Advantage plans are constantly reviewing their provider networks. If there's a specific doctor that's utilizing significantly more than everybody else in that region with no explained reason, they can eliminate that doctor from the network, and so these are all different ways that the companies can be more efficient. Now, when I say that Medicare Advantage is viable over the long-term, I should probably be a little bit more specific. The way things are set up right now, Medicare Advantage can absolutely be viable in urban areas—I think Miami and Los Angeles. Definitely more of a question of whether Medicare Advantage can survive in some of the rural markets. So Mark alluded to this in terms of the way the payments are set up as well as the ability to control cost. As you look at the last couple of years, the fee-for-service Medicare program is consistently showing cost increases generally in the 3 to 5-percent range. Medicare Advantage, their cost increases have been closer to 0 to 2-percent over the last couple of years. So there has been a pretty significant difference in those cost trends in the last couple of years.

As you think about where Medicare Advantage is going, I think it's helpful to understand where they are today. And so,

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this just gives you a summary of the Medicare Advantage program today, a little bit over 14 million people in risk plans. The average payment that the plans get today is right around \$900 a month. In annualized basis, Medicare Advantage private plans' are taking in about \$155 billion in revenue. On average, they're paying roughly 85-percent of those dollars in hospital, doctor and drug costs, so that's close to 85-percent medical loss ratio - 10-percent of those payments are going to SG&A. So, fee-for-service, the SG&A ratio is in the low single digits. The difference between the fee-for-service and the 10-percent that the Medicare Advantage plans are spending--some of that are executive salaries and the rest of it is the care management programs that I was taking about. Keeping people out of emergency rooms, fraud, and abuse, all of that stuffs cost money and that's what the SG&A is. And the private plans on average earn a margin of about 5 1/2-percent.

What's interesting to me is if you look at the payment rates to Medicare Advantage plans, in the last five years, they haven't gone up a single year. The base reimbursement has fallen, including some 4 to 5-percent cuts in a couple of those years. So, as we think about the cuts that are coming in 2014, this is not a totally new environment for these plans. They've been working through reimbursements, reductions, everything in the last couple of years. Now, what's interesting is if you

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look at the period between 2010 and 2014, despite these reimbursement cuts, Medicare Advantage plan enrollment has accelerated, margins have been stable to better, and the benefits that the plans offered to the seniors have been relatively consistent. So again, another indication that the plans have been able to mitigate these rate cuts through some of the cost savings mechanisms that we talked about earlier.

This is a chart from Humana. What it does is it breaks their enrollment into the four different payment quartiles. So, if you look at the far left, that's 95-percent. So think urban areas, Miami. The green bar down at the bottom is the people that have benefits that are 15-percent or better than fee-for-service and you can see over those that three-year period, the benefits have actually increased. So again to that point despite the rate cuts, the benefits have actually been stable to better and that's been relatively consistent across all the payment quartiles, although much more significant in the urban areas.

The ability that plans have to save money versus fee-for-service, it does vary quite a bit. So again, these are Humana statistics. What it does is it breaks down their membership in terms of the provider reimbursement that they have. So global capitation, which is about a quarter of their lives, that's where hospitals and doctors are actually taking

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on all the risks. Humana gets paid by the government. They turn money over the hospital and doctor and then it's up to the provider to be able to manage care. In those situations, Humana can save almost 30-percent versus fee-for-service. And again, that goes back to the point of why I think Medicare Advantage can be viable in this payment system in those urban areas. If you scroll down to the bottom, providers that have no incentives or very little incentive, the savings that Humana is able to generate is only 9-percent. And so, in those types of areas, it is going to be much more difficult to offer the extra benefits that attract seniors into the program.

And so, this I think helps to explain why companies like Humana are doing everything they can to try to move more people into HMO products and into more of the products where providers are taking risk even to the point that Humana among other companies has gone and actually started buying up doctor practices. You've seen a couple of those acquisitions across the industry over the last couple of years. This runs through the publicly traded companies and gives you sense of where their membership is today among the different products. And so you can see, there are some pretty significant differences. You know, on one end of the spectrum, you've got a large Medicare company, United, where almost 70-percent of their membership is in HMO products, very little in PPO and private fee-for-service

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or somebody like Humana, only little bit more than 40-percent of their membership is in HMO products. And so, as you think about the environment over the next couple of years, as you deal with these rate cuts, it's much easier for a company like United with a lot of HMO, with a lot of risk-sharing with the hospitals and doctors, to be able to work through those cuts than it would be for a company like Humana and other example Universal American that have a significant amount of membership in more rural areas with providers that have no incentive to try to keep their cost runs down.

One other thing that I think is going to become significantly more important, that has been touched on by couple of people, are these star bonus payments. So again, the higher quality Medicare plans get increased amounts of payments. Starting in 2015, you have to get to four stars to get a 4-percent bonus payment. Currently, if you're a three star or better plan, you get a bonus payment, but starting in 2015, that's going to end. If you don't get the four stars, you get no bonus payment. And so, what that's going to mean is if you're a three or a three and a half star plan in 2015, not only do you not get that 4-percent bonus payment, but as Mark mentioned, you also get less of a rebate if you bid below the benchmark. And so, what that's going to translate to roughly in a specific example that I've got a bonus slide, you could have

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a \$50 a month differential between one plan that's four-star rated and one that's not. That's a significant amount of extra benefits that the four-star rated plan is going to be able to offer seniors. So, these payments do become significantly more important. And again, this has the publicly traded companies and where they stand from a star ratings perspective. So, Humana is one example, is almost a four star just under. So they're in a relatively good position versus somebody like WellCare who's under three stars at this point. WellCare operates specifically in HMO markets, particularly urban areas. South Florida is one big market. It's going to be extremely difficult for them to compete in that market in 2015 if they're not getting bonus payments and everybody else around them continues to. So, I will stop there and we can start up the questions?

ED HOWARD: Terrific. Thanks very much Carl. You now have the opportunity to join the conversation. If you are going to one of the microphones, we would ask you to identify yourself and to keep the question as brief as possible. If you have a question to write on a green card, hold it up and someone will bring it forward and will spring it on our panelists. So, I believe you were first?

STUART GORDON: Thank you Ed. Alissa did a great job of highlighting—I'm sorry. I'm Stuart Gordon from WellPoint —

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ED HOWARD: You want to identify yourself?

STUART GORDON: Stuart Gordon from WellPoint. Alissa did a great job of highlighting the WellPoint successes but one of the things that happened to the final call letter is that they changed the risk adjustment in such a way that it's going to impact particularly the low income and chronic needs folks that are in WellPoint's Chronic Care Special Needs plans and Dual Eligible Special Needs plans. In fact, it looks to our actuaries as though the impact will be a reduction in reimbursement, almost equal to the growth factor increase that got ballyhoo in the press. Dr. Miller has the MedPAC staff had a chance to look at the impact of the risk adjustment calculations on the D-SNPs and the C-SNPs?

MARK E. MILLER, PhD: So, what we've done there is when CMS made, it put out its call letter, we had a comment on that change and we were concerned about it too. We felt that CMS kind of mixed the coding adjustment with the risk adjustment. We always think that risk adjustment should be as accurate as possible and all of that but we felt that there were some mixing of the coding change. And so, we suggested that we step back and not implement that right away and what we have done—and we've not ground through that particular analysis—but what we have done—and this is talked about in our June 2012 report—we think that there does need to be some improvement to the

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risk adjustment system for these types of populations and we made a set of recommendations which we think would tighten up the risk adjustment system. [Laughter] And we do think that there are some adjustments that can be made to the risk adjustment system that would take the distribution and for those people who are taking the dual eligible and chronic-condition patients, the risk adjustment system would work better for them. So, we have a set of recommendations which we've been saying to CMS that they should be pursuing to go after that particular problem. Now, this is already out, this is out in June 2012 and I was supposed to say during my talk that a lot of the things that I was saying are in our March 2013 report, but I forgot to tell you that.

ED HOWARD: Okay, yes ma'am.

CAROLINE POPLIN, MD: I'm Dr. Caroline Poplin. I'm a primary care physician. We know that 20-percent of the Medicare population is responsible for 80-percent of the cost. In the early days of Medicare Advantage, there was a concern that the cohort, the population was attracted to Medicare Advantage or that Medicare Advantage was seeking was healthier than the population in the fee-for-service section so that their cost would be lower. And I was wondering if you check for that, if anybody has looked to that recently. Nobody's mentioned it.

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ED HOWARD: Gretchen, do you want to take a shot at that?

GRETCHEN JACOBSON, PhD: I think, there's been some examinations of that issue and has found that overall, the differences in the risk scores, which I think is what you're referring to, has narrowed over time, is what most recent studies have found. Although, of course, this will differ across plans and differ across the country. So, that's something to consider and I think more research intends to examine this as well.

CAROLINE POPLIN, MD: Thank you.

ED HOWARD: Mark. [Interposing] - Sorry, go ahead Alissa.

ALISSA FOX: And I would just say that initially when the program began, there was in a risk adjustor that has been added to the program and that I think it has made a significant difference as well to make sure that appropriate payment is made for those with chronic illnesses and what you see in the Medicare Advantage plans are a huge emphasis on coordination and emphasis on primary care to make sure those individuals are getting the right care.

CAROLINE POPLIN, MD: But is there a discount for people who don't require any care at all?

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ALISSA FOX: Yes, you get lower payments because of the risk adjustment. Yes.

CAROLINE POPLIN, MD: Thank you.

MARK E. MILLER, PhD: Yes. And I think, I would've said the same thing that Gretchen said. There has been some narrowing of the differences but there were three recent studies, I think, in the last year or so and they're still finding some lower risk profile for MA beneficiaries but it's not as high that's been in the past.

JIM GUTMAN: I'm Jim Gutman of Medicare Advantage News. I'd like to ask Carl McDonald the question that Gretchen Jacobson brought up and that's the degree to which beneficiaries are actually using the star ratings in making enrollment decisions. Did we see any change in that in the most recent annual election period? To what extent our beneficiaries are doing this and to what extent you think that's likely to increase in the coming years?

CARL MCDONALD: Yes. I'll exaggerate here and say directly basically zero. Seniors don't care. And so, the examples I would give you is that—if you're in, what's considered a low performing plan, so under three star for certain period of years. The seniors get mailed letter from CMS alerting them to that, giving them the opportunity for special election period to move to a higher rated plan. Very few

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seniors choose to make that move and generally the feedback from senior shopping experience has been—they care about premiums, first and foremost. It's so much easier to sell a zero premium plan than it is a \$50 premium plan. And then, it'll be things like drug coverage, primary care co-pays, etcetera. But, the point that I made indirectly if you're a higher rated plan, you could offer extra benefits and so with that extra dollars, you're able to offer lower premium plans and extra benefits. So, there is an indirect but generally now, seniors don't care about star ratings.

JIM GUTMAN: And, I assume you don't see that changing in the next couple of years in terms of how much they care directly about it?

CARL MCDONALD: Probably not.

DIANE ROWLAND: I'm going to follow up to Gretchen for question we had that still relates to the star rating system and that's what kind of measures of provider quality are included in that. So, is that really a good system for the beneficiary to know about the providers in the network beyond satisfaction and other factors?

GRETCHEN JACOBSON, PhD: Well, part of what's included in the star rating system are what are known as HEDIS measures which are quality measures that measure things such as: Did someone get the appropriate test? What they should have

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received? Are they getting the appropriate preventive care that they should receive and measures such as that, which should be correlated to the quality of the physician. Other measures are measures such as the patient's satisfaction and also some administrative measures that are included in the star ratings as well. So, there are some measures in there in terms of whether or not the physicians are doing what they should be doing.

DIANE ROWLAND: But not directly about the physician?

GRETCHEN JACOBSON, PhD: No.

ELLEN SINGER: Hi. I'm Ellen Singer of the Heritage Foundation and I have a question about enrollment in the future. In 2010, the actuary said the ACA would reduce MA enrollment by 50-percent.

ED HOWARD: Could you stand a little closer to the microphone. Thank you.

ELLEN SINGER: Enrollment would decrease by 50-percent and in March 2012, the CBO said at the end of their 10-year budget window, 11 million people will be enrolled in MA and in May, they now say that's going to be 21 million in 2023 which is nearly 100-percent increase in MA enrollment, in which of course includes the [inaudible] reductions so—I know none of you are with the CBO but do have any idea why CBO has drastically changed their enrollment projection?

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CARL MCDONALD: They haven't given any explanation that said I'm aware of what drove this changed so I'm speculating here; but historically, CBO hasn't assumed any cost savings through managed care companies. So basically, all they've done is look at the projected payment rates for the plans over the future period of time and made assumptions about the enrollment. So my guess to have that kind of a swing is they have to be assuming some level of efficiency that the managed care companies are able to realize. My perspective is that these new numbers I think are directionally better. All of these do seem a little bit optimistic to me given the payment challenges that we're going to face over these next couple of years.

ED HOWARD: Mark.

MARK E. MILLER, PhD: Yes. I'm going to take this opportunity not to answer your question. I don't know why they changed their estimate, but I do want to pick up on some things that Carl said and what might be implied by why people like Carl and others are looking out. I'm often asked to these things to be the kind of [inaudible] unhappy guy and I'm sure I accomplished that this time but what I want say is just that actually, I think there's really good news here and again I think some Carl's comments get to it. So under the old payment system where the benchmarks are set well above fee-for-service

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and people were bidding again above fee-for-service, we are getting average bids out of managed care that were 102 to 104-percent fee-for-service. Basically, the private plans were saying, I can't provide this benefit as efficiently as the traditional fee-for-service and as a contrary, we were paying 10-percent above fee-for-service for that privilege. Now, what's happening is under the pressure of the benchmarks and the fact that certain sets of plans have been kind of moved out of the managed care environment—the private fee-for-service plans—you now have much more focus on the plans that actually can delivery the benefit more efficiently. The average bid now is 96-percent of fee-for-service. Managed care plans can provide services less expensively than fee-for-service. The question is whether as a program, we take advantage of that. HMO plans, their average bid is 92-percent and this is why I think Carl stated people try to move people in their products where they can control their expenditures. Why you're seeing that happen? Maybe, that has something to do with people looking forward with projections and thinking that the plans may be viable in that environment but that's not official from CBO. Okay.

ED HOWARD: Alissa, when you get your members together, do you hear optimistic or pessimistic views in the future enrollment?

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ALISSA FOX: When you look at the numbers that are out there in the years to come in terms of the cuts, the new tax—it's hard to see how you can keep the level of service, the level of cost-sharing, and the level of benefits stable because there're such huge cuts ahead. So, it is a big concern. It is a very big concern how people are going to want our care to keep stability for their beneficiaries because it's really critical for older people to make sure—they get scared. I know my parents were in Medicare+Choice. I guess in the 90s, when plans left and they called me everyday. I mean, it's a huge problem for people when they're in a plan—these premiums go up where they have to leave the program because of these funding cuts, so we look at the numbers ahead and are very concerned about the sizable cuts, and then you look at the SGR coming in December or people are going to come and say oh we're going hit Medicare Advantage again. So, it is a huge concern and looking at the cuts, the tax—it is very significant, so a lot of worry, but a lot of work. We're going to continue to work on new innovations using what we're doing on the private sector, that's been very effective, and translating that into our Medicare Advantage plans.

CARL MCDONALD: In addition, one interesting side to know, I think, it's helpful to think about the existing program versus new seniors that could potentially come into the

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program. And the distinction I would make there is that for seniors that are already in the program, plans can do basically whatever they want to those seniors and they will not leave. Meaning like you can raise premiums as much as you want, you can cut benefits as much as you want; and time and time again, seniors have shown that they will not leave and go back to fee-for-service. Potentially, they'll switch to another plan, but even going back to BBA, back in the late 90s or early 2000s, the seniors left and went back to fee-for-service when their plans pulled out of the market. As you think about the growth of the program, when you think about the cuts, it is really going to be how attractive is Medicare Advantage to seniors that aren't in the program now.

ED HOWARD: Go ahead, George.

GEORGE STRUMPF: I'm George Strumpf with EmblemHealth Plan of New York. For better or worse, we've been contracting with Medicare since 1965 and now we serve about 186,000 Medicare Advantage members, so with that background in full honesty, I have to say I've never heard so much I can disagree with [laughter] and in particular, the tone of the optimistic enrollment forecast and if you forgive me—on page 13 of your excellent report—the optimistic sentence that the fact that the enrollment continues to grow; and you know, I'm shortening that sentence. So, in your report you point out the 45-percent of

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Medicare Advantage members are in the high fee-for-service areas, that is not quest, and the high percentage of those are in what we call zero-premium plans. Most of these are in urban areas serving people—I saw the data before—who cannot afford Medicare supplemental coverage. I mean, that's a big part the constituency. The other part of constituency—sorry, you have been talked about—are the employer members who age in. Okay, now, as projected, the rates in those urban areas are going to go down to 95-percent, and if you add to that, the data that Alissa gave you on the impact of the several of the cuts. We've just gone through the exquisite pleasure of presenting our bid to CMS for next year. How can you make this optimistic enrollment forecast? What am I missing here? The comment that you can charge anything and people won't leave? I'm sorry, you know, 40-percent of a membership is employer-based. They are very price sensitive. They will leave depending on price. Those low-income people who cannot afford MedSup, they leave depending on price. So, maybe somebody on the panel can tell me what I'm missing, but when we can comeback on the title of this presentation, The Future of Medicare Advantage, I have been doing this since 1971. I'm very pessimistic, so please tell me what I am missing here. [Interposing] [Laughter]

CARL MCDONALD: No question it's a difficult environment in 2014, particularly, there's going to be a very

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challenging year, but the way I see next year playing out to start there, as I think enrollment in the program is going to continue to grow, not nearly as much as what we have seen the last couple of years because of all these cuts, but I think some of the things to keep in mind is—you know, one is that there are just many seniors turning 65 now, than the case five or 10 years ago. There is a demographic aspect to it. Overall, most plans are looking at something in the vicinity of a 5-percent reimbursement cut in 2014. Now, if you're assuming that cost runs are going to rise a percent or two. It means plans are facing, somewhere in the vicinity of 700 basis point headwind, pricing down 5-percent, cost runs up too. Plans are going to be able to adjust the benefits in most the regions to be able to absorb the bulk of that. There are maybe a little bit of margin pressure as well, but I think, that type of reimbursement cut not too dissimilar to what we saw in 2010 when rates fell 5-percent. Now, things have been compounded over the last couple of years because rates have been going up, but I would think about 2010 is being a somewhat comparable example where reimbursement was down quite a bit. Plans were able to cut benefits, managed through it, and you actually did see the enrollment increasing in 2010. So, there is some historical precedent for some seemingly big reimbursement cuts being able to be mitigated by the cost efficiencies.

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MARK E. MILLER, PhD: I was going to say this once again, I think the change in the benchmarks have put the plans under pressure to find the efficiencies that in theory, they should have been pursuing all along, and so I do think that—I don't mean this, you asked what you're missing, and I mean I'm not saying that you're missing this—but what I see is a big change over the last three to four years, is the bids of the plans relative to fee-for-service have come down and they are creating the room under fee-for-service to finance the benefits. Each year, we keep looking at these bids and you tell me the bids come in and the plans themselves are projecting 9 and 10-percent increases in enrollment. They think they're going to be increasing enrollment. We're in an environment where everybody is pressurized. It's not just MA plans. Fee-for-service is under pressure. The same sequester that hits the MA Plans, hits fee-for-service. MA Plans can actually bid themselves away from some of that to some extent, although, they risk losing beneficiaries. Apparently this does not help you. But rightly or wrongly, the Congress set up the system to have higher benchmarks in those parts of the country where managed care can't do as well. That's an important policy question we ought to discuss, but one of the reasons that people might be optimistic is they are specifically subsidizing plans in certain parts of the country and then something else

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that other people said—I'm sorry, I talk so much, I did not mean to say all these. You know, the quality ratings, I mean, that will drive money to certain plans and I think if plans can leverage that, they can continue to even get additional resources to offer benefits. I don't mean to imply that you're missing anything, but that's what I look at and at least in the near term, that's what I see. You know, the projections 10 and 15 years out, I have no idea.

PAUL COTTON: Hi, I'm Paul Cotton with the National Committee for Quality Assurance. Thanks for a great panel. When we look at the scores that are coming in to us, we're seeing a lot of the plans that in the past were not very serious about their quality scores; and now that dollars are attached to them, they're being very creative. What are some of the examples that you're seeing from the panelists' perspective, the things that are helping to get the plan scores up? And also as a second question. Carl, in particular, how can we make those measurements more relevant to the beneficiaries, so they do actually care about them when they go to pick a plan? For example right now, when you go to the Plan Finder, Medicare lists them by the cheapest plan first and you have to really care and want to know what the quality score to find it. Maybe if they had the high quality plan first, will that help drive more enrollment to high quality plans?

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CARL MCDONALD: Yes. Let's say from the plan perspective, what the companies have done—as you said, they've actually started to care about them, now that there's some dollars attached. So, if you go to anyone of these companies, they'll have a whole team of people that will be able to tell you down to a contract—where are we on each specific matter? And so, what the companies have done is they first or after the low-hanging fruits, so if there's a county or a contract where they are currently at 3.8 stars and if they can get 50 more people and to see a primary care physician, that's going push them up to four. Well, that's where the first dollars are going to go to, and they'll start making outbound calls saying either to the doctor or to member, you need to go and then see your doctor, so it's been very, very targeted to this point. As the star rating starts to get better, it's going to be more difficult for the plans to see those kind of improvements because getting from a three and a half to a four star, obviously, is a much bigger jump than if you're right on the cusp, but that's what they've done up until this point. In terms of how you get seniors to care about it, I mean, your idea of the sorting, I guess, it's theoretically worth to try, but it just seems like every single selling season, it's — number one is what's the premium, then maybe right below that, is my doctor in the network, and then everything else is just

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so far down the list in terms of co-pays, deductibles, star ratings; just a huge gap between those first two and really everything else.

ALISSA FOX: I would add that plans are working hard to try to get better data because a lot of it has to do with getting the data, then employing the types of practices where you can see improvement and results. So, there's a lot of greater focus and I don't know—I agree with you that the people are paying attention to the ratings. I think you are seeing greater attention to the ratings, and I know that CMS is looking at using similar ratings for the exchanged product, so I think we are going to see a tension to these kinds of rating systems across the board.

ED HOWARD: Please go ahead.

BRIAN CONKLIN: Hi, my name is Brian Conklin. I am with the National Rural Health Association, and I'm wondering what effect do you see these payment reductions and other changes having on Medicare Advantage plans' relationship with rural safety-net providers, specifically critical access hospitals?

ALISSA FOX: I just think the cuts just need to be candid. Those cuts are huge up ahead and it's going to put a lot of pressure on payment rates to the providers, on keeping the benefits at the levels. You're going to see cutbacks in benefits. You're going to see increased cost-sharing and it's

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going to be difficult to maintain the kinds of levels we've seen, so we're very worried about all of that. I mean, the cuts ahead are just huge.

ED HOWARD: Please go ahead, Mike.

MIKE MILLER: I'm Mike Miller. I'm a Health Policy Consultant and blogger. Mark brought up the concept of how Medicare Advantage sort of competes in the same market as fee-for-service in different regions. One thing, I've heard about people talking about is that ACO or the Shared Savings Programs are in some ways like a training ground or minor leagues for full capitation or Medicare Advantage. Can anybody in the panel talk about those kinds of plans or organizations that evolving and growing into Medicare Advantage and how that might affect the future bandwidth for Medicare Advantage, both number of plans and number of enrollees. Thanks.

MARK E. MILLER, PhD: Actually, I don't know. Maybe people at the other end of the table would be in a better position to speak about this, being closer to the industry. But the people are coming into my office—so the people, who are coming into our offices and talking to us about ACO, seemed to mostly breakout on the side of—no, no, this is provider-driven organization, it is a different than an insurance organization, and there are certain advantages to that and even though, we

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might want to drive towards the capitation, or more often partial capitation environment, we're not thinking insurance. But then, I wouldn't—I don't know how characterize this in percentages or anything—there are people who can show off and say we're thinking down the road, we might jump the fence. But the sense is that most of the people are coming in and talking to us about the ACO stuff is, it's a different model and at least for the near term that's the way they're thinking about it, just a quick brush.

ALISSA FOX: Blue plans are partnering with a variety of ACOs including, we consider Patient-Centered Medical Homes are really the foundation of the ACOs and we have Patient-Centered Medical Homes now in almost all states and so we're partnering with those physician practices in our private business as well as our Medicare Advantage business, and we are also partnering with the hospital-driven ACO types as well. So as part of our arrangements, we will be incorporating those types of arrangements going forward.

CARL MCDONALD: I think the ACO concept is interesting, but it's a challenge for provider groups to become a managed care company. You basically need to transfer the actuarial underwriting capability of the managed care plans down to the provider level to really make that a success. We do have a nonprofit hospital conference in New York, and two years ago,

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all the providers and all the hospitals come in, gung ho. We're going to take risk. We're going to become managed care companies. We don't need them anymore. This past year, we did it and the direction is still the same, but the phase and the tone are very different from when we started this, and you know what, it's actually kind of complicated. These companies have doing it for decades and they still missed earnings every three years. So, the idea is that we can just come in and price it appropriately. I think they've realized this that it's a very significant challenge. They just don't have that infrastructure today, and so I think the one thing that the plans are doing better this time around relative to the physician practice management issues of a couple of decades ago is rather than plans giving risk to any provider group that's willing or dumb enough to take it, as Mark said they are starting sort of baby steps year. So year one is here's your cost threshold. If you stay below, you get a bonus. If you go above it, that's okay, try better next year. Year two is double-sided risk and then potentially at some point down the road, you can have providers taking on full risk as opposed to jumping into it from day one.

AL MILLICAN: Al Millican, AM Media. Bipartisan letters from the Congress more than 160, I see in one of the handouts to CMS, the Centers for Medicare and Medicaid Services. How effective were these? [Interposing] Well, the changes, the cut

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that turned into an increase earlier this year.

ALISSA FOX: You're talking about the update about what the assumption was with respect to the physician payment update. We felt that CMS should have always assumed that Congress would fix the payment rate in the Medicare Advantage update for several years. We wrote to CMS, I think, it was three years ago, with the legal opinion saying that it did not make any sense to assume that Medicare Advantage that there would be a big payment cut of the physicians that would be included in the Medicare Advantage update which essentially cut significantly and then you pay it back the year after. That's not the way we set our contracts with hospitals and doctors, so we think it was very important that this year in particular, when Medicare Advantage Plans were facing such a significant cut, to make sure that the payment rates reflected the correct assumption with respect to the physician fee schedule that there wouldn't be the kind of cuts that were initially put into the fee schedule, as for the last, I think, it was 10 years. There's always been an assumption in baseline that doctor fees would be cut, but the Congress has acted every year in that period to make sure that didn't happen. So, we were very supportive of the CMS's final decision on that.

CARL MCDONALD: I may have my timing off here a little bit, but the bipartisan letters have support. I think, at the

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end of the day, probably it didn't end up mattering in the sense studies all of these have come out about who knew, what, when. It seems like after the initial rates came out in February; fairly shortly after that within a couple of weeks, they made the decision that they were going to fix the payment rates to the Medicare Advantage plans. So, by the time the bulk of those letters came out, I think the decision have already been made internally that they would give the plans some relief on a based payment.

AL MILLICAN: If they had been earlier, would've it made more a difference? Do you think? [Laughter]

CARL MCDONALD: Yes, I think, it you can't hurt. I mean, I think part of it is who's sending a letter. So if like the Florida Delegation is sending a letter, well, of course, they're sending letters, like everybody in Florida is on Medicare Advantage plans, so it matters a little bit more who the people are and whether it's some nontraditional.

DIANE ROWLAND: We like to think the letters matter, [laughter] so it is just how much do they matter. It's an unanswerable question. Next.

HARVEY SLOANE: Harvey Sloan with the Eurasian Medical Education Program. I wonder if you can talk a little bit about primary care physician recruitment. Is that a problem? Is it more of a problem with the fee-for-service with increased

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beneficiaries now? Are you seeing that as a big situation that's going to deal with?

ALISSA FOX: Yes, we believe. We've been focusing a lot of our efforts on trying to increase primary care to place a greater emphasis on primary care. That's why we think the Patient-Centered Medical Homes are so critical and such a major foundation as a way of trying to improve care to people. I haven't seen the numbers on graduation rates and how many people are going into primary care recently; but I know that, our plans are working closely. In fact, some our plans have actually partnered with medical schools to try to get more graduation rates and more people going in to primary care residency, so that is a major focus of plan efforts across the country.

MARK E. MILLER, PhD: Again, it's just a little bit off the subject, but I think your question is also broader. So, in our work, we survey beneficiaries every year for access problem. We've seen a lot of stability in their access, but to the extent, there is noise, each person is looking for new primary care physicians. The Commission has made a series of recommendations to try and rebalance the physician fee schedule in order to move resources towards primary care and away from procedural services, and I can walk you through the gory detail, but that's something that we are worried about. Sorry,

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back to you.

DIANE ROWLAND: Okay. And for Alissa, you've talked a lot about the impacts of the cuts and that they will be devastating. So, this question is what tools do you have or do Blue Cross Blue Shield plans have and plan to use to try mitigate the increased cost, especially those imposed by the ACA Health Insurance Plan. So, what will happen from these cuts?

ALISSA FOX: First of all, we are urging Congress to repeal that tax for everybody. It is very expensive. It's going to add significantly not only to Medicare Advantage premiums but to premiums to individuals and small businesses. It adds, for small businesses or a family, \$400 a year according to the Joint Committee on Taxation, so we're working to try to repeal that tax. That's difficult because it saves a cost of 100 billion dollars, so you have to find it and offset, which is obviously challenging and plans are working to constantly try to work with their providers. We're working on Patient-Centered Medical Homes. CareFirst, for example, they're not Medicare Advantage, but CareFirst has shown again for second year in a row, I think it was 2.5-percent savings from their second year of their program. And so plans across the country are working closely in partnership with their hospitals and doctors to rein in costs, employ better management techniques. But when you

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look ahead, the health insurance tax is clearly a tax since it's going to increase the cost to beneficiaries, both in terms of Medicare and Medicaid. It is a cost to Medicaid, Federal employees, and to others, so it is a big problem.

DIANE ROWLAND: What are some of the actions that plans can take to reduce their cost at the beneficiary end of the day? I mean, how are you changing what services are provided or what reviews are being done to beneficiaries?

ALISSA FOX: Well, each plan will look at their own situation, but people may be increasing cost-sharing, may look at reduced benefits, doing more coordination and management. You don't really want to increase cost-sharing or reduced your benefits. You're going to look at more efficiencies in your system, but everyone's going to look at their own plan and try to be as efficient as possible, try to get the prices down. If they're paying their hospitals and doctors, employ more coordination and management of services before cutting back those benefits to increase cost-sharing, but my is guess it's just going to be a combination of all of those.

CARL MCDONALD: And just one quick add on to this, I think one thing you will see in 2014, not to a wide extent but you will see in a couple of markets, is plans exit. I think in a couple of cases, maybe more to make a point to CMS than anything else. Think of the company like United or Humana

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picking three rural markets where they don't have a lot of members and just leaving in the county. Basically, just to be able to make a point to CMS next year that if you put us through this rate situation again, there will be consequences. No rates got cut in 2014. We exited these counties. We'll do it again if we have to. It's not going to be widespread but, I think, you will see a little bit of that in response.

ALISSA FOX: And that's a major concern because we know what the beneficiaries want is security and stability of their benefits. As I mentioned, the older people, they're very concerned about their healthcare expenses because they are so significant. I think, just last week, there is an article in the post about the financial stability of older people's healthcare expenses and it's a great worry for people so we're very concerned about the impact.

STUART GORDON: Stuart Gordon from WellPoint again. Let me run an idea by you that we've been knocking around the public policy offices and that is we've heard that star ratings don't have a huge impact on beneficiary choice of plans. So, supposed CMS could essentially assess star ratings on folks and fee-for-service, collate them by county or by something commensurate to the plans in the state, and put the rating for the fee-for-service enrollees on the report card with the ratings for the plans. With that take, would that make the

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ratings for the plans anymore relevant? Dr. Miller, you may know how difficult that would be for CMS or Gretchen, you might know?

DIANE ROWLAND: Actually, we even have a question asking Mark to comment on how you would compare quality in fee-for-service to managed care if you're trying to achieve neutrality between the two.

MARK E. MILLER, PhD: We actually did an extensive report on this and the report is now I'm going say at least three years old. I'm getting a nod. There are several issues and some of this goes to one of the big issues that arise is you have a different structure. We think the research suggests that and so anything you put out there, you have to be able to kind of subtract through the differences and risk and that's not a simple thing, not necessarily impossible, but not a simple a thing. And another issue that arises is kind of the geography, like sometimes you say, well here's the plan, but the plan has reached across many different markets and to truly make those comparisons fair, which you probably ended up needing to do is comparing the plan in that market to fee-for-service versus the plan as an entity across many markets in the country. Those are at least a couple of challenges. Then the report goes into much more detail, some of the differences in the measures and what would have to change in order to do this,

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and this is an extraordinarily tall order and would be very expensive. And when we put the report out, it was a requested report to Congress, we said these are the kinds of steps you have to take—and I only touched a few of ones that I can remember of the top of my head—but also CMS would need to be given the resources to pull this off because it would be a very big undertaking. But you're absolutely right, we think in terms of payment neutrality, which I again did not have time to say this, where you ultimately want to be in terms of payment neutrality is that if managed care has an entity, I don't think this proposition is there yet, notwithstanding in some of the research that was cited, if managed care is better quality product, then payment should reflect that relative to fee-for-service and the signal to the beneficiary should be, well, there's higher quality over here. So, we definitely agree that this matrix should be established and that comparison between the two settings should be made, but it's a tall order and that was written up a few years back and maybe it will give you something to work with.

ED HOWARD: Good answer.

DIANE ROWLAND: Alissa, this question—is if you are a beneficiary, why you should choose an MA Plan instead of one of the Blue's Medigap plans?

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ALISSA FOX: Well, we're lucky, we offer both. [Laughter]
So, we think people should have a choice of plans. So, all Blue plans offer Medigap and most plans also offer Medicare Advantage and people choose Medicare Advantage for the coordinated care they get. They get lower cost-sharing and higher benefits and so we think a lot of people make the decision for those reasons.

DIANE ROWLAND: And the follow-up question was does the CAP apply in your Medigap plans the same way as it does in the Advantage plan?

ALISSA FOX: It does apply in the Medigap but you pay a lot of money for it and you can't charge for it in the Medicare Advantage program so there are additional requirements in the Medicare Advantage that are above what people in traditional fee-for-service get.

DIANE ROWLAND: And then for Gretchen, are the quality measures in the Star System good enough or have they've been improved?

GRETCHEN JACOBSON, PhD: [Laughter] Okay, so we've done a fair amount of work looking at the quality star ratings and I think as Mark mentioned, they are comprised of a lot of different measures and pretty much most of the measures that are currently out there that could be used. So, they are comprised of HEDIS measures which measure whether or not

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physicians are doing the appropriate test. Also include the health outcome survey measures. They also include the CAHPS measures which assessed whether patients are satisfied with their plans and then they also included administrative measures. So everything such as, do they have the right translators to their customer service? So, given that they include all of these measures, I think, some have raised some questions as to whether or not there needs to be a different balance to the measures or some measures to be weighed more than others and I think that it's still debated and still up in the air but they do include many quality measures in them.

ED HOWARD: Alissa, you want to add to that? Okay. Mark, we have a question that came in advance directed to you but it's not really fair to direct it completely to you [laughter] because it quotes the Medicare trustees' report saying that the Medicare Advantage plan bid assumptions were lowered to reflect recent data suggesting that certain provisions in the Affordable Care Act will reduce growth in these costs by more than was previously projected. What are the recent data that were referred to? And as I say, I don't want to hold Mark responsible for what the trustees and anyone on the panel who would want to respond to that should feel free. [Laughter] [Interposing]

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ED HOWARD: Okay, you stumped the panel. [Laughter].

Well, we have, go ahead, Diane.

DIANE ROWLAND: I think we're done.

ED HOWARD: We've run of card questions. We've exhausted the people at the microphone. [Interposing] And you should take the time while Diane is digesting and reading this question out loud to fill out the blue evaluation forms that are in your packets for our identification after you're done.

DIANE ROWLAND: I would only say, I think the Star System has generated a lot of interest so in our last question that we will take today, some plans have complained that they've been scored on some Star criteria before they knew what the criteria were. Is this a problem, and is HHS working to improve this? And I do know we don't have anyone from HHS on the panel.

ALISSA FOX: Well, I would say sort of our concerns about this. We always thought it should go through the normal notice in common periods so that you know what the criteria are, and there'd be an opportunity to comment through it and that doesn't really happen. There's a lot of guidance today and so we would like to see a more formalized process underway.

DIANE ROWLAND: Is there are any indication that the department is moving to a more formalized process?

ALISSA FOX: Not that we're aware of.

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ED HOWARD: If there's any one in the audience from the department who like to chime in on this, they should feel free [laughter] or not.

DIANE ROWLAND: Well, obviously, there are a lot of interests in being able to assess how well the beneficiaries may go when they are choosing one managed care plan over another or over fee-for-service. I think we've seen a lot of issues raised today, but I think we also are hearing very clearly that we need better ways to measure what we're getting for what we're paying and also for how to pay, and I know that MedPAC and everyone in town is going to continue to work on this challenging issue and next time we won't put Mark on the spot as often.

ED HOWARD: And I would just add to that, that we're going to continue our examination of different aspects of Medicare in another briefing we are bringing to you with the partnership of the Kaiser Family Foundation next month on the fee-for-service cost-sharing plan proposals that are floating around on Capitol Hill and elsewhere. So we look to deepen our knowledge about a different part of Medicare program at that point. And I would just say thank you for keeping the conversation going in a very lively and useful direction and we thank the Kaiser Family Foundation for their contribution for

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making this a success. I ask you to help me thank the panel for
a very useful conversation. [Applause]

[END RECORDING]

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