Medicare Advantage:

Key Issues and Implications for Beneficiaries

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Statement of Patricia Neuman, Sc.D

Chairman Spratt, Mr. Ryan and distinguished members of the Committee, thank you for inviting me here today to discuss the role of Medicare Advantage plans. I am Patricia Neuman, a Vice President of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project.

The proliferation of private health plans under Medicare is fundamentally changing the coverage landscape for the 44 million people on Medicare, presenting new choices and challenges. In the past few years, we've seen millions of beneficiaries take up new coverage under Medicare Advantage plans for prescription drug and other Medicare benefits. Today, a record number of health insurance companies are contracting with the government to offer Medicare Advantage plans, including HMOs, PPOs, Private Fee-for-Service plans and special needs plans. Virtually all beneficiaries, including those living in rural areas, now have access to one or more Medicare Advantage plans, and in many areas, beneficiaries can choose from dozens of plans. Enrollment in Medicare Advantage plans is at an all-time high and projected to rise rapidly over the next several years (Exhibit 1).

Enrollment in Medicare Advantage plans is highly concentrated among a small number of firms (Exhibit 2). UnitedHealth leads in terms of overall enrollment, covering one of every six Medicare Advantage enrollees nationwide. Together, UnitedHealth, the Blue Cross/Blue Shield affiliates, Humana and Kaiser Permanente enroll more than half of all Medicare Advantage enrollees.

The Medicare Advantage program is now a subject of heightened interest for many reasons, not the least of which is the impact on Medicare spending. CBO, the HHS Office of the Actuary, MedPAC and academic researchers report that Medicare now pays more per beneficiary than it would pay for the same beneficiaries under traditional Medicare. Higher payments to these private plans, coupled with the rapid expansion of the Medicare Advantage program, have important implications for Medicare's fiscal health, and for beneficiaries' coverage and out-of-pocket costs.

My testimony draws on a number of studies commissioned and conducted by the Kaiser Family Foundation, as well as other reports. This testimony provides an overview of the characteristics of beneficiaries enrolled in Medicare Advantage plans, discusses benefits provided by plans to enrollees, and examines key issues for beneficiaries and for Medicare's future.

Characteristics of Medicare Advantage Enrollees

The number of Medicare beneficiaries enrolling in Medicare Advantage plans is on the rise, yet the majority of Medicare beneficiaries continue to be covered under Medicare's traditional fee-for-service program (Exhibits 3). Today, 8.7 million beneficiaries - about 20 percent - are enrolled in a Medicare

Advantage plan, up from 5.3 million in 2003, but there is wide variation in enrollment rates across states (Exhibit 4). Fewer than 10 percent of beneficiaries are enrolled in a Medicare Advantage plan in 19 states, while more than 30 percent of beneficiaries are in Medicare Advantage plans in 8 states.

Recent discussions have focused on whether Medicare Advantage plans serve a disproportionate share of people who are among the most vulnerable in Medicare, focusing on income, race/ethnicity, and rural location. Our analysis of the most recent data available from the Centers for Medicare and Medicaid Services (CMS) in the 2005 Medicare Current Beneficiary Survey finds:

- *Income*. Medicare Advantage enrollees are neither disproportionately low-income nor high-income (Exhibit 5). Roughly the same share (50 percent) of beneficiaries in traditional Medicare and in Medicare Advantage plans lives on an income below $20,000.

    - About one in ten beneficiaries with incomes below $10,000 is enrolled in Medicare Advantage plans; for this group, Medicaid is the primary source of supplemental coverage. For those with incomes above $10,000, Medicare Advantage enrollment rates are higher, but employer and individually-purchased Medigap policies play a far more prominent role in providing supplemental coverage. (Exhibit 6).

- *Race/Ethnicity*. Medicare Advantage enrollment rates are similar for white and African American beneficiaries (Exhibit 7). A larger share of Hispanic beneficiaries is enrolled in Medicare Advantage plans; half of all Hispanic Medicare Advantage enrollees live in California and Florida.

- *Rural Location.* Access to Medicare Advantage plans for beneficiaries living in rural areas has increased considerably in the past two years. In 2005, only 2 percent of all Medicare beneficiaries living in rural areas were enrolled in a Medicare Advantage plan (Exhibit 8). In 2006, the rate was up to 7 percent, according to MedPAC's more recent analysis of enrollment data.

- *Health Status.* Self-assessed health status is generally considered to be a relatively strong predictor of future medical needs and our analysis finds a smaller share of Medicare Advantage enrollees reporting that they are in fair or poor health than their counterparts in traditional Medicare (Exhibit 9). Medicare Advantage plans also enroll a smaller share of beneficiaries who are under age 65 and have permanent disabilities, as well as a smaller share of beneficiaries living in nursing homes and other institutional settings.

It will be important to track the characteristics of Medicare Advantage enrollees over time, as new data become available, given the growth in enrollment that has occurred since 2005.

Benefits and Out-of-Pocket Costs

While Medicare Advantage enrollees are generally healthier than beneficiaries in traditional Medicare, a key concern for the 24 percent of Medicare Advantage enrollees who say their health status is fair or poor is likely to be the adequacy of their plan's coverage and out-of-pocket costs associated with their medical care.

Medicare Advantage plans generally provide benefits that are covered under the traditional Medicare program, but are permitted to vary cost-sharing and deductibles as long as the overall benefit package is equivalent in value to traditional Medicare. In addition, many plans provide additional benefits to their enrollees that are not covered under traditional Medicare. Current law requires plans to use 75% of "extra payments" (the difference between the plan's bid for services under parts A and B and the benchmark amount determined by CMS) to fund extra benefits, which are broadly defined and can include marketing and other administrative costs.

Beneficiaries may be attracted to Medicare Advantage plans by the promise of additional benefits and lower cost-sharing, but beneficiaries are not always better off financially in Medicare Advantage plans than in traditional Medicare. For any given beneficiary, out-of-pocket costs depend on many factors, including their individual medical needs and the particular plan they choose. On the one hand, many Medicare Advantage plans waive deductibles, reduce cost-sharing requirements, offer a stop-loss limit on catastrophic spending for services covered under Parts A and B and provide some additional benefits, including Part D drug coverage, and other benefits, such as vision and dental. On the other hand, many Medicare Advantage plans impose daily hospital copayments, daily copayments for home health visits, and daily copayments for the first several days in a skilled nursing facility that are not required under traditional Medicare.

Of course, extra benefits may result in lower out-of-pocket costs for some beneficiaries. Yet, even with extra benefits, enrollees could end up paying more in a Medicare Advantage plan than they would pay under traditional Medicare, which may seem counter-intuitive. Consider the following hypothetical case of an 80-year old widow, Mrs. Rollins, who broke her hip, was admitted to the hospital for eight days, transferred to a skilled nursing facility for 27 days, and then sent home where she received 47 home health visits to support her rehabilitation. For ease of illustration, this case example does not take into account the variety of other medical services and supplies she may need.

- If Mrs. Rollins were covered under traditional Medicare, she would pay $1,860 out-of-pocket in traditional Medicare, plus $1,122/year in Part B premiums for a total of $2,982. She would pay this amount regardless of where she lives because Part B premiums, deductibles and skilled nursing facility copayments are uniform throughout the country.

- If Mrs. Rollins lived In Oakland, California (zip code 94601) and chose to enroll in a Medicare Advantage plan, she would be able to choose from nearly two dozen Medicare Advantage plans in her area. Under five of the plans, she would pay less than she would under traditional Medicare for premiums, hospital and post-acute care (although none of these plans include a prescription drug benefit). But under the majority of plans offered in her area, she could pay substantially more out-of-pocket than she would under traditional Medicare for her medical needs in this scenario (Exhibit 10), with annual out-of-pocket costs, including premiums, ranging from $2,515 to $5,210.

- In Pensacola, Florida (zip code 32425), a more rural area, there are fewer Medicare Advantage plans available, but a similar picture emerges. Mrs. Rollins would pay less under four plans than she would under traditional Medicare, but under the remaining 12 plans, she would pay more, with total costs ranging from $2,515 to $6,062 across all plans offered in her area (Exhibit 11).

Mrs. Rollins could end up with lower out-of-pocket costs under a Medicare Advantage plan than she would under traditional Medicare. However, a big challenge for beneficiaries like Mrs. Rollins is predicting what services they are likely to need before they enroll in a plan. This is especially difficult given the wide variation in benefits which severely limits the ability of consumers to make apples-to-apples comparisons across plans.

A review of plans in Oakland and Pensacola raises a number of issues.

- Seniors with inpatient and post-acute needs could pay substantially more for their medical care under some Medicare Advantage plans than under traditional Medicare; this is true even in plans that have out-of-pocket spending limits as many Medicare Advantage plans do.

- For seniors with limited incomes, out-of-pocket costs may consume a significant share of income. If Mrs. Rollins' income is equal to the mean for Medicare beneficiaries, which is about $18,000, her average out-of-pocket costs for premiums, hospital and post-acute care could consume between 14 percent and 29 percent of her income in Oakland. Under traditional Medicare, she would pay 17 percent of her income in premiums and cost-sharing for these services.

- Some plans charge daily copayments for hospital stays that can add up to substantially more than the Medicare Part A deductible ($992).

    - One Private Fee-for-Service plan in Oakland requires a $124 per day copayment for the first 24 days in a hospital; another HMO charges $275 per day for the first 10 days in the hospital.

    - Some plans have daily fees for the front end of a skilled nursing facility stay, unlike traditional Medicare which has no cost-sharing for the first 20 days. One Oakland plan for example, charges $90 per day for days 4-100 in a skilled nursing facility; and some impose coinsurance for each home health visit, unlike traditional Medicare.

- Annual supplemental premiums vary widely ($0 to $1,932 in Oakland) and can contribute significantly to annual costs. Some plans with supplemental premiums do not offer a prescription drug benefit.

- Most but not all Medicare Advantage plans offer prescription drug coverage; some plans with supplemental premiums do not offer prescription drug benefits; none of the plans offered in Oakland or Pensacola cover brand-name drugs in the Part D coverage gap, consistent with national data (Exhibit 12).

Equity Concerns: Who Gets Extra Benefits and Who Pays?

Relatively generous payments allow Medicare Advantage plans to offer extra benefits to enrollees, as noted above. As a result, the current payment system essentially finances additional benefits for the one in five beneficiaries who are enrolled in Medicare Advantage plans, without providing similar coverage to the other four out of five beneficiaries enrolled in traditional Medicare. This un-level playing field has raised questions about the extent to which Medicare distributes extra benefits equitably across the Medicare population.

A second equity issue relates to financing; the current payment system translates into higher Part B premiums for beneficiaries to help support higher payments to Medicare Advantage plans. This is because Medicare Advantage plans cover benefits under Medicare Parts A and B, so the costs associated with Part B benefits provided by Medicare Advantage plans are financed by general revenues (paid by taxpayers) and by Part B premiums (paid by all beneficiaries, or by Medicaid which pays premiums on behalf of low-income beneficiaries who have Medicaid as a supplement to Medicare).

As a result, nearly 30 million beneficiaries in traditional Medicare pay higher monthly Part B premiums to help support the current payment system to Medicare Advantage plans, but of course do not receive the extra benefits that Medicare Advantage plans offer to their enrollees. The HHS Office of the Actuary recently reported that the current Medicare Advantage payment system has increased Part B premiums by an additional $2 per month. It is worth noting that many of the beneficiaries in traditional Medicare who are paying higher Part B premiums to support higher payments to Medicare Advantage plans live on fixed incomes, and can ill-afford additional financial burdens.

Further, the current payment system has the effect of cutting short by two years the solvency of the Part A trust fund, according to the HHS Office of the Actuary, potentially affecting coverage for current beneficiaries as well as younger adults who are approaching the age of Medicare eligibility.

Summary

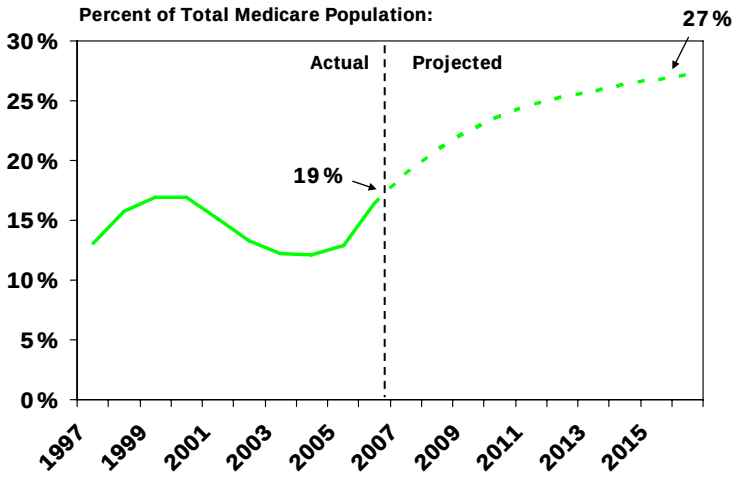
The Medicare Advantage program plays an important role as an alternative to traditional Medicare; however, the on-budget costs associated current payment policies, coupled with rapid enrollment growth in relatively high payment areas, raise a number of important policy questions.

Critical questions relate to whether the positive attributes of the Medicare Advantage program are balanced by the higher costs associated with the current payment system. Relatively generous payments to plans from Medicare help to provide extra benefits to a subset of beneficiaries who enroll in a plan, raising questions about the extent to which Medicare distributes extra benefits equitably across the entire Medicare population. The current payment system also increases program expenditures, cuts short the life the Part A trust fund by two years and increases Medicare premiums, leading some to question the affordability of Medicare Advantage for beneficiaries and taxpayers in light of the long-term fiscal challenges facing Medicare.

Future research is needed to monitor coverage, care and costs associated with the Medicare Advantage program, and to gain insights that may be used to strengthen and improve care for the majority of beneficiaries covered under the traditional Medicare program.

Exhibit 1

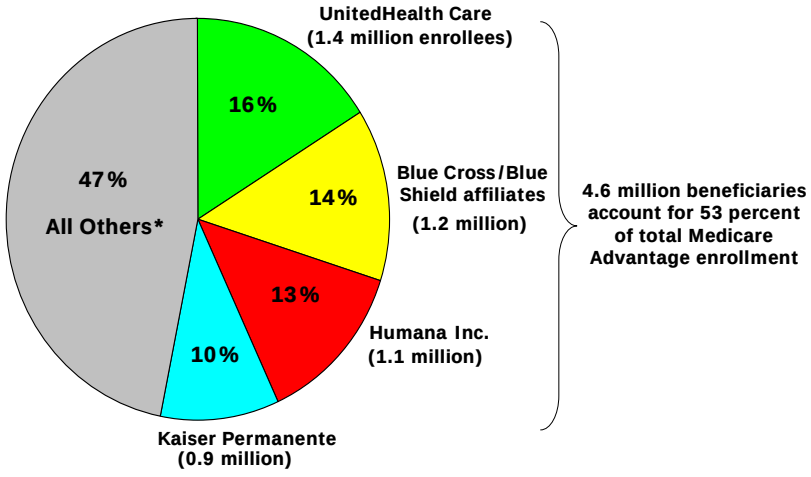
Actual and Projected Medicare Advantage Enrollment, 1997-2016



SOURCE: Centers for Medicare and Medicaid Services, 2007 Medicare Trustees Report Table IV.B6.

Exhibit 2

Enrollment in Medicare Advantage plans is highly concentrated

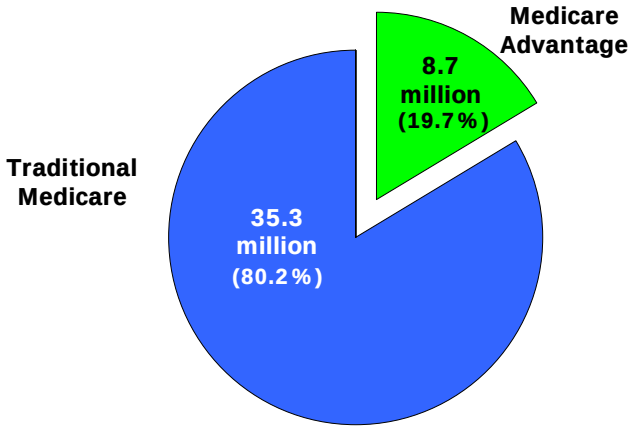


Total Medicare Advantage Enrollment = 8.7 million

NOTE: All Other Medicare Advantage Plans includes plans with enrollment less than 230,000 beneficiaries. Total for Blue Cross/Blue Shield affiliates provided by Blue Cross/Blue Shield. Numbers rounded. Data as of May 15, 2007. SOURCE: Centers for Medicare and Medicaid Services (CMS), June 2007 Monthly Summary.

Exhibit 3

Medicare Advantage Enrollment, June 2007



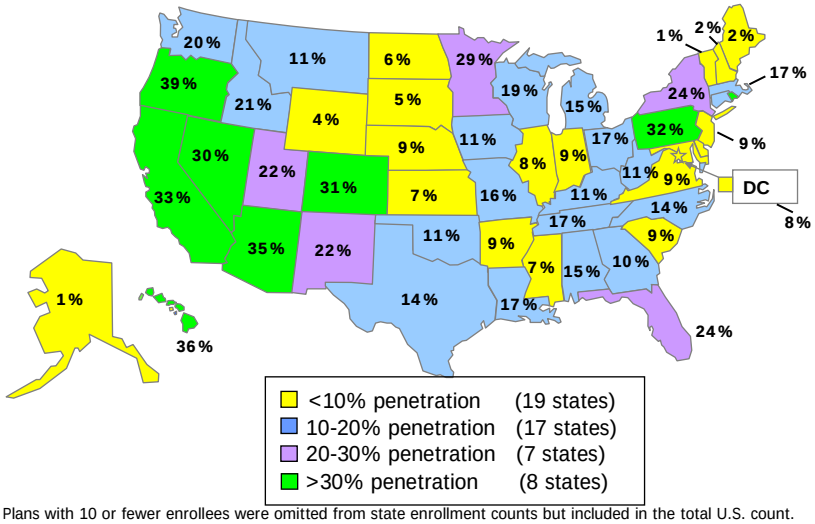
Total Medicare Beneficiaries = 44 million

Source: Centers for Medicare and Medicaid Services (CMS), Monthly Tracking Report, June 2007.

Exhibit 4

Medicare Advantage penetration varies by state

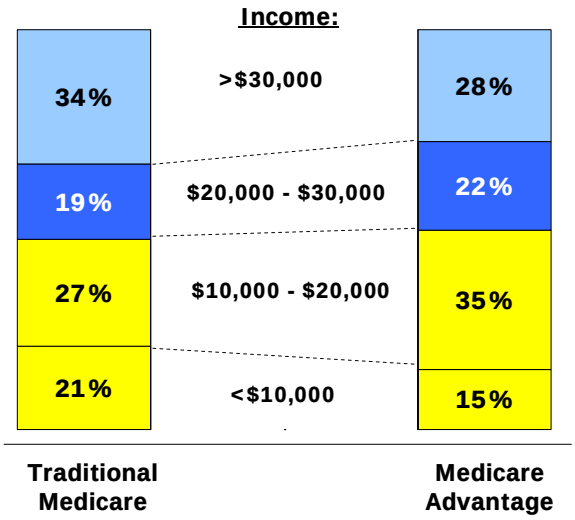
U.S. Penetration, June 2007*: 19.7%



NOTE: Plans with 10 or fewer enrollees were omitted from state enrollment counts but included in the total U.S. count.
Source: Centers for Medicare and Medicaid Services (CMS), June 2007.

Exhibit 5

About half of all beneficiaries in traditional Medicare and in Medicare Advantage plans live on incomes below $20,000

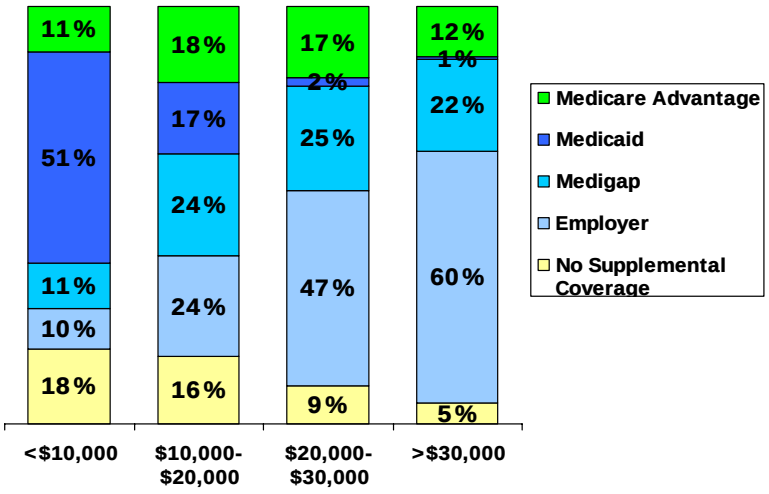


NOTES: Numbers do not add to 100% due to rounding. Data exclude 3.6 million beneficiaries due to missing income data.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 6

Across all income groups, most are in traditional Medicare

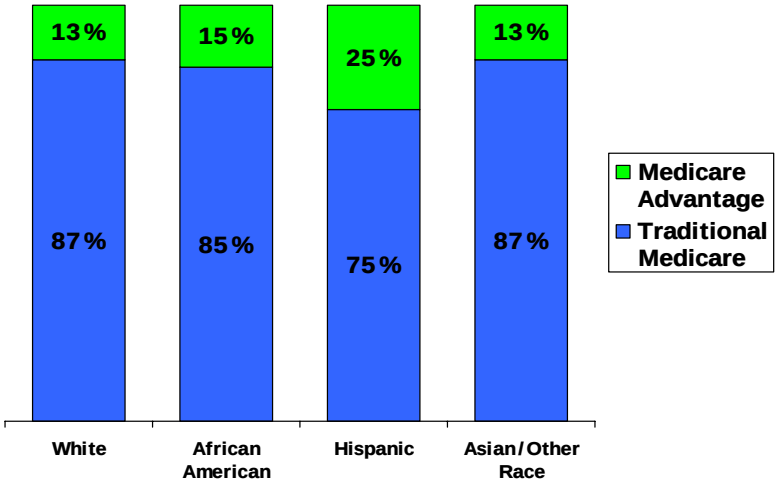
Medicaid is the primary supplement for low-income beneficiaries



NOTES: Numbers do not add to 100% due to rounding. Excludes beneficiaries with "other" public sources and those with missing income data. Employer includes those with TriCARE/Military coverage.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 7

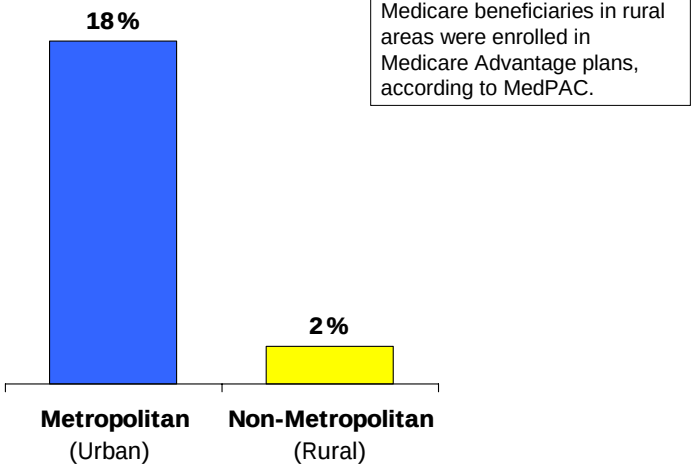
Medicare Advantage enrollment rates are similar for White and African American beneficiaries; enrollment rates are higher among Hispanic beneficiaries



NOTES: Numbers do not add to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 8

A small but growing share of beneficiaries in rural areas are enrolled in a Medicare Advantage plan

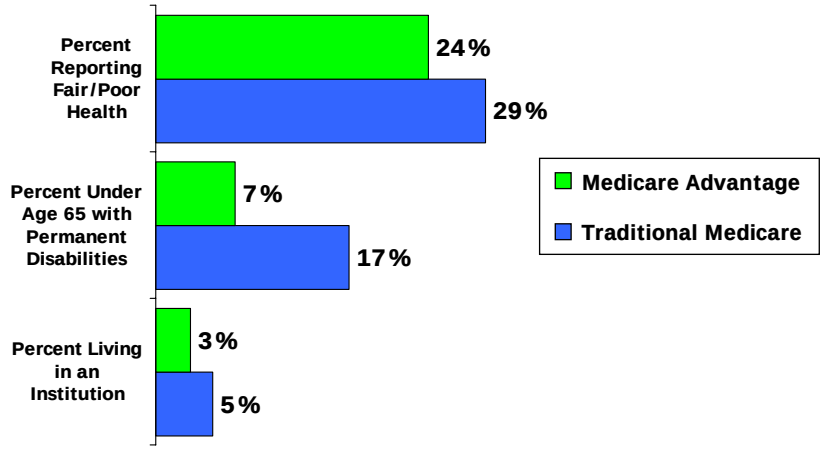


Note: As of 2006, 7% of Medicare beneficiaries in rural areas were enrolled in Medicare Advantage plans, according to MedPAC.

SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 9

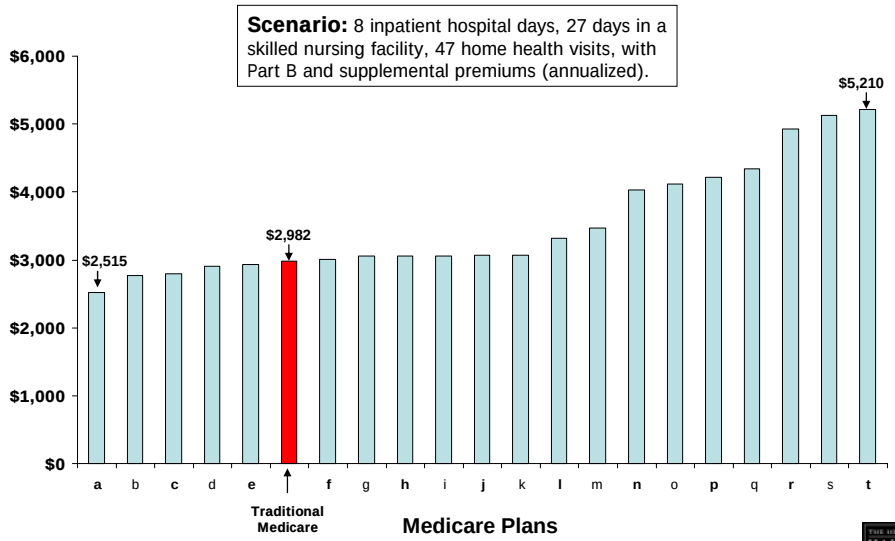
Medicare Advantage enrollees are generally in better health than beneficiaries in traditional Medicare



SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

Exhibit 10

Comparison of Out-of-Pocket Costs for Hypothetical Elderly Woman in Traditional Medicare and Medicare Advantage Plans (Case Example, zip code 94601, Oakland, CA)

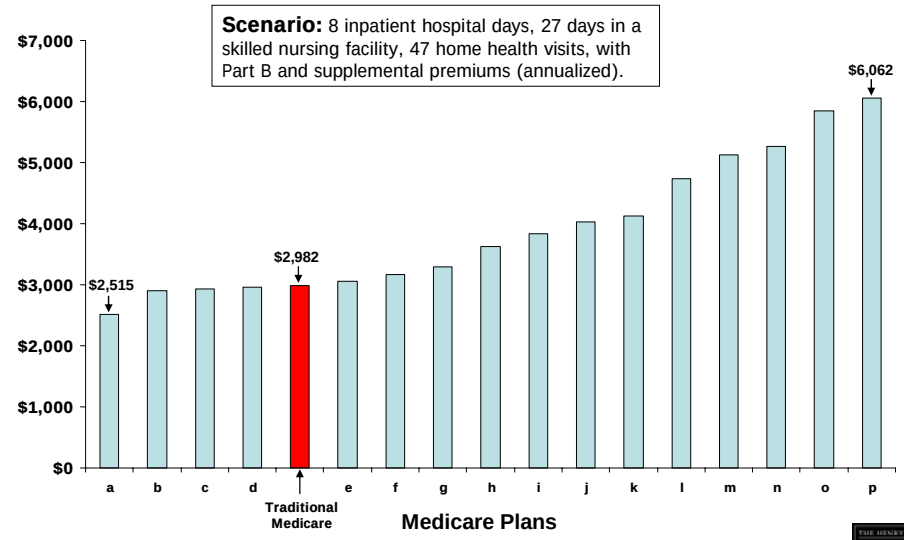


NOTE: Numbers correspond to the available Medicare Advantage plans on the Medicare Compare Plan Finder.
SOURCE: Kaiser Family Foundation analysis of www.Medicare.gov Medicare Compare Plan Finder.

Exhibit 11

Comparison of Out-of-Pocket Costs for Hypothetical Elderly Woman in Traditional Medicare and Medicare Advantage Plans

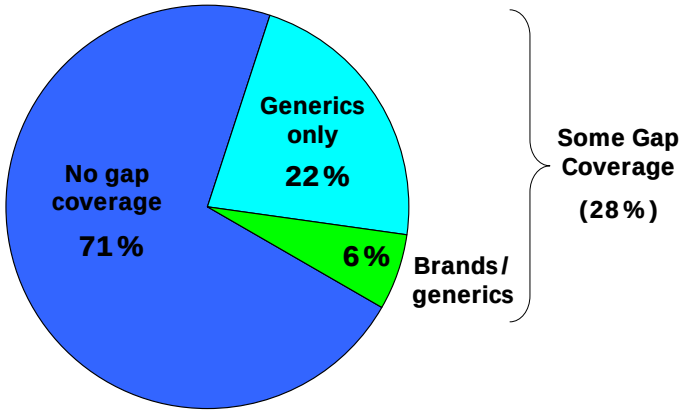
(Case Example, zip code 32425, Pensacola, FL)



NOTE: Numbers correspond to the available Medicare Advantage plans on the Medicare Compare Plan Finder.
SOURCE: Kaiser Family Foundation analysis of www.Medicare.gov Medicare Compare Plan Finder.

Exhibit 12

More than two-thirds of Medicare Advantage Prescription Drug Plan enrollees were in plans without gap coverage in 2006



NOTES: Numbers do not add to 100% due to rounding.

SOURCE: Cubanski, Juliette and Patricia Neuman. "Status Report on Medicare Part D Enrollment in 2006: Analysis of Plan-Specific Market Share and Coverage," *Health Affairs*, 2006.