



## Testimony

# Medicare Advantage: Assessing the Impact of ACA Funding Reductions

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Chairman Pitts, Ranking Member Pallone and Members of the Energy and Commerce Health Subcommittee, thank you for inviting me to discuss impact of funding reductions in the Patient Protection and Affordable Care Act (ACA) on Medicare Advantage. In this testimony I seek to make three key points:

- 1) Medicare Advantage is a vital program that gives seniors needed options and provides value;
- 2) The ACA was sold to Congress and the public with a promise that those who liked their coverage could keep it. We know this is not true with regard to the private insurance market, and due to cuts in the ACA it is proving untrue for Medicare Advantage beneficiaries as well; and
- 3) The Medicare Advantage cuts are already having a negative impact on enrollment and seniors' plan choice. Those most hurt by the cuts are low-income seniors in rural areas without other options for supplemental Medicare coverage. Additional scheduled cuts in the future will broaden the damage to Medicare Advantage.

## Background

Medicare Advantage (MA) is an option within Medicare in which beneficiaries elect to have their benefits covered by a private company. The companies then design plans that cover the standard Medicare services, or more. Depending on the plans' bids and whether prescription drug coverage is included, the MA plan may charge a small premium to enrollees above what they would pay for Part B and/or Part D coverage in traditional Medicare. Surveys indicate that the program is popular and successful. Enrollment has increased every year since 2004 and reached 14.4 million individuals in 2013, which represents 28 percent of the Medicare population.<sup>[1]</sup>

Seniors choose MA plan over the traditional Fee For Service (FFS) for numerous reasons, but key among them are access to coordinated care, preventative care services, supplemental benefits, and lower out of pocket liabilities.

As a result of the fixed payment per enrollee, Medicare Advantage plans are designed with the financial incentive to keep patients healthy and provide the best care in cost-effective settings; often this means coordinated care. This differs from the silos, duplicative care, and lack of provider communication that characterize FFS Medicare. In fact, traditional Medicare is changing itself with Accountable Care Organizations and other care coordination efforts, to become more like many MA plans.

Successful MA plans are tremendously innovative in how they work with seniors to manage chronic conditions and post-acute care. Plans are experimenting with both high-tech and low-tech solutions, everything from surgery checklists to nurse-led care teams making house calls to wearable telehealth technology in a patient's

home. Because they are working with a smaller population and a limited provider network, MA plans can experiment with different payment models and care initiatives to determine affordable solutions for patient care.

In addition, MA plans often offer supplemental services not covered by FFS. This is particularly important for lower-income seniors who may not have other avenues to access dental or vision services. Since there are a range of plans with a variety of supplemental benefits, a Medicare beneficiary with robust plan choice in his area can compare plans and choose one that best suit his or her needs.

Lastly, MA is valuable for seniors without access to retiree coverage or a Medigap plan because the cost sharing is generally lower than FFS and has a maximum cap on out of pocket spending. Seniors paying MA premiums have more predictable annual costs and can better budget for their health care needs.

## **Impact of ACA Reductions on MA Funding**

A central feature of the budgetary structure of the ACA is to pay for the new and expanded entitlement programs by cutting Medicare benefits. The law takes \$200 billion from MA payments over 10 years, which is estimated to result in 4.8 million fewer beneficiaries by 2019 compared to the previous enrollment projections.<sup>[2]</sup> In addition to payment cuts, the law includes a health insurance tax that will be paid by most companies offering MA plans.<sup>[3]</sup>

There has been much speculation about the impact of the ACA cuts to MA plans. The common threads running through analyses of the MA landscape in 2014 are (1) fewer plan choices, (2) higher costs to beneficiaries, (3) foregone benefits, and (4) tighter provider networks.

The open enrollment period for 2014 is expected to feature 142 fewer MA plans than last year, representing a 5.3 percent decrease, according to a report by Avalere Health.<sup>[4]</sup> The Kaiser Family Foundation reports a smaller decrease of 60 fewer plans, acknowledging that 349 plans will be discontinued and only 289 plans will enter the market.<sup>[5]</sup> Areas of the country will experience varying effects; the Avalere Health report mentions that “plan sponsors are responding by reducing their footprint in rural markets,” and notes that counties in the South and Midwest regions will see the largest impact. In Iowa, nearly 10,000 seniors – most of who live in rural areas – have already received cancellation notices.<sup>[6]</sup> In New Jersey, that number is 50,000.<sup>[7]</sup> These seniors will have other plans to choose from, but they may pay more in premiums, lose certain benefits and/or no longer have access to their regular physicians. Most importantly, even if they like their current MA plan, they can’t keep it.

The Kaiser Family Foundation’s Medicare Advantage Spotlight updated November 25, 2013 predicts premiums and out of pocket costs for MA enrollees that do not switch plans will increase in 2014.<sup>[8]</sup> In addition, the Kaiser Foundation found that average out of pocket caps increased from \$4,333 in 2013 to \$4,797 in 2014, with 41 percent including caps that topped \$5,000.<sup>[9]</sup> This is particularly disconcerting given the population of MA enrollees; the program draws a significant number of low income and minority beneficiaries.

An analysis of the Medicare Beneficiary Survey done by America’s Health Insurance Plans in 2011 provides a breakdown of Medicare enrollment by income level. Among those with incomes below \$10,000 annually, 27 percent are enrolled in MA, 47 percent are enrolled in Medicaid, 9 percent have another form of supplemental coverage (either employer-sponsored retiree coverage or a Medigap plan) and only 16 percent have traditional Medicare exclusively. Among those with incomes between \$10,000 and \$20,000 annually, 33 percent are in MA plans, 22 percent are enrolled in Medicaid, 23 percent have another form of supplemental coverage, and 20 percent have traditional Medicare exclusively. Among the higher-income beneficiaries, MA plans remain

popular, drawing in 20 percent of Medicare beneficiaries with annual incomes above \$50,000; but 71 percent of this population has other supplemental coverage through their employer or a Medigap plan.<sup>[10]</sup>

The data mentioned above demonstrate MA's importance for lower income seniors who do not have access to other forms of supplemental coverage to mitigate high out of pocket spending inherent in traditional Medicare – which has no out of pocket cost cap. Keeping MA plans viable and affordable for a lower income senior population should be a top priority for Congress and the administration.

If plans chose to keep cost sharing constant, they will need to absorb the cuts elsewhere. Whether this takes the form of more limited provider networks, a reduction in supplemental benefits, or scaling back plan offerings in certain areas; these cuts will impact MA enrollees, especially those in poor health or dealing with complicated chronic conditions. One insurance firm with a large MA business announced that they would be scaling back their provider networks in MA plans by 10-15 percent.<sup>[11]</sup> Other MA plans with prescription drug benefits may change which drugs are covered.<sup>[12]</sup>

## **Conclusion**

The majority of recent attention on the ACA has focused on the failing exchange websites, dramatically increased premiums for young adults, and cancelled health insurance plans for those in the individual market. The impact on seniors' MA plans is yet another reminder of the ACA's broken promises. Despite the president's assurances that that the ACA would not cause anyone to lose a health insurance plan they liked, the law's dramatic payment cuts guaranteed that some plans would leave the market and others would restructure their benefits in order to remain affordable and viable. Many MA enrollees around the country will get plan cancellation notices, learn that a benefit they previously had has been stripped from their plan, or find out that a doctor they had a relationship with is no longer in the network.

In closing I would urge Congress and the administration to reconsider the planned cuts to MA. MA is a high-value option and beneficiaries will benefit from robust plan choices as the means to receive high quality, coordinated care and limit their out of pocket spending. The ACA promise of unaltered coverage for those content with their insurance has already been broken as the law makes it impossible for many MA enrollees to continue with the *status quo*. Continued cuts will simply magnify this fact. Further, much of MA's value is based on the plans' ability to innovate and offer needed additional benefits, both of which are compromised in the face of large payment rate cuts.

<sup>[1]</sup> <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>