

EVENT SUMMARY
Medicare Advantage: Lessons for the Future
May 4, 2009

The Alliance for Health Reform, with co-sponsorship from the Henry J. Kaiser Family Foundation, held a briefing at Russell Senate Office Building to address the basics of Medicare Advantage (MA).

Ed Howard, executive vice president at the Alliance, welcomed those in attendance and noted that there has been much talk about Medicare Advantage in recent months. Analysts have concluded that Medicare pays Medicare Advantage plans more per beneficiary than it would under traditional Medicare, a controversial finding.

Tricia Neuman, vice president of the Kaiser Family Foundation, stated the importance of understanding Medicare Advantage and the role private health plans play in the delivery of care to over 10 million beneficiaries. Ms. Neuman also addressed the rapid growth in MA enrollment and the need to address payment issues within Medicare Advantage.

The first panelist, **Marsha Gold**, senior fellow at Mathematica Policy Research, discussed the evolution of Medicare Advantage from the Tax Equity and Fiscal Responsibility Act of 1982 which allowed contracting with HMOs, to the Medicare Modernization Act of 2003 that implemented Part D, regional PPOs, and payment benchmarks. Dr. Gold also addressed the substantial increase in Medicare private enrollment, specifically in private fee-for-service plans. In addition, Dr. Gold discussed how beneficiaries have a diverse range of plans to choose from. She noted that firms are competing for Medicare Advantage business; yet enrollment is concentrated within a few firms that are dominating the market. She also said that traditional Medicare leaves beneficiaries with a lot of out-of-pocket expenses.

The second panelist, **Mark Miller**, executive director of the Medicare Payment Advisory Commission (MedPAC) stated that fee-for-service (FFS) is a fragmented system that doesn't focus on quality of care, while monthly capitated payments encourage coordinated care and quality improvements. Dr. Miller addressed how benchmarks are supposed to result in cost-savings for beneficiaries and provide extra benefits. He explained that Medicare Advantage benchmarks are administratively set and based on a county's fee-for-service spending. This becomes a concern when counties with higher per-beneficiary costs—and thus higher benchmarks-- are able to provide extra benefits that counties with lower per-beneficiary FFS costs cannot. Dr. Miller stated that HMOs have the ability to offer coverage more cost efficiently rate than traditional FFS Medicare. He expressed concern that Medicare Advantage is drawing in the private FFS plans that are not a good fit for the program.

The third panelist, **Jonathan Blum**, director of the Center for Medicare Management within the Centers for Medicare and Medicaid Services (CMS), discussed the letter that sets contract rules and payment rates with health plans for 2010. He stated that 43 percent of health plans have fewer than 100 beneficiaries, and that there are too many health plans offered by the same plan sponsor. He stated that a goal of CMS is to assure that beneficiaries have a variety of choices that are meaningful and that beneficiaries understand their coverage options. In addition, Mr. Blum discussed President Obama's plan to make cost-savings a priority and to restructure the way CMS calculates benchmarks.

A lively question and answer session followed.