MEDICARE ADVANTAGE: CHANGING NETWORKS and EFFECTS ON CONSUMERS

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Senator Blumenthal and Senator Whitehouse, thank you very much for convening this hearing today on this new and important Medicare issue.

The focus of this hearing -- the "network narrowing" of physicians by United HealthCare's Medicare Advantage plans -- is an important issue now in Connecticut and is certain to become even more important all across the nation in the years ahead. New Medicare policies to address the situation discussed here today will be very important to elderly and disabled Medicare beneficiaries both in Connecticut and nationwide.

I am Dr. Brian Biles. I am a physician and a professor in the Department of Health Policy at George Washington University. My research at GWU, supported by the Commonwealth Fund, has focused on Medicare and managed care plans, with an emphasis on the costs and quality of care for beneficiaries for more than 10 years. At GWU, my team has analyzed Medicare Advantage (MA) plan costs per Medicare beneficiary relative to average costs in traditional Medicare fee-for-service (Traditional Medicare) since 2006. Most recently we have modeled the impact of the MA plan policies in the Affordable Care Act, when fully implemented in 2017, on MA plans and Medicare beneficiaries. Copies of these studies are included for the record.

The focus of today's hearing is United HeathCare's recent action to reduce the number of physicians participating in the United HeathCare's Medicare Advantage network in Connecticut for 2014.

The United HealthCare MA plans will not include over 2,000 providers in CY 2014 that were previously included in the United provider network in Connecticut. Most notably, United HealthCare did not extend participation in its MA plan network of physicians by the Yale Medical Group.

This issue especially focuses on the effect of this timing of the announcement of this reduction which was _____, after the beginning of the Medicare beneficiary open enrollment period that ran from October 15 to December 7 in 2013.

The term "network narrowing" has been used to describe the reduction of the number of physicians participating in a managed care plan's physician and provider network. Today I will focus my comments on five areas regarding MA plan "network narrowing" as a national issue of importance to the elderly and disabled that now requires new Medicare policies.

The first and most important point is that Medicare beneficiaries always have the option to be covered by traditional Medicare and receive their care from the large majority of the physicians in the nation who participate in traditional Medicare fee-for-service. Since its inception in 1982, Medicare managed care plans have always been a voluntary option to, and not a replacement for, the basic traditional Medicare program.

Second, the managed care plan "network narrowing" that we now see in Connecticut is neither new nor limited to Medicare. The fundamental concept of HMOs and managed care began with the Nixon proposal in 1971. HMOs subsequently expanded significantly in the 1990s and became a national issue at that time.

Now, the Kaiser Family Foundation, which tracks private employer health insurance coverage, reports that employed based health insurance has seen the number of employers whose largest plan is based on a more narrow or "high-performance" provider network increased from 15% percent in 2007 to 23% in 2013.

Third, Medicare has paid private plans more than the costs in traditional Medicare fee-for-service – or "extra payments" – for beneficiaries enrolled in the plans beginning with plans in rural counties in the Balanced Budget Act of 1997. Extra payments to MA plans were extended to virtually all Medicare private plans nationwide by the Medicare Modernization Act of 2003, the legislation that established the Medicare prescription drug benefit.

Our research at GWU found that extra payments to MA plans in 2009 averaged 13% and $1,100 per enrollee for total of $___ b in annual extra payments.

Fourth, as Medicare extra payments to MA private plans are gradually reduced over many years, from an average of 113% of costs in traditional Medicare in 2009 to an average of 101% in 2017, by policies included in the Affordable Care Act, MA private plans across the nation will need to become more efficient – including by selecting physicians and other providers that practice a more efficient, effective model of care.

Fifth, new policies that protect Medicare beneficiaries but that also allow MA plans to develop narrow networks are important. These policies would include clear advance notification to beneficiaries of changes in physician networks before the beginning of the MA plan open enrollment period on October 15 and special enrollment periods. They would also include an special enrollment period for enrollees in a MA plan that reduced its provider and physician network in the middle of a plan enrollment calendar year.

I will now discuss these five points in somewhat more detail.

The first, and most important, point relative to changes in Medicare Advantage plan physician networks is the underlying fact that Medicare beneficiaries may always choose to be covered by, and receive their care from, physicians in the traditional Medicare fee-for-service program.

Traditional Medicare is the nation's largest health insurance program and has the largest physician network of any insurer. MedPAC reports that a 2011 survey of Medicare patients in traditional Medicare, and for comparison 50- 64 year olds in private health insurance, found that overall access to physician care by Medicare beneficiaries is good. The survey found that "while most Medicare beneficiaries have multiple doctor appointments in a given year, most beneficiaries continue to report timely appointments" and that "Medicare beneficiaries were more satisfied with the timeliness of their routine appointments" than the privately insured under 65 population.

It is especially notable that, in spite of the national pattern that trains a many fewer new US physicians in primary care that other nations, only 1.3% of Medicare beneficiaries reported a major problem finding a primary care physician.

The second point is that managed care plans with limited or "narrow" networks are neither new nor limited to Medicare. This is not surprising given the national attention to increasing health care costs – first in the early 1970s as Medicare and employer health care costs increased, next twenty years ago in the early 1990s by employers and insurers, and now again by employers in recent years.

The first proposal to address increasing health care costs by establishing private managed care plans was made by President Nixon in 1971, in the era of increasing health care costs following the implementation of Medicare in 1966. The initial Federal health maintenance organization, HMO, development program was adapted from the Kaiser-Permanente group practice model system. It anticipated that the all of the new HMO plans would include limited numbers of selected physicians and providers. These plans would manage the costs of care for by limiting each of the price, volume and intensity of medical care.

The early approach to restraining health care cost increases based on HMOs with limited provider networks was expanded nationwide in the early 1990s during a recession as employers sought to limit employee health insurance costs. This focus on limiting heath care costs with

narrow provider networks was subsequently lost in the late 1990s with a robust economy and a vigorous backlash to the strictures of managed care by both physicians and employees.

More recently, there has been a renewed interest by employers in health insurance plans with limited networks. The Kaiser Family Foundation tracks private employer health insurance coverage with an annual survey. Kaiser reported in September 2013 that among large firms with employer based health insurance, the firms with a largest plan that included a more limited "high-performance" provider network increased from 15% in 2007 to 23% in 2012.

The third point, and the one that explains the most about why Medicare plans have had very extensive provider networks, is that Medicare from 2006 through 2010 explicitly paid private plans in virtually every county in the nation more that the costs for the same beneficiary in traditional Medicare fee-for-service.

Beginning with the enactment of prospective payment to HMO plans by Medicare in 1982, private plans were paid 95% of average cost in traditional Medicare in the county. Studies by CBO and others later found that, to inadequate risk adjustment of payments, Medicare in this era actually paid the HMO plans more than average costs in traditional Medicare.

In 1997, the Balanced Budget Act of 1997 for the first time explicitly paid Medicare plans – those in rural areas – more than average costs in traditional Medicare in the same county. These extra payments to MA plans in rural areas were extended to plans in counties with low costs in urban areas in 2000, and then to Medicare private plans in all areas of the nation by the Medicare Modernization Act of 2003.

Our research at GWU found that with the MMA payment policies, extra payments to MA plans nationwide averaged 13% and $1,100 per enrollee in 2009. The costs of extra Medicare payments to MA plans in excess of costs in traditional Medicare fee-for-service were projected by CBO at just more than $150 b over 10 years in 2009.

The fourth point is that the ACA included a number of new policies to reduce future Medicare payments and make Medicare more efficient. These policies, in addition to reducing future Medicare payments to hospitals and other providers, phased down the extra payments to MA plans over seven years to a national average of 101% of the costs of traditional Medicare in 2017.

As Medicare extra payments to MA private plans are gradually reduced over the seven years through 2017, MA plans will need to change their internal organization and operation. These changes will logically include new provider organization and payment policies since payments to providers average 85% of plan operating costs. History and current plan practices in the employer market suggest that changes by MA plans to accommodate the phase out of extra payments will likely include some "network narrowing".

The fifth point is that new policies Medicare that would both protect beneficiaries while allowing MA plans to pursue "network narrowing" in future years are very important at this time.

The most important of these new beneficiary protection policies would include clear advance notification to beneficiaries of changes in physician networks before the beginning of the MA plan open enrollment period on October 15. Plan physician and provider changes would thus become part of the Annual Notice of Change (ANOC), that plans now report, which now include changes in MA plan benefits covered and cost sharing but not do include the clearly more important elimination of network physicians and providers.

The new October 1 ANOC change announcement would include the names and locations of all providers leaving the plan provider network. This pre-open enrollment notification would give every beneficiary enrolled in a MA plan adequate time to understand the personal meaning of any specific "network narrowing" for the following year that begins on January 1.

The new policy should also include a new Special Enrollment Period for MA plan enrollees if a MA plan acts to discontinue plan physicians or other providers during a plan calendar year.

Finally, the Medicare plan finder now includes no information on in-network physician and other providers.

In conclusion, Medicare beneficiaries are all elderly over the age of 65 or are permanently and total disabled. It goes without saying that many individuals in these two groups need and use large amounts of health care. Many of them depend on their primary care physician, and often on specific specialty physicians to keep them healthy and accommodating their medical conditional as much as possible.

In the future year, it will clearly be reasonable for MA plans to reduce their physician and other provider networks. These plan network changes should not be prohibited, but new and

important protections for elderly and disabled Medicare beneficiaries who depend on their physicians and other providers should be adopted now – in time for the new policies to be in effect by the fall of 2014 when the next round of MA plan "network narrowing" is likely to occur.