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Hearing Statement of Senator Max Baucus (D-Mont.)
An Examination of the Medicare Advantage Program

Medicare didn't have any private plans when it first started in 1965. But in the early 1970s, Congress began down a path that would allow private plans to play a large role in Medicare. The goal was to offer choices that could improve the health of beneficiaries and reduce their out-of-pocket costs, while saving Medicare money. The vision was a promise of integrated and efficient health plans providing high quality comprehensive care to consumers.

Here we sit some 30 years later and it is time to take stock of where we are. Congress has been lax in its oversight of how private plans are working for Medicare beneficiaries. We're here today to change that.

One of the questions I hope we all keep in mind today is whether the promise of efficient and effective managed care has been realized. Do plans coordinate care, improve the health of their enrollees, and lower health care costs? Do they add value to the program? Are they worth what we are paying?

My understanding of Medicare Advantage is that it has had a long, but rocky history. Until 1993, enrollment in Medicare private plans was largely stagnant, then it tripled from 1993 to 1997. In an effort to define the role of private plans in Medicare, Congress created the Medicare+Choice program in the Balanced Budget Act of 1997.

At that time, the Congressional Budget Office projected that nearly one-third of all people with Medicare would enroll in private plans.

But the new law's effect was the opposite of what Congress intended: plans dramatically reduced their service areas; some plans left the program altogether. Enrollment and plan access declined significantly.

In 2003, Congress acted to stabilize and revive Medicare+Choice through the Medicare Modernization Act. I supported the MMA because it provided a prescription drug benefit, which was long overdue. The MMA also added much needed resources for rural providers. And I also supported the MMA because of the provisions to stem the rapid decline in Medicare+Choice.

The MMA renamed Medicare+Choice Medicare Advantage. It increased MA payment rates across the country. It also allowed new types of MA plans to enter the program – regional preferred provider organizations and special needs plans.

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Seniors who enroll in an MA plans may be able to receive extra benefits that the traditional Medicare program does not provide. For example, they could receive lower copayments for doctor visits, better coverage of prescription drugs, vision care and gym memberships. These extra benefits vary widely. MA plans often do not charge a premium for these additional benefits.

Over the last three years, there has been explosive growth in the number of plans ¬and the number of beneficiaries choosing them. Today, beneficiaries in every part of the country have access to at least one Medicare Advantage plan. Nearly one in five Medicare beneficiaries gets care through a private plan rather than the traditional fee-for-service program. Four years ago this number was one in ten.

In my home state of Montana, about one in ten Medicare beneficiaries has opted for Medicare Advantage. Most of them receive benefits through a "private fee-for-service plan" rather than an HMO.

That means, 89% of Montana beneficiaries remain in traditional Medicare. The vast majority are happy with the program. And we can never lose sight of their needs as well.

The recent changes we've seen in the MA program have touched millions of beneficiaries. But they are not without controversy. MedPAC and CBO tell us that, on average, plans are paid 12 percent more than fee-for-service. This difference varies significantly by plan and by region of the country.

For several years, MedPAC has recommended that Congress set payment for plans equal to fee-for-service. CBO estimates such a policy could generate significant savings — $54 billion over five years, and $149 billion over ten years. Paying MA plans at fee-for-service rates could also result in many plans leaving the program, and mass disruptions to beneficiaries, yet again.

Plans can provide services that traditional Medicare does not cover—such as calls or visits from nurse practitioners to help beneficiaries manage chronic illnesses. Plans can coordinate care across providers to improve patient health outcomes and lower costs. We're here today to find out if they really do, and if these strategies really do lower health care costs.

We will hear more on these points from our witnesses today. But I want to emphasize—this hearing is not simply about payment or extra benefits. Plans have the potential—and the resources—to do more than just receive Medicare payment and pay providers.

In order for Congress to assess the impact of such proposals, it needs more information about how geographic areas would be affected. I cannot stress enough how important it is for Congress to have accurate, timely data from its Congressional support agencies. Oftentimes national data are all that we need, but in this case, we need a more detailed picture.

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Our job today will be to listen and learn so that can decide whether Medicare Advantage brings value to beneficiaries and to American taxpayers.

I thank our panelists for coming today, and I look forward to hearing their ideas.

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