

The Value of Medicare Advantage

MA Plans Enhance Quality,

Improve Efficiency, and

Offer Member Savings



UnitedHealth Group®

Medicare Advantage (MA) plans have a track record of improving health outcomes and quality, as well as enhancing delivery system efficiency. MA plans also provide value, choice, and savings for millions of American seniors. More details about these program strengths are outlined below.

MA plans improve outcomes and quality. MA plans are designed to provide care through a coordinated care model. They provide beneficiaries with a comprehensive and integrated set of benefits that are coordinated across a continuum of health care services and are localized to fit the circumstances of particular communities. Benefits of this approach include the following:

- **MA Plan Members Use Preventive Services More.** MA beneficiaries are less likely than Medicare fee-for-service (FFS) beneficiaries to report trouble in receiving care, more likely to have a usual source of care, and more likely to receive necessary preventive services — such as those for pneumococcal and influenza immunizations, mammography, colorectal screening, and prostate screening.¹
- **MA Plans Enhance Quality.** Data from the Journal of the American Medical Association (JAMA) and the National Committee for Quality Assurance (NCQA) suggest that MA plans outperform FFS in numerous HEDIS quality measures.

MA plans' disease management efforts improve health and save money. Today, chronic illnesses are the leading cause of death and disability in the U.S. — and individuals with multiple chronic conditions cost Medicare the most. For example, the half of Medicare beneficiaries with five or more ailments accounted for 75 percent of Medicare spending in 2002. Coordinated care can help beneficiaries live healthier lives — with less cost to Medicare — by applying the best of evidence-based medicine through a comprehensive approach addressing the needs of each person as a whole. Examples of this approach include the following:

- **MA Plans Manage Care When Members are Sick.** Over the past five years, MA plans have reduced acute hospital days associated with congestive heart disease and chronic obstructive pulmonary disease by 18 percent and 26 percent, respectively, with strong quality results — by such measures as the percentage of patients on beta-blockers, the percentage of patients on ARB or ACEi, and the percentage of patients not on oral cortisosteroids.² In addition, specific disease management initiatives reduce hospital admissions. For example, UnitedHealth Group's Congestive Heart Failure disease management program has led to substantial reductions in hospital admissions for participating members.³
- **MA Plans Reduce Avoidable Hospital Admissions.** Research has found that patients in MA HMOs have fewer avoidable hospitalizations than Medicare FFS patients. A published randomized control study has shown there is a 30 percent reduction in hospital readmissions at both 30 and 90 days after discharge thanks to transition management programs like those available in some MA HMOs.⁴ Further, a recent study by Basu and Mobley found that in the two states with largest and longest-running HMO penetration, MA members had the lowest rate of preventable admissions and that the reduction in preventable admissions was mainly concentrated among the most seriously ill patients.⁵

- **MA Plans' Activities Reduce Hospital Readmissions.** UnitedHealth Group's MA HMO plans have a hospital readmission rate of 14.7 percent — substantially lower than the hospital readmission rate of nearly 20 percent in Medicare FFS.⁶ Further, Evercare nurse practitioners work in nursing homes to coordinate care with members and their physicians. These kinds of direct care delivery programs have reduced institutional patients' acute hospitalizations by nearly 50 percent. Members and physicians report high satisfaction with the programs, and note that patients receive more personalized care.⁷ **Successfully applying these interventions to reduce inappropriate hospital readmissions could generate substantial financial savings across Medicare — about \$4.5 billion annually.**⁸

MA plans focus on prevention and health promotion. MA plans take a number of steps to encourage their members to get appropriate preventive care and to have a healthy lifestyle, all within a continuum of coordinated care services. These activities have a demonstrated track record of improving health and encouraging use of preventive care services.

- **MA Members Get Appropriate Screenings.** Due to prevention and health promotion programs incorporated in MA plans, MA members were 30 percent more likely in 2007 to have colorectal screenings and 24 percent more likely to have had a breast cancer screening than FFS Medicare beneficiaries.⁹ Early results show that members in the intervention group were 65 percent more likely to start appropriate medication than control group members.¹⁰
- **Fitness Programs Encourage Physical Activity.** Almost 60 percent of the MA plan members who joined the SilverSneakers® fitness program have never used a gym before. These SilverSneakers® members have about the same number of chronic conditions as their peers, but they report feeling better and having fewer problems with daily activities. Sixty-two percent of SilverSneakers® members report having switched from a sedentary lifestyle to one that includes regular exercise.¹¹

MA plans facilitate good consumer decision-making. The tools and services that MA plans provide to their members help to improve informed decision-making about treatment options. In turn, better decisions can lead to reductions in inappropriate utilization.

- **Availability of Nurse Lines Enhances Decision-Making.** Nearly 80 percent of our users report that access to a telephonic nurse line improved their overall ability to make health care decisions and to talk more effectively with their doctors.¹²
- **Improved Decision-Making can Reduce Inappropriate Surgeries.** Treatment decision supports helping consumers make informed decisions resulted in a 16 percent reduction in unnecessary surgeries within certain conditions with high variability.¹³

MA plans provide excellent value to beneficiaries. The out-of-pocket savings that MA plans provide to beneficiaries are particularly significant in the current economic environment. Examples of the value that MA plans provide to beneficiaries include the following:

- **Members' Overall Costs are Less.** MA plans provided members with an average of \$82 in savings per month in improved benefits and lower out-of-pocket costs, compared with what they would have paid in the Medicare FFS program. For 10 million Americans enrolled in MA this equals about \$10 billion annually.
- **Members Save Money on Drugs.** Nearly 90 percent of members have access to zero-premium plans that include Part D coverage. Almost two-thirds have some level of prescription drug coverage in the Part D "coverage gap."
- **Members Can Save Money on Primary Care and Hospital Services.** Nearly two-thirds of members have copayments of \$10 or less for primary care visits. About 90 percent have access to a plan that could cost them approximately half as much or less for a six-day hospital stay when compared to traditional Medicare.¹⁴

MA plans provide particular benefits to low-income and minority individuals. Ways in which MA plans are particularly beneficial to vulnerable populations include the following:

- **MA Plans Provide a Safety Net from High Out-of-Pocket Costs.** Nearly 38 percent of beneficiaries with annual incomes less than \$30,000 who lack Medicaid or employer coverage rely on MA plans for comprehensive benefits and protection from high out-of-pocket costs.¹⁵
- **Minority Individuals Have Particular Gains.** About 40 percent of African Americans and about 53 percent of Hispanic beneficiaries who lack Medicaid or employer coverage rely on an MA plan. Funding cuts will disproportionately affect these beneficiaries, and will force them to face the higher out-of-pocket costs in FFS Medicare.¹⁶
- **MA Plans Provide Critical Supplemental Coverage to Low-Income Beneficiaries.** About 29 percent of FFS Medicare beneficiaries rely on Medigap for supplemental coverage; these beneficiaries tend to have higher incomes and be in better health. By contrast, low-income, at-risk beneficiaries losing access to their MA plan would have greater difficulty in obtaining Medigap coverage.¹⁷



The many activities that MA plans undertake to enhance health and well-being for their members are proven to improve clinical outcomes for MA beneficiaries — while also reducing inappropriate and unnecessary spending.

- 1 Centers for Medicare and Medicaid Services, Medicare Advantage 2007 Hill Notification Document, 11.
- 2 Internal UnitedHealth Group data, 2001-2007.
- 3 Internal UnitedHealth Group data, 2008.
- 4 The Care Transitions Intervention: Results of a Randomized Controlled Trial, E. Coleman, C. Perry, S. Chalmers, S. Min, *Archives of Internal Medicine* 166, September 25, 2006, 1822-1828.
- 5 Do HMOs Reduce Preventable Hospitalizations for Medicare Beneficiaries? J. Basu, L. Mobley, *Medical Care Research and Review* 64(5): October 2007, 544-567.
- 6 Internal UnitedHealth Group data, 2001-2007.
- 7 The Effect of Evercare on Hospital Use, R. Kane, G. Keckhafer, S. Flood, B. Bershadsky, M. Said Siadaty, *Journal of American Geriatrics Society* 51(10), October 2003; Internal UnitedHealth Group data, 2008.
- 8 This estimate is based on a recent analysis published in *The New England Journal of Medicine*. Rehospitalizations Among Patients in the Medicare Fee-for-Service Program, S. Jencks, M. Williams, E. Coleman, *New England Journal of Medicine* 360(14): April 2, 2009, 1418-28. According to Jencks, "Medicare payments for unplanned rehospitalizations in 2004 accounted for about \$17.4 billion of the \$102.6 billion in hospital payments from Medicare ... [t]his cost estimate is derived by multiplying the 19.6% rehospitalization rate by 90%, which represents the percentage of unplanned rehospitalizations, and multiplying that product by 96%, since DRG-based payments for rehospitalizations are 4% lower than those for index hospitalizations." Updating the Jencks cost estimate for 2005 generates an estimate of \$18.1 billion in hospital payments for unplanned readmissions. [19.6% multiplied by 90% (the percentage of unplanned rehospitalizations), multiplied by 96% (the DRG factor), multiplied by total Medicare FFS short stay inpatient hospital spending in 2005 of \$107.055 billion.] Medicare Advantage's hospital readmission rate is 14.7%. Internal UnitedHealth Group data, 2001-2007. If Medicare's hospital readmission rate had been comparable to that of MA, spending for hospital readmissions in 2005 would have been \$13.6 billion [14.7% multiplied by 90% (the percentage of unplanned rehospitalizations), multiplied by 96% (the DRG factor), multiplied by total Medicare FFS short stay inpatient hospital spending in 2005 of \$107.055 billion.] The difference between the two cost estimates (i.e., cost savings) would have been \$4.5 billion.
- 9 Internal UnitedHealth Group data, 2008.
- 10 Internal UnitedHealth Group data, 2008.
- 11 Internal UnitedHealth Group data, 2008.
- 12 Internal UnitedHealth Group data, 2007.
- 13 Internal UnitedHealth Group data, 2007.
- 14 Centers for Medicare and Medicaid Services, 2008.
- 15 *Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries*, A. Atherly, K. Thorpe, September 2005.
- 16 *Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries*, A. Atherly, K. Thorpe, September 2005.
- 17 *A Data Book: Healthcare Spending and the Medicare Program*, MedPAC, Section 6, June 2008.