



## An untapped advantage

Medicare Advantage may  
help health plans transition  
from “volume to value”

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cutting through complexity



**Part I** – Provides an

**Part II** – Examines the consumer behaviors that health plans should consider as they


**Part III** – Looks at how health plans can work with pharmaceutical companies to influence consumer pharm

#### Part IV – Highlights advantages health plans can communicate to providers who join Medicare Advantage network

**Part V** – Gives an overview of how health plans currently view Medicare Advantage in relation to their long-term

**Part VI & VII** – Provide insight into how companies can work with KPMG to plan and execute business





Medicare Advantage represents an untapped opportunity for achieving “value for outcomes” in the healthcare industry.

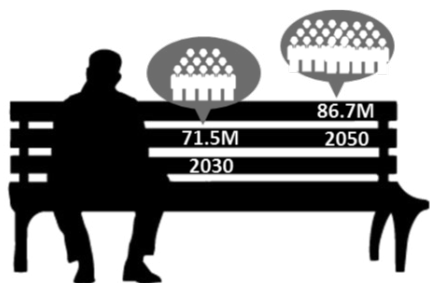
**C**reated by Congress in 2003 to give private insurance companies an incentive to enter the senior care market, Medicare Advantage (MA) comprises narrow networks (PPOs and HMOs) and is an alternative to traditional Medicare Parts A and B. Since its inception, Medicare Advantage has gained consumer appeal due to its lower premiums, one-stop shopping, and greater transparency into the cost of medical care.

Medicare Advantage wasn't historically an attractive proposition. In the earlier days of the initiative, premiums were higher and quality was lower. Sicker patients were apt to switch out of MA plans and back to Medicare, as they experienced frustration with prescription drug coverage. Since then, quality measures have increased dramatically: Women in MA plans are more likely to receive annual mammograms, for example. Those with chronic conditions such as diabetes and cardiovascular disease receive regular A1C tests and cholesterol screenings. Flu shots and pneumonia vaccines are more prevalent among MA subscribers.<sup>1</sup>

The hypothesis that Medicare Advantage could be an important driver in the evolving value-based healthcare system led KPMG to work with Strategic Health Perspectives (a service of Nielsen Consumer Insights) to initiate the **Medicare Advantage Strategies Study**.<sup>1</sup> Conducted in mid-2014, the research included a quantitative survey of 175 US residents aged 64+ who were open to joining an MA plan in 2015; and qualitative interviews with senior administrators at prominent hospital groups. (The statistical significance of findings is at the 95% confidence level.) Additional findings reflected in this paper are from two other Strategic Health Perspectives surveys: (1) an online quantitative survey of 100 health plan executives from commercial payers, “Blues,” government-sponsored plans, and others, and (2) an online quantitative general population survey of 2,501 Americans age 18+.

**Our aim is to help health plans evaluate whether Medicare Advantage can support their transformation to a value-based model.** In addition, providers may find the information we offer helpful as they consider how Medicare Advantage fits with their own strategies to reach “value for outcomes” and options they communicate to patients. Pharmaceutical companies may want to think about their very important role in shaping future Medicare Advantage offerings. For both providers and pharmaceutical companies, we will, in the coming months, offer follow-on pieces that go into greater depth regarding their particular concerns.

<sup>1</sup>Please note that all facts and figures stem from the KPMG/Nielsen Consumer Insights Medicare Advantage Strategies Study, unless otherwise referenced.



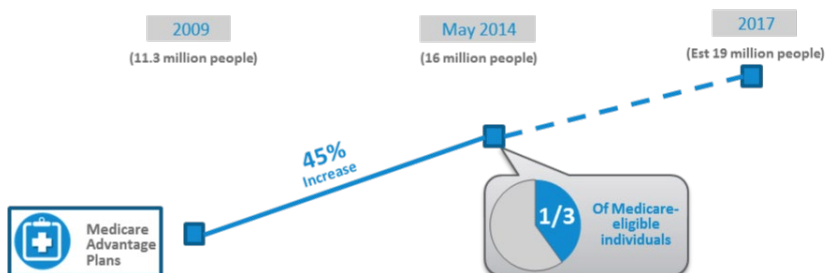
The Medicare Advantage expansion is likely to continue as the group of those over 65 grows to 71.5 million in 2030 and 86.7 million by 2050.

## I. HOW MEDICARE ADVANTAGE IS GROWING

### An Alternative to Medicare

Congress conceived Medicare Advantage in 2003 to address consumer dissatisfaction with traditional Medicare. Like many other “privatization” initiatives, the prevailing wisdom was that private insurance companies could better serve the senior care market. As we enter Medicare Advantage’s twelfth year, many view the idea as a success. As of May 2014, one-third of Medicare-eligible individuals (16 million people) were insured in Medicare Advantage plans. That number represents a 45 percent increase from the 11.3M enrolled in 2009.<sup>ii</sup>

### Growth of Medicare Advantage from the present projected through 2017



And that number is poised to grow. As the Baby Boom generation continues to retire, predictions are that the number of Medicare Advantage enrollees will expand to 19M by 2017, according to the Congressional Budget Office.<sup>iii</sup> By contrast, there are 42.5 Medicare beneficiaries currently, a pool of potential converts to MA.<sup>iv</sup>

“Baby boomers are prime candidates for Medicare Advantage.”



### Baby Boomers Know Managed Care

*Jerry is a 65-year-old chemical engineer, recently retired from his 35-year career at a large manufacturing firm. Over the years, he has felt secure in the company-sponsored insurance offered*

*to him and his family. Through his wife’s three caesarian sections, his son’s tonsillectomy, his daughter’s appendix removal, back surgery to repair several herniated discs, and his recent diagnosis with diabetes, Tom felt that he could get his family the treatment they needed. He has come to depend on managed care’s more predictable costs and coordinated care.*

Baby boomers like Jerry are prime candidates for Medicare Advantage. They have recent experience with managed care and are comfortable with narrow networks. And their numbers are about to explode. The full group of baby boomers was born between 1946 and 1964; those over age 65 are projected to number 71.5M by 2030 and 86.7M by 2050.<sup>v</sup> And, Baby Boomers are currently choosing MA plans at a rate of almost 50 percent.<sup>vi</sup> This represents a tremendous market opportunity for Medicare Advantage plans.

## Managing Chronic Illness

Health plans might be thinking at this point: We know how to influence Baby Boomers. Who else might be interested?



### ***The Chronically Ill Have Their Own Set of Criteria***

*Carol is a 70-year-old woman with chronic obstructive pulmonary disorder (COPD) from years of smoking. She takes an oral medication, self-administers a daily nebulizer treatment, and wears oxygen at night. Although Carol hasn't smoked in 20 years, she knows her condition is degenerative. She has been frustrated with her current regimen of twice-yearly checkups, which focus only on raising medication dosages. She knows there is more she could be doing to improve her quality of life.*

*After enrolling in Medicare Advantage, Carol feels more*

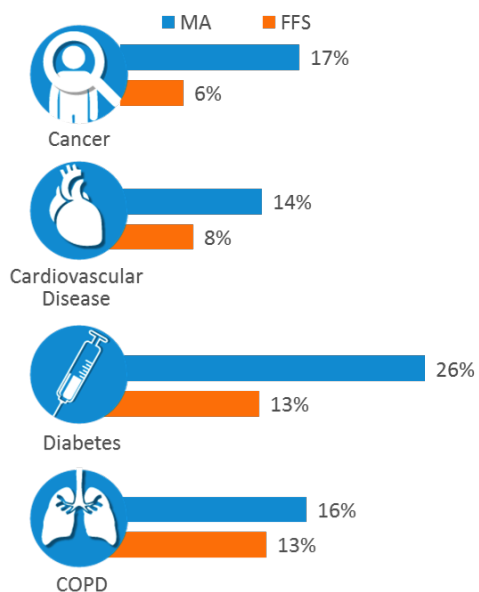
*empowered and in control of her condition: She attends a weekly support group with other COPD sufferers. She practices relaxation and breathing exercises to make better use of her current lung capacity. Her new doctor recommended a cutting-edge medication alternative, while taking care to change her blood pressure medication to one that isn't contraindicated. And the nutritionist in her doctor's office helped her start a diet and exercise program so she feels less breathless on a daily basis. The result is, Carol feels better and is more optimistic about the rest of her life.*

One of the most surprising findings of our Medicare Advantage Strategies research is the prevalence of chronically ill consumers like Carol enrolled in Medicare Advantage plans. In past years, these plans were touted as a better way to manage "wellness," i.e., by incenting members to be proactive about their health through such measures as gym memberships, regular screenings, and annual pneumonia and flu shots. Now, health plans may want to consider positioning their MA plans on the opposite end of the spectrum – as a better way to manage chronic illness.

Our study shows that two-thirds (66 percent) of current MA enrollees have at least one serious chronic illness. This is in stark contrast to traditional Medicare, which serves only 34 percent with chronic conditions. This disparity is likely to continue: More than half of those who said they were likely to enroll in MA in 2015 have a chronic condition. And in terms of satisfaction with their current plan, 77 percent of MA enrollees with chronic conditions are satisfied with their health plan, versus 62 percent of those with no chronic condition.

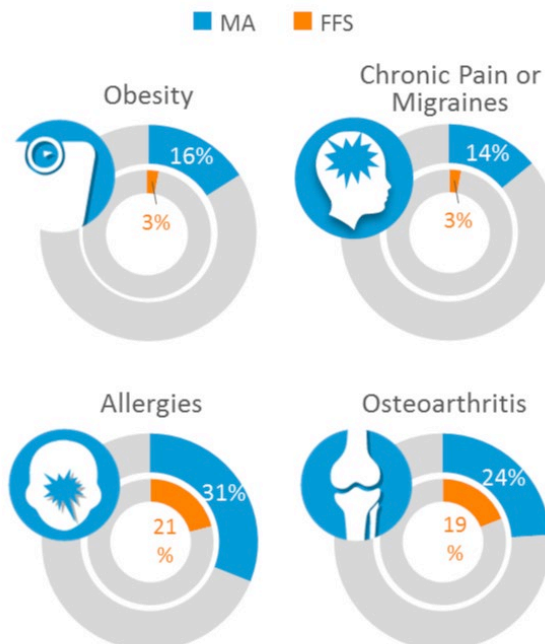
“One of the most surprising findings is the prevalence of chronically ill consumers enrolled in Medicare Advantage plans.”

## Comparison of preferences for Medicare Advantage vs. Fee-for-service Medicare



When we drilled down into specific conditions, things became even more interesting. At left is a comparison of specific chronic illnesses represented by MA versus fee-for-service Medicare.

And below is a comparison of less critical, but still chronic, conditions represented by MA vs. FFS Medicare:



## Between Baby Boomers and the chronically ill, there is a significant untapped pool of consumers who may be interested in switching to Medicare Advantage.

And our survey illustrates that many of them are open to the idea. Of all respondents (not opposed to MA), two out of three (64%) surveyed said they are somewhat or very likely to select an MA plan in 2015, and this number includes 33 percent of current FFS Medicare enrollees.



Percentage of those not currently enrolled in MA who said they are likely to choose an MA plan in 2015.



Percentage of current FFS Medicare enrollees who are planning to switch to an MA plan in 2015.



## II. CONSUMER BEHAVIOR

### What drives consumers to switch to Medicare Advantage...

As health plans structure and market Medicare Advantage plans, it is important that they understand what drives consumer behavior.

#### Low Premiums

By far, the most significant factor driving seniors to enroll in Medicare Advantage plans is very low premiums (a 2014 average of \$49 a month<sup>vii</sup>) or, in some cases, no premium at all. This compares favorably with the several hundred dollars per month it costs to get Medicare gap insurance. The 2013 Strategic Health Perspectives consumer survey found that, in a tradeoff analysis, the top priority for current MA beneficiaries was low monthly premiums. By contrast, consumers in traditional Medicare said their top priority is keeping their current doctor.

There are some subtleties to these findings, however. The survey found that, if Medicare gap insurance increased by \$100 a month, it appears that a certain amount of consumer inertia might set in, with only 38 percent of those surveyed saying they would switch to a closed network plan to save money. However, in the event that Medicare gap insurance increased by \$200 or more per month, 54 percent state they would switch to a plan with a closed network, presumably Medicare Advantage.

**As Medicare gap insurance premiums increase, so does the percentage of consumers who would switch to a closed network plan.**



#### Predictable Cost-Sharing

Only slightly less important than a low premium is keeping out-of-pocket costs under control. “The key selling point of Medicare Advantage plans is that they come at a lower cost than traditional fee-for-service Medicare with a supplement,” said a senior executive with a nationally recognized health plan, who was interviewed as part of this project.

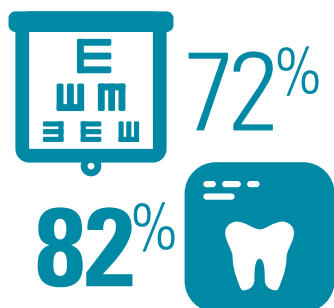
**Having a chronic condition was a major mediating factor in how important low out-of-pocket costs were to beneficiaries.** For those in our survey with a chronic condition, 82 percent valued a low out-of-pocket (OOP) cost, as opposed to 62 percent with no chronic condition. Of course this makes sense as the chronically ill are likely to have more doctors’ visits, hospitalizations, procedures, and medications. All of these come with the likelihood of out-of-pocket costs, as well as the potential for surprise fees that, in the case of catastrophic health events, could significantly impact an individual’s financial security.<sup>viii</sup>

As 7 out of 10 consumers report that cost transparency would make them somewhat or much more likely to choose an MA plan, health plans should focus on MA plans’ predictable fees as a major value propositions. Further, as the Centers for Medicare and Medicaid (CMS) increased the OOP limit from \$4,333 in 2013 to \$4,797 in 2014.<sup>ix</sup> Therefore health plans should remember that they may remain more competitive if they keep their own OOP limits lower than the federal guidelines.

Consumers’ desire to be in control of OOP costs may be more a matter of psychology than finances, according to the CFO of a major New York-area hospital. He asserts that price sensitivity is driven by the belief that you didn’t receive what you paid for, as opposed to fear of economic hardship. Those with chronic health problems may be more open to predictable cost sharing than are people who are very healthy or in the middle of a health emergency.

“As health plans structure and market Medicare Advantage plans, it is important to understand what drives consumer behavior.”

Availability of vision and dental care was very important to those with no chronic conditions.



Popularity of “one-stop shopping” increases significantly in those without a chronic condition.



## Other Drivers

Finally, there were drivers that had particular currency with the non-chronically ill. Those with no chronic conditions are more motivated (than those with chronic conditions) to switch to MA plans with the following benefits:

- Free preventative or wellness services (82% vs 75% with no chronic condition)
- Availability of vision care (72% vs 57%) and dental care (82% vs 71%)
- Cash rewards/incentives for such health measures as in-range cholesterol levels, lower blood sugar readings, and improved blood pressure control (62% vs 46%)
- “One stop shopping” – having all benefits and services in one place (62% vs 33%)

## Good Reviews

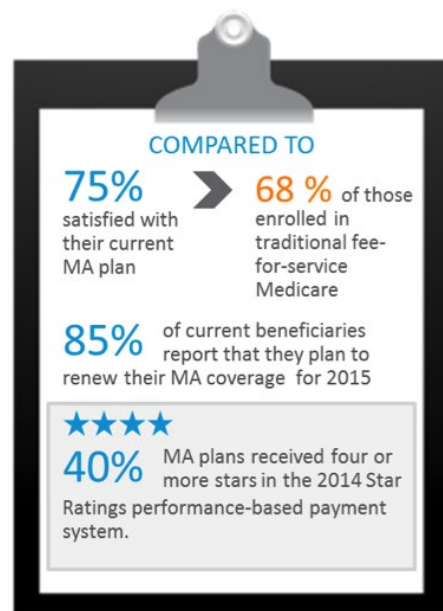
Health plans should remember that all potential and new enrollees will likely be influenced by positive feedback from current MA members. Of current MA enrollees surveyed, 75 percent are very or somewhat satisfied with their current plan, compared to only 68 percent of those enrolled in traditional fee-for-service Medicare. And 85 percent of current Medicare Advantage beneficiaries report that they are very or somewhat likely to renew their MA coverage for 2015.

Other surveys support this finding: According to Harvard economists, “Seniors, by a 9-to-1 margin, rank MA plans favorably for high quality of care, [network of] doctors, [and] the coverage they receive.”<sup>x</sup> This feedback is reflected in the fact that 40 percent of MA plans received four or more stars in the 2014 Star Ratings performance-based payment system. This is crucial for MA plans going forward, as only 4- and 5-star plans will be eligible for bonus payments in 2015.<sup>xi</sup>

HEALTH PLANS SHOULD REMEMBER THAT ALL NEW ENROLLEES WILL LIKELY BE INFLUENCED BY POSITIVE FEEDBACK FROM CURRENT MA MEMBERS.



According to *Harvard economists*, “seniors, by a 9-to-1 margin, rank MA plans favorably for high quality of care, [network of] doctors, [and] the coverage they receive.”





## ...and what deters consumers?

### The Threat of Higher Premiums

It raises a red flag that 34 percent of health plans surveyed said that they would consider increasing their MA premiums depending on the impact of incremental federal payment cuts. At present, cuts are predicted to amount to 5.9 percent of current levels in 2015, according to AHIP.<sup>xiii</sup> Bearing in mind seniors' resistance to premium increases, health plans should be prudent about raising their premiums lest they risk jeopardizing enrollment. A senior executive from a prominent health plan stated it succinctly: "Premium trumps all."

### Cuts in the Physician Network

Another critical factor is a thoughtfully considered physician network. "Most seniors are concerned with keeping their doctor to provide continuity of care," says the hospital CFO. "Particularly if that doctor has helped them through a significant health issue." Thirty-seven percent of survey respondents said that they wouldn't choose a Medicare Advantage plan if they were restricted in their choice of physicians or hospitals. And consider, of those open to an MA plan for 2015, 75 percent would change their mind if their primary care physician (PCP) weren't in the network.


Looking again at the chronic condition sub-segment of consumers, 33 percent of those who did not choose an MA plan said it was because the physician and hospital networks were too limited. And this group was particularly concerned about having to get a referral from a PCP to see a specialist, with close to half (48 percent) asserting that referral requirements would make them unwilling to enroll in MA.

Health plans should note that cost reductions and discounts do not hold much promise for offsetting networks that are perceived as too narrow. Even with a 20 percent discount, the number of seniors willing to sign up for an MA plan that didn't have their PCP in-network would only increase 11 percent (from 9 percent before a discount was offered). And if an individual's "most critical specialist" (PCP or specialty provider) were missing from the network, discounts would be no incentive at all—again, just 11 percent would pick this kind of plan.

“Of those already contemplating an MA plan for 2015, 75 percent would change their mind if their primary care physician weren't in network.”

“A senior health plan executive sums it up: 'Premium trumps all.'”



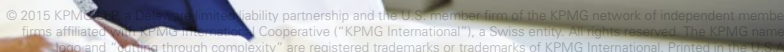


**25%** of those with no chronic condition were attracted by ambulance services, transportation to doctors, health club memberships, and reward/incentive programs.

Inertia is an issue that health plans will need to address, particularly among the chronically ill. In our study, a small but significant percentage of FFS beneficiaries with chronic conditions (10 percent) said that they didn't sign up for MA because they "didn't get around to it." This is reinforced by other behavioral studies, including one conducted by the Robert Wood Johnson Association and Yale University.<sup>xiii</sup> That study showed that less healthy individuals, while in a better position to evaluate the quality of care under particular health plans, are less likely to switch plans. This is because switching might disrupt existing relationships with providers and require [them to] learn the administrative protocols of [a] new plan, a potentially daunting task for people who expect to require a substantial set of services in the immediate future. Given that the chronically ill represent a large pool of potential enrollees in Medicare Advantage, health plans might want to consider keeping the plan-switching process simple, crafting clear plan descriptions, and/or providing enrollment incentives for those switching from traditional Medicare.

Finally, the chronically ill and the relatively healthy view differently the relative importance of deterrents and drivers to Medicare Advantage enrollment. For example, the relatively healthy are more uneasy with managed care plans than those with chronic conditions. They are also somewhat more likely to cite discomfort with managed care generally as the reason for not choosing an MA plan (36%, vs 29% of those with chronic conditions). Those with chronic conditions who are on MA now are much more likely to cite prior managed care experience as a reason for choosing MA (34%, vs 15% of those with no chronic conditions).

Twenty-five percent of MA members with no chronic condition were attracted by extra benefits like ambulance services, transportation to doctors' appointments, health club memberships, and reward/incentive programs. By contrast, those with chronic conditions reported being distinctly disinterested in some of the features valued by their more healthy counterparts. For example, only 46 percent of the chronically ill were interested in cash rewards (vs. 62 percent of the non-chronically ill). And slightly fewer chronically ill were interested in health club memberships than non-chronically ill were (40 vs. 47 percent). Health plans may want to take disparities such as these to heart and provide opt-in/opt-out capabilities for certain "extras."





### III. PHARMACY PREFERENCES

**The perceived quality of pharmacy coverage could be a pivotal factor for those on the fence about switching from Medicare to Medicare Advantage.**

#### The Landscape

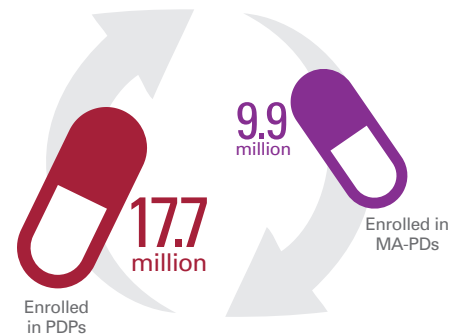
There are 17.7M Americans enrolled in stand-alone prescription drug programs (PDP), i.e., they receive Parts A and B benefits through traditional Medicare, coupled with a Part D prescription drug program, according to a recent Harvard Medical School study.<sup>xiv</sup> By contrast, there are 9.9M beneficiaries enrolled in Medicare Advantage Prescription Drug plans (MA-PD), i.e., they receive both medical and pharmacy benefits in an integrated MA program.

#### Perception of Drug Costs – The Pendulum is Swinging

On the one hand, satisfaction with Medicare Part D has been steadily rising – from 64 percent in 2010 to 78 percent in 2014, perhaps due to media coverage surrounding the gradual phasing out of the “donut hole.” However, given MA-PDs’ lower average premiums, deductibles that are often close to zero, and additional benefits in the coverage gap, there is significant opportunity for Medicare Advantage plans to pull-through consumers currently enrolled in FFS by highlighting the relative advantages of MA prescription drug plans.

There is evidence of growing dissatisfaction with specific aspects of Medicare Part D. The number of consumers who think that Part D lowers the cost of prescription drugs has shrunk from 37 percent in 2013 to only 29 percent in 2014, according to our study. And drug costs are a significant driver for potential Medicare Advantage enrollees, who place more importance than those in traditional Medicare on low copays for generic drugs, reasonable copays for brand drugs, and access to all brand-name drugs at low cost-sharing levels.

Further, among elderly Medicare beneficiaries with multiple chronic conditions, lower drug costs have even more appeal. As things stand, this population is suffering under Medicare: There is significant evidence of non-compliance with treatment regimens due to the high cost of medications. Specifically, among those with four or more chronic conditions, there has been an increase of cost-related non-adherence from 14.4 percent in 2009 to 17 percent in 2011. And, the number of people who forgo basic needs in order to afford medications has increased from 6.8 percent in 2009 to 10.2 percent in 2011, according to a recent study from the National Institute on Aging, supported by Harvard University.<sup>xv</sup>



**Enrollees in stand-alone PDPs vs. Medicare Advantage plans.**



**Consumers who think that Part D lowers the cost of prescription drugs**



“The limitations of Medicare Part D present an opportunity for health plans to highlight the lower costs associated with MA prescription plans.”

\$86.68

Monthly savings in the first year per patient in MA-affiliated practices, as reported by providers.

## Formulary Size and Scope

Those who sign up for Medicare Advantage recognize that its formulary is smaller than Medicare's. However, they appear willing to overlook this limitation to gain greater access to the newest specialty drugs and better quality drugs. The statistics show that MA-PDs were significantly more likely than PDPs to cover brand-name drugs that have generic equivalents in all four non-protected classes (Alzheimer's disease drugs, ARBs, bisphosphonates, and statins), according to the Harvard Medical School study.<sup>xvi</sup> And these drugs do not require prior authorization, something that has been shown to be compelling to the chronically ill and could, therefore, be a driver to MA plans. It is important for health plans to note that, the older a beneficiary is, the more likely he or she is to be disinterested in generic drugs and to value no restrictions on specialty drugs, particularly for cancer.

The limitations of Medicare Part D present an opportunity for health plans to highlight the lower costs and better quality associated with MA prescription plans. Further, health plans should focus on the fact that, in MA plans, medical treatments and pharmaceutical interventions are integrated. This can help improve health outcomes and minimize adverse events – all factors in lowering an individual's healthcare costs.

## IV. ATTRACTING PHYSICIANS

As much as health plans feel they are in the driver's seat when it comes to which providers they accept into their MA networks, they should bear in mind that their reputations and enrollment numbers are dependent on the quality of providers they attract. Many providers are currently evaluating whether it makes sense for them to get into the MA business and whether participating in MA networks provides them a competitive edge. Health plans should drive home the message that a carefully considered MA strategy can be a significant component of providers' long-term transition to a fee-for-outcomes model.

First of all, there are the sheer numbers. Enrollment in MA has grown steadily since 2008 and is expected to reach 16.3 million subscribers by 2015. Further, many of these subscribers have chronic health conditions, giving physicians access to a population of patients that need more extensive care.

Second, MA plans help providers fulfill many of the criteria that consumers value, such as “one-stop-shopping,” cost transparency, and no surprise fees.

Third, there are reputational benefits for providers as MA facilitates programs that lead to consumer savings and improved health outcomes: A study published in the American Journal of Managed Care (AJMC) found that Medicare Advantage plans had readmission rates 13 to 20 percent lower than Medicare FFS. And Medicare Advantage plans outperformed Medicare FFS in nine out of 11 clinical quality measures, as cited in an article in AJMC.<sup>xvii</sup>

Finally, a study conducted by the MD-Value in Prevention (MDVIP) network of primary care physicians found that enhanced patient/provider relationships and personalized preventive medicine – both models under Medicare Advantage – can reduce healthcare spending significantly. Specifically, providers espousing these types of models under Medicare Advantage reported reduced emergency department visits and inpatient admissions amounting to program savings of \$86.68 per member per month in the first year and \$47.03 in the second year, compared with patients in non-Medicare Advantage-affiliated practices.<sup>xviii</sup>

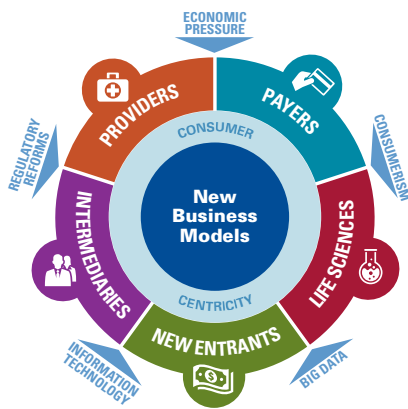


## V. THE FUTURE PLANS OF HEALTH PLANS

There is evidence that health plans consider Medicare Advantage to be a major component of their future makeup. However, there are also indications that companies may not be aware of the degree to which MA programs can be an integral part of their transformation in an outcomes-based healthcare environment.

On the one hand, three of the companies with the largest numbers of Medicare beneficiaries saw double-digit percentage growth in their Medicare Advantage enrollment during 2014.<sup>xix</sup> Almost half of health plans we surveyed consider Medicare Advantage to be a “somewhat important” or “very important” part of their business. And four out of five intend to remain with MA even in the face of federal payment cuts.

On the other hand, it seems that health plans could still increase their understanding of the current size and composition of the Medicare Advantage market; the plan features that have the most currency with consumers; how they can work with pharmaceutical companies to make the MA drug plan a major differentiator; and the benefits they should be communicating to potential providers who might join their networks. Our hope is that this paper, and subsequent conversations with KPMG, will help illuminate the answers to these questions.



## VI. HOW KPMG CAN HELP

**How to integrate Medicare Advantage into your long-term growth plans will require proactive thought and, perhaps, strategic counsel.** KPMG's Healthcare & Life Sciences practice assists health plans in transforming business models to meet the needs of today's healthcare economy. With our long-standing advisory practice and the growth of our strategic consulting arm, we are considered a leader in the transformation space.

We have a considered and insightful outlook on the issues that inform a health plan's Medicare Advantage strategy: With a unique perspective on industry convergence, we can assist health plans in determining how and to what extent to align with providers, hospital systems, pharmaceutical companies, and medical device manufacturers to shape the future state of, not only Medicare Advantage but, the industry. In particular, as the industry moves toward "fee for outcomes," we are helping health plans define what this means for them—from the impact on corporate brand, to position in the market, to operational structure, to specific offerings such as Medicare Advantage and how to market them effectively. We can help you determine whether a Medicare Advantage strategy will enhance patient access, reduce costs, improve the quality of patient care, and help you play an integral role in accountability for outcomes.

We know that making decisions such as whether to incorporate Medicare Advantage into a business plan must be viewed through the lens of regulatory requirements. We help companies scrutinize plan quality to improve standing in the new CMS star-rating rubric, and build upon reimbursement model and rate parameters to create more attractive plan features. We also provide guidance on maintaining value in the face of changes stemming from the ACA, including how Medicare Advantage premium levels are set and complying with more stringent Medical Loss Ratio standards.

When it comes to understanding the Medicare Advantage marketplace, we have advanced data and analytics capabilities that serve as a foundational piece of many of our client solutions: We assist health plans in mining and analyzing medical and financial data to foster highly targeted marketing campaigns, proactive management of chronic illnesses, better understanding of population health patterns, and, ultimately, more effective clinical outcomes – all critical variables in the strategic decision of whether or not to enter the Medicare Advantage market.



## VII. CONCLUSION

As the healthcare industry transitions from volume to value, all entities are going to be held accountable for outcomes. One development that is poised to contribute to that transition is the rise of Medicare Advantage plans. Touted for their higher quality, care coordination under the guidance of the primary care physician, lower costs, and price transparency, MA plans meet many of the mandates currently being rolled out under the Affordable Care Act.

Value for outcomes is inevitable and, as daunting as the transition may seem, will benefit not only consumers but the health plans, providers and life sciences firms that serve them. Health plans that want to explore offerings like Medicare Advantage would be wise to consider carefully how these plans can be structured and positioned to meet the needs of Baby Boomers, the chronically ill, and a general public that is currently considering its options. To the extent that health plans can offer MA options with low premiums, predictable out-of-pocket costs, carefully considered physician networks, and varied and high-quality drug formularies, they will have a much greater chance of thriving as the healthcare industry continues to evolve.

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<sup>xii</sup> Overwhelming evidence shows Medicare Advantage improves health outcomes. *AHIP*, March 28, 2014.

<sup>xiii</sup> Schlesinger, M., Druss, B. and Thomas, T. (1999). No exit? The effect of health status on dissatisfaction and disenrollment from health plans, *Health Services Research*, 34:2, 547-576.

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