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Health Policy Brief

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Medicare Advantage Plans: Almost 1 in 4 Medicare beneficiaries is in a private Medicare health insurance plan. Studies show these plans are paid more than traditional Medicare. A debate is under way over cutting payments.

Number of Medicare Advantage Enrollees (millions)

2009
10.4

2006
6.0

What's the issue?

Medicare was created in 1965 to provide government-subsidized health insurance for elderly and disabled Americans. Since the 1970s, beneficiaries have had the option of leaving traditional Medicare and enrolling in privately run health insurance plans that participate in what is now called the "Medicare Advantage" program (the difference between "traditional Medicare" and private plans is explained below).

This year, the government will pay these private plans an average of 14 percent — or about $12 billion — more than it would pay for people in traditional Medicare. "This added cost contributes to the worsening long-range financial stability of the Medicare program," said the Medicare Payment Advisory Commission (MedPAC), a nonpartisan group Congress established to monitor Medicare, in a March 2009 report to Congress.

MedPAC has proposed calculating the payments differently, to eliminate the extra cost of Medicare Advantage and to slow Medicare's growing costs. Others, including the Obama administration, want the plans to bid against each other for Medicare contracts in the hope of achieving greater savings to put toward health reform.

Defenders of the private health plans object to these proposed reforms, for a variety of reasons described below.

What's the background?

In traditional Medicare, patients can go to the doctors and hospitals they choose, and the government pays these providers usually according to set fees (a system known as "fee-for-service"). In Medicare Advantage, the government pays insurers a set amount every month for each Medicare member they enroll in plans that cover hospitalization, doctors' visits, and other benefits. This year, 23 percent of Medicare beneficiaries — or about 10.4 million out of the 45 million people in Medicare — have joined a Medicare Advantage plan.

Most Medicare Advantage beneficiaries are enrolled in health maintenance organizations (HMOs), in which members are usually limited to a network of health care providers in certain areas. Local and regional preferred provider organizations (PPOs) are another type of plan that allows access to a network of providers and may also allow access to out-of-network providers at additional cost; "special needs plans," or SNPs (pronounced "snips"), are primarily for people with disabling health problems who are typi-

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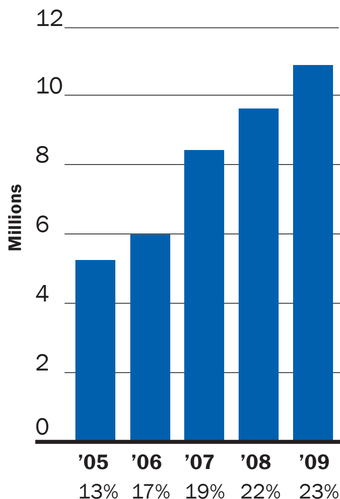
Number of Medicare Advantage Plans

2009
3,354

2006
1,383

EXHIBIT 1

National Enrollment in Medicare Private Health Plans



Year (percent of all Medicare beneficiaries)

Source: Mathematica Policy Research for the Kaiser Family Foundation.

cally eligible for both Medicare and Medicaid. The fastest-growing Medicare Advantage option is private-fee-for-service (PFFS) plans, which allow members to go to any provider who agrees to treat them. Private fee-for-service plans are not required to have a network of providers who accept their payments, although this will change in 2011.

All Medicare Advantage plans are required to offer at least the same benefits that traditional Medicare offers. But they have become increasingly popular because they frequently offer benefits not covered by traditional Medicare — such as vision, hearing, and dental care; health club memberships; preventive and wellness care; and free nonprescription drugs. They may also pick up some costs Medicare beneficiaries normally have to pay out of pocket.

Medicare pays these private plans through complex arrangements. These arrangements link what the government pays private plans to what it costs to provide care to similar beneficiaries in traditional Medicare. Payments are set at the county level, and because Medicare costs vary within and among states, the payments to plans vary by county as well.

Here's how the system works: The process starts each year when plans first submit bids to the government. These bids cover what the plans expect to spend in the following year in each county to offer Medicare's core benefits: the hospital, or Part A, benefits, as well as the Part B benefits, which cover doctors' visits, home health care, and other professional medical services. The bids also cover the plans' projected administrative costs plus profits.

The bids are then measured against a set amount, or "benchmark" rate, that Medicare has decided to pay to provide care to beneficiaries in a particular county. Benchmark amounts are determined annually by the U.S. Department of Health and Human Services (HHS) and increase every year either by 2 percent or by a rate equivalent to the overall growth in Medicare spending, whichever is greater. The benchmark is also adjusted for several other factors. These include an adjustment to reflect an individual Medicare enrollee's age and heath problems, under a methodology known as "risk adjustment." This gives plans attracting sicker members relatively more money, while plans with healthier members get less.

Medicare Advantage benchmarks are also adjusted to help private plans operate in rural areas. This adjustment was added because several years ago, health insurers complained that they didn't receive enough from the government to cover their costs in rural areas.

Next steps in the process: If a private plan's bid to provide Medicare benefits in a particular county comes in above the benchmark, that means the plan is offering to cover a Medicare enrollee in that county for more than the government is willing to pay. In this rare situation, people in Medicare can still sign up for that plan, but they will then pay the additional cost in the form of a monthly premium. By contrast, if a plan's bid is below the benchmark, the plan keeps 75 percent of the difference between the plan's bid and the benchmark as a rebate. The plan must use the rebate to provide extra benefits; cut members' costs, such as reducing copayments or other member costs; or both. The government keeps the other 25 percent.

This complex system results in what MedPAC and other analysts consider excessive payments to Medicare Advantage plans. At the core of the problem, according to MedPAC, is the fact that the county-by-county benchmarks are set too high. This is no accident. Congress set the benchmarks high to ensure that private plans would participate in Medicare Advantage. It also created a system where the benchmarks could only be raised, never lowered, since the private plans are usually guaranteed the increase in the benchmark rate of 2 percent or at the overall growth rate of Medicare spending, whichever is greater.

This year, however, an unusual confluence of issues may change how next year's Medicare Advantage payments are set. The new wrinkle is explained below.

What's the argument?

Cut the payments: Critics of Medicare Advantage have long argued that payments to these plans as a whole exceed what Medicare would spend for similar beneficiaries if they were enrolled in traditional Medicare. In 2009, Medicare Advantage HMO plans are paid 13 percent above traditional Medicare, or $1,188 more per member; regional PPO plans get 12 percent or $1,044 more; and private fee-for-service plans receive 18 percent or $1,368 more, according to MedPAC's March 2009 report. In the end, the entire Medicare program winds up costing more than it would otherwise — $157 billion more over a decade, according to estimates by the Congressio-

Percent of Enrollees in Medicare Advantage Plans, 2008

Urban Areas

25%

Rural Areas

13%

nal Budget Office (CBO). Because Medicare costs are rising that much faster, Medicare's Hospital Insurance Trust Fund will be exhausted an estimated 18 months sooner than it would have been otherwise. In effect, these higher expenditures mean that federal taxpayers pay more for Medicare than if all beneficiaries were enrolled in traditional Medicare.

Critics also say that the higher outlays produce serious inequities between beneficiaries in traditional Medicare and those in private plans. For example, federal law requires that all Medicare beneficiaries enrolled in Part B pay 25 percent of the cost of Part B's services. Since Part B costs are higher because of the higher payments to private plans, premiums rise for all Medicare beneficiaries. Thus, as MedPAC calculates, the extra cost for Medicare Advantage in 2009 can add up to $3.26 to the monthly premiums all beneficiaries pay, even though most beneficiaries are not in Medicare Advantage.

Critics further argue that although beneficiaries in traditional Medicare pay more than they would otherwise, they receive none of the extra benefits that go to enrollees in private plans. What's more, these private-plan enrollees seldom pay anything for the extra benefits because of the inflated benchmarks. Because the inflated benchmarks vary from county to county, they produce a patchwork of plans offering extra benefits that also vary by county and plan. Instead of this patchwork of benefits available to those who join private plans, critics say, Congress should expand benefits or lower costs for all Medicare beneficiaries — or at least improve premium and cost-sharing subsidies for low-income beneficiaries.

Finally, critics of the overpayments to private plans also say that taxpayer dollars are being used to underwrite private plans' returns to investors and to pay the plans' additional administrative overhead. An estimated 13.4 percent of the Medicare Advantage payments will go toward 2009 profits and administrative costs, MedPAC found.

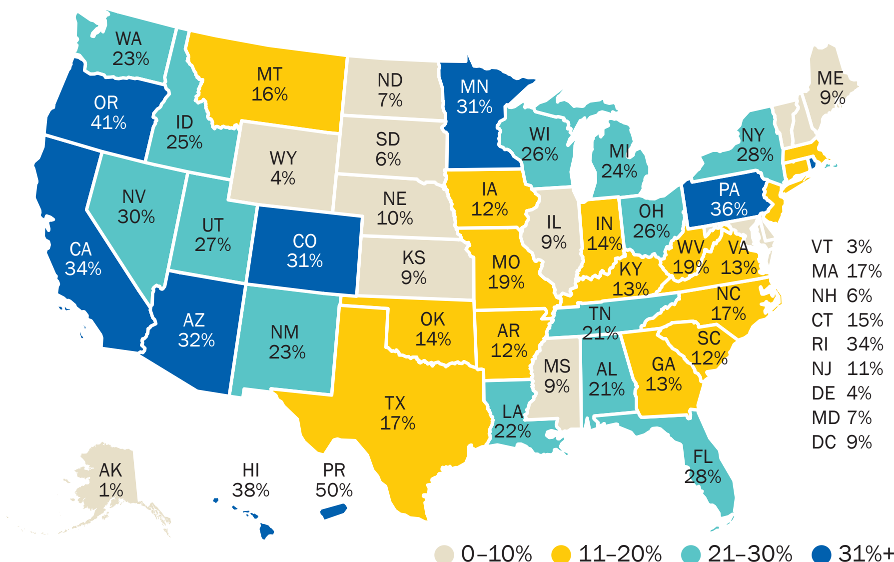
Don't cut the payments: Defenders of Medicare Advantage plans say cutting payments would have a number of deleterious effects. They say that lower payments would inevitably lead private insurers to slash members' benefits, raise premiums, or drop coverage entirely and would force beneficiaries back into traditional Medicare. They also say experience has shown that Medicare Advantage plans cannot stay in business when revenue falls short of expenses.

Medicare Advantage supporters believe that the plans bring important other benefits to the Medicare program. They say that private insurance companies can do a better job than traditional Medicare of slowing health cost growth by negotiating contracts with providers, using prior authorization, disease management, and other techniques that traditional Medicare generally does not use. The health insurance industry also says that some of the benefits available in private health insurance plans may lead to savings in the long run, as innovative preventive and wellness programs or careful management of medications reduces the overall use of health care.

Finally, defenders of Medicare Advantage point out that many low-income and minority beneficiaries often choose to enroll in Medicare Advantage plans. Since relatively few of them could afford to purchase standard private insurance coverage to supplement Medicare, enrolling in Medicare Advantage plans may be the only way they can obtain extra benefits, such having to pay less out of pocket or getting dental coverage.

EXHIBIT 2

Medicare Beneficiaries in Private Plans, 2009



Source: Mathematica Policy Research for the Kaiser Family Foundation.

What's next?

Congress faces two sets of issues this year: a short-term issue related to the Medicare Advantage benchmarks, and a long-term issue over restructuring the payments to private plans.

The short-term issue is that payments to

Range of Monthly Medicare Advantage Benchmark Payments, per Member, Depending on County, 2009

From

$740.82

To

$1,365.68

Medicare Advantage plans appear likely to fall an estimated 5 percent in 2010, according to an insurance industry analysis. The drop stems from several factors, all necessitated by law. But one of these factors — changes in physician payment — is actually a wild card that might or might not reduce the size of this expected cut.

Under a congressionally mandated formula, payments to physicians who treat patients in traditional Medicare are scheduled to fall 21 percent in 2010. This cut would lower the rate of growth in Medicare spending and drive down payments to Medicare Advantage plans. However, Congress is expected to rescind the physicians' pay cut, as in previous years. This will increase projected Medicare costs.

If timing were not an issue, the effect of these rising costs would be to push up Medicare Advantage payments and offset some of the downward payment pressure from other factors. Insurance industry analysts estimate that payments would then drop roughly 1 percent. But timing is an issue. By law, Medicare officials have already had to make their calculations for 2010 on the basis of current cost projections. So unless Congress acts, the industry predicts that Medicare Advantage plan payments will fall about 5 percent next year.

Sen. Max Baucus (D-MT), chairman of the Senate Committee on Finance, and Sen. Charles Grassley (R-IA), the committee's senior Republican, have asked Obama administration officials to find an "innovative solution" that will not result in Medicare Advantage payment cuts. Another 15 senators have made a similar request. As of publication of this policy brief, action on this was uncertain.

The long-term issue Congress faces is whether to restructure payments to private plans in more fundamental ways.

There are a number of competing proposals for doing so. For example, President Barack Obama wants what's called "payment neutrality" between Medicare Advantage and traditional Medicare. He proposes a competitive-bidding system that administration officials say would generate an estimated $177 billion over a decade. President Obama proposes to use these savings to expand health coverage to the nation's uninsured. (The president's proposal will be discussed further in a forthcoming Health Policy Brief.)

Congress is likely to consider the Obama administration's proposal in the months ahead, along with other restructuring plans. These include the following:

- Phasing down the Medicare Advantage payments so that they eventually equal traditional Medicare costs, as contemplated by legislation that passed the U.S. House of Representatives, but was not enacted into law, in 2007.
- Making further modifications in the complex Medicare Advantage payment formula. The modifications would allow some exceptions to payment equality between traditional Medicare and private plans, to sustain Medicare Advantage plans in some parts of the country that could not operate otherwise. MedPAC is studying various formula changes and will be reporting its recommendations to Congress in June.
- Keeping the current complex payment formula and adjustments but cutting benchmarks across the board.
- Limiting Medicare Advantage plan profits in order to reduce Medicare outlays or to compel plans to expand benefits.

In a year where Congress is grappling with a significant budget deficit while also trying to fund health care reform and other priorities, it seems likely that extra payments to private plans in the Medicare program will come under increasing scrutiny — either as part of new health care legislation or as part of a package that will form the 2010 budget.

Resources

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About Health Policy Briefs

Written by **Susan Jaffe**
Senior Writer, *Health Affairs*
Contact: info@healthaffairs.org

Editorial review by
Robert A. Berenson
Senior Fellow,
Health Policy Center,
The Urban Institute

Marsha Gold
Senior Fellow, Mathematica
Policy Research

Susan Dentzer
Editor-in-Chief, *Health Affairs*

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