

## The Advantage of Medicare Advantage: Why Reducing Seniors' Choices Won't Protect Taxpayers

By John R. Graham

### Key Points

- Congress and the Obama administration intend to reduce seniors' choices of Medicare Advantage plans, which would reduce Medicare spending by about 2 percent but would also increase the "hidden tax" on the privately insured Americans without fixing the flaws in traditional Medicare.
- Eliminating Medicare Advantage will simply throw seniors onto the mercy of a traditional Medicare which labors under a Soviet-style fee schedule that increasingly threatens seniors' ability to access medical care.
- Medicare Advantage appears to deliver superior outcomes to patients according to a number of quality indicators, including appropriate prescribing and preventive care, outcomes from hospitalization, and management of chronic illnesses, than traditional Medicare does.

Medicare Advantage, in which about one-quarter of Medicare beneficiaries are currently enrolled, is a program that subsidizes beneficiaries' access to private health insurance. The Pacific Research Institute will shortly publish *Medicare Advantage or Medicare Monopoly?* a thorough analysis of the costs and benefits of this program for Medicare beneficiaries and taxpayers, which proposes reforms that improve the program.<sup>1</sup> This installment of *Health Policy Prescriptions* explains why the government's crude attack on Medicare Advantage plans harms both seniors and taxpayers.

Congress and President Obama object to the cost of Medicare Advantage. At time of writing, two proposals are under active consideration in Congress, H.R. 3962 and the bill approved by the Senate Finance Committee. Both propose reducing payments to Medicare Advantage plans.<sup>2</sup> These steps are expected to save between \$124 billion and \$172 billion over the next 10 years.<sup>3</sup> They would also have significant consequences for seniors' access to medical services. In a recent survey of 45 leading managed-care executives, almost all of them concluded that these changes would materially affect beneficiaries' Medicare Advantage options in the future.<sup>4</sup>

In a *very narrow sense*, Medicare Advantage plans cost more, per beneficiary, than the traditional government-run Medicare monopoly does, and this increases the total costs of Medicare by about \$12 billion a year, or 2.3 percent. Traditional Medicare, however, imposes a "hidden tax" on privately insured Americans that amounts to \$49 billion a year: *four times* the so-called extra costs of Medicare Advantage. This is because

traditional Medicare operates under a Soviet-style price-fixing regime that does not pay providers their full costs. Most Medicare Advantage plans do not work this way. Rather than imposing higher costs, Medicare Advantage actually exposes the hidden tax and transfers the burden from the privately insured to society in general.

In 2008, Medicare Advantage cost taxpayers \$91 billion, a rapid increase from \$60 billion in 2006, and almost 20 percent of the estimated Medicare total of \$466 billion.<sup>5</sup> President Obama asserts that “Medicare overpays Medicare Advantage plans by 14 percent more on average than what Medicare spends for beneficiaries enrolled in the traditional fee-for-service program.”<sup>6</sup>

MedPAC concludes that Medicare is spending about \$12 billion more on Medicare Advantage plans in 2009 than it would spend if the beneficiaries had been enrolled in traditional Medicare.<sup>7</sup> While no credible analyst questions these estimates, we need to keep them in perspective: Medicare spending in 2009 is estimated to be \$503.1 billion, so the overpayments amount to only 2.3 percent of total Medicare spending.<sup>8</sup> Nevertheless, we need to understand why payments are higher than in traditional Medicare, and to examine whether these payments provide value to taxpayers. The most obvious reason for high payments is the high benchmarks the government has established to determine the subsidies that Medicare Advantage plans receive. These high benchmarks are the result of policies destined to send them on an upward spiral.

Medicare Advantage plans bid for government subsidies they anticipate will cover the Part A (hospital) and Part B (outpatient) costs for a beneficiary of average health in a defined payment area, usually a county. Each bid is measured relative to a benchmark. If the bid is above the benchmark, beneficiaries pay the difference. If a plan bids below the benchmark, the government sets the payment at the bid plus 75 percent of the difference between the bid and the benchmark.<sup>9</sup> Overall, Medicare Advantage benchmarks are set at 118 percent of traditional fee-for-service (FFS) payments in 2009. Average bids are well below the benchmark at 102 percent, and the formula results in payments of 114 percent of traditional FFS costs.<sup>10</sup> The “extra” 14 percent is the fundamental driver of alleged overpayments to Medicare Advantage plans and also drives the growth of the program.

Unfortunately, the Obama administration’s narrow focus on the “extra” costs that Medicare Advantage plans impose on taxpayers ignores the role of these plans in relieving the hidden tax that traditional Medicare imposes on private payers. Research from the early 2000s shows that Medicare HMOs paid doctors 20 to 30 percent more than traditional Medicare did.<sup>11</sup>

The table below shows payment-to-cost ratios for inpatient care by payer in California in 2005. Private insurers paid \$129 for every \$100 of hospital costs. Meanwhile, traditional Medicare paid only \$74, and other government payers also fail to cover the cost of treatment. Although Medicare Advantage HMOs in California did not pay as well as fully private payers, they did not impose the hidden tax of either traditional Medicare or other government plans. Obviously, hospitals could not deliver the care they do if they relied fully on traditional government payers.

<b>Net Revenue as Percentage of Average Cost per Adjusted Patient Day, 2005</b>					
<b>Private</b>	<b>Medicare Advantage HMOs</b>	<b>Traditional Medicare</b>	<b>Medi-Cal Managed Care</b>	<b>Traditional Medi-Cal</b>	<b>County/ Other Indigent</b>
129%	99%	74%	65%	56%	42%
Source: California HealthCare Foundation <sup>12</sup>					

It appears that Medicare’s failure to pay its way poses a dilemma: We can pay for its shortfall either through the hidden tax (or cost shift) levied on private payers, or via direct taxation, by subsidizing Medicare Advantage plans.

In 1965, Congress established Medicare as a federal-government monopoly. Today, Medicare's Part A (covering hospitalization) and Part B (covering outpatient services) rely on Soviet-style central planning to fix prices, which results in misallocation of resources.

William Hsiao, the economist who designed the Medicare Prospective Payment System, first implemented in 1983, determined Medicare's fees as follows: "He put together a large team that interviewed and surveyed thousands of physicians from almost two dozen specialties. They analyzed what was involved in everything from 45 minutes of psychotherapy for a patient with panic attacks to a hysterectomy for a woman with cervical cancer. They determined that the hysterectomy takes about twice as much time as the session of psychotherapy, 3.8 times as much mental effort, 4.47 times as much technical skill and physical effort, and 4.24 times as much risk. The total calculation: 4.99 times as much work. Eventually, Hsiao and his team arrived at a relative value for every single thing doctors do."<sup>13</sup>

Today, Medicare's Resource-Based Relative Value Scale (RBRVS) and Sustainable Growth Rate (SGR) "rules" for fixing prices are so flawed that "the Congress that consistently champions this price-setting process is annually engaged in a routine effort to change, modify, or even stop the progress of its own pricing machinery before it inflicts damage on the public and the medical profession. This is evident in the annual Chinese fire drill to prevent the legally ordained Medicare physician payment cuts . . ."<sup>14</sup>

As it is, providers are finding it increasingly difficult to levy the hidden tax on private payers. A survey of randomly chosen physicians (in all specialties) conducted this summer found that 62 percent ranked private insurers superior to Medicare on "adequacy of payments to you," and only 9 percent ranked Medicare superior, while 16 percent ranked them equally. With respect to "your overall experience," 46 percent of respondents ranked private insurers superior, and only 21 percent ranked Medicare superior, while 22 percent ranked them equally.<sup>15</sup> In another survey of 12,000 physicians conducted in 2008, 36 percent of respondents stated that Medicare payments did *not* cover the cost of providing care, and 12 percent

reported that they had already closed their practices to new Medicare patients. "Reimbursement issues" were the most dissatisfying feature of practicing medicine, and "Medicare/Medicaid/government regulations" ranked third.<sup>16</sup>

The "canary in the coal mine" was the announcement earlier this year by Houston's Kelsey-Seybold Clinic, that city's largest medical practice, that it would no longer accept new patients enrolled in the traditional Medicare Part B program because reimbursements had fallen too low. Almost all of the clinic's Medicare patients have switched to Medicare Advantage plans, which negotiate their own payment rates with providers.<sup>17</sup> In October, the Mayo Clinic decided that it could no longer accept traditional Medicare patients at its two primary-care clinics in Arizona.<sup>18</sup> And these are only two examples reported in the media. One can reasonably assume that other providers have come to similar decisions quietly.

Even if providers' capacity was adequate to satisfy seniors' needs in traditional Medicare, evidence strongly suggests that Medicare Advantage plans provide better care. The Medicare Payment Advisory Commission (MedPAC) "supports private plans in the Medicare program, as they enable beneficiaries to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater ability to innovate and, if paid appropriately, would have the incentive to do so."<sup>19</sup>

A 2004 literature review, published by America's Health Insurance Plans (AHIP), the health insurers' largest trade association, concluded that Medicare Advantage plans outperformed traditional Medicare in five of seven key quality indicators: prescribing beta blockers after heart attacks (as well as other appropriate treatment), annual flu vaccinations, breast-cancer screenings (resulting in earlier diagnosis), diabetes testing, and diabetes/lipid screening. The review concluded that, in addition to breast cancer, Medicare Advantage patients were screened and diagnosed

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earlier in cases of cervical cancer, colon cancer, and melanoma. It also concluded that terminally ill cancer patients in Medicare Advantage plans had greater access to hospice care.<sup>20</sup>

A more recent working paper reported that, while there was no peer-reviewed literature doing head-to-head comparisons of health outcomes, its members' proprietary data led to the conclusion that membership in Medicare Advantage plans had largely beneficial effects on patients with diabetes and heart disease. Looking at data from eight local Medicare Advantage HMO plans in 2005 and 2006, the working paper concluded that both types of patients had equal or lower rates of hospital admission and fewer days hospitalized, ER visits, and re-admissions than patients in traditional Medicare. In seven of the eight MA plans, diabetic patients had fewer potentially avoidable admissions—that is, re-admission for the same diagnosis-related group (DRG) within 90 days—than patients in traditional Medicare, and the same was true of heart-disease patients in six of the eight plans.<sup>21</sup> These Medicare Advantage HMOs also had lower ER use, along with more outpatient visits.<sup>22</sup> Overall risk scores for the Medicare Advantage patients were slightly lower than those of patients in traditional Medicare.<sup>23</sup>

A subsequent paper looked at all hospital admissions for Medicare patients in California and Nevada in 2006, concluding that Medicare Advantage patients admitted to California hospitals had 30 percent fewer inpatient days, and those in Nevada 23 percent fewer inpatient days, than traditional Medicare patients. Potentially avoidable admissions were 6 percent lower.<sup>24</sup>

The evidence is compelling: Overall, Medicare Advantage plans deliver superior care and do not cost taxpayers more than traditional Medicare does, after *all costs* are taken into account. The government's attack on this valuable option for seniors is misguided.

## Endnotes

- <sup>1</sup> John R. Graham, *Medicare Advantage or Medicare Monopoly? Protecting Seniors' Choices and Taxpayers' Wallets in the Federal Government's Largest Entitlement Program* (San Francisco, CA: Pacific Research Institute, forthcoming).
- <sup>2</sup> Kaiser Family Foundation, *Focus on Health Reform: Health Care Reform Proposals* (Menlo Park, CA: Henry J. Kaiser Family Foundation, October 15, 2009), p. 15.
- <sup>3</sup> Kaiser Family Foundation, *Side-By-Side Comparison of Key Medicare Provisions in 2009 Health Reform Legislation: H.R. 3200 and Senate Finance Committee's Chairman's Mark*, Publication No. 7948 (Menlo Park, CA: Henry J. Kaiser Family Foundation, October 1, 2009), pp. 19–20.
- <sup>4</sup> Peyton Howell, "Payer Perspectives on Healthcare Reform," *American Health & Drug Benefits*, vol. 2, no. 4 (June/July 2009), p. 182.
- <sup>5</sup> *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006*, GAO-09-132R (Washington, DC: Government Accountability Office, December 8, 2008), pp. 1 and 6, and reference; CMS, *NHE Historical and Projections, 1965–2018* (Baltimore: Centers for Medicare & Medicaid Services, July 7, 2009). Available at [http://www.cms.hhs.gov/NationalHealthExpendData/03\\_NationalHealthAccountsProjected.asp#TopOfPage](http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage).
- <sup>6</sup> *President Obama's Fiscal 2010 Budget. Transforming and Modernizing America's Health Care System*, Fact Sheet (Washington, DC: Office of Management and Budget, May 7, 2009). Available at [http://www.whitehouse.gov/omb/fy2010\\_key\\_healthcare/](http://www.whitehouse.gov/omb/fy2010_key_healthcare/).
- <sup>7</sup> *Report to the Congress: Medicare Payment Policy* (Washington, DC: Medicare Payment Advisory Commission, March 2009), p. 258.
- <sup>8</sup> *National Health Expenditure Projections, 2008–2018* (Baltimore: Centers for Medicare & Medicaid Services, 2009), table 3.
- <sup>9</sup> *Medicare Advantage Program Payment System* (Washington, DC: Medicare Payments Advisory Commission, October 2008), pp. 1–4.
- <sup>10</sup> *Report to the Congress*, pp. 257–258.
- <sup>11</sup> CBO, *Designing a Premium Support System for Medicare*, Publication No. 2596 (Washington, DC: Congressional Budget Office, December 2006), pp. 13-14.
- <sup>12</sup> California HealthCare Foundation, *Snapshot: Financial Health of California Hospitals* (Oakland: California HealthCare Foundation, 2007), p. 12.
- <sup>13</sup> Rick Mayes and Robert A. Berenson, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006), p. 86.
- <sup>14</sup> Robert E. Moffit, *The Success of Medicare Advantage Plans: What Every Senior Should Know*, Backgrounder No. 2142 (Washington, DC: Heritage Foundation, June 13, 2008), pp. 7–8.
- <sup>15</sup> Salomeh Keyhani and Alex Federman, *Physician Views on the Public Health Insurance Option and Medicare Expansions* (Princeton, NJ: Robert Wood Johnson Foundation, September 2009), p. 8.
- <sup>16</sup> Merritt Hawkins & Associates, *The Physicians' Perspective: Medical Practice in 2008: Survey Summary & Analysis* (Boston, MA: Physicians' Foundation, October 2008), pp. 3 and 8.
- <sup>17</sup> Cindy George, "Kelsey-Seybold Opts Out of Medicare," *Houston Chronicle*, February 17, 2009, p. B1.
- <sup>18</sup> Ginger Rough, "Mayo Unit No Longer to Accept Medicare," *Arizona Republic*, October 9, 2009, p. 1.
- <sup>19</sup> *Report to the Congress*, p. 255.
- <sup>20</sup> *The Value of Private Sector Health Choices in Medicare* (Washington, DC: America's Health Insurance Plans, September 2004), pp. 1–2.
- <sup>21</sup> AHIP Center for Policy and Research, *Working Paper: A Preliminary Comparison of Utilization Measures among Diabetes and Heart Disease Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-for-Service in the Same Service Areas*, revised (Washington, DC: America's Health Insurance Plans, September 2009).
- <sup>22</sup> *Ibid.*, pp. 12–13.
- <sup>23</sup> *Ibid.*, p. 10.
- <sup>24</sup> AHIP Center for Policy and Research, *Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions among Medicare Advantage Enrollees in California and Nevada, 2006* (Washington, DC: America's Health Insurance Plans, September 2009).