

Medicare Advantage or Medicare Monopoly?

Protecting seniors' choices and taxpayers' wallets in the federal government's largest entitlement program



By John R. Graham

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Executive Summary

Medicare Advantage, in which about one-quarter of Medicare beneficiaries are currently enrolled, is a program that subsidizes beneficiaries' access to private health insurance.

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, but most Medicare Advantage plans do not. Rather than imposing higher costs, Medicare Advantage actually exposes the hidden tax and transfers the burden from the privately insured to society in general.

Medicare Advantage has a number of costs and benefits:

- ✓ 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.
- ✓ While Medicare Advantage does increase access to medical care for low-income and rural beneficiaries, it does this inefficiently and is not as popular as Medigap, which supplements traditional Medicare.
- ✓ If there is a part of Medicare Advantage that adds cost without value, it is likely the private fee-for-service (PFFS) plans, which enter areas with the highest subsidies, appear to have the least satisfied beneficiaries, and have not had to negotiate contracts with providers. However, many do add value by protecting beneficiaries against catastrophic costs, which traditional Medicare does not, and they will have to negotiate contracts with providers starting next year.
- ✓ While the government has significantly improved its risk adjustment of payments to Medicare Advantage plans, which are designed to pay higher subsidies for sicker beneficiaries, evidence strongly suggests that Medicare Advantage plans successfully enroll patients whose actual medical claims will be lower than those expected by the model. Indeed, it is unlikely that effective risk adjustment can ever result from central planning.
- ✓ Medicare Advantage lacks consumer direction. Plans use their subsidies to reduce beneficiaries' cost sharing, which reduces beneficiaries' incentives to be sensitive to the prices of medical goods and services.

Congress and the Obama administration intend simply to cut subsidies to Medicare Advantage, which would reduce Medicare spending by about 2 percent, without improving traditional Medicare. Unfortunately, this is a very poor policy, because it would throw millions of Medicare beneficiaries back into traditional Medicare fee-for-service and increase the hidden tax on the privately insured.

A superior alternative would be to force the traditional Medicare program to be a bidder against Medicare Advantage plans. In this case, if traditional Medicare's costs for an average beneficiary in a county were higher than the average or minimum of all bids, the government would not be allowed to subsidize beneficiaries who chose to stay in traditional Medicare above that "benchmark." This reform would save 8 to 11 percent of Medicare costs. Beneficiaries would be automatically enrolled in the lowest-cost Medicare plan. Thus they would have to make a deliberate choice if they wanted a more expensive one, for which they would pay with their own money.

Another option would be to inject more consumer power into Medicare Advantage plans' purchasing decisions, by giving beneficiaries more control of Medicare dollars. The government discourages plans with out-of-pocket costs greater than \$3,400, but \$5,000 would be a more appropriate limit. Current incentives are in the wrong direction: Taxpayers finance rebates that *reduce* beneficiaries' cost sharing, thereby artificially increasing consumption. The government should encourage beneficiaries to accept higher deductibles, co-pays, and co-insurance, by permitting Medicare Advantage plans to win bids by increasing beneficiaries' cost sharing.

The most complex, but most effective, reform would be to transform Medicare Advantage from a program in which private plans bid annually into one in which they offer long-term, portable, guaranteed renewable health insurance. Allowing the market, rather than government, to price risk eliminates the incentive for insurers to profit from risk selection. That, in turn, gives health plans and providers aligned incentives to optimize patients' care over the long term. This reform would achieve this by adopting two characteristics of Medigap insurance (which currently supplements traditional Medicare): an open-enrollment period of six months after becoming a Medicare beneficiary, followed by guaranteed renewability.

Because these new Medicare Advantage plans would protect beneficiaries from the long-term financial consequences of becoming sick, their premiums would be higher than those of current Medicare Advantage policies. However, these would not be new costs: The higher costs already exist in the form of Medicare's unfunded liabilities. By reducing the unfunded liability of traditional Medicare and increasing the funded liability of health-status premiums, the government could give fiscal certainty to public finances and motivate seniors to migrate voluntarily to a program with superior incentives and a more solid guarantee of access to care than they have in the obsolete traditional Medicare.

The Questionable Future of Choice in Medicare

Congress established Medicare in 1965 as a single-payer, government-monopoly health plan for most Americans over 65 years of age. However, in 1997 Congress passed legislation creating Medicare+Choice. This program allowed Medicare beneficiaries to choose health benefits managed by private insurers, which bid for the opportunity to enroll Medicare beneficiaries and receive subsidies from the Centers for Medicare & Medicaid Services (CMS) in return. The size and design of the subsidies are the critical factors informing private health plans' decisions to compete to enroll beneficiaries.

Subsidies were increased during the Bush Administration, which had stated a goal of increasing Medicare beneficiaries' choices through an expanded Medicare+Choice program, now renamed Medicare Advantage. The Obama administration has a different perspective. The president's February 2009 budget proposed significant cuts to Medicare Advantage payments: "Under current law, 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. The Administration believes it's time to stop this waste and will replace the current mechanism to establish payments with a competitive system in which payments would be based upon an average of plans' bids submitted to Medicare. This would allow the market, not Medicare, to set the reimbursement limits, and save taxpayers more than \$175 billion over 10 years, as well as reduce Part B premiums. These overpayments threaten Medicare's finances and increase the premiums paid by participants in traditional Medicare."¹

Congress shares the president's objections to the cost of Medicare Advantage. At the time of writing, there are two proposals 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, either by using average bids to determine the payments (similar to the president's proposal) or by gradually moving the currently defined "benchmarks" for each locality down to 100 percent of the fee-for-service (FFS) payments for traditional Medicare.² These steps are expected to save between \$124 billion and \$172 billion over the next 10 years.³ However, 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.⁴

Even in the absence of new legislation, Medicare beneficiaries' choices are already shrinking significantly because of laws passed towards the end of the Bush administration and current administrative changes within the privilege of the executive. Avalere, a health care consulting company, predicts that the number of Medicare Advantage plans offered in 2010 will drop by 40 percent.⁵ An official of the Centers for Medicare & Medicaid Services recently announced that premiums for Medicare Advantage were expected to rise by 25 percent, from \$32 up to \$39 per month, in 2010, and that more than 667,000 seniors would lose access to Medicare Advantage plans next year.⁶

The current administration's policy of reducing Medicare beneficiaries' choices will have significant consequences for seniors. The anticipated savings from eliminating these choices must be understood within the context of a traditional Medicare program that is unwieldy, out of control, and careening into crisis.

The Traditional Medicare Monopoly Is a Clear and Present Danger to Seniors' Security

One of the characteristics of this summer's town-hall meetings and tea-party rallies was the presence of grey-haired retirees who were worried that a further government takeover of Americans' access to medical services would have negative consequences for their Medicare benefits. Unfortunately, Medicare beneficiaries are likely to lose access to medical services even faster than many of these folks anticipate. Younger Americans are a little more realistic about the likelihood of Medicare's being able to finance their health-care needs in retirement. While only 39 percent of current retirees are "not too" or "not at all" confident that "the Medicare system will continue to provide benefits of at least equal value to the benefits received by retirees today," 61 percent of current workers express this lack of confidence in future Medicare benefits.⁷

While Medicare's long-term unfunded liabilities are a gathering threat to its future beneficiaries' ability to get medical services when they need them, Medicare's current operational dysfunction is a clear and present danger to seniors' access to medical services today. This is because most Medicare beneficiaries depend on Medicare's traditional Part A and Part B for hospitalization and outpatient coverage.

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."⁸

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 . . ."⁹

Fortunately for those who turned 65 years of age between 1966 and today, the failure of Medicare's regime of central planning has been disguised by two pressure valves, both of which derive from the fact that the program is only for senior citizens, rather than "universal" for the entire population.

In 2005, only 10 percent of Medicare beneficiaries relied on traditional Medicare alone for their health insurance.

The first pressure valve was demographic: Medicare was enacted at a time when there were more workers than retirees, a situation that is changing for the negative. In the past 35 years, Medicare enrollment has doubled, and it is expected to double again over the next 35 years. However, the number of workers paying taxes into Medicare increased by only two-thirds over the last 35 years, and will increase by only about one-fifth over the next 35 years.¹⁰ While every beneficiary in 2008 enjoyed hospital benefits funded by the payroll taxes of about 3.7 workers, the ratio will worsen to about 2.4 in 2030 and 2.1 in 2080.¹¹

And this is only for the hospital insurance (HI) trust fund. Traditional Medicare has two parts. Part A, hospital insurance, is funded by a payroll tax on workers and their employers, and pays hospital claims of beneficiaries. Part B, supplementary medical insurance (SMI), which pays for outpatient services, is voluntary and partially paid by premiums, deducted from beneficiaries' Social Security payments. However, it is heavily subsidized by general tax revenues, so that about 95 percent of eligible beneficiaries participate in Part B.¹²

Medicare's Part A is still funded by payroll taxes and by interest on the so-called "trust fund." However, beneficiaries' premiums cover only 25 percent of Part B's costs and 10 percent of the cost of the Part D (prescription drug) benefit enacted in 2003.¹³ Overall, Part B will cost \$203 billion in 2009 and Part D, \$66 billion.¹⁴ Recall that Part B started paying claims in 1966 and Part D in 2006, and realize that Medicare has been slowly but surely drifting away from even the limited fiscal responsibility imposed by a specified payroll tax and towards reliance on general revenues instead. Further, when Part B started, beneficiaries' premiums actually funded 50 percent of program costs; the share was gradually reduced to 25 percent by 1980.¹⁵ Today, general tax revenue funds 40 percent of *all* Medicare spending, while payroll taxes fund 43 percent. Beneficiaries' premiums fund less than 13 percent of Medicare's costs.¹⁶ At that, the Medicare trustees *overestimate* premiums received in Part B and Part D because some premiums for "dual-eligible" beneficiaries (enrolled in Medicaid as well as Medicare) are paid by Medicaid, a joint state and federal program. Some of the premiums calculated by the CMS are actually just transfers from another government account.¹⁷

The second pressure valve is the dominance of private payers in U.S. health care. Medicare's reimbursements do not cover providers' total costs, which results in a cost shift (or "hidden tax") to private insurers. Nationally, Medicare payment rates were only 78 percent of those of private payers in 2007.¹⁸ In 2006, hospitals reported an average net *negative* margin of 9 percent from Medicare payments, versus an average positive margin of 23 percent from private payments.¹⁹ Overall, this hidden tax reduced Medicare's costs by \$49 billion in 2007, by shifting the costs to private payers.²⁰ Along with the cost shift from the joint federal-state Medicaid program, this added \$1,788 to the health costs of a family of four in 2007.²¹ Because

the government tolerates private insurers, Medicare beneficiaries have access to much a greater choice of medical services than they would under a true single-payer health-care system, which would significantly reduce providers' capacity.²²

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.²³ 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.²⁴

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.²⁵ In October, the Mayo Clinic decided that it could no longer accept traditional Medicare patients at its two primary-care clinics in Arizona.²⁶ And these are only two examples reported in the media. One can reasonably assume that other providers have come to similar decisions quietly.

The government, fortunately, allows most seniors (somewhat limited) means of compensating for traditional Medicare's inadequacies. In 2005, only 10 percent of Medicare beneficiaries relied on traditional Medicare alone for their health insurance. Almost one-third had employer-sponsored supplemental benefits, more than one-quarter had Medigap supplemental insurance, and others had either Medicaid (through dual eligibility) or Medicare Advantage (table 1). Of all Medicare beneficiaries who did *not* have employer-sponsored supplemental insurance or Medicaid, 52 percent had Medigap, versus 28 percent who had Medicare Advantage.²⁷

Table 1: Sources of Supplemental Coverage among Non-Institutionalized Medicare Beneficiaries, by Beneficiaries' Incomes, 2005

	Employer-sponsored	Medigap	Medicaid	Medicare Advantage	Other public	Medicare only
All beneficiaries	32%	28%	14%	15%	1%	10%
Below poverty	11%	14%	50%	10%	2%	13%
100%–200% of poverty	23%	27%	17%	17%	2%	14%
200%–400% of poverty	40%	31%	2%	17%	1%	9%
Over 400% of poverty	47%	38%	0%	12%	0%	3%
Urban	32%	27%	13%	19%	1%	8%
Rural	32%	34%	17%	2%	2%	14%

Source: MedPAC 2008; author's calculations²⁸

Medigap: A Popular Addition to Traditional Medicare

Although employer-sponsored supplemental health benefits are the most prevalent method of supplementing traditional Medicare, they are in decline. In 1988, of employers who had 200 or more employees and offered health benefits to active workers, 66 percent also offered health benefits to retirees. The rate dropped to 29 percent this year. Among smaller firms, only 5 percent offered retirees health benefits this year.²⁹ Clearly, individuals will increasingly have to take responsibility for finding their own alternatives to traditional Medicare.

Medigap is the most popular of these options. Because this analysis will recommend that the government adopt some of the characteristics of Medigap for Medicare Advantage, this section will explain Medigap in some detail. Unlike Medicare Advantage, Medigap is not an *alternative* to traditional Medicare but an *addition* to fill in the gaps in the original program.

Traditional Medicare Part A has the following cost sharing for hospitalization in 2009:

- ✓ \$1,068 deductible, but zero co-insurance from days 1 through 60 of each “benefit period” (which ends 60 days after the patient is discharged);
- ✓ \$267 daily co-payment for days 61 through 90 of each benefit period;
- ✓ \$534 daily co-payment per “lifetime reserve day” after the 90th day in hospital (a beneficiary has 90 reserve days over the course of his lifetime).

Part A also covers hospice care, skilled-nursing facilities, and home health care, with some limits.³⁰

Traditional Medicare Part B, for outpatient care, also requires that beneficiaries pay some of their costs directly. The annual deductible is \$135, and most physicians’ services are subject to a 20 percent co-payment, or a 50 percent co-payment for mental-health care. Most importantly, Part B has *no maximum out-of-pocket costs*.³¹ As a result, Medicare Part B fails as *insurance*—i.e., a mechanism to reduce the risk of unexpected costs to the insured.

There are a number of differences between Medigap and Medicare Advantage:

1. Medicare Advantage plans must cover the same benefits as traditional Medicare Parts A and B, and can offer whatever extra benefits their sponsors see fit, subject to approval by the CMS. Medigap, by contrast, is a portfolio of 12 different choices, identified by letter (A through L), within which each plan sponsor must offer exactly the same package of supplemental benefits (originally defined by Congress in 1990). These might include covering the deductible or co-payment for traditional Parts A and B, as well as non-Medicare benefits such as foreign-travel emergency coverage.³² As a result, there can be considerable overlap between traditional Medicare plus Medigap, on the one hand, and Medicare Advantage on the other.

2. Because Medigap is *in addition* to traditional Medicare, it does not affect the fees paid to providers and thus does *not* relieve the cost shift described above.
3. Medicare Advantage plans are governed solely by the CMS, which regulates marketing and advertising, and whose rules are becoming increasingly restrictive. Indeed, as of 2010, the CMS will not allow plans to enroll people themselves, but will allow enrollment only through the CMS's online enrollment center. (There will be some minor exceptions.) This is to frustrate sponsors that have allegedly enrolled beneficiaries in different plans from the ones they selected.³³ Medigap plans are regulated by state insurance law, and sold under regulations similar to those for the individual market.
4. The federal government subsidizes Medicare Advantage participation with risk-adjusted payments: It pays higher subsidies for more expensive patients. By contrast, beneficiaries buy Medigap plans with their own money; they bear the risk and have the opportunity of choosing the right plan for their long-term health needs (because Medigap plans are guaranteed renewable from year to year).
5. Participation in a Medicare Advantage plan may last for only one year: Beneficiaries have the right to switch between November 15 and December 31, the period of open enrollment, and Medicare Advantage plans must accept anyone who applies, while charging the same premiums to all. Such policies are called "community rating" and "guaranteed issue." Medigap, on the other hand, is subject to underwriting approval except during the six months in which a beneficiary has both enrolled in traditional Medicare Part B and turned 65 (except in Massachusetts, Minnesota, and Wisconsin, where Medigap is always guaranteed issue), or in special cases, such as when a beneficiary has switched to a Medicare Advantage plan but switched back during a trial period.³⁴ Beyond these special cases, insurers are not required to accept applicants if they miss open enrollment.
6. In Medicare Advantage, premiums are determined annually by bids submitted to the CMS by plan sponsors. Medigap premiums are set in the market and increase annually for beneficiaries in one of three ways: community-rated (premiums the same for everyone enrolled, regardless of age), issue-age-rated (premium based on age when a beneficiary enrolls), or attained-age-rated (premiums based on a beneficiary's current age).³⁵
7. As of January 1, 2006, Medigap plans are no longer permitted to offer prescription benefits. This is a consequence of the Medicare Prescription Drug Improvement and Modernization Act of 2003, which had a goal of causing seniors to migrate to the new Medicare Part D drug plans or Medicare Advantage drug plans. It had an immediate effect: In 2006, 55 percent of Medicare beneficiaries received their prescription-drug coverage from newly available Medicare Advantage or Part D options.³⁶ Beneficiaries who had bought Medigap plans with prescription-drug coverage before 2006 were allowed to keep them.

Because taxpayers subsidize Medicare Advantage's extra benefits, but not Medigap's, Medigap beneficiaries spend more of their own money on health care. In 2005, Medigap beneficiaries paid monthly out-of-pocket costs of about \$224 and monthly premiums of \$225 (of which the Medigap premium alone was about \$147).³⁷ That same year, however, Medicare Advantage beneficiaries paid an average of \$49 per month out of pocket and monthly premiums of about \$128 for Medicare Advantage plus prescription-drug coverage (MA-PD plans).³⁸

Clearly, individuals will increasingly have to take responsibility for finding their own alternatives to traditional Medicare.

Even popular publications have noticed this. In 2008, the *Spokane Journal of Business* reported that most Medicare Advantage plans in Spokane County charged premiums of less than \$100 per month for coverage that included prescription drugs, whereas Medigap policies cost between \$90 and \$200, and beneficiaries had to pay for a Part D prescription-drug plan on top of that.³⁹ *Kiplinger's*, a publisher of popular financial advice, noted in 2007 that Medigap policies cost an average of \$140 per month, and a Medicare prescription-drug plan, \$24 per month. If a beneficiary instead enrolled in a Medicare Advantage plan that charged him nothing over the Part B premium of \$93.50 per month, he could save nearly \$2,000 per year.⁴⁰

The Rise, Fall, and Rebirth of Choice in Medicare

The idea of private plans competing against the government for Medicare patients is not new, but it has had a checkered history of political interference. Although health maintenance organizations (HMOs) were allowed to compete in Medicare as early as 1972, few plans entered the field. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allowed Medicare to pay HMOs 95 percent of the average cost (within counties) of traditional Medicare for beneficiaries whom they enrolled. Plans bore the risk of costs above this benchmark, but they could reduce beneficiaries' premiums or add optional benefits (including prescription drugs) to attract new members, if they could cut costs below 95 percent.

Enrollment reached 1.4 million beneficiaries in 1991, and kept growing from there. Corresponding with the general growth of HMOs in the 1990s, enrollment in Medicare HMOs reached more than six million members: 15 percent of the eligible population. Nevertheless, although the payments were crudely risk-adjusted for age, sex, institutionalization, and Medicaid status, the government accused Medicare HMOs of over-enrolling healthy beneficiaries, and thereby increasing the costs of those who remained in traditional Medicare. As a result, the government imposed new taxes and regulations on the HMOs to push them out of the market.⁴¹

The government also sought to improve the way it adjusted payments to private plans that enrolled patients with expected medical costs that were higher than the average per capita medical cost in their counties. This was especially important to the Bush administration, which had a goal of reversing the decline in private plans' participation in Medicare. Effectively risk-adjusted payments are critical to ensuring that Medicare Advantage plans compete on service, and just not by attracting and enrolling beneficiaries who are healthier than average, which risks the kind of political retribution experienced in the late 1990s.

The government has steadily increased the sophistication of its risk adjustment. In 2000, the initial, blunt adjustments used in the 1990s were replaced by inpatient diagnostic cost groups, which used principal diagnoses from hospitalization in the previous year to predict each patient's costs in the upcoming year. In 2004, the CMS introduced partial use of a risk adjuster that considered the disease burden of enrollees, amplified by diagnostic information from outpatient settings as well as hospitals. Flowing from hundreds of inputs, the CMS Hierarchical Condition Categories (CMS-HCC) system was fully implemented in 2007.⁴²

Because Medicare Advantage plans continue to attract beneficiaries who are healthier than traditional Medicare beneficiaries, full risk adjustment *reduces* payments to Medicare Advantage plans. The purpose of the risk-adjustment exercise was somewhat defeated by the Budget-Neutral Risk Adjustment (BNRA) policy, introduced in 2003, which increased rates across the board so that the risk adjustment would *not* reduce aggregate payments to Medicare Advantage plans.⁴³

Nevertheless, the CMS-HCC risk-adjusted payments have led Medicare Advantage plans, overall, to enroll patients with higher projected medical costs than they did previously. From 2003 to 2004, risk-scores for MA beneficiaries increased significantly, from 12 percent lower than traditional Medicare beneficiaries' scores to only 6 percent lower.⁴⁴

The idea of private plans competing against the government for Medicare patients is not new, but it has had a checkered history of political interference.

Medicare Advantage grew out of a goal of giving Medicare beneficiaries choices beyond HMOs. In 1997, Congress passed the Balanced Budget Act, which created Medicare Part C, known as Medicare+Choice (M+C). M+C added preferred provider organizations (PPOs) and private fee-for-service plans (PFFS) as choices beyond HMOs. This was the period, however, when Medicare HMOs were coming under attack for selecting healthier

patients. Plans were limited to annual payment increases of only 2 percent, even though their medical costs were growing faster. Plans withdrew from the M+C program, and enrollment dropped.⁴⁵

In June 2000, the first PFFS plans began to compete against the managed-care plans in M+C, and these plans entered counties that M+C managed-care plans had exited.⁴⁶ Further, the proportion of enrollees having the option of buying into plans that charged zero premiums for extra benefits declined dramatically, from 62.3 percent to 17.2 percent, between January 1999 and March 2001.⁴⁷ M+C enrollment declined from 6.35 million in 1999 to 5 million in 2003.⁴⁸

However, the fortunes of M+C turned around soon after the Benefits Improvement and Protection Act (BIPA) of 2000, which reflected understanding that patient choice within Medicare was in a tailspin because of inadequate payments. BIPA authorized M+C plans to rebate premiums starting in 2003. This meant that they could not only add on extra benefits for no cost, but also use the payments that they received from Medicare to reduce beneficiaries' premiums or co-payments for their traditional Medicare Part A and B benefits. This allowed them to compete on price, instead of just by offering optional benefits.⁴⁹

In 2003, President Bush signed major health care legislation, the Medicare Prescription Drug Improvement and Modernization Act, more commonly known as the Medicare Modernization Act (MMA). One of the goals of the 2003 reform was to attract more PPOs into M+C, now renamed the Medicare Advantage program. According to the CMS administrator at the time, "the president's plan is based on combining the best of Medicare . . . with the option chosen by . . . 130 million Americans, the flexible PPO benefit model."⁵⁰ At that time, the country had experienced a significant backlash against HMOs, so it is not surprising that the administration wanted to encourage other forms of private health insurance within Medicare Advantage.

Another goal of the 2003 reform was to increase choices in rural areas. Incumbent HMOs, which had marketed county-specific plans, were protected. However, new PPOs were required to market uniform plans within each of 26 regions within the United States. The goal was to improve access to private plans by merging underserved rural areas with well-served urban ones. To reinforce the message, new plans were not allowed to market county-specific offerings between 2006 and 2008.⁵¹

Even at the time, scholars realized that the regional PPOs (RPPOs) faced skewed incentives. Medicare Advantage plans win the right to enroll beneficiaries in a county or region by bidding against benchmarks, which the CMS establishes based on projected average costs per beneficiary in the traditional Medicare program's Part A and Part B. Because the benchmarks for RPPOs were *regional* benchmarks, RPPOs had an incentive to enroll people in counties (within each region) with low projected medical claims, a variant of the familiar cream-skimming problem.⁵² They could do this, despite the best efforts of the CMS to stop it, through tactics such as selective networking and narrowly targeted marketing. However, RPPOs have proved unable to make significant inroads. As of 2008, there were only 258,000 RPPO enrollees, and three-quarters were from urban counties.⁵³ Plan sponsors suggest that the flawed design of RPPOs will continue to limit their growth.⁵⁴

Although RPPOs have not been a success, other Medicare Advantage plans have enjoyed significant growth since 2003, as shown in table 2.

Plan type	Medicare + Choice enrollment, December 2003 (millions)	Medicare Advantage enrollment, June 2008 (millions)	Difference (millions)	Contribution to net growth
Total	5.3	10.0	4.7	100%
Private Fee-for-Service (PFFS) (individual)	0	1.6	1.6	35%
Special-Needs Plans (SNPs)	0	1.1	1.1	24%
HMO	4.7	5.4	0.7	15%
Private Fee-for-Service (PFFS) (group)	0	0.6	0.6	13%
Local PPO/POS	0.1	0.6	0.5	11%

Source: Gold 2009⁵⁵

This growth took place largely because the MMA significantly increased the benchmarks against which plans bid to participate in Medicare Advantage. Under the MMA, benchmarks for each county were set annually at the *highest* of eight different reference rates. One of these is the projected payment for traditional Medicare Parts A and B, so each benchmark must necessarily have been *at least* 100 percent of the payment for traditional Medicare when the benchmarks were first instituted. Since then the benchmarks have crept

up, and growth has accelerated, especially in the last couple of years: From November 2007 to November 2008, Medicare Advantage enrollment increased by 16 percent (1.4 million beneficiaries).

As Medicare Advantage payments versus traditional Medicare increased, rather than compressed, Medicare Advantage's costs per beneficiary, political pressure to change this quickly increased, even during the Bush administration. The Deficit Reduction Act of 2005 pulled some money away from MA plans to offset the costs of deferring a cut in traditional Part B payments to physicians, as did the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.⁵⁶

Medicare Advantage grew out of a goal of giving Medicare beneficiaries choices beyond HMOs.

Furthermore, the Deficit Reduction Act of 2005 phased out the Budget-Neutral Risk Adjustment, such that only 55 percent of the BNRA factor was applied in 2007, 40 percent in 2008, and 25 percent in 2009; the figure will be 5 percent in 2010 and zero in 2011.⁵⁷ For 2010, the full BNRA factor is 2 percent, so the net factor that will be applied will be only 0.10 percent (5 percent of 2 percent).⁵⁸ As a result, the BNRA has dwindled towards irrelevance as a cost driver of Medicare Advantage.

Some of the growth in coordinated-care plans (CCPs), which include both HMOs and PPOs, has been within the category of special-needs plans (SNPs). SNPs include plans for dual-eligible Medicaid and Medicare patients. As the CMS instituted risk adjustment for Medicare Advantage plans, many Medicaid managed-care plans converted to Medicare Advantage SNPs to benefit from the risk-adjusted payments, and their beneficiaries passively followed.⁵⁹

To summarize, the share of Medicare beneficiaries participating in private plans is now higher than it has ever been. Before the post-MMA boom, the previous high-water mark was 16 percent of beneficiaries, a result of the BBA of 1997, which prevailed from 1998 through 2000. The share declined to 12 percent in 2002 and 2003 before turning around.⁶⁰ As of April 2009, more than 10 million beneficiaries—about 25 percent of those enrolled in Medicare Part A and Part B—were in Medicare Advantage plans.⁶¹

Medicare Advantage Today

Medicare Advantage plans bid for government subsidies they anticipate will cover the Part A and Part B 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.⁶² Overall, Medicare Advantage benchmarks are set at 118 percent of traditional 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.⁶³ The “extra” 14 percent is the fundamental driver both of allegations of overpayment to Medicare Advantage plans, and of the growth of the program.

The three-quarters of the difference between plans’ bids and the benchmarks, which is paid to the plan, must be used for enhanced benefits. Enhanced benefits can include:

- ✓ Reduction of cost sharing—that is, deductibles, co-payments, and co-insurance (co-payments are usually fixed amounts, whereas co-insurance is a percentage)—for Medicare Part A and Part B;
- ✓ Provision of added, non-Medicare benefits, such as routine dental and vision care;
- ✓ Reduction of the Part D premium of an MA-PD plan;
- ✓ Enhancement of the drug benefit in an MA-PD plan;
- ✓ Reduction of the member’s Part B premium.⁶⁴

While Medicare Advantage plans may require more cost sharing for *any given service*, they must not impose higher cost sharing *overall* than that borne by beneficiaries in traditional Medicare.⁶⁵

The adjectives “additional,” “optional,” and “enhanced” are used inconsistently in official sources. The Medicare Payments Advisory Commission (MedPAC) refers to rebates funding “enhanced” benefits including “added, non-Medicare benefits, such as routine dental and vision care.”⁶⁶ The Government Accountability Office (GAO) asserts that rebates can fund “additional” benefits but not “optional” benefits, without defining the difference.⁶⁷ Examples of benefits that are allowed are vision, hearing, foreign-travel emergency, extra days in a hospital or skilled-nursing facility, and health education.⁶⁸

A Medicare Advantage plan’s bid has three components: Part A and Part B medical costs, administrative costs, and profit, of which the last two are referred as “load” or the “loading factor.” MedPAC estimates the average load for 2009 across all Medicare Advantage plans to be 13.4 percent of the bid (but this may be low, judging by the historical evidence). The loading factor applies to the reduction in Part A and B cost sharing and extra benefits, but *not* to the reduction in Part B premium. For Part D benefits, the load factor is

a component of both premium reduction and extra benefits.⁶⁹ This likely explains why only 2 percent of the average rebate goes towards Part B premium reduction versus 7 percent towards Part D reduction, although Part B is a much larger share of Medicare.

In 2007, Medicare Advantage plans projected an average per-member, per-month rebate of \$87, of which \$10 (11 percent) would be for additional benefits, \$61 (69 percent) for reduced cost sharing, and \$17 (20 percent) for reduced premiums.⁷⁰ In 2007, plans received \$8.3 billion in rebates (suggesting bids were \$11.6 billion below the benchmarks, overall).⁷¹ Whether a Medicare Advantage plan offers rebates or not,

A Medicare beneficiary who enrolls in a Medicare Advantage MSA plan cannot deposit any more money into his MSA than Medicare has given him.

it may charge additional premiums to provide additional benefits or reductions in cost sharing not financed by rebates. While 95 percent of MA beneficiaries receive rebates, 41 percent *also* pay additional premiums for additional benefits.⁷² Rebates pay for about 77 percent of the cost of additional benefits, and extra premiums 23 percent.⁷³

Medicare beneficiaries who enroll in Medicare Advantage plans have three types of choices: HMOs and local PPOs, which can serve individual counties and vary premiums and benefits county by county; RPPOs, which offer a uniform premium and benefit in each of the 26 Medicare regions (which comprise one or more states), are the *only type that must have limits on out-of-pocket expenditures*, and have less extensive network requirements than local PPOs; and PFFSs, including plans tied to medical savings accounts (MSAs), which usually do *not* have provider networks and use traditional Medicare FFS payment rates with *fewer quality-reporting requirements* and less ability to coordinate care (emphasis mine).

In another quirk, a Medicare beneficiary who enrolls in a Medicare Advantage MSA plan cannot deposit any more money into his MSA than Medicare has given him. However, the maximum amount is the *entire* difference between the plan's bid and the benchmark (that is, the Medicare Trust Fund does not retain 25 percent of the difference). Furthermore, the bid payments are not subject to geographical adjustment, as they are in other MA plans.⁷⁴

HMOs and both types of PPO come under the larger grouping labeled coordinated-care plans (CCPs), which also include special-needs plans. SNPs are for beneficiaries dually eligible for Medicare and Medicaid, for people with certain severe chronic illnesses, and for institutionalized beneficiaries. All three categories also include employer group plans, available to Medicare beneficiaries who belong to employer or union groups.⁷⁵ As shown in Table 2, while HMOs are still the most common Medicare Advantage plans, other types have grown rapidly in recent years. All Medicare beneficiaries had access to a Medicare Advantage plan in 2009, with an average of 34 plans available in each county. All beneficiaries have PFFS plans available, and 88 percent have either an HMO or a local PPO plan available.⁷⁶

Benefits of Medicare Advantage: Quality

At first glance, quality in Medicare Advantage plans seems similar to that in traditional Medicare: 90 percent of both Medicare Advantage and traditional Medicare beneficiaries report that they usually or always get care when they think they need it.⁷⁷ Nevertheless, 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.”⁷⁸

Although MedPAC claims that “we currently do not have a basis for comparing plan performance with the quality of care in (traditional) FFS Medicare,” this is because, while Medicare Advantage plans are subject to reporting requirements—especially the National Center for Quality Assurance’s Healthcare Effectiveness and Data Information Set (HEDIS)—traditional Medicare is not. To be sure, Medicare Advantage is so new that almost half of plans are not reporting yet, especially MA PFFS plans.⁷⁹

Another reporting mechanism is the CMS’s Health Outcomes Survey (HOS), which surveys two-year cohorts of Medicare beneficiaries; the most recent covers 2005 to 2007. A full 90 percent of plans have outcomes within the expected range. However, the highest-ranked Medicare Advantage plans are older, with all having six years of Medicare contract experience, as well as offering top-rated commercial plans to non-Medicare patients. Of the 15 lowest-ranked plans, seven have no commercial business and three others have no commercial enrollment, serving only government programs such as Medicaid, in addition to Medicare Advantage. Further, 10 of the 15 lowest-ranked plans are newcomers, dating from 2004 or later.⁸⁰ This suggests that recent changes in policy have encouraged lower-quality plans to enter the program.

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 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.⁸¹

A more recent working paper published by AHIP 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.⁸² These Medicare Advantage HMOs also had lower ER use, along with more outpatient visits.⁸³ Overall risk scores for the Medicare Advantage patients were slightly lower than those of patients in traditional Medicare.⁸⁴

A subsequent paper (also from AHIP) looked at all hospital admissions for Medicare patients in California and Nevada in 2006, concluding that Medicare Advantage patients who were 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. Although the MA patients had slightly lower risk scores, the study adjusted for this difference.⁸⁵ The California Association of Physician Groups (CAPG) buttresses these conclusions with a 2007 report concluding that its members are confident that they provide superior care, especially to patients with chronic illness, via Medicare Advantage than via traditional Medicare.⁸⁶

Medicare Advantage patients were screened and diagnosed earlier in cases of cervical cancer, colon cancer, and melanoma.

Scholars are aware that many of the same providers will give medical care to both traditional Medicare and MA HMO patients, which poses the likelihood of spillover effects in areas with penetration by Medicare HMOs. A few scholarly papers have explored this. In the first, the effect was negative: A higher market share for Medicare managed care was associated with a slight reduction in the percentage of traditional Medicare patients who underwent angiography after having been admitted for acute myocardial infarction.⁸⁷ In another, the effect was positive: A 1 percent increase in penetration by Medicare HMOs in a county was associated with a 0.9 percent reduction in spending by traditional Medicare beneficiaries, observed in patients with at least one chronic condition.⁸⁸ Similarly, data from the late 1980s showed that a 20 percent to 30 percent increase in Medicare HMO market share was associated with lowering Medicare expenditures by 3 percent to 7 percent.⁸⁹

Even the most thorough analysis, however, cannot quite capture the reality that traditional Medicare is a free rider on innovation that happens in the private sector among patients, payers, and providers. There is only one condition for which traditional Medicare exerts near monopsony power for patients of any age: end-stage renal failure. In 1972, President Nixon signed the bill establishing the End-Stage Renal Disease Program, which made Medicare the single-payer health plan for patients suffering this condition. Indeed, patients with end-stage renal disease are not eligible for Medicare Advantage plans, unless they develop it *after* being enrolled.⁹⁰

History suggests that Medicare has impeded the adoption of innovation in the treatment of end-stage renal disease. Effective dialysis was an emerging technology in the 1960s. Its innovators founded the American Society of Nephrology in 1966. “Nephrologists trooped to Seattle in the early 1960s to learn how to perform dialysis, and programs sprang up across the country, each growing over time as means were found to finance treatment.” In the late 1960s, “there were fewer than 1,000 patients being dialyzed in the entire country, but that number had been increased to approximately 10,000 by the time the 1972 legislation was adopted.”⁹¹

Kidney dialysis in America today is in a relatively dire situation. Dialysis itself is difficult enough, but it is also very inconvenient because patients have to travel to dialysis centers. Although it's possible to dialyze at home, 92 percent of patients are “treated in centers, not because it's optimal but because that is the way it has been done for nearly four decades.”⁹²

It is hard to think of any other medical specialty—cardiology? psychiatry? orthopedic surgery?—in which the standard of practice has remained largely unchanged over four decades. In 1972, President Nixon and a majority in Congress believed that they were providing a benefit to dialysis patients. Unfortunately, the long-run negative consequences for innovation from Medicare's crowding out private insurers have undoubtedly been greater than the short-term benefits.

There are 350,000 patients undergoing dialysis today.⁹³ The overall population has increased by 45 percent (from 210 million to 305 million), so we can reasonably assert that the eligible population for dialysis in 1972 was about 240,000 patients. At the rate of growth prevalent until 1972, it would have taken seven more years, until 1979, for private initiative to cover everyone. But it is also reasonable to claim that the pace would likely have accelerated as the technology was broadly accepted as effective.

Eliminating (or significantly reducing) Medicare beneficiaries' access to private coverage is likely to have a similarly stifling effect on the adoption of innovation in other fields, especially in diseases that prevail in the population over 65 years of age.

Benefits of Medicare Advantage(?): Access

America's Health Insurance Plans asserts that Medicare Advantage is especially valuable because it provides choices to low-income and minority beneficiaries. As noted, the government has attempted to make MA more available to beneficiaries in rural areas. While MA does enroll a higher share of low-income beneficiaries, this appears to be primarily because of their lack of access to employer-based (including retiree) benefits to supplement Medicare. Far more low-income beneficiaries have *only* traditional Medicare than higher-income beneficiaries do, according to AHIP's own analysis (table 3).

Although it uses the same source of data as MedPAC (in table 1), AHIP's analysis of 2007 data shows significantly fewer beneficiaries enrolled in Medigap plans than MedPAC's analysis does (table 3). Table 1 reports that 28 percent of Medicare beneficiaries had Medigap policies, and only 10 percent of beneficiaries had Medicare alone, in 2005.⁹⁴ AHIP's previous analyses of the distribution of Medicare beneficiaries have also reported a significantly higher share of people on Medicare only than MedPAC does.⁹⁵ This may be because AHIP uses the Medicare Current Beneficiary Survey (MCBS) Access to Care files, which it suggests are more likely to be influenced by beneficiaries' gaps in care, and therefore show fewer beneficiaries with supplemental coverage, than the MCBS Cost and Use files, which MedPAC uses.⁹⁶

Table 3: Income Range of Medicare Beneficiaries, by Coverage Type, 2007

	All income ranges	Less than \$10,000	\$10,000 to \$20,000	\$20,000 to \$30,000	\$30,000 to \$40,000	\$40,000 to \$50,000	More than \$50,000
Medicare Advantage	19%	18%	23%	21%	17%	16%	16%
Medicaid	13%	46%	17%	2%	<1%	<1%	<1%
Employer-based	31%	7%	17%	36%	46%	51%	52%
Medigap	19%	8%	20%	22%	22%	21%	23%
Other public	1%	1%	2%	1%	<1%	<1%	<1%
Medicare only	17%	19%	21%	18%	14%	11%	9%
Total	100%	100%	100%	100%	100%	100%	100%

Source: AHIP 2009⁹⁷

Considering MedPAC's analysis of 2005 data, it appears that Medigap and Medicaid are more important sources of supplemental benefits for rural and low-income Medicare beneficiaries than Medicare Advantage plans are. While 34 percent of rural beneficiaries bought Medigap policies, only 2 percent bought Medicare Advantage policies. Medigap was more popular than Medicare Advantage in all income groups, even though Medigap policyholders receive no subsidy (table 1).

Attempts to expand rural enrollment in Medicare Advantage have not served taxpayers' interests well. Just under half of MA enrollment is in areas where MA's risk-adjusted costs per beneficiary are below traditional Medicare's costs, and these tend to be urban. Medicare Advantage's costs in rural areas tend to be higher than costs for traditional Medicare.⁹⁸ Counties where the deliberately inflated rural "floor" benchmark applies contain 19 percent of total Medicare beneficiaries but receive only 11 percent of extra payments, because 85 percent of the beneficiaries remain in traditional Medicare.⁹⁹

Medicare Advantage penetration is about 25 percent among urban beneficiaries and only 13 percent among rural beneficiaries. Nevertheless, Medicare Advantage PFFS plans are attracted to these rural counties, because they have inflated benchmarks and the costs to the otherwise dominant Medicare Advantage HMOs of forming networks is high.¹⁰⁰

Certainly, rural enrollment grew twice as fast as urban enrollment in 2008. However, 54 percent of rural enrollees were in Medicare Advantage PFFS plans (7 percent of all rural Medicare beneficiaries) versus only about 17 percent of urban enrollees (4 percent of all urban Medicare beneficiaries).¹⁰¹ As discussed below, it is exceedingly unlikely that Medicare Advantage PFFS plans add the same value as coordinated-care plans.

While it is true that Medicare Advantage has increased low-income and rural beneficiaries' choices in Medicare, it has not been very effective at doing so, and has done so at significant cost to taxpayers, as discussed below.

Costs of Medicare Advantage: High Benchmarks (versus the Hidden Tax in Traditional Medicare)

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.¹⁰² As noted above, 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.”¹⁰³

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.¹⁰⁴ An independent estimate, published by the Commonwealth Fund, comes within a whisker of MedPAC’s: \$11.4 billion, or \$1,138 per MA enrollee.¹⁰⁵ The same authors have previously asserted that such overpayments totaled \$7.2 billion in 2006, \$7.9 billion in 2007, and \$8.5 billion in 2008.¹⁰⁶

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.¹⁰⁷ Furthermore, these simple accounting measurements ignore the increasingly compelling evidence that Medicare Advantage plans allow beneficiaries superior access to medical care. Because MA plans offer more benefits, calling the difference “overpayment” when “one is covering the benefits that the other is not is a classic apples-to-oranges comparison, and it only highlights the traditional Medicare program’s serious gaps in not covering services that many seniors need and for which nine out of 10 must pay extra for supplemental insurance.”¹⁰⁸

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.

The Balanced Budget Act of 1997 set a benchmark rate for each county that was the *highest* of three amounts: a minimum “floor” rate, a blend of the local and national average rate, and the minimum increase from the previous year’s rate.¹⁰⁹ Benchmarks can change by two methods: “updating” and “rebasing.” Each can only *raise* benchmarks, never *lower* them.

In updating, which occurs annually, each county’s benchmark increases by the *greater* of 2 percent *or* the national per capita “Medicare Advantage growth percentage,” which is the CMS’s estimate of the growth in total per capita Medicare spending for the year.

In rebasing, which occurs at least every three years, each county’s FFS spending per capita is recalculated, and that becomes the new benchmark *if* it is *higher* than the updated rate. Rebasing leads to permanent

increases in benchmarks, although the underlying events may be idiosyncratic for that year, such as a flu epidemic, random variation (especially in counties with few beneficiaries), or unusually high fraud. For example, Miami/Dade County received an increase of 13 percent in its benchmark for 2009, based on growth in costs, much of which has subsequently been determined to be owing to fraudulent claims.¹¹⁰

However, the Deficit Reduction Act of 2005 has removed the 2 percent minimum for updating starting in 2010.¹¹¹ As a result, the national growth factor next year will be only 1 percent for aged beneficiaries, and negative 0.41 percent for disabled beneficiaries.¹¹²

Hospitals could not deliver the care they do if they relied fully on traditional government payers.

Special treatment of so-called “floor” counties has resulted in their benchmarks averaging 120 percent of traditional FFS spending, in order to attract more plans. These include rural counties and urban counties with more than 250,000 residents. Other counties’ benchmarks average 112 percent of traditional FFS spending.¹¹³

A couple of idiosyncrasies have also inflated benchmarks, but these will shortly be eliminated. First, benchmarks have included an amount that reflects indirect medical education (IME) payments, which Medicare traditionally paid to teaching hospitals. However, the CMS continues to pay IME subsidies to teaching hospitals, whether beneficiaries are in traditional Medicare or Medicare Advantage, so there should be no need *also* to pay these amounts to Medicare Advantage plans, in the hope that they will pass them on to teaching hospitals. These extra payments are increasing MA payments by 2.2 percent in 2009 and are being eliminated in 2010.¹¹⁴

As noted above, the Budget-Neutral Risk Adjustment provision will also be eliminated. The BNRA added 0.9 percent to benchmarks in every county in 2009.¹¹⁵ So, without the IME payments and the BNRA, the benchmarks would have been only 114.9 percent of FFS spending, instead of 118 percent. Assuming the bids would have been unchanged, this would have resulted in payments of about 112 percent of traditional Medicare costs, instead of 114 percent.

Employer-based group plans, which enrolled 1.7 million beneficiaries in 2008, are significantly more expensive than individual plans. Overall, the bids of employer-based plans are 108 percent of traditional Medicare spending. Medicare Advantage HMO employer-based bids are 11 percentage points higher than Medicare Advantage HMO individual bids (108 percent of traditional FFS versus 97 percent), and PFFS bids are 4 percentage points higher for employer-based groups than for individuals (112 percent of traditional FFS versus 108 percent). These bids are high because the bidding process is poorly designed and subject to little competitive pressure. Plans submit bids to the CMS and *then* enroll employer-based groups, by offering to use the Medicare Advantage program to shift costs from the employer or union onto taxpayers. These plans can negotiate specific benefits and premiums with employers *after* winning their bids, so there is an incentive not to bid much below the benchmark.¹¹⁶

Excluding employer-based groups would lower the average Medicare Advantage bid to 99 percent of the average cost of traditional Medicare FFS.¹¹⁷ There was always some group enrollment in the predecessors of Medicare Advantage, although previous versions simply allowed retirees to stay in the same HMOs to which they had belonged when they were employees.¹¹⁸ Recently, however, growth in employer-based Medicare Advantage plans has occurred in the PFFS plans discussed more thoroughly below.

However, many of the employers choosing Medicare Advantage group plans for their retirees are state and local governments, which will now have to account for their retirees’ health benefits the way private employers do, under GASB 45, a rule established by the Governmental Accounting Standards Board.¹¹⁹ While the GASB has long required them to account for their pension liabilities, they had not previously had to account for other post-employment benefits, primarily health care benefits. The smallest agencies have until next year to comply, and the emerging figures are shocking.

For example, California’s Public Employee Post-Employment Benefits Commission reported in January 2008 that California’s public-retiree health care liabilities were \$115 billion, and 78 percent of the public-sector employers *did not pre-fund at all*. Even worse, 22 percent of cities did not respond to the survey, nor did 54 percent of school districts, 46 percent of community colleges, and a whopping 82 percent of special districts (like the Golden Gate Bridge, Highway and Transportation District).¹²⁰ So, to the degree that Medicare Advantage’s high benchmarks are attracting public-sector employers, it is just a transfer of costs from one group of taxpayers to another largely overlapping group of taxpayers.

Similarly, the Obama administration’s narrow (or, perhaps, exclusive) 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, discussed above. Research from the early 2000s shows that Medicare HMOs paid doctors 20 to 30 percent more than traditional Medicare did.¹²¹

Table 4 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.

Table 4: Net Revenue as Percentage of Average Cost per Adjusted Patient Day, 2005					
Private	Medicare Advantage HMOs	Traditional Medicare	Medi-Cal Managed Care	Traditional Medi-Cal	County/Other Indigent
129%	99%	74%	65%	56%	42%
Source: California HealthCare Foundation ¹²²					

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.

Not all Medicare Advantage plans are equally "over-subsidized." As we saw above, MA employer-based group plans are especially expensive. Moreover, recent growth in MA group enrollment has occurred mainly in PFFS plans, a version of Medicare Advantage that has faced flawed incentives.

Costs of Medicare Advantage: Medicare Advantage Private Fee-for-Service (PFFS)

As shown in table 2, Medicare Advantage PFFS plans have experienced remarkable growth in the last few years. Even more of this growth has occurred in the individual market than in the group market, indicating that individual incentives are even stronger. Since 2005, Medicare Advantage PFFS enrollment has increased 11-fold while enrollment in HMOs and other CCPs has grown by half. From 2007 to 2008, PFFS enrollment grew by 35 percent, while CCP enrollment grew by only 12 percent.¹²³ PFFS enrollment of 2.2 million, in 2008, was concentrated amongst four companies: Humana, with 700,000 enrollees, and Blue Cross/Blue Shield of Michigan, Coventry, and WellPoint, which collectively account for another third of the market.¹²⁴

Unfortunately, there are compelling signals that PFFS plans are the least likely to add value. In 2006, 88 percent of PFFS beneficiaries were in “floor” counties with especially high benchmarks, although this declined to 79 percent in 2008, primarily because of the increase in employer-sponsored group PFFS plans.¹²⁵ As discussed above, high rural “floors” were demanded by politicians from rural constituencies, because Medicare Advantage HMOs were not investing in their areas.¹²⁶ Establishing network-based plans in rural areas is extremely challenging, because of low density, few providers, and providers’ resistance to network contracting.¹²⁷ As a result, PFFS plans sprang up to take advantage of the artificially high benchmarks.¹²⁸

Also, PFFS plans use significantly less of their rebates for additional benefits than other plan types do: 8 percent, versus 12 percent for HMOs and 16 percent for PPOs, in 2007.¹²⁹ These enhanced benefits come at a very high price: Each dollar of PFFS benefits costs the taxpayer more than three dollars.¹³⁰ More than other Medicare Advantage plans, PFFS plans use taxpayers’ money to reduce seniors’ cost sharing. Taxpayers give PFFS beneficiaries a great deal: The national average PFFS premium in 2008 was \$38.52, net of Part B premium rebates (but not Part D, because some plans covered prescription drugs but some did not), and the average co-pay for a physician’s visit was \$18.47. This national average includes Blue Cross/Blue Shield of Michigan, which has a quarter of a million enrollees paying an unusually high average monthly premium of \$114.08. Excluding Blue Cross/Blue Shield of Michigan as an outlier results in an even lower national average premium of \$28.92.¹³¹

Most importantly, while PFFS plans are permitted to establish their own fee schedules and balance-billing rules, which can differ from those for traditional Medicare FFS, they have not generally done so. Indeed, PFFS plans typically do not have provider networks, and they “free ride” on traditional Medicare’s FFS payment rates.¹³² Thus, they do not address the hidden tax created by Medicare’s cost shift. This is not the way it was supposed to work: The CMS requires PFFS plans to pay providers *at least* as much as traditional Medicare, but it reports that PFFS plans’ non-compliance with this is a significant problem.¹³³

As long as other, network-based plans operate in a county, the CMS “deems” providers contracted to the PFFS plan, under 42 CFR §422.216(f), unless they decline *before* the service is given, and most PFFS plans take advantage of this regulation to pay traditional Medicare fees.¹³⁴ Basically, all an insurer has to do to set up a Medicare Advantage PFFS plan is replicate Medicare’s claims-processing functions.¹³⁵ Even worse, there has been a *disincentive* for PFFS plans to negotiate contracts with providers: If they do, they must pay their negotiated rates to non-contracted providers as well.¹³⁶

The CMS is also concerned that PFFS plans are confusing their beneficiaries about the difference between *prior authorization* and *prior notification*. PFFS plans’ communications to beneficiaries have inappropriately used the term “prior authorization,” which is illegal for PFFS plans. While CCPs may require prior authorization or referral for certain covered services, PFFS plans may not. On the other hand, PFFS plans can demand prior *notification*, which neither traditional Medicare nor other Medicare Advantage plans do, and can impose financial penalties for failing to “pre-notify.” For example, one PFFS plan levied a co-insurance payment of 30 percent on certain durable medical equipment, but this jumped up to 70 percent if beneficiaries *or* providers failed to pre-notify the plan. For traditional Medicare or other Medicare Advantage plans, providers bear the financial risk of not determining coverage. To add to the confusion, the CMS has provided inconsistent and even incorrect guidance to plans.¹³⁷

On the other hand, PFFS plans may use prior notification to offer a reduction in cost sharing if either the provider or the beneficiary notifies the plan before the beneficiary receives the service. The CMS intends to require that MA PFFS plans ensure that their beneficiaries understand that they may enjoy this benefit of prior notification, but are *not* burdened by prior authorization.¹³⁸

Amidst all this confusion, it is not surprising that PFFS plans have much higher disenrollment rates than CCPs do: 21 percent versus 9 percent in the first quarter of 2007.¹³⁹ Insurers representing 90 percent of this market agreed with the CMS to suspend marketing temporarily in June 2007.¹⁴⁰

However, MA PFFS plans don’t *just* mimic traditional Medicare FFS: They also offer benefits such as a cap on catastrophic out-of-pocket expenses, emergency care overseas, and lower cost sharing for some services.¹⁴¹ In 2007, 60 percent of PFFS beneficiaries enjoyed out-of-pocket caps between \$1,001 and \$5,000, and 68 percent were in plans that capped out-of-pocket payments for a 90-day hospital stay at \$1,000, versus the \$8,432 for traditional Medicare Part A.¹⁴²

A recent analysis of the effect of reducing the benchmarks to 100 percent of traditional Medicare concluded that PFFS plans would shrink by 85 percent, and 1.9 million enrollees would either migrate to another Medicare Advantage plan or go back to traditional Medicare. While PFFS plans could reduce benefits, instead of simply exiting this market, history suggests the latter.¹⁴³

The same analysis estimated that 1.4 million enrollees would have left their PFFS plans if the law had required those plans to negotiate contracts with providers, as it soon will.¹⁴⁴ In 2011, PFFS plans will lose

the ability to have providers “deemed” contracted. Instead they will have to negotiate contracts with them, and the CMS will no longer consider them compliant if they just pay providers traditional Medicare FFS rates.¹⁴⁵ Also, starting next year, the CMS will enforce Quality Improvement Program regulations on PFFS plans, just as it does with other Medicare Advantage plans; PFFS plans had previously been exempt.¹⁴⁶

While “reforms” to Medicare Advantage will significantly reduce the availability of Medicare Advantage PFFS plans, that is not entirely a bad thing: It is fairly clear that these plans add the least value to beneficiaries, while costing taxpayers the most.

Costs of Medicare Advantage: Risk Adjustment

As noted above, the CMS fully implemented a complex model for risk adjustment in 2007. This means that it adjusts Medicare Advantage plans' bids on the basis of *prospective* medical costs of enrollees. If the CMS simply paid plans the average cost per enrollee, plans would compete by seeking to enroll beneficiaries who are healthier than average. This, of course, is what the government previously alleged, when it reduced the role of private plans in the 1990s. However, historical evidence of risk selection in Medicare managed care is mixed.

If Medicare managed-care plans attracted healthier beneficiaries, one would expect sicker beneficiaries to buy Medigap plans, thus driving up their premiums. Using data from 1996–1997, researchers found that an increase in Medicare HMO participation of just over 8 percent was associated with a one-standard-deviation increase in Medigap premiums.¹⁴⁷ This was echoed by another scholarly article, analyzing data from 1994 through 2000, which concluded that greater Medicare HMO penetration is associated with adverse selection into Medigap. The article estimated elasticities from 0.09 to 0.025, suggesting that an increase in Medicare HMOs' market share from 12 percent to 22 percent would raise average Medigap premiums by 23 percent.¹⁴⁸ However, other researchers, looking at data from 1993–1996, did *not* find that healthier beneficiaries were choosing Medicare managed care and thereby causing premiums for Medigap to increase.¹⁴⁹

As of April 2001, Medicare Advantage (especially PFFS) enrollees were healthier than traditional Medicare beneficiaries. Using CMS risk scores, the Government Accountability Office found that beneficiaries in PFFS plans had projected health expenditures that were 7 percent lower than the average for beneficiaries in other MA plans, and 10 percent lower than the average for beneficiaries in traditional Medicare. They were also younger: Only 26 percent of PFFS enrollees were between 75 and 84 years old, and 6 percent were over 85 years old. The comparable shares for other Medicare Advantage plans were 34 percent and 11 percent, and for traditional Medicare they were 30 percent and 12 percent.¹⁵⁰ Also, disenrollees were sicker than enrollees in PFFS plans, with projected medical expenses 6 percent higher than enrollees.¹⁵¹ Other Medicare Advantage plans, even with significantly lower disenrollment, also demonstrated this risk selection though to a lesser degree. Members who dropped out had projected medical expenses 3 percent higher than those who remained enrolled.¹⁵²

Certainly, the implementation of more sophisticated risk adjustment has led to savings in cases where Medicare Advantage plans *have* enrolled sicker beneficiaries. Using 2004 risk-adjustment data, Medicare Advantage plans in counties with the highest monthly Medicare spending (more than \$700 in 2005), which accounted for 27 percent of Medicare Advantage enrollees, were able to hold costs down to 92 percent of traditional Medicare spending per beneficiary. However, the national average for *all* Medicare Advantage plans was 3 percent higher than for traditional Medicare. This was down from 11 percent using 2003 risk adjustment, which indicates that the partial implementation of more complex risk adjustment in 2004 was a step in the right direction.¹⁵³

Nevertheless, current anecdotal evidence sets off loud warning bells that Medicare Advantage plans continue to profit from risk selection. Nor, perhaps, should we be surprised. Scholars who have analyzed health insurance in Switzerland, where the government has more experience supervising *retrospective* risk-adjustment payments between private insurers, have concluded that private plans are nevertheless still able to select risks favorably instead of managing costs and care.¹⁵⁴

As of April 2001, Medicare Advantage (especially PFFS) enrollees were healthier than traditional Medicare beneficiaries.

Medicare Advantage plans are not allowed to levy higher projected cost sharing than would be projected for a beneficiary under traditional Medicare. However, they can levy higher cost sharing for *some services*, as long as the actuarial equivalence of the *overall* cost sharing is lower than that in traditional Medicare. This is sometimes a matter of negotiation between the CMS and a plan, whereby the CMS attempts to ensure that high cost sharing is not targeted at unhealthy enrollees.¹⁵⁵ It does not look as if regulators are achieving this goal.

William Vaughan of Consumers Union collected information on 70 Medicare Advantage marketing events held in Pinellas County, Florida, during the winter of 2008–2009, finding that almost two-thirds of them were held in affluent ZIP codes, implying that the plans were seeking wealthier (and therefore likely healthier) enrollees.¹⁵⁶ The *Washington Post* recently profiled seniors enrolled in Medicare Advantage plans in Arizona who enjoyed free gym memberships, prescription glasses, and hearing aids. However, one beneficiary who had a free gym membership alleges that his Medicare Advantage HMO refused to pay for tests and medical consultations that he undertook after having vomited blood.¹⁵⁷

The CMS proposes to manage risk selection by increased regulation: Plans must submit all marketing material to the CMS for review at least 45 days before using it, unless they are using “model” language developed by the CMS, in which case they can submit up to 10 days before using.¹⁵⁸ However, the CMS has developed guidelines to allow plans to “file and use” some marketing materials after only five days if they “certify” that they comply with the guidelines, and some organizations that qualify for less stringent review can file and use after five days without certification.¹⁵⁹

The CMS reviews Medicare Advantage plans’ participation annually, and it has recently warned that it is unlikely to approve plans that re-allocate rebate reductions by increasing cost sharing for services used by small numbers of sick people (such as inpatient care, skilled-nursing facilities, and home health care) unless those plans first increase cost sharing for more widely used Medicare-covered services or non-Medicare benefits.¹⁶⁰

President Obama’s proposed budget includes administrative savings in Medicare totaling \$3.5 billion in FY 2010 and \$27 billion over 10 years. Of this, improving Medicare Advantage “coding intensity” is supposed to save \$3.3 billion immediately, and none in later years. (“Coding” refers to the codes for different diagnoses and services that providers use when they submit claims for payment.) This means that the

CMS will adjust Medicare Advantage risk-score payments to bring coding-intensity in line with those of traditional Medicare.¹⁶¹ The CMS asserts that Medicare Advantage risk scores have been rising faster than traditional Medicare risk scores because Medicare Advantage plans are more effective at coding.

Finally, there is the question of the continuing popularity of Medigap, which makes little sense in the context of today's very generous Medicare Advantage options. Millions of seniors are spending their own money on Medigap policies, when they should be rushing to take advantage of heavily subsidized access to Medicare Advantage. This is difficult to explain in the absence of risk selection by Medicare Advantage plans.

Millions of seniors are spending their own money on Medigap policies, when they should be rushing to take advantage of heavily subsidized access to Medicare Advantage.

Perhaps this should not surprise us. Adjusting payments for risk is complex. No matter how narrowly the CMS defines a category, it will contain more than one person, so health costs are skewed even *within* a given category, leading to opportunities for risk selection.¹⁶² If we think it absurd that a government planner should determine relative *prices* of medical goods and services, it is far from obvious that determining the *risk* that someone will need particular medical goods and services would be an improvement. In fact, we may have made things worse by making the plans more opaque. The CMS needs a decentralized, market-based mechanism for pricing risk.

Costs of Medicare Advantage: Lack of Consumer Direction

As we have seen, Medicare Advantage plans use taxpayers' dollars to provide higher quality and greater access to medical services for Medicare beneficiaries. However, they also use taxpayers' dollars to reduce beneficiaries' premiums, co-insurance, and co-payments. Subsidizing Medicare Part B and D premiums obviously constitutes a simple transfer of money from taxpayers to Medicare beneficiaries. However, reducing cost sharing also increases the problem of moral hazard that is well known in insurance markets: Nobody spends someone else's money as carefully as he spends his own.

The RAND Health Insurance Experiment was a famous study conducted in the late 1970s and early 1980s to determine the value of co-insurance and deductibles in governing patients' use of medical services. The researchers found that a 100 percent co-insurance rate halved the consumption of medical services, 50 percent co-insurance cut it by 36 percent, and 25 percent co-insurance cut it by 29 percent, compared to those with zero co-insurance. Deductibles had a similar effect in reducing consumption.¹⁶³ Extrapolating from the results of the RAND experiment, as well as other literature, professors Andrew J. Rettenmaier and Thomas R. Saving figured that a Medicare deductible of \$4,642 in 2006 dollars would reduce hospital expenditures by 27.4 percent and all other expenditures by 49.3 percent. Rounding up, they modeled a \$5,000 deductible with zero co-pay above the deductible, which cuts hospitalization spending to 73 percent of the status quo and physician spending to 51 percent of what it would be in a policy with zero deductible.¹⁶⁴

These results have been tested again in the real world in the last few years, with the growth of consumer-driven health plans, which charge lower premiums and allow employers and individuals to fund health savings accounts (HSAs), health reimbursement arrangements (HRAs), and flexible spending accounts (FSAs). Patients use the dollars in these accounts to pay medical providers directly for non-catastrophic medical spending. Greg Scandlen of Consumers for Health Care Choices recently reviewed the emerging evidence from these fast-growing plans. He found that such plans dramatically reduce premiums (by around 20 percent, versus traditional health-care plans); annual growth in premiums is several percentage points less than that of traditional health-care plans; individuals have invested more than \$10 billion in HSAs; and patients are increasingly satisfied with this coverage.¹⁶⁵

Remarkably, it is *illegal* for Medicare beneficiaries to fund HSAs, although they can maintain and spend from accounts that they opened prior to enrolling in Medicare. It took until January 2007 for the government finally to allow Medicare Advantage medical savings account (MSA) plans. Although Medicare Advantage MSA plans look strikingly similar to private consumer-driven health plans, they are available to only 68 percent of Medicare beneficiaries, and they enrolled only 3,000 beneficiaries in 2008.¹⁶⁶ Medicare Advantage MSA plans are so unpopular that as of 2010 they will be available only in Pennsylvania.¹⁶⁷ The problem is that MSA plans are part of the flawed PFFS program, discussed above.¹⁶⁸ MSA plans are still a

little too tightly regulated, and they cannot include the Medicare Part D prescription-drug benefit, which seniors still have to sign up for separately—an unnecessary complication.¹⁶⁹ Among Medicare beneficiaries choosing the Part D prescription-drug benefit, one-third chose an integrated Medicare Advantage/ Prescription Drug (MA-PD) plan.¹⁷⁰ Clearly, seniors value the simplicity of choosing just one Medicare Advantage plan.

However, the artificial separation of Medicare Advantage MSA plans from Medicare Part D plans is surely not the only reason for the slow uptake of this consumer-driven option. Because the government still fixes prices for medical goods and services in Medicare Advantage PFFS plans, taxpayers should not expect that Medicare Advantage MSAs will create consumer-driven Medicare.

Nobody spends someone else's money as carefully as he spends his own.

Meanwhile, Medicare beneficiaries who invest in Medigap policies face another predicament. Many seniors would surely prefer to insure against the catastrophic medical costs that traditional Medicare does not cover, but not to insure against expenses that they could fund directly. This is difficult to do via Medigap. Recall that Medigap policies must conform to standard designs, and these designs tend to cover from (almost) the “first dollar,” as well as catastrophic costs. In 2007, 60 percent of Medigap policyholders owned just two types of the 12 different Medigap policies: F and J. These policies are unusual in that they are the only two Medigap policies that both fully cover Medicare Part B excess charges (up to 15 percent above the Medicare-approved rate, for physicians who do not accept assignment) *and* offer a high-deductible option of \$2,000.¹⁷¹ Clearly, a large number of Medigap beneficiaries appreciate protection from catastrophic costs and the ability to escape, at least partially, the government’s price fixing, in order to increase their access to care when they need it.

Unfortunately, the ability of Medicare beneficiaries to control their own health-care dollars, already extremely limited, is likely to decline even more under the current administration. The 2010 *Call Letter*, which the CMS issues annually to describe the Medicare Advantage bidding process, was the first in the Obama Administration. While Medicare Advantage plans can still impose co-insurance rather than the traditional co-payments, the CMS is concerned that such co-insurance might entail out-of-pocket (OOP) costs that are too high. So it will discourage plans with OOP maximums higher than \$3,400, which the CMS asserts represents the 85th percentile of OOP spending in traditional Medicare Part A and Part B in 2010.¹⁷² The CMS will also pay special attention to plans that have high cost sharing for chronic and acute conditions that have high total costs.¹⁷³ Experienced observers interpret this *Call Letter* as a signal that the CMS intends to impose even stricter limits on OOP spending in the future.¹⁷⁴

In October, a CMS official announced that 1,100 plans will be forced to lower requirements for cost sharing by beneficiaries.¹⁷⁵ This policy will harm Medicare beneficiaries’ already limited ability to decide their own spending on medical goods and services.

Conclusions

Medicare Advantage has significant benefits, as well as costs.

First: 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.

Second: While Medicare Advantage does increase access to medical care for low-income and rural beneficiaries, it does this inefficiently and is not as popular as Medigap, which supplements traditional Medicare.

Third: In a *very narrow sense*, Medicare Advantage plans cost more, per beneficiary, than traditional Medicare does, and this increases the total costs of Medicare by about \$12 billion a year, or 2.3 percent. However, traditional Medicare imposes a hidden tax on privately insured Americans that accounts for \$49 billion a year: four times greater than the narrowly defined extra costs of Medicare Advantage. Most Medicare Advantage plans actually relieve this hidden tax, because they appear to pay providers enough to cover their costs. Thus, the “extra” payments to Medicare Advantage are actually a method of exposing the hidden tax and transferring the burden from the privately insured to the government’s general account—that is, society at large.

Fourth: If there is a part of Medicare Advantage that adds cost without adding value, it is likely the private fee-for-service (PFFS) plans, which enter areas with the highest benchmarks, appear to have the least satisfied beneficiaries, and have not had to negotiate contracts with providers. However, many PFFS plans do add value by protecting beneficiaries against catastrophic costs, which traditional Medicare does not, and they will have to negotiate contracts with providers starting next year.

Fifth: While the CMS has significantly improved its risk adjustment of payments to Medicare Advantage plans, evidence strongly suggests that MA plans successfully enroll patients whose actual medical claims will be lower than those expected by the model. Indeed, it is unlikely that effective risk adjustment can ever result from central planning.

Sixth: Medicare Advantage lacks consumer direction. Plans use their subsidies to reduce beneficiaries’ cost sharing, which reduces beneficiaries’ incentives to be sensitive to the prices of medical goods and services.

Clearly, Medicare Advantage can improve, but simply cutting reimbursements to Medicare Advantage plans will not achieve this goal.

Policy Options

A handful of proposals have focused on the easy way to “fix” Medicare Advantage: cut subsidies. One first step is to eliminate the one-sided rebasing process, which would reduce MA spending by \$21 billion from 2010 to 2014, and \$61 billion from 2010 through 2019, according to the Congressional Budget Office (CBO).¹⁷⁶

MedPAC would like to have Medicare Advantage benchmarks reduced to 100 percent of traditional Medicare FFS average spending per patient. However, MedPAC’s *Report to the Congress* states: “To be clear, even though we are using the FFS Medicare spending level as a measure of parity for the MA program, it should not be taken as a conclusion that the Commission believes FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program.”¹⁷⁷

Unfortunately, this is a very poor policy because it continues the fundamental error of establishing benchmarks based on the disastrously flawed fee structure of traditional Medicare. This is as if the government had used administered prices for Soviet Ladas or East German Trabants to decide how much Toyota or Honda automobiles are worth. The CBO recently examined the effects of four changes in the way benchmarks are determined:¹⁷⁸

- ✓ First, echoing MedPAC, it considered setting the benchmark for each county at a blended rate: 75 percent of the county per capita spending plus 25 percent of the national average per capita spending. The CBO estimates that this would reduce federal spending by \$40 billion in the years 2010 through 2014 and \$133 billion in 2010 through 2019. It also estimates that the number of Medicare Advantage beneficiaries in 2019 would be 5.1 million lower than under the status quo (8.8 million versus 13.9 million—a drop of more than one-third). (A 2007 study, conducted when 8 million Medicare beneficiaries had Medicare Advantage plans, concluded that 3 million would lose Medicare Advantage and go back to traditional Medicare if benchmarks were set at 100 percent of counties’ traditional Medicare costs.)¹⁷⁹
- ✓ Second, the CBO modeled a policy of gradual reduction in benchmarks over four years, county by county, whereby the counties with the highest benchmarks would experience the fastest reductions. This would lead to only 1.8 million fewer beneficiaries in Medicare Advantage plans than the status quo, with a fiscal effect about half the size of the first scenario’s.
- ✓ Third, the CBO estimated the effects of President Obama’s proposal, whereby the average bid of all plans in a county would become the benchmark, and beneficiaries would either pay the difference in higher premiums (if they chose a plan with a high bid) or receive the difference as extra benefits. This would result in federal savings of \$35 billion over five years and \$159 over 10 years, and a reduction in the number of enrollees by 7 million. (The administration asserts that its proposal would save \$45 billion from 2010 to 2014, and \$177 billion from 2010 to 2019.)¹⁸⁰

- ✓ Fourth, the CBO examined a proposal similar to the president's, but with bonus payments related to the availability of coordinated care plans and other so-called evidence-based quality improvement, which it figured would result in federal savings of \$25 billion over five years and \$108 billion over 10 years, and a reduction of 2.6 million Medicare Advantage enrollees.

In an earlier analysis, the CBO estimated that federal Medicare spending would have been 8 to 11 percent lower if *minimum* bids in each county had been used to set benchmarks, with the largest savings in higher-cost counties. Instituting this change would cause benchmarks to drop 15 percent from the status quo; and they would be 6 to 8 percent lower than traditional Medicare FFS payments.¹⁸¹ In such a case, both beneficiaries who chose to enroll in other plans and those in traditional Medicare (where costs are higher than the minimum Medicare Advantage bid) would pay the difference between their plans' costs and the minimum benchmark.

This CBO report also emphasizes that any bidding mechanism that anticipates rebates to beneficiaries is likely to experience bids that are inflated, unless the government rebates 100 percent of the difference between bid and benchmark. The playing field would not be level if a beneficiary choosing a more expensive plan had to pay 100 percent of the amount above the benchmark while a beneficiary preferring a plan that bid below the benchmark received only 75 percent of the difference as a rebate.¹⁸²

Professor Robert F. Coulam and colleagues have reported initial findings of static simulations of different reforms. They estimate that paying Medicare Advantage plans the same as traditional Medicare (as MedPAC has advised) would save 1 percent of total Medicare spending. The Obama administration's proposal to set the benchmark at the average Medicare Advantage bid for each county would save 2 percent of total costs. A third alternative, setting the benchmark at the lower of the average MA bid or the traditional Medicare payment, would save 4 percent of costs. Finally, forcing traditional Medicare itself to be a bidder would save 8 percent of costs, if the CMS accepted the lowest of all bids, including traditional Medicare's. As in the CBO analysis, in those counties where traditional Medicare's costs are higher than the benchmark, beneficiaries who choose traditional Medicare would pay higher premiums or co-pays.¹⁸³

This last proposal saves taxpayers the most money, while coming closest to forcing the government to compete on a level playing field with private plans. Plus, it would influence more people to enroll in Medicare Advantage plans, and further relieve the hidden tax of traditional Medicare. However, traditional Medicare would still have an unfair advantage in enrollment, because it remains the default option for seniors, who must take deliberate action to enroll in a Medicare Advantage plan by visiting a government website. Joseph Antos of the American Enterprise Institute notes that dual-eligible patients (those eligible for both Medicaid and Medicare) are randomly assigned to Medicare Part D prescription-drug plans, and suggests that a similar policy applied to Medicare Advantage would increase enrollment in those plans too.¹⁸⁴ A variation of this would be automatically to enroll beneficiaries in each county in the lowest-cost Medicare plan, either traditional Medicare or the lowest-bidding Medicare Advantage plan, and require them to make a deliberate choice if they want a more expensive one, for which they would pay with their own money.

Another option, which could be combined with those above, would be to inject more consumer power into Medicare purchasing decisions. Medicare Advantage MSA plans (which, as we have seen, are virtually non-existent) deposit rebates into beneficiaries' MSAs. One important step would be to merge HSAs and HRAs with Medicare Advantage MSAs. There is no reason to require patients who had an HSA before enrolling in Medicare to establish a different bank account when they enter Medicare. However, a bigger barrier to the updating of MSAs is that Medicare Advantage plans are not allowed to levy higher cost sharing than is actuarially equivalent to anticipated out-of-pocket costs for patients in traditional Medicare FFS, and the CMS intends to discourage plans with OOP maximums greater than \$3,400, which represents the 85th percentile among traditional Medicare beneficiaries.

Medicare's only advantage over private health insurance is that it is portable and long term.

Rettenmaier and Saving argue that the limit should be about \$1,600 above this. Current incentives are in the wrong direction: Taxpayers finance rebates that *reduce* beneficiaries' cost sharing, thereby artificially increasing consumption. If anything, taxpayers should be "bribing" beneficiaries to accept higher deductibles, co-pays, and co-insurance. If Medicare Advantage plans are able to bid below the cost of the average traditional Medicare beneficiary in a county by increasing deductibles, co-pays, and coinsurance, this should be permitted.

Of course, this reintroduces the challenge of risk selection, which central planners are unlikely to manage well, despite increasingly sophisticated actuarial models. This is magnified by the fact that Medicare Advantage plans only exist, de facto, for one year, following which both beneficiaries and managers must start over again. This limits the ability of both patients and managers to plan for the long term. However, Medigap shows that insurers can successfully offer policies that renew year after year, with prices established by the market, rather than by government. There is no reason why Medicare Advantage plans could not do the same. So, the most radical policy option is to import two characteristics of Medigap into Medicare Advantage: an open-enrollment period of six months after becoming a Medicare beneficiary, followed by guaranteed renewability.

Medicare's only advantage over private health insurance is that it is portable and long term. Working Americans are generally dependent on their employers for health benefits. This has resulted in fragmented access to health insurance, and insurers have responded by offering coverage that is renewed annually. This makes no sense for an individual, because a person's health status is not related to the period of time that it takes the earth to revolve around the sun. If the government allowed us to buy health insurance that was our own property, we would demand policies that did not put us at risk of a huge rate hike if we lose continuous coverage after becoming sick. After all, this is how term life insurance functions. Medicare Advantage creates the perfect opportunity to allow the development of individual health-status insurance, as developed by professor John H. Cochrane. Cochrane's model combines long-termism with the ability to switch insurers if one becomes dissatisfied with one's current coverage.¹⁸⁵

Suppose a low-risk 65-year-old has expected annual medical expenses of \$6,000, along with a 1 percent chance of developing an illness that will raise his annual costs to \$30,000. If he is expected to live another 30 years, the net present value (NPV) of that \$30,000 (at a discount rate of 5 percent) is approximately \$460,000. The annual premium to pay for this protection is 1 percent of the NPV: \$4,600. So, the total premium is $\$6,000 + \$4,600 = \$10,600$. If the beneficiary suffers that 1 percent chance, the insurer credits his health-status account with \$460,000. If the beneficiary decides to transfer to another insurer, he takes that money with him.

At first blush, this seems too complicated to figure out in the real world. After all, there are many illnesses, and the ordinary person cannot be expected to calculate his chances of getting any one of them. However, as Cochrane explains, these illnesses can be bundled into a much smaller number of categories for the purpose of reckoning their cost. As people realized that they were going to make a long-term commitment to health insurance as soon as they became Medicare beneficiaries, we could expect them to invest in learning the optimal payoffs. We would also see trusted intermediaries arise to inform beneficiaries' decision making.

If we allowed the market, rather than government, to price risk, the incentive for insurers to profit from risk selection would disappear, and insurers and providers would have aligned incentives to optimize patients' care over the long term.

There are, nevertheless, two closely related obstacles to this reform. First, we need to find the money to pay beneficiaries' health-status premiums. Second, as long as traditional Medicare is unreformed, and seniors can drop back into it whenever they like, we need to figure out how to motivate them to invest in health-status insurance. The first, although politically difficult, is mathematically easy: The proposed health-status premiums already exist notionally. Basically, they are what we call Medicare's "unfunded liabilities."

If the government finds the courage to fund those liabilities, then that money can be used to subsidize health-status premiums. The second problem then largely disappears on its own: By reducing the unfunded liability of traditional Medicare and increasing the funded liability of health-status premiums, the government will give fiscal certainty to public finances and at the same time motivate seniors to migrate voluntarily to a program with superior incentives and a more solid guarantee of access to care than the obsolete traditional Medicare.

There are a number of possible reforms to Medicare Advantage but none can "fix" Medicare, as long as the government insists on perpetuating its harmful price-fixing mechanism in traditional Medicare. The Obama administration is focused on the second-least effective reform of those that have been proposed: limiting subsidies to the average of Medicare Advantage bids in a county, and exempting traditional Medicare from the consequences. This would save some money, but a relatively small amount; and it ignores the benefits of Medicare Advantage, both to patient care and in relieving the hidden tax that traditional Medicare imposes on the privately insured.

Better options include setting the Medicare Advantage benchmark at the average or minimum bid submitted in each county, but including traditional Medicare as a bidder. If the benchmark were lower than the cost of traditional Medicare, beneficiaries who chose to remain in traditional Medicare would have to pay the difference.

Additionally, incentives for wise use of medical services can be improved if the government repeals its policy of preventing Medicare Advantage plans from reducing costs by submitting low bids financed (below a catastrophic cap) by higher deductibles, co-pays, and co-insurance than are fixed in traditional Medicare.

Finally, a more complex reform would make Medicare Advantage plans long-term health-status policies, instead of plain insurance policies that terminate every year. This would improve patients' and providers' incentives to co-ordinate care to improve long-term health outcomes, eliminate the potential for risk selection, and bring fiscal certainty to public finances.

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