



Impact of the Medicare Advantage Payment System on Medicare Beneficiaries

Congress is currently considering changes to the way Medicare pays for services delivered through private health insurance plans called Medicare Advantage (MA) plans. This is due in large part to the Medicare Payment Advisory Commission's findings that MA plans are, on average, paid at much higher rates than traditional Medicare. This fact sheet examines how MA plans are currently paid, why overpayments occur, and the impact of these overpayments on Medicare beneficiaries and the fiscal solvency of the Medicare program.

Background

Medicare beneficiaries can choose how their health care is delivered – either through traditional fee-for-service Medicare or through MA plans. MA options include: HMOs, local and regional PPOs, special needs plans, private fee-for-service (PFFS) plans and medical savings accounts.

Enrollment in the MA program has grown more than 80 percent in the last two years, increasing to about 19 percent of all Medicare enrollment, or 8.3 million beneficiaries. PFFS is by far the fastest growing type of plan, experiencing a growth rate of nearly 300 percent over the past year and a half.

MA plans are required to offer beneficiaries all Medicare Part A and Part B benefits except hospice care. All plans, except PFFS plans, must also offer an option that includes the Part D drug benefit in each market in which it participates.

Payments to Plans

Each year, MA plans submit bids to the Centers for Medicare and Medicaid Services (CMS). CMS compares the plan's bid to a benchmark or bidding target. If the plan bid is higher than the benchmark, the plan is paid the benchmark amount and the plan enrollees pay the difference between the plan's bid and the benchmark in the form of a higher premium. If a plan's bid is below the benchmark, the plan is paid its bid, and 75 percent of the difference between the plan's bid and the benchmark is supposed to be returned to the plan enrollees in the form of reduced premiums (Part B and/or Part D), additional benefits, or reduced cost sharing. The remaining 25 percent is retained by the Medicare program.

According to the Medicare Payment Advisory Commission (MedPAC), in 2006, MA program payments were 112 percent of FFS expenditure levels, and benchmarks were at 116 percent of fee-for-service, on average. The Congressional Budget Office has estimated that reducing the county-level benchmarks under MA to the level of local per capita FFS spending would save \$54 billion over five years and \$150 billion over ten years.

Why Overpayments Occur

Excess payments result from several factors. The local MA benchmarks are based on the county-level payment rates used to pay MA plans before 2006. Those payment rates were at least as high as per capita fee-for-service Medicare spending in each county. Some are significantly higher due to specific statutory changes (enacted in the Balanced Budget Act of 1997 and other laws) which required minimum county payment rates, or floors (e.g., rural, large urban).

On average, Medicare has been overpaying MA plans due to the better average health status of plan enrollees. Although MA payments have been adjusted for health status since 2004, certain decisions by CMS delayed full implementation of risk adjustment, including a decision to hold MA plans harmless for reductions in payments due to risk adjustment. This “hold harmless” adjustment is scheduled to decline over time, but it had the effect of raising the benchmarks significantly in 2006.

In addition, the calculation of the MA benchmarks includes payment for indirect medical education (IME) even though Medicare makes separate IME payments to hospitals treating MA enrollees. In effect, Medicare is making double payments for IME. MedPAC has recommended that IME be removed from MA payments.

Impact on Medicare Beneficiaries and the Broader Program

- **Current Medicare payment policy clearly favors the MA program over traditional Medicare, which is unfair to the majority of beneficiaries who participate in the traditional program.** All taxpayers and all beneficiaries – not just the roughly 20 percent enrolled in MA plans – are funding these excess payments. But these extra benefits only go to those enrolled in MA plans, they are not distributed equitably across the entire Medicare population. More than a third of beneficiaries in six states are enrolled in MA plans, but fewer than 10 percent are enrolled in 20 states.
- **Overpaying MA plans is an inefficient way to provide extra benefits to beneficiaries.** Many MA plans use the overpayments to pay for additional benefits or reduce cost sharing to enrollees. If policymakers want to provide additional benefits or target low-income and/or minority beneficiaries, there are better approaches that reach greater numbers of beneficiaries. For example, the Medicare Savings Programs and low-income subsidies under Part D ensure that low-income beneficiaries get extra help they need paying premiums and cost sharing. That is not always the case with MA plans, where cost sharing varies, and can sometimes disproportionately benefit the healthy (e.g., by charging higher co-payments for hospital stays).

- Private plans often offer beneficiaries extra benefits not currently available in traditional Medicare such as vision care, hearing services, more preventive care, and care coordination. **In the past, private plans were able to provide extra benefits without costing more than traditional Medicare by restricting the selection of providers, negotiated prices, and other strategies.** MedPAC has said the current MA payment system has few incentives for efficiency because the benchmarks are set well above the cost of traditional Medicare.
- **The solvency of the Medicare Trust Fund is negatively affected by current payment policies to MA plans.** CMS actuaries estimate that equalizing payment rates between FFS and MA could push back the date that the Medicare Hospital Insurance Fund would become insolvent by two years.

AARP Position

- **AARP supports a genuine choice of health plan options for Medicare beneficiaries.** The traditional Medicare plan should remain a viable and affordable option, while a range of private plan options should also be available.
- **AARP believes Medicare payments should be neutral with respect to coverage options.** Congress should set the benchmarks upon which MA plan payments are based so that MA payments do not exceed fee-for-service costs.
- **All types of MA plans should be subject to the same rules.** Private-fee-for-service plans, in particular, have an unfair advantage in the marketplace. For example, they do not have to report quality measures and they do not have to establish contracts with providers in advance. AARP believes these inequitable rules have led to confusion for beneficiaries and have contributed to unwarranted cost growth to the Medicare program. Marketing abuses have been especially problematic in the PFFS market. These rules need to be tightened and better regulated.
- **AARP believes that a portion of the offsets from any reductions in MA overpayments should be reinvested first in improving the Medicare program.** Chief among the improvements is changing the asset test thresholds so that more low-income beneficiaries qualify for the Part D subsidy and protecting the Part B premium from any costs associated with changes in physician payment.
- **MA overpayments should be phased out over time in order to prevent any undue market disruptions that could impact beneficiaries.**

For additional information please contact Nora Super of the Federal Affairs Health and Long-Term Care Team at 202-434-3770.