Executive Summary
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The Success of Medicare Advantage Plans: What Seniors Should Know

Robert E. Moffit, Ph.D.

Medicare Advantage, the new Medicare program of competing private health plans, is a success. The main reason: Seniors enjoy an unprecedented level of personal freedom in choosing health care options. Record numbers of senior and disabled citizens are enrolling in private health plans of their choice and securing better value for their health care dollars than is available to those enrolled in traditional Medicare.

Congress enacted Medicare Advantage as part of the Medicare Modernization Act of 2003. It is superior to previous private health plan experiments in Medicare because of its improvement in financing and a greater level of market penetration and stability. Most important, it gives senior and disabled citizens new private health plan options, more affordable care, and broader and better benefits, including care management programs and prescription drug coverage. Its key features:

- **Broad Access to Private Health Plans.** More than 9 million Medicare beneficiaries (roughly one of every five) are enrolled in private health plans under Medicare Advantage. While the heaviest enrollment is in urban areas, Medicare Advantage plans are available in every region of the United States, including rural areas where private plans have been sparse and difficult to get. Total enrollment in Medicare Advantage plans has already surpassed Medicare's previous private plan enrollment.
- **A Variety of Health Care Options.** Seniors have a variety of options, including health maintenance organizations (HMOs); local and regional preferred provider organizations (PPOs); private fee-for-service health plans; medical savings accounts (MSAs); and "special needs plans" (SNPs) that serve Medicare enrollees with chronic illnesses and disabilities. As of 2007, on average, seniors had a choice of 20 different plans.
- **Broader Health Benefits.** The health plans cover all of traditional Medicare's benefits and much more. Seniors can choose plans with higher premiums and lower cost-sharing or lower premiums and higher cost-sharing. Beyond prescription drug coverage, the plans offer preventive-care services and provide coordinated care or care management programs for enrollees with chronic conditions. Plans also offer routine physical examinations, additional hospitalization and skilled nursing facility stays, routine eye and hearing examinations, and glasses and hearing aids.
- **Superior Value for Health Care Dollars.** Under Medicare Advantage, seniors are getting better

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value for their health care dollars in an integrated system that is clearly superior to traditional Medicare. Based on an analysis of additional health benefits, including prescription drugs, hospital stays, and physician services, as well as premium savings in the Medicare Advantage system, the Centers for Medicare and Medicaid Services (CMS) estimates that Medicare beneficiaries have secured, on average, additional monthly benefits valued at $96 by enrolling in a health plan in the Medicare Advantage program. CMS findings of additional value are in accord with independent private analyses.

While there are problems with the payment methods for Medicare Advantage plans, most of these problems stem from basing Medicare Advantage payment on traditional Medicare's flawed payment system. Traditional Medicare payments do not reflect real market conditions of supply and demand, but are the product of a highly politicized administrative pricing mechanism, replete with price controls. At the same time, Congress should recognize that the criticism of government "overpayment" for Medicare Advantage is a criticism of payment for additional benefits and that cutting Medicare Advantage payment amounts to cutting these additional (and often necessary) benefits, thus forcing seniors to lose private coverage and buy supplemental coverage.

The Next Stage of Reform. While Medicare Advantage is an integrated system of health insurance, it is only the first stage of serious Medicare reform. Given the enormous fiscal challenge of Medicare's $36.3 trillion in unfunded liabilities, Congress must start the process of building on the success of the program's robust competition while controlling costs for current and future taxpayers. This can only be done through a comprehensive reform of the entire Medicare program.

The best option for such a comprehensive reform is a new system of premium support in which government makes a defined payment to a health plan of a beneficiary's choice. This would not only build on the positive experience of market competition in the Medicare Advantage program, but also would also achieve parity in payment for different health care options, including traditional Medicare itself.

In designing a new premium support system for Medicare, Congress should make sure that government payments are based on real market conditions, not arbitrary payment formulas; that they are not open-ended, thus encouraging serious cost control; that they encourage beneficiary savings; and that they are adjusted for such factors as age, income, or health condition.

Conclusion. The Medicare Advantage program is a success. Medicare patients are choosing health care options they like; they are getting superior benefits at affordable prices, and health plans are competing to provide value for health care dollars. Through the purchase of an integrated health plan, seniors are not forced to pay an additional premium for additional supplemental coverage to cover the needed benefits that traditional Medicare does not provide.

Medicare Advantage can serve as the first stage of reform. To ensure affordability for future generations, Medicare will have to be restructured, and for reform to be successful, Congress will have to change the existing payment system and provide a generous but predictable government contribution—a system of premium support, properly adjusted, for each beneficiary. At the same time, Congress should make sure that Medicare enters into a reliable partnership with private-sector health plan providers—and soon. The government will have to prove itself a good business partner.

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Robert E. Moffit, Ph.D.

Medicare Advantage, the new program of private health plans within the Medicare system, is a success. The main reason: Seniors enjoy an unprecedented level of personal freedom in choosing health care options that they think are best for them. Record numbers of senior and disabled citizens are enrolling in private health plans of their choice, securing better value for their health care dollars than is available to those who are enrolled in traditional Medicare. Of course, if they do not like their integrated private health plans, they are free to enroll in traditional Medicare and buy additional supplemental coverage if they wish.

Congress enacted Medicare Advantage as part of the Medicare Modernization Act of 2003. While best known for creating the costly universal prescription drug entitlement, the Act also replaced Medicare Plus Choice (Medicare Part C)—a program created under the Balanced Budget Act of 1997 that allowed Medicare recipients to choose coverage from among several private plans—with Medicare Advantage.[1]

Medicare Advantage has several features that are superior to previous private health plan experiments: an improvement in financing and a greater level of market penetration and stability than Medicare Plus Choice. Most important, it gives senior and disabled citizens new and different private health plan options, more affordable care, and broader and better benefits, including care management programs and prescription drug coverage. Its key features:

- **Broad Access to Private Health Plans.** More than 9 million Medicare beneficiaries (roughly one of

Talking Points

- Medicare Advantage, which enrolls 20 percent of all Medicare beneficiaries, allows seniors an unprecedented level of personal freedom in choosing health plan options.
- Medicare Advantage has several design features that are superior to previous private health plan experiments. It gives senior and disabled citizens new private health plan options, more affordable care, and broader and better benefits, including care management programs and prescription drug coverage.
- While these features are substantial improvements over traditional Medicare, what is needed next is more robust competition for the entire program and parity in the payment to health care options that seniors choose.
- For future generations to afford Medicare, it will have to be reformed in a comprehensive fashion. Congress will have to restructure the existing payment system and provide a generous but fixed contribution—a system of premium support, properly adjusted, for each Medicare beneficiary.

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every five) are enrolled in private health plans under Medicare Advantage.[2] While the heaviest enrollment is in urban areas, Medicare Advantage plans are now available in every region of the United States, including rural areas where private health plans have been sparse and difficult to get. Total enrollment in Medicare Advantage plans has already surpassed Medicare's previous private plan enrollment.

- **A Variety of Health Care Options.** Seniors have a variety of options, which include health maintenance organizations (HMOs); local and regional preferred provider organizations (PPOs); private fee-for-service (PFFS) health plans; medical savings accounts (MSAs); and "special needs plans" (SNPs) that serve Medicare enrollees with chronic illnesses and disabilities. As of 2007, seniors had, on average, a choice of 20 different plans.[3]
- **Broader Health Benefits.** The health plans cover all of traditional Medicare's benefits and much more. Seniors can choose plans with higher premiums and lower cost-sharing or lower premiums and higher cost-sharing. Beyond prescription drug coverage, the plans offer preventive-care services and provide coordinated care or care management programs for enrollees with chronic conditions. Plans also offer routine physical examinations, additional hospitalization and skilled nursing facility stays, routine eye and hearing examinations, and glasses and hearing aids.
- **Superior Value for Health Care Dollars.** Under Medicare Advantage, seniors have consistently been getting better value for their health care dollars in a system that is far superior to traditional Medicare. Based on an analysis of additional health benefits, including prescription drugs, hospital stays, and physician services, as well as premium savings in the Medicare Advantage system, the Centers for Medicare and Medicaid Services (CMS) estimates that Medicare beneficiaries have secured, on average, an additional monthly value of $96 (additional benefits or services worth that amount) by enrolling in a health plan in the Medicare Advantage program.[4] CMS findings of this additional value provided by Medicare Advantage plans are in accord with independent private analyses. [5]

The Next Stage of Reform

While these Medicare Advantage features are substantial improvements over traditional Medicare, the next stage of reform must also make the *total* program affordable, modernize its insurance arrangements, and improve the delivery of medical services. Because of its unfunded liability, Medicare imposes an enormous burden on current and future federal taxpayers. According to the Medicare Trustees in their 2008 annual report, Medicare faces long-run excess costs of $36.3 trillion, based on a 75-year actuarial projection, or roughly two and a half times the size of the entire U.S. economy.[6] While there is a need to improve and modernize the program's basic insurance functions, Congress must

1. Medicare Plus Choice was compromised from the start. Governed by a new and very different system of financing that capped Medicare payments to health care plans, the program was also burdened with a 900-page regulatory regime that stifled both innovation and plan flexibility. The result was an exodus of health plan providers and a reduction in choice for millions of seniors who wanted an alternative to traditional Medicare.
2. This dramatic surge in popularity has surpassed most official expectations. The Congressional Budget Office projected that enrollment in Medicare Advantage plans would reach only 16 percent by 2013, and the Department of Health and Human Services projected an enrollment close to 30 percent. The previous record of private plan enrollment was set in 2000, with 6.3 million enrollees, 16 percent of the Medicare population. Data from Henry J. Kaiser Family Foundation, "Medicare at a Glance," April 2005, at *http://www.kff.org/medicare/upload/Medicare-at-a-Glance-Fact-Sheet.pdf*.
3. Medicare Payment Advisory Commission, *Data Book: Health Care Spending and the Medicare Program*, June 2007, p. 151.
4. Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 27, 2008.
5. See, for example, Mark Merlis, "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006," Henry J. Kaiser Family Foundation *Issue Brief*, January 2008, at *http://www.kff.org/medicare/upload/7744.pdf* (May 21, 2008).

also address the severe mismatch between Medicare's long-run costs and dedicated revenues.

Correcting Flaws. The Democratic congressional leadership wants to scale back Medicare Advantage, and Bush Administration officials have signaled their support of a presidential veto of any such cuts.[7] Congressional opponents of the program say that Medicare Advantage health plans should not receive higher levels of Medicare funding than traditional Medicare receives, even though the congressionally designed payment system for traditional Medicare, as many of these same Members of Congress are willing to concede, is flawed and routinely in need of legislative correction or modification.

A new system of premium support could establish equity in Medicare payment, with positive results similar to the experience of the Federal Employees Health Benefits Program (FEHBP). Based on the FEHBP's almost five decades of experience, the intense competition among health plans, driven by consumer choice, would deliver high-quality care to beneficiaries efficiently and without the level of mind-numbing congressional micromanagement and frenzied provider lobbying that routinely burdens traditional Medicare.

No Illusions. Members of Congress must be honest and up-front about their intentions. Rarely are proposed Medicare Advantage payment cuts motivated by a newly found sense of fiscal responsibility: The program accounts for less than 15 percent of all Medicare spending. Rather, they are advanced as new funding sources for even higher government spending, such as the proposed expansion of the State Children's Health Insurance Program (SCHIP).[8]

What congressional opponents of Medicare Advantage also often do not say is that their proposed cuts in these private health plans are not really cuts in the plans, but cuts in seniors' health benefits. While these health plans get net payments that are approximately 12 percent higher than traditional Medicare's per capita costs, they also provide more extensive benefits and more comprehensive health coverage.[9] Under the legally ordained Medicare Advantage bidding system established by Congress, any payments that exceed a health plan's bid must be returned to seniors in the form of lower cost-sharing or benefits, such as hearing, vision, and physical exams. So cutting payments to the health plans would mean, in effect, cutting these benefits for seniors.

Members of Congress should also be prepared to acknowledge that proposed Medicare Advantage payment cuts could result in another exodus of health plans from Medicare, as happened with congressional cuts in Medicare Plus Choice in 1997, when millions of seniors lost access to private health coverage. Traditional Medicare routinely covers only 54 percent of the total spending for beneficiaries' health care.[10] Without access to Medicare Advantage plans, seniors would have two choices: either settle for the inferior level of coverage of traditional Medicare and go without the additional benefits or buy additional coverage through Medigap or some other supplemental coverage option.

6. See Greg D'Angelo and Robert E. Moffit, Ph.D., "Congress Must Not Ignore the Medicare Trustees' Warning," Heritage Foundation *WebMemo* No. 1869, March 26, 2008, at *http://www.heritage.org/research/healthcare/wm1869.cfm*; see also U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, at *http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf*.
7. "If the President is presented with legislation that would result in the loss of access to additional benefits or choices in the Medicare Advantage program, the President's senior advisors would recommend he veto the bill." Letter to Senator Chuck Grassley (R–IA) from Michael O. Leavitt , Secretary, United States Department of Health and Human Services, May 22, 2008, p. 1.
8. For example, Medicare Advantage payment cuts were embodied in the Children's Health and Medicare Protection Act (H.R. 3162), a bill to expand SCHIP coverage to middle-class families, which was passed by the House of Representatives in 2007. Facing the threat of a presidential veto, it was not enacted by the Senate.
9. Peter R. Orszag, Director, Congressional Budget Office, "The Medicare Advantage Program," testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007, p. 4.

Meanwhile, the rollback of Medicare Advantage plans would impose a disproportionate burden on the low-income and minority seniors who enroll in them, as well as reduce seniors' access to Medicare Advantage plans in rural areas.[11]

Achieving Parity. If Congress sincerely believes that parity of Medicare payment for different options is a desirable policy objective, then that worthy goal can be achieved through an equitable premium support system of financing, wherein the government contributes a specific amount to the premium cost of a health plan, that is combined with other measures, such as the creation of a risk adjustment mechanism for insurance, that will assure a level playing field for plan competition. In a Medicare premium support system, seniors would receive a direct contribution to the health plan of their choice. The money would follow the patient, letting the patient control the flow of dollars. This is the kind of financing that governs the popular and successful FEHBP. With seniors directly controlling the flow of Medicare dollars, all Medicare plans would either provide value—high-quality benefits and service for their premium dollars—in a robust competitive environment or lose market share.

If Congress is concerned with assuring some measure of fairness in the distribution of government funds to seniors, then it could easily adopt a system of income-related subsidies, providing more help to lower-income seniors and less to those with higher incomes. This policy has been partially in effect since 2007 through rule changes in Medicare Part B that require upper-income beneficiaries to pay slightly higher premiums.[12] This policy could easily be applied to the entire Medicare program. It may be, as the Government Accountability Office (GAO) and many health care economists have suggested, more efficient to target subsidies directly to a defined low-income population than it is to subsidize premiums and cost-sharing for all Medicare beneficiaries, including those who are "well off."[13]

Why Congress Created Medicare Advantage

Medicare Advantage is the latest generation of private health plan competition in Medicare, a feature of the Medicare program since 1972 when Congress enacted legislation to allow health maintenance organizations (HMOs) to provide coverage for Medicare beneficiaries. Initially, Congress paid plans based on the average per capita costs of providing traditional Medicare services in different geographic areas or, alternatively, on what Medicare officials determined to be the "reasonable cost" of providing such services.[14] Later, in 1982, Congress set Medicare payments to private health plans at 95 percent of traditional Medicare payments in each county, and the number of plans increased rapidly but not uniformly. There were still areas of the country where there were no private health plan options at all.

Based on a desire to expand the availability of health plan options, as well as a growing dissatisfaction with its own administrative payment formula for private plans in Medicare, Congress created the Medicare Plus Choice program as part of the Balanced Budget Act of 1997—a compromise between the Clinton Administration and the congressional

10. This refers to health care spending among non-institutionalized "fee for service" Medicare beneficiaries. Private sources pay 18 percent; beneficiaries pay 16 percent through their out-of-pocket spending; and public sources, primarily Medicaid, pay 12 percent. See the Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, June 2007, p. 66.
11. Slightly more than half of all Medicare beneficiaries in rural areas are enrolled in the increasingly popular private fee for service plans (PFFs). See Marsha Gold, "Medicare Advantage in 2008," Henry J. Kaiser Family Foundation *Medicare Issue Brief*, June 2008, p. ii.
12. As of 2007, under the Medicare Modernization Act of 2003, Medicare beneficiaries with annual incomes over $80,000 ($160,000 per couple) have been required to pay higher monthly Part B premiums.
13. U.S. Government Accountability Office, "Medicare Advantage: Higher Spending Relative to Medicare Fee for Service May Not Ensure Lower Out of Pocket Costs to Beneficiaries," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 28, 2008, p. 12.
14. America's Health Insurance Plans, "The Value of Private Health Care Choices in Medicare," October 2005, p. 6.

Republican leadership—to replace the previous system of private health plans (mostly HMOs) with tight networks of doctors and other medical professionals. The rationale for the new program was to "allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare" and to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options."[15]

Loss of Private Coverage. The effort, plagued with unintended consequences, backfired: With the enactment of the Balanced Budget Act of 1997 and the creation of the Medicare Plus Choice program, Congress changed the payment policy and authorized the Medicare bureaucracy to set in place a series of new regulations on private plans. The impact was twofold: Congress authorized capping payment increases in the plans while expanding the Medicare bureaucracy's regulatory reach over their operations.[16]

This combination was deadly and caused the number of private health plans in the Medicare program to drop by more than half.[17] In 1998, the first year of the new Medicare Plus Choice program, 346 health plans were offered to senior and disabled citizens; by 2003, that number had sunk to 151.[18] While millions of seniors lost the opportunity to enroll in alternative health plans, the congressional architects of the policy cynically blamed the private sector for the results of their own handiwork.

With the enactment of the Medicare Modernization Act of 2003, Congress changed policy again, reversing the cuts it had enacted in the late 1990s and approving additional funding to lure private plans back into Medicare. The private sector responded with an additional set of benefits and health plan options. While the program got off to a rocky start,[19] the end result was a dramatic reversal of the dismal downward trends in private health coverage that had been set in motion under the restrictive 1997 Balanced Budget Act. The number of private health plans competing in the Medicare Advantage program increased rapidly.[20] That rapid increase has resulted in the highest enrollment in private health plans in the history of Medicare.

The richer benefits package in Medicare Advantage, including disease management and care coordination programs, would prove to be particularly attractive to seniors with chronic medical conditions and would mitigate potential adverse selection against traditional Medicare that critics of participating private health plans historically have feared.

The very presence of competing private health plans and the increasing demand for their services have also had a positive impact on the management and costs of traditional Medicare. In a recent study on the impact of Medicare HMO penetration on traditional Medicare itself, researchers found a "spillover effect" from such geographical penetration: Areas where such penetration was high also had lower costs in traditional Medicare. Specifically, examining county data, researchers found that a 1 percent increase in Medicare HMO penetration would reduce annual spending in traditional Medicare by 0.9 percent.[21]

Likewise, Jeff Lemieux, a former analyst at the Congressional Budget Office (CBO), also correctly

15. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy,* March 1999, p. 42.
16. For a detailed description of the degree of micromanagement of "Medicare Plus Choice," see Bruce Merlin Fried and Janice Ziegler, "The Medicare+Choice Program: Is It Code Blue?" ShawPittman, June 8, 2000.
17. For an incisive discussion of the numerous problems that plagued the ill-fated Medicare Plus Choice experiment, see Sandra Mahkorn, M.D., M.P.H., M.S., "How Not to Reform Medicare: Lessons from the Medicare+Choice Experiment," Heritage Foundation *Backgrounder* No. 1319, September 15, 1999, at *http://www.heritage.org/Research/HealthCare/BG1319.cfm*.
18. Henry J. Kaiser Family Foundation, "Medicare Advantage," September 2005, at *http://www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf* (May 21, 2008).
19. In the aftermath of Hurricane Katrina, the Senate, for example, pondered cutting the initial $10 billion in federal stabilization funding in order to jump start the participation of new private health plans.
20. Henry J. Kaiser Family Foundation, "Medicare Advantage," September 2005.

predicted that a "big surge" in enrollment in this alternative program would encourage Medicare administrators to find ways to make traditional Medicare more efficient.[22] The rapid popularity and growing success of Medicare Advantage could also encourage administrators of traditional Medicare to modernize their delivery of care as well as their payment practices. This could then establish the groundwork for traditional Medicare to compete directly with private health plans in a new premium support system to provide the best medical care for senior and disabled citizens.

How Medicare Advantage Is Financed

Under the Medicare Modernization Act of 2003, the Secretary Health and Human Services (HHS) determines a benchmark payment equal to the maximum amount that Medicare will pay private health plans for providing all Medicare Parts A and B benefits and hospital and physician services in a given geographic area. The CMS benchmarks are based in part on projected Medicare costs at the county level and are updated annually. Under current law, the government benchmark must be "at least as great as per capita" traditional Medicare expenditures in every county and, as the CBO observes, in many counties are higher than traditional Medicare expenditures.[23]

When a health care organization wants to participate in Medicare, it must submit a bid with an estimate of its per capita payment for providing Medicare Parts A and B benefits. Estimates must also be submitted for prescription drug benefits, as well as for any additional benefits not covered by Medicare. Plan bids are risk-adjusted according to CMS rules, which means that the plan's estimate reflects the characteristics of the Medicare population in specific geographic areas. Plan estimates also include the administrative costs or profits that the plan projects. The CMS reviews and approves the bids for the plans.

Rebates to Beneficiaries. Under Medicare law, if a health plan's bid is higher than the government's benchmark payment for the core benefits in traditional Medicare, the Medicare beneficiary is responsible for paying the difference in the form of a higher premium for enrolling in the plan. If, on the other hand, a bid is lower than the government's benchmark, 75 percent of the difference between the bid and the benchmark must be returned to the Medicare beneficiary as a rebate; the other 25 percent of the difference is to be returned as savings to the government.

Overwhelmingly, health plans offer the core Medicare benefit package at levels *below* the government benchmark. In 2006, 95 percent of Medicare Advantage plans bid below the government benchmark.[24] Rebates to Medicare patients can be in the form of lower cost-sharing, including lower copayments and lower premiums, or the provision of additional or enhanced benefits, including more affordable drug coverage. Under current CMS rules, the health plans have a high degree of flexibility in this matter.

Risk Adjustment. A key component of the new financing for private health plans is a more sophisticated system of risk adjustment. When health care organizations bid to cover enrollees in a given geographical area for traditional Medicare benefits—the core Part A hospitalization and Part B physicians' services—the plan providers need to consider the level of risk they are assuming, which includes the variability among enrollees in terms of their health status or health risks, including the prevalence of chronic disease, and patterns and costs of medical practice in a given geographical area. According to Dr. Gerald Kominski:

> In this case, risk adjustment raises or lowers the premium [that] Medicare pays the plan, based on patient characteristics that have

21. Michael Chernew, Phillip DeCicca, and Robert Town, "Managed Care and Medical Expenditures of Medicare Beneficiaries," National Bureau of Economic Research *Working Paper* No. 13747, January 2008, p. 4, at *http://www.nber.org/papers/w13747*.
22. See Jeff Lemieux, "Will Congress Contain Medicare's Exploding Costs?" Heritage Foundation *Lecture* No. 857, December 17, 2004, pp. 6–7, at *http://www.heritage.org/research/healthcare/hl857.cfm*.
23. Orszag, "The Medicare Advantage program," p. 4.
24. Mark Merlis, "Medicare Advantage Payment Policy," *Background Paper*, National Health Policy Forum, George Washington University, September 24, 2007, p. 6, at *http://www.nhpf.org/pdfs_bp/BP_MAPaymentPolicy_09-24-07.pdf* (May 21, 2008).

> been shown to affect the risk that the enrollee will have higher or lower than average health care needs. Without risk adjustment, premiums would not adequately reflect the expected costs of a plan's enrollees. This would have several consequences. Some plans would be overpaid while others would be underpaid.[25]

While Medicare payments to private health care providers have previously been risk-adjusted, in recent years, the adjustment mechanisms have become more refined, going beyond demographic factors like age and sex to include measurements and classifications of medical conditions.[26]

The Debate on Funding

At the heart of the current debate over Medicare payments to private health plans is the current standard of payment: the traditional Medicare payment. In traditional Medicare, doctors and hospitals are paid through a complex system of pricing with fixed payments for hospital services based on hundreds of diagnostic categories, fee schedules for thousands of physicians' services, and ancillary formulas governing annual payment adjustments and updates.

These payments are also adjusted geographically, so Medicare payments vary dramatically in different parts of the country, with per capita spending the lowest in Utah and the highest in Massachusetts.[27] Congress's pricing system rewards high-priced providers in certain areas of the country and penalizes low-cost providers in others. According to one prominent study of this variation, total Medicare spending would fall by a stunning 29 percent if all Medicare spending were the same as spending in low-spending regions of the country.[28] This means that there is a lot of unnecessary spending embedded in the existing payment structure of the old Medicare program, which is hardly an ideal basis on which to base payments to health plans in a new program.

Arbitrary Pricing. Traditional Medicare sets and caps prices for medical services under Parts A and B. Few in Congress would defend their handiwork by pretending that Medicare's pricing represents prices that would survive in a real market in which the interaction of supply and demand determines the price of medical goods and services. As the CBO notes, Congress created and refined these pricing mechanisms over time, and they have yielded prices that are "below private sector levels" for payment to doctors and hospitals.[29]

Over the years, Congress has attempted to refine pricing for medical services under Medicare Parts A and B with pricing mechanisms such as the Resource-Based Relative Value Scale (RBRVS)—the fee schedule for doctors' reimbursements—and the sustainable growth rate (SGR) formula for physician payment updates. These were, of course, initially presented as rational and fair and even, in the case of the RBRVS's, as scientific.[30] In fact, they are nothing of the sort, and 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

25. Gerald F. Kominski, Ph.D., "Medicare's Use of Risk Adjustment," *Background Paper*, National Health Policy Forum, George Washington University, August 21, 2007, p. 5, at *http://www.nhpf.org/pdfs_bp/BP_RiskAdjustMedicare_08-21-07.pdf* (May 21, 2008).
26. *Ibid.*, p. 9.
27. Congressional Budget Office, *Geographic Variation in Health Care Spending*, Publication No. 2978, February 2008, p. 1. See also John E. Wennberg *et al.*, "Geography and the Debate Over Medicare Reform," *Health Affairs* WebExclusive, February 13, 2002, at *http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Wennberg&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT* (May 22, 2008).
28. *Ibid.*
29. Congressional Budget Office, "Health Care and the Budget: Issues and Challenges for Reform," statement of CBO Director Peter R. Orszag before the Committee on the Budget, U.S. Senate, June 21, 2007, p. 7, at *http://www.cbo.gov/ftpdoc.cfm?index=8255&type+)&sequence=0* (May 22, 2008).
30. See Robert E. Moffit, Ph.D., "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Heritage Foundation *Backgrounder* No. 865, September 23, 1991, at *www.heritage.org/research/healthcare/bg865.cfm*.

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 physicians payments cuts, which would reduce doctors' pay by 10 percent in July of 2008, from going into effect.[31]

Traditional Medicare payments, in any case, do not reflect market prices. As Mark Merlis observes:

> In some areas [Medicare] may be paying less than a market price for services, and in others more. At least in theory, competition among private health plans would more nearly ensure that providers were being paid the "right" prices than the current system of administratively set FFS payment rates.[32]

Congressional critics, especially champions of Medicare's administrative pricing and price controls, argue that Medicare payments to Medicare Advantage plans should be reduced precisely because they exceed traditional Medicare payments. In calling for these cuts, these Members of Congress invariably cite the Medicare Payment Advisory Commission, which estimated that Medicare payments for beneficiaries enrolled in private health plans were, on average, 12 percent higher than payments for those enrolled in traditional Medicare in 2006. The CBO also estimated that "net payments" to these health plans in 2007 were 12 percent higher than the per capita costs of traditional Medicare.[33] The GAO and the Commonwealth Fund, a liberal health policy group based in New York, have likewise found that Medicare Advantage plans are paid at levels higher than the cost of traditional Medicare in different areas of the country.

Once again, however, the issue is the precise basis of comparison. To compare two different insurance systems with different levels of benefits and suggest overpayment because 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.

As noted, Medicare Advantage payments include the payments for the extra benefits and services not included in traditional Medicare, integral to the legally binding rebate system, not merely the core benefits of Medicare Parts A and B. The issue is not simply what Medicare is paying, but what seniors are getting. As Merlis, among others, emphasizes:

> These extra benefits are really at the center of the debate. Medicare continues to expose many beneficiaries to potentially catastrophic costs, especially beneficiaries whose incomes are too high to qualify for Medicaid and who cannot afford private Medigap coverage.[34]

A Better Way? There is a growing consensus among both champions and critics of the Medicare Advantage program that the traditional payment system is flawed and should be corrected. Once again, the estimated net "overpayment" encompasses high-cost and low-cost areas, and low-cost areas are where the traditional Medicare payment is often too low to enable private health plans to survive. That is why congressional proposals to reduce Medicare Advantage payment to 100 percent of the traditional fee-for-service Medicare payment would result in the deepest cuts in health plans in traditionally low-cost counties, while high-cost counties would be comparatively unaffected.

Dr. Robert Berenson, a senior fellow at the Urban Institute and one of the most prominent critics of the Medicare Advantage "overpayments," nonethe-

31. John S. O'Shea, M.D., "Ending the Physician Payment Crisis: Another Reason for Major Medicare Reform," Heritage Foundation *WebMemo* No. 1931, May 20, 2008, at *http://www.heritage.org/research/healthcare/wm1931.cfm*. In this connection, Gail R. Wilensky, Administrator of the Health Care Financing Administration during the first Bush presidency, says: "One thing is clear. Policy analysts, members of Congress, congressional staff, and much of the physician community are unhappy with the current reimbursement strategy…." See Gail R. Wilensky, "The Need to Aggregate: What Comes Next for Medicare Physician Payment," *Health Affairs* Blog, February 25, 2008, at *http://healthaffairs.org/blog/2008/02/25*.
32. Merlis, "Medicare Advantage Payment Policy," p. 16.
33. Orszag, "The Medicare Advantage Program," p. 4.
34. Merlis, "Medicare Advantage Payment Policy," p. 18.

less calls on Congress to recognize the serious flaws in the existing Medicare payment system at the county level and urges a new method of setting benchmarks by blending national and local rates, resulting in a more equitable payment system than we have today.[35]

An even better option is a direct premium support system of health care financing that enables all plans to compete. In some versions of premium support, this would include direct competition with traditional Medicare.

There are many ways to design a premium support system for Medicare.[36] One could base payment, for example, on the average premium of competing health plans themselves rather than on a benchmark set by traditional Medicare payments. But there would be neutrality in the government's payment to health plans, including payment to traditional Medicare; if beneficiaries wanted to choose a health plan with a richer set of benefits, they could do so and would be responsible for paying any additional amount over the government contribution.[37]

Another option would be to pay health plans on the basis of an annual budget determination, whereby Congress explicitly decides how much it is willing spend on Medicare, factoring in the needs of the Medicare population along with other competing budgetary considerations. This is broadly similar to global budget proposals often proffered by champions of a "single-payer" health care system.

Yet another option is to combine a payment based on a market-based bid combined with a capped dollar amount based on the average premium payment, which is very much like the FEHBP. Beyond the setting of the basic Medicare payment, however, Congress may wish to adjust that payment further for age, health status, and income—adjustments absent in the FEHBP payment system.

Superior Quality and Benefits

Medicare Advantage plans cover all of the health benefits that are included in traditional Medicare Part A and Part B programs—the hospital and physicians' services, respectively—but Medicare Advantage plans improve on traditional Medicare, adding new medical benefits that are not currently provided under the traditional program. Under traditional Medicare, for instance, a patient would pay an initial hospital deductible of $1,024, with a graduated per diem coinsurance; but Medicare Advantage plans include a variety of hospital copayments, and many offer unlimited hospital stays.

Likewise, under traditional Medicare, the patient would pay a $135 deductible and 20 percent coinsurance for physician services, with no limit on out-of-pocket expenses; but many Medicare Advantage plans offer physician benefits with no deductible and limited copayments.

With prescription drugs, as provided under Medicare Part D, the government standardizes the drug benefit, prescribing a $275 deductible monthly premium for insurance coverage, but with a deliberate gap in coverage: the so-called donut hole, where Medicare patients would have to pay 100 percent of the drug costs until a pre-specified upper limit is reached. With the regulatory flexibility provided to Medicare Advantage plans, seniors may pay no deductible or copayment, depending on the plan they choose, and be able to secure some level of coverage in the "gap," allowing them to get coverage for generic and brand-name drugs. The Medicare Advantage plans can and often do use their rebates to reduce Part D prescription drug premiums, benefiting millions of seniors.

35. Berenson's thoughtful analysis could serve as a starting point for a discussion of reform of Medicare's traditional payment system. See Robert A. Berenson, "From Politics to Policy: A New Payment Approach in Medicare Advantage," *Health Affairs*, March/April 2008.
36. For a detailed discussion of the Medicare premium support option and the issues involved in designing such an option, see Congressional Budget Office, "Designing a Premium Support System for Medicare," Publication No. 2596, December 2006, at *http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf* (May 22, 2008).
37. The Medicare Payment Advisory Commission (MedPAC) "has long supported giving Medicare beneficiaries a choice in health care delivery systems, provided that such choices do not increase Medicare program expenditures." Medicare Payment Advisory Commission, *Issues in a Modernized Medicare Program: Report to Congress*, June 2005, p. 76.

The plans in Medicare Advantage have proved their worth. As of 2005, they provided lower copayments and deductibles for the required Medicare-covered services; sensible out-of-pocket limits on medical spending for certain benefits; more generous drug benefits than are generally available through the combination of traditional Medicare and a prescription drug plan; coordination of care for chronic illnesses including heart disease, diabetes, lung disease, and cancer; nutritional, wellness, and preventive benefits; and dental and vision benefits.[38] Of particular interest in this connection is the demand for special needs plans that focus on chronic conditions. As of 2007, CMS approved 476 such plans, which have a total enrollment of 843,000 beneficiaries.[39]

A key issue in Medicare financing is not simply the level of health care spending, which will accelerate in any case with the retirement of the baby-boom generation. Even more important, the issue is what patients and taxpayers are getting in return for that spending. This should be measured in terms of results, better medical outcomes, and greater success in curing and treating diseases. So quality is another key component of sound health policy. While there are more refined definitions of quality of care, it can be summarized as getting the right diagnosis and the right treatment at the right time. Recently, CBO Director Peter Orszag said that he had not seen sufficient data from health plans or the CMS on the performance of the plans in delivering superior outcomes. Health plans, of course, are working to produce those data, which are sure to be enlightening.

Nonetheless, there is some preliminary evidence—such as data in reported in *The Journal of the American Medical Association*, the *Archives of Internal Medicine*, and *The American Journal of Public Health*—that Medicare Advantage patients are receiving care superior to that provided to patients in traditional Medicare. In a summary review of these findings, researchers at America's Health Insurance Plans, a national trade association with nearly 1,300 member companies, report that Medicare Advantage plans outperform traditional Medicare in providing beta-blockers after heart attacks, breast cancer screening, immunizations for the flu, and diabetes testing. Medicare Advantage patients were also less likely to have late-stage cervical and breast cancer diagnoses.[40]

More Affordable Care. The GAO recently found that more than nine in 10 health plans submitted bids that were lower than the government's benchmark and returned these savings to seniors in the form of lower costs. According to the GAO, 91 percent of those plans got an average rebate of $87 per member per month, and 89 percent of those rebates were returned to beneficiaries as lower copayments and coinsurance, as well as premium reductions.[41] Eleven percent of the rebate payments went to Medicare beneficiaries in additional health care benefits that are not covered by traditional Medicare.

Of course, the GAO also found that some beneficiaries who enrolled in certain plans could face higher out-of-pocket costs for certain benefits, such as home health care and inpatient services, than those enrolled in traditional Medicare.[42] These beneficiaries can always switch to what they determine to be a superior option.

The GAO also found that 87 percent of the total Medicare Advantage revenues went to pay medical

38. Centers for Medicare and Medicaid Services, "Medicare Beneficiaries to see bigger savings with Medicare Advantage health plan than ever before," press release, April 5, 2005.
39. Medicare Payment Advisory Commission, *Data Book: Healthcare Spending and the Medicare Program*, pp. 157–158.
40. America's Health Insurance Plans, "The Value of Private Health Care Choices in Medicare," p. 3.
41. U.S. Government Accountability Office, "Medicare Advantage: Higher Spending Relative to Medicare Fee for Service May Not Ensure Lower Out of Pocket Costs to Beneficiaries," p. 3.
42. "Although plans projected that beneficiaries' overall cost-sharing was lower, on average, than Medicare FFS cost-sharing estimates, some MA [Medicare Advantage] plans projected that cost-sharing for certain categories of services was higher than Medicare FFS cost-sharing estimates. This is because overall cost-sharing in MA plans is required to be actuarially equivalent or lower compared to overall cost-sharing in Medicare FFS, but may be higher or lower for specific categories of services." *Ibid.*, p.7.

expenses for seniors, while 9 percent went to a combination of administrative and marketing expenses and competing plans were able to secure a profit of 4 percent.[43] While the GAO found that approximately 1.7 million seniors were enrolled in plans where less than 85 percent of revenues were spent on medical expenses, the overall Medicare Advantage level is generally higher than that of existing Medigap policies and approximates that of health plans in the private sector.[44] Given the fact that most seniors have chosen to enroll in managed care options, which naturally have a higher level of administration, this distribution of revenues is hardly unreasonable.

A variety of reports from different government agencies show a consistency in provision of affordable health care options for seniors under Medicare Advantage. When the program was implemented in 2004, the new funding for private plans was immediately directed to enhancing benefits and reducing beneficiary costs. As a result of the funding changes in 2004 and 2005, 95 percent of the funding increase was used by the plans to reduce premiums and cost-sharing for the beneficiaries, enhance their benefit offerings, and ensure increased access to doctors and other medical professionals.[45]

These findings are confirmed by private-sector analyses. In a recent study for the Kaiser Family Foundation, Mark Merlis found that, compared to seniors enrolled in traditional Medicare, those enrolled in Medicare's rapidly growing private fee-for-service plans would receive benefits valued at $55.92 per month more than traditional Medicare benefits and those in other Medicare Advantage plans would be able to get additional benefits valued at $71.22 higher per month.[46] Merlis points out that if the sickest and highest-cost enrollees (with health spending that would have placed them in the top 5 percent of all Medicare beneficiaries) were to choose a private fee-for-service plan, they would have higher out-of-pocket spending than "comparable enrollees" in other Medicare Advantage plans, amounting to an additional $1,000 a year.[47]

Once again, beneficiaries have their own personal reasons for picking different options, even if their personal out-of-pocket spending might be higher. Consider the rapid growth in PFFS health plans, particularly in rural areas. The private fee-for-service option may be increasingly popular among seniors precisely because it *is* a private fee-for-service option, and they can go to any doctor or specialist they want. These plans are not burdened by the network restrictions on physicians and other medical professionals that are characteristic of managed care plans, particularly HMOs.[48] Given the strong consumer backlash against managed care in recent years, this should not be at all surprising.

Medicaid Savings. Equally notable is the 2005 study conducted by Adam Atherly, professor at the Rollins School of Public Health at Emory University, and Ken Thorpe, formerly a senior health policy expert in the Clinton Administration. Atherly and Thorpe found that for senior and disabled citizens enrolling in a Medicare Advantage plan, the program would provide an additional $3 billion in benefits a year, or $615 per enrollee.[49] But their more interesting finding is that this provision of additional benefits for seniors would also result in a reduced reliance on Medicaid, the huge government program for the poor.[50] In other words, by reducing dependence on the increasingly expensive

43. *Ibid.*, p. 4.

44. U.S. Government Accountability Office, *Medicare Advantage: Increased Spending Relative to Medicare Fee for Service May Not Always Reduce Beneficiary Out of Pocket Costs*, GAO-08-359, February 2008, p. 27, fn. 30.

45. America's Health Insurance Providers, "The Value of Private Health Care Choices in Medicare," p. 9.

46. Merlis, "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006," p. 1.

47. *Ibid.*

48. Merlis, "Medicare Advantage Payment Policy," p. 11.

49. Adam Atherly, Ph.D., and Kenneth E. Thorpe, Ph.D., "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," Blue Cross and Blue Shield Association, September 20, 2005, at *http://www.magnetmail.net/images/clients/BCBSA1/attach/KenThorpeMAReport.pdf* (May 22, 2008). Estimates are in 2005 dollars.

Medicaid program, taxpayers at both the federal and state levels would gain significant savings from the expanded enrollment in Medicare Advantage.[51]

Just as there are significant geographical variations in the cost of traditional Medicare services,[52] the premiums for private health plans, including those competing for consumer dollars under Medicare Advantage, would vary by geographical region. In many areas of the country, Medicare beneficiaries can enroll in a health plan with a "zero premium" option, meaning no additional premiums beyond the Part B premium, or secure rebates that would reduce these Part B premiums.

Strong Minority and Low-Income Participation. Affordability of health care options is, of course, universally attractive, but it is worth noting that Medicare Advantage has proven to be especially attractive to low-income and minority Medicare beneficiaries.

In their 2005 study, Atherly and Thorpe found that Medicare beneficiaries with incomes between $10,000 and $20,000 registered significantly higher enrollment in Medicare Advantage plans than in other options: Nearly 38 percent chose to enroll in Medicare Advantage, compared to 33 percent who opted for a Medigap plan or just over 29 percent who had Medicare only.[53] Atherly and Thorpe also found that black and Hispanic beneficiaries showed a disproportionately greater enrollment in Medicare Advantage plans than did white beneficiaries: Nearly 33 percent of white beneficiaries who had Medicare Advantage plans available to them chose them, while fully 40 percent of black seniors and nearly 53 percent of Hispanics selected them.[54] Atherly and Thorpe estimated that the then-proposed congressional reductions in payments to Medicare Advantage plans would likewise significantly and disproportionately affect these low-income and minority beneficiaries.

Premium Support: Building on the Success of Medicare Advantage

Medicare Advantage has been a success, but it is far short of comprehensive Medicare reform. Members of Congress who wish to see a fair and equitable Medicare payment system can achieve that most easily through a new system of premium support in which all plans could compete on a level playing field.

A first-order decision is how to budget for future Medicare spending. Congress could make an annual budgetary decision on what will be spent for Medicare, based on an assessment of its entire set of fiscal obligations, and make Medicare payments accordingly, allocating a specific amount to Medicare beneficiaries on a per capita basis.[55] Congress could also pay Medicare plans based on the prevailing market rates of health plans in a competitive environment, reflecting the dynamics of a changing market but cap the payment amount, as is done to today in the FEHBP.

A second-order decision is whether to include traditional Medicare in health plan competition or whether to maintain the competition among private health plans alone in a new premium support system exclusively for new retirees.[56] If policymakers decided to include traditional Medicare in a head-to-head competition with private health options, they would have to make significant programmatic and administrative changes to Medicare to enable Medicare to compete effectively.[57]

50. *Ibid.*
51. *Ibid.*
52. Congressional Budget Office, "Geographic Variation in Health Care Spending," February 2008.
53. Atherly and Thorpe, "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries." AHIP's analysis also shows a preference among low-income and minority beneficiaries for Medicare Advantage plans.
54. *Ibid.*
55. This is the approach broadly recommended by analysts at the American Enterprise Institute. "We could restrict the growth of public spending per beneficiary, replacing Medicare's open-ended entitlement with a credit that grows at a rate that is financially sustainable. Seniors could use the credit to help pay for health plans of their own choosing and add their own money to buy more expensive plans." Joseph Antos and Mark V. Pauly, "Saving Medicare," American Enterprise Institute *On the Issues*, May 2008, p. 1.

In developing a new system, Congress can build on the success of Medicare Advantage while borrowing the best features of two other working models: Medicare Part D, the competitive Medicare prescription drug program, and the popular and successful Federal Employees Health Benefits Program (FEHBP), a consumer-driven system of competing private health plans that serves federal workers and retirees and their families.

Learning from Part D. As in the FEHBP, drug plans in Medicare Part D bid against each other. Part D also features transparency, registers high patient satisfaction, and is characterized by intense competition and dramatic cost control. Since the inception of the competitive program in 2006, average monthly drug premiums for seniors have declined by almost 40 percent.[58] In sharp contrast to virtually every other area of the health care sector, the intense market competition in this program is driving costs down for both seniors and taxpayers. On average, seniors are saving $1,200 every year on their drug prescriptions.[59] HHS Secretary Michael O. Leavitt has suggested the right policy: Make Medicare Parts A and B more like the competitive system in Medicare Part D:

> If the Medicare Part D structure was applied to Parts A and B, it would revolutionize the entire system. Imagine, if you will, a physician practice investing resources to monitor and to track patients with chronic conditions. [It] might, if the program provided beneficiaries with information on the quality of their care and especially if we rewarded it financially. It would drive quality up and the cost down.[60]

To the extent practicable, the Congress should follow the example of FEHBP. There is a wealth of literature on FEHBP as a model for a future Medicare program.[61] It is free of the stultifying bureaucracy, benefit standardization, price controls, and regulatory overhead that tie up doctors, hospitals, and medical professionals in red tape and bury them in paperwork. Historically, the consumer-driven FEHBP not only has outperformed conventional employer-based insurance in terms of cost, but also, when controlling for the value of benefits, has matched or surpassed even traditional Medicare.[62]

In designing a new premium support system for Medicare, Congress should adopt five principles:

56. This is a tricky problem. It is difficult to have a fair competition between a private health plan, which assumes risk, and a federal government entity heavily subsidized by the federal government, with the taxpayers assuming the risk. The problem of securing fair competition is compounded when the federal government itself is making the rules for the competition with private plans. This is tantamount to the government acting as player and umpire at the same time. In the FEHBP, this is not a problem. The U.S. Office of Personnel Management (OPM), the agency that administers the program, does not sponsor or fund a "government health plan"; the program for federal employees and retirees is a system of competing private health plans only. The taxpayers, moreover, do not assume the risks incurred by the competing private health plans.
57. For a discussion of this issue, see Stuart M. Butler, Ph.D., "Restructuring Medicare for the Next Century," testimony before the Committee on Finance, U.S. Senate, May 27, 1999, at *http://www.heritage.org/research/healthcare/test052799.cfm?renderfor print=1*.
58. Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, "Medicare: Drifting Toward Disaster," remarks at the Newseum, Washington, D.C., April 29, 2008.
59. Office of Management and Budget, *Fiscal Year 2009 Budget of the U.S. Government* (Washington, D.C.: U.S. Government Printing Office, 2008), p. 64.
60. Leavitt, "Medicare: Drifting Toward Disaster."
61. See Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare program," *Health Affairs*, Winter 1995; Harry Cain, "Moving Medicare to the FEHBP Model or How to Make an Elephant Fly," *Health Affairs*, July/August 1999; Walton Francis, "The FEHBP as a Model for Medicare Reform: Separating Fact from Fiction," Heritage Foundation *Backgrounder* No. 1674, August 7, 2003, at *http://www.heritage.org/research/healthcare/bg1674.cfm*; and Walton Francis, "Using the Federal Employees' Model: Nine Tests for Rational Medicare Reform," Heritage Foundation *Backgrounder* No. 1675, August 7, 2003, at *http://www.heritage.org/research/healthcare/bg1675.cfm*.
62. Francis, "The FEHBP as a Model for Medicare Reform," and Michael J. O' Grady, *Health Insurance Spending Growth: How Does Medicare Compare*, staff report, Joint Economic Committee, U.S. Congress, June 10, 2003.

1. **Government payments should be based on real market conditions.** Government payment should not be based on traditional Medicare's artificial benchmarks, but on the real-life premiums charged by competing health plans. Congress should develop the new payment system on the basis of the FEHBP and Medicare Part D, not Medicare Advantage. In the FEHBP, the government sets the level of the contribution at a percentage of the average weighted premiums (72 percent) of all health plans competing in the system. In Medicare Part D, the government pays health plans a risk-adjusted payment based on the average of plan bids for covering enrollees' drug costs.
2. **Government payments should not be open-ended.** In this instance, Congress could follow the example of the FEHBP, which, while setting the government standard on the average premium payment, also caps the dollar amount per capita that the government will pay toward a health plan. The cap could be based, as noted, on the average premium of competing plans in the program or on a legislatively budgeted amount. In either case, a cap would encourage health plan providers to offer their benefits at competitive prices. Such a policy would also allow beneficiaries to pay more than the capped amount for more expansive plans with richer benefits.
3. **Government payments should encourage beneficiary savings.** Ideally, beneficiaries should be able to secure the full savings of any choices that they make, which means that they would be able to pocket 100 percent of the difference between the government contribution and the price of a lower-cost health plan. Under Medicare Advantage, the beneficiaries can secure only 75 percent of the savings from choosing a plan that offers a product at a price below the Medicare benchmark. Under the FEHBP formula, the government contribution for federal employees and retirees is limited to 75 percent of the premium cost of any competing health plan, up to the capped amount.

   Incidentally, the FEHBP's own payment formula could be improved. If the government contribution in that program were permitted to reach 100 percent of the capped amount, it would encourage federal employees to choose less expensive plans, gaining savings for themselves as well as for taxpayers. Such an arrangement should be provided to future Medicare beneficiaries in any new premium support system.
4. **Government payments should be risk-adjusted.** Remarkably, the FEHBP has no risk adjustment system. In this case, Congress should build on the success of Medicare Advantage, which has made significant progress in developing and applying risk adjustment. This is particularly important for beneficiaries who are older, who have higher health care costs, or who suffer from chronic diseases.
5. **Government payments should be income-related.** While every Medicare beneficiary who financially supports the program through taxes should be guaranteed a reasonable benefit, any new premium support system should also recognize the vast differences in financial need and in the ability to pay for insurance premiums and medical services among a very diverse population of future beneficiaries. This principle is modestly advanced under Medicare Part B, which requires higher premiums for high-income beneficiaries.

   Under a new premium support system, government payments should also be income-related. Such a measure could strengthen a future Medicare program and, given the fiscal challenges facing Medicare, could also win the support of liberals and conservatives alike. As Stuart Butler and Maya MacGuineas argue, "Rather than being seen as breaking the web of mutual obligations that bind us together as a community, means testing should be seen as enabling us to strengthen the safety net so that no one falls through."[63]

63. Stuart M. Butler and Maya MacGuineas, "Rethinking Social Insurance," The Heritage Foundation and the New America Foundation, February 19, 2008, p. 6.

Conclusion

The Medicare Advantage program is a success. Medicare patients are choosing health care options they like; they are getting superior benefits at affordable prices, and health plans are competing to provide value for health care dollars. By purchasing an integrated health plan, seniors are not forced to pay an additional premium for an additional private health plan, supplemental coverage, or drug plan to cover the needed benefits that traditional Medicare does not provide.

There are clearly problems with the payment methods for Medicare Advantage plans—mostly problems that stem from basing the methods on the flawed payment system of traditional Medicare. Medicare payments do not reflect real market conditions of supply and demand, but rather are the product of a highly politicized administrative pricing mechanism, replete with price controls that yield results that are often absurd or unacceptable, as in the case of Medicare physician payment.

Medicare Advantage plans are not "overpaid" if the value of the benefits that they are providing is factored into the calculation. Under traditional Medicare, seniors need to pay an additional premium and buy supplemental coverage to secure the missing benefits they need or the extra benefits that they want that are not included in the traditional program. With Medicare Advantage, beneficiaries are getting access to an integrated package of benefits, just like their fellow citizens who purchase group or individual insurance in the private markets, and can dispense with the hassle of two payments for separate insurance products. Meanwhile, the reliance of lower-income seniors on Medicare Advantage reduces their reliance on Medicaid, a welfare program, and thus produces reductions in Medicaid spending.

For future generations to be able to afford Medicare, the program will have to be restructured and reformed. For that reform to be successful, Congress will have to reform the existing payment system and provide a fixed-contribution system of premium support, properly adjusted, for each beneficiary. At the same time, Congress should make sure that Medicare enters into a reliable partnership with private-sector health plan providers—and soon. In other words, the government will have to prove itself to be a good business partner.

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