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Medicare Advantage: The Case for Protecting Patient Choice

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Medicare Advantage, the new system of competing private health plans created under the Medicare Modernization Act of 2003, is a success. More seniors are getting a wider variety of health plan options with better benefits, lower cost-sharing and more affordable health care coverage, and access to specialized programs that provide care coordination and care management if they suffer chronic or debilitating illnesses.

Moreover, by enrolling in Medicare Advantage plans, seniors are able to purchase an integrated health plan with richer benefits and prescription drug coverage while paying only one premium and one set of co-payments. For many seniors, this option is far superior to staying in traditional Medicare and paying a second premium for another health plan to supplement Medicare benefits.

Medicare Part C, the Medicare Advantage Program, accounts for only 14 percent of total Medicare spending.[1] Nonetheless, House Ways and Means Committee Chairman Charles Rangel (D–NY) reportedly is contemplating budget legislation that would cut payments to Medicare's private health plans by an estimated $50 billion over five years while adding $50 billion to the State Children's Health Insurance Program (SCHIP) and imposing a 45 cent tax increase on a pack of cigarettes. The Senate Finance Committee is also preparing legislation that would target the Medicare Advantage plans.[2] The President should veto any legislation that undercuts either consumer choice or competition in Medicare Advantage.

Overpayment? Some congressional leaders say that Medicare is paying too much to Medicare Advantage plans, and they want to cut funding for this option and thus reduce the number of plans that serve Medicare beneficiaries. Representative Pete Stark (D–CA), Chairman of the House Ways and Means Subcommittee on Health, says that "Medicare overpayments fatten company profits, even as many seniors face higher costs in private plans than they would in traditional Medicare."[3]

Overpayments to Medicare Advantage exist only if one assumes that Medicare's administrative pricing and price controls constitute a legitimate basis of payment. In fact, payment in traditional Medicare is largely insulated from the conditions of supply and demand, and Medicare routinely underpays and sometimes overpays for medical services. Most Members of Congress do not demonstrate confidence in their own payment formulas, as evidenced by their routine refusals to accept their own handiwork on physician payment.[4]

Moreover, the charge of "overpayment" does not consider the value of the benefits offered by Medicare Advantage. In fact, the estimated 4 percent profit margins of Medicare Advantage plans are considerably

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below the profit margins for most major industries. According to an analysis of Medicare Advantage plans by the Government Accountability Office (GAO), some seniors in some plans would indeed face higher costs for *certain* categories of benefits, but overall, the cost-sharing for enrollees in Medicare Advantage would be 42 percent of the estimated cost-sharing by enrollees in traditional Medicare.[5]

The Record. Medicare Advantage registers a high degree of patient satisfaction and is particularly attractive to low-income and minority seniors, who disproportionately enroll in these health plans. Of course, if seniors are dissatisfied with a Medicare Advantage plan, they retain the right to choose traditional Medicare as an alternative. Meanwhile, Medicare Advantage plans have a solid record of performance. For example:

- **The health plans are popular.** In 2008, approximately 9 million Medicare beneficiaries, roughly one out of every five Medicare enrollees, were enrolled in Medicare Advantage plans. The heaviest concentration of enrollment is in urban areas, but rural enrollment is growing rapidly. Medicare Advantage plans are now available in every region of the United States, including in rural areas where private plans have not been widely available. Thus far, the total enrollment in Medicare Advantage plans has surpassed Medicare's previous private plan enrollment.
- **The health plans are varied.** Health plan options include health maintenance organizations (HMOs); local and regional preferred provider organizations (PPOs); private fee-for-service (PFFS) plans; and, as of 2007, medical savings account (MSA) plans. There are also "special needs plans" (SNPs), which serve special Medicare populations with chronic illnesses and disabilities. While the largest concentration of senior and disabled citizens is found in local coordinated care plans (both HMOs and PPOs), PFFS plans and regional PPOs experienced the fastest growth during the past two years. A large and growing number of seniors clearly like these options even though many liberals in Congress do not.
- **The health plans offer better benefits.** In the traditional Medicare program, Congress and the Centers for Medicare and Medicaid Services (CMS), which is under congressional authorization, basically define the benefits that seniors can get and the circumstances under which they can get them. Medicare Advantage offers seniors the most robust set of benefit options outside of traditional Medicare. The health plans cover all of the traditional Medicare benefits and much more. Seniors can choose among plans with higher premiums and lower cost-sharing or with lower premiums and high-cost sharing. Beyond prescription drug coverage, they often cover preventive care services and provide coordinated care or care management regimens for enrollees with chronic conditions. Seniors also have access to a wide variety of specific benefits not covered by traditional Medicare. These include routine physical examinations, additional hospitalization and skilled nursing facility stays, routine eye and hearing examinations, eye glasses, and hearing aids.
- **The health plans offer superior value for health care dollars.** Seniors enrolled in Medicare Advantage are progressively getting better value for their health care dollars. Based on an analysis of additional health benefits, including drug, hospital, and physician services, as well as premium savings in the Medicare Advantage system, officials at the CMS estimate that Medicare beneficiaries are, on average, getting additional

1. Kaiser Family Foundation, *Medicare: A Primer*, March 2007, p. 1.
2. Drew Armstrong, "Political Playbooks Open as Parties Ponder Medicare Trigger Legislation," *CQ Today*, February 25, 2008.
3. Cited in Robert Pear, "Private Medicare Plans' Cost Questioned," *The New York Times*, February 28, 2008.
4. Under the current congressional physician payment update formula, physicians would face a 10 percent pay reduction, which many in Congress vow to "fix."
5. 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. 18.

benefits in the program worth more than $90 per month, or $1,100 per year.[6] Recent CMS estimates of the additional value provided by Medicare Advantage plans are in accord with previous independent private analyses.[7]

Disparate Impact of Medicare Advantage Cuts. Almost half (47 percent) of Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL): $20,420 for an individual and $27,380 for a couple.[8] The ethnic, income, and racial distribution is also noteworthy; more than 70 percent of African American and Hispanic beneficiaries have incomes below 200 percent of FPL, compared to 28 percent of white beneficiaries.[9]

Empirical analysis shows that low-income and minority beneficiaries have disproportionately enrolled in Medicare Advantage plans, taking advantage of the lower cost-sharing and richer benefits.[10] According to a 2007 CMS report, 57 percent of Medicare beneficiaries have incomes between $10,000 and $30,000 annually, compared to 46 percent of beneficiaries in traditional Medicare. Also, 27 percent of Medicare Advantage enrollees are minorities, compared to 20 percent of enrollees in traditional Medicare.[11]

The growing popularity of Medicare Advantage among low-income beneficiaries is not surprising. Historically, upper-income retirees have been concentrated in employer-based plans or could afford the premiums for Medigap, an insurance program that covers costs not covered by Medicare, including coinsurance and deductibles.[12]

A Better Policy. Instead of cutting payments to Medicare Advantage, Congress should re-target larger Medicare subsidies to lower-income persons and smaller subsidies to upper-income families. There is a growing bipartisan understanding that this is a reasonable approach to Medicare and other entitlement programs.[13]

The President has applied this principle in legislation submitted to comply with the "trigger" in current law that requires adjustments in Medicare funding to reduce an excessive dependence on general revenues.[14] Among his proposals is the application of the existing rules governing premium payments in Medicare Part B, the part of the program that pays physicians, to Medicare Part D, the prescription drug program.

For Medicare Part B, most seniors currently pay a standard premium equal to 25 percent of the total premium, or $93.50 per month in 2007 dollars. But individuals with annual incomes of $80,000 (or couples with a combined income of $160,000) would pay a higher premium according to a progressive scale related to their income. Part B rules should be applied to Part D, and Congress should also reform the costly Medigap program. In either case, upper-income persons would pay proportion-

6. The Hon. Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, testimony before the House Ways and Means Subcommittee on Health, February 28, 2008.
7. 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.
8. Kaiser Family Foundation, *Medicare: A Primer*, p. 3. The income citations here are in 2007 dollars.
9. Kaiser Family Foundation, *Medicare: A Primer*, p. 4.
10. See Adam Atherly and Kenneth Thorpe, "The Value of Medicare Advantage to Low Income and Minority Medicare Beneficiaries," Emory University, Rollins School for Public Health, September 20, 2005.
11. Centers for Medicare and Medicaid Services, "Medicare Advantage," 2007.
12. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program,* June 2007, p.62, at *www.medpac.gov.*
13. The growing pressure of rapidly rising entitlement costs will force Americans to make a choice. "We can reduce the growth of expected benefits for everybody, or we can trim them more for people who rely on the programs less. We believe that it is preferable to reduce benefits through means testing for those who do not need them in order to ensure the economic security of those who do." Stuart M. Butler and Maya MacGuineas, "Rethinking Social Insurance," The Heritage Foundation and the New America Foundation, February 19, 2008, p. 6.
14. Robert E. Moffit, "The President's Medicare Budget: A First Step Toward Entitlement Reform," Heritage Foundation *WebMemo* No. 1797, February 5, 2008.

ately more, and lower-income persons would pay proportionately less. The President's proposal is progressive; targeting Medicare Advantage is not.

Conclusion. Medicare Advantage is a success. The health plans are popular and provide a variety of options, better benefits, and more affordable care. They have proven especially attractive to low-income and minority beneficiaries. Members of Congress should consider the overall record of Medicare Advantage and disregard criticisms that are grounded in a narrow ideological hostility to private health insurance.

Individual freedom, including personal choice of different health plans and benefit options, is not negotiable. Unfortunately, many in Congress want to expand government control over health care financing and delivery while contracting private insurance and denying or curtailing the patient's right to pick a better plan. If Congress attempts to limit either personal choice or plan competition in Medicare Advantage, the President should not hesitate to veto any such measure.

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