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The Baucus Bill: Medicare Advantage and Medicare Savings Lost to Medicare Reform

Robert E. Moffit, Ph.D.

Senator Max Baucus (D–MT) is proposing major changes to the Medicare program under the America's Healthy Future Act of 2009. According to the Congressional Budget Office (CBO), these changes would reduce Medicare spending by hundreds of billions of dollars over 10 years. Unfortunately, the projected Medicare savings would not be sequestered and redirected back into the financially troubled Medicare program, nor would they constitute a down payment on real Medicare reform. This policy would, in other words, simply fuel expanded government at taxpayers' expense.

The Medicare proposal is a grab bag of large and small policy changes ranging from benefit expansions to payment formula changes for doctors (including the physician payment update) and hospitals combined with new reporting requirements and even more layers of regulation. The CBO estimates that these Medicare payment changes would save an estimated $182 billion over 10 years.[1] But the major policy change is the introduction of "competitive bidding" to Medicare Advantage, a new way of financing the system of private health plans created by the Medicare Modernization Act of 2003. This would save an estimated $123 billion over 10 years.[2]

A Policy Success. In many (though not all) respects, Medicare Advantage has been a policy success.[3] Traditional Medicare covers slightly more than half of the health care costs of senior and disabled citizens. To make up for the gaps in Medicare coverage, roughly nine out of 10 enrollees buy some form of supplemental private insurance or Medi-gap coverage.

Seniors who enroll in Medicare Advantage—approximately 23 percent—usually pay a single premium and have broad access to a variety of integrated private health plans, including HMOs, local and regional PPOs, private fee-for-service plans, "special needs" plans and even medical savings account plans. The plans offer a broader and richer package of health benefits, including preventive care and prescription drugs, and deliver superior value for seniors' dollars. Note the Medicare Advantage enrollment by state. (See Table 1.)

Medicare Advantage provides seniors with choice, variety, and value. This is especially true for those residing in rural America, where seniors have previously not had sufficient private alternatives. Because lower-income and minority enrollees are disproportionately enrolled in Medicare Advantage plans, they would also be disproportionately affected by payment reductions, likely resulting in a greater reliance on Medicaid or the more expensive Medi-gap plans.

Meanwhile, with emphasis on preventive care and coordinated care for chronic conditions, the plans are

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Washington, DC 20002–4999
(202) 546-4400 • heritage.org

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clearly delivering quality and meeting some of the key stated objectives outlined by the Obama Administration. For example, based on preliminary analysis, reductions in hospital readmissions for Medicare patients were significantly higher than those enrolled in traditional Medicare.[4]

Under current law, federal financing of Medicare Advantage plans is based on a government benchmark payment for the estimated costs of providing hospital and physician services, under the traditional Medicare program, in given geographic areas of the country. The competing plans make bids to provide these services under Medicare Parts A and B, plus separate bids for drugs under Medicare Part D.

If a plan's bid is higher than the government benchmark, then the Medicare patient enrolled in that plan pays the difference in the form of a higher premium payment. If the plan's bid is lower than the benchmark, then, by law, the Medicare patient gets a rebate from the plan (equal to 75 percent of the difference) and the government taxpayer gets the savings (equal to 25 percent of the difference).

Historically, most plans have bid below the government benchmark, and the Medicare patients have enjoyed rebates in the form of lower premiums and co-payments or richer health benefits. These rebates amount to roughly $1,200 annually per beneficiary.

In terms of overall financing, the federal government has been paying private insurers involved in Medicare Advantage plans 12–14 percent more, on a per capita basis, than it has to traditional Medicare. For that, among other reasons, liberals in Congress have proposed cuts in payments

Medicare Advantage Enrollment

State	Medicare Beneficiaries in 2008	Medicare Advantage Plan Enrollment in 2009	Share of Beneficiaries in Advantage Plans
Oregon	580,425	243,304	41.9%
Hawaii	193,333	75,142	38.9%
Pennsylvania	2,210,989	813,279	36.8%
California	4,470,439	1,547,064	34.6%
Rhode Island	177,279	60,713	34.2%
Arizona	852,880	279,833	32.8%
Colorado	574,263	185,673	32.3%
Minnesota	746,505	237,035	31.8%
Nevada	327,629	102,090	31.2%
Florida	3,180,256	919,561	28.9%
New York	2,877,270	802,917	27.9%
Utah	262,064	71,429	27.3%
Ohio	1,830,807	487,578	26.6%
Wisconsin	871,111	230,406	26.4%
Idaho	212,381	55,464	26.1%
Michigan	1,571,709	383,595	24.4%
New Mexico	292,363	69,416	23.7%
Washington	896,838	209,878	23.4%
Louisiana	653,018	145,465	22.3%
Tennessee	995,254	211,865	21.3%
Alabama	804,351	170,475	21.2%
West Virginia	371,770	72,009	19.4%
Missouri	961,308	185,281	19.3%
Texas	2,778,533	492,428	17.7%
North Carolina	1,392,450	241,331	17.3%
Massachusetts	1,015,086	174,549	17.2%
Montana	159,650	26,085	16.3%
Connecticut	546,623	82,334	15.1%
Indiana	958,270	139,203	14.5%
Oklahoma	575,298	81,765	14.2%
Georgia	1,145,727	153,374	13.4%
Virginia	1,071,681	141,101	13.2%
Kentucky	724,356	92,212	12.7%
South Carolina	714,008	89,143	12.5%
Iowa	504,944	61,156	12.1%
Arkansas	505,634	60,177	11.9%
New Jersey	1,279,020	148,061	11.6%
Nebraska	270,435	28,071	10.4%
Illinois	1,769,546	167,047	9.4%
Maine	252,025	23,760	9.4%
Kansas	416,167	39,191	9.4%
Mississippi	476,564	42,584	8.9%
North Dakota	106,005	7,458	7.0%
Maryland	740,811	49,058	6.6%
South Dakota	131,368	8,504	6.5%
New Hampshire	203,608	11,845	5.8%
Wyoming	75,790	2,964	3.9%
Delaware	139,709	5,074	3.6%
Vermont	104,460	3,362	3.2%
Alaska	59,435	394	0.7%
US Total	**44,031,445**	**9,931,703**	**22.6%**

Source: Kaiser Family Foundation, "Medicare Health and Prescription Drug Plan Tracker," at *http://healthplantracker.kff.org/geography.jsp?pt=8* (October 5, 2009).

Table 1 • WM 2641 heritage.org

to Medicare Advantage plans. Nonetheless, the higher payments to these plans have resulted in additional benefits for the Medicare patients enrolled in them, and the congressionally proposed cuts would mean cuts in patients' benefits.[5] Those seniors losing access to the benefits of these private plans—particularly the low-income and minority seniors that are disproportionately enrolled in Medicare Advantage—would be forced to rely on the more expensive Medi-gap coverage. More poor seniors would be forced to rely on Medicaid, a welfare program.

The Baucus Proposal. Baucus would change the financing of these Medicare Advantage plans, and beginning in 2011, phase in the calculation of the government benchmark payment in the geographical regions on *actual plan costs* rather than the *administered pricing* of medical services under Medicare Parts A and B.

This is a significant change. There is a consensus among policy analysts that the existing system of Medicare-administered prices does not reflect actual market conditions, and their imposition sometimes results in overpayment—unnecessary spending—and more often underpayment for Medicare services.

By 2014, the new benchmark would be based on the "weighted average" of the health plan bids in a given geographical area. Rebates for health plans that bid below the benchmark would be 100 percent rather than 75 percent. As under current law, any rebate would be required to be used as a benefit enhancement. Plans offering supplemental benefits would be required to charge an additional premium.

Meanwhile, health plans that meet certain efficiency, performance, or quality standards would get special bonus payments.

Private plans would be forbidden from imposing a cost sharing that is greater than the traditional Medicare for certain services. Medicare Advantage plans would also no longer be able to reduce or eliminate the Part B premiums, nor could they exclude certain benefits, such as chemotherapy drugs, from beneficiary out-of- pocket spending limits.

The Baucus Medicare Advantage provisions are superior to those of the House bill (H.R. 3200) and a modest improvement in Medicare's troubled financing. Competitive bidding as the basis of Medicare payment, when applied only to Medicare Advantage enrollees in isolation from the rest of Medicare, however, does not end the imbalance in the "playing field" between traditional Medicare and Medicare Advantage; it only reinforces the balkanization of the program and would almost certainly disadvantage Medicare patients enrolled in the private plans. In fact, CBO Director Douglas Elmendorf recently told the Senate Finance Committee that the proposed Medicare Advantage payment cuts in the Baucus bill would result in a reduction in seniors' benefits.[6]

A Better Policy. The right policy is to build on the success of Medicare Advantage. If the argument is that enrollees in Medicare Advantage benefit unfairly under current financing—getting a per capita payment advantage of 12–14 percent—the right answer is to treat all beneficiaries the same, regardless of their plan choices. This could be done through a "premium support" system (i.e., a direct

1. Douglas W. Elmendorf, director, Congressional Budget Office, letter to the Honorable Max Baucus (D–MT), chairman, Committee on Finance, United States Senate, September 16, 2009, p. 6.
2. *Ibid.*
3. Robert E. Moffit, "The Success of Medicare Advantage Plans: What Seniors Should Know," Heritage Foundation *Backgrounder* No. 2142, June 13, 2008, at *http://www.heritage.org/Research/HealthCare/bg2142.cfm*.
4. See, for example, Center for Policy and Research, America's Health Insurance Plans, "Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada 2006," September 2009.
5. CBO has concluded that proposed payment cuts would lead to reduced benefits, higher premiums and reduced plan participation in the Medicare Advantage program. Editorial, "Medicare Mythmaking," *The Washington Post*, October 1, 2009, p. A-18.
6. Erica Warner, "Budget Chief Contradicts Obama on Medicare Costs," *Associated Press*, September 22, 2009.

government contribution) that applies equally to all enrollees.

In other words, the only way to determine the right Medicare plan payment is with a competitive bidding system that includes all of the options, including traditional Medicare, not aggravating an un-level playing field by making it even more un-level.

The competition among health plans, then, should not be confined to private plans alone but should also include traditional Medicare, as former Senators John Breaux (D–LA) and Bill Frist (R–TN), among others, recommended years ago.[7]

For those in Congress who insist that a "public plan" can and should compete with private health plans—and do so on a *truly level* playing field—full Medicare competition would be a sound test run of the practicality of their position, as well as a true test of their sincerity.

Basing the government payment to health plans on the weighted average costs of actual plans on a local or regional basis, as Baucus has proposed, is the right approach. Transforming that new financing change into a "premium support" program invites three refinements:

1. For purposes of a per-capita government contribution, the government premium payment for beneficiaries should be adjusted for age and income, recognizing the diversity of health care needs that vary with age and also expanding the principle of income-related subsidies that already governs seniors' premium payments in Medicare Part B;
2. There should be an annual dollar cap on the amount of the government contribution to an enrollee's health plan;
3. Any Medicare savings—from this or other program changes—should be sequestered to enhance Medicare solvency.

The Right Policy Direction. The old fee-for-service Medicare program, based on central planning and price controls, is an outdated model for the baby boomers, the next generation of retirees. For them, the best model for a reformed Medicare program would be the Federal Employees Health Benefits Program (FEHBP). In the FEHBP, government payment for enrollees' health plans is calculated on the weighted average premium of the health plans that compete for consumers' business, and the enrollees get a generous contribution to the plan of their choice.

In making payment to private health plans in Medicare based on the weighted average of actual plan costs, the Baucus proposal is going in the right policy direction. With modifications, Congress could adopt a premium support system broadly similar to the FEHBP and secure the same positive results in intense competition, patient choice, high quality care, and patient satisfaction. Without such modifications, there is no real reform but just more of the same.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.

7. See Robert E. Moffit, "Using the Breaux–Frist Medicare Proposals to Craft Solid Medicare Reform," Heritage Foundation *Backgrounder* No. 1423, March 27, 2001, at *http://www.heritage.org/Research/HealthCare/bg1423.cfm*.

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