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The Wrong Medicare Advantage Reform: Cutting Benefits, Limiting Choices, and Increasing Costs

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The health care bills currently under active consideration in Congress would substantially modify the Medicare Advantage (MA) program, imposing deep benefit cuts to partially offset new non-Medicare entitlement spending while reducing health plan choices for seniors and bending the cost curve in the wrong direction.

Over 9.9 million seniors would be restricted from choosing the plan that best suits their needs, with an estimated 8.5 million losing MA coverage entirely. According to the Congressional Budget Office (CBO), MA payments would be cut by $117 billion in the Senate Finance Committee bill[1] and by $156 billion in the House bill[2] from 2010 to 2019.

Reform should mean more patient choice and health plan accountability. But these current proposals would lead in the opposite direction—toward a system of less choice, less accountability, and eventually lower-quality health care at higher costs.

Problems with Medicare Fee-for-Service. By 1982, it became apparent that the original Medicare program, in its traditional fee-for-service (FFS) form, had serious shortcomings. With fees tied to crude cost measures, FFS pays more for a high-cost, low-value service than for a high-value, low-cost alternative. As a result, spending spiraled out of control, and holding down fees failed to contain spending because the per-beneficiary volume of service increased more than enough to make up the difference. Separate payments to every entity caring for a patient encouraged fragmentation of the health care system, leading to higher total payments and lower quality.[3]

Furthermore, most beneficiaries find the FFS program inadequate and obtain supplemental coverage from a former employer's retiree plan,[4] Medicaid, or an individual "Medigap" plan. Overall, 89 percent of FFS beneficiaries have some source of additional coverage.[5] Thus, the actual spending by Medicare beneficiaries far exceeds the Medicare premium. For example, in 2008 the average Medigap premium was $1,895 per year.[6]

Establishment of Medicare Advantage. In 1982, Congress sought to address these problems by giving beneficiaries access to private-sector coverage options. The "risk contracting program" allowed health maintenance organizations to provide coverage for a fixed monthly "capitated" payment in exchange for accepting financial risk. In 1997, the program was modified to allow a form of bidding for beneficiaries based on regional "benchmark" prices. If a beneficiary chooses a plan that bids under the benchmark price, the savings is shared: 25 percent to the government and 75 percent to the beneficiaries in the form of additional health benefits, lower cost-sharing, or a rebate on

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premiums. Therefore, most MA plans provide an enhanced benefit package at a lower cost than FFS plus a supplemental plan.

Implications of Cuts. Reforms contemplated in the House and Senate bills would have significant adverse repercussions for Medicare beneficiaries and the future of the Medicare program. These repercussions include:

- *Benefit reductions.* The chief actuary of the Centers for Medicare and Medicaid Services (CMS) found that the House bill would result in "less generous" benefit packages.[7] CBO estimated that an MA policy similar to the one in the House bill would produce benefit cuts averaging nearly $1,000 per MA enrollee in 2019.[8]
- *Worse options.* The CMS chief actuary estimated that the House bill would force 8.5 million MA enrollees (of the 9.9 million) out of the health plan they have chosen and into the FFS program they have rejected and exacerbate the problems associated with fragmentation of care.
- *More financial risk.* Mass migration from capitated payment plans into FFS would transfer more financial risk to the taxpayer and undermine provisions to establish accountability for providers.
- *Higher state and federal Medicaid costs.* Many lower-income seniors choose MA to obtain comprehensive coverage. Without that option, some would obtain Medicaid support for FFS co-payments and deductibles. If Medicaid-eligible seniors currently enrolled in MA switched to FFS, average annual Medicaid spending on those beneficiaries would increase from an average of only $30 to $1,128 per beneficiary.[9]
- *Higher prescription drug spending.* MA plans must include prescription drug coverage, and their bids for that component average well below the premiums of standalone Part D prescription drug plans. Consequently, migration from MA plans would drive up Part D spending—both beneficiaries and the government would pay more.

The Wrong Kind of Reform: Reducing Choice and Restricting Innovation. The Senate Finance Committee bill seeks to make "additional benefits…more consistent across plans,"[10] an approach equivalent to limiting patient choice by homogenizing plans. The goal should be the opposite: to have

1. Congressional Budget Office, "Preliminary Analysis of the Insurance Coverage Provisions Contained in the Amended Chairman's Mark," October 7, 2009, at *http://cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf* (October 29, 2009).
2. Congressional Budget Office, "Preliminary Analysis of the Insurance Coverage Specifications Provided by the House Tri-Committee Group," July 17, 2009, at *http://cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf* (October 29, 2009).
3. AHIP Center for Policy and Research, "Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada, 2006," October 2009, at *http://www.ahipresearch.org/pdfs/CAvsNV.pdf* (October 29, 2009).
4. This includes Tricare (military retiree) and Veterans Health Administration programs.
5. Medicare Payment Advisory Commission, "A Data Book: Healthcare Spending and the Medicare Program," June 2008, p. 25, at *http://medpac.gov/documents/Jun08DataBook_Entire_report.pdf* (October 29, 2009).
6. Heritage Foundation calculations using the data set of insurer regulatory filings from Mark Farrah Associates, *Health Plans USA, Annual 2008* (Ed Haislmaier, October 7, 2009).
7. Richard S. Foster, "Estimated Financial Effects of the 'America's Affordable Health Choices Act of 2009' (H.R. 3200), as Reported by the House Ways and Means Committee," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, October 21, 2009, at *http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3200_.pdf* (October 29, 2009).
8. For an earlier proposal very similar H.R. 3200. Douglas W. Elmendorf, Director of the Congressional Budget Office, letter to Sen. Mike Crapo (R–ID, May 18, 2009, at *http://cbo.gov/ftpdocs/102xx/doc10233/05-18-Letter_Hon_Crapo_on_4_MA_options.pdf* (October 29, 2009).
9. Adam Atherly and Kenneth E. Thorpe, "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," Emory University, September 20, 2005, pp. ii and 7, at *http://www.bcbs.com/issues/medicaid/research/Value-of-Medicare-Advantage-to-Low-Income-and-Minority-Medicare-Beneficiaries.pdf* (October 29, 2009).

plans as different from each other as possible so that patients can choose a plan that most closely meets their needs. Patients have a wide variety of needs: the greater the diversity of plans, the greater the likelihood that these needs will be met.

The bill[11] would restrict patient choice by requiring that cost savings be applied in a set "priority order"—first to reduce cost-sharing, followed by wellness care (to be defined), then other benefits. Some seniors might care more about the benefits than the cost-sharing; this would restrict their ability to find a plan that meets their needs.

Indeed, the imposition of any "priority order" restricts patient choice and inhibits innovation—including innovation that could "bend the cost curve." Even worse, requiring plans to "use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original Medicare fee-for-service program"[12] expressly encourages MA plans to provide incentives to patients that would *increase* spending rather than decrease it. This not only inhibits the ability of MA plans to achieve lower costs than FFS; it also encourages incentives that will bend the cost curve *upward* rather than downward.

The prohibition on reducing or eliminating the monthly premium[13] would hamper the ability of MA plans to attract seniors but do nothing to restrain costs. This would most severely harm low-income seniors, destroying their ability to find plans more affordable than traditional FFS.

The bill would also "categorize" plans[14] according to the ratio of their "rebate" to a "benchmark" and require plans to market themselves on that basis. This would keep seniors narrowly focused on how much money they would get rather than what health care services they would receive. By focusing on one component of the plan—money—this "categorization" distracts attention from innovations that might deliver better care at lower costs.

The entire package is designed to produce one-size-fits-all MA plans, all but prohibiting innovation in health care delivery and severely limiting seniors' choices by reducing the wide variety of plans currently available. To achieve real reform, innovation should be encouraged, not eliminated.

Genuine Competitive Bidding Must Include FFS. The Medicare Payment Advisory Commission and others have argued that the payment mechanism "overpays" MA plans in some regions.[15] This is mainly due to the fact that the current system is based on "benchmarks" that are the result of a series of discrete policy decisions, the cumulative effect of which is a somewhat arbitrary structure. A much more rational payment system—based on market principles—is possible. However, cutting the payment rates—by tying them either to local average FFS spending or to the average of bids offered only by MA plans—would be even worse than the current system.

Requiring MA plans to bid competitively for patients is a good idea in principle—but only if they would compete directly with FFS based on price. Otherwise, by simply bidding against each other, they would drive down only their own payments while their main competitor, FFS, could remain inefficient and expensive with impunity. The result would be higher costs, less innovation, fewer choices for patients, and more restricted benefits. Moreover, primary reliance on FFS leaves Medicare

10. Committee on Finance, U.S. Senate, "Chairman's Mark: America's Healthy Future Act of 2009," September16, 2009, p. 138, at *http://finance.senate.gov/sitepages/leg/LEG%202009/091609%20Americas_Healthy_Future_Act.pdf* (October 29, 2009).
11. "America's Healthy Future Act of 2009," S. 1796, Section 3202.
12. *Ibid.*, Section 3202(b)(1)(C)(iii)(I).
13. *Ibid.*, Section 3202(b)(1)(C)(iii).
14. *Ibid.*, Section 3202(c).
15. See, for example, Mark E. Miller, "The Medicare Advantage Program and MedPAC Recommendations," testimony before Committee on the Budget, U.S. House of Representatives, June 28, 2007, at *http://medpac.gov/documents/062807_Housebudget_MedPAC_testimony_MA.pdf* (October 29, 2009); January Angeles and Edwin Park, "Curbing Medicare Advantage Overpayments Could Benefit Millions of Low-Income and Minority Americans," Center on Budget and Policy Priorities, February 19, 2009, at *http://www.cbpp.org/files/2-19-09health.pdf* (October 29, 2009).

vulnerable to the counterproductive pressures that favor high-cost, low-value services in today's overly regulated payment system.

The Ideal Outcome. The ideal outcome of any Medicare Advantage reform would be a wide variety of choices for seniors, ranging from plans with baseline benefits and lower patient costs to those with more comprehensive benefits, perhaps with supplemental payments. The way to get there is with a true competitive marketplace in which all plans bid for services, including the FFS program. With true competition, an MA plan can innovate and cut costs to gain a competitive advantage relative to FFS and thus attract enrollment.

Implemented properly, this system would produce increased patient choice, better benefit packages, and lower costs. MA would become the "private option" that would "keep Medicare honest."

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