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BACKGROUNDER

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Medicare Advantage Under the ACA: Replace Payment Cuts with Market-Based Reforms

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Abstract

Medicare Advantage (MA) is a highly popular program that offers seniors a private alternative to traditional Medicare. While MA enrollment steadily increases, the Affordable Care Act of 2010 (ACA) makes major changes to how the government pays these private plans. Insurers are responding by making significant changes to their plans, directly affecting MA beneficiaries, increasing out-of-pocket costs and premiums while narrowing the network of available providers. While administrative action has lessened the impact, the long-term effects of the payment changes are still unclear. Rather than continue the ACA's payment cuts or revert back to the previously flawed payment system, Congress should change the benchmark payment in MA to a solely market-based system, detaching it from the traditional Medicare pricing regime.

Medicare Advantage (MA) offers seniors the option of private health plans as an alternative to traditional Medicare. The private plans in Medicare Advantage provide more comprehensive coverage and are typically more generous that traditional Medicare. Today, more than 30 percent of Medicare beneficiaries are enrolled in an MA plan.

The Affordable Care Act of 2010 (ACA), commonly referred to as Obamacare, makes major changes to the government payment formula for private plans providing Medicare benefits to seniors in the Medicare Advantage program. These changes are designed to reduce federal spending and better align the costs of MA with the cost of traditional Medicare. Indeed, the Congressional Budget Office (CBO) estimates that these changes will reduce federal spending on the program by $156 billion between 2013 and 2022.[1]

Key Points

- Medicare Advantage (MA) is a popular and growing alternative to traditional Medicare, enrolling about 30 percent of all Medicare beneficiaries.
- The Affordable Care Act (ACA) makes major changes to how the MA program is paid, reducing payments to private plans by about $156 billion over 10 years.
- Although enrollment has not declined as a result of the cuts, plan designs have changed considerably since the law's implementation, making the program less generous and directly affecting seniors enrolled in MA.
- To preserve and advance the MA program, Congress should rescind the ACA's changes and delink the MA payment system from traditional FFS Medicare.
- The payments should be based solely on a competitive, market-based payment system. Greater competition would financially benefit both seniors and taxpayers.

This paper, in its entirety, can be found at **http://report.heritage.org/bg3020**

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While actions by the Obama Administration have blunted the full impact of these payment cuts, MA plans are still changing their benefit designs in many ways that make them less generous than before the ACA. This includes an increase in Medicare beneficiary out-of-pocket costs and premiums and a shrinking of plans' provider networks.

Although the previous methodology for calculating payments to MA plans was flawed, the ACA's changes are also flawed. Therefore, Congress should eliminate the ACA payment cuts and instead use a market-based payment system for MA plans that would foster greater competition among private plans and secure savings for seniors and taxpayers alike.

Medicare Advantage: The Alternative to Traditional Medicare

Medicare Advantage is a program of competing private health plans that provide Medicare benefits to seniors. Today, the program has more than 17 million enrollees, comprising more than 30 percent of the Medicare population.

By law, MA plans must provide at least the same benefits as the traditional fee-for-service (FFS) Medicare Parts A and B. Yet in addition to those standard benefits, MA allows seniors to obtain all of their health benefits under one comprehensive plan, rather than the fragmented, piecemeal structure of care in traditional Medicare.

MA offers more comprehensive coverage than traditional Medicare. MA typically includes more generous benefits, such as dental, vision, and prescription drugs. For instance, 86 percent of MA plans in 2015 include drug coverage, whereas seniors enrolled in traditional Medicare must purchase this benefit separately through the Medicare Part D program. Unlike traditional Medicare, MA plans must also cap beneficiaries' out-of-pocket costs. This eliminates the need to enroll in supplemental coverage to protect beneficiaries from catastrophic expenses, as 90 percent of beneficiaries in traditional Medicare do.[2]

Medicare Advantage plans often offer additional benefits such as vision or dental, lower out-of-pocket costs, and cap out-of-pocket expenses.

MA also offers seniors a choice of plan designs. MA enrollees can choose from a variety of plans, ranging from health maintenance organizations (HMOs) to private fee-for-service to special needs plans.[3] Moreover, MA plans have been leaders in integrating care coordination and case management into their benefit packages.

Medicare Advantage is often criticized for a payment system that causes unnecessary spending and that costs more per enrollee than the traditional Medicare program.[4] However, this is a result of the program's flawed payment design and with the extra funds, Medicare Advantage plans often offer additional benefits such as vision or dental, lower out-of-pocket costs, and cap out-of-pocket expenses.[5]

Growing Enrollment a Measure of Success. MA is an increasingly attractive option for millions of senior and disabled Americans because it offers

1. Douglas W. Elmendorf, letter to Speaker John Boehner (R–OH), July 24, 2012, pp. 13–14, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf (accessed August 13, 2014). The letter estimates the cost of repealing the ACA, which would increase Medicare spending by the amount due to the absence of the law's Medicare payment reductions.
2. Medicare Payment Advisory Commission, "Health Care Spending and the Medicare Program," June 2014, p. 27, Chart 3-1, http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf (accessed May 13, 2015).
3. Special needs plans, as defined by CMS, are Medicare Advantage plans that "limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve." Centers for Medicare and Medicaid Services, "Medicare Special Needs Plans (SNP)," http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/special-needs-plans.html (accessed May 13, 2015).
4. For instance, payments to MA plans averaged 102 percent of FFS spending in 2015. In the past, they have been much higher. See Medicare Payment Advisory Commission, *Medicare Payment Policy*, March 2015, p. 325, http://www.medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf (accessed April 20, 2015).
5. Jeet S. Guram and Robert E. Moffit, "The Medicare Advantage Success Story—Looking Beyond the Cost Difference," *The New England Journal of Medicine*, Vol. 355, No. 13 (March 29, 2012), http://www.nejm.org/doi/full/10.1056/NEJMp1114019 (accessed May 12, 2015).

many advantages over traditional FFS Medicare. In 2005, MA enrollment constituted about 13 percent of the overall Medicare population. By 2010, it grew to 25 percent of the Medicare population.[6]

In 2015, more than 17 million of an estimated 56 million seniors enrolled in Medicare[7] are expected to be enrolled in an MA plan.[8] That means that nearly one-third of all seniors will be in an MA plan rather than in traditional Medicare.

ACA's Changes to Medicare Advantage

The ACA's payment changes are intended to better align MA costs with the costs of traditional Medicare. However, the new payment methodology still does not resolve the disparity.

The ACA implements various changes and payment reductions throughout the Medicare program, reducing overall Medicare spending by an estimated $716 billion for 2013–2022.[9] Of these "savings," MA spending is reduced by an estimated $156 billion. The ACA achieves these savings by fundamentally changing how the government pays Medicare Advantage plans.

The law makes three major changes to MA reimbursement:

- A new methodology for calculating benchmark payments that is based on fee-for-service costs;
- Bonus benchmark payments that are linked to quality ratings; and
- Rebates paid to plans that bid below the benchmark payment linked to quality measures.[10]

These changes are designed to bring MA's costs more in line with those of traditional FFS Medicare.

New Benchmark Payments. Before enactment of the ACA, the MA benchmark payment in any given county was based on the previous year's benchmark for that county increased by the per capita growth rate in Medicare. However, the Secretary of Health and Human Services (HHS) has the authority to deem any given year a rebasing year, which would make the benchmark the greater of the previous year's benchmark increased by spending in overall Medicare or projected per capita FFS spending in traditional Medicare in that county.

Under the ACA, benchmark payments are no longer based on the previous year's costs, but are set as a percentage of per capita FFS spending. Counties are divided into quartiles with a FFS multiplier of 95 percent, 100 percent, 107.5 percent, or 115 percent. Counties with the highest FFS spending use the lowest FFS percentage to determine the benchmark and vice versa. The transition to the ACA benchmarks began in 2011, with a freeze on benchmarks and the phase-in of the changes occurring from 2012 through 2017. Counties with the biggest benchmark decrease have the longest transition period. The ACA also prohibits a benchmark from being greater than it would have been under prior law, further constraining payments.

New Benchmark Quality Adjustment Payments. The ACA provides a new bonus payment system for qualifying plans that are based on plan "quality ratings." These quality ratings are based on a five-star scale and determined by the Centers for Medicare and Medicaid Services (CMS).[11]

6. Centers for Medicare and Medicaid Services, *The 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 198, Table V.B4, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf (accessed May 12, 2015).
7. Ibid.
8. Mark Farrah Associates, "Medicare Advantage Tops 17 Million Members," March 27, 2015, http://www.markfarrah.com/healthcare-business-strategy/Medicare-Advantage-Tops-17-Million-Members.aspx (accessed April 20, 2015).
9. Douglas W. Elmendorf, letter to Speaker John Boehner, pp. 13–14. The letter estimates the cost of repealing ACA, which would increase Medicare spending due to the absence of ACA's Medicare cuts.
10. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152. Section 3210 of the Patient Protection and Affordable Care Act, as amended, alters the payment formula for MA plans.
11. For more information on star quality ratings, see Centers for Medicare and Medicaid Services, "Medicare 2015 Part C & D Star Rating Technical Notes," October 3, 2014, http://cdn5.medicarehelp.org/wp-content/uploads/2014/10/2015_Tech_Notes_2014_10_03.pdf (accessed May 12, 2015).

Plans that receive a four-star rating or higher receive an increase in their benchmark payment by a certain percentage. The bonus payment was supposed to gradually increase from 1.5 percentage points in 2012 to 3.0 percentage points in 2013 and 5 percentage points in 2014.

Thus far, the law's changes have not produced a reduction in enrollment. Indeed, enrollment has increased by 45 percent.

New Rebate Policy. As noted, prior to enactment of the ACA, if a plan bid below its benchmark payment, it received a rebate. In that system, 75 percent of the difference between the bid and the benchmark was given to the plan as a rebate, and the Medicare program retained 25 percent as savings. Plans were required to pass rebates on to the beneficiary in the form of richer benefits or lower premiums and out-of-pocket costs, but not as cash given directly to the beneficiary.

Under the ACA, rebates are now based on a plan's quality rating. The share of the rebate is reduced to 70 percent of the difference between the bid and the benchmark for plans that receive a quality score between 4.5 stars and 5 stars. For plans with scores between 4.5 stars and 3.5 stars, the rebate share is 65 percent. For those below 3.5 stars, the share is 50 percent. The change took effect in 2012 and is to be phased in over three years.

Impact of the ACA Thus Far

Shortly after the law's enactment, the Congressional Budget Office,[12] the CMS Chief Actuary,[13] the Medicare Trustees,[14] and nonpartisan analysts projected that the law's MA changes would significantly reduce the MA benefits and thus reduce enrollment.

Indeed, in April 2010, the Chief Actuary said, "We estimate that in 2017, when the [ACA's] MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law)."[15] Even nongovernment analysts predicted a decline in benefits and enrollment.[16]

Thus far, the law's changes have not produced a reduction in enrollment. Indeed, enrollment has increased by 45 percent, jumping from 11.9 million enrollees in 2011 to more than 17.3 million in 2015.[17] In the wake of this unanticipated growth, the CBO[18] and the Medicare Trustees[19] have reversed their earlier projections for a decline in MA enrollment and currently project increases rather than decreases,

12. The Congressional Budget Office projected that MA enrollment would decrease from 10.9 million in 2010 to 8.2 million in 2020. Congressional Budget Office, "CBO's August 2010 Baseline: Medicare," http://www.cbo.gov/sites/default/files/cbofiles/attachments/MedicareAugust2010FactSheet.pdf (accessed August 13, 2014).
13. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services, April 22, 2010, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf (accessed August 13, 2014).
14. The trustees said, "In 2009, enrollment in private health plans represented 24 percent of total Medicare beneficiaries, with nearly all such enrollees participating in Medicare Advantage health insurance plans. Enrollment in MA plans is expected to decline in the future, both in number and as a percent of total beneficiaries. As noted, the Affordable Care Act reduces Medicare payments to private plans, which will result in less-generous plan benefit packages and/or higher premiums. By 2017 when these changes are fully phased in, an estimated 15 percent of Medicare beneficiaries would remain in private Part C health plans, with the balance reverting back to traditional 'fee-for-service' Medicare." Centers for Medicare and Medicaid Services, *The 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 49, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2010.pdf (accessed May 12, 2015).
15. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," p. 11.
16. Robert A. Book and James C. Capretta, "Reductions in Medicare Advantage Payments: The Impact on Seniors by Region," Heritage Foundation *Backgrounder* No. 246, September 14, 2010, http://www.heritage.org/research/reports/2010/09/reductions-in-medicare-advantage-payments-the-impact-on-seniors-by-region.
17. Mark Farrah Associates, "Medicare Advantage Tops 17 Million Members."
18. The CBO first changed its projection from a decline in enrollment to an increase in May 2013, projecting an increase from 13 million enrollees in 2013 to 21 million in 2023. Congressional Budget Office, "CBO's May 2013 Medicare Baseline," http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf (accessed August 13, 2014).
19. Centers for Medicare and Medicaid Services, *2014 Annual Report*, p. 197.

although to varying degrees. Neither the CBO nor the trustees have yet offered an explanation for the dramatic shift in MA future enrollment projections. While enrollment has not decreased, MA insurers have clearly been making considerable changes to the plans that they offer seniors since 2011.

Benefit Changes. As the ACA's changes are being phased in, MA insurers are altering their plan designs to reduce their costs to offset the law's payment reductions. However one judges the desirability of these changes as a matter of policy, they are directly affecting seniors enrolled in MA. The clear trend is higher costs for beneficiaries. For instance, Stephen Hemsley, chief executive officer of UnitedHealth Group, the largest MA insurer with 20 percent of MA enrollees, said recent reductions in funding to MA have resulted in an average annual cost shift of $900 per beneficiary to UnitedHealth beneficiaries. This shift has taken the form of increased premiums and reduced benefits.[20]

The five following examples show how plans have changed since the implementation of the ACA:

- **Fewer "zero-premium" plans.** Most Medicare Advantage plans include prescription drug coverage, called MA-PD plans. Some MA-PDs are "zero-premium" plans, which do not charge an additional premium beyond the Part B premium. Thus, beneficiaries in zero-premium plans receive prescription drug coverage at no additional premium cost. However, access to such plan offerings has steadily declined with the implementation of the ACA. In 2011, 90 percent of beneficiaries had access to at least one zero-premium MA-PD. This percentage declined to 88 percent in 2012, 86 percent in 2013, 84 percent in 2014, and 78 percent in 2015.[21]

- **Increasing out-of-pocket maximums.** Unlike traditional FFS Medicare, which provides no catastrophic protection, MA plans are required by the CMS to cap enrollees' out-of-pocket costs at no more than $6,700 annually.[22] According to an analysis by the Kaiser Family Foundation, "The share of MA-PDs that limit out-of-pocket expenses to $3,400 or less has decreased from 51 percent in 2011 to 9 percent in 2015. In contrast, almost half (48 percent) of plans will have limits above $5,000 in 2015, up from 24 percent in 2011."[23] Kaiser Foundation research shows that this shift has increased the average out-of-pocket maximum by $752 from 2011 to 2015.

- **Higher-cost prescription drug coverage.** In 2015, 86 percent of MA plans include prescription drug coverage. However, since ACA implementation began, drug deductibles have increased. In 2011, 88 percent of MA-PD plans had no deductible for drug coverage, and in plans with a deductible, it averaged $26.27. In 2015, only 63 percent of plans have no drug deductible, and for plans with a deductible, the average is $89.72. Between 2014 and 2015, the number of plans with no deductible dropped by 23 percent, and the average deductible increased by 134 percent.[24]

- **Narrowing provider networks.** Based on reports from across the country, a significant part of UnitedHealthcare's strategy to combat federal payment reductions has been to narrow its provider networks. For example, in Missouri, UnitedHealthcare has reportedly reduced its networks by 5 percent to 7 percent.[25] In Virginia, it was expected to reduce its provider network by

20. Paul Demko, "Insurance Execs Vow to Fight Further Cuts to Medicare Advantage," Modern Healthcare, October 8, 2014, http://www.modernhealthcare.com/article/20141008/NEWS/310089963/insurance-execs-vow-to-fight-further-cuts-to-medicare-advantage (accessed April 20,2015).
21. Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 324.
22. CMS recommends a cap of $3,400 or lower and allows plans with lower out-of-pocket limits to charge higher cost sharing for some services.
23. Gretchen Jacobson et al., "Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes," Henry J. Kaiser Family Foundation *Issue Brief*, December 2014, p. 9, http://files.kff.org/attachment/data-spotlight-medicare-advantage-2015-data-spotlight-overview-of-plan-changes (accessed April 15, 2015).
24. Ibid., p. 11.
25. Tara Kulash, "UnitedHealthcare Cuts Missouri Physicians from Medicare Advantage," *St. Louis Post-Dispatch*, June 18, 2014, http://www.stltoday.com/news/special-reports/mohealth/unitedhealthcare-cuts-missouri-physicians-from-medicare-advantage/article_b4cca6be-6bc1-5c74-96aa-88f96cd6dd31.html (accessed August 8, 2014).

2 percent to 4 percent.[26] In response to provider cuts in Ohio, United Healthcare said that "more focused provider networks help deal with the financial pressures created by severe cutbacks in funding of Medicare Advantage and other government-sponsored programs."[27] Regrettably, this means that some seniors may find that their doctors are no longer in their plan's network.

- **Increasing premiums.** MA premiums vary significantly across markets and plan types. A CMS press release says the average MA premium submitted by health plans for 2015 increased by $35 annually compared with 2014.[28] However, an analysis by the Kaiser Family Foundation breaks premiums down by insurer and plan type, showing the weighted average premium for plans offered in 2014 and 2015 increased by 20 percent from 2014 to 2015.[29] For HMO plans, which constitute about two-thirds of all MA enrollees,[30] the average unweighted premium across all plans increased by about $35 per year. For UnitedHealthCare, the MA insurer with the most enrollees, HMO premiums increased 100 percent from last year from $13 per month in 2014 to $26 per month in 2015—a $157 annual increase from 2014. For Humana, the second-largest MA insurer, annual unweighted HMO plan premiums increased $60.[31]

Administrative Actions Have Blunted Real Impact

Changes are obviously occurring in the MA benefit design, decreasing the MA benefit for seniors. Thus far, the benefit changes have not reduced enrollment as originally projected. However, the CMS has taken certain actions—some legally questionable[32]—that have blunted the real impact of the changes. These actions have included $8.35 billion in special bonus payments and reversal of two planned payment reductions.

Special Bonus Payments. Instead of implementing the bonus payment structure that was outlined by the ACA, the Obama Administration created a quality bonus payment demonstration program. This demonstration took place from 2012 to 2014 and cost an estimated $8.35 billion. The program awarded any plan earning more than three stars (nearly all plans) a quality bonus payment and increased the size of the bonus payments relative to the ACA.

> In 2013 and 2014, the CMS reversed planned reductions in MA's annual payment rate for the following year.

According to a report by the Government Accountability Office (GAO), the Office of the Actuary "estimated that the demonstration will offset more than one-third of the reduction in MA payments projected to occur under [ACA] during the demonstration years. The largest annual offset will occur in 2012—71 percent—followed by 32 percent in 2013 and 16 percent in 2014."[33] At the time, the GAO questioned the HHS Secretary's legal authority to create the demonstration program and recommended ending the program early because of its inability to achieve

26. Tammie Smith, "UnitedHealthcare to Narrow Medicare Advantage Network," *Richmond Times Dispatch*, May 16, 2014, http://www.timesdispatch.com/business/health/unitedhealthcare-to-narrow-medicare-advantage-network/article_616236bf-5510-56a6-b59d-89c8281d6bc0.html (accessed August 12, 2014).
27. Ben Sutherly, "Medicare Insurer UnitedHealthcare Cuts Doctor Network," *The Columbus Dispatch*, October 26, 2013, http://www.dispatch.com/content/stories/local/2013/10/26/medicare-insurer-cuts-doctor-network.html (accessed August 12, 2014).
28. Press release, "Medicare Advantage Enrollment at All-Time High; Premiums Remain Affordable," Centers for Medicare and Medicaid Services, September 9, 2014, http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-09-18.html (accessed April 15, 2015).
29. Jacobson et al., "Medicare Advantage 2015 Data Spotlight," p. 15, Table A1. Premiums were weighted by plan enrollment.
30. Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 316.
31. Jacobson et al., "Medicare Advantage 2015 Data Spotlight," p. 20, Table A6.
32. For instance, the CMS established a questionable demonstration program that overrode the ACA's bonus structure and awarded bonuses to nearly all plans. James C. Cosgrove, "Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings," letter to Senator Orrin Hatch, March 21, 2012, http://www.gao.gov/assets/590/589473.pdf (accessed April 20, 2015).
33. Ibid.

its stated purpose. This extra funding allowed formal implementation of the ACA's benchmark payment changes, but softened their impact on seniors.

Two Reversals of Planned Payment Reductions. In 2013 and 2014, the CMS reversed planned reductions in MA's annual payment rate for the following year. In February 2013, the CMS released its advance notice of the estimated MA payment rate for 2014. The notice revealed that MA payment rates were set to decrease by 2.2 percent in 2014.[34] Yet in the final payment notice, rates *increased* by 3.3 percent for 2014 due to a change in spending assumptions that directly affected the final rate calculation.[35]

In her explanation, the HHS Secretary instructed the Office of the Actuary to assume a higher level of Medicare spending in its determination of payments.[36] The final payment notice stated:

> Although the Office of the Actuary agrees that Congress is very likely to override the physician fee reduction, the assumption conflicts with the Office's professional judgment that, as in all past years, the determination should be based on current law, not an assumed alternative.[37]

A similar situation played out in 2014 for the 2015 payment rate. The advance notice announced that MA payment rates would decrease on net by 1.9 percent next year.[38] Yet when the CMS finalized the rate, the rate slightly increased by 0.04 percent for 2015.[39]

As the CMS's final rate announcement for 2015 payment showed, the ACA's benchmark payment changes were still implemented.[40] However, the policies on risk assessment and adjustment were altered at the Secretary's discretion in a way that resulted in a small increase in the overall rate for 2015 payments.

The Medicare Payment Advisory Commission (MedPAC) estimates that there was a 5.5 percent reduction in average base benchmarks from 2014 to 2015, but notes, "These effects, however, are partly (or may be fully) offset by changes in the risk-adjustment calculations and risk coding intensity."[41] MedPAC explains further:

> [A]s part of the benchmark-setting process, the risk-score normalization factor was lowered significantly, resulting in an approximate increase in payment risk scores of 5 percent. (These changes raise the standardized spending for both FFS Medicare and MA. The effect of this restandardization of payments is to raise payments for MA enrollees by 5 percent but leave the ratio with FFS Medicare unchanged.)[42]

Unclear Long-Term Effects. As noted, the ACA's payment reductions were formally implemented, but

34. Centers for Medicare and Medicaid Services, Office of the Actuary, "Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter," February 15, 2013, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Advance2014.pdf (accessed August 14, 2014).
35. America's Health Insurance Plans, which is the trade association representing private MA plans, launched a large-scale campaign against the payment reductions. For more information on its activities regarding the MA payment rate since 2013, see America's Health Insurance Plans, "Medicare Advantage," https://www.ahip.org/Issues/Medicare-Advantage.aspx (accessed May 14, 2015).
36. HHS incorporated spending for a "doc fix," meaning that Medicare spending is significantly higher because the sustainable growth rate formula is overridden and Medicare physician payment is not cut.
37. Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 1, 2013, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2014.pdf (accessed April 21, 2015).
38. Centers for Medicare and Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter," February 21, 2014, http://capsules.kaiserhealthnews.org/wp-content/uploads/2014/02/Advance2015.pdf (accessed April 21, 2015).
39. Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 7, 2014, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf (accessed April 21, 2015).
40. Press release, "Strengthening Medicare Advantage," Centers for Medicare and Medicaid Services, April 7, 2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-04-07.html (accessed April 21, 2015).
41. Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 325.
42. Ibid.

the administrative decisions of the HHS Secretary significantly reduced their impact. These policies—the special bonus payment program and changes in the annual payment rate calculation—likely account for the ACA's weaker impact on the program and its beneficiaries than initially anticipated.

Moreover, the ACA's benchmark payment reductions will not phase in fully until 2017. In 2015, about 75 percent of the nation's counties are fully transitioned to the ACA benchmark payment level.[43] However, these counties account for only 62 percent of MA beneficiaries. For the remaining 25 percent of counties and 38 percent of beneficiaries, the benchmark is based on a methodology that is a blend of prior law and the ACA, but primarily the ACA.

What Congress Should Do

As ACA implementation continues, MA plans will continue to implement changes to cope with the reduced payments, eventually affecting all enrollees. Yet how plans will change and how beneficiaries will react cannot be predicted with certainty. Therefore, Congress should focus on a new approach to reforming the MA payment system. Specifically, Congress should:

- **Rescind the ACA's MA payment changes.** Although the ACA makes major changes to the MA payment calculations, it perpetuates a flaw of the prior law by connecting the methodology to the costs of traditional FFS Medicare. Linking payment to FFS causes unnecessary Medicare spending even though the private market has demonstrated that it can deliver Medicare benefits to seniors, even the most medically needy seniors,[44] more cheaply than the government can.[45]

- **Use market-based bids for benchmark payments.** Congress should delink benchmark payments from FFS and instead base payment solely on the bids that MA plans submit to the CMS to provide the traditional Medicare benefit (Parts A and B) to MA beneficiaries. There are a variety of ways to do this. For example, the new MA benchmark payment could be based on the weighted average bid of all plans in each county.[46] Under this method, each bid would be weighted by the proportion of beneficiaries enrolled in that plan in the preceding year. The benchmark payment could also be set at the levels proposed under various premium support proposals, such as the second-lowest cost plan[47] or the average of the three lowest-cost plan bids.[48] Bids would reflect the cost of providing benefits for a beneficiary in average health, and insurers would receive larger or smaller risk-adjusted payments from the government if an enrollee's health was worse or better than average. If a plan were to bid higher than the benchmark payment, enrollees would pay the difference through increased premiums. If a plan were to bid below the benchmark payment, enrollees would receive the difference in a plan rebate.

  Basing the benchmark payment solely on market-based bids would foster greater competition among plans. Ideally, the new benchmark should be set at a level that would protect MA beneficiaries from significant benefit cuts, but not exceed what MA would have cost under the ACA changes.

- **Allow rebates to flow directly to the beneficiary.** If a plan bids below the benchmark payment, a portion of the difference between the benchmark and the bid is rebated back to the plan. The rebate can be used to reduce the Part B premium and out-of-pocket expenses or to provide extra benefits, such as drug coverage. As a result of the ACA, the amount of the rebate now depends on the plan's quality rating, as determined by CMS metrics.

43. Ibid.
44. In 2015, the average bid of special needs plans was 93 percent of FFS spending. Ibid.
45. In 2015, the average bid of all plans was 94 percent of FFS spending. Ibid.
46. This is similar to how the bidding and payment process works in the Federal Employees Health Benefits Program. See Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, DC: AEI Press, 2009).
47. Ron Wyden and Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 15, 2011, http://budget.house.gov/UploadedFiles/WydenRyan.pdf (accessed May 8, 2015).
48. Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, The Heritage Foundation, 2011, http://savingthedream.org/about-the-plan/plan-details/.

Congress should replace the ACA's star-rating system for rebates and instead rebate 100 percent of the difference directly to the senior. Beneficiaries could receive the rebate as they do today in some mix of reduced premiums and cost sharing or additional benefits, or as a deposit in a health account to pay for out-of-pocket health expenses.

In addition to these changes, any reduction in Part B premiums as a result of the plan rebate should be made more transparent to the enrollee. Today, a reduction to the Part B premium is not as visible as it could be. Price transparency is important to improve the effects of competition.[49] All of these changes would reward seniors more directly for being more cost-conscious in choosing their plans.

Conclusion

Medicare Advantage plans are a popular alternative to traditional Medicare. However, the ACA made several changes to payments in these plans. The immediate impact of these changes has not been as dramatic as expected, but plans have reacted by altering their designs, directly affecting seniors.

The MA program offers several clear advantages over traditional Medicare, including reduced out-of-pocket costs, the security of catastrophic coverage protection, drug coverage, and more comprehensive coverage. Moreover, experience in MA shows that private plans can routinely deliver the Medicare Part A and Part B benefits more cheaply than traditional Medicare.

To preserve and advance this alternative, Congress should delink the MA payment system from traditional FFS Medicare, provide a more market-based payment system, and allow seniors to save as well. These changes have enormous potential to save money for taxpayers and seniors and offer a glide path to much needed structural reforms of Medicare.[50]

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49. Medicare Payment Advisory Commission, *Medicare Payment Policy*, pp. 326–327.
50. See Robert E. Moffit, "The Second Stage of Medicare Reform: Moving to a Premium Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, http://www.heritage.org/research/reports/2011/11/the-second-stage-of-medicare-reform-moving-to-a-premium-support-program/.