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CURBING MEDICARE OVERPAYMENTS TO PRIVATE INSURERS COULD BENEFIT MINORITIES AND HELP EXPAND CHILDREN'S HEALTH COVERAGE

By Edwin Park and Robert Greenstein

The budget resolutions approved by both the House and the Senate include up to $50 billion for expanded Medicaid and SCHIP coverage for millions of uninsured low-income children, provided these costs are offset.[1] A proposal under consideration in Congress would help finance this expansion of children's coverage by reducing the substantial overpayments to private health insurance companies that participate in Medicare.

Not surprisingly, the insurance companies are waging an aggressive campaign to defend their overpayments, arguing that low-income and minority beneficiaries rely disproportionately on the private health plans in Medicare and that the overpayments are used to provide extra benefits not available through regular Medicare. But as explained below, the industry campaign, like most such lobbying efforts, does not provide a balanced assessment of the pros and cons of curbing the overpayments, either from taxpayers' perspective or that of Medicare beneficiaries.

KEY FINDINGS

- Congress is considering reducing the large overpayments being made to private insurance companies in Medicare and using part of the savings to expand children's health coverage.
- To defend these overpayments, private insurers claim that low-income and minority beneficiaries rely disproportionately on them for supplemental coverage. In fact, such beneficiaries are far more likely to get supplemental coverage through Medicaid.
- The overpayments also harm the 35 million people in regular Medicare by raising their premiums and weakening the program's long-term finances.
- Reducing the overpayments and reinvesting the savings in better health care for low- and moderate-income seniors, people with disabilities, and children would produce a significant gain in health coverage for minorities as well as low-income Americans.

Overpayments to Private Insurers Carry a High Cost

Medicare beneficiaries can elect to receive coverage through "Medicare Advantage" health plans offered by private insurance companies rather than through traditional fee-for-service Medicare, and about one in five beneficiaries do so. (However, as the *New York Times* reported May 7 in a front-page article, the rising enrollment in private plans may be due, in part, to abusive marketing practices by insurance agents; see the Appendix.)

[1] The "pay-as-you-go" rule that Congress is reinstating requires that any new entitlement spending or tax cuts be "paid for."

Private insurers were brought into Medicare on the theory that they would be more efficient than regular Medicare and would reduce Medicare costs. In fact, however, the opposite has happened.

- According to both the Medicare Payment Advisory Commission (MedPAC) — Congress' expert advisory body on Medicare payment policy — and the Congressional Budget Office (CBO), Medicare is paying private insurers *12 percent more* than it costs to treat the same beneficiaries under the regular Medicare program. The overpayment works out to about $1,000 per beneficiary per year, on average. This disparity costs Medicare billions of dollars each year.

- CBO has reported that it expects the overpayment per beneficiary to climb still higher in the years ahead.

As a result of these findings, MedPAC has unanimously recommended that Congress "level the playing field" by paying the insurance companies the *same* amounts it pays under the regular Medicare program. A paper issued by the Congressional Black Caucus Foundation in 2004 made the same recommendation. (See the box on page 5.) CBO has reported that this step would save $54 billion over five years and $150 billion over ten years.

The private insurance companies vigorously oppose this recommendation. One of their principal arguments is that curbing the overpayments would be especially harmful to low-income and minority Medicare beneficiaries, whom they claim rely disproportionately on Medicare Advantage for supplemental coverage and the additional benefits it provides.[2] (These additional benefits can include help in paying Medicare premiums and cost-sharing and some health benefits not covered by traditional Medicare.) The insurance companies' claims, however, rely on the misleading use of data.[3]

Low-Income and Minority Beneficiaries Rely More on Medicaid for Supplemental Coverage

Medicaid, not Medicare Advantage, is the primary source of supplemental coverage for low-income and minority Medicare beneficiaries.

- Many low-income elderly and disabled Medicare beneficiaries also qualify for Medicaid. These individuals, known as "dual eligibles" because they qualify for both Medicare and Medicaid, receive supplemental coverage through Medicaid that Medicare does not provide, such as coverage for long-term care. Medicaid also pays dual eligibles' Medicare premiums and co-payments.[4]

- Many low-income Medicare beneficiaries whose incomes are too high for full Medicaid qualify for the Medicare Savings Programs. These programs, which are technically part of Medicaid,

[2] An overwhelming majority of Medicare beneficiaries have additional coverage that supplements their Medicare benefits. Sources include Medicaid, employer-based retiree coverage, Medigap plans, other forms of public coverage such as military and veteran's health care, and Medicare Advantage plans.

[3] See Edwin Park and Robert Greenstein, "Low-Income and Minority Beneficiaries Do Not Rely Disproportionately on Medicare Advantage Plans," Center on Budget and Policy Priorities, revised April 12, 2007. This report analyzes the underlying Medicare Current Beneficiary Survey data cited by the insurance companies to support their claims.

[4] A separate component of the Medicare drug benefit helps low-income beneficiaries with the premiums, deductibles, and co-payments associated with that benefit.

pay the Medicare premiums for beneficiaries with incomes up to 135 percent of the poverty line. They also pay the Medicare cost-sharing charges for beneficiaries with incomes up to 100 percent of the poverty line.

- As a result, the number of low-income Medicare beneficiaries who receive supplemental coverage through Medicaid *far exceeds* the number who are enrolled in Medicare Advantage.

- Similarly, many more minority Medicare beneficiaries receive supplemental coverage through Medicaid than through Medicare Advantage. This is because minority beneficiaries are disproportionately low-income: some 42 percent of African American beneficiaries, 59 percent of Hispanic beneficiaries, and 42 percent of Asian American and Pacific Islander beneficiaries have annual incomes below $10,000, which is roughly 100 percent of the poverty line for a single individual. Significantly larger percentages have incomes below 135 percent of the poverty line.

Just as it is incorrect to claim that Medicare Advantage is the primary source of supplemental coverage for low-income and minority Medicare beneficiaries, it also is incorrect to claim that these beneficiaries make up a disproportionate share of all Medicare Advantage enrollees. Based on the insurance companies' own analysis of data for 2004, the percentage of Medicare Advantage enrollees who are minority is no higher than the percentage of all Medicare beneficiaries who are minority.[5] Similarly, the percentage of Medicare Advantage enrollees who are low-income is no higher than the percentage of all Medicare beneficiaries who are low-income.[6]

Large Portion of Overpayments Goes to Industry Profits and Expenses, Not to Benefits

To be sure, the private insurance companies participating in Medicare Advantage do offer some additional benefits not available through regular Medicare. But the additional benefits are not the only, or necessarily the primary, place that the overpayments go. For example, among private fee-for-service plans, the type of Medicare Advantage plan that receives the largest overpayments, MedPAC has found that half of the revenue from the overpayments goes to profits — which are very substantial, as a recent *Wall Street Journal* article documented — as well as to marketing and administrative costs (which are much higher than under regular Medicare), rather than to additional benefits.

Moreover, some private insurers appear to design these additional benefits to entice healthy Medicare beneficiaries, who are less costly to treat, to sign up while designing their benefit packages in ways that can *discourage* sicker (and thus costlier) beneficiaries from enrolling.

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[5] In 2004, according to the insurers' analysis of data from the 2004 Medicare Current Beneficiary Survey, 17 percent of Medicare Advantage enrollees were minority. This was about the same as the percentage of all Medicare beneficiaries living in areas with access to a Medicare Advantage plan who were minority; that percentage was 18 percent. See Table 8A in America's Health Insurance Plans (AHIP), "Low-Income and Minority Beneficiaries in Medicare Advantage Plans," February 2007 (analyzing the Access to Care File). Data for years after 2004 have not yet been made available.

[6] The percentage of Medicare Advantage enrollees with incomes below $10,000 is lower than the percentage of all Medicare beneficiaries with such incomes. The percentage of Medicare Advantage enrollees with incomes below $20,000 is about the same as the percentage of all Medicare beneficiaries with such incomes.

For example, some private insurance companies reduce certain health benefits that are used primarily by sicker individuals. Federal law allows the private insurance companies to expand some Medicare benefits and curtail others, and sicker beneficiaries can wind up significantly worse off if they enroll in Medicare Advantage. Both MedPAC and the Medicare Rights Center have found that some Medicare Advantage beneficiaries who need hospital care and specialty services like chemotherapy end up paying more per service, or receiving fewer needed benefits, under the coverage the private companies offer.

This problem is particularly significant for low-income and minority beneficiaries, who tend to be in poorer health, on average, than other Medicare beneficiaries.

In addition, beneficiaries who sign up with the private insurance companies often also have more restricted access to health-care providers than those who enroll in regular Medicare.

Overpayments Mean Higher Premiums for Tens of Millions of Beneficiaries

Both MedPAC and the Medicare actuaries have documented that overpayments to private insurers are harming tens of millions of beneficiaries — those enrolled in regular Medicare.

The size of the monthly premiums that Medicare beneficiaries must pay is tied to Medicare costs: when costs rise, so do premiums. Since the overpayments raise Medicare costs, they drive premiums higher than they otherwise would be. As a result, 35 million seniors and people with disabilities enrolled in regular Medicare are charged higher premiums each month to help subsidize the cost of these overpayments. (Approximately 7 million of the beneficiaries are dual eligibles; Medicaid pays the Medicare premiums for these individuals, so the higher Medicare premium costs that the overpayments create for these people are borne by the federal government and the states, which jointly fund Medicaid.)

In contrast, only about 8 million Medicare beneficiaries are enrolled in Medicare Advantage, and not all of them actually access the additional benefits offered by the private plans. In addition, as noted above, sicker individuals can end up with *fewer* benefits under the private plans.

In other words, many elderly and disabled beneficiaries are being charged more so that private companies can make larger profits and a much smaller number of beneficiaries can get some added benefits.

Overpayments Also Weaken Medicare's Long-Term Finances and Speed Up Insolvency

In addition, a critical point often ignored in debates over the overpayments is that the overpayments to private insurance companies are significantly weakening Medicare's long-term finances by ballooning the program's costs. This is the conclusion of the Medicare actuaries, who recently testified that the overpayments move up by two years the date when the Medicare Hospital Trust Fund will become insolvent.

The overpayments, therefore, are directly contributing to the growing fiscal pressure for steep Medicare cuts in the future, including cuts in benefits or increases in cost-sharing that could be particularly detrimental to low- income and minority beneficiaries.

Congressional Black Caucus Foundation Warns That Overpayments Harm Medicare

In a paper issued in early 2004 on the recently enacted Medicare prescription drug legislation, the Center for Policy Analysis and Research of the Congressional Black Caucus Foundation reported:

"The [2003 prescription drug] bill provides an unprecedented amount of financial assistance to private insurers that will have the effect of diverting precious resources away from the traditional fee-for-service Medicare plan. Instead of using federal funds to prop up private insurers, this money could have been used to improve upon traditional Medicare — where more than 85% of beneficiaries receive their care. The preferential financial treatment of private insurers also establishes an unfair competition between the private plans and traditional Medicare…. Traditional Medicare is set up for failure because government-subsidized private plans will lure beneficiaries away with offers of more generous benefits leaving the traditional program struggling to make ends meet while still covering the most expensive beneficiaries whom private plans refuse to accept…. [T]his approach pave[s] the way for the privatization of Medicare. …"

The paper concluded that "the need to improve the Medicare program's fiscal stability has been subverted by massive transfers of federal funds (subsidies) to private insurers who will likely pocket much of these taxpayer dollars through artificially derived profit margins." The paper calls for the elimination of "unfair subsidies and other advantages provided to Medicare Advantage plans so that traditional Medicare can compete on a level basis."*

* Maya Rockeymoore and Laura Hawkinson, "Structured Inefficiency: The Impact of Medicare Reforms on African Americans," Center for Policy Analysis and Research, Congressional Black Caucus Foundation, Inc., January 2004.

Restraining the overpayments thus would benefit the vast bulk of Medicare beneficiaries, both by reducing their monthly premiums and by improving Medicare's long-term sustainability. This is why AARP, among others, has endorsed MedPAC's recommendation to end the overpayments.

Congress Can Rein in Overpayments While Protecting Enrollees and Expanding Coverage

Private insurers have warned that if their overpayments are eliminated, they will be forced to scale back or eliminate the additional benefits they offer. To the extent that curbing the overpayments may affect current Medicare Advantage enrollees, it can — and should — be phased in gradually, with care taken to avoid undue burdens to beneficiaries, as MedPAC has suggested.

In this context, it should be noted that private insurance companies offered some additional benefits to enrollees *before* the federal government greatly increased the payments to the private insurers as part of the 2003 prescription drug bill, so some additional benefits can be expected to continue even if the overpayments are curbed. This is especially true of the most efficient private plans, such as some high-performing HMOs. (One of the biggest problems with the current payment system is that it lavishly subsidizes efficient and inefficient insurance companies alike.)

Most important, the savings from reducing the overpayments can be *reinvested* in better health care for low- and moderate-income people, of whom a highly disproportionate share are minorities. An array of leading authorities — MedPAC and a wide array of other independent health-care experts — have emphasized that strengthening the Medicare Savings Programs (such as by extending them

to more beneficiaries of limited means) would be a far more cost-effective way to improve Medicare coverage for low-income and minority beneficiaries than continuing the overpayments to private plans. Congress could use a portion of the savings from reducing the overpayments for this purpose.

Congress also could use a substantial portion of the savings to expand health coverage for low-income children as part of this year's SCHIP reauthorization. *More than 60 percent of the nearly 9 million uninsured children in the United States are members of racial or ethnic minorities.* Curbing the Medicare Advantage overpayments and using a large share of the savings to cover more low-income children would directly benefit millions of low- and moderate-income minority children. (Moreover, without Medicare Advantage savings, it will be difficult — if not impossible — for Congress to devote anything close to $50 billion over the next five years to broadening children's coverage.)

Curbing Overpayments Would Be a Net Winner for Low-Income and Minority Beneficiaries

Simple math proves that low-income and minority communities would be substantially better off if the Medicare Advantage overpayments were reined in and the savings used both to expand children's health coverage and to strengthen the Medicare Savings Programs. At present, only a modest fraction of the overpayments go to additional benefits that reach minority beneficiaries — not only because some of the overpayments goes to corporate profits and expenses, but also because only about one-fifth of Medicare Advantage enrollees are members of a minority group.

By contrast, *all* of the savings produced by reining in the overpayments can be used to improve benefits for lower-income Medicare beneficiaries and provide coverage to millions of uninsured low-income children. A highly disproportionate share of the people who would directly benefit under this approach *would* be minorities. The result would be a large net increase in health benefits for minority communities.

APPENDIX

Medicare Advantage Plans Use Abusive Marketing Practices and Target Vulnerable Low-Income Medicare Beneficiaries

On May 7, the *New York Times* featured a front-page article documenting a pattern of misleading and abusive marketing practices by enrollment brokers seeking to entice Medicare beneficiaries to enroll in Medicare Advantage plans (particularly private fee-for-service plans) rather than to remain in traditional Medicare. A January 2007 analysis by the Medicare Rights Center, a consumer-oriented organization, and California Health Advocates (as well as other news accounts) provides further, extensive documentation of such practices.[7]

The abusive practices identified by the *New York Times*, the two organizations, and other news accounts include:

- signing up Medicare beneficiaries for private plans without their permission, engaging in prohibited door-to-door high-pressure sales tactics, and falsely claiming that beneficiaries would lose their Medicare coverage unless they enrolled in the private plans;

- failing to disclose that beneficiaries may be required under various private plans to make larger co-payments for certain health care services than under regular Medicare, that they may not be able to continue using their current physicians if they enroll in the private plans, and that they may face more stringent coverage rules — like prior authorization — before being allowed to obtain certain services; and

- targeting low-income Medicare beneficiaries who are also on Medicaid, many of whom live alone, have cognitive difficulties, or have limited English proficiency — and hence may be unable to understand that their supplemental Medicaid coverage already provides coverage of additional benefits and pays their Medicare premiums and cost-sharing.

The overpayments to private insurance companies contribute to these marketing abuses. Because private plans receive a 12-percent overpayment, on average, for each Medicare beneficiary they enroll, plans have an incentive to maximize enrollment. As a result, many private plans have established lucrative commission structures for their enrollment brokers, providing as much as $500 per new enrollee, as well as free trips and other financial incentives. ("Dual eligibles" can be enrolled in private plans at any time, rather than only during an annual open enrollment period for other Medicare beneficiaries; this is why some brokers have targeted dual eligibles.)

Reducing the overpayments, as well as increasing regulation and oversight of the enrollment practices of private plans, could help bring these marketing abuses under control.

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[7] See, for example, Robert Pear, "Hard Sell Cited as Insurers Push Plans to Elderly," *New York Times*, May 7, 2007; David Lipschutz, Paul Precht, and Bonnie Burns, "After the Goldrush: The Marketing of Medicare Advantage and Part D Plans," California Health Advocates and the Medicare Rights Center, January 2007; Victoria Colliver, "Medicare plans under scrutiny: Complaints are adding up from seniors upset with private health care packages," *San Francisco Chronicle*, January 26, 2007; and Milt Freudenheim, "Luring Customers from Medicare," *New York Times*, September 22, 2006.