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CONGRESS TO CONSIDER REPEAL OF MEDICARE DEMONSTRATION PROJECT DESIGNED TO PROMOTE PRIVATIZATION, RATHER THAN YIELD VALID RESULTS

Project Also Would Drive Up Premiums for Traditional Medicare

by Edwin Park and Robert Greenstein

Executive Summary

The House Energy and Commerce Committee and the House Ways and Means Committee will begin work this week on major health care legislation. Among other proposals, they plan to consider repealing a provision of the 2003 Medicare drug law that requires a large-scale, six-year demonstration project under which private insurance companies will compete directly with traditional Medicare fee-for-service to see if they offer better coverage at lower cost.

Well-designed demonstration projects can provide important tests of new policy ideas. Unfortunately, this project — which congressional conferees inserted in the drug law behind closed doors — "stacks the deck" in favor of private plans over traditional Medicare in order to produce an ideologically preordained result. Consequently, it likely would do more to mislead policymakers and the public than to illuminate the policy debate. It also is likely to create hardship for large numbers of beneficiaries in the demonstration areas by causing premiums for traditional Medicare to rise significantly in those areas.

Under the demonstration, which will start in 2010 and cover up to six metropolitan areas, each Medicare beneficiary will receive a choice of enrolling in traditional Medicare or Medicare Advantage, the part of Medicare that provides coverage through private insurance plans. The federal government will provide a fixed dollar amount per beneficiary, based on the average cost per beneficiary in the previous year in that metropolitan area over both traditional Medicare and Medicare Advantage.[1] If the cost of enrolling in traditional Medicare or a particular private plan exceeds the fixed dollar amount for the metro area, beneficiaries who enroll in the more costly coverage will have to pay higher premiums to fully cover the difference.

As the Congressional Budget Office and other analysts indicate, traditional Medicare tends to be more efficient, on average, than private Medicare Advantage plans because of its lower

[1] In determining the average cost for a metropolitan area, the costs for each plan will be weighted by the percentage of Medicare beneficiaries in the area who are enrolled in that plan. The costs of Medicare fee-for-service will be equal to average fee-for-service expenditures in the metro area, while the costs of each private plan will be equal to their bids (i.e., to the amount of payment that plans will accept to cover Medicare beneficiaries in the metro area).

administrative and marketing costs. Yet its costs per beneficiary are generally higher than those of the private plans because the population it serves is less healthy, on average, and thus more costly to serve. In the demonstration areas, then, the cost of enrolling in Medicare will likely exceed the fixed dollar amount provided per beneficiary, forcing beneficiaries who wish to remain in traditional Medicare to pay higher premiums. That will give healthier beneficiaries a strong incentive to enroll in private Medicare Advantage plans, which tend to design their benefit packages and provider networks to appeal to healthier beneficiaries (and deter sicker ones).

As healthy beneficiaries leave traditional Medicare, the population that remains will become sicker, on average, further increasing its per-beneficiary costs. That, in turn, will drive up premiums for traditional Medicare even more — and induce even more healthy beneficiaries to abandon Medicare for the private plans.

"Those wishing to remain in the fee-for-service program [i.e., traditional Medicare] will have to spend far more than they do now on premiums," according to two academic researchers who analyzed the demonstration project and similar approaches to altering Medicare. Under the approach that the demonstration project will implement, they added, "Medicare fee-for-service would enter a gradual death spiral, as healthier individuals switch to HMOs and sicker ones remain in fee-for-service."[2]

The researchers also noted that in the demonstration areas, beneficiaries who are women aged 80 and over, members of a minority group, or people with less than a high-school education are likely to be the most adversely affected because they are in poorer health than Medicare beneficiaries on average. Many could be stranded in a traditional Medicare program with escalating premiums, as healthier beneficiaries abandon it.

Demonstration Project Tilted in Favor of Private Plans

That the demonstration is likely to produce such results should come as no surprise. The Medicare actuaries reported in 2003, *before* the legislation mandating the demonstration was enacted, that the type of approach to be implemented under the demonstration would produce sharp increases in premiums for traditional Medicare.

In fact, the demonstration's supporters may well have *intended* this result, which would induce increasing numbers of beneficiaries to abandon traditional Medicare for private plans and could then be used to justify the nationwide application of the demonstration-project approach. Indeed, the version of the Medicare drug bill that the House originally passed would have instituted the demonstration-project approach on a nationwide basis starting in 2010. When the Senate declined to go that far, the House provision was converted in conference into a demonstration project.

The demonstration will supposedly provide a test of direct competition between private plans and traditional Medicare to determine whether private plans can (a) serve beneficiaries at a lower cost to the federal government and beneficiaries and (b) attract beneficiaries from traditional Medicare by using efficiency savings to reduce premiums and improve benefits.

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[2] Thomas Rice and Katherine Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy, and Law*, December 2004.

In reality, the demonstration will *not* operate on a level playing field and will *not* provide a valid test of these issues. To the contrary, it is tilted heavily in favor of private plans and is designed so that they will attract healthier beneficiaries from traditional Medicare, driving up its costs per beneficiary — even if the private plans are significantly less efficient than traditional Medicare.

Traditional Medicare Has Less-Healthy Beneficiaries and Thus Higher Costs

The Congressional Budget Office (CBO) has found that, on average, traditional Medicare tends to be more efficient on a per beneficiary basis than private Medicare Advantage plans because of its lower administrative and marketing costs.[3] (Despite the private plans being less efficient, both CBO and the Medicare Payment Advisory Commission have determined that the plans are paid 12 percent more, on average, than traditional Medicare to cover comparable beneficiaries.)

Yet average costs per beneficiary can be significantly lower in the private plans than in traditional Medicare because the Medicare beneficiaries who enroll in private plans are *not* comparable to those in regular Medicare. Studies have consistently shown that private plan enrollees are healthier, on average, and thus less costly to treat than enrollees in traditional Medicare.[4]

A major reason why beneficiaries in the private plans tend to be healthier is that some of the private plans design their benefit packages and cost-sharing rules to attract healthier people, as well as to discourage sicker people from signing up. For example, they may charge less than traditional Medicare for services that healthy beneficiaries use, offer additional benefits that are attractive to healthier people (such as exercise classes), or charge more than traditional Medicare for services upon which sicker people rely, such as chemotherapy drugs and hospital care.

In addition, many sicker beneficiaries prefer traditional Medicare because it generally offers a greater choice of physicians and other medical providers than do private plans. (Private plans often limit access to networks of specific providers and charge additional cost-sharing for going outside the network, if they permit it at all.) Sicker beneficiaries generally place greater weight than healthier ones on the ability to choose one's doctor and to retain other existing providers.

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[3] According to CBO, plans can only be more efficient than traditional fee-for-service Medicare if they lower use of health care services by their enrollees (through the use of managed care) and/or reduce provider reimbursements by enough to more than offset their higher administrative costs. See Congressional Budget Office, "Designing a Premium Support System for Medicare," December 2006.

[4] As the academic study cited above noted: "A number of studies have been conducted that compare the health status and cost of Medicare beneficiaries in the FFS system [i.e., traditional Medicare] with those of beneficiaries enrolled in HMOs. Nearly all show that, on average, healthier, less expensive individuals join Medicare HMOs." (Rice and Desmond, *op cit.*) The Medicare Payment Advisory Commission, Congress' expert advisory body on Medicare, also has reported that people enrolled in Medicare Advantage are healthier than those in Medicare fee-for-service, on average. (Medicare Payment Advisory Commission, "Report to the Congress: Promoting Greater Efficiency in Medicare," June 2007.) Also see June Gibbs Brown, "Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997," Office of Inspector General, U.S. Department of Health and Human Services, September 18, 2000; General Accounting Office, "Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits," May 1997; and General Accounting Office, "Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem," November 1995.

How Private Plans Attract Healthier Beneficiaries

A Congressional Budget Office report issued in December 2006 and an article written by Henry Aaron and Robert Reischauer over a decade ago explain how private plans can attract healthier beneficiaries and discourage sicker ones.

From the Aaron and Reischauer article in *Health Affairs*:[*]

"A plan might attract a disproportionate number of healthy or younger elderly enrollees by offering exercise classes or other services that such participants find attractive or by locating its facilities in certain geographic areas. Similarly, subtle differences in the availability of services might make a plan unattractive to people with certain chronic health problems or might encourage participants who become heavy users to leave a plan."

"…. a health plan might find it attractive to sponsor an active event and offer information about its plan near the end, when only the most robust remain. A plan might understaff for the treatment of particularly costly illnesses, putting staff physicians in a position in which their medical ethics might force them to tell a patient newly diagnosed with a given illness: 'We can care for you. But, in all honesty, Plan X across the street really can do a better job.' The avenues through which imaginative risk selection can occur are myriad, and no amount of regulation can close them all."

From the CBO Report:[**]

"If payments to [private] plans were not adequately adjusted to account for differences in the expected costs of their enrollees [due to the differences in health status], plans would have a strong incentive to discourage such beneficiaries with costly chronic conditions. Plans could design their benefit packages to discourage such beneficiaries from enrolling (if benefits were not standardized) or could exclude from their networks providers who are highly regarded for treating certain high-cost conditions. Plans could also impose stringent utilization controls to limit access to certain specialists, which would in all likelihood encourage their costliest enrollees to switch to other plans at the next open enrollment period."

"…. Medicare spending is highly concentrated in a relatively small proportion of the beneficiary population. [In 2001, the costliest 5 percent of beneficiaries enrolled in traditional fee-for-service, or FFS, Medicare accounted for 43 percent of total spending, and the costliest 25 percent accounted for 85 percent of total spending.[***]] If [under the type of approach the demonstration project will test] the FFS program attracted enrollees who were sicker and had higher health care costs than average — and such differences were not adequately accounted for in determining payments to plans — then beneficiaries' premiums for the FFS program would be higher as a result. Those higher premiums could discourage beneficiaries from enrolling in the FFS program, even if that program was able to provide Medicare benefits at the same cost as private plans for the same set of enrollees."

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[*] Henry Aaron and Robert Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs*, Winter 1995.

[**] Congressional Budget Office, "Designing a Premium Support System for Medicare," December 2006.

[***] See Congressional Budget Office, "High-Cost Medicare Beneficiaries," May 2005.

The fact that beneficiaries in traditional Medicare tend to be more expensive to treat than those in private plans has significant implications for the validity of the demonstration project. Under the project, a fixed dollar amount will be provided on behalf of all beneficiaries in a metro area. This amount will reflect the average cost per beneficiary in the area for traditional Medicare and the private plans considered together. Since the private plans serve healthier, less costly beneficiaries, the fixed amount will generally be *less* than the average cost for beneficiaries enrolled in traditional Medicare but *more* than the average cost for beneficiaries enrolled in private plans. As a result, premiums for traditional Medicare generally will be increased, while premiums for private plans will be reduced.

The result of such a structure is predictable: over the life of the demonstration project, a substantial number of the healthier beneficiaries enrolled in traditional Medicare will gradually switch to the private plans, which will become a better deal for them as premiums for traditional Medicare rise significantly. Their departure will make the pool of people remaining in traditional Medicare even less healthy, on average, and thus even more expensive to serve. That, in turn, will push premiums for traditional Medicare still higher. With each passing year, as more healthy beneficiaries abandon traditional Medicare for the private plans, premiums for traditional Medicare will climb further, inducing still more beneficiaries to abandon it. Over an extended period of time, the approach used in the demonstration project could trigger a "death spiral" of steadily rising premiums and steadily falling enrollment in traditional Medicare, as the study cited above explained.

This outcome appears to be intentional. As noted above, the Medicare actuaries projected in 2003, before the demonstration project was inserted into the Medicare drug law, that beneficiaries in traditional Medicare would face sharply higher premiums under this approach. Under nationwide application of the system that the demonstration project will "test," the actuaries estimated that premiums for traditional Medicare would eventually rise by as much as 25 percent nationally and by more than 80 percent in some counties. (A 2006 CBO report similarly found a significant likelihood that premiums for traditional Medicare would increase, perhaps substantially, in higher-cost areas.[5])

To be sure, the demonstration project limits premium increases for traditional Medicare to 5 percent per year, on top of the premium increase imposed each year to compensate for rising Medicare costs nationally. In addition, beneficiaries who qualify for the low-income subsidy under the Medicare drug benefit (generally those with incomes below 150 percent of the poverty line and modest assets) will be exempt from the premium increases the demonstration engenders.

But these protections are limited, allowing a 25 percent increase in premiums for traditional Medicare over the course of the demonstration. Such increases would affect hundreds of thousands — and quite possibly several million — elderly and disabled people of modest means who do not qualify for the low-income subsidies and who wish to remain in traditional Medicare, especially if they have significant medical needs.

Demonstration Cannot Adequately Adjust for Differences in Beneficiaries' Health

In theory, the problems described here could be addressed through a process known as "risk adjustment." In calculating the fixed dollar amount that it would provide per beneficiary for each metro area in the demonstration project, the federal government would "risk adjust" the per-beneficiary cost for each private plan and for traditional Medicare to take into account the actual health status of the plan's beneficiaries. If the beneficiaries in a private plan are found to be in *above*-average health, the plan's average cost per beneficiary would be adjusted upward to reflect what that cost would be if its beneficiaries were in only average health. Similarly, if the beneficiaries in traditional Medicare are found to be in *below*-average health, its average cost per beneficiary would be adjusted downward to reflect what that cost would be if its beneficiaries were in average health.

Under the demonstration project, the Centers for Medicare and Medicaid Services are supposed to employ the risk adjustment system now used to set Medicare payment rates for Medicare

[5] Congressional Budget Office, *op cit.*

Advantage plans. Unfortunately, that will fall well short of addressing the serious problems described here.

- No system of risk adjustment exists that can fully adjust for the differences in health status among enrollees in different types of health plans. As CBO has explained, "Current risk-adjustment systems tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high spending."[6]

- CBO also has warned that under the approach used in the demonstration project, the lack of a risk-adjustment mechanism capable of fully capturing the differences in health status "could cause premiums for enrollees in plans that attract higher-cost beneficiaries [i.e., traditional Medicare] to rise substantially over time."[7]

- The academic study cited above reached a similar conclusion, warning that the current state-of-the-art in risk adjustment is inadequate to prevent an upward spiral of premiums in traditional Medicare under the approach that the demonstration project will "test."[8]

Compounding this problem, private plans and regular Medicare may differ in how they characterize the health status of beneficiaries who are in comparable health. To compare the health status of patients enrolled in private plans with those enrolled in traditional Medicare, the risk adjustment process uses the diagnostic codes that hospitals and physicians assign to their patients. There is now evidence that this process is being compromised by what is known as "upcoding" or "coding creep," which occurs when Medicare beneficiaries are assigned codes that make them appear less healthy than they actually are.

In analyzing the diagnostic coding patterns of Medicare Advantage plans, CBO found that between 2003 and 2004 — in apparent anticipation of full implementation of risk adjustment — the difference in reported health status between enrollees in Medicare Advantage plans and those in traditional Medicare, as measured by the diagnostic codes, suddenly declined by *half* in a single year despite no apparent change in the health status of enrollees in either Medicare Advantage or traditional Medicare.[9] The sudden halving of the reported difference in health status strongly suggests a pattern of "upcoding" on the part of a substantial number of private plans.

Similarly, the Centers for Medicare and Medicaid Services have reported that as risk adjustment has been fully implemented between 2004 and 2006, the "risk scores" (a measure of health status, with a higher score meaning a sicker beneficiary) of enrollees in private plans have risen more rapidly than the risk scores of enrollees in traditional Medicare.[10] Unfortunately, this suggests that upcoding is rendering an already imperfect risk adjustment system even less able to adjust for differences in health status between enrollees in private plans and those in traditional Medicare.

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[6] Congressional Budget Office, *op cit.*

[7] *Ibid.*

[8] Rice and Desmond, *op cit.*

[9] Congressional Budget Office, *op cit.*

[10] Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2008 Medicare Advantage Capitation Rates and Payment Policies," April 2, 2007.

Still another problem is that the demonstration project does not provide traditional Medicare with the same tools that private plans are allowed to use to attract beneficiaries. For example, unlike private plans, traditional Medicare will not be permitted to offer additional benefits beyond the current benefits package, even if traditional Medicare proves more efficient than private plans. Nor will traditional Medicare be allowed to reduce costs for certain services through the use of competitive bidding, or be provided additional funding to institute health information technology improvements that would help lower costs and improve coordination of care.

The bottom line is that under the demonstration project, the playing field will be tilted heavily in favor of the private plans.

Demonstration Results Likely to Be Misused

Proponents of Medicare privatization are certain to seize on the demonstration project's largely preordained result — that traditional Medicare will become increasingly costly compared to private plans as healthier beneficiaries abandon the program — as evidence that private plans are both more efficient than traditional Medicare and more desirable to beneficiaries. As noted, the Medicare drug legislation that the House passed in 2003 would have instituted on a nationwide basis the system the demonstration is supposed to "test." Privatization proponents can be expected to use the "findings" from the demonstration to press for continuing the demonstration after its scheduled expiration at the end of 2015 and extending it nationwide.

The timing could be advantageous for such a campaign. Under current projections, the Medicare Hospital Trust Fund will be close to insolvency when the demonstration is completed. The only way to save Medicare, privatization proponents may argue, is to institute the approach implemented under the demonstration on a nationwide basis. If that happens, Medicare privatization on a large scale will become inevitable.

For these reasons, Congress should remove the demonstration from the Medicare drug law. Demonstrations can be useful, but only if they are designed to provide valid tests of policy alternatives, not to produce ideologically based results that may mislead policymakers rather than inform them.