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HOUSE HEALTH LEGISLATION WOULD CURB MEDICARE OVERPAYMENTS TO PRIVATE PLANS, WHILE AIDING MEDICARE BENEFICIARIES OVERALL

by Edwin Park

The House is considering major health legislation this week. The legislation would not only reauthorize the State Children's Health Insurance Program and extend coverage to five million uninsured children but also would curb excessive payments now being made to private Medicare Advantage plans under the Medicare program and thereby strengthen Medicare's finances.

Although private plans were initially brought into the Medicare program to reduce costs, both the Medicare Payment Advisory Commission (MedPAC) — Congress' expert advisory body on Medicare payment policy — and the Congressional Budget Office have found that private plans are paid 12 percent more, on average, than it would cost traditional Medicare to cover the same beneficiaries. According to an analysis by The Commonwealth Fund, these overpayments are estimated to average about $1,000 for each beneficiary enrolled in a private plan. CBO estimates that these overpayments will equal at least $54 billion over the next five years and $149 billion over ten years.

These overpayments weaken Medicare' finances; the Medicare actuaries have reported that the overpayments accelerate the date when the Medicare Hospital Insurance Trust Fund will become insolvent by two years, from 2021 to 2019. The overpayments also drive up the

KEY FINDINGS

- The Medicare provisions in the House SCHIP bill would produce significant net gains for Medicare beneficiaries, particularly those with low incomes.
- The House bill would strengthen Medicare's finances by phasing out overpayments to private Medicare Advantage health plans. This would add three years to the life of the trust fund and significantly reduce the size of the benefit cuts (or Medicare tax increases) that ultimately will be required to sustain the program. It would also slow the rate of growth in Medicare premiums.
- Furthermore, the bill would expand the programs that help lower-income beneficiaries with their premiums and out-of-pocket costs under Medicare, including the Medicare drug benefit.
- In addition, the bill would improve access to preventive care and other services (including mental health services and screening for colon cancer) for all beneficiaries.

monthly Medicare premiums that 35 million seniors and people with disabilities enrolled in regular Medicare are charged (by $2 per month per beneficiary) in order to help cover the added costs that result from the overpayments.[1]

To address these overpayments, MedPAC has recommended for a number of years that Congress "level the playing field" by setting payments to private plans at the same levels as it would cost to serve comparable beneficiaries under the traditional Medicare program. This recommendation has been endorsed by the AARP, the American Medical Association, and numerous Medicare beneficiary advocacy groups.

Indeed, when the Medicare payment rates to private plans were set at 95 percent of the cost of traditional Medicare, the private plans called for payment increases to pay them at the same level as the cost of traditional Medicare. In the late 1990s, the private plans said that reimbursing them at levels equal to those under regular Medicare would close a "fairness gap" and "create a level playing field between [private plans] and fee-for-service."[2] This is what the House bill would do. But now that the private plans receive such large overpayments, they are vigorously resisting the level playing field that they themselves used to champion.

The House legislation would essentially adopt the MedPAC recommendation to "level the playing field" as well as several other MedPAC recommendations related to Medicare payments to private plans. According to preliminary Congressional Budget Office estimates, the various House provisions curbing Medicare Advantage overpayments would save $50.1 billion over the next five years and $157 billion over ten years.

The key Medicare Advantage payment reforms in the House bill include:

- **Reducing private plan payments over four years so that, by 2011, private plan payments equal 100 percent of costs under regular Medicare.** Payments to private plans would remain unchanged in 2008. Starting in 2009, Medicare Advantage payment rates would begin to transition away from the current payment system and toward payments equal to regular Medicare costs. The transition would be complete by 2011. As noted, MedPAC has long recommended leveling the playing field. (It also has endorsed a transition period to avoid disruption for beneficiaries now enrolled in Medicare Advantage.)

- **Ending the double payments related to indirect medical education.** MedPAC has found that Medicare essentially pays *twice* for medical education costs incurred by hospitals — once by reimbursing teaching hospitals directly for such medical education costs, and a second time by inflating payments to private plans to cover such costs. To remove the double payments, MedPAC has called for eliminating these costs from the payments made to private plans, a recommendation the House bill adopts.

- **Eliminating the remainder of the Medicare "stabilization fund".** The Medicare drug law

[1] Approximately 7 million of the 35 million beneficiaries charged the higher premiums are low-income beneficiaries whose premiums are paid for them by the Medicaid program; the costs of the higher Medicare premium for these individuals are borne by the federal government and the states, which jointly fund Medicaid

[2] See, for example, Karen Ignagni, Testimony before the Senate Finance Committee, American Association of Health Plans, May 27, 1999.

developed a new type of private plan — the regional Preferred Provider Organization (PPO) — to provide care to Medicare beneficiaries. As an inducement for PPOs to enter and remain in regional markets, the drug law established a $10 billion "stabilization fund" to provide additional funds to PPOs, beyond the regular payments they receive. MedPAC has recommended eliminating the fund both to eliminate unnecessary costs and to ensure fair competition among different types of private plans.

Congress reduced the stabilization fund — which Senator Judd Gregg, in his former role as Senate Budget Committee chairman, referred to as a "slush fund" — by two-thirds last year to help finance a tax-cut and health bill. The new House health bill would eliminate the remainder of the stabilization fund.

Substantial Gains for Medicare Beneficiaries Due to Elimination of Private Plan Overpayments

The private plans have attempted to portray any reduction in the excessive payments they receive from Medicare as harming Medicare beneficiaries. The plans argue that a portion of the overpayments go to additional benefits provided to Medicare Advantage enrollees, especially low-income beneficiaries, and that curbing the overpayments would take away these additional benefits. (The plans usually fail to note that a large portion of the overpayments go *not* to extra benefits but rather to administrative costs, marketing, and profits, and that low-income beneficiaries do not enroll disproportionately in private plans.)

Contrary to the claims that the private insurance companies are virtually certain to make, however, the House Medicare provisions would produce *significant net gains* for Medicare beneficiaries, particularly those with low incomes. The House bill would:

- **Strengthen Medicare's finances.** Preliminary estimates from the CMS actuaries indicate that based on the Congressional Budget Office cost estimates of the bill, the reduction in Medicare Advantage overpayments would push back the date of insolvency of the Medicare Hospital Insurance Trust Fund by three years and ensure there would be sufficient Medicare funding to maintain current benefit levels through fiscal year 2022. Of particular importance, the reductions in Medicare benefits (or increases in Medicare taxes) that ultimately will be required to sustain the program in future decades would be significantly smaller than otherwise would be necessary as a result of the Medicare changes in the House bill.

- **Reduce Medicare beneficiary premiums.** Medicare beneficiaries in traditional Medicare now pay $2 per month more than they would otherwise have to pay because of the overpayments to private plans. By eliminating these overpayments, the bill should slow the growth of beneficiary premiums, a matter of particular significance to the millions of seniors and people with disabilities who live on fixed incomes.

- **Increase direct assistance for lower-income Medicare beneficiaries.** The House bill reinvests a substantial portion of the savings from its Medicare Advantage payment reforms — $10.8 billion over five years and $41 billion over 10 years — in measures that would assist lower-income Medicare beneficiaries with their out-of-pocket Medicare costs. The House bill would expand the "Medicare Savings Programs," which help low- and moderate-income

beneficiaries pay their Medicare premiums and/or cost-sharing; more individuals would be made eligible, and barriers to enrollment in these programs would be eased to increase participation among those who are eligible. The bill also would improve the Low Income Subsidy within the Medicare drug benefit, by expanding eligibility for the subsidy, making it easier for eligible individuals to enroll, strengthening the cost-sharing protections for the lowest income beneficiaries, and eliminating cost-sharing for those beneficiaries who also receive Medicaid and require long-term care, but manage to continue living in the community rather than going into a nursing home.

- **Improve access to preventive care and other services for all Medicare beneficiaries.** The House bill would waive the deductible and cost-sharing for preventive services (including additional preventive services that may be added by the HHS Secretary under new authority that the bill provides), waive the deductible for colorectal screening tests, and reduce the cost-sharing rate for outpatient mental health services. In addition, it would make modest changes to the Medicare prescription drug benefit to ensure access to needed drugs. The physician payment provisions that avert a scheduled steep cut in Medicare reimbursements, as well as rural provider provisions, may also increase (or avert reductions in) beneficiaries' access to Medicare services.

- **Protect Medicare beneficiaries enrolled in Medicare Advantage plans from higher out-of-pocket costs.** Currently, private plans have the flexibility under Medicare not only to offer additional benefits, but also to *scale back* existing Medicare benefits (so long as the actuarial value of the overall benefit packages is not less than under traditional Medicare). Some private plans seek to deter sicker — and thus more costly — beneficiaries from enrolling by cutting back certain Medicare benefits that are used primarily by sicker individuals. For example, plans may impose substantially higher co-payment charges for days in the hospital or costly treatments like chemotherapy. As a result, some beneficiaries who are in poorer health can wind up significantly worse off if they enroll in Medicare Advantage. The House bill would prohibit private plans from establishing cost-sharing charges for Medicare services that exceed the charges under traditional Medicare, a change that should not only help many Medicare Advantage enrollees who become sick during the year but also make it harder for private plans to deter less-healthy individuals from signing up.

- **Increase regulation and oversight of private plan marketing practices.** The House bill would provide safeguards for Medicare beneficiaries against abusive marketing practices by private plans and their agents, which have been reported across the country in recent months. (Eliminating the overpayments also should help, as it would reduce the financial incentives for such marketing practices by reducing the windfall profits many private plans now enjoy.) The House bill would require the federal government to work with the National Association of Insurance Commissioners to develop model marketing and advertising protections for private plans, as Congress previously did in the area of Medigap policies. The bill also would increase federal *and state* oversight of marketing by plans and their agents; one reason these abuses have become more widespread recently is that the 2003 Medicare drug law sharply curtailed states' longstanding authority to regulate the marketing of these plans.

Conclusion

In Congressional testimony earlier this year, MedPAC chairman Glenn Hackbarth warned that Medicare faces "a very clear and imminent risk from this [Medicare Advantage] overpayment that will put this country in an untenable position."[3] The House health legislation takes strong steps to address this danger by eliminating the excessive payments that private plans now receive under the Medicare Advantage program.

In so doing, the House bill strengthens Medicare's overall finances and thereby aids Medicare beneficiaries generally. It also eases pressure on beneficiary premiums and increases the access of vulnerable low-income beneficiaries to health care services by expanding and improving measures that help low-income seniors and people with disabilities pay the Medicare premium and cost-sharing charges.

[3] BNA Health Care Policy Daily, "Growth of Managed Care Plans Threaten Program's Finances, MedPAC Chairman Says," March 2, 2007.