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PRIVATE PLANS CONTINUE TO USE MISLEADING ARGUMENTS TO OPPOSE REFORMS OF MEDICARE OVERPAYMENTS

by Edwin Park

KEY FINDINGS

A recent letter from America's Health Insurance Plans (the trade group representing private health insurers) to two House committees employs a number of misleading claims regarding the House proposal to curb federal overpayments to private "Medicare Advantage" plans:

- ***Claim:*** The House bill would disproportionately affect low-income and minority beneficiaries.
  Reality: Low-income and minority beneficiaries do not disproportionately enroll in Medicare Advantage.

- ***Claim:*** Cutting overpayments to the private plans would hurt beneficiaries' quality of care.
  Reality: There is no evidence that private plans provide better care than traditional Medicare.

- ***Claim:*** The elimination of the overpayments would translate directly into the loss of the extra benefits the plans provide.
  Reality: While some of the overpayments go to additional benefits, a substantial share go to profits and to marketing and administrative costs.

- ***Claim:*** The bill's proposed regulatory changes to Medicare Advantage have not been thought through and would create inconsistency across states.
  Reality: The bill would restore (and strengthen) the joint federal-state regulatory framework that was in place before the 2003 Medicare drug law.

- ***Claim:*** The private plans should not be required to report the share of their payments that go to providing health care.
  Reality: The bill would close a gap in the oversight of the private plans that results from the lack of standards on how much of plan payments can go to administration, marketing, and profits, rather than to providing health care.

This week, the House is scheduled to consider health legislation developed by the chairmen of the House Energy and Commerce and the House Ways and Means Committees to reauthorize and expand the State Children's Health Insurance Program (SCHIP). This legislation, known as the "CHAMP Act,"[1] would not only reauthorize the State Children's Health Insurance Program (SCHIP) and extend coverage to nearly five million uninsured children, but also curb excessive payments now being made to private insurance plans under the Medicare Advantage program.

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

[1] CHAMP stands for the Children's Health and Medicare Protection Act of 2007 (H.R. 3162, as introduced).

beneficiaries. 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, the National Committee to Preserve Social Security and Medicare, and numerous other Medicare beneficiary advocacy groups.

The CHAMP Act would essentially adopt the MedPAC recommendation to "level the playing field" — i.e., to pay private plans the same amount as it would cost to insure comparable beneficiaries under regular Medicare — as well as several other MedPAC recommendations related to excessive Medicare payments to private plans. According to preliminary Congressional Budget Office estimates, the various House provisions curbing overpayments to private plans would save $50.2 billion over the next five years.

On July 27, America's Health Insurance Plans, the trade group representing the private plans, sent letters to Members of the House Energy and Commerce and Ways and Means Committees opposing the CHAMP Act's provisions to reduce their overpayments. In doing so, AHIP used a number of misleading arguments, some of which repeat dubious arguments it has been making throughout the year:[2]

1. AHIP claim #1: "Its [the CHAMP Act's] impact would be particularly hard for low-income beneficiaries and minority beneficiaries with low incomes – especially those who fall just short of qualifying for Medicaid – who have no other place to turn for the affordable high quality, comprehensive coverage they receive through Medicare Advantage."

The reality: Low-income and minority beneficiaries do not disproportionately enroll in Medicare Advantage plans. The proportion of beneficiaries with incomes under $20,000 who are enrolled in Medicare Advantage is about the same as (not greater than) the proportion of *all* Medicare beneficiaries who are enrolled in Medicare Advantage.

Among racial-ethnic groups, African American and Asian American beneficiaries make up the same or a smaller proportion of Medicare Advantage enrollment than they do of the overall Medicare population. Hispanics are modestly more likely to enroll in Medicare Advantage, but this simply reflects where they live. Half of all Hispanic Medicare Advantage enrollees live in California and Florida. In those states, the proportion of people enrolled in managed care plans — through employer-based coverage as well as through Medicare — is higher than in other parts of the country.

Finally, for *every* racial/ethnic group, including Hispanics, the number of Medicare beneficiaries who are enrolled in *regular* Medicare rather than in Medicare Advantage plans — and who are thus charged higher Medicare premiums every month to help cover the cost of the Medicare Advantage

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[2] See, for example, Edwin Park, "Informing the Debate about Medicare Advantage Overpayments," Center on Budget and Policy Priorities, July 19, 2007; Edwin Park and Robert Greenstein, "Curbing Medicare Advantage Overpayments to Private Insurers Could Benefit Minorities and Help Expand Children's Health Coverage," Center on Budget and Policy Priorities, May 10, 2007; and Edwin Park and Robert Greenstein, "Low-Income and Minority Beneficiaries Do Not Rely Disproportionately on Medicare Advantage Plans: Industry Campaign to Protect Billions in Overpayments Rests on Distortions," Center on Budget and Policy Priorities, April 3, 2007.

overpayments — is about *three to seven times* the number of beneficiaries who are enrolled in Medicare Advantage plans.

2. AHIP claim #2: "Another serious concern is the impact the proposed funding cuts would have on health care quality for beneficiaries."

The reality: There is no evidence supporting AHIP's claim that the private plans provide higher quality care than traditional Medicare. MedPAC has reported that it is difficult to assess differences in the quality of care between Medicare Advantage and fee-for-service, due to the lack of comparative quality measures, but that levels of beneficiary satisfaction are similar and that fee-for-service beneficiaries are less likely to report problems accessing specialists.

Similarly, the Congressional Budget Office has concluded "though Medicare Advantage plans cost more than care under the FFS program does, on average, they would be more cost-effective if they delivered a sufficiently higher quality of care. The limited [quality] measures available suggest that Medicare Advantage plans are *not* more cost-effective than the FFS program" (emphasis added).

3. AHIP claim #3: The reduction in the payments to private plans (due to the elimination of the overpayments) would translate entirely into reductions in additional benefits provided to Medicare Advantage enrollees.

The reality: While some of the overpayments go to additional benefits, a substantial share goes to profits, marketing costs, and administrative costs. A portion of the overpayments that private plans receive goes to provide additional benefits to enrollees, such as services that Medicare otherwise does not cover or lower cost-sharing than Medicare otherwise charges. The rest of the overpayments goes, however, to profits, marketing, and administrative costs. According to MedPAC, the type of private plan that gets the largest overpayments — "private fee-for-service plans" — receives payments that average 19 percent more than it would cost to treat comparable beneficiaries under regular Medicare, with *half* of these overpayments going to profits, marketing, and administrative costs.

In its letter to Members of Congress, AHIP implies that leveling the playing field (i.e., phasing out the overpayments) would reduce payments to the private plan by 20 percent in Oakland, California and other surrounding areas of Alameda County (to cite one example) and hence reduce benefits to Medicare Advantage enrollees by 20 percent. But this is not correct. While private plans likely would scale back the additional benefits they offer if their overpayments are curbed, a substantial share of the reduction in overpayments would come out of plans' profits, marketing, and administrative costs. (AHIP's own argument here also highlights how large the overpayments are: in Alameda County, plans receive payments that are 20 percent higher than it costs to treat comparable beneficiaries under regular Medicare.)

Moreover, MedPAC has noted that "if the justification for higher payments to [private] plans is that extra payments are being provided to low-income beneficiaries who choose such plans, there are less costly and more efficient ways to achieve this result," such as by improving the Medicare Savings Programs — which pay the Medicare premiums (and in many cases, the deductibles and co-payments as well) for low-income beneficiaries — or by strengthening the low-income subsidy in

the Medicare prescription drug benefit. As AHIP itself acknowledges, the *CHAMP Act does both of these things,* devoting a substantial portion of the savings from curbing Medicare Advantage overpayments to expanding and improving both the Medicare Savings Programs and the Medicare Part D low-income subsidy.

Finally, under current law, the private plans have the flexibility not only to offer additional benefits, but also to *scale back* some existing Medicare benefits. Many private insurers use this flexibility to design their benefit packages so as to entice healthy Medicare beneficiaries, who are less costly to treat, and *to deter* sicker and more costly beneficiaries. Some private plans scale back certain Medicare benefits that are primarily used by sicker individuals, such as by imposing substantially higher co-payment charges for days in the hospital or costly treatments like chemotherapy. As a result, some beneficiaries in poorer health can wind up significantly worse off if they enroll in Medicare Advantage. The CHAMP Act fixes this problem, by barring Medicare Advantage plans from charging higher cost-sharing for benefits that are provided under regular Medicare. This aspect of the legislation represents an improvement in the Medicare Advantage benefit packages. Not surprisingly, the AHIP letter fails to mention it.

4. AHIP claim #4: "We have major concerns with provisions of [the CHAMP Act] that call for sweeping regulatory and administrative changes in the Medicare Advantage program without any discussion or study.... We are particularly concerned about the impact of introducing 50 state regulatory agencies into a national program, creating inconsistent enforcement mechanisms."

The reality: The CHAMP Act would restore (and strengthen) the joint federal-state regulatory framework for private plans that was in existence before the 2003 drug law. Over the past year, numerous media reports and several Congressional hearings have documented a pattern of misleading and abusive marketing practices by some insurance agents who seek to entice Medicare beneficiaries to enroll in Medicare Advantage plans (particularly private fee-for-service plans). In addition, in a survey recently conducted by the National Association of Insurance Commissioners, 37 of the 43 states responding reported complaints about inappropriate or confusing marketing practices that led Medicare beneficiaries to enroll in private plans without understanding how the plans differed from traditional Medicare in such areas as benefits and provider availability.

Prior to the 2003 Medicare drug law, the federal government and the states *shared* regulatory oversight of the private plans. One reason these marketing abuses have been more widespread of late is that the Medicare drug law sharply curtailed states' longstanding authority to regulate the marketing of these plans. The CHAMP Act would reestablish this joint oversight. It also would provide additional safeguards for Medicare beneficiaries against abusive marketing practices by private plans and their agents and 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. (Eliminating the overpayments also should help, as it would reduce the financial incentives for such marketing abuses by reducing the windfall profits that many private plans now secure by signing people up.)

5. AHIP Claim #5: "The bill also establishes new requirements addressing medical loss ratios for Medicare Advantage plans, but fails to recognize the value of health plan initiatives (which are included in administrative costs) to coordinate care, manage chronic conditions, and assure quality."

The reality: The CHAMP Act would address a gap in the oversight of private plans that results from the absence of any standards on how much of plan payments can go to administrative costs, marketing and profits, rather than to the provision of health care services to Medicare beneficiaries. The CHAMP Act would require plans to report their medical loss ratios (i.e., the proportion of their payments that go to the provision of health care). By 2010, plans would have to meet a minimum medical loss ratio of 85 percent or face penalties. Requiring a minimum medical loss ratio would be broadly similar to what is already required of Medigap plans (federal law establishes a minimum medical loss ratio for those plans), as well as of private insurers operating in the commercial market under state health insurance regulations in a number of states. This would allow the Centers for Medicare and Medicaid Services to better enforce the *current* Medicare Advantage requirement that plan bids be reasonably related to plan costs, rather than include excessive administrative costs, marketing costs, and profits, at taxpayers' expense.