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ADOPTING MEDPAC RECOMMENDATIONS TO REDUCE EXCESSIVE MEDICARE MANAGED CARE PLAN PAYMENTS COULD YIELD LARGE BUDGET RECONCILIATION SAVINGS

By Edwin Park

Under the requirements of the Congressional budget resolution, the Senate Finance Committee and the House Energy and Commerce Committee are expected to consider reconciliation legislation as early as the week of October 17 that contains at least $10 billion in spending cuts over five years in programs under their jurisdictions.[1] While it has been previously assumed that Medicaid should be the principal target for these cuts, reductions in overpayments to private Medicare managed care plans could achieve Medicare savings that would meet or even exceed the $10 billion in required savings.[2] Recent media reports indicate the Senate Finance Committee now may be looking to Medicare as the source for much of these savings.[3]

In developing the reconciliation legislation, Congress is likely to consider some Medicaid changes that could adversely affect vulnerable low-income patients (such as increases in beneficiary cost sharing which, according to the research, would likely lead substantial numbers of low-income people to go without health services or medications they need, and provisions that would make certain benefits unavailable to some of the low-income populations that Medicaid covers). Fortunately, cuts that carry risks such as these are not needed to reach the $10 billion savings target. Both the Senate Finance Committee and the House Energy and Commerce Committee could consider carefully designed *Medicaid* proposals that would produce savings without placing beneficiaries' health in jeopardy, as well as *Medicare* recommendations made by the Medicare

[1] The Administration as well as Senate and House Republican leaders are apparently pushing for larger cuts in mandatory spending than the Congressional budget resolution requires. See, for example, David Wessel, "Bush Budget Aide Weighs Cut in Benefit Outlays," *Wall Street Journal*, September 26, 2005; Jonathan Weisman, "GOP Divided Over Range and Severity of Spending Cuts," *Washington Post*, October 6, 2005; and Carl Hulse, "Republicans in Congress Seek Budget Cuts for Storm Relief," *New York Times*, October 7, 2005.

[2] While the Senate Finance Committee has exclusive jurisdiction over Medicare, the House Energy and Commerce Committee shares Medicare jurisdiction with the House Ways and Means Committee. The Energy and Commerce Committee has primary jurisdiction over Medicare Part B, which covers outpatient services, and shares jurisdiction over Medicare Part C, which involves private plans, and Medicare Part D, the new drug benefit. Ways and Means has primary jurisdiction over Medicare Part A, which covers hospital and nursing home care.

[3] See, for example, Peter Cohn and Emily Heil, "As Some in GOP Weigh More Cuts, Deficit Picture Improves -- For Now," *Congress Daily*, October 7, 2005.

Payment Advisory Commission (MedPAC), the official, independent federal advisory body to Congress on Medicare payment policy. In a June 2005 report, MedPAC recommended various changes in how Medicare pays managed care plans under Medicare Advantage, the renamed Medicare managed care program (previously known as Medicare+Choice), in order to reduce inefficient and wasteful Medicare payments.[4] The Congressional Budget Office has estimated that the MedPAC proposals would save *$20 billion to $30 billion* over five years.

The MedPAC recommendations, which are the focus of this brief analysis, include the following:

- Eliminate the Medicare "stabilization fund" for regional Preferred Provider Organizations (PPOs); CBO estimates this would produce savings of $5.8 billion over five years.

- Set benchmarks for bids for Medicare managed care plans at 100 percent of the costs of Medicare fee-for-service — savings of $12.6 billion over five years.

- Remove the double payments for indirect medical education costs that currently are included in managed care reimbursement rates — savings of $2.6 billion over five years.

- Require that Medicare bids and payment benchmarks for regional PPOs, rather than just for plans serving local areas, be revised to reflect the average cost of serving the actual Medicare beneficiaries whom the PPOs enroll, rather than the average cost of *all* Medicare beneficiaries in the region — a savings of $2.2 billion over five years.

MedPAC also endorsed a proposal from the Centers for Medicare and Medicaid Services, which is part of the U.S. Department of Health and Human Services, to phase out the "hold harmless" policy that currently offsets the impact of "risk adjustment" on managed care payments. CMS plans to phase out the "hold harmless" policy administratively. The Congressional Budget Office estimates that writing the phase-out into law would save $6.1 billion over five years. (CBO's budget "baseline" does not assume that CMS will actually phase out this policy. As a result, CBO regards a proposal to write the phase-out into law as producing savings.)

The appendix at the end of this brief analysis explains these MedPAC proposals in more detail.

In short, Congress could enact MedPAC's recommendations to reduce the excessive payments being made to Medicare managed care plans and thereby make Medicare more efficient, and in so doing could help meet the budget reconciliation targets. Following this approach would have another benefit as well: since these payment reforms would lower Medicare costs, they would automatically reduce the premiums that Medicare beneficiaries are charged. Following this course would enable Congress to meet the savings target of $10 billion that the Congressional budget resolution sets *without* adopting Medicaid proposals that could inflict harm on substantial numbers of low-income children, parents, seniors and people with disabilities.

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[4] Medicare Payment Advisory Commission, "Report to Congress: Issues in a Modernized Medicare Program," June 2005. All of the recommended changes to Medicare Advantage payments that are discussed here were unanimously approved (with one member absent) by MedPAC, with the exception of the recommended elimination of the Preferred Provider Organization (PPO) stabilization fund. That recommendation was approved 15-1 with one member absent. Reducing Medicare Advantage reimbursements also would have the effect of reducing the Medicare Part B premiums that beneficiaries pay.

Appendix

This appendix briefly describes the MedPAC recommendations cited in the attached paper.

1. **Eliminate the "stabilization fund" for regional PPOs.** The 2003 Medicare Prescription Drug, Improvement and Modernization Act (MMA) developed a new type of private managed care plan — the *regional* Preferred Provider Organization (PPO) — that will be available to provide care to Medicare beneficiaries starting in 2006. The goal is to encourage participation by PPOs in service areas larger than counties, including rural areas that traditionally have not been served by managed care plans. As an inducement for PPOs to enter and remain in regional markets, the MMA established a $10 billion "stabilization fund" that could provide additional funds to PPOs from 2007 through 2013, above and beyond the regular Medicare Advantage payments that these PPOs would receive. Such additional payments would *not* be available to Medicare HMOs.

   MedPAC recommends eliminating the stabilization fund to ensure a "level playing field" for competing types of Medicare plans, whether traditional fee-for-service, HMOs, or the new regional PPOs. Otherwise, due to the higher reimbursements that will be made available through the stabilization fund, the PPOs would have an unequal competitive advantage in attracting Medicare beneficiaries to their plans, as compared to traditional fee-for-service and to a lesser extent, Medicare HMOs.[5] While Congress may have believed that the stabilization fund would help reduce the financial risk faced by PPOs in entering regional markets and thus encourage participation, MedPAC noted that Congress has already instituted other protections to limit PPOs' risks.

   For example, through the use of "risk corridors" that provide additional Medicare payments if PPO's costs are higher than expected, PPOs will be partially shielded from risk for the first two years. In addition, a recent study estimates that regional PPOs could be overpaid by as a result of current Medicare payment rules and procedures, regional PPOs could be overpaid as much as $60 billion over the next ten years, even without the stabilization fund.[6] MedPAC noted that Congress may wish to consider incentives to induce participation in the future *if* problems in PPO participation arise, but concluded that the stabilization fund is unnecessary now and should be eliminated.

   The Congressional Budget Office (CBO) estimates that removal of the stabilization fund would save *$5.8 billion* over the next five years.

2. **Set the benchmarks for managed care plan bidding at 100 percent of the costs of fee-for-service Medicare**. Starting in 2006 under the Medicare Advantage program, private managed care plans will make competitive bids for the provision of care to Medicare beneficiaries and a new reimbursement system will be used. Under the previous

[5] For example, the regional PPOs could use the additional payments to reduce beneficiary cost-sharing or provide additional benefits not otherwise covered under Medicare.

[6] Steven D. Pizer, Roger Feldman, and Austin B. Frakt, "Defective Design: Regional Competition in Medicare," *Health Affairs*, Web Exclusive, August 23, 2005. See footnote 6.

reimbursement system, plans have been paid a flat amount in accordance with an administratively-set local payment rate. These local payment rates often have been set well above the average cost of fee-for-service Medicare.

Unfortunately, the new benchmarks against which the competitive bids will be evaluated will be based on these current, often-inflated payment rates. On average, according to MedPAC, Medicare payment rates to private managed care plans now equal *107 percent* of the costs of providing fee-for-service Medicare to comparable beneficiaries.[7]

To address this problem, MedPAC has recommended that the benchmarks be set at *100 percent* of the costs of fee-for-service Medicare. This would ensure equity between managed care plans and traditional fee-for-service. Medicare beneficiaries could choose to enroll in managed care plans or fee-for-service based solely on quality of care and efficiency. (In the absence of this change to level the playing field, managed care plans can use the excess payments that they receive to reduce beneficiary cost-sharing or to add health benefits, in order to make themselves appear more attractive to beneficiaries and thereby to gain an unfair competitive advantage over traditional fee-for-service Medicare.)

CBO estimates savings of *$12.6 billion* over five years from setting the managed care payment benchmarks at 100 percent of comparable fee-for-service costs. (In a preliminary estimate, CBO also estimated that phasing in this policy over five years would save $6.8 billion.)

3. **Remove the double payments for indirect graduate medical education costs included in managed care reimbursements.** Medicare currently reimburses teaching hospitals for graduate medical education costs (GME) that teaching hospitals incur when treating Medicare beneficiaries. These payments include reimbursement for the *direct* costs of GME (such as residents' salaries and benefits and teaching costs) as well as for *indirect* medical education costs (IME), which are the higher costs that teaching hospitals, as compared to non-teaching hospitals, generally incur (for such reasons as that they generally offer a wider array of health care services and that the patients whom they serve tend to be in poorer health). Thus, Medicare already provides additional IME payments to teaching hospitals for costs related to Medicare beneficiaries, including beneficiaries who are enrolled in private managed care plans.

   The benchmarks that will be used to evaluate bids from managed care plan bids, however, will continue to be based on the current administratively-set payment system, which incorporates IME costs. As a result, Medicare essentially pays for IME *twice*, by reimbursing teaching hospitals directly for IME costs and by inflating payments to Medicare Advantage plans to cover IME costs. According to MedPAC, IME overpayments to managed care plans account for two percentage points of the overall seven percentage point overpayment to Medicare managed care plans. (As noted above, on average, payments to managed care plans equal 107 percent of the payments made under traditional Medicare fee-for-service for treating comparable enrollees.) MedPAC consequently recommends eliminating IME from the calculation of the managed care plan payment benchmarks.

   CBO estimates that this change would produce Medicare savings of *$2.6 billion* over the next five years.

[7] Medicare Payment Advisory Commission, *op cit.*

4. **Require that regional PPO bids and payment benchmarks both reflect the average cost of serving the Medicare beneficiaries whom a PPO actually enrolls, rather than the average cost of the overall Medicare population in the region.** Both the bids and the payment benchmarks of managed care plans that serve local areas are based on the average cost of their actual enrollees. In contrast, starting in 2006, while regional PPOs will make bids that reflect the average cost of the Medicare beneficiaries they expect to enroll, their payment benchmarks will be based on the average cost of all Medicare beneficiaries in the region. If a regional PPO targets counties within a region in which beneficiaries have lower average costs than the region as a whole but the PPO is paid based on the higher average cost for the entire region, this will result in higher payments to the regional PPO than to local plans that serve similar beneficiaries.[8] According to MedPAC, these overpayments create an unfair competitive advantage for regional PPOs over local plans.[9] MedPAC recommends that both bids and benchmarks for regional PPOs be calculated in the same manner as bids and benchmarks for local plans.

   CBO estimates that requiring both bids and benchmarks for regional plans to take into account the plans' actual enrollments would save *$2.2 billion* over five years.

5. **Write into statute the planned phase-out of the current "hold harmless" policy that offsets the impact of "risk adjustment" on Medicare managed care payments.** The Centers for Medicare and Medicaid Services (CMS), which administer Medicare, have developed a more accurate method of adjusting Medicare managed care payments to reflect the health status of the members of managed care plans, rather than relying solely on demographically-related risks. This improved process, known as "risk adjustment," ensures that Medicare does not overpay private plans if the beneficiaries enrolled in such plans are healthier, and thus less costly to treat, than the beneficiaries enrolled in traditional Medicare fee-for-service. The lack of proper risk adjustment is one of the key reasons that Medicare managed care plans are paid, on average, 107 percent of the cost of providing Medicare fee-for-service coverage to comparable beneficiaries.[10]

   CMS has, however, implemented a "hold harmless" policy that increases payments to private plans to offset the payment reductions that result from use of this more accurate risk adjustment method. This "hold harmless" provision artificially inflates payments to managed care plans.

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[8] See Pizer, Feldman, and Frakt, *op cit*. This study raises the concern that regional PPOs will concentrate primarily on enrolling lower cost beneficiaries within the region they serve, even though the overall Medicare population in the region may have higher average costs. Since the benchmarks used in calculating regional PPOs payments are based on average costs across the counties served, weighted by the entire Medicare population, rather than being based on the average cost of the beneficiaries whom the PPOs actually enroll, the study estimates this practice could result in overpayments to regional PPOs of as much as $60 billion over ten years.

[9] See Pizer, Feldman, and Frakt, *op cit*. This study raises the concern that regional PPOs will concentrate primarily on enrolling lower cost beneficiaries within the region that they serve. Since the benchmarks used in calculating regional PPOs payments will be based on average costs across the counties served, weighted by the entire Medicare population, rather than being based on the average cost of the beneficiaries whom the PPOs actually enroll, the study estimates that 0this practice could result in overpayments to regional PPOs of as much as $60 billion over ten years.

[10] Medicare Payment Advisory Commission, *op cit.*

To address this problem and to implement a system that pays managed care plans appropriately, based on the actual health status of their enrollees, the Administration has proposed to phase out the hold harmless policy administratively between 2007 and 2010. MedPAC has endorsed this proposal.

The Congressional Budget Office, however, does not assume that the hold-harmless policy will, in fact, be phased out administratively. As a result, writing the proposed phase-out into the statute would produce savings, according to CBO. CBO estimates that enacting the Administration's proposal to phase out the hold-harmless policy would save *$6.1 billion* over five years. (CBO also has estimated that eliminating the hold-harmless policy immediately in 2006, rather than phasing it out between 2007 and 2010, would increase the savings to $11.7 billion over five years.)