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Executive Order, Other Administration Actions Would Weaken Medicare

By Paul N. Van de Water

President Trump billed a recent executive order as “protecting and improving Medicare for our nation’s seniors” and “enhancing [Medicare’s] fiscal sustainability,” but it would actually do the opposite.¹ Although many of its proposed changes are vague, and most would require changes in laws or regulations, the order would weaken Medicare and its financing. It would promote private Medicare Advantage (MA) plans, which are prone to overpayments, over traditional Medicare. It could also raise costs for some or all beneficiaries by increasing payment rates to providers; moving toward Medicare premium support, which would likely increase premiums for traditional Medicare; removing limitations on private contracts between patients and providers, thus allowing higher charges for Medicare-covered services; and making it easier for seniors to opt out of Medicare, likely leaving behind a lower-income, sicker patient pool.

The executive order comes amid other Trump Administration actions that would undermine Medicare or have already done so. The Administration supports a lawsuit to invalidate the entire Affordable Care Act (ACA), which would reopen the Medicare drug “donut hole,” reintroduce cost sharing for preventive services, and create confusion and uncertainty around payments to plans and providers. The Administration’s proposal to lower the federal poverty line would cut benefits for hundreds of thousands of low-income enrollees. And the 2017 tax cuts enacted by the Administration and Congress have already weakened Medicare’s finances.

Executive Order Would Weaken Medicare

The executive order would weaken Medicare and adversely affect beneficiaries in several ways.

Promoting Medicare Advantage

The executive order promotes private Medicare Advantage plans as a way of increasing choice for beneficiaries while ignoring indications that these highly profitable plans are overpaid.

Medicare beneficiaries may choose to receive their hospital and physician benefits in one of two ways: through either traditional Medicare, which offers a wide range of providers, or private MA plans, which offer some additional benefits but restrict the choice of providers and access to

¹ Donald J. Trump, *Executive Order on Protecting and Improving Medicare for Our Nation’s Seniors*, October 3, 2019, <https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/>.

services. Currently, about two-thirds of beneficiaries opt for traditional Medicare (sometimes called Medicare fee-for-service, or FFS), and one-third are enrolled in Medicare Advantage.

Medicare Advantage plans have considerable latitude in designing their benefit packages, and plans can use supplemental benefits to attract healthier or other more profitable enrollees. For example, MA plans frequently include a fitness benefit. The law also requires MA plans to limit total annual out-of-pocket spending by beneficiaries — a vital benefit that traditional Medicare currently lacks. MA plans can thus provide comprehensive health benefits in a single package, whereas enrollees in traditional Medicare must also purchase supplemental coverage against catastrophic expenses (Medigap) and a separate prescription drug plan.

Medicare’s payment system attempts to correct for differences in the health status of plans’ enrollees through a process known as “risk adjustment.” Nonetheless, the Medicare Payment Advisory Commission estimates that MA plans are overpaid by about 1 percent compared to traditional Medicare because of the way they code their enrollees’ health conditions.²

And some evidence indicates that that the overpayments may be even greater. In a recent study, for example, the Kaiser Family Foundation found that people who switched from traditional Medicare to MA had \$1,253 (or 13 percent) less Medicare spending, on average, in the previous year than beneficiaries who remained in traditional Medicare, even after risk adjustment. This suggests that “basing payments to plans on the spending of those in traditional Medicare” — as under current law — “may systematically overestimate expected costs of Medicare Advantage enrollees,” according to the Kaiser researchers.³

For this and other reasons, insurers find Medicare Advantage highly profitable. Gross margins in the MA market are about twice as large as those in the individual and fully insured group markets.⁴ The major health insurers are expanding their MA offerings, and even more venture-capital-funded companies are entering the MA market.⁵ Plans are thus in a strong financial position to offer additional benefits, leading to more growth in MA enrollment and higher federal costs.

But the executive order gets this situation backwards. It directs Secretary of Health and Human Services (HHS) to take steps to “ensure that, to the extent permitted by law, FFS Medicare is not

² Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, “Chapter 13, The Medicare Advantage program: Status report,” March 2019, http://medpac.gov/docs/default-source/reports/mar19_medpac_ch13_sec.pdf.

³ Gretchen Jacobson and Tricia Neuman, *Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?* Kaiser Family Foundation, May 7, 2019, <https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/>.

⁴ Gretchen Jacobson *et al.*, *Financial Performance of Medicare Advantage, Individual, and Group Health Insurance Markets*, Kaiser Family Foundation, August 5, 2019, <https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief/>. See also Paul D. Jacobs and Richard Kronick, “Getting What We Pay For: How Do Risk-Based Payments to Medicare Advantage Plans Compare with Alternative Measures of Beneficiary Health Risk?” *Health Services Research*, December 2018, <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12977>.

⁵ Bertha Coombs, “The 2020 Medicare enrollment season brings fierce competition for baby boomers among insurers,” CNBC, October 16, 2019, <https://www.cnbc.com/2019/10/16/the-2020-medicare-enrollment-season-brings-fierce-competition-for-baby-boomers-among-insurers.html>.

advantaged or promoted over MA with respect to its administration.” If anything, current arrangements favor MA plans over traditional Medicare. MA plans can provide benefits that traditional Medicare does not offer, and the executive order would move further in this direction by encouraging “innovative MA benefit structures and plan designs,” including “innovations in supplemental benefits.”

Actually letting Medicare Advantage and traditional Medicare compete on a level playing field would mean reducing excessive payments to MA plans as well as disparities in benefit design. The executive order goes in the opposite direction and threatens to increase federal costs.

Increasing Payment Rates

One of the order’s most unclear yet potentially dangerous provisions is its call to “modify Medicare FFS to more closely reflect the prices paid for services in MA and the commercial insurance market.” Although MA plans may pay some health care providers less than traditional Medicare for some items — such as laboratory services and durable medical equipment — commercial insurers in the private market generally pay considerably more across the board. For example, one recent study finds that private health plans pay almost two and a half times as much as Medicare, on average, for hospital inpatient and outpatient services.⁶

Lowering traditional Medicare’s payment rates in those cases where MA plans pay less could produce modest savings. But raising Medicare’s payment rates to more closely match commercial rates would greatly increase financial pressures on the program, speeding the depletion of Medicare’s Hospital Insurance (HI) trust fund and requiring higher levies on taxpayers. By increasing spending for physician and hospital outpatient services, it would also increase beneficiaries’ premiums, which cover one-quarter of the cost of Medicare Part B.⁷

Expanding Private Contracting

The executive order directs the HHS Secretary to “identify and remove unnecessary barriers to private contracts” — a step that would increase costs for beneficiaries or the Medicare program by making it easier for physicians to opt out of Medicare and allowing them to charge more for Medicare-covered services.

Almost all physicians and practitioners registered with Medicare (96 percent) are participating providers. Participating providers accept Medicare’s fee schedule rates as full payment for their services, and beneficiaries generally pay 20 percent of the scheduled amount as coinsurance. A few physicians (4 percent) are non-participating providers. Non-participating providers may charge 15 percent more than what Medicare pays, and beneficiaries are liable for that additional amount on top of the usual coinsurance. Very few physicians and dentists (0.7 percent of practitioners) opt out of

⁶ Chapin White and Christopher Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, RAND Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3033.html.

⁷ Paul N. Van de Water, *Medicare Is Not Bankrupt*, Center on Budget and Policy Priorities, May 1, 2019, <https://www.cbpp.org/research/health/medicare-is-not-bankrupt>.

Medicare. Opt-out providers may charge whatever they and their Medicare patients agree to through a private contract; Medicare pays nothing, and the patient must pay the entire amount.

The Medicare law protects beneficiaries from excessive charges by limiting private contracting in several ways. Physicians who wish to opt out of Medicare must do so for all patients and all services, and they cannot return to Medicare for two years.⁸ Physicians may not contract with patients who are experiencing a medical emergency or are eligible for Medicaid. Relaxing any of these restrictions on private contracting would make it easier for physicians to opt out of Medicare, subject Medicare beneficiaries or the Medicare program to higher costs, reduce access to doctors by low- and moderate-income beneficiaries who could not afford to pay the higher charges, and lead to the development of a two-tier Medicare system. Beneficiaries could also receive surprise medical bills if they signed a private contract without fully understanding its implications.

Moving Toward Premium Support

Another ambiguous but possibly far-reaching provision of the executive order directs the HHS Secretary to study and recommend approaches to move “toward true market-based pricing in the FFS Medicare program,” including “competitive bidding in FFS Medicare.” On the one hand, this language may merely reiterate the idea of paying providers in traditional Medicare at MA rates, in those instances when they are lower, as previously discussed. On the other hand, it may signal a move towards premium support.

Premium support would replace Medicare’s guarantee of health coverage with a flat payment, or voucher, that beneficiaries would use to purchase either a private health insurance plan or a version of traditional Medicare. The voucher’s value would depend on insurers’ bids, including that of traditional Medicare, which would be treated as a competing plan. As a result, the impact on individual beneficiaries would differ significantly depending on whether traditional Medicare or private plans provided less costly coverage in their area of the country, as well as on the details of the proposal. In general, however, premium support would substantially increase premiums for traditional Medicare and thereby push many beneficiaries out of traditional Medicare and into a private plan.⁹

Conservatives, notably former House Speaker Paul Ryan, have long promoted premium support. Although full-scale implementation would require legislation, the Administration could conduct an extensive demonstration through the Center for Medicare and Medicaid Innovation.

Allowing Beneficiaries to Opt Out

Another portion of the executive order would allow seniors to opt out of the HI portion of Medicare (Part A) without giving up their Social Security benefit, thereby threatening the universality of the program, which is vital to preserving its solvency and popularity.

⁸ Cristina Boccuti and Tricia Neuman, *Private Contracts Between Doctors and Medicare Patients: Key Questions and Implications of Proposed Policy Changes*, Kaiser Family Foundation, January 2017, <https://www.kff.org/medicare/issue-brief/private-contracts-between-doctors-and-medicare-patients-key-questions-and-implications-of-proposed-policy-changes/>.

⁹ Congressional Budget Office, *A Premium Support System for Medicare: Updated Analysis of Illustrative Options*, October 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53077-premiumsupport.pdf>.

At present, a person age 65 or older who is receiving Social Security is considered as having applied for Medicare Part A as well. In a 2012 decision, the U.S. Court of Appeals for the D.C. Circuit held that a Social Security beneficiary who is 65 or older is also entitled to Medicare Part A and cannot decline that entitlement. The court found that this result is required by the Social Security Act and rejected a minority view that HHS had incorrectly interpreted the law.¹⁰

The executive order directs the HHS Secretary to “revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A.” Those most likely to opt out would likely be healthier and wealthier than average.

Other Administration Policies Threaten Medicare

The Trump Administration is also pursuing other policies that put Medicare beneficiaries at risk.

Striking Down the ACA

The administration has joined 18 Republican attorneys general in asking the courts to invalidate the entire ACA. If it succeeds, Medicare beneficiaries, providers, and plans could face severe harm.¹¹

Striking down the ACA, as the Department of Justice asks, would reopen the Medicare drug “donut hole,” reintroduce cost sharing for preventive services, and create confusion and uncertainty around payments to plans and providers.

Striking down the ACA would also greatly weaken Medicare financing. The ACA extended the solvency of the HI trust fund by about eight years and eliminated more than three-quarters of its long-run shortfall. Invalidating the ACA would also eliminate the Center for Medicare and Medicaid Innovation, the driver of administration policies that can strengthen Medicare, such as reforming payments for dialysis care.

Lowering the Poverty Line

The Trump Administration is considering a change to the federal poverty line that would cut benefits for low-income Medicare beneficiaries. The Office of Management and Budget has requested comments on updating the Census Bureau’s poverty thresholds using an alternative, lower measure of inflation than the traditional Consumer Price Index. That change would lower the poverty line by growing amounts each year relative to the current approach. It would ultimately cause hundreds of thousands to lose access to the Medicare Part D Low-Income Subsidy, which helps them afford prescription drugs. Hundreds of thousands of seniors and persons with disabilities would also lose help paying their Medicare Part B premiums and cost sharing.¹²

¹⁰ U.S. Court of Appeals, District of Columbia Circuit, *Hall v. Sebelius*, February 7, 2012, <https://caselaw.findlaw.com/us-dc-circuit/1593485.html>.

¹¹ Paul N. Van de Water, “Striking Down ACA Would Weaken Medicare,” Center on Budget and Policy Priorities, July 8, 2019, <https://www.cbpp.org/blog/striking-down-aca-would-weaken-medicare>.

¹² Aviva Aron-Dine *et al.*, *Administration’s Poverty Line Proposal Would Cut Health, Food Assistance for Millions Over Time*, Center on Budget and Policy Priorities, June 18, 2019, <https://www.cbpp.org/sites/default/files/atoms/files/6-18-19pov.pdf>.

Weakening the Hospital Insurance Trust Fund

Actions already taken by the Administration and Congress in 2017 and 2018 have also weakened the HI trust fund. By cutting tax rates, the 2017 tax law reduced income taxes on Social Security benefits, part of which go to the trust fund. Repealing the tax penalty for failing to get health insurance (also part of the tax law) will increase the number of uninsured and increase Medicare payments for uncompensated care. The Bipartisan Budget Act of 2018, meanwhile, repealed the Independent Payment Advisory Board, an important tool for slowing Medicare's cost growth.