



Issue Brief

Medicare Advantage: A Windfall For Insurers; Downfall for Beneficiaries

August 2007

Introduction

Nearly 44 million Americans are Medicare beneficiaries. Although 80 percent receive their health care services through the traditional Medicare program, about one in five—8.7 million—receive care through Medicare Advantage (MA) plans. The government pays MA plans, on average, 12 percent more than the cost for the same beneficiary would be under traditional Medicare, contributing to a rapid rise in the number of plans. In turn, aggressive marketing and the offer of benefits not available under traditional Medicare promote an upsurge in the number of enrollees in such plans. Overpayments to some plans exceed 50 percent. Overpayments to Medicare Advantage plans cost every Medicare beneficiary at least \$2 extra per month in Part B premiums, have a deleterious effect on the solvency of the Medicare trust fund, and promote inequality of benefits among Medicare beneficiaries in what is intended to be a uniform, national program based on social insurance principles.

This issue brief from the Alliance for Retired Americans Educational Fund (ARAEF) provides an overview of the shortcomings of Medicare Advantage plans overall and of the fastest growing of MA plan types, the Private Fee-For-Service (PFFS) plans, in particular. PFFS plans are overpaid as much as 19 percent and are exempt from many legislative and regulatory requirements imposed on other MA plans. Legislation introduced in the 110th Congress addresses many of the shortcomings and includes improvements to benefits in traditional Medicare.

The brief should be read in conjunction with another ARAEF issue brief on Medicare privatization: *Medicare Under Attack: Will Privatizing Measures Destroy the Program?*

Background

Where did Medicare Advantage plans come from? The name is new but they are actually the successors to the failed Medicare+Choice program, created in 1997.

Managed care health plans such as health maintenance organizations (HMOs) have been an option in Medicare since 1976, but few plans participated until the Balanced Budget Act (BBA) of 1997. Originally, plans were paid a capitated (a flat amount per enrolled beneficiary) rate, which was ninety-five percent of the average per beneficiary cost in Medicare. The idea of “managed care” was that the savings achieved by operational efficiencies would allow plans to offer more benefits. In the BBA, Congress created Medicare+Choice as Part C in Medicare in an attempt to bring the rising costs of the Medicare program under control. New plan types such as preferred provider organizations (PPOs), provider sponsored organizations (PSOs), Medical Savings Accounts (MSAs), and private fee-for-service (PFFS) were added as alternatives to the HMO option, but HMOs continued to be the leading choice. (See the chart on next page for description of types of managed care plans in Medicare.) After an initial spurt, the growth in Medicare managed care declined by 2001 due, in part, to constraints in growth in Medicare payments generally. Plans began to withdraw, blaming the payment rate as insufficient. The exodus of plans left hundreds of thousands of beneficiaries feeling stranded and betrayed.

The 2003 Medicare Prescription Drug, Improvement and Modernization Act (MMA) included favorable payment structures for Medicare Part C plans, changed the name from Medicare+Choice to Medicare Advantage and added two new delivery systems: Special Needs Plans (SNPs), and Regional PPOs.

Since MMA, the number of MA contracts has doubled, rising from 300 plan contracts in 2004 to 602 in 2007. The growth in enrollment matches the plan growth. In 2003 and 2004, MA plans accounted for 11 percent of enrollment in Medicare; in 2007 it is nearly 20 percent and is projected to be 27 percent by 2016. Over half (53 percent) of MA enrollment is concentrated in four organizations: UnitedHealth Care; Blue Cross/Blue Shield affiliates; Humana Inc.; and Kaiser Permanente.

Why the Rapid Growth in Medicare Advantage Plans?

The growth is largely attributed to higher payments from the Medicare Trust Fund to private MA plans. An analysis by the Medicare Payment Advisory Commission (MedPAC), the independent body that advises Congress on Medicare, shows that Medicare payments on behalf of enrollees in MA plans generally average 112 percent of the cost of serving the same beneficiary in traditional Medicare; PFFS plans are paid, on average, 119 percent of the cost to traditional Medicare.

The Alphabet Soup of Medicare Advantage Plans

MA. Medicare Advantage. Managed care plans under Part C of Medicare offered by private insurers. Predecessor was called Medicare+Choice. The following are types of MA plans.

HMO. Health Maintenance Organization. Managed care plan primarily owned and operated by insurers that acts as both insurer and provider of health care services to enrolled population.

MSA. Medicare Medical Savings Account. A high deductible MA plan combined with a medical savings account for medical expenses.

PFFS. Private Fee-For-Service. Health insurance plan that decides how much it and beneficiary will pay. Does not have restrictions required of other MA plans. Providers are reimbursed at same rate as Medicare.

PPO. Preferred Provider Organization. A group of physicians and doctors that contract with an insurer to offer services at negotiated rates that are lower than those charged to non-enrollees.

PSO. Provider Sponsored Organization. Managed care plan owned and operated by providers.

Regional PPO. PPO that is provided in one or more entire regions. These plans receive additional payments through a “stabilization fund” beyond the regular payments they receive.

SNP. Special Needs Plan. Plan that provides health care for specific groups of people, such as those dually eligible for Medicare and Medicaid, nursing home residents, or those with certain severe and disabling conditions.

The MMA instituted a bidding process to determine payments to MA plans. MA plans (other than regional PPOs) bid against county level benchmarks established by the Centers for Medicare & Medicaid Services (CMS). If a plan’s bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium. If the bid is lower, the Medicare program retains 25 percent of the savings and the plan gets the other 75 percent, which should be returned to the enrollees in the form of additional benefits or lower Part B or D premiums.

Understanding the Risks When Choosing a Medicare Advantage Plan

If you are a Medicare beneficiary contemplating joining a MA plan, you should consider the following:

Your costs may be greater than traditional Medicare. Although MA plans must provide a benefit package that is at least as good as Medicare's, they do not have to cover every benefit in the same way. Some plans may require a higher co-payment, or they may place limits on the frequency of services, leaving the enrollee to pay full price beyond the limit. You must also pay more for out-of-network services.

There is no guarantee that the plans offer more than Medicare offers. Medicare officials admit that they have no process to determine whether any MA plan actually provides additional benefits to enrollees.

You may not be able to get emergency or other care when you need it. If you are traveling and need emergency care outside the plan's network, you may be denied reimbursement for any claims for that care. Additionally, there may be limitations on your access to specialists or the facilities where care can be received. Although plans may promise to coordinate your care, little evidence exists of whether they do and whether such coordination results in better outcomes for enrollees.

Your doctor may not be in the plan or accept it. Most MA plans have a network of providers and your doctor may not belong. Or, you may find that your doctor or hospital does not accept the plan you have chosen.

You have little protection from fraudulent marketing. Nearly 80 percent of states report complaints of deceptive or high-pressure sales tactics by plan agents. Yet the MMA significantly limits the ability of states to regulate these practices.

MA plans can change from year to year. Plans may revise what benefits they offer each year and the out-of-pocket costs an enrollee must pay. Or, your plan could merge with another plan and services that were previously available to you might not be covered by the new plan. Once you enroll in a plan, you are "locked-in" for a year.

MA plans may withdraw altogether. Although they currently receive substantial subsidies from the government, experience has shown that private insurers will not stay in the business of offering their plans if they are not making a profit. Traditional Medicare, however, will always be there for you.

However, although they receive higher payments there is no guarantee the plans are spending them on beneficiaries. CMS officials admit that they have no system for holding plans accountable for providing the additional benefits they are required to offer to enrollees. Plans invest heavily in marketing and enrollment, have significant administrative costs and, as for-profit businesses, are motivated to show a profit.

According to MedPAC, this current payment approach for MA plans does not promote efficiency. The commission called for financial neutrality or equality between payments under traditional Medicare and payments to private plans.

MA plans must cover everything that Medicare covers but they are not required to cover services in the same way. Since they have the flexibility, plans design benefit packages to entice healthy Medicare beneficiaries to enroll and deter those who are sicker and more costly. Thus, they may charge higher cost-sharing than traditional Medicare or limit frequency of some services such as home health care, hospitalizations, nursing home care, chemotherapy, and durable medical equipment through utilization management techniques such as prior authorization.

Private-Fee-for Service (PFFS) Plans at a Glance

The number of plans and enrollees have surged since the 2003 Medicare Modernization Act was enacted.

They are paid 19 percent more than what traditional Medicare would pay for the same enrollee.

Unlike most other Medicare Advantage plans, they:

- Do not have provider networks (but not all providers accept PFFS coverage)
- Are not required to have quality and utilization review policies
- Are not required to offer the Part D prescription drug benefit
 - If they do offer a Rx benefit, they are not required to negotiate drug prices with manufacturers, and
 - They do not have to have drug utilization or medication therapy management programs
- Are not required to conduct a baseline health assessment of enrollees
- Are not required to coordinate care, and
- Their enrollees are not permitted to purchase a Medigap plan to supplement their cost-sharing.

Private Fee-For-Service Plans

Although they make up just 18 percent of all MA enrollment, the growth of PFFS plans is 30 times that of other MA plans. The enrollment growth for HMOs and PPOs between December 2005 and February 2007 was 18 percent; for PFFS plans, the growth rate was 535 percent over the same period.

PFFS plans had fewer than 20,000 enrollees in 2001, rising to 200,000 enrollees at the end of 2005, and jumping to 1.6 million by June 2007, with 700,000 added in the first half of 2007 alone. All Medicare beneficiaries have access to a PFFS plan in 2007.

PFFS enrollment is concentrated in six plan sponsors, with over half in Humana (42 percent) and BlueCross BlueShield of Michigan (11 percent). Other dominant plan sponsors are United Healthcare-Pacificare, WellPoint, Universal American and Coventry.

<p>The enrollment growth for Medicare Advantage HMOs and PPOs between December 2005 and February 2007 was 18 percent; for PFFS plans, the growth rate was 535 percent.</p>

What Is the Attraction of PFFS?

For Beneficiaries. These plans potentially offer a greater choice of providers than beneficiaries will find in other MA plans such as HMOs or PPOs because they are not confined to provider networks as the others are. This is particularly attractive in rural areas that may not be able to support provider networks. Enrollees typically pay the same monthly Part B premium as under traditional Medicare and may also pay an additional premium.

However, although the law requires that the extra payments to plans and the additional premiums should generate more benefits for enrollees, there is no system to verify that such benefits are delivered, a fact that CMS admits.

For Plans. The MMA boosted payment rates providing an incentive to establish plans. PFFS plans have to meet fewer requirements than other MA plan types (See Chart *PFFS Plans at a Glance*). The PFFS plans do not have to establish provider networks so there is flexibility in establishing plans and they can be made available to nearly all Medicare beneficiaries. Although the MMA requires most MA plans to offer the new Medicare prescription drug benefit, PFFS plans were explicitly exempted from the requirement and they are not required to have quality and utilization review policies. If they do offer a Part D

benefit, they do not need to negotiate drug prices with manufacturers in order to provide discounted prices to members. They do not have to maintain a drug utilization management program nor a medication therapy management program. Additionally, they do not need to ensure that services are accessible to members with diverse cultural and ethnic backgrounds nor do they have to coordinate care.

For some insurers, PFFS plans could serve as a foundation for gradually moving enrollees into more complex and expensive plans with higher profit potential.

Reining In Medicare Advantage Plans

The problems with MA plans are multi-faceted:

Fraudulent enrollment and misrepresentation of benefits. Aggressive marketing has led some Medicare beneficiaries to join a plan without fully understanding that they did enroll and thus left traditional Medicare. In addition, beneficiaries may not realize that they may no longer have access to all Medicare-participating doctors and other health care providers. A recent survey found that 37 of 43 states reported complaints of inappropriate or confusing marketing practices. Compounding the situation, the MMA limits state regulation of private Medicare plans.

Shortfalls of plans, particularly PFFS. PFFS plans are not required to provide the prescription drug benefit (Part D) as other MA plans are. In 2006, about half of PFFS plans did not offer the prescription drug benefit. Additionally, PFFS enrollees are not permitted to purchase a Medigap plan to supplement their cost-sharing requirements. Providers, such as doctors and hospitals, are not required to accept enrollees of PFFS plans even if they accept patients enrolled in traditional Medicare.

Beneficiary confusion about what benefits are covered and to what extent. As with the stand-alone drug plans, it can be challenging for beneficiaries to compare plan offerings and choose the plan that is best for them. Co-payments for routine services may be lower than in traditional Medicare, but may be higher for services used by frailer or sicker enrollees or those with chronic conditions. If enrollees travel to another county or part of the country, they may find they cannot obtain coverage if they are out of the plan network.

Quality of Care. The quality of care varies across plans. There is no evidence that plans provide higher quality of care than traditional Medicare. The head of the Congressional Budget Office (CBO) has said that the limited quality

measures available suggest that even with higher payments, MA plans are not delivering a sufficiently higher quality of care.

Inequality among beneficiaries. MA plans will receive several billion dollars in overpayments this year alone. These payments raise the costs for taxpayers, for the rest of the Medicare program and for beneficiaries who are not in MA plans. The method of payments increases Part B premiums that are paid by all beneficiaries. If the inflated payments were equalized with traditional Medicare, the Part B premium could be reduced by \$2 per month per beneficiary. In addition, the MA plans create a system of inequity in the type of services Medicare beneficiaries receive. Plans have a financial advantage over Medicare that allows them to offer extra benefits that those in traditional Medicare don't have.

Cost to program. According to the Congressional Budget Office, increased payments to MA plans are a threat to Medicare's financial future. Overpayments will amount to \$54 billion over the next four years and \$149 billion over ten years. These accelerate depletion of the Medicare Trust Fund by two years.

Legislative Repairs

On August 1, 2007, the U.S. House of Representatives passed the Children's Health and Medicare Protection Act of 2007 (CHAMP, H.R. 3162) to address many of the flaws of the Medicare Advantage program and improve benefits in traditional Medicare.

Among reforms to the Medicare Advantage program, H.R. 3162 would:

- reduce MA plan payments over four years until they are equal in costs to Medicare, thereby reducing Part B premiums for all beneficiaries and saving billions of dollars for the Medicare Trust Fund;
- eliminate the remainder of the Regional PPO stabilization fund;
- eliminate special treatment of PFFS plans; and
- increase state regulation of MA marketing practices.

Among Medicare beneficiary improvements, H.R. 3162 would:

- protect MA enrollees from higher cost-sharing than is allowed in traditional Medicare;

- prohibit Part D enrollees from being locked into their plan if the formulary is changed;
- provide protections for low-income beneficiaries such as:
 - adjusting the asset test for eligibility for the Medicare Savings and Low-Income Subsidy (LIS) programs
 - allowing enrollment in LIS at any time without penalty
 - limiting out-of-pocket spending for vulnerable individuals, and
 - expanding and making the Qualified Individual (QI) program permanent;
- add coverage and waiver of cost sharing and deductibles for preventive and essential screening services;
- reduce the coinsurance for mental health services; and
- allow coverage of currently excluded drugs under MMA such as benzodiazepines, a class of drugs used to manage medical conditions such as anxiety disorders and seizures.

Other provisions would repeal sections in the MMA that will undermine Medicare such as an arbitrary 45 percent limit on general revenue funding of Medicare, and a demonstration project beginning in 2010 that throws Medicare into competition with private plans.

Conclusion

Medicare Advantage plan overpayments promote privatization and fragmentation that undermine the fundamental structure of the Medicare program as a uniform national benefit on the social insurance model. Ultimately, payments and overpayments to private plans, whether to stand-alone drug plans or Medicare Advantage plans, lead or push the Medicare population into a multitude of private health plans with disparate benefits.

Privatization of Medicare should raise alarm bells around the country. Policy makers should be on notice that they are tampering with a national treasure. Rather than perniciously dismantling the program that provides critical health security for the nation's older and disabled populations, they should focus instead on shoring up Medicare and improving the program with a comprehensive benefits package.

Resources

Center for Budget and Policy Priorities. Informing the Debate About Curbing Medicare Advantage Overpayments. July 19, 2007.

Congressional Budget Office.

Medicare Advantage: Private Health Plans in Medicare. Report. June 28, 2007 and testimony by CBO director, Peter Orzag, before the House Budget Committee. June 28, 2007.

Kaiser Family Foundation publications at www.kff.org/medicare

An Examination of Medicare Private Fee-for Service Plans, March 2007

Medicare Advantage Fact Sheet, July 2007

Medicare Advantage: The Role of Private Health Plans in Medicare, a

KaiserEduTutorial. July 2007

Medicare Payment Advisory Commission. Report to the Congress: Promoting Greater Efficiency in Medicare. June 15, 2007.

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