

The Public Cost of Privatized Medicare

*How Medicare Advantage
is hurting Medicare beneficiaries
and other Vermont taxpayers*



Prepared by USAction Education Fund

June 2007

The Public Cost of Privatized Medicare

\$600,000 in Industry Subsidies from Vermont

Vermont Medicare beneficiaries Pay \$1.5 million in extra premiums

Medicare is privatizing, and it is costing U.S. taxpayers billions. Private Medicare plans (known as “Medicare Advantage” or “MA” plans) have grown rapidly in the past several years. Today, about 8.5 million Medicare beneficiaries nationwide are enrolled in some form of private Medicare plan – nearly 20 percent of all Medicare beneficiaries, and a 60 percent increase from 2003. This growth is the result of decisions Congress and the Bush Administration made as part of the 2003 Medicare Modernization Act (MMA), which substantially increased subsidies to private insurance companies and has accelerated the privatization of the Medicare system.

Private plans in Medicare were first introduced in the early 1980s. Initially, private plans were promoted as a way to save money for both beneficiaries and taxpayers. In theory, plans would be able to negotiate lower rates with health care providers by promising them a steady stream of patients. In addition, managed care offered the potential of better-coordinated patient care than the traditional fee-for-service Medicare system, which could lead to improved health outcomes and increased savings.

In reality, however, private Medicare plans have never saved money compared to traditional Medicare. Today, on average, Medicare Advantage plans receive a payment of 12 percent more per member than it would cost to provide care for that person in traditional Medicare. Taxpayers are paying billions of dollars to maintain these overpayments while seniors and others in Medicare are paying millions more in inflated Medicare premiums.

This problem is especially serious this year, as Congress looks to expand health coverage for low-income children and seniors while maintaining tight fiscal discipline. Overpayments to private Medicare plans need to be rolled back. Private plans can exist in Medicare, but only if they are willing to compete on a level playing field, without the additional billions in taxpayer subsidies.

How is Medicare Advantage different than traditional Medicare?

Medicare Advantage differs from traditional Medicare, both in how it serves beneficiaries and how it is financed. In traditional Medicare, beneficiaries can go to any provider who accepts Medicare; their health care providers bill Medicare directly. In Medicare Advantage, a plan usually limits a beneficiary’s choice of providers, and may alter the existing Medicare benefits package. While plans may provide benefits beyond what is covered by traditional Medicare, they also are permitted to scale back existing Medicare benefits or increase the cost-sharing related to such benefits. The government pays a plan a flat rate per beneficiary, which varies by county.

Medicare Advantage includes several different kinds of private health care plans: HMOs, which typically have relatively tight provider networks; PPOs, which have looser provider networks; and a new type of plan that has grown rapidly since 2005, Private Fee-for-Service (PFFS). PFFS plans do not have a provider network and are not required to coordinate members' care.

Private Plan Overpayments Burden Taxpayers

The Medicare Payment Advisory Commission (MedPAC), a non-partisan organization created by Congress to advise it on Medicare issues, and the Congressional Budget Office both estimate that nationwide, Medicare Advantage plans are paid on average 12 percent more per person than it would cost to provide the same care to a beneficiary in traditional Medicare. According to MedPAC, PFFS plans are paid an even higher overpayment rate of 19 percent per person.¹ CBO estimates that the overpayment levels are expected to rise over time.

Each payment to a plan is determined by a complicated formula that determines the payment rate for each county in the United States.

A portion of the overpayments to private plans must be passed along to MA beneficiaries, in the form of either added benefits and/or reduced premiums or cost sharing. But MA companies also retain a substantial and unspecified share of the overpayment for agent commissions, marketing, and profits – costs which the traditional Medicare program does not incur.

MedPAC has recommended equalizing the reimbursement rate for MA plans with that of traditional fee-for-service Medicare. MA plans would still be welcome to participate in Medicare and compete with the traditional program, but they would do so on a level playing field. The Congressional Budget Office estimates that equalizing these payments would save the government \$54 billion over five years (2008-2012) and \$149 billion over 10 years (2008-2017).²

Plan Overpayments Cost Beneficiaries and Medicare Itself³

The overpayments to MA plans also cost the majority of Medicare beneficiaries who remain in traditional Medicare. Subsidies to plans increase the cost of the Medicare Part B premium that most beneficiaries pay. Each beneficiary in traditional Medicare pays \$24 more in Part B premiums each year to finance overpayments to MA plans.⁴ These costs will increase in the future if health care costs, the size of the overpayment, and Medicare Advantage enrollment increase as predicted.

The Burden in Vermont

Payment rates to Medicare Advantage plans vary across states and from county to county, based on a complex formula created by Congress. The amount of overpayments depends on these payment rates, and the number of beneficiaries enrolled in a plan. As Medicare Advantage enrollment has risen over the past two years, the amount of overpayments has grown as well.

Overpayments to Plans

In Vermont, MA plans are overpaid an average of 17.0 percent per enrollee. This means it costs \$1,143 more per year for every person enrolled in an MA than it would cost to provide care for that person in traditional Medicare. Based on January 2007 enrollment in MA plans, this amounts to an overpayment of \$600,000 to private plans for Vermont alone.

State	Average Extra Payment Greater than Traditional Medicare	Average Extra Payment per Medicare Advantage Enrollee, 2007	Total Overpayment to Private Plans, 2007
Vermont	17.0%	\$1,143	\$600000

Source: Brian Biles et al, *The Cost of Privatization: Extra Payments for Medicare Advantage Plans* (updated for 2007). See methodology for details.

Additional Part B Premiums

While most of Vermont's Medicare beneficiaries remain in traditional Medicare, they also pay higher Part B premiums to subsidize private Medicare plans – to the tune of \$24 per person per year. This \$24 per person adds up quickly. Roughly 64,000 Vermont seniors and people with disabilities⁵ are paying a total of more than \$1.5 million in additional Part B premiums to subsidize private Medicare plans.

State	Number of Beneficiaries Paying Additional Premiums	Total Additional Part B Premiums Paid, 2007 (millions)
Vermont	64,000	\$1.5

See methodology for sources.

Do MA Plans Help Minorities and Low-Income Beneficiaries?

Defenders of Medicare Advantage claim that their subsidies are worthwhile because the plans provide extra benefits to plan members. In particular, they argue that MA plans are particularly beneficial to minority and low-income beneficiaries, because the additional benefits in MA plans provide an affordable way to supplement traditional Medicare. But

at the same time MA plans also can scale back existing Medicare benefits. For example, plans appear to have designed their benefits in a way to discourage enrollment by beneficiaries in poorer health, by charging higher co-payments for hospital coverage, home health and chemotherapy drugs than under regular Medicare.

Minority and low-income beneficiaries are not disproportionately served by MA plans. In fact, whatever additional benefits Medicare Advantage plans provide are poorly targeted to reach those who need them. More than 80 percent of all Medicare beneficiaries are enrolled in traditional Medicare. The vast majority of all seniors, both whites and minorities, are enrolled in traditional Medicare, not Medicare Advantage. Among seniors, 3 out of 4 Hispanic seniors, and more than 4 out of 5 African-American, Asian and white seniors are in traditional Medicare.⁶ Most seniors, therefore, pay higher Part B premiums to subsidize Medicare Advantage plans, but receive no benefits themselves.

Similarly, Medicare Advantage is not a significant help for low-income seniors. Medicaid, not Medicare Advantage, is the main source of additional coverage for people with limited incomes. Among seniors with incomes under \$10,000 a year, 48 percent have Medicaid coverage, while only 10 percent are in an MA plan.⁷

Do MA Plans Treat People Fairly?

The fastest growing form of Medicare Advantage plan is Private Fee-for-Service (PFFS). Enrollment in these plans increased by almost 600 percent in the past 18 months, from 200,000 in late 2005 to 1.3 million in January 2007. These plans, which have exponentially swelled in rural areas, are not managed care plans like HMOs or PPOs. Instead, they provide uncoordinated fee-for-service benefits, but at a higher cost than traditional Medicare. These plans do not have formal provider networks, do not negotiate reduced rates with providers, and do not have to report data about the quality of their services. There is no evidence that these plans can save money or provide any better care than does traditional Medicare. In some cases, beneficiaries with serious medical conditions may find themselves facing significantly higher costs than they would have under traditional Medicare.

Moreover, many beneficiaries appear also to have received false or misleading information when joining a Medicare Advantage plan, without understanding the limitations of their new plan. Medicare Advantage plans offer generous commissions to agents and brokers who sign up members for their plans – commissions may be five times higher for a Medicare Advantage enrollment compared to an enrollment in a stand-alone Part D drug plan.⁸ Incapacitated, mentally infirm, seniors with limited English proficiency, and even deceased beneficiaries have been signed up in the rush to capitalize on the lucrative Medicare Advantage market.

A recent survey found that 39 of 41 state insurance commissioners surveyed reported receiving complaints about abusive marketing practices directed at Medicare beneficiaries by agents of Medicare Advantage plans.⁹ These beneficiaries can end up in

plans that their doctors do not accept, forcing patients to disrupt their health care. Some plans charge substantially higher cost-sharing for some services, saddling members with large, unexpected medical bills.

How to Do Better

Congress has the opportunity to both fix the subsidies that are privatizing Medicare, and improve health care for low-income children and seniors. Congress is considering significant increases in funding for the SCHIP and Medicaid programs. These increases could go a long way in covering most of the 9 million uninsured children in this country. In addition, Congress is considering improving and expanding Medicare Savings Programs – programs that help low-income Medicare beneficiaries pay their Medicare premiums and cost-sharing. These programs provide vital help directly to beneficiaries who need it most, rather than providing excessive payments to private plans that may eventually trickle down to some beneficiaries.

Funding these improvements will not be easy. Congress needs to consider several sources of funding, including reducing the overpayments to Medicare Advantage plans. Bringing these overpayments in line with traditional Medicare, as recommended by non-partisan experts like MedPAC, would serve several purposes. It would provide much-needed funding to help uninsured children and low-income Medicare beneficiaries. It would also stop the dangerous and costly privatization of Medicare, which is undermining the system on which millions of seniors and people with disabilities rely.

Methodology

State-specific estimates of the amount and rate of Medicare Advantage overpayments for 2007 are drawn from updates to Brian Biles et al., *The Cost of Privatization: Extra Payments to Medicare Advantage Plans – Updated and Revised* (New York: The Commonwealth Fund, November 2006). The updated figures are based on February 2007 enrollment and 2007 payment rates, and are available from the study's authors.

Estimates of the number of beneficiaries paying additional Part B premiums paid by beneficiaries in traditional Medicare are based on 2005 Medicare beneficiary enrollment by state. Those in Medicare Advantage in 2007 were subtracted. Also, dual eligibles in each state were not included because they do not pay Part B premiums out of pocket. Data on overall Medicare, MA, and dual eligibles enrollment are from Kaiser State Health Facts Online, available at www.statehealthfacts.kff.org. In addition, approximately 2.5 million working aged beneficiaries do not pay Part B premiums. State-by-state figures of the number of work aged beneficiaries are not available. To approximate the impact of the work aged exemption, a uniform ratio of 5.7% of Medicare beneficiaries in each state were not included. Because overall state enrollment is based on 2005 Medicare enrollment, the number published here is likely an underestimate of the number of beneficiaries subject to additional Part B premiums.

¹ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: Medicare Payment Advisory Commission, March 2007).

² Peter Orzag, *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects* (Washington: Congressional Budget Office, April 11, 2007) (testimony to the Senate Finance Committee).

³ Overpayments to MA plans place a burden on the Medicare program as a whole. Medicare's Hospital Insurance trust fund is projected to be insolvent by 2019. Extra payments to private plans draw down the trust fund prematurely. At current levels, they are shortening the life of the Medicare Hospital Insurance Trust Fund by two years.³ Just reducing MA payments to the level of traditional Medicare would extend the Medicare trust fund's life to 2021.

⁴ Testimony of Richard Foster, CMS Chief Actuary, before the House Ways & Means Subcommittee on Health, April 25, 2007.

⁵ This total does not include dual eligibles whose Part B premium is paid by Medicaid, or a small number of working aged who do not pay Part B premiums. See methodology for details.

⁶ AHIP Center for Policy and Research, *Low-Income and Minority Beneficiaries in Medicare Advantage Plans* (Washington: AHIP Center for Policy and Research, February 2007). Enrollment data is from 2004 Medicare Current Beneficiary Survey.

⁷ AHIP Center for Policy and Research, *Low-Income and Minority Beneficiaries in Medicare Advantage Plans* (Washington: AHIP Center for Policy and Research, February 2007). Enrollment data is from 2004 Medicare Current Beneficiary Survey.

⁸ Testimony of Sean Dilweg, Wisconsin Insurance Commissioner, before the Senate Special Committee on Aging, May 16, 2007.

⁹ Robert Pear, "Oklahoma Chides Insurer in Medicare Marketing Case," *New York Times*, May 15, 2007.