

Improve the Part D Benefit by Eliminating Large Subsidies to Insurance Companies

http://www.ncpssm.org/news/archive/vp_eliminating/

Some Members of Congress have held the extreme view that the Medicare program should be allowed to “wither on the vine”. One way to accomplish this goal is to siphon certain groups of beneficiaries out of the traditional Medicare program and into private plans. In such a system, healthier and wealthier beneficiaries are pursued by the plans and enticed out of Medicare, while our country's most vulnerable seniors—those who are among the oldest, poorest, and sickest—are left in the traditional Medicare program. The lack of a large and diverse risk pool creates a cycle of increased costs and higher abandonment by healthier seniors, ultimately transforming the traditional Medicare program into little more than a welfare program.

The Medicare Modernization Act of 2003 (MMA) clearly improved the environment for this transformation by substantially increasing government payments to private health plans, boosting their profit margins and laying the groundwork for their continued siphoning off of Medicare's most profitable participants. This uneven playing field makes it impossible for traditional Medicare to compete with the overly-subsidized private plans, hastening the program's inevitable decline.

National Committee Position

Congress should eliminate subsidies to private plans and use the billions of dollars saved to improve the Medicare Part D benefit for seniors. Over the years, proponents of the privatization of government programs have argued that private health and insurance companies can provide health services to seniors less expensively than Medicare, thus saving the federal government money.

However, actual experience with private plans in Medicare has been unequivocal— **private plans do not reduce Medicare's cost, they increase it** . The government's own estimates of the MMA have shown that private plans would cost the program billions of dollars over its first decade alone. For example, the Congressional Budget Office projected that increases in payments to private HMOs under the MMA would cost \$14 billion, while the Medicare Actuary estimated that these overpayments would total \$46 billion. Other estimates have been even higher. Removing these overpayments would generate substantial savings that could be used to improve the Part D benefit by reducing costs to seniors, including the notorious “coverage gap” or “donut hole” that requires beneficiaries to pay 100% of the cost of prescription drugs while continuing to pay full premiums to the private plans. At a minimum, the National Committee recommends the following steps be taken to eliminate overpayments to private plans:

- Pay private plans at the same rate that the traditional Medicare program is paid for covering beneficiaries. This would save \$12.6 billion over five years and \$34.9 over ten years. ¹
- Prevent private plans from receiving reimbursement for double payments for indirect medical education, saving \$2.6 billion over the next five years and \$6.6 billion over ten years. ²
- Eliminate the PPO stabilization fund, thus saving the Medicare program approximately \$5 billion over the next five years and \$10 billion over ten years. ³
- Permanently remove the offset that protects private plans from receiving lower risk-adjusted payments. Estimates show this could save \$22 billion over the next ten years. ⁴

Subsidizing private health plans undermines traditional Medicare and increases costs to seniors.

Ultimately, the substantial overpayments paid to private Medicare plans undermine the financial stability of the Medicare program and increase costs for all Medicare beneficiaries. Due to these overpayments, every person who switches from traditional Medicare to a private plan increases the Medicare program's overall costs. These overpayments to private health plans have already shortened the solvency of the Medicare Federal Hospital Insurance (Part A) trust fund, and will continue to do so in the future. In addition, all beneficiaries—regardless of whether they enroll in a private plan or not—subsidize payments to HMOs by paying higher Part B premiums. In 2006, seniors experienced the second largest Part B premium increase (in dollar terms) in the history of the Medicare program. Medicare Part B premiums increased by 13 percent, or \$10.30, from \$78.20 a month in 2005 to \$88.50 a month in 2006. According to actuaries at the Centers for Medicare and Medicaid Services, almost one-quarter of this premium increase was due to excessive payments to private plans.⁵

Subsidizing private plans exacerbates the fracturing of the insurance risk pool that has been essential to the success of the Medicare program. It creates a downward spiral as increased costs – including the costs of the subsidies themselves – are spread over a pool of seniors that continues to shrink as younger, healthier beneficiaries are enticed into the more profitable managed care plans. Because the subsidies are mostly hidden from view, many seniors are unaware that they are helping pay for the process that is undermining the only universal, affordable health insurance they can rely upon throughout their retirement.

The National Committee strongly believes that beneficiaries who choose to remain in the traditional Medicare program should not be asked to subsidize the inflated costs of private Medicare plans, nor should they unknowingly be required to contribute to the dissolution of the Medicare program. We also strongly believe that traditional Medicare can outperform the private sector when allowed to compete on a level playing field, using the purchasing power of America's 43 million seniors to lower costs, and to create broad risk pools that spread the insurance burden among all beneficiaries. Savings achieved through a strengthened traditional Medicare program should be used to reduce costs to participants or further enhance benefits.

Summary of key private plan subsidies:

Inflated per capita reimbursements:

This type of overpayment results from an inflated payment policy for Medicare Advantage plans in all geographic areas of the country. Medicare is paying Medicare Advantage plans (HMOs) an average of 11 percent more than it would cost to cover the same beneficiaries under the traditional fee-for-service Medicare program. According to an analysis by the Commonwealth Fund, Medicare spent an average of \$800 more on payments to private plans than it spends for an average beneficiary in traditional Medicare.⁶ Congress explicitly designed the MMA to increase these payments to providers.⁷ The National Committee believes program payments should be equal regardless of whether beneficiaries are enrolled in private health plans or in traditional Medicare. Without this financial pressure, private plans have less motivation to improve their productivity and efficiency.⁸

Inflated risk adjustments:

Another type of overpayment results from the failure of the Medicare program to accurately and permanently calculate risk adjustment payments to private plans. Government experts have found that, on average, private plans attract healthier enrollees than the traditional Medicare program. The risk adjustment payment process is intended to ensure that those private plans serving healthier, less expensive beneficiaries also receive

lower Medicare payments, thus reducing any windfall to the private plans. For the past few years, however, the federal government has been providing extra payments to HMOs to reverse the effects of risk adjustment. The Deficit Reduction Act of 2005, which became law earlier this year, temporarily phases out these overpayments over the next five years, but then allows HMOs to receive these overpayments again after the five-year budget window. The National Committee urges Congress to permanently eliminate these overpayments to offset the effects of risk adjustment. Without appropriate risk adjustment, private plans have an incentive to enroll healthier individuals, avoid sicker ones, and stint on care.⁹

Eliminate the “stabilization fund” created to entice PPOs into Medicare:

A third type of overpayment stems from a provision in the MMA that created a \$10 billion “stabilization” fund to benefit regional Preferred Provider Organizations. The goal of the fund was to entice private preferred provider organizations (PPOs) into the Medicare program. From the beginning of 2007 until the end of 2013, the government plans to dole out extra payments to PPOs. Currently, there is heavy PPO participation in the Medicare program without the use of the additional incentives, and it appears unlikely these incentives will be needed to entice PPOs to participate in the program in future years. The nonpartisan MedPAC has also recommended that this stabilization fund be eliminated.¹⁰

Government Relations and Policy, June 2006

1 Congress of the United States, Congressional Budget Office, *Selected Updates to Budget Options*, (Washington, D.C. : March 2005).

2 Note: In some areas, the Medicare program is double paying to cover the indirect costs of graduate medical education because private plans can be paid a higher rate for GME payments even though the program pays teaching hospitals to compensate for their indirect GME costs. This represents another unnecessary overpayment to private health plans giving them an unfair advantage over traditional Medicare. Source: Ibid.

3 MedPAC, *Report to Congress: Issues in a Modernized Medicare Program*, (Washington , D.C. : June 2005) & Congress of the United States , Congressional Budget Office, *Selected Updates to Budget Options* , (Washington , D.C. : March 2005).

4 Note: Although the Deficit Reduction Act of 2005 achieved budgetary savings by temporarily removing these offsets over the next five years, permanently removing them could produce even more significant savings.

Source: Weisman, Jonathan. Washington Post, *Closed-Door Deal Makes \$22 Billion Difference: GOP Negotiators Criticized for Change in Measure on HMOs* , January 24, 2006 & House Budget Committee, Democratic Caucus, *Spending Reconciliation Bill: Harmful Cuts and Fiscal Irresponsibility* (Washington, D.C.: January 31, 2006).

5 Centers for Medicare and Medicaid Services/Office of the Actuary. *Analysis of 2006 Part B Premium Rate Increase* , September, 16 2005.

6 Brian Biles, Lauren Hersch Nicholas, and Stuart Guterman, The Commonwealth Fund, *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal* , (Washington , D.C. : May 2006).

7 Note: According to MedPAC, MA plans receives higher payments than traditional Medicare because: (1) Congress created two “floor rates” to raise provider payments in low-rate counties; and (2) plans receive higher payments to include the costs of indirect medical education even though Medicare already makes payments to teaching hospitals to cover these costs.

Source: MedPAC, *Report to Congress: Issues in a Modernized Medicare Program*, (Washington , D.C. : June 2005).

8 MedPAC, *Report to the Congress: Medicare Payment Policy*, (Washington , D.C. : March 2004).

elimsubsidies.doc

9 &10 MedPAC, *Report to the Congress: Medicare Payment Policy*, (Washington , D.C. : March 2006) & MedPAC, *Report to Congress: Issues in a Modernized Medicare Program*, (Washington , D.C. : June 2005).

The National Committee is a nonprofit, nonpartisan organization that acts in the interests of its membership through advocacy, education, services, grassroots efforts and the leadership of the board of directors and professional staff. The work of the National Committee is directed toward developing a secure retirement for all Americans.