CBO TESTIMONY

Statement of
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The Medicare Advantage Program

before the
Committee on the Budget
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Mr. Chairman, Representative Ryan, and Members of the Committee, I am pleased to appear before you today to discuss the Medicare Advantage program. My testimony focuses on several themes:

- Unexpectedly strong growth in enrollment in the Medicare Advantage program during 2006 and the beginning of 2007 led the Congressional Budget Office (CBO) to increase its projections for both enrollment in and spending on the program.

- Medicare's payments for beneficiaries enrolled in Medicare Advantage plans are higher, on average, than what the program would spend if those beneficiaries were in the traditional fee-for-service (FFS) sector. As a result, shifts in enrollment out of the FFS program and into private plans increase net Medicare spending. Policymakers need to weigh that additional cost against the benefits provided by Medicare Advantage plans.

- The additional cost to the government for Medicare Advantage plans subsidizes the beneficiaries who enroll in such plans, which fuels the plans' growth in enrollment, but also raises costs for the rest of the Medicare program and for beneficiaries who are not in Medicare Advantage.

- The rate of growth in enrollment and the cost differential with the traditional FFS sector are particularly large in private fee-for-service (PFFS) plans, which draw significant enrollment from rural areas.

- Reducing the payment differential between Medicare Advantage and the FFS program could result in substantial savings to the Medicare program but also in a decline in the supplemental benefits and cash rebates that Medicare Advantage plans can offer to enrollees and reduced enrollment in those plans. Lowering payments to those plans would slightly reduce the standard premiums for Part B (Supplementary Medical Insurance) and delay the exhaustion of the trust fund that supports Part A (Hospital Insurance).

- Many Medicare Advantage plans offer disease management, care coordination, and preventive care programs, but little information is available on the degree to which the plans generate better health outcomes than the traditional Medicare program. Expanded reporting of health outcomes would be helpful in assessing the value of the care management services provided by the plans.

- The central long-term fiscal challenge facing the nation involves health care costs. Over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private-sector health markets. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing overall cost growth for health care. A variety of evidence suggests opportunities to constrain health care costs without harming incentives for innovation or Americans' health (and perhaps even improving it). Moving the nation toward that possibility—which will inevitably be an iterative process in which policy steps are tried, evaluated, and reconsidered—is essential to putting the country on a sounder long-term fiscal path. Changes to the Medicare program should be evaluated with that broader perspective in mind.

Background on Medicare Advantage Plans

Medicare provides federal health insurance for 43 million people who are aged or disabled or who have end-stage renal disease. Part A of Medicare covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B of Medicare covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. Home health care is covered by Part A and Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit beginning in 2006 under Part D.

The majority of Medicare beneficiaries receive services through the traditional fee-for-service part of the program, which compensates providers using a set fee for each service or bundle of services. In nearly all areas of the country, however, Medicare beneficiaries have the option of enrolling in Medicare Advantage—the program through which private plans participate in Medicare—rather than receiving their care through the FFS program.[1] As of June 2007, about 18 percent of beneficiaries are enrolled in Medicare Advantage plans, which accept the responsibility and financial risk for providing Medicare benefits.[2] Although the payment system for private plans has been modified several times during the more than 20 years that they have participated in Medicare, a key feature of the system has remained intact: Plans that offer Medicare benefits for less than the amount of their payment from the government are required to return the difference to beneficiaries in the form of additional benefits or, in an option that became available

1. The program through which private plans participate in Medicare is also called Part C. Previously, the Medicare Advantage program was called Medicare+Choice.

2. That figure excludes about 1 percent of beneficiaries who are enrolled in group plans besides Medicare Advantage plans (which include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans).

recently, rebates on their Part B or Part D premiums.[3] Those additional benefits and rebates of premiums are a major incentive for beneficiaries to enroll in Medicare Advantage plans and are particularly attractive to people without Medicaid or employer-sponsored supplemental health insurance.

About 80 percent of the Medicare beneficiaries enrolled in Medicare Advantage are in health maintenance organizations (HMOs) or preferred provider organizations (PPOs).[4] Both HMOs and PPOs have comprehensive networks of providers, but PPOs allow beneficiaries to obtain care outside the network if they pay higher amounts. Some HMOs offer coverage for services received outside their network (and thus resemble PPOs), while others require that their enrollees receive all of their nonemergency care within the network. A key feature of many HMO and PPO plans is the use of care management services that are intended to promote better coordination and more effective use of health care.

The other main type of Medicare Advantage plan is private fee for service. Such plans allow their enrollees to obtain care from any provider who will furnish it and are not required to maintain networks of providers. In contrast to the FFS system, which requires participating providers to accept Medicare's rates for all covered services and all beneficiaries, providers in a private fee-for-service plan can decide each time they see a patient whether to accept the plan's terms of participation and payment rates, which are usually those of Medicare's FFS program. Beneficiaries' copayments and deductibles are generally lower than those in the FFS program, and private fee-for-service plans typically provide significantly less care management and utilization control than do HMOs and PPOs.

In 2007, 82 percent of beneficiaries live in a county served by an HMO or a local PPO, up from 67 percent in 2005.[5] Nearly all beneficiaries who do not have access to a local HMO or PPO have access to a regional PPO (and 99 percent have access to one of the three). All beneficiaries have access to a PFFS plan in 2007, up from 80 percent in 2006 and only 45 percent in 2005.

The Payment System for Medicare Advantage Plans

The latest legislative changes to the payment system for private health plans were enacted in 2003 in the Medicare Modernization Act. The modified payment system is analogous to the previous system, and the incentives facing plans and beneficiaries are similar.

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3. Plans have had the option of giving their enrollees rebates on their Part B premiums since 2003. Since 2006, plans can also offer rebates on the Part D premiums.
4. PPOs in the Medicare Advantage program are either local or regional; regional PPOs, an option that became available in 2006, are required to serve broad regions of the country rather than defining their service areas on a county-by-county basis. About 2 percent of Medicare Advantage beneficiaries are enrolled in regional PPOs.
5. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2007), Chapter 4, "Update on Medicare Private Plans," pp. 237–266.

Since 2006, private plans wanting to participate in Medicare must submit bids indicating the per capita payment for which they are willing to provide Medicare's Part A and Part B benefits.[6] The government compares those bids with county-level benchmarks that are determined in advance through statutory rules. The benchmarks are the maximum payments that the government will make for enrollees in private plans, though bids by and net payments to plans are usually lower than the benchmarks.[7,8]

Under current law, benchmarks are required to be at least as great as per capita FFS expenditures in every county and are higher than FFS expenditures in many counties. For 2007, CBO calculates that benchmarks are 17 percent higher, on average, than projected per capita FFS expenditures nationwide. Net payments to plans will be approximately 12 percent higher than per capita FFS costs. The differential is more pronounced for private fee-for-service plans: According to estimates by the Medicare Payment Advisory Commission (MedPAC), the payments to those plans in 2006 averaged 19 percent above FFS costs.[9] Of that difference, 10 percentage points' worth went to beneficiaries in the form of extra benefits or rebates. In contrast, payments to HMOs averaged 10 percent above FFS costs, MedPAC estimates. On average, HMOs offered extra benefits and rebates equal to 13 percent of FFS costs; those additional benefits reflected the difference between the benchmarks (which averaged 10 percent above FFS costs) and plans' bids (which averaged 3 percent below FFS costs).

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6. Plans must also submit bids for the voluntary prescription drug benefit and their premiums for any supplemental benefits they intend to offer.

7. The description of the MMA payment mechanism in this section pertains to plans that participate in Medicare on a county-by-county basis (or local plans). The payment mechanism for regional PPOs is analogous to the mechanism described here for local plans but uses a modified approach to compute benchmarks. See Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (June 2005), pp. 59–81.

8. The benchmark for a plan that serves more than one county is a weighted average of the county-level benchmarks in its service area (using the plan's expected enrollment in every county as weights). Plans are paid their bid (up to the benchmark) plus 75 percent of the amount by which the benchmark exceeds their bid. Plans must return that 75 percent to beneficiaries as additional benefits or as rebates of their Part B or Part D premiums. Plans whose bid is above the benchmark are required to charge enrollees the full difference between the two as an additional premium for the Medicare benefit package. For 2007, the Medicare Payment Advisory Commission reports that nearly all (99 percent) of beneficiaries have access to Medicare Advantage plans that do not require an additional premium for Parts A and B benefits and any supplemental benefits offered by the plans but not offered by Medicare. See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 248.

9. See Statement of Glen M. Hackbarth, Chairman, Medicare Payment Advisory Commission, *The Medicare Advantage Program and MedPAC Recommendations*, before the Senate Committee on Finance (April 11, 2007), p. 5.

Benchmarks are updated each year by either the growth in national per capita Medicare spending or 2 percent, whichever is greater.[10,11] For 2008, the Centers for Medicare & Medicaid Services (CMS) announced that benchmarks will increase by 3.5 percent.

Medicare also adjusts payments to Medicare Advantage plans to reflect their enrollees' health status. That "risk adjustment" is meant to encourage plans to compete on the basis of efficient delivery of services rather than selective enrollment of healthier beneficiaries. To that end, CMS collects information on the medical diagnoses of every beneficiary and uses it to calculate the relationship between individuals' health and subsequent spending on their behalf for Medicare services and to thereby adjust payments to plans (upward for those with sicker beneficiaries and downward for those with healthier beneficiaries).

In managing the risk adjustment system, CMS has to confront difficult issues of data collection and validity, statistical complexity, and potentially different coding practices between plans and the fee-for-service sector. Each judgment the agency makes for each of those aspects of risk adjustment can increase or decrease payments to Medicare Advantage plans.

Geographic Patterns of Enrollment

The relationship between the cost of offering Medicare benefits and the benchmarks is an important determinant of the types of plans that are available in various areas of the country. To offer a product that is attractive to beneficiaries, a plan

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10. The benchmarks for 2007 were updated from the payment rates for private plans that were established by the Balanced Budget Act of 1997 (BBA) and modified through subsequent legislation. Before the enactment of the BBA, plans were generally paid 95 percent of the local per capita FFS costs. Under the BBA, the payment rate in each county was the greatest of three amounts: a minimum, or "floor," rate; a blend of a local rate and the national average rate; and a minimum increase from the previous year's rate (which was equal to 2 percent in most years). The floor amount established in 1998 ($367 a month that year) was increased each year by the national rate of increase in per capita Medicare spending. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 increased that floor amount to $475 for 2001 and established a $525 floor for metropolitan areas with at least 250,000 residents. Those amounts also were increased each year by the national rate of increase in per capita Medicare spending.

11. The BBA's rules resulted in rates in some counties that were higher—in some cases, by a substantial amount—than local per capita spending in the FFS program. In other counties, however, the update mechanism resulted in payment rates that were lower than local per capita FFS spending. The MMA modified the benchmarks to be the higher of the BBA benchmarks or local per capita spending. The MMA also requires that the government "rebase," or reestimate, per capita FFS expenditures in each county at least once every three years using the most current data available. In those years in which rebasing occurs, the benchmark for each county will be the greater of the rebased per capita FFS expenditures or the update from the previous year's rate. The Centers for Medicare & Medicaid Services rebased the FFS rates in 2004, 2005, and 2007.

must have a cost of offering Medicare benefits that is low enough, relative to the benchmarks, to enable it to provide some combination of additional benefits and cash rebates. Those additional benefits—which are similar to the supplemental benefits offered by private supplemental insurance polices—often include reduced cost sharing for medical services or prescription drugs. They may also include coverage of services that are not covered by Medicare, such as dental care, and they often include disease management, care coordination, and preventive care programs to promote better use of services.

Both the cost of providing benefits, as reflected in plan bids, and the maximum amount Medicare will pay for those benefits, as reflected in the benchmarks, vary greatly among communities. That variation, in combination with characteristics of plans themselves, results in distinctive patterns of enrollment in Medicare Advantage as a whole and among the various types of plans.

Until recently, HMOs and PPOs accounted for nearly all enrollment in Medicare Advantage, and most of that was concentrated in urban and suburban areas. Those plans incur substantial administrative costs to establish and maintain networks of providers, to acquire and maintain enrollment, and to manage utilization. To the extent that they negotiate payment rates with providers that are higher than Medicare's payment rates for services furnished in the fee-for-service sector, those plans may also incur higher costs for medical services. They also have higher administrative costs per enrollee than the traditional Medicare program does because of their smaller scale of operations and their costs associated with network development and retention, care management, marketing, and reinsurance. As a result, private plans must offset their higher costs of operations with savings from lower utilization or reductions in payment rates for providers. The ability of plans to achieve such savings varies greatly among geographic areas.

Previous work by CBO has shown that plans' bids for operating Medicare Advantage plans vary less from county to county than per capita FFS spending does (see Table 1). As a result, in areas with high FFS costs per capita, Medicare Advantage plans' bids are relatively low in comparison with FFS spending, and vice versa. In particular, in areas with the highest per capita FFS spending, health plans' bids are about 9 percent below FFS spending. By contrast, in the lowest-cost FFS areas, health plans' bids are about 16 percent above FFS spending. Benchmark rates in those areas vary in similar fashion, from an average of about 4 percent above FFS costs in high-cost FFS areas to an average of about 26 percent above in low-cost areas.

Most enrollment in HMOs and PPOs tends to be in relatively densely populated urban and suburban areas (where it is easier to establish provider networks) with

Table 1.

Private Plans' Bids for Providing Medicare Benefits Relative to Costs in the FFS Program, 2007

Average per Capita FFS Expenditures in Plans' Service Areas (Dollars)	Difference Between Plans' Bids and per Capita FFS Expenditures (Percent)	Plans' Projected 2007 Enrollment in Category (Percent)
More Than 750	-9	26
700 to 749	1	19
650 to 699	3	25
600 to 649	9	17
Less Than 600	16	13
National Average	2	100

Source: Congressional Budget Office based on data submitted by private plans to the Medicare program for 2007.

Note: FFS = fee for service.

relatively high benchmarks and generally high per capita FFS spending.[12] Because private plans try to restrain medical costs by managing the level and intensity of service utilization, they have greater potential to achieve savings relative to the FFS program in geographic areas where FFS practice involves relatively high utilization of costly services—which also tend to be areas with high per capita FFS expenditures. Private plans have much less opportunity to achieve such savings in areas where utilization rates for expensive services in the FFS sector are already relatively low.

In contrast to HMOs and PPOs, private fee-for-service plans generally do not incur the costs of establishing and maintaining networks of providers or managing utilization, and the payment rates PFFS plans pay to providers often are the same as Medicare rates. However, PFFS plans incur administrative costs for acquiring and maintaining enrollment, and they do not realize comparable savings from utilization management, which is often cited by supporters as an important public policy benefit from other types of Medicare Advantage plans.[13]

Private fee-for service plans have enrollment that is far more dispersed than that of local HMOs and PPOs, including significant enrollment in rural areas. The rapid growth of those plans increased the market share of private plans in rural areas

12. It is easier for a plan to establish a network in a relatively densely populated area that has a relatively large number of providers than in a more sparsely populated area because the plan's leverage in negotiations with providers (to get them to accept relatively low payment rates and to cooperate with the plan's efforts to manage utilization) is to promise them some volume of business by diverting to them patients from providers who do not participate in the network.

13. Some PFFS plans employ certain utilization controls, such as counseling and monitoring of patients with phone calls from nurses.

from about 4 percent in 2005 to about 7 percent in 2006, and CBO expects that share to continue to grow under current law as private fee-for-service plans play an increasingly large role in Medicare Advantage. They are able to grow in rural areas, first, because they face little competition from other types of private plans there; unlike HMOs and PPOs, they do not require networks of providers, which are difficult to establish in those areas. Second, the rules enabling plans to pay the same rates to providers as Medicare does give them a competitive advantage against HMOs and PPOs, which often pay higher rates than that program does. Finally, benchmarks in rural areas are sufficiently high that private fee-for-service plans are able to offer extra benefits or rebates to attract members even without the cost-reducing tools available to other types of plans (that phenomenon is particularly notable in the rural counties with benchmarks at the floor amounts).[14]

Care Management in Medicare Advantage

Medicare's FFS program provides a generally unmanaged approach to the delivery of medicine because providers are paid for the number and types of services they deliver and not for the quality of the outcomes they bring about.[15] Health plans may be more able to manage care through their knowledge of members' health conditions, contact with providers, and centralized administrative arrangements. Medicare Advantage plans also have a strong incentive to manage care to reduce costs, as any savings that they can generate accrue directly to them and their members. Health plans' various efforts at disease management, care coordination, and preventive care often include:

- Phone calls from nurses or caseworkers to provide reminders and periodic health assessments,
- Health coaches to encourage healthy behaviors,
- Educational programs to teach members and physicians about guidelines for effective treatment, and
- Efforts to connect members with resources in the community.[16]

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14. In 2006, the average benchmark in urban counties with benchmarks at the floor amounts was 121 percent of per capita FFS spending, the benchmark in other "floor counties" (largely rural) was 134 percent, and the benchmark in other counties was 111 percent. (A floor county is paid at one of the two minimum rates established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 and updated each year.) See Medicare Payment Advisory Commission, *Medicare Payment Policy*, p. 244.

15. See Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (June 2006), Chapter 2, "Care Coordination in Fee-for-Service Medicare," pp. 53–80.

16. See Blue Cross and Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management* (February 2007); and America's Health Insurance Plans, *Innovations in Chronic Care* (March 2007).

Some plans also employ more intensive case management services targeted to their most medically complex members. Such programs have the potential to reduce plans' costs to the extent that they eliminate unnecessary services or manage chronic conditions so as to avoid relatively costly episodes, such as extended hospital stays. (Each of the techniques described above can also result in increased costs to plans if they are ineffective.)

Initially, any cost savings that health plans realize (after bids and premiums are set) from such activities accrue entirely to the plans, not to the government. Medicare spending would not be reduced, for instance, if inpatient admissions in Medicare Advantage plans declined in 2007. Plans (except for regional PPOs for a limited period of time) accept the full risk for their beneficiaries, so, within the payment period, they also realize all gains from their medical management strategies.

In the long run, any reductions in cost achieved by health plans should be passed back to the beneficiaries (75 percent) and the government (25 percent) through the operation of the bidding mechanism. If a plan can provide services for a lower cost, it has a strong incentive to reduce its bid in order to increase the extra benefits and rebates that it can use to attract members. Similarly, any care management technologies that cause plans to increase their bids will result in reduced benefits and rebates for beneficiaries and increased costs to the government. Even if improvements in care management yielded significant improvements in efficiency in Medicare Advantage, the government would realize, at most, 25 percent of those savings.

Reporting on Measures of Health Plans' Quality

One possible benefit of the Medicare Advantage program is the higher quality of care beneficiaries may receive through more disease management, care coordination, and preventive care than they would receive in the Medicare fee-for-service program. But the extent to which such services lead to improved health outcomes is difficult to assess with the currently available data. Policymakers may therefore want to explore options for expanded reporting of outcomes.

Some Medicare Advantage plans are required to report on the quality of care they provide, as measured by several surveys administered by the National Committee for Quality Assurance:

- The Health Plan Employer Data and Information Set (HEDIS), which collects information on the quality of care delivered by plans and their affiliated providers;

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS), which collects information on members' experience in interacting with plans and their affiliated providers; and

- The Health Outcomes Survey (HOS), which collects information on the overall mental and physical health of plans' populations.

Some of the information collected is made available to the public through Medicare's "plan finder" Web site and other distribution channels.

The current data sources and reporting requirements, however, do not provide sufficient information to assess whether health plans produce better health outcomes or deliver more cost-effective care than the FFS sector (as indicated by the quality of care per dollar of federal spending). PFFS plans, the fastest growing component of Medicare Advantage, are exempt from many of the reporting requirements, including all HEDIS measures.[17] Furthermore, the measures collected by the HEDIS and CAHPS surveys largely measure the quality of the process of delivering health care rather than the outcomes of that care. Plans are surveyed about their adherence to medical recommendations (for instance, treatment of heart attack patients with beta blockers and management of antidepressants), ability to deliver preventive health services and screenings (for instance, controlling high blood pressure and providing breast cancer screenings), availability of care, and members' perceptions of their responsiveness and accessibility. The HOS collects population-level health information on each plan but does not provide insight into the plans' efficiency of operations.

Though Medicare Advantage plans cost more than care under the FFS program does, on average, they would be more cost-effective if they delivered a sufficiently higher quality of care. The limited measures available suggest that Medicare Advantage plans are no more cost-effective than the FFS program.[18] In addition, the quality measures reported for HMOs and PPOs show dramatic variation in performance between the best- and worst-performing plans.[19] Developing reporting systems to comprehensively measure health outcomes in the Medicare Advantage and FFS programs would be helpful in assessing the value of care management techniques employed by Medicare Advantage plans. Expanded reporting on outcomes would also allow analysis of varying approaches adopted by different plans, which could be a valuable tool in the search for ways to restrain the cost of health care in the United States while maintaining or improving the quality.

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17. PPO plans are also exempt from some reporting requirements. In comparison to HMOs, both PFFS and PPO plans have less access to medical records, making some reporting requirements more difficult for them. All plans are required to report on only a subset of the measures in HEDIS; in particular, plans are not required to report on the cost-of-care measures implemented in recent versions of the survey.

18. See Medicare Payment Advisory Commission, *Issues in a Modernized Medicare Program*, p. 70.

19. See Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 67.

Anticipated Trends in the Medicare Advantage Program

Increasing spending for Medicare Advantage is driven by rapidly increasing enrollment in private plans and is partially offset by decreasing enrollment and spending in FFS Medicare. Payments to Medicare Advantage plans increased from $36 billion in calendar year 2004 to about $60 billion in 2006.[20] CBO projects that those payments will increase to $77 billion in 2007 and $196 billion by 2017 and will total $1.5 trillion over the 2007–2017 period.[21] Because payments to Medicare Advantage plans are higher than payments made to FFS providers, shifts of enrollment to Medicare Advantage plans result in higher net costs for the Medicare program overall. CBO projects that the share of Medicare spending for Part A and Part B benefits that is paid to Medicare Advantage plans will increase from 17 percent in 2006 to 27 percent in 2017.

Increasing Enrollment in Medicare Advantage

In 2003 and 2004, Medicare Advantage plans accounted for 11 percent of enrollment in Medicare, the lowest level since 1996. Over the past two years, however, enrollment in those health plans has increased to about 18 percent of all enrollment, or 8 million beneficiaries.[22] That increase reflects, among other factors, changes enacted in the Medicare Modernization Act that increased payment rates and added the prescription drug benefit to complement the medical benefits provided under Parts A and B of Medicare. CBO projects that, under current law, enrollment in Medicare Advantage will grow at an annual average rate of about 7 percent over the next 10 years, compared with a growth rate of about 2.5 percent for Medicare overall—reaching 21 percent of total enrollment in 2008 and 26 percent by 2017 (see Figure 1).

The projected increase in enrollment in Medicare Advantage is driven largely by CBO's expectation of continuing growth in enrollment in private fee-for-service plans, which rose from 200,000 members at the end of 2005 to nearly 1.6 million members in June (see Table 2). About 700,000 of those members were added in 2007. CBO projects that enrollment in PFFS plans will reach 5 million members

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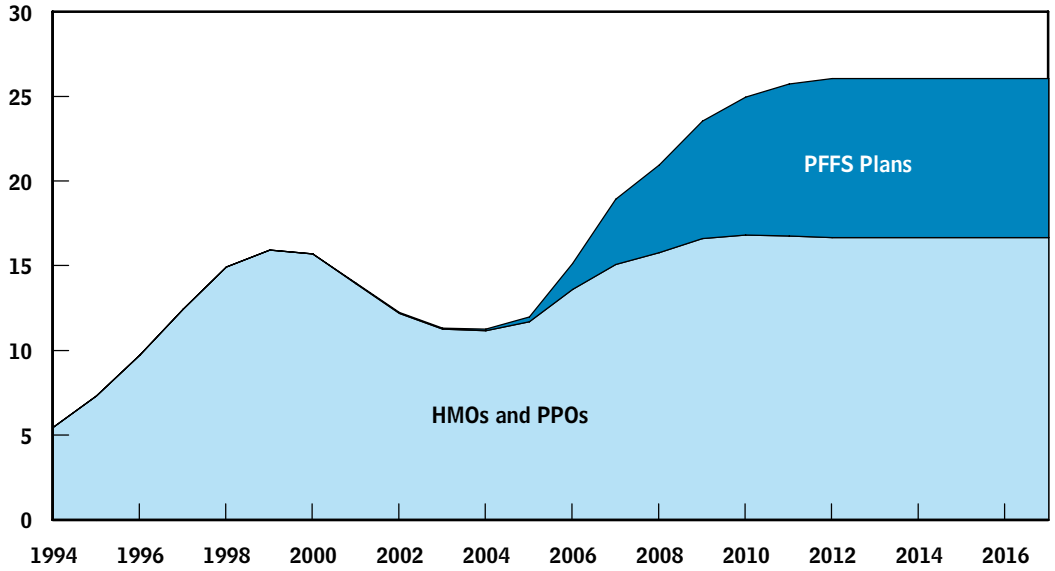
20. Spending on Medicare Advantage during fiscal year 2006 was $52 billion. The discussion here focuses on calendar years because changes in enrollment (open seasons) and payment rates are implemented on a calendar year basis and because spending on a fiscal year basis is complicated by timing shifts. (Plans are paid on a monthly basis. There can be 11, 12, or 13 payments during a fiscal year; there are always 12 payments during a calendar year.)

21. Those amounts exclude payments to group health plans besides Medicare Advantage plans (which include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans). Under current law, CBO projects, payments to those group plans outside of the Medicare Advantage program will decline from $4 billion in 2007 to $1 billion in 2017.

22. That figure excludes about 1 percent of beneficiaries (or about 600,000) who are enrolled in group plans besides Medicare Advantage plans.

Figure 1.

Enrollment in Medicare Advantage as a Percentage of Enrollment in Medicare



Source: Congressional Budget Office.

Notes: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee for service.

For the purpose of this figure, enrollment in Medicare is considered to be that in Part A (Hospital Insurance).

by 2017, accounting for one-third of all Medicare Advantage enrollment at that time, up from about one-sixth now.

HMOs and local PPOs grew strongly in 2006 as well, adding approximately 1 million members from the end of 2005 to June 2007. Membership in such plans now numbers approximately 6.2 million. Growth in 2007 for those types of Medicare Advantage plans was slower than that for 2006, however, and, according to CBO's projections, that portion of the program will grow more slowly than the PFFS portion over the next several years. In addition, the expiration of the authorization for a special needs program after December 31, 2008, will eliminate one of the fastest-growing components of local HMOs and PPOs, limiting the future growth of such plans under current law.[23]

23. Special needs plans were authorized by section 231 of the Medicare Modernization Act. As of May 2007, about 900,000 beneficiaries were enrolled in such plans, the majority of whom were in HMOs. Those plans are permitted to market to and restrict enrollment to specific subgroups of beneficiaries, including people who are dually eligible for Medicare and Medicaid, who have chronic conditions, and who reside in institutions.

Table 2.

Recent Enrollment in Medicare Advantage and Other Group Health Plans

(Thousands of people)

	Total, December 2005	Additions: During 2006	Additions: During 2007	Total, June 2007
Medicare Advantage				
Local HMOs and PPOs	5,160	840	190	6,190
Private fee for service	210	660	720	1,590
Regional PPOs	0	100	60	160
Subtotal, Medicare Advantage	5,370	1,600	970	7,940
Other Group Health Plans[a]	760	-130	-10	620
Total, All Group Health Plans	6,120	1,470	960	8,560

Source: Congressional Budget Office based on data from the Centers for Medicare & Medicaid Services.

Notes: HMO = health maintenance organization; PPO = preferred provider organization.

Figures do not add up to totals because of rounding.

a. Other group plans include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and some demonstration plans.

Rising Costs for Medicare Advantage

CBO projects that payments to Medicare Advantage plans will rise from an estimated $60 billion in calendar year 2006 to $196 billion in 2017, an annual average growth rate of 11 percent (see Table 3). Much of that increase will result from growing enrollment (about 7 percent per year); the rest from increasing payments per enrollee (about 4 percent per year). By comparison, CBO estimates that total enrollment in Medicare will grow much more slowly and that total spending will increase by an average of 6.5 percent per year. Spending for Medicare Advantage is projected to total approximately $1.5 trillion over that 11-year period.

Because beneficiaries can be enrolled in only the Medicare Advantage program or the FFS program, increasing enrollment in the former leads to partially offsetting decreasing spending in the latter. However, because payments to Medicare Advantage plans are higher, on average, than costs in the FFS sector, shifts in enrollment out of the FFS program and into private plans increase net Medicare spending.

CBO projects that private fee-for-service plans will account for a rapidly growing share of Medicare Advantage spending, with payments to them increasing from approximately $5 billion in calendar year 2006 to $13 billion in 2007 and $59 billion in 2017. That increase represents an annual average nominal growth rate of 25 percent over the 11-year period and reflects a 20 percent average rate of growth

Table 3.

CBO's Baseline Estimates for Medicare Advantage

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017	2006-2017
	Enrollment (Calendar year average, in thousands)														
Local HMOs and PPOs	5,740	6,400	6,790	7,230	7,380	7,460	7,560	7,720	7,920	8,120	8,320	8,530			
PFFS	650	1,670	2,290	3,120	3,720	4,170	4,490	4,680	4,770	4,840	4,900	4,960			
Regional PPOs	70	140	180	240	290	350	420	490	570	650	730	810			
Subtotal, Medicare Advantage	**6,460**	**8,210**	**9,260**	**10,590**	**11,390**	**11,980**	**12,470**	**12,890**	**13,260**	**13,610**	**13,950**	**14,300**			
Other Group Plans[a]	640	590	520	310	160	160	150	150	150	150	150	140			
Total, Medicare Group Plans[b]	7,100	8,800	9,780	10,900	11,550	12,140	12,620	13,040	13,410	13,760	14,100	14,440			
Medicare Advantage Enrollment as a Percentage of Hospital Insurance Enrollment	15	19	21	23	25	25	26	26	26	26	26	26			
	Spending (Calendar year incurred, in billions of dollars)														
Local HMOs and PPOs	54	63	70	78	83	87	92	97	103	110	118	127	411	965	
PFFS	5	13	19	27	33	39	44	47	50	52	55	59	162	424	
Regional PPOs	1	1	2	2	3	4	4	5	6	8	9	10	15	53	
Subtotal, Medicare Advantage	**60**	**77**	**91**	**107**	**119**	**130**	**140**	**149**	**159**	**169**	**182**	**196**	**587**	**1,442**	
Other Group Plans[a]	4	4	4	2	1	1	1	1	1	1	1	1	8	13	
Total, Medicare Group Plans[b]	64	81	95	109	120	131	141	150	160	170	183	197	596	1,455	
Fiscal Year Outlays[c,d]	56	75	91	106	117	140	128	150	158	167	195	194	582	1,446	
Number of Capitation Payments[d]	11	12	12	12	12	13	11	12	12	12	13	12	60	121	
	Enrollment Growth (Percent)														
Local HMOs and PPOs	16	11	6	6	2	1	1	2	3	2	3	3	3	3	4
PFFS	435	156	37	36	19	12	8	4	2	1	1	1	22	12	20
Regional PPOs	n.a.	98	30	36	23	21	19	16	16	14	12	11	25	19	25
Subtotal, Medicare Advantage	**27**	**27**	**13**	**14**	**8**	**5**	**4**	**3**	**3**	**3**	**3**	**3**	**9**	**6**	**7**
Other Group Plans[a]	-13	-8	-11	-41	-48	-1	-1	-1	-1	-1	-1	-1	-24	-13	-13
Total, Medicare Group Plans[b]	22	24	11	11	6	5	4	3	3	3	3	3	7	5	7

Continued

Table 3.

Continued

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017	2006-2017
							Annual Net per Capita Spending Growth (Percent)								
Local HMOs and PPOs	8	4	6	4	4	4	4	3	4	4	5	5	4	4	4
PFFS	0	4	6	4	4	4	4	3	4	4	5	5	4	4	4
Regional PPOs	n.a.	4	6	4	4	4	4	3	4	4	5	5	4	4	4
Subtotal, Medicare Advantage	**6**	**2**	**5**	**3**	**3**	**4**	**3**	**3**	**4**	**4**	**5**	**5**	**4**	**4**	**4**
Other Group Plans[a]	5	4	4	-5	-18	4	4	3	4	4	5	5	-3	1	1
Total, Medicare Group Plans[b]	7	3	5	4	4	4	3	3	4	4	5	5	4	4	4
							Annual Spending Growth (Percent)								
Local HMOs and PPOs	26	16	12	11	6	5	5	6	6	6	7	8	8	7	8
PFFS	437	167	45	42	24	17	12	8	6	5	6	6	27	16	25
Regional PPOs	n.a.	107	38	42	28	26	23	20	20	19	18	17	31	25	31
Subtotal, Medicare Advantage	**36**	**30**	**18**	**18**	**11**	**9**	**8**	**7**	**7**	**6**	**7**	**8**	**13**	**10**	**11**
Other Group Plans[a]	-9	-4	-8	-44	-58	3	2	2	2	2	3	4	-25	-13	-12
Total, Medicare Group Plans[b]	32	27	17	16	10	9	8	7	7	6	7	8	12	9	11

Source: Congressional Budget Office.

Notes: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee for service; n.a. = not applicable.

a. Other group plans include cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and some demonstration programs.

b. Does not include spending from the stabilization fund for regional PPOs or for certain demonstration programs.

c. Includes spending from the stabilization fund for regional PPOs and for certain demonstration programs.

d. In general, capitation payments to group health plans and prescription drug plans for the month of October are accelerated into the preceding fiscal year when October 1st falls on a weekend. However, the Balanced Budget Act of 1997 required that the October payment in 2006 be made on October 2 instead of September 29.

in enrollment and a 4 percent average annual rate of growth in net payments per enrollee. In 2006, PFFS plans accounted for approximately 8 percent of Medicare Advantage spending; CBO anticipates that those plans will account for 17 percent of that spending in 2007 and 29 percent in 2017.

Despite the rapid projected growth in PFFS plans, local HMOs and PPOs are projected to continue to account for the largest portion of spending throughout the projection window. According to CBO's estimates, payments to those organizations will increase from approximately $54 billion in calendar year 2006 to approximately $63 billion in 2007 and $127 billion in 2017, reflecting an annual average nominal growth rate of 8 percent. That increase results from projected annual average growth of 4 percent in enrollment and 4 percent in net per capita payments.

Regional PPOs are projected to grow from the current 160,000 members to about 800,000 in 2017 (under an assumption that current law remains in place). Payments to such plans were approximately $1 billion in 2006 and, by CBO's projections, will be $1 billion in 2007 and $10 billion in 2017—representing an annual growth rate of 31 percent, 25 percent from enrollment and 4 percent from growth in net per capita payments.

CBO's baseline projections also include approximately $3.5 billion in spending in 2012 and 2013 from the "stabilization fund" established under the Medicare Modernization Act to encourage regional PPOs' participation in the Medicare Advantage program.

Estimated Spending Reductions from Alternative Policies

A number of policy options exist that would reduce spending on Medicare Advantage. This testimony presents three options drawn from CBO's February 2007 *Budget Options* report.[24]

Pay Plans at Local FFS Rates

The first policy would reduce the county-level benchmarks under Medicare Advantage to the level of local per capita FFS spending. Relative to spending under current law, CBO estimates, this policy would save $9.5 billion in 2009, $54 billion over the 2009–2012 period, and $149 billion over the 2009–2017 period (see Table 4).[25] Limiting benchmarks to 100 percent of FFS costs for private fee-for-service plans and maintaining current-law benchmarks for other plans

24. Congressional Budget Office, *Budget Options* (February 2007). See Options 570-2, 570-3, and 570-4.

25. The county-level benchmarks for 2008 have been announced, and the bid approval process is under way. The estimates assume that the policies under discussion would take effect in 2009 to avoid interrupting that process for 2008.

Table 4.

Estimated Budgetary Effects of Alternative Policies

(Billions of dollars, by fiscal year)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
Pay Plans at Local FFS Rates	0	-9.5	-13.7	-16.2	-14.6	-16.8	-17.7	-18.6	-21.2	-20.8	-54.0	-149.1
Eliminate Double Payments for Indirect Medical Education	0	-0.8	-1.1	-1.3	-1.1	-1.3	-1.4	-1.6	-1.8	-1.7	-4.2	-12.0
Eliminate the Remainder of the Regional PPO Stabilization Fund	0	0	0	0	-1.6	-1.6	-0.4	0	0	0	-1.6	-3.5

Source: Congressional Budget Office.

Notes: Figures do not add up to totals because of rounding.

The estimates are net of changes in premium receipts resulting from policy changes.

would reduce federal spending by about $14 billion over the 2009–2012 period and $43 billion over the 2009–2017 period. Requiring PFFS plans to maintain networks similar to local PPOs would have similar effects, saving $13 billion over the 2009–2012 period and $40 billion over the 2009–2017 period, if implemented in 2009. Each policy would, however, have a considerable impact on both plans and their participants.

All counties have benchmarks set at or above local FFS rates. Many counties have rates well above local per capita FFS costs, particularly counties where the floor payment rates were in effect before the enactment of the Medicare Modernization Act. Reducing benchmarks to FFS levels would result in a significant reduction in benchmarks in most counties. CBO estimates that in 2007, the average payment will be 12 percent above FFS rates; that difference will be greater for PFFS plans and lower for HMOs and PPOs. One force pushing that payment difference still higher in the future is the continuing growth of PFFS plans, although other forces could offset or reinforce that increase (such as changes to the calculations of county benchmarks and changes in the reported health status of enrollees).

Reducing benchmarks would leave less money for health plans to offer reduced premiums or supplemental benefits. That change, in turn, would make the program less attractive to beneficiaries and lead some to return to the traditional fee-for-service program. Others who would have joined Medicare Advantage plans would remain in the fee-for-service program. The change also would make the Medicare Advantage program less attractive for health plans and cause some to leave the program, as they did after the Congress restrained growth in payment rates in the Balanced Budget Act of 1997. By CBO's estimates, enacting this policy would reduce enrollment in Medicare Advantage by about 6.2 million beneficiaries in 2012 relative to the baseline projection, a decline of about 50 percent—leaving

Table 5.

Estimated Budgetary Effects of Policies Capping the Benchmarks under Medicare Advantage

(Billions of dollars, by fiscal year)

Limit on MA Benchmarks as a Percentage of FFS Costs	Change in Direct Spending	
	2008–2012	2008–2017
100	-54	-149
105	-43	-120
110	-32	-90
115	-23	-64
120	-15	-42
125	-10	-28
130	-6	-18
135	-4	-10
140	-2	-7
145	-2	-5
150	-2	-4

Source: Congressional Budget Office.

Notes: MA = Medicare Advantage; FFS = fee for service.

The estimates are net of changes in premium receipts resulting from policy changes. Each policy would limit the Medicare Advantage program's county benchmarks to some level above local per capita FFS costs.

total Medicare Advantage enrollment at about 6.3 million (and the program's share of total enrollment in Medicare at 13 percent), which is roughly 1.7 million enrollees fewer than there are today. Limiting the policy change to private fee-for-service plans would result in a smaller reduction in enrollment, approximately 3.3 million beneficiaries in 2012. Requiring PFFS plans to have PPO-like networks would have approximately the same effect.

CBO also has estimated the budgetary effect of variations on this option that would limit the benchmarks to certain levels above local FFS costs (see Table 5). For example, the Congress could limit all local benchmarks to 110 percent or 120 percent of local per capita FFS spending. Such policies would have similar, but smaller, effects on payments to plans and enrollment. CBO estimates that capping benchmarks at 110 percent of local per capita FFS costs would reduce spending by $32 billion over the 2009–2012 period and $90 billion over the 2009–2017 period ($12 billion and $38 billion, respectively, for the PFFS-only option). Capping rates at 120 percent of FFS costs would save $15 billion from 2009 to 2012 and $42 billion from 2009 to 2017 ($7 billion and $22 billion, respectively, for the PFFS-only option).

In general, those spending reductions mirror the spending distribution of Medicare Advantage payments. About 52 percent of Medicare Advantage spending is in counties where the benchmark is greater than 110 percent of local FFS costs,

Table 6.

Distribution of Medicare Advantage Spending, by the Percentage by Which County Benchmarks Exceed Local FFS per Capita Costs

(Percent)

Percentage by Which Benchmark Exceeds FFS Costs	Portion of Medicare Advantage Spending	
	Within Category	Within or Above Category
0	10	100
Greater Than 0 to 9.9	38	90
10 to 19.9	31	52
20 to 29.9	12	21
30 to 39.9	5	9
40 to 49.9	1	4
50 and Higher	3	3

Source: Congressional Budget Office.

Note: Categories are based on the Medicare Advantage program's local county benchmarks and local fee-for-service (FFS) rates. The total spending is calculated as if all bids were equal to the benchmark and all beneficiaries had average expected costs. The analysis includes all counties with reported FFS spending for 2007 (as well as Puerto Rico).

meaning that about one-half of spending would be affected (see Table 6). (That fact does not mean, however, that one-half of spending would be cut from the program, because the portion of spending below 110 percent of local FFS costs in those counties would be unaffected by the change.)

Because the payment reduction is largest in counties with the highest benchmarks relative to local FFS costs, the reductions in extra benefits and declines in enrollment under the policy would be largest in those areas. Plans in counties paid at one of the two floor rates would experience the largest payment cuts and enrollment reductions; those counties generally have low FFS costs. Plans in counties with benchmarks nearest FFS costs would see the smallest payment and enrollment reductions; those counties are generally urban and suburban counties with relatively high FFS costs. In virtually no county would plans avoid a payment reduction if benchmarks were set at FFS rates, however; the minimum update requirement has kept the rates for counties where payments were at FFS rates in 2004 (the first year plans were paid at the local FFS level) above FFS costs subsequently in the majority of cases.

Eliminate Double Payments for Indirect Medical Education

Medicare's payments to teaching hospitals for inpatient services in the traditional fee-for-service sector include an "indirect medical education" (IME) adjustment. That adjustment is intended to account for the fact that teaching hospitals tend to have greater expenses than other hospitals. Teaching hospitals, for example, typi-

cally offer more technically sophisticated services than other hospitals do and treat patients who have more-complex conditions.

Those IME payments are included in the benchmarks in counties where the benchmark has been tied to FFS spending. Nevertheless, Medicare also pays the IME amount to teaching hospitals that treat patients enrolled in Medicare Advantage plans.

This policy would eliminate that double payments by removing IME payments from the benchmarks in counties where the benchmark has been associated with per capita spending in the fee-for-service sector. By CBO's estimates, such a change would save $1 billion in 2009, $4.5 billion over the 2009–2012 period, and $12 billion over the 2009–2017 period (compared with spending under current law).

This option is only one method of implementing such a payment reduction. The Administration's budget for fiscal year 2008 proposed an alternative approach: remove the double payments for IME in all counties (not just the FFS-based counties) by eliminating the separate IME payments for Medicare Advantage enrollees treated in teaching hospitals. The Administration's proposal would phase in that change over the 2008–2016 period. According to CBO's estimates, that provision would save $500 million in 2008, $5 billion over the 2008–2012 period and $19 billion over the 2008–2017 period (this policy generates savings in 2008 because payments to hospitals can be changed more quickly than payments to plans made through the bidding system). The choice of whether to eliminate the double payments from the health plan side or from the hospital side could have important financial consequences for health plans and teaching hospitals.

Eliminate the Remainder of the Regional PPO Stabilization Fund

The stabilization fund established by the MMA was authorized to spend $10 billion over the 2007–2013 period to encourage the participation of regional PPOs in the Medicare Advantage program. The Tax Relief and Health Care Act of 2006 repealed $6.5 billion of that amount and prohibited spending the remainder until 2012. This option would eliminate that fund and would save an estimated $1.6 billion in 2012 and $3.5 billion over the 2008–2017 period.

Conclusion

The Medicare Advantage program has been growing rapidly and is projected to continue to do so. Such growth, under current payment policies, increases net costs to Medicare because payments made to Medicare Advantage plans exceed costs under the traditional fee-for-service program. Policymakers evaluating options for reducing payments to Medicare Advantage plans need to weigh the cost savings against benefits that the plans provide in managing care, the effect on health care costs overall, and the impact on beneficiaries. Finally, expanded reporting on health outcomes may help policymakers better evaluate both the overall effects and specific care management approaches of Medicare Advantage plans.

Congressional Budget Office

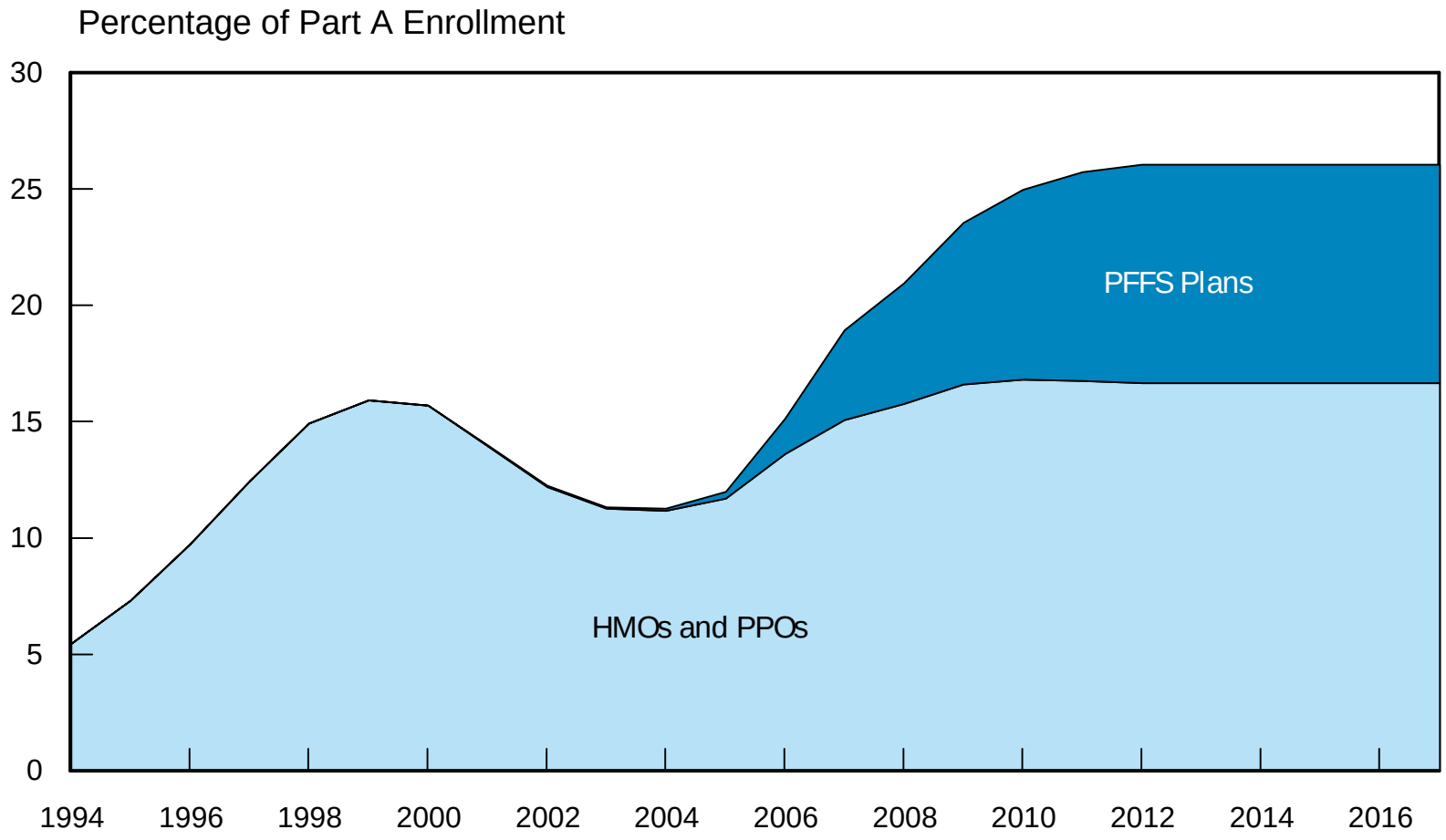
The Medicare Advantage Program

June 28, 2007

Recent Enrollment in Medicare Advantage and Other Group Health Plans

		Additions		
	Total, Dec. 2005	During 2006	During 2007	Total, June 2007
Medicare Advantage				
Local HMOs and PPOs	5,160	840	190	6,190
Private fee for service	210	660	720	1,590
Regional PPOs	0	100	60	160
Total for All Group Health Plans	6,120	1,470	960	8,560

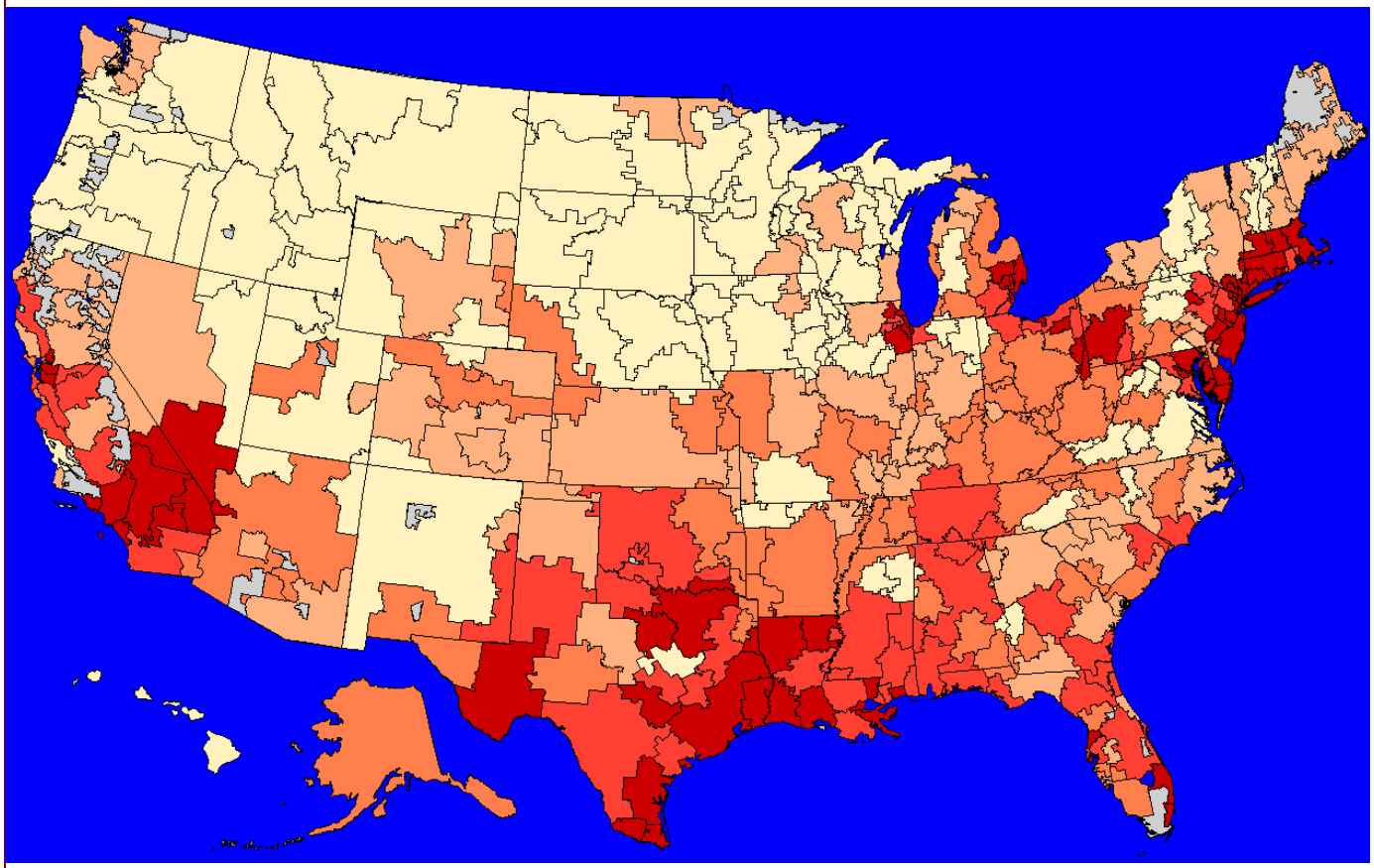
Enrollment in Medicare Advantage as a Percentage of Enrollment in Medicare



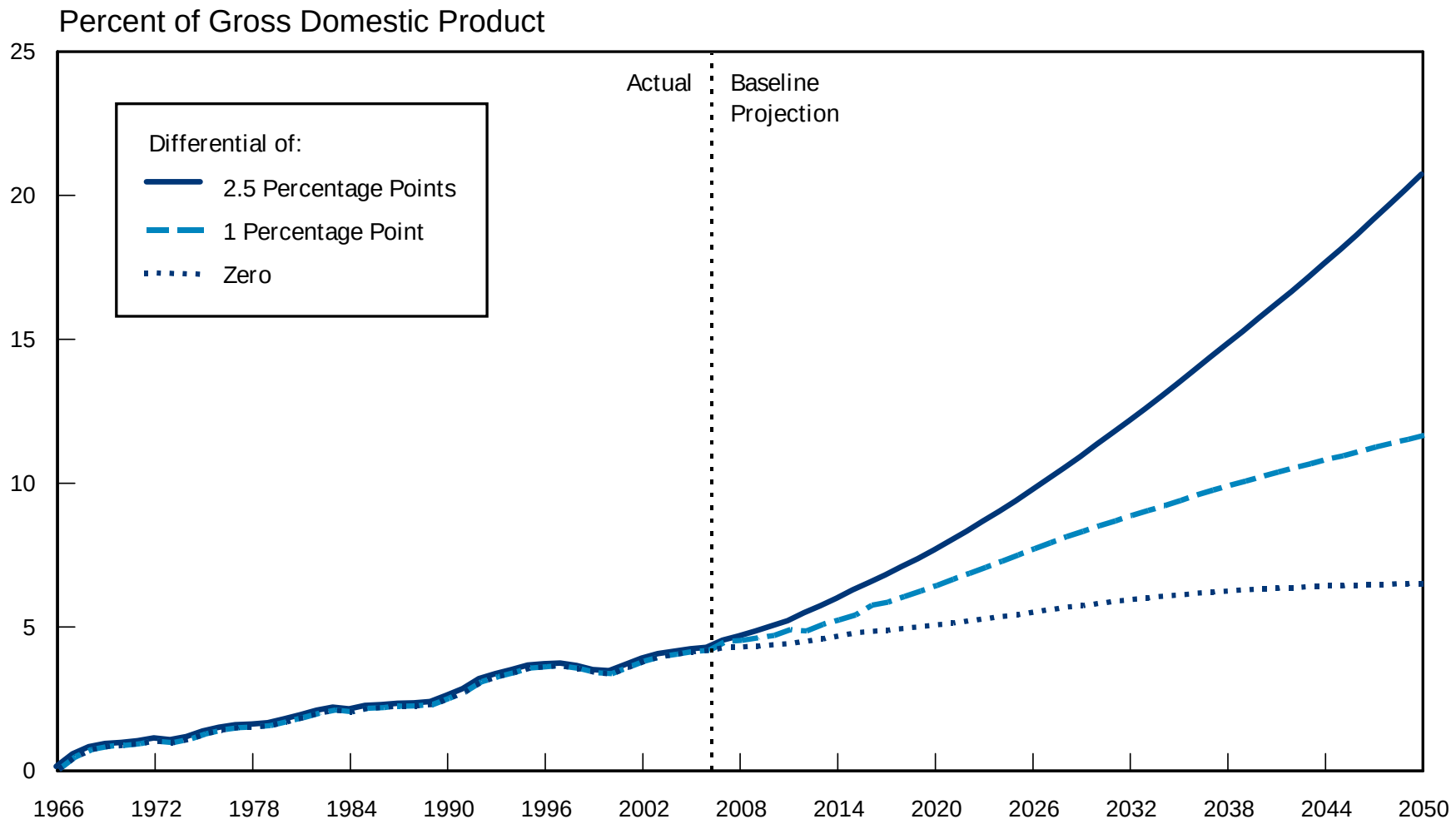
Estimated Budgetary Effects of Policies Capping the Benchmarks under the Medicare Advantage Program

Limit on MA Benchmarks as a Percentage of FFS Costs	Change in Direct Spending (Billions of dollars)	
	2008–2012	2008–2017
100	-54	-149
110	-32	-90
120	-15	-42
130	-6	-18
140	-2	-7
150	-2	-4

Medicare Spending per Capita in the United States, by Hospital Referral Region, 2003



- $7,000 to 11,352 (63)
- 6,500 to < 7,000 (53)
- 6,000 to < 6,500 (56)
- 5,500 to < 6,000 (64)
- 4,272 to < 5,500 (70)
- Not Populated

www.dartmouthatlas.org

Total Federal Spending for Medicare and Medicaid Under Assumptions About the Health Cost Growth Differential