



Forum Session Meeting Announcement

Friday, June 22, 2007
11:45am–12:15pm — Lunch
12:15–2:00pm — Session

Medicare Advantage in 2007: What Are the Choices?

A Discussion Featuring:

Mark E. Miller, PhD
Executive Director
Medicare Payment Advisory Commission

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Senior Fellow
Mathematica Policy Research, Inc.

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Senior Vice President
Secure Horizons/UnitedHealth Group

Location

**Reserve Officers Association
of the United States**
One Constitution Avenue, NE
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(Across from the Dirksen Senate
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Medicare Advantage in 2007: What Are the Choices?

OVERVIEW

Recent analysis indicates that Medicare spends more on Medicare Advantage (MA) enrollees than the program would have spent on those enrollees had they remained in traditional, fee-for-service (FFS) Medicare. Does this mean that Medicare is paying MA plans too much? Do these higher payments result in more value for selected groups of Medicare beneficiaries? This Forum session will explore these and other key issues facing policymakers as major changes in the MA program are debated in Congress this summer. Speakers will discuss why Medicare pays more for beneficiaries in managed care than in traditional FFS. Whether the additional Medicare funding translates into valuable benefits, particularly for low-income beneficiaries, will be debated. The sharp jump in private FFS plan enrollment and the benefits those plans offer will also be examined. Finally, the business strategies of managed care companies in deciding what types of products to offer in different geographic areas and to different beneficiary groups will be highlighted.

SESSION

One might observe that Medicare Advantage (MA) in 2007 has all the trappings of modern day political theater: charges of government overspending, competition between urban and rural interests, allegations of disproportionate effects on low-income and minority populations, and suggestions of influence from groups concerned about end-of-life care. Controversies have arisen over privatization of Medicare versus its original social insurance model and prioritization of spending on children versus the elderly. Decision makers have their work cut out for them as Congress considers funding changes that bring a wide array of interests into play. And certainly, the over 7 million beneficiaries enrolled in MA plans have much at stake in the outcome of the debate.

The focus of the current MA debate is the perceived inequity between MA payments and expenditures under FFS Medicare. Forging a more equitable payment policy is complicated by the reality that MA is not one product but rather a montage of different offerings, including health maintenance organizations (HMOs), regional preferred provider organizations (PPOs), local PPOs, private fee-for-service (PFFS) plans, special needs plans (SNPs), and other options. According to the Medicare Payment Advisory Commission (MedPAC), enrollment in MA products in 2006 is concentrated in HMOs, with significant enrollment in PFFS and SNPs as well (see table, right).

**Enrollment in Selected
MA Product Types, July 2006**

Product Type	Enrollment
HMO	5,195,000
Local PPO	285,000
Regional PPO	82,000
Private Fee-For-Service (PFFS)	774,000
Special Needs Plans (SNPs)	541,000*

**150,000 of the 541,000 enrollees reside in Puerto Rico.*

Source: Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2007, p. 244; available at www.medpac.gov/publications/congressional_reports/Mar07_EntireReport.pdf.

The different types of MA plans also offer varying benefit packages, beneficiary premiums, provider networks, cost sharing, and other features. Some plans offer benefits not covered by fee-for-service Medicare, and nearly all beneficiaries have access to a plan with a zero premium. Extra benefits come in the form of lower cost sharing for physician, hospital, or other services; reduced Medicare Part B or Part D premiums; and dental care, vision, or other benefits. According to the Centers for Medicare & Medicaid Services (CMS), the value of extra benefits offered by MA plans is \$86 per month on average. PFFS plans offer extra benefits valued at \$63 per month on average.¹ At first glance, MA plans seem to be a good deal for beneficiaries. Some analysts believe, however, that there are risks to beneficiaries in enrolling in some types of MA products, including cost sharing that can be higher than under FFS Medicare for particular services, or the potential for difficulty in accessing physician services in some geographic areas.²

The array of MA products available in the market gives beneficiaries the opportunity to choose a plan that is more tailored to their particular needs. The number and type of MA products available varies depending on the geographic area. In some areas, Medicare beneficiaries may choose among dozens of MA plans. In 2007, for example, there are 56 MA plans available in Miami, 30 in Boston, and 25 in Sioux City.³

Is Medicare paying too much for this array of product choices? According to MedPAC, Medicare spends more on MA enrollees than the program would have spent had those enrollees remained in FFS Medicare. MA plan payments, on average, are 112 percent of FFS expenditures. (PFFS plan payments are 119 percent of FFS expenditures; SNP payments, 118 percent; and local PPO payments, 117 percent.) MedPAC maintains that this payment inequality leads to missed opportunities for both delivery innovation and more intense price negotiation between plans and providers.⁴ Others believe that the disparity in payments is at best exaggerated due to methodological limitations. In addition, MA plans offer benefits to Medicare beneficiaries that may be particularly valuable to lower-income beneficiaries, so some observers say that reducing MA payments consistent with spending for fee-for-service Medicare would harm the beneficiaries Medicare should most want to protect. But the question remains: is the current approach, with its payment inequalities, the best way to subsidize care for low-income beneficiaries?

As Congress considers changes to the MA program, it must balance the need for stability in program choices for beneficiaries with the need to control spending and ensure fair payments. Over the next several months, policymakers must consider the goals of the MA program carefully and decide whether the current payment policy is facilitating achievement of those goals.

KEY QUESTIONS

- What types of MA plans are most popular among beneficiaries, and why? Why has enrollment in PFFS plans grown quickly whereas regional PPO enrollment has not?

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- Is Medicare paying too much to MA plans? Why are MA benchmarks and payments higher than FFS expenditures? What makes PFFS and SNP benchmarks and payments so high in comparison to FFS? Should Medicare expect to pay the same amount for a beneficiary enrolled in an MA plan as in Medicare fee-for-service?
- Are MA plans a good deal for beneficiaries? What extra benefits do MA plans offer, and at what cost to beneficiaries and taxpayers? Is MA a better deal for Medicare beneficiaries than Medicare plus supplemental insurance (Medigap)?
- Are MA plans helping a disproportionate share of low-income and minority populations? Are Medicare payments to MA plans as they are currently structured the best approach for assisting these groups?
- What factors do managed care companies consider in deciding whether to offer a certain MA product in a particular geographic area?

SPEAKERS

Mark E. Miller, PhD, is executive director of the Medicare Payment Advisory Commission (MedPAC). He came to MedPAC in 2002 from the Congressional Budget Office, where he was assistant director of the Health and Human Resources Division. Before joining CBO, Dr. Miller was deputy director of Health Plans at the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration), where he managed nearly 500 staff members and was responsible for Medicare private plan policy and operations, quality standards, demonstrations, and beneficiary education. He was previously chief of the Health Financing Branch at the Office of Management and Budget and a senior research associate at the Urban Institute. Mr. Miller holds a PhD degree in public policy analysis from the State University of New York at Binghamton.

Marsha Gold, ScD, is a senior fellow at Mathematica Policy Research, Inc. Her research and policy analysis focuses on health care delivery and financing, especially in managed care and in public programs including Medicare and Medicaid. Dr. Gold has published extensively and is on the editorial board of national journals including *Health Affairs* and *Health Services Research*, and she has served on the board of directors of AcademyHealth. She received her doctorate from the Harvard School of Public Health and master's degrees from the Massachusetts Institute of Technology and the University of California at Berkeley, and she graduated with distinction from Cornell University.

Cindy Polich is senior vice president of Secure Horizons, where she is responsible for product development and management, including the Secure Horizons Medicare Advantage Plans. She held the same position at PacifiCare prior to the UnitedHealth Group acquisition. Ms. Polich was previously vice president of managed care for the aged at UnitedHealth Care, where she developed the national EverCare demonstration project.

She has also served as the president of InterStudy and faculty member at the University of Minnesota's Center for Health Services. She holds a bachelor's degree from the University of Texas and a master's degree from the University of Minnesota's Humphrey Institute of Public Affairs with a concentration in gerontology.

ENDNOTES

1. Abby L. Block, Centers for Medicare & Medicaid Services (CMS), "Medicare Advantage Private Fee-For-Service Plans," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 22, 2007; available at <http://waysandmeans.house.gov/media/pdf/110/block%20testimony.pdf>.
2. See Marsha Gold, "Medicare Advantage in 2006-2007: What Congress Intended?" *Health Affairs*, 26, no. 4 (May 15, 2007): pp. w445-w455.
3. The number of plans available in these regions was generated by the Medicare Plan Finder feature of the CMS Web site, available at www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp, on June 1, 2007. Not all plans listed by this search function are available to all beneficiaries.
4. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2007, p. 244, available at www.medpac.gov/publications/congressional_reports/Mar07_EntireReport.pdf; and Mark E. Miller, Executive Director, MedPAC, "Private Fee-For-Service Plans in Medicare Advantage," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 22, 2007, available at <http://waysandmeans.house.gov/media/pdf/110/MillerTestimony.pdf>.



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