

Medicare Advantage Payment Policy

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OVERVIEW — *Medicare Advantage (MA) plans are an important source of supplemental benefits for many Medicare beneficiaries. Often, MA plans are able to finance these extra benefits only because Medicare is paying them more than it would have spent to cover the same beneficiaries on a fee-for-service basis. As Congress considers curbing MA plan payments, this background paper explains how MA plans are paid and reviews recent trends in plan participation and enrollment. It then considers key issues raised by proposals to change the payment system.*

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The Medicare program has been contracting with private health plans to serve beneficiaries since the 1970s. Plan participation and enrollment grew rapidly in the 1990s but then dropped sharply, partly because of legislation in 1997 that restricted growth in Medicare payments in some areas. More recently, the Medicare Modernization Act (MMA) of 2003, the law that established the Part D prescription drug coverage program, made changes that have resulted in higher payments to what are now known as Medicare Advantage (MA) plans. As a result, many more private plan options are available to beneficiaries, and MA enrollment has risen dramatically, reaching 8.2 million enrollees—nearly one in five beneficiaries—as of June 2007.

MA plans usually provide broader benefits than the original Medicare program at a lower cost to beneficiaries than other sources of supplemental coverage, such as the individual Medigap policies sold by private insurers. However, many plans are able to finance these extra benefits only because Medicare is paying them more than it would have spent to cover the same beneficiaries on a fee-for-service basis. In the face of pressures to reduce Medicare spending and the overall deficit, Congress is considering possible reductions in MA plan payments. Critics of these proposals contend that they would sharply reduce access to MA plans and cut off an important source of benefits for low-income and minority beneficiaries.

BACKGROUND: MA PLAN PAYMENTS AND RECENT TRENDS

Most Medicare beneficiaries in an area served by an MA plan may choose to enroll in that plan during an annual open enrollment period. The plan receives a fixed monthly payment from Medicare, in return for which it accepts the financial risk for furnishing the full range of services covered by Medicare Part A (hospital insurance) and Part B (supplementary medical insurance, which covers physician and outpatient services). Many MA plans, known as MA-PD plans, also include coverage of prescription drugs under the new Medicare Part D program. Plans commonly provide additional benefits, including reductions in required Medicare cost sharing and coverage of services excluded from Medicare. In some cases, beneficiaries may have to pay the plan a premium; this is in addition to the premium (\$93.50 a month in 2007) paid by all beneficiaries enrolled in Part B. Many MA plans have a zero premium for their entire benefit package, and a few also offer a full or partial reduction of the Part B premium.¹

Types of MA Plans

There are four basic types of MA plans:

Local coordinated care plans (CCPs) include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). Each local CCP serves a county or set of counties selected by the organization itself, with the approval of the Centers for Medicare & Medicaid Services (CMS).² Except in emergencies, enrollees in HMOs must obtain services through the plan's network of affiliated providers. PPO enrollees may use out-of-plan providers but may incur higher out-of-pocket costs for these providers' services. (A PSO may adopt either structure, and some HMOs offer a point-of-service option that resembles a PPO.) A CCP must offer at least one MA-PD option in its service area; it may offer plans without prescription drug coverage, but enrollees in such plans may not obtain Part D coverage separately through a freestanding prescription drug plan (PDP).

Regional PPOs operate like local PPOs, except that they agree to cover one or more geographic regions defined by CMS instead of defining their own service areas. (CMS has divided the country into 26 PPO regions.) If they are unable to establish a provider network in some parts of the region, enrollees must be allowed to obtain out-of-network services without financial penalties.

Private fee-for-service (PFFS) plans, like local CCPs, define their own service areas. A PFFS plan usually does not have a provider network. An enrollee in a non-network PFFS plan may use any provider willing to accept the plan's payment, which may not be less than what original Medicare would pay for the same service. A PFFS plan does not have to offer prescription drug coverage; if it does not, the enrollee may obtain this coverage separately through a freestanding PDP.

Medical savings account (MSA) plans offer high-deductible coverage in conjunction with a tax-favored medical savings account that can be used by the enrollee for cost sharing or noncovered services. They resemble the combination health savings account/high-deductible health plans offered by private health insurers and employer group plans.

A single health insurance company or other organization may offer two or more of the basic models in a given area. In the District of Columbia, for example, Aetna offers a local HMO, a local PPO, a regional PPO, and a PFFS plan. Within each model an organization may offer several distinct plans with different beneficiary premiums and supplemental benefits. Aetna has four different HMO plans in the District of Columbia. In this paper, "organization" will be used to refer to an entity contracting with CMS, while "plan" will refer to a specific model and set of benefits offered by an organization in a given area. Six organizations—UHC/Pacificare, Humana, Kaiser Permanente, Wellpoint, Highmark, and Health Net—accounted for half of total MA enrollment in June 2007.³

An organization may offer special needs plans (SNPs), which are designed to serve a specific subpopulation of Medicare beneficiaries, such as dual Medicare/Medicaid eligibles, people with chronic illnesses or disabilities, or institutionalized beneficiaries. The bidding and payment process for SNPs, except for certain plans treated as demonstration projects, is generally the same as for plans serving the general population.

As of June 2007, nearly all MA enrollees were in local CCPs or PFFS plans (Figure 1). MSA plans, although authorized by law in 1997, were never actually offered until this year. Regional PPOs are available to approximately 88 percent of beneficiaries but have not yet attracted many enrollees.

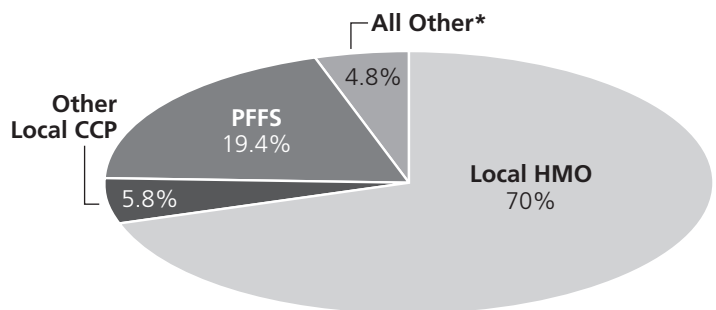
Plan Bidding and Payment

For each contract year and each plan it wishes to offer, an MA organization submits a bid reflecting its monthly revenue requirements for providing the core Part A and Part B benefits to its projected Medicare population. This bid includes costs for services, as well as administrative costs and a projected surplus or profit amount (or sometimes a loss). Note that the bid is net of the average amount enrollees would pay in cost sharing under the usual Medicare rules, such as the inpatient deductible and 20 percent coinsurance for most part B services. Most plans actually require lower cost sharing by enrollees, but this is an extra benefit accounted for later in the process. CMS may review bids for reasonableness and may negotiate bid amounts with plans other than PFFS and MSA plans.

Once the bid is approved, CMS compares it to a benchmark amount to determine whether the beneficiary will have to pay a basic premium for the core benefits or whether the plan will receive a rebate with which to finance extra benefits. There are actually two separate comparisons involved; these differ in the way they adjust for demographic and health risk differences between the plan's enrollees and other Medicare beneficiaries. For the sake of simplicity, the following discussion assumes that a plan's enrollees are representative of all beneficiaries in its market area.

CMS annually establishes a separate benchmark for each county; the benchmark for a plan serving multiple counties is a weighted average of the county benchmarks based on the expected geographic distribution of its enrollees. If the plan's bid is higher than the benchmark, Medicare will pay the plan the benchmark amount, and the beneficiary will have to pay a premium for the core benefits equal to the excess of the bid over the benchmark (in addition to any premium needed to cover extra benefits). If the plan's bid is less than the benchmark, Medicare will pay the plan its bid amount plus 75 percent of the difference between the bid and the

FIGURE 1
Distribution of Medicare Advantage Enrollees by Type of Plan, June 2007



*"All other" includes MSA plans, regional PPOs, employer or union plans contracting directly with CMS as MA plans, and the Program of All-Inclusive Care for the Elderly (PACE) plans and similar demonstrations, which cover both Medicare and Medicaid services for the frail elderly.

Source: Author's analysis of Centers for Medicare & Medicaid Services (CMS) June 2007 contract enrollment data; available at www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/Monthly%20Enrollment%20by%20Contract%20-%20June%202007.zip.

benchmark. The plan must use the Medicare payment in excess of its bid, known as the rebate, to fund extra benefits for enrollees. If the rebate is insufficient to cover the full package of extra benefits the plan offers, the enrollee must make up the difference, again through a premium.⁴ There is a more complicated system, described below, for setting benchmarks and payment amounts for regional PPOs.

Rebates and Extra Services

In 2006, 95 percent of MA plans bid less than the benchmark for core benefits and thus had some rebate amount to use for extra services. Plans may apply the rebate in any of four ways:

- **Reduced Medicare cost sharing.** They may reduce deductibles and coinsurance, replace coinsurance with fixed copayments whose cost is less for an average beneficiary, or set an overall limit on enrollees' out-of-pocket costs.⁵
- **Additional services.** They may cover services Medicare generally excludes, such as dental and vision care, or cover services beyond Medicare's coverage limits, for example, by providing unlimited inpatient hospital days.
- **Part B premium.** They may reduce or eliminate the Part B premium.
- **Drug coverage.** MA-PD plans, which include the Part D drug benefit, have a separate premium for the cost of the drug coverage. However, they may use some of the rebate amount established in the Part A/Part B bid process to reduce their Part D premium, often to zero.

Table 1 illustrates the possible results when two plans, both MA-PDs, bid against the 2007 benchmark of \$882 for the District of Columbia. (Again for the sake of simplicity, the illustration assumes that the plans' populations are an exact cross-section of District of Columbia beneficiaries. It thus omits the health risk adjustments applied to benchmarks, bids, and plan payments.) Although both plans bid below the benchmark, one has a lower bid for core benefits than the other and thus receives a larger rebate to fund extra benefits. Both plans reduce required Medicare cost sharing, perhaps using fixed copayments for services in place of Medicare's deductibles and coinsurance. MA-PD 1 offers enhanced Part D drug coverage at no

TABLE 1
Illustrative Calculation of Plan Bid, Medicare Payment, Extra Benefits, and Beneficiary Premium

	MA-PD 1	MA-PD 2
Benchmark	\$882	\$882
Plan Bid		
— Expected gross revenue requirement for Part A / Part B benefits	\$803	\$845
— Less cost-sharing amounts enrollees would pay under original Medicare rules	\$85	\$91
— Net Bid	\$718	\$754
Benchmark Minus Bid	\$164	\$128
Rebate (75% of benchmark less bid)	\$123	\$96
Total Base Medicare Payment Before demographic, risk, or geographic adjustment	\$841	\$850
Extra Benefits		
— 50% reduction in Medicare cost-sharing	\$43	\$46
— Buy-down of Part D basic premium	\$30	\$30
— Buy-down of premium for enhanced Part D coverage	\$15	Basic coverage only
— Dental and vision benefits	\$10	\$25
— Reduction in Part B premium	\$25	No reduction
Total Cost of Extra Benefits	\$123	\$101
Less Rebate Amount	\$123	\$96
Enrollee Premium	\$0	\$5

Note: The figures included in this table are for illustrative purposes only and do not reflect the health risk adjustments applied to benchmarks, bids, and plan payments.

cost; MA-PD 2 chooses instead to offer only basic drug coverage and to provide a more costly dental and vision package. MA-PD 1 has enough of its rebate left over to fund a partial reduction of the \$93.50 Part B premium its enrollees would otherwise have to pay.

In sum, the benefits an MA plan can offer beneficiaries and the premium it charges for those benefits depend on two basic variables: (i) the applicable benchmark for its service area and (ii) the plan's relative "efficiency," the extent to which it bids below the benchmark because of negotiated price discounts, care management, or other factors.

Setting Benchmarks

Under the MMA, the starting benchmark for each county is set equal to the higher of two amounts. The first is CMS's estimate of average fee-for-service (FFS) Medicare costs in the county for the year the benefits are delivered, that is, the cost of furnishing the core Part A and B benefits to a typical beneficiary in the same county under the original Medicare program. The second is the payment rate set for the county in the preceding year, updated for expected national average growth in Medicare spending. These updated rates, often grandfathered from before the MMA, are sometimes much higher than the FFS average, for reasons discussed below.

For the time being, the starting benchmark for each county is adjusted upwards, using a budget neutrality factor meant to account for the effects of health risk adjustment. As noted earlier, the actual calculation of Medicare payments and beneficiary premiums for a given plan includes adjustments if the plan's enrollees score higher or lower than average under a health risk assessment system developed by CMS.⁶ Overall, the Medicare beneficiaries who have chosen to enroll in MA plans are healthier than those who remain in original Medicare, meaning that aggregate payments to plans should be lower than they would be if plans enrolled a typical mix of beneficiaries. Instead, the budget neutrality adjustment prevents any risk-related reduction in overall payments to MA plans. A plan with lower-risk enrollees is still paid less than one with higher-risk enrollees, but all plans are paid more than they would be without the adjustment. This "hold harmless" rule will be phased out by 2010, but benchmarks for 2007 are still 3.9 percent higher than they would be if the budget neutrality adjustment were not used.

Because of the budget neutrality adjustment, all of the county benchmarks for 2007 are above Medicare's projected FFS costs. However, as Table 2 shows, the difference between benchmarks and FFS varies dramatically among counties. In 2007, 9 percent of MA plan enrollees are in counties where the benchmark is less than 5 percent above FFS, while 16 percent are in counties where the benchmark exceeds FFS by 30 percent or more. The different treatment of counties originated with the payment policy changes enacted in the Balanced Budget Act (BBA) of 1997.

TABLE 2
Distribution of MA Enrollees
by 2007 County Benchmarks
Relative to FFS Costs

Percentage by which county benchmark exceeds FFS cost	MA Enrollees (March 2007)
Under 5%	9%
5% – 9.9%	20%
10% – 14.9%	18%
15% – 19.9%	17%
20% – 24.9%	12%
25% – 29.9%	8%
30% or more	16%
TOTAL	100%

Source: Author's analysis of CMS 2007 rate calculation data, available at www.cms.hhs.gov/medicareadvtspecratestats/Downloads/calculationdata2007.zip, and of March 2007 contract enrollment data, available at www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/MAEnrollmentbySCC-March2007.zip.

From 1985 to 1998, payment rates for HMOs—the only kind of plan allowed to contract with Medicare on a risk basis at that time—were set at 95 percent of each county’s FFS costs. The figure was known as the adjusted average per capita cost, or AAPCC. It was assumed that efficient HMOs would be able to provide core Medicare benefits at some even lower cost and would therefore be able to use the difference to offer attractive supplemental benefits. (In practice, many HMOs were being paid more than FFS costs for a comparable population because they were enrolling healthier-than-average beneficiaries and risk adjustment had not been implemented.)

Under this system, HMOs tended to operate in areas with higher FFS costs, usually large urban areas, because there was greater potential for savings in these areas. In addition, it has always been difficult for HMOs to establish an adequate provider network in rural or small urban areas. Because there might be only a few competing providers in the area, the plans might not have the leverage needed to negotiate favorable rates. Some utilization management activities, such as discharge planning, are also localized and can be costly to establish in rural areas. Even if an organization could overcome these barriers, it might not wish to incur the expenses needed to market its plan in an area with a small target population of beneficiaries.

The BBA folded the existing HMO contracting program into a new Medicare+Choice program. The new program aimed to broaden the types of health plan choices available to beneficiaries, allowing contracts with new types of plans, including PPOs, PSOs, MSA plans, and PFFS plans. At the same time, it changed the payment system to reduce geographic variation and encourage plans to enter low-cost areas. Beginning in 1998, rates in the lowest-cost rural counties were set equal to a fixed “floor” amount that was higher than the counties’ FFS costs. (A separate urban floor was established in 2000.) The MMA grandfathered in the high benchmarks for “floor counties” by specifying that benchmarks are to be based on either the county’s benchmark for the previous year, with a fixed annual update, or its current FFS cost. This means that counties with rates set well above FFS costs will go on having relatively high benchmarks permanently (unless growth in a county’s FFS costs brings that number above the inflated floor level).

Plan Efficiency and Plan Bids

The value of the additional benefits available to a plan’s enrollees depends on the difference between the plan’s bid for core Medicare benefits and the benchmark for its service area. Table 3 (next page) shows the Medicare Payment Advisory Commission’s (MedPAC’s) estimates of MA plan bids, rebates, and Medicare payments relative to FFS costs for 2006. It should be noted that MedPAC’s FFS cost estimates are about 2 percentage points lower than the estimates used by CMS in calculating benchmarks. This is

TABLE 3
MA Plan Payments and Benchmarks Relative to Medicare FFS Spending by Plan Type, Weighted by Enrollment, 2006

	HMO	Local PPO	Regional PPO	PFFS	All MA plans with bids
Bid for Medicare A/B Benefit as percent of FFS	97%	108%	103%	109%	99%
Rebate as percent of FFS	13%	9%	7%	10%	13%
Payment (bid plus rebates) as percent of FFS	110%	117%	110%	119%	112%
Benchmark as percent of FFS	115%	120%	112%	122%	116%

Source: Medicare Payment Advisory Commission, Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007; available at www.medpac.gov/documents/Jun07_EntireReport.pdf.

because MedPAC factors out certain spending related to graduate medical education in teaching hospitals.⁷ All other benchmark/FFS comparisons in this report use the CMS numbers.

MA plans overall were bidding 99 percent of FFS (or about 97 percent, according to CMS) to furnish the core Medicare benefits. Benchmarks averaged 16 percent more than FFS. Rebates available to fund supplemental benefits averaged 13 percent of FFS (75 percent of the difference between the 99 percent bid and the 116 percent benchmark). Only 1 percentage point of this amount was attributable to plan efficiency in furnishing core benefits, while the other 12 percentage points reflect the fact that benchmarks exceeded FFS costs.

HMOs were the only type of plan that actually furnished core Medicare benefits for less than the cost of original Medicare. Regional PPOs were slightly less efficient, and local PPOs considerably less so. Finally, PFFS plans were bidding 109 percent of FFS for core benefits. This is not surprising: they pay full Medicare rates for services, incur higher administrative costs than the original Medicare program, and may have fewer mechanisms for controlling utilization than managed care plans. (A non-network PFFS plan may have preauthorization or other control systems, but may not engage in selective contracting or provide financial incentives for reduced utilization.) The result is that extra benefits for enrollees were worth 10 percent of FFS costs--only about half of the 19 percent difference between FFS costs and Medicare payments to the PFFS plans.

Although CMS has not released MA bidding and payment figures for 2007, it has reported that MA enrollees are receiving extra benefits with an average value of \$86.19. This would be consistent with MedPAC's findings

for 2006: nearly all extra benefits are funded through Medicare payments in excess of FFS costs. PFFS plans are again providing the least generous supplements, with an average value of about \$63 a month.⁸

Plan Growth and Competition

All Medicare beneficiaries now have access to one or more MA plans, compared to just 75 percent of beneficiaries in 2004.⁹ Virtually all beneficiaries have access to a PFFS plan. As shown in Table 4, about 82 percent of beneficiaries have at least one HMO or other local CCP available, and most of the rest have access to a regional PPO. Fewer than 2 percent have only a PFFS option.

PFFS plans are nearly always competing with other types of plans. Yet they have gained 1.5 million new enrollees in the last two years, accounting for nearly two-thirds of total MA enrollment growth. The dramatic growth in PFFS enrollment followed the enactment of the MMA, but whether it is actually attributable to the MMA's health plan provisions is unclear. The PFFS option has existed since 1998, and the counties with high PFFS enrollment had high payment rates relative to FFS costs before the MMA. However, some industry sources suggest that the MMA's promise of annual benchmark increases equal to the growth in FFS spending made insurers more willing than before to invest in the development of PFFS plans.

It is perhaps not surprising that PFFS plans have been able to compete with local PPOs, which bid nearly as much for core benefits and may not be able to offer more attractive benefits than PFFS plans in the same area. Regional PPOs have not gained much of a foothold anywhere, for reasons considered later in this paper. However, 63 percent of all PFFS enrollees live in a county that is also served by an HMO.

Table 5 (next page) shows PFFS penetration (enrollment as a percent of the beneficiary population) in areas with and without an HMO option. In areas with no HMO, penetration rates rise directly with the difference between the local benchmark and FFS costs. In areas with an HMO, the HMOs attract roughly the same proportion of Medicare beneficiaries at each benchmark level. PFFS enrollment in these areas is negligible until benchmarks are 20 percent or more above FFS.

As was shown earlier, HMOs are on average considerably more efficient than PFFS plans. All else being equal, an HMO ought to be able to offer better benefits than a PFFS plan in the same area. This may not be true in some rural areas, where HMOs must spread their fixed costs over a

TABLE 4
Beneficiary Access to MA Plans
by Plan Type, 2007

	Percent of Counties	Percent of Beneficiaries*
Local CCP available	49.0%	81.9%
– HMO available	39.2%	75.8%
– Local PPO or PSO only	9.9%	6.1%
PFFS Only	5.0%	1.6%
PFFS and Regional PPO	45.9%	16.5%
TOTAL†	100.0%	100.0%

* December 2005; latest data available.

† Includes one county with only an MSA plan available.

Note: Excludes plans available only to employer groups. Numbers may not sum because of rounding.

Source: Author's analysis of CMS, Medicare Compare database as of March 15, 2007, update available at www.medicare.gov/Download/DownloadDB.asp, and of CMS December 2005 county beneficiary data, available at www.cms.hhs.gov/HealthPlanRepFileData/Downloads/SC-2005.zip.

TABLE 5
PFFS and HMO Penetration Rates, by Percent Difference Between Benchmark and FFS Costs

		Difference Between Benchmark and FFS Costs				TOTAL
		Under 10%	10% – 19.9%	20% – 29.9%	30% or more	
Counties without HMO option	Beneficiaries*	2,676,000	4,363,000	2,371,000	890,000	10,301,000
	PFFS Enrollees[†]	69,000	189,000	159,000	74,000	491,000
	% of Beneficiaries Enrolled in PFFS Plans	2.6%	4.3%	6.7%	8.3%	4.8%
Counties with HMO option	Beneficiaries*	10,131,000	12,008,000	6,837,000	3,196,000	32,171,000
	PFFS Enrollees[†]	114,000	271,000	298,000	155,000	837,000
	% of Beneficiaries Enrolled in PFFS Plans	1.1%	2.3%	4.4%	4.8%	2.6%
	HMO Enrollees[†]	1,656,000	1,981,000	930,000	548,000	5,116,000
	% of Beneficiaries Enrolled in HMOs	16.3%	16.5%	13.6%	17.1%	15.9%

* December 2005; latest data available

[†] March 2007

Note: HMO enrollment figures exclude 0.5 million enrollees living in a county not in the service area of any HMO.

smaller number of enrollees and may have to offer providers more than Medicare rates to participate in a network. Moreover, in areas with very high benchmarks, even less efficient PFFS plans may still be able offer attractive supplemental coverage.

Some beneficiaries choosing PFFS plans may be doing so for reasons unrelated to their relative value. One obvious explanation is that many beneficiaries are wary of restrictive networks. Even if HMOs in a given area can offer better benefits, the difference may not always be large enough to outweigh a preference for free choice of providers. Other factors may also contribute to their choices. Enrollees may have difficulty evaluating different benefit packages and cannot easily identify the better deal. Or a plan that is inferior to another in actuarial terms—that is, when measured against the needs of a fully representative group of beneficiaries—may be better suited to the needs of specific subgroups.

Finally, some observers have noted that employers are showing increasing interest in offering the PFFS option to their retirees. Because PFFS plans are available everywhere, they can serve groups whose retirees are geographically dispersed, and retirees may be less likely to object to being pushed into a PFFS plan than into a managed care arrangement. In addition, employers can negotiate a PFFS contract tailored to resemble the benefits offered to active employees.¹⁰

Source: Author's analysis of the following: CMS 2007 rate calculation data, available at www.cms.hhs.gov/medicareadvtspecratestats/Downloads/calculationdata2007.zip; Medicare Compare database as of March 15, 2007; CMS December 2005 county beneficiary data, available at www.cms.hhs.gov/HealthPlanRepFileData/Downloads/SC-2005.zip; and March 2007 contract enrollment data, available at [www.cms.hhs.gov/MCRAAdvPartDEnrolData/Downloads/MA Enrollment by SCC - March 2007.zip](http://www.cms.hhs.gov/MCRAAdvPartDEnrolData/Downloads/MA%20Enrollment%20by%20SCC%20-%20March%202007.zip).

THE DEBATE OVER BENCHMARK LEVELS

Medicare pays MA plans considerably more than it would have spent if the plans' enrollees had remained in original Medicare. MedPAC and others have recommended ultimately setting benchmarks at 100 percent of FFS costs in all counties.¹¹ The Children's Health and Medicare Protection Act of 2007 (H.R. 3162), passed by the House in August 2007, would have retained the current benchmarks for 2008 but would then have begun a three-year phase-down, with all benchmarks for 2011 set equal to FFS costs. (This provision was not included in the revised child health legislation considered in September 2007.) The Congressional Budget Office (CBO) projected that this change and other technical changes in the benchmark calculation would have resulted in Medicare savings of \$50.4 billion over the five years from 2008 through 2012. (Note that this estimate assumed a slowdown in MA enrollment growth as well as reductions in payments for current enrollees.)¹² Medicare beneficiaries who are not in MA plans would also have saved money. Because MA plan payments are included in the calculation of the Part B premium, payments to plans in excess of FFS costs raise the premium by about \$2 per month.¹³ MedPAC has suggested some alternative transitional approaches, including freezing benchmarks that are above FFS at the current level until FFS spending in the county catches up with the benchmark or setting a fixed upper limit on the amount by which a county's benchmark could exceed FFS.¹⁴

Critics of the current payment system contend that, while private plans should remain an option for beneficiaries, they should be expected to operate at least as efficiently as original Medicare. CMS, the insurance industry, and others argue that MA plans are a vital source of supplemental coverage for low-income and minority beneficiaries. Reduced benchmarks could drive plans out of the program, especially in the areas where MA options have only recently become available, and would force others to curb benefits. Finally, some argue that FFS costs, which reflect federally administered prices, are an artificial target, and that reliance on the private market could improve efficiency in the long run.

There is also a more general argument that private plans may offer improved access, quality, and coordination of care and may be able to help manage the chronic illnesses that are likely to be the major drivers of future Medicare spending. CMS and health plans have offered a variety of comparisons of enrollee satisfaction in MA plans and original Medicare, along with examples of successful disease management and care coordination programs.¹⁵ The examples are confined to CCPs, not the fast-growing PFFS plans, and little information is available about the outcomes of these programs.¹⁶ And it is not clear that enrollment in capitated private health plans is the only way to improve coordination. CMS is funding numerous demonstration programs that provide disease management or coordinate care for chronically ill beneficiaries in original Medicare.¹⁷ While assessment of various approaches for improving care is beyond the scope of this

paper, MA plans' potential in this area must certainly be considered when weighing options for payment policy.

Benefits for Low-Income and Minority Enrollees

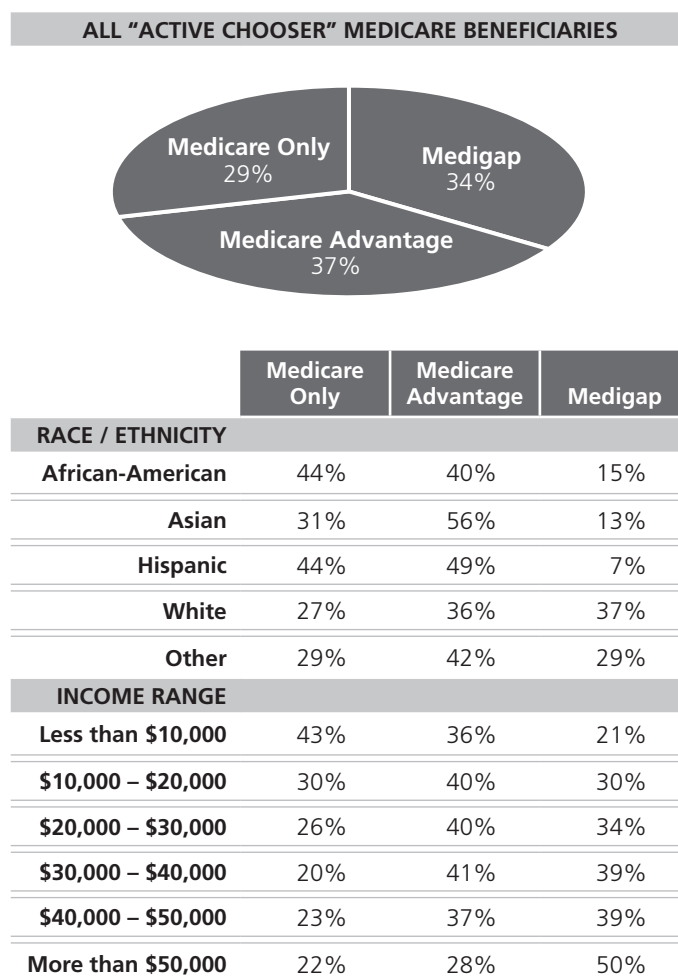
Even before the MMA, Medicare+Choice plans were an important source of supplemental coverage for beneficiaries whose incomes were too high to qualify for Medicaid and who could not afford to purchase Medigap coverage. In most states, Medicaid covers Medicare premiums and cost sharing only for beneficiaries with incomes below the poverty level, \$10,210 for a single person and \$13,690 for a couple in 2007, and with limited assets. (Beneficiaries with slightly higher incomes may receive assistance with the Part B premium, but not with deductibles and coinsurance.)

Table 6 shows estimates by America's Health Insurance Plans (AHIP) of coverage in 2004 for noninstitutionalized "active choosers," Medicare beneficiaries who lived in an area served by at least one MA plan and who did not have employer coverage or qualify for Medicaid. Minority beneficiaries were considerably more likely to rely on MA than to buy Medigap. Beneficiaries with incomes below \$40,000 were also more likely to choose MA plans than Medigap, although the difference diminished as income rose.

On the other hand, a Kaiser Foundation study using 2005 data found no clear relationship between low income and MA enrollment. The lowest-income beneficiaries were equally likely to be in MA or Medigap, while those in the \$10,000 to \$20,000 income range were more likely to choose Medigap. Note, however, that this study, unlike the AHIP estimates, was not limited to areas in which an MA plan was available, and thus may not reflect the behavior of beneficiaries who actually had a choice between MA and Medigap.¹⁸

Data for more recent years are not yet available, so there is no way of knowing what kinds of beneficiaries have been joining MA plans during the recent period of rapid enrollment increases. One factor that might have affected enrollment is the availability of low-income subsidies for Part D prescription drug coverage beginning in 2006. Before the implementation of Part D, some low-income

TABLE 6
Coverage of "Active Chooser"
Medicare Beneficiaries by Race / Ethnicity
and Income Level, 2004



Note: "'Active chooser' Medicare beneficiaries" excludes beneficiaries covered by employer plans or Medicaid and those in an area not served by an MA plan in 2004.

Source: America's Health Insurance Plans, "Low Income and Minority Beneficiaries in Medicare Advantage Plans," February 2007; available at www.ahipresearch.org/PDFs/FullReportAHIPMALowIncomeandMinorityFeb2007.pdf.

people who were not eligible for drug coverage through Medicaid might have joined an MA plan specifically to obtain low-cost drug coverage. Now that they have an affordable alternative, they may be less likely to choose MA plans. As of June 2006, 447,000 non-Medicaid drug subsidy recipients were in MA-PDs, while 2.2 million had chosen a stand-alone prescription drug plan.¹⁹ (Some people in stand-alone plans may also be enrolled in a PFFS plan that does not offer drug coverage.)

Whatever the recent developments, the current payment system is an inefficient way of targeting assistance with supplemental coverage. Table 7 shows data from the March supplements to the Current Population Survey (CPS) conducted by the Census Bureau; three-year averages are used to improve reliability. Because CPS allows analysis only at the level of states, benchmarks are based on population-weighted averages of all counties within each state.

The share of non-Medicaid beneficiaries with incomes below 200 percent of poverty is about the same in states with comparatively low and comparatively high benchmarks. The same is true for Hispanic and non-Hispanic black beneficiaries, except that they account for a smaller share of beneficiaries in the states where average benchmarks are highest. The value of supplemental benefits financed through high benchmarks depends on where beneficiaries live, rather than on how much assistance they need.

Plan Availability

One recent analysis has contended that reducing benchmarks to 100 percent of FFS “would effectively eliminate PFFS as a plan offering.”²⁰ This seems likely: PFFS plans bid 109 percent of FFS for core Medicare benefits in 2006. To operate, they would have to charge a beneficiary premium equal to 9 percent of FFS simply to provide the core benefits, with no extra coverage at all. However, most beneficiaries in areas not served by a local CCP have access to at least one regional PPO, as well as a PFFS plan. The question is, would the regional PPOs also disappear, or might they continue to be available as an alternative in areas that have failed to attract any local HMO or PPO?

The MMA established a separate system for setting regional PPO benchmarks. For each of the 26 regions, the benchmark is a blend of a statutory component, based on a beneficiary-weighted average of the benchmarks

TABLE 7
Medicare Beneficiaries, 2003–2005,
by 2007 Benchmark Level, Income, and Race/Ethnicity

Statewide difference between 2007 benchmark and FFS	Beneficiaries excluding those with Medicaid (millions)	Percentage of Beneficiaries	
		With income below 200% of poverty	Who were Hispanic or non-Hispanic black
5% – 9.9%	5.181	43.5%	15.9%
10% – 14.9%	5.264	46.6%	11.9%
15% – 19.9%	18.340	46.2%	14.6%
20% and over	5.378	45.1%	9.2%
TOTAL	34.164	45.7%	13.5%

Note: Current Population Survey (CPS) data reflect insurance coverage and income during the preceding calendar year.

Source: Author’s analysis of CMS 2007 rate calculation data, available at www.cms.hhs.gov/medicareadvtspecratestats/Downloads/calculationdata2007.zip, and of data from U.S. Bureau of Labor Statistics, “Current Population Survey,” March 2004, 2005, and 2006 supplements, available at www.bls.census.gov/cpsftp.html#cpsmarch.

for the counties in the region, and a component based on the actual bids submitted by the PPOs in the region for core benefits. In 2007 the blend is about 85 percent statutory and 15 percent plan bids; the bids in the different regions move the final benchmark about 1 percent higher or lower than the statutory component.

Note that the statutory component is based on weighted average benchmarks for all Medicare beneficiaries in the region, not for those who have enrolled in regional PPOs. This means that, in low-cost counties, the benchmark is higher than the individual benchmarks for those counties, giving the regional PPO a competitive advantage over any local plans in those counties. Conversely, the regional benchmark will be lower than the individual benchmarks in high-cost counties, leaving regional PPOs less able to compete with the local HMOs already operating in those areas.

After the MMA was enacted, some observers predicted that regional PPOs might move to exploit the benchmarking system by marketing heavily in low-cost counties where no local HMOs or PPOs operated. In one scenario,²¹ they were projected to enroll as many as 4 million beneficiaries, at an average cost per enrollee of \$1,600 above FFS. In fact, the regional PPOs have enrolled only 156,645 beneficiaries as of June 2007, and their enrollment is only slightly tilted toward lower-cost areas. The current statutory component is 117 percent of FFS, based on March 2007 enrollment distribution. If the statutory component were based on an average of the benchmarks for the enrollees' counties, rather than for all beneficiaries in the region used, it would be about 114 percent of FFS. This suggests that the PPOs have been only somewhat successful in targeting low-cost counties, perhaps because of problems in establishing a satisfactory network in those counties or because of barriers to marketing in sparsely populated areas.

If county-level benchmarks were set at 100 percent of FFS, but the current weighting system for regional PPOs were continued, their statutory component would drop to 103 percent of FFS. This is equal to the regional PPOs' bids for core Medicare benefits in 2006, meaning that they would at best break even on those benefits and would have to finance any supplemental benefits entirely through enrollee premiums or become more efficient. Even so, regional PPOs might be able to compete favorably with the major non-MA option for supplemental coverage, individual Medigap plans. Medigap carriers have to cover all their administrative costs and desired surplus on the fraction of spending represented by Medicare cost sharing, while the PPOs can spread these costs over the full Medicare spending amounts.

However, the very narrow excess of the regional benchmarks over FFS would continue to be available only if the plans could maintain the current mix of enrollees in high-cost and low-cost counties. Even a slight shift of the distribution of enrollees toward higher-cost counties could mean that the PPOs would lose money on the core benefits. In effect, the current rules

for county benchmarks have provided the regional PPOs with a cushion against the risk of unfavorable enrollee distribution. If this cushion were taken away, it seems unlikely that organizations would continue to offer the regional PPO model.

FFS Costs as an Artificial Target

Original Medicare operates as what economists call a monopsony—a buyer with so much power in the market that it can more or less pay whatever prices it chooses to dictate. No hospital, and very few physicians, can afford to refuse Medicare patients altogether, but they may prefer to treat other patients when Medicare demands steep discounts from the rates paid by other insurers. As a result Congress is continually walking a tight-rope between controlling Medicare spending and maintaining adequate access to care. In some areas, it may be paying less than a market price for services, and in others more. At least in theory, competition among private health plans would more nearly ensure that providers were being paid the “right” prices than the current system of administratively set FFS payment rates.

As CBO puts it, without necessarily endorsing the concept:

Another argument is that private plans should not be expected to provide Medicare services in all markets at a cost that is less than per capita FFS spending because Medicare may be able to use its market power to set FFS payment rates at levels below those that are determined through private-market forces. Below-market payments to health care providers may result in a less-efficient allocation of resources than would be achieved if more beneficiaries were enrolled in private plans that paid providers at rates determined in the market.²²

This argument is somewhat paradoxical when applied to the current system. PFFS plans are allowed to pay the same administered prices that Medicare pays. It had originally been thought that non-network PFFS plans might pay more than Medicare rates in order to ensure access to care for their enrollees, but instead they appear generally to be paying 100 percent of FFS. (Whether some providers will actually accept PFFS patients at these rates has been questioned by consumer advocates.)²³ Other types of plans are more likely negotiating prices, but their payments from Medicare are still largely based on benchmarks that are either arbitrary (in the case of floor counties) or ultimately derived in part from original Medicare’s own price levels.

In a more fully market-driven system, Medicare benchmarks or payments might be set by competition among the health plans—much as Medicare contributions to prescription drug plans are now determined by average plan bids for the basic benefit. The MMA actually provides for such a system on a demonstration basis, beginning in 2010. In up to six metropolitan areas, Medicare contributions for both original Medicare and MA enrollees would be based on a blend of FFS costs and local MA plan bids for core

benefits. Beneficiaries choosing less costly plans would get extra benefits, as in the current system; those choosing more costly plans (including, if applicable, original Medicare) would pay a higher Part B premium, subject to caps. Similar demonstrations of “premium support” systems have been proposed in the past, but have failed to get off the ground, either because health plans themselves were not interested or because members of Congress raised “not in my backyard” objections.²⁴ Some people think the MMA demonstrations will face even greater barriers, because—unlike the previous demonstrations—they would include original Medicare. In any event, numerous technical issues will need to be resolved before the MMA demonstrations can begin.²⁵

Geographic Variation

Before the 1997 BBA, Medicare payment rates for health plans were set at 95 percent of FFS costs. If a plan could cover the core benefits at 85 percent of FFS, then it could offer enrollees \$75 worth of extra benefits in a county where FFS costs were \$750 a month, but only \$35 worth in a county where FFS costs were \$350. The implicit premise of the program was that beneficiaries in high-cost counties should be encouraged to join private plans, because Medicare’s nominal 5 percent savings would be higher in those counties.

The BBA essentially inverted this principle by squeezing down payment rates in high-cost counties and raising them to an arbitrary floor in low-cost counties. The ultimate goal was to transition to a system of uniform national rates, with adjustments only for local input prices, such as hospital wages or office rental costs. The assumption behind the BBA was that the previous system might make extra benefits available to beneficiaries in areas where providers were inefficient or provided unnecessary services, while denying these benefits to beneficiaries in areas where providers operated efficiently. Uniform rates would compel plans in high-cost counties to dramatically improve their management of care, while beneficiaries in low-cost counties would be rewarded with extra benefits even if their health plans operated at higher cost than original Medicare.

The current benchmark system stands more or less midway between the pre- and post-BBA approaches. Benchmarks as a percentage of FFS are higher in low-cost areas. In absolute dollars, however, benchmarks are still higher in high-cost counties. Because high-cost areas may have more unnecessary utilization, plans in those areas may have more opportunity to achieve savings. In addition, these areas have tended to attract the most efficient types of plans, while the less efficient PFFS plans are concentrated in low-cost areas. The result has been that the most generous benefits are available in two types of counties: those where FFS costs are so high that plans can achieve large savings, and those where benchmarks are so far above FFS costs that even an inefficient plan can save money. Less extensive benefits are available in areas with FFS costs in the middle

range, because plans in these areas have less chance for efficiency gains than in the highest-cost areas and relatively lower benchmarks than in the lowest-cost areas.

Setting all benchmarks at 100 percent of FFS would more or less return the program to its pre-BBA state: beneficiaries would get free extra benefits only in areas with high (and arguably unnecessary) utilization, while those in areas where FFS providers operated more efficiently might not have access to plans.²⁶ This would raise again the equity issue the BBA was meant to resolve.

Possibly the key barrier to developing a fair system is the problem of quantifying differences in “efficiency” of the FFS program in different geographic areas. The BBA’s formulas assumed that any cost differences that could not be traced directly to differences in local wages and other input prices must reflect overservice in some places and insufficient levels of service in others. But there could be many other factors affecting local costs, such as differences in population needs or in relative access to beneficial technologies. Some beneficiaries may be getting too much care and others too little, and it might never be possible to develop a formula that could identify precisely how much utilization in high-cost areas is “unnecessary.” The difficulty of establishing a fair system based on FFS experience might be another argument for pursuing the bid-based competitive approach discussed in the preceding section.

CONCLUSION

Whatever the outcome of the current debate on MA plan payment, benchmarks are already scheduled to temporarily grow more slowly than FFS costs, because of the phase-out of the budget neutrality factor for risk adjustment. The minimum difference between benchmarks and FFS costs will drop from 3.9 percent in 2007 to 1.7 percent in 2008. If all counties’ FFS cost levels grow at equal rates, by 2010 benchmarks will be equal to FFS costs in areas where 7.5 percent of MA plan enrollees live. Proposals to change the way benchmarks are set might, then, have little effect on the established Medicare HMOs, which have been operating in high-cost areas for more than 20 years. If they can continue to operate more efficiently than other plans, they might still be able to offer at least a modest package of free extra benefits.

The component of the program that would be affected by benchmark reductions would be the PFFS sector, which has emerged only recently and which some might say is functioning in effect as a pass-through for Medicare financing of extra benefits for certain groups of beneficiaries. These extra benefits are really at the center of the debate. Medicare continues to expose many beneficiaries to potentially catastrophic costs, especially beneficiaries whose incomes are too high to qualify for Medicaid and who cannot afford private Medigap coverage. For the time being, the private plan option is serving as an ad hoc solution, although it is not equally

available to all beneficiaries in need and may be providing assistance to many higher-income beneficiaries.

If at least one of the policy goals of the MA program is to help modest-income beneficiaries obtain additional benefits, there may be a number of better ways of targeting assistance. One is to expand or at least standardize eligibility for the Medicare Savings Programs, under which Medicaid covers Medicare premiums and sometimes cost sharing for low-income beneficiaries. Eligibility for this coverage varies considerably among states because of different decisions about income-determination methodologies and allowable assets.²⁷ Another is to improve basic Medicare coverage, either by “modernizing” the benefits to include catastrophic limits and other cost-sharing changes or by providing a low-cost voluntary FFS Medicare supplement.²⁸ These proposals are beyond the scope of this paper and may have little chance of adoption in the current budgetary environment. But it might also be possible to improve targeting within the MA program itself.

For example, the amounts now paid in excess of FFS could be replaced by a low-income subsidy system for MA plan premiums related to Part A and Part B benefits that is comparable to the subsidies now available for Part D premiums. With reduced benchmarks, MA plans would have to charge higher premiums for supplemental benefits, but the increases could then be offset through subsidies for enrollees meeting specified income eligibility standards. While this approach might preserve benefit levels for some current low-income enrollees, there could still be many areas in which no private plan was available at all.

Private plans have higher administrative costs than original Medicare, because they perform some activities Medicare does not (such as marketing), may not be able to match Medicare’s economies of scale, and, in the case of investor-owned plans, must provide earnings for shareholders. Some plans have been able to offset these costs by furnishing benefits more efficiently, most commonly in areas where Medicare FFS costs are high. In other areas, plans have been able to operate only because of the extra financing provided by the current payment system. Changing that system now may be politically difficult, because many beneficiaries might lose access to low-cost benefits. But change might be even harder in the future, if recent enrollment trends continue and millions of additional beneficiaries come to rely on the program.

While the current focus is on the budgetary implications of MA payment, there is also a need to bring stability and consistency to the program, so that insurers can make the long-term investments needed to improve quality and efficiency and so that beneficiaries can find a medical home in their health plans. The current scrutiny of the program presents an opportunity for Congress to reassess its overall goals in promoting the private plan option and to ensure that payment policies are rationally aligned with those goals.

ENDNOTES

1. Higher-income beneficiaries now pay an additional, income-related Part B premium; plans may not contribute more than the standard \$93.50.
2. Plans must generally serve entire counties; CMS will allow coverage of partial counties only in special circumstances.
3. Author's analysis of data in Centers for Medicare & Medicaid Services, "Medicare Advantage/Part D Contract and Enrollment Data: Monthly Enrollment by Contract," June 2007; available at www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/Monthly%20Enrollment%20by%20Contract%20-%20June%202007.zip.
4. A plan may offer an optional additional package of supplemental benefits beyond the mandatory package provided to all its enrollees; these optional benefits are funded entirely through premiums.
5. Regional PPOs and MSA plans must set an overall limit, but this may or may not be less than the average a typical beneficiary would have paid.
6. Health risk factors are established by assigning the enrollee to one or more disease groups, known as "hierarchical condition categories" (HCCs), on the basis of diagnoses reported on hospital and physician claims in the preceding year. A scoring system identifies enrollees likely to incur higher-than-average or lower-than-average costs, and payment calculations are modified accordingly. Because there is no claims history for new Medicare beneficiaries, demographic factors alone are used in their first year of program participation.
7. Medicare reimburses teaching hospitals (those that train residents) for both direct costs, such as residents' salaries, and indirect medical education (IME) costs. The IME adjustment reflects the fact that teaching hospitals treat more complex cases and may have higher costs for other reasons—for example, because residents will order more tests or procedures as part of their learning experience. Medicare pays IME costs directly for all Medicare patients, including those in MA plans, but the costs are included in the MA plan benchmarks. MedPAC's view, with which the administration concurs, is that this amounts to double payment for MA plan enrollees. As passed by the House, H.R. 3162, the Children's Health and Medicare Protection Act of 2007, would remove IME costs from benchmarks beginning in 2009. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Issues in a Modernized Medicare Program*, June 2005, available at www.medpac.gov/documents/June05_Entire_report.pdf; and Leslie V. Norwalk, Centers for Medicare & Medicaid Services (CMS), testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 21, 2007, available at <http://waysandmeans.house.gov/media/pdf/110/Testimony32107/NorwalkTestimony.pdf>.
8. CMS, "Medicare Advantage in 2007," April 20, 2007, available at www.cms.hhs.gov/hillnotifications/downloads/MedicareAdvantagein2007.pdf; and Abby L. Block, CMS, 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>.
9. CMS, *2006 Medicare and Medicaid Statistical Supplement*, table 13.2, available at www.cms.hhs.gov/MedicareMedicaidStatSupp/downloads/06MMC.zip.
10. Jonathan Blum, Ruth Brown, and Miryam Frieder, "An Examination of Medicare Private Fee-for-Service Plans," Medicare Issue Brief, Henry J. Kaiser Family Foundation, March 2007, available at www.kff.org/medicare/upload/7621.pdf; and Catherine Schmitt, Blue Cross Blue Shield of Michigan, 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/hearings.asp?formmode=view&id=5968>.
11. MedPAC, *Issues in a Modernized Medicare Program*. Note that MedPAC's recommendation in 2005 would have used the resulting savings to establish a pay-for-performance system for MA plans. This option has not been discussed in more recent reports and testimony.

Endnotes / continued ►

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12. Congressional Budget Office (CBO), "Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act," prepared for the Committee on Rules, U.S. House of Representatives, August 1, 2007; available at www.cbo.gov/ftpdocs/85xx/doc8519/HR3162.pdf.

13. Glenn M. Hackbarth, MedPAC, "The Medicare Advantage Program and MedPAC Recommendations," testimony before the Committee on Finance, U.S. Senate, April 11, 2007; available at www.senate.gov/~finance/hearings/testimony/2007test/041107testgh.pdf.

14. MedPAC, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007; available at www.medpac.gov/documents/Jun07_EntireReport.pdf.

15. See, for example, CMS, *Medicare Advantage in 2007*; and Blue Cross Blue Shield Association, "Medicare Advantage: Improving Care Through Prevention, Coordination and Management," February 2007, available at www.bcbs.com/issues/medicare/background/Medicare-Advantage-Plan-Profile-FINAL.pdf.

16. Peter R. Orszag, CBO, "The Medicare Advantage Program: Enrollment Trends and Budgetary Effects," testimony before the Committee on Finance, U.S. Senate, April 11, 2007; available at www.cbo.gov/ftpdocs/79xx/doc7994/04-11-MedicareAdvantage.pdf.

17. For a summary of current programs see CMS, *CMS Active Projects Report: A Comprehensive Guide to CMS's Research Activities*, 2007; available at www.cms.hhs.gov/ActiveProjectReports/downloads/2007_Active_Projects_Report.pdf.

18. Patricia Neuman, Henry J. Kaiser Family Foundation, "Medicare Advantage: Key Issues and Implications for Beneficiaries," testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007; available at www.house.gov/budget_democrats/hearings/TN_final_testimony.pdf.

19. U.S. Department of Health and Human Services, "Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage," press release, June 14, 2006; available at www.hhs.gov/news/press/2006pres/20060614.html.

20. Adam Atherly and Kenneth E. Thorpe, "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries," Emory University, prepared for the Blue Cross Blue Shield Association, April 2007; available at www.bcbs.com/issues/medicare/background/Medicare-Advantage.pdf.

21. Steven D. Pizer, Roger Feldman, and Austin B. Frakt, "Defective Design: Regional Competition in Medicare," *Health Affairs Web Exclusive* (August 23, 2005), pp. W5-399-W5-411.

22. CBO, *Budget Options*, February 2007, p. 167; available at www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf

23. David Lipschutz, California Health Advocates, 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/hearings.asp?formmode=view&id=5966>.

24. For a variety of perspectives on past competition initiatives, see "Medicare's Experience with Competitive Pricing," Special Section, *Health Affairs*, 19, no. 5 (September/October 2000): pp. 8-84.

25. For a discussion of the issues, see CBO, *Designing a Premium Support System for Medicare*, December 2006; available at www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf.

26. The one important difference is that, under the pre-BBA rules, Medicare nominally took a larger share of plan savings. (Again, inadequate risk adjustment in those years meant that real savings were smaller or nonexistent.) If a plan could furnish core benefits for 91 percent of FFS, Medicare kept 5 percent and beneficiaries got 4 percent in extra benefits. Under the current rebate rules, Medicare would keep 2.25 percent and the beneficiary would receive 6.75 percent.

Endnotes / continued ►

Endnotes / continued

27. H.R. 3162 includes some changes in income and asset tests for low-income assistance. For more extensive options, see Mark Merlis, "Eligibility Standards for Medicare/Medicaid Dual Eligibles: Issues and Options for Reform," National Academy of Social Insurance, September 2005; available at www.nasi.org/usr_doc/Merlis_Dual_Eligibles_Paper_05.pdf.

28. Stephanie Maxwell, Matthew Storeygard, and Marilyn Moon, "Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures," Commonwealth Fund, November 2002, available at www.commonwealthfund.org/usr_doc/maxwell_modernizingmedicare_571.pdf?section=4039; and Karen Davis *et al.*, "Medicare Extra: A Comprehensive Benefit Option For Medicare Beneficiaries," *Health Affairs Web Exclusive* (October 4, 2005), pp. W5-442–W5-454.



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