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Commentary: Don't Further Privatize Medicare

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Abstract

The Medicare program is quietly becoming privatized through increasing enrollment in Medicare Advantage (MA) plans, even though MA has not lived up to its promise of delivering better care at lower cost. Policymakers must reverse this trend and ensure parity between traditional Medicare and MA rather than encourage it through legislation that only benefits MA. Furthermore, as discussions of expanding health insurance coverage through Medicare intensify, policymakers should explore what version of Medicare they wish to expand.

Keywords

Medicare Advantage, Medicare, privatization, CMS, traditional Medicare

Without much public attention, the Medicare program is becoming more privatized as the private Medicare Advantage (MA) program and plans continue to grow, with much encouragement from the Administration. Over 20 million people—34% of all Medicare beneficiaries—were enrolled in MA plans in 2018,[1] an amount that the Congressional Budget Office projects will grow to about 42% by 2028.[2]

Based on our own experience assisting Medicare beneficiaries as consumer advocates at the Center for Medicare Advocacy, and by several external measures, however, MA is not serving either the Medicare program or its own enrollees well. Nonetheless, policymakers continue to enact laws and implement policies that favor MA. Instead of further incentivizing Medicare beneficiaries to enroll in private MA plans, policymakers must ensure parity between traditional Medicare and MA.

Higher Cost and Mixed Health Outcomes

There are certain advantages of enrollment in MA plans, including "one-stop shopping" through the inclusion of Part D prescription drug coverage by most plans, and the availability of some additional benefits and services not covered by the traditional Medicare program. But part of the promise of having private plans participate in the Medicare program was that they could deliver better care at a lower cost. That promise has not been met.

While payment to private plans was initially pegged at 95% of projected spending in traditional Medicare, payment increases (notably through the Medicare Modernization Act of 2003) led to increased programmatic costs, borne by all Medicare beneficiaries and taxpayers.[3] While the Affordable Care Act reined in significant overpayments to MA plans (that at one point averaged 114% of traditional Medicare) and brought average payment more in line with what traditional Medicare spends on a given beneficiary, payment inequity between MA and traditional Medicare lingers—some of which is due to questionable risk-adjustment practices that can result in annual overpayments to MA of billions of dollars. (As noted in a *New England Journal of Medicine* article entitled "Medicare Advantage Checkup" [November 2018], after many years of Medicare payments to MA plans being "considerably higher," payment to MA plans today are "roughly equal to the per capita costs in traditional Medicare (101% of those costs, on average)." The article notes: "[c]urrent methods that are used to compare [MA] payments with traditional Medicare costs may overstate the true costs to plans of providing Medicare benefits" for example, the current risk-adjustment system may allow MA plans to "boost [. . .] their payments by as much as 2% (on average) in 2018, on the basis of how they code their enrollees' health conditions." Some analysts have tried to quantify how much MA plans are being overpaid

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based on how they code their enrollees' health status. A 2017 study published in *Health Affairs* found that coding intensity practices could result in overpayments to MA plans totaling $200 billion over the next decade. Similarly, in April 2016, the General Accounting Office [GAO] issued a report stating that CMS estimates that about 9.5% of its annual payments to MA organizations were improper—totaling $14.1 billion in 2013 alone—"primarily stemming from unsupported diagnoses submitted by MA organizations.") Although there is research indicating that MA plans may more effectively control cost growth compared to traditional Medicare,[4] a new study by the Kaiser Family Foundation suggests that favorable self-selection into MA plans is occurring, "raising questions about the extent to which plans are actually lowering spending or managing care."[5] (See also *Does Medicare Advantage Cost Less Than Traditional Medicare?*[6] This study found that "the costs of providing benefits to enrollees in private Medicare Advantage [MA] plans are slightly less, on average, than what traditional Medicare spends per beneficiary in the same county. However, MA plans that are able to keep their costs comparatively low are concentrated in a fairly small number of US counties.")

Remarkably, despite such significant overpayments to MA plans, there is limited data about beneficiaries' experiences in such plans, but the data that are available are decidedly mixed, at best. A recent health policy report by researchers at the Kaiser Family Foundation assessed the current MA landscape, including what is known and not known about enrollees' experience.[7] While the Kaiser researchers note that MA enrollees "appear to be somewhat healthier than beneficiaries in traditional Medicare," they also state that "[s]urprisingly little is known" about MA enrollees out-of-pocket spending in comparison to traditional Medicare. Furthermore, the authors note that MA plans "tend to score better than traditional Medicare on some quality metrics, but the results are mixed and data are limited"; while MA plans "generally score better . . . on preventive services and screening measures" and "appear to use post-acute care less intensely with better outcomes . . . [s]omewhat counterintuitively, there seems to be no difference between Medicare and [MA] plans with respect to care coordination, receipt of needed prescriptions by beneficiaries, and adherence rates for diabetes and cholesterol medications."[7,8-10]

Perhaps most alarming, Kaiser researchers note that "[l]ittle is known about the quality of care for [MA] enrollees with serious illnesses" but "[s]everal studies have flagged concerns about the quality of care received by high-need, high-cost enrollees, on the basis of disenrollment rates and other measures."[7,10-13] (The study by Rahman et al[14] examined the rates at which participants who used 3 high-cost services [long-term nursing home care, short-term nursing home care, and home health care] switched between Medicare Advantage and traditional Medicare. The authors found that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction. These results were magnified among people who were enrolled in both Medicare and Medicaid. The study by Meyers et al[15] concluded that "high-need enrollees, particularly those who are dual eligible, disenroll from MA at substantially higher rates than other enrollees.") The authors note that the variation in quality of plans, lack of data, and "eye-brow raising disenrollment rates among higher-need patients appear to warrant attention and oversight."[7]

The Center for Medicare Advocacy's experience serving Medicare beneficiaries bears this out. While people do not contact us to tout how well their care is being coordinated, we regularly hear from numerous individuals who have trouble obtaining medically necessary coverage through their private MA plan which would otherwise be covered under traditional Medicare, including premature termination or outright denial of coverage in nursing facilities and home health care.

Thumbs on the Scale for MA

Despite the inflated payment and what is known—and not known—about health outcomes for beneficiaries in MA plans, policymakers continue to promote the MA program without regard to the growing inequity between MA and traditional Medicare.

Over the last several years, legislative changes have worked to favor MA, including a prohibition of people eligible for Medicare on or after January 1, 2020, from purchasing a Medigap policy that covers the Part B deductible (sometimes referred to as policies that offer "first dollar coverage"); the reinstatement of the Medicare Advantage Open Enrollment Period (MA-OEP); expanding MA to individuals with end-stage renal disease (ESRD) without corresponding Medigap rights; and the expansion of supplemental benefits in MA to individuals with chronic conditions, but not, correspondingly, in traditional Medicare.[16]

In addition, a number of policies are being implemented that favor MA plan sponsor "flexibility" by allowing MA plans to offer supplemental benefits in a way that will make things more complex, not less, for all Medicare beneficiaries, at the same time those in traditional Medicare are being left behind.[17] This effort to increase flexibilities for MA plans has been accompanied by a departure from the neutral manner in which Medicare options are supposed to be presented to the public by the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program. Since Fall 2017, advocates have noted that CMS's outreach and enrollment materials have encouraged beneficiaries to choose a private Medicare plan over traditional Medicare, instead of objectively presenting enrollment options.[18,19]

Conclusion

Kaiser researchers project that, assuming MA enrollment continues to grow, "the Medicare of tomorrow could look much different than it does today—more like a marketplace of private plans, with a backup public plan, and less like a national insurance program."[7]

The Center for Medicare Advocacy urges policymakers to reverse this trend. Instead of continuing to favor MA regardless of cost, without comprehensive data about how enrollees fare in such plans, complete equity between MA and traditional Medicare must be advanced—including both the scope of services provided and programmatic spending. Wasteful spending on MA should be reinvested into the Medicare program to benefit all people with Medicare, not just those who choose to enroll in private plans.

Finally, as discussions of using Medicare as a vehicle to expand health insurance coverage intensify, policymakers should explore what version of Medicare they wish to expand—taking note that "Medicare for all" may actually mean "Medicare Advantage for all" if current trends continue.

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