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CURBING MEDICARE ADVANTAGE OVERPAYMENTS COULD BENEFIT MILLIONS OF LOW-INCOME AND MINORITY AMERICANS

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More than 25 million Americans belonging to minority groups lack health coverage; minorities constitute 34 percent of the nation's population but nearly 55 percent of the uninsured. Enactment of comprehensive health reform that achieves universal coverage would therefore disproportionately benefit minorities.

One way to help finance universal coverage, as President Obama has noted, would be to curb excessive payments to the private insurance companies that serve some Medicare beneficiaries through the Medicare Advantage program. Although private insurers were brought into Medicare to reduce costs, Medicare pays them an average of $1,000 more per beneficiary per year than it costs to treat the same beneficiaries through traditional Medicare. These overpayments threaten Medicare's finances and increase the premiums paid by participants in traditional Medicare. As a result, Congress' official expert advisory body on Medicare payment policy, the Medicare Payment Advisory Commission, has recommended "leveling the playing field" and paying private plans the same amounts as traditional Medicare.

Private insurers contend that curbing the overpayments would harm low-income and minority Medicare beneficiaries, whom they claim rely disproportionately on Medicare Advantage for benefits that supplement their Medicare coverage. In fact, however, *Medicaid* is the overwhelming source of supplemental coverage for low-income beneficiaries and beneficiaries of color.

KEY FINDINGS

- Minorities would benefit disproportionately from a system of universal health coverage; they constitute 34 percent of the population but nearly 55 percent of the uninsured. Some 14.8 million Hispanics, 7.0 million African Americans, and 3.4 million Asian Americans and other people of color are uninsured.
- One way to help finance universal coverage would be to eliminate the large overpayments to the private insurers that serve some Medicare beneficiaries through the Medicare Advantage program. These overpayments will cost $157 billion over the coming decade, weakening Medicare's finances and raising costs for beneficiaries in traditional Medicare.
- To defend these overpayments, insurers claim that low-income and minority beneficiaries rely disproportionately on them for supplemental coverage. In fact, such beneficiaries are more likely to get this coverage through Medicaid.
- Furthermore, only a small share of the Medicare Advantage overpayments actually go toward helping low-income and minority beneficiaries afford health care.
- A better way to help low-income and minority Americans would be to curb the overpayments and reinvest the savings to help finance a system of universal coverage and to strengthen the Medicare Savings Programs and Medicare Part D Low-Income Subsidy, which help beneficiaries pay premiums and cost-sharing.

Furthermore, overpayments to private plans represent a poorly targeted approach to making health care more affordable for these beneficiaries. Only a portion of the overpayments actually go to reducing beneficiaries' out-of-pocket costs and covering additional services, and only a small portion of these enhanced benefits accrue to low-income and minority beneficiaries.

A better approach would be to eliminate the overpayments and use the savings in two ways that would directly assist low-income and minority individuals to a much greater degree. The first is to help finance comprehensive health reform legislation that achieves universal coverage. The second is to strengthen two programs that help low-income and minority Medicare beneficiaries with their out-of-pocket health care costs: the Medicare Savings Programs within Medicaid and the Low-Income Subsidy program within the Medicare prescription drug benefit.

Minorities Much More Likely Than Whites to Be Uninsured

Minorities constitute a disproportionate share of the 46 million Americans who are uninsured. According to the most recent Census data, nearly 55 percent of the uninsured were people of color in 2007, even though minorities account for only 34 percent of the overall population. Hispanics had the highest rate of uninsurance, with nearly one-third lacking coverage. One out of five African Americans and one out of six Asian Americans also lacked health insurance in 2007. In comparison, one in ten whites were uninsured.[1]

Moreover, minorities tend to be uninsured for longer periods of time because of disparities in income and employment. Many minorities work in small firms and service industries where health insurance is typically not offered as a benefit. In addition, those who are offered employer-based insurance often do not take up the coverage because their low wages render them unable to afford the premiums. As a result, minority Americans are much less likely to have health insurance through their jobs, even after accounting for differences in employment rates.[2]

Enacting comprehensive health care reform that achieves universal coverage would represent a significant step towards improving access to health care for millions of minority Americans. It would benefit up to 14.8 million Hispanics, 7.0 million African Americans, and 3.4 million Asian Americans and other people of color who are now uninsured (see Table 1).

But universal coverage would be expensive and would likely require

TABLE 1: SIGNIFICANTLY MORE MINORITIES WOULD BENEFIT FROM EXPANDING COVERAGE THAN ENHANCING MEDICARE ADVANTAGE BENEFITS

	Minorities Who Are Uninsured (in millions)	Minorities in Medicare Advantage (in millions)
African American	7.0	0.8
Hispanic	14.8	1.1
Asian / Other/ Multiple Race	3.4	0.3

Source: Center on Budget and Policy Priorities analysis of data from the 2008 Current Population Survey and Kaiser Family Foundation analysis of the 2006 Medicare Current Beneficiary Survey.

[1] Center on Budget and Policy Priorities analysis of data from the 2008 Current Population Survey.

[2] Cara James, Megan Thomas, Marsha Lillie-Blanton, and Rachel Garfield, "Key Facts: Race, Ethnicity and Medical Care," Henry J. Kaiser Family Foundation, January 2007.

offsetting spending cuts and/or tax increases. Ensuring that all Americans have health insurance thus requires that the federal government identify potential savings. This includes curbing the excessive payments that private insurers now receive through the Medicare Advantage program. President Obama and Senator Max Baucus, the Chairman of the Senate Finance Committee, both have cited these overpayments as one source of savings that could help finance health reform.

Medicare Advantage Overpayments Harm Beneficiaries and Increase Risk of Cutbacks

Under Medicare Advantage, Medicare beneficiaries have the option to receive their coverage through private health plans rather than the traditional Medicare fee-for-service programs. Private plans ostensibly were brought into Medicare to reduce costs, but evidence shows they have actually cost the program much more money. The Medicare Payment Advisory Commission (MedPAC), Congress' expert advisory body on Medicare payments, reports that overpayments to private insurance plans through Medicare Advantage are costing Medicare billions of dollars each year.

MedPAC recently estimated that in 2009, Medicare will pay the private plans *14 percent more per beneficiary* than it would cost to cover these beneficiaries in traditional Medicare.[3] The overpayments average approximately $1,000 for each beneficiary enrolled in a private plan, according to the Commonwealth Fund. Between 2004 and 2008, the overpayments totaled nearly *$33 billion*.[4] The Congressional Budget Office estimates they will cost $157 billion over the coming decade.[5]

These overpayments raise costs for taxpayers — and for beneficiaries in traditional Medicare. This is because beneficiaries' monthly premiums are tied to Medicare costs: when costs rise, so do premiums. Since the overpayments increase Medicare costs, they drive premiums higher than they otherwise would be. According to the chief actuary at the Centers for Medicare and Medicaid Services (CMS), the overpayments now raise premiums by about $3 per month per person (or $72 a year for a couple).[6]

Consequently, roughly 31 million seniors and people with disabilities enrolled in regular Medicare are forced to pay higher premiums each month to subsidize the cost of these excess payments, even though these beneficiaries receive no extra coverage in return.[7] This reduces the disposable income that tens of millions of seniors and people with disabilities — including large numbers of minority beneficiaries — have to live on.

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[3] Scott Harrison and Carlos Zarabozo, "The Medicare Advantage Program," presentation for the Medicare Payment Advisory Commission (MedPAC), December 5, 2008.

[4] Brian Biles, Emily Adrion, and Stuart Guterman, "The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008," The Commonwealth Fund, September 2008.

[5] "Budget Options, Volume I: Health Care," Congressional Budget Office, December 2008.

[6] See Fawn Johnson, "Stark, Camp Disagree Over Paths to Keep Medicare Solvent," *Congress Daily*, April 1, 2008 and "Cutting Managed Care Pay Would Prolong Medicare Trust Fund Solvency, Actuary Says," *BNA Health Care Policy Daily*, April 2, 2008.

[7] Mark Miller, "Medicare Advantage Program and MedPAC Recommendations," Testimony before the Subcommittee on Health, House Ways and Means Committee, Medicare Payment Advisory Commission, March 21, 2007.

By raising Medicare costs, the overpayments also "contribute to the worsening long-range financial sustainability of the Medicare program," as Glenn Hackbarth, MedPAC's chairman, has warned Congress.[8] The CMS chief actuary testified last year that the overpayments advance the date when the Medicare Hospital Insurance Trust Fund will become insolvent by 18 months.[9] As a result, restoring Medicare's solvency will require substantially larger benefit cuts and/or tax increases than would otherwise be needed. Those benefit cuts could be particularly harmful to low-income and minority beneficiaries.

For a number of years, MedPAC has called on Congress to rein in the excessive payments to private plans and has recommended several specific reforms. In 2008, Congress adopted one of these recommendations, phasing out double payments to Medicare Advantage for the costs of indirect medical education.[10] This, along with other provisions that would slow the rate of enrollment growth in private fee-for-service plans (the type of Medicare Advantage plan with some of the largest overpayments), will save an estimated $12.5 billion over five years (2009-2013) and $47.5 billion over ten years (2009-2018), according to the Congressional Budget Office.

However, Congress has yet to adopt the largest of MedPAC's proposed reforms, which would equalize payments between private plans and regular Medicare to create a "level playing field." CBO has estimated that doing so starting next year would save $55 billion over five years (2010-2014) and $157 billion over ten years (2010-2019).[11] Other provisions to address excessive Medicare payments to private plans could save billions of dollars more.[12]

Industry Claims That Curbing Overpayments Would Harm Minorities Are Overblown

Some private plans have responded that Medicare Advantage provides significant benefits to key underserved populations, and that curbing the overpayments would have adverse consequences for low-income and minority Medicare beneficiaries. For example, America's Health Insurance Plans (AHIP), the insurers' trade association, claims that these beneficiaries rely disproportionately on Medicare Advantage for "supplemental coverage" — that is, for help in paying Medicare premiums and cost-sharing and for some benefits not covered by traditional Medicare fee-for-service.

Such claims are heavily overstated. In general, low-income and minority individuals are not overrepresented in Medicare Advantage. Beneficiaries with incomes of less than $10,000 constitute 17 percent of all Medicare beneficiaries and 16 percent of Medicare Advantage enrollees. African Americans represent 10 percent of all beneficiaries and 11 percent of Medicare Advantage enrollees,

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[8] Glenn Hackbarth, "Report to the Congress: Medicare Payment Policy," testimony before the Subcommittee on Health, House Ways and Means Committee, March 11, 2008.

[9] See Fawn Johnson, *op cit.*

[10] The double payments occurred because Medicare Advantage rates included medical education (IME) payments, even though Medicare was already making separate payments for indirect medical education to teaching hospitals treating Medicare enrollees, including those in Medicare Advantage. Most of the cost savings cited in this paragraph can be attributed to the IME provision. See Congressional Budget Office, "Cost Estimate for H.R. 6331, Medicare Improvements for Patients and Providers Act of 2008," July 23, 2008.

[11] "Budget Options, Volume I: Health Care," Congressional Budget Office, December 2008.

[12] See, for example, Edwin Park, "Informing the Debate About Medicare Advantage Overpayments" Center on Budget and Policy Priorities, May 13, 2008.

while Asian Americans constitute 1 percent of beneficiaries and 1 percent of Medicare Advantage enrollees.[13]

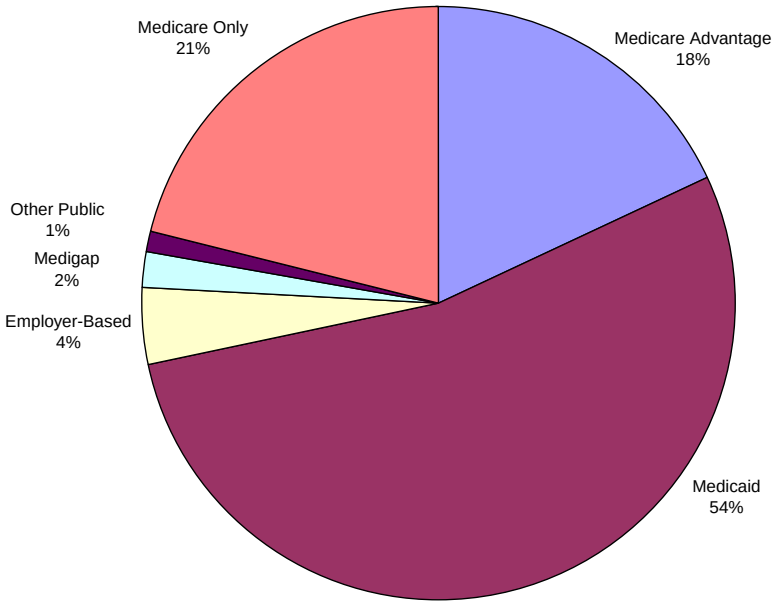
Hispanics are more likely to enroll in Medicare Advantage; they make up 2 percent of all beneficiaries and 4 percent of plan enrollees. This, however, likely reflects the fact that residents of states like California and Florida, which have large Hispanic populations, have traditionally been more likely than residents of other states to obtain health coverage through managed care organizations, both in Medicare and in employer-based insurance.

Medicaid, Not Medicare, Is Main Source of Groups' Supplemental Coverage

What AHIP's analysis actually shows is that low-income and minority beneficiaries overwhelmingly rely on *Medicaid*, not Medicare Advantage, for supplemental coverage. According to AHIP's own analysis, 45 percent of Medicare beneficiaries with incomes below $10,000 were enrolled in Medicaid in 2006. This is more than 2.5 times the proportion of beneficiaries who were enrolled in Medicare Advantage (17 percent).

FIGURE 1

More Than Half of Minority Medicare Beneficiaries Earning Less than $10,000 Rely on Medicaid for Supplemental Coverage



Source: America's Health Insurance Plans' analysis of the 2006 Medicare Current Beneficiary Survey

Similarly, among minority groups:

- 52 percent of Asian American Medicare beneficiaries received supplemental coverage through Medicaid, while just 14 percent were enrolled in Medicare Advantage;
- 26 percent of African American beneficiaries received supplemental coverage through Medicaid, while 20 percent were enrolled in Medicare Advantage;
- 37 percent of Hispanic beneficiaries received supplemental coverage through Medicaid, while 32 percent were enrolled in Medicare Advantage.

[13] See Tables 6B and 7B of "AHIP: Low Income and Minority Seniors Depend on Medicare Advantage," America's Health Insurance Plans, September 22, 2008.

Furthermore, the large majority of minority beneficiaries — 86 percent of Asian Americans, 80 percent of African Americans, and 68 percent of Hispanics — are enrolled in *traditional Medicare* rather than Medicare Advantage.[14]

Overpayments an Inefficient Way to Help Low-Income and Minority Beneficiaries

Medicare Advantage plans have also argued that they play a significant role in reducing beneficiaries' out-of-pocket costs because they use a portion of the overpayments they receive to reduce premiums and/or cost sharing and provide extra benefits. For two main reasons, however, the overpayments are an extremely costly and inefficient way to reduce out-of-pocket costs or increase benefits for low-income and minority beneficiaries.

First, a significant portion of the overpayments go to insurer profits and other non-medical costs rather than to additional benefits. For example, MedPAC has found that among private fee-for-service plans — the fastest-growing type of Medicare Advantage plan that is also not required to coordinate care — about *half* of the overpayments go to profits, marketing, and administrative costs.[15] Moreover, a recent MedPAC analysis found that every $1 in enhanced benefits delivered by Medicare Advantage plans costs Medicare an average of $1.30; in private fee-for-service plans, every $1 in enhanced benefits costs Medicare more than $3.[16] Thus, excess payments to private plans represent a highly inefficient way of delivering extra Medicare services.

Second, only a fraction of the additional benefits and lower premiums and cost-sharing that private plans provide actually go to low-income and minority beneficiaries, since these groups constitute just a fraction of total Medicare Advantage enrollment.[17] Fewer than one-fifth of Medicare Advantage enrollees are members of a minority group, and an even smaller segment (16 percent) have incomes below $10,000. (Note: The median income for Medicare beneficiaries is very low — it was only $15,000 in 2005.[18]) The remainder of the benefits goes to Medicare Advantage beneficiaries whose incomes are higher and who are not minority. As a result, these overpayments are a poorly targeted way to help make health care affordable for low-income and minority beneficiaries.

As MedPAC has stated, "if the justification for higher payments to [private] plans is that extra payments are being provided to low-income beneficiaries who choose such plans, there are less costly and more efficient ways to achieve this result."[19] Similarly, the Government Accountability

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[14] See Table 5B of America's Health Insurance Plans, *op cit.*

[15] Mark Miller, "The Medicare Advantage Program and MedPAC Recommendations," testimony before the House Budget Committee, Medicare Payment Advisory Commission, June 28, 2007 and Glenn Hackbarth, oral testimony before the Senate Finance Committee, April 11, 2007. See also Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2008.

[16] Scott Harrison and Carlos Zarabozo, *op cit.*

[17] Glenn Hackbarth, "Report to the Congress: Medicare Payment Policy," testimony before the Subcommittee on Health, House Ways and Means Committee, March 11, 2008

[18] See Tricia Neuman, Juliette Cubanski, and Anthony Damico, "Revisiting 'Skin in the Game' Among Medicare Beneficiaries: An Updated Analysis of the Increasing Financial Burden of Health Care Spending from 1997 to 2005," Henry J. Kaiser Family Foundation, February 2009.

[19] Mark Miller, *op cit*, and Glenn Hackbarth, *op cit*.

Office (GAO) has concluded that "if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost-sharing for all [Medicare Advantage] beneficiaries, including those who are well off."[20]

It also is important to note that low-income and minority beneficiaries in poorer health can wind up significantly *worse* off if they enroll in Medicare Advantage. This is because the private plans have the discretion to scale back specific benefits so long as the actuarial value of their overall benefit package is not less than the value of the package under traditional Medicare.[21] Some private insurers evidently use this flexibility to design their benefits packages to entice healthy Medicare beneficiaries, who are less costly to treat, while deterring sicker (and more costly) beneficiaries from enrolling.[22] For example, some plans impose substantially higher co-payments for days in the hospital or costly treatments like chemotherapy.

Better, More Targeted Ways Exist to Make Health Care More Affordable

A better way to help low-income and minority individuals afford health care would be to eliminate the Medicare Advantage overpayments and use the savings to:

- help finance comprehensive health reform that achieves universal coverage; and
- enhance existing subsidy programs to help Medicare beneficiaries with their out-of-pocket medical costs. These programs include the Medicare Savings Programs within Medicaid, which help low-income enrollees pay Medicare premiums and other out-of-pocket costs, and the Low-Income Subsidy program within Medicare Part D, which helps cover the premiums and cost-sharing associated with Medicare prescription drugs.

As noted above, comprehensive health reform that achieves universal coverage would be particularly beneficial to low-income and minority individuals and families, since they are much more likely than other Americans to be uninsured.

In addition, both MedPAC and GAO have stated that strengthening existing subsidy programs for low-income Medicare beneficiaries would be a more targeted and effective way to help low-income and minority beneficiaries than continuing the Medicare Advantage overpayments.[23] Legislation enacted in 2008 included some improvements in the Medicare Savings Programs and the Part D Low-Income Subsidy. A portion of the savings from curtailing the Medicare Advantage overpayments could now be used to further improve benefits and/or expand eligibility for these

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[20] Government Accountability Office, *op cit*.

[21] See, for example, Brian Biles, Lauren Hersch Nicholas, and Stuart Guterman, "Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?" The Commonwealth Fund, May 2006.

[22] While Medicare generally prohibits Medicare Advantage plans from discriminating on the basis of health status, an analysis by the Commonwealth Fund found that that "compliance with this broad policy is not carefully defined and enforced by CMS." Biles *et al., op cit.*

[23] Out-of-pocket health care spending poses a greater financial problem for Medicare beneficiaries who are poor or near-poor than for those at higher income levels. Improving these subsidy programs would be more effective in helping low-income beneficiaries with their health care costs. See Tricia Neuman, Juliette Cubanski, and Anthony Damico, *op cit.*

programs. For example, the Medicare Savings Programs only cover Medicare deductibles and co-payments for beneficiaries with incomes below the poverty line — now $10,400 for an elderly individual living alone — and only subsidize Medicare premiums for those up to 135 percent of the poverty line. These cost-sharing protections could be extended modestly farther up the income scale. People who qualify for the Medicare Savings Programs are more likely to be in poor health and have a greater need for medical services than other Medicare beneficiaries.[24]

Conclusion

The federal government's overpayments to private Medicare Advantage plans weaken Medicare finances, raise costs for other Medicare beneficiaries, and tie up resources that could be used more productively. Industry claims that curbing these excess payments would hurt low-income and minority beneficiaries are vastly exaggerated: most of these individuals who have supplemental coverage receive it through Medicaid, and most of the overpayments that actually fund improved benefits (rather than profits or other non-medical purposes) go to Medicare Advantage beneficiaries who are neither minority nor low-income.

A better approach would be to curb the overpayments and use the savings to help finance the cost of extending health insurance coverage to all Americans, as well as to provide some additional targeted help to low-income and minority Medicare beneficiaries by strengthening the Medicare Savings Programs and the Medicare Part D Low-Income Subsidy. Such reforms would provide significant, and disproportionate, benefits to low-income and minority communities.

[24] See Edwin Park and Danilo Trisi, "Improving the Medicare Savings Programs Would Help Low-Income Seniors Cope with Higher Medical Expenses," Center on Budget and Policy Priorities, May 20, 2008, http://www.cbpp.org/5-20-08health.htm.