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# The Impact of Reductions in Medicare Advantage Funding on Beneficiaries

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By: Adam Atherly, Ph.D. and Kenneth E. Thorpe, Ph.D.

April 2007



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## Table of Contents

<b>Executive Summary</b> .....	i
<b>Introduction</b> .....	1
<b>1: Value of Supplemental Benefits for Medicare Advantage Enrollees</b> .....	3
<b>2: The Impact of Lower MA Payments on MA Enrollees</b> .....	5
a) Proposal: Setting MA Benchmarks at FFS Costs .....	5
b) Proposal: Freezing MA Benchmarks.....	7
<b>3: Impact of Payment Reductions on State-level MA Enrollment</b> .....	9
<b>Conclusions</b> .....	10
<b>Appendix A: Methodology</b> .....	11

## Executive Summary

More than 8 million Medicare beneficiaries rely on Medicare Advantage (MA) to provide additional benefits and lower cost-sharing than traditional Medicare. This study assesses the impact of proposals to reduce MA funding on the value of benefits offered and enrollment under the Medicare Advantage program.

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### Value of Supplemental Benefits for Medicare Advantage Enrollees

Medicare Advantage plans provided Medicare beneficiaries more than \$5 billion dollars in supplemental benefits in 2006, up from an estimated \$3 billion in 2005. Per beneficiary, this translates into \$825 per enrollee, on average, in 2006; an increase of 34 percent from 2005. These benefits are provided in the form of lower cost-sharing, coverage of benefits not provided under traditional Medicare, enhanced drug coverage, or buy-down of Part B and Part D premiums.

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### Impact of Lower MA Payments on MA Enrollees

The study analyzes the impact of two proposals that may be considered by Congress to reduce payments to Medicare Advantage plans: setting MA benchmarks at county-level fee-for-service (FFS) costs and freezing updates in MA payments.

- **Impact of setting MA benchmarks at county-level FFS costs.** Under this proposal, an estimated 3 million enrollees in the MA program – including 1.8 million enrolled in HMOs and PPOs – would leave the program and return to traditional Medicare. Based on previous research, the study estimates that more than 700,000 of these 1.8 million MA HMO/PPO enrollees (over one-third of those who disenroll) would go without any additional supplemental coverage.
- **Impact of freezing MA benchmarks.** If MA payments increase at 1 percent per year (as they have in 2007) and underlying health care costs increase at 5 percent per year, the total dollar value of supplemental benefits would decline to \$2.2 billion in 2008 and to \$1.2 billion by 2009. If medical inflation is greater than 5 percent, supplemental benefits would decline even faster. Enrollment in MA plans would decline further under this scenario with 3 million HMO/PPO members – about half of all HMO/PPO enrollees – leaving MA and returning to traditional Medicare. Enrollment declines would be even larger if all MA plans were included.

Freezing future MA payment increases at 1 percent would increase average beneficiary costs by a total of \$412 over the 2006-2009 time period, on average, for those who remain in the MA program. Beneficiaries who disenroll from the Medicare Advantage program would see even greater increases in out-of-pocket costs estimated at \$825 a year, the current value of per capita supplemental benefits in MA.

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## **Impact of Payment Reductions on State-level MA Enrollment**

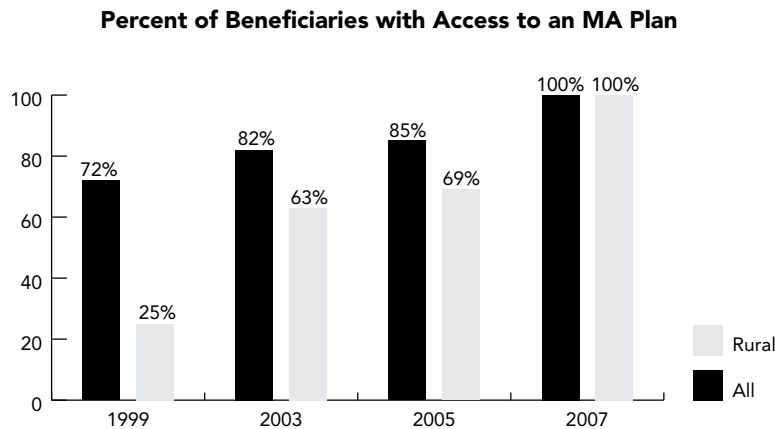
Beneficiaries now have access to MA options in every state. If Congress enacts reductions in MA payment rates, both the total number of MA enrollees and MA penetration rates are projected to decline. If Congress sets MA rates at the level of county FFS spending, 11 states are predicted to lose more than 100,000 MA enrollees each, including: California, Colorado, Oregon, Washington, Massachusetts, Wisconsin and Illinois. An additional 13 states would lose between 50,000 and 100,000 MA enrollees, including: Missouri, North Carolina, New Jersey, Alabama, Georgia, Minnesota, Florida, New York, Louisiana, Kentucky, Virginia, Indiana and Tennessee.

## Introduction

More than 8 million Medicare beneficiaries rely on Medicare Advantage (MA) to provide additional benefits and lower cost-sharing than traditional Medicare. Medicare Advantage enrollees receive Medicare-covered services at lower out-of-pocket costs and receive supplemental coverage for additional benefits not covered under traditional Medicare.

Our previous research found that Medicare Advantage is especially important for low-income and minority beneficiaries.<sup>1</sup> In our previous research, we showed that 36 percent of Medicare eligible beneficiaries with incomes below \$10,000 and 37.8 percent of those with incomes from \$10,000 to \$20,000 without Medicaid or employer coverage enrolled in Medicare+Choice plans (the predecessors to MA plans) in 2003. Moreover, 40 percent of African American and 52.9 percent of Hispanic beneficiaries without Medicaid or employer coverage enroll in these plans, as compared with 32.7 percent of non-Hispanic, white beneficiaries.

Since our last report, Medicare Advantage has grown substantially. MA enrollment has increased from 5.2 million members in 2005 to over eight million today. According to the Centers for Medicare and Medicaid Services (CMS), all beneficiaries have access to a private health plan option in 2007. This is a significant increase in private plan access since prior to the 2003 Medicare Modernization Act (MMA). In 2003, only 63 percent of beneficiaries in rural areas and 82 percent of all beneficiaries had access to a private plan option.



In an effort to increase enrollment and benefits in low payment counties, Congress made policy decisions to increase payments to MA plans as part of the MMA. These increases allowed plans to enhance the benefits they offer to Medicare beneficiaries and led to the expansion of MA options, and especially Private Fee-For-Service (PFFS) plans, into new areas. However, as a consequence of congressional policy decisions to expand the availability of MA plans, payments for MA now exceed county-level costs under traditional Medicare in many areas. The Medicare Payment Advisory Commission (MedPAC) estimates that MA plans were paid, on average, 112% of costs under traditional Medicare in 2006.

<sup>1</sup> Atherly and Thorpe, "Value of Medicare Advantage to Low-Income and Minority Beneficiaries," Emory University, September 20, 2005.

The Congressional Budget Office (CBO) has estimated that there would be substantial Medicare savings associated with equalizing MA payments with county-level fee-for-service Medicare spending. Moreover, MedPAC has proposed freezing MA benchmarks as a way of reducing spending on the MA program. This report analyzes the impact that such approaches would have on Medicare beneficiaries enrolled in this program.

Lower payments to MA plans, if enacted, would reduce both supplemental benefits and enrollment under Medicare Advantage. This is a simple cause and effect relationship: beneficiaries perceive the value of MA as a function of cost and additional benefits. If MA payment increases are less than increases in underlying medical costs, benefits will decline, premiums will increase, or both, thus reducing the value of MA coverage to beneficiaries.

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## Purpose of Report

The purpose of this report is to examine the impact of lower MA plan payments on Medicare beneficiaries. This study addresses three questions:

- (1) *What is the current value of supplemental benefits for Medicare Advantage enrollees?*** This section estimates the current value of supplemental benefits provided to enrollees.
- (2) *What would be the impact of proposals to reduce Medicare Advantage funding on MA enrollees? How many Medicare Advantage enrollees would disenroll?***
  - a. The impact of setting MA benchmarks equal to FFS costs
  - b. The impact of freezing MA rates
- (3) *How would these lower payments affect enrollment at the state level?***

## 1. Value of Supplemental Benefits for Medicare Advantage Enrollees

Medicare beneficiaries join the MA program because the plans provide lower cost-sharing and additional benefits not covered under traditional Medicare. As payments increase relative to MA plan costs, plans offer additional benefits to beneficiaries and lower (or no) premiums, leading to increased enrollment. As plan payments are reduced, supplemental benefits are reduced and enrollment declines.

Under the statutory bidding and payment formula for MA plans, beneficiaries in plans that can provide Medicare Parts A and B services at a cost below the government benchmark receive supplemental benefits equal to 75 percent of the difference between a plan's bid and the benchmark.<sup>2</sup> The government retains the remaining 25 percent as savings.

This study primarily modeled the supplemental benefits offered by MA HMO plans because they have about 80 percent of all enrollment. We estimate that MA HMOs provided \$5 billion in supplemental benefits in 2006, up from an estimated \$3 billion in 2005. Per beneficiary, this translates into \$825 per enrollee, on average, in 2006; an increase of 34 percent from 2005. This represents the net dollar value of the supplemental benefits provided, less the cost of any premiums paid by enrollees.

These benefits are provided to Medicare beneficiaries in the form of lower cost-sharing, coverage of benefits not provided under traditional Medicare, enhanced drug coverage, or buy-down of Part B and Part D premiums. Most plans reduce cost-sharing under traditional Medicare (e.g., reducing the Medicare hospital deductible or replacing 20 percent cost-sharing with fixed dollar copayments), which may improve access to care relative to traditional Medicare with no supplemental coverage.<sup>3</sup> MA plans also typically include limits on out-of-pocket costs, while there is no such limit under traditional Medicare. According to MedPAC, 98 percent of all Medicare beneficiaries had access to a MA plan with an annual out-of-pocket limit of \$5,000 or less and 65 percent had availability of a plan with an out-of-pocket limit of \$2,000 or less in 2006.<sup>4</sup>

Our estimates of supplemental benefits correlate well with the estimates of the CMS Office of the Actuary. According to CMS' estimates, MA plans are able to return \$6.8 billion dollars of supplemental benefits to beneficiaries and \$2.1 billion dollars in savings to the government. Our estimate of the total dollar value of supplemental benefits is smaller primarily because we looked only at MA HMOs.

<sup>2</sup> According to CMS, nearly all MA plans (95%) bid below the benchmark in 2006, allowing them to provide supplemental benefits to enrollees.

<sup>3</sup> The Medicare Payment Advisory Commission (MedPAC) has found that beneficiaries without supplemental coverage are five times more likely to delay care due to cost.

<sup>4</sup> MedPAC. "Report to the Congress: Increasing the Value of Medicare." June 2006, pp. 210-211

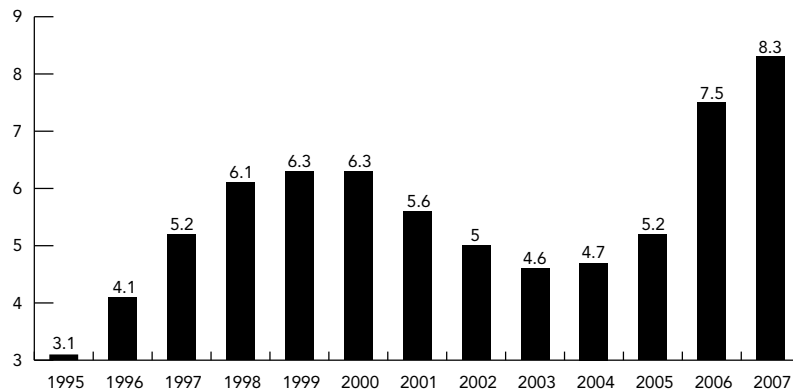
## 2. The Impact of Lower MA Payments on MA Enrollees

We modeled the impact of reduced funding on the availability of supplemental benefits using an update of a beneficiary choice model developed for the Blue Cross and Blue Shield Association in 2002 and published in *Health Affairs* later that year. A statistical model of individual choice was used to predict the probability of Medicare Advantage enrollees dropping coverage for different levels of reductions in supplemental benefits. See appendix A for additional details on our methodology.

MA plan enrollment is a function of the combination of annual increases in MA plan payments and MA plan costs. Beneficiaries are sensitive to value: they enroll in MA plans when they perceive that MA plans are a better value than traditional Medicare. When plan payment increases do not keep pace with medical inflation, plans either reduce benefits or increase cost-sharing, thus reducing their perceived value to beneficiaries.

Historical participation in the Medicare+Choice program (the predecessor of the Medicare Advantage program) clearly shows the impact of changes in payment rates. Medicare HMO enrollment reached its maximum in the late 1990s, with approximately 6.3 million members. After private plan payments were reduced following the 1997 Balanced Budget Act (BBA) and held to 2 percent increases (during a period of double-digit medical cost inflation), enrollment fell to 4.6 million in 2003.

**Chart 1: Private Medicare Plan Enrollment, 1995-2007**



Source: CMS Monthly Summary Text Reports. Enrollment from December of given year, except 2007, which has enrollment from January

The passage of the Medicare Modernization Act of 2003 (MMA), which increased funding for MA plans, caused enrollment to rebound as plans returned to the program and offered enhanced benefits. Enrollment in private plans reached a new high of 8.3 million in 2007. Most of this enrollment remains in HMO plans, which cover approximately 6 million beneficiaries. However, other types of plans, such as private-fee-for-service (PFFS) plans and preferred provider organizations (PPOs) have experienced rapid growth. Much of this growth has occurred in rural areas over the last two years as a result of past congressional policy to enhance payments in rural areas.

Our model allows us to predict the impact of MA funding reductions on the dollar value of supplemental benefits and beneficiary enrollment. We begin by estimating the impact of the existing reductions in Medicare Advantage funding enacted by Congress in the 2005 Deficit Reduction Act (DRA). This legislation phases-out certain payments to Medicare Advantage plans beginning in 2007. The Congressional Budget Office (CBO) estimated that these changes would reduce funding for the Medicare Advantage program by \$6.5 billion between 2006 and 2010.

As a result of the DRA, we assume that payments to MA plans will increase by an amount that is 4% below the rate of medical cost inflation in 2007 (about 5 to 6%). Because 2007 MA payments will not keep up with anticipated health care inflation, the total value of supplemental benefits for MA HMOs under the Medicare Advantage program are projected to decline in 2007. Under current law, we estimate that the total dollar value of net supplemental benefits will decline from more than \$5 billion in 2006 to \$4.7 billion in 2007 for MA HMOs.

We then analyzed the impact of two proposals under consideration in Washington to reduce payments to Medicare Advantage plans: a) setting MA benchmarks at county-level FFS costs; and b) freezing updates in MA payments.

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### **a) Proposal: Setting MA Benchmarks at FFS Costs**

The first proposal would reduce payments for Medicare Advantage plans to the level of county fee-for-service claims costs under traditional Medicare as recommended by MedPAC. For the purpose of this analysis, we approximate MedPAC's estimate of the difference in costs for Medicare Advantage and FFS by also removing graduate medical education costs from the calculation of costs under traditional Medicare (as MedPAC has proposed).

Our model predicts reductions in Medicare Advantage enrollment that are similar – though potentially larger – than those observed in the period following enactment of the 1997 Balanced Budget Act, which limited payment increases to only 2 percent for most plans during a period of high medical cost inflation. During this period, nearly two million beneficiaries disenrolled from Medicare+Choice plans.

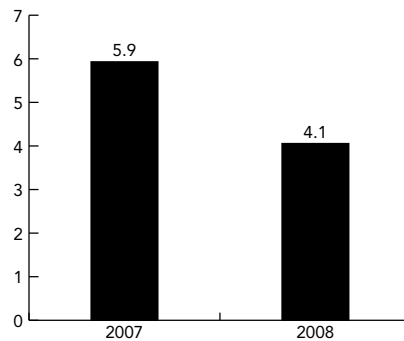
We estimate that, if MA benchmarks were equalized with county-level FFS expenditures, three million enrollees in the MA program would leave the program and return to traditional Medicare<sup>5</sup>. Two-thirds of the reduction in MA enrollment would come from beneficiaries leaving local HMOs and PPOs and one-third would come from a significant reduction in private fee-for-service plans.

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<sup>5</sup> Estimate includes 1.9 million enrollees in MA HMO plans and 1.3 million enrollees in MA PFFS plans.

Roughly 1.8 million of current MA members enrolled in HMOs and PPOs would leave the MA program due to increases in premiums, reductions in benefits, or withdrawal of their MA plan (see chart below). These beneficiaries would move into traditional Medicare and, based on our previous work, we estimate that more than 700,000 of those who would lose coverage would go without any additional supplemental coverage. These beneficiaries would face higher cost-sharing and fewer benefits than they currently receive with their MA plan.<sup>6</sup>

**MA HMO Enrollment Equalizing MA Rates w/FFS (in millions)**



Reducing MA payments to 100 percent of FFS costs would also reduce enrollment in private fee-for-service (PFFS) plans. The CBO projects that PFFS enrollment will exceed 1.6 million in 2007 and approach 2.3 million by 2008. PFFS plans have proliferated because they offer additional benefits, lower cost-sharing, or both within a fee-for-service setting. Setting MA payments at 100 percent of local FFS spending would effectively eliminate PFFS as a plan offering. Some of those enrolled in PFFS would choose other MA plans (where available) while others would simply select the traditional Medicare program. Our model does not allow an empirical estimate of how PFFS enrollees would sort among other MA plans and traditional Medicare. If half of those expected to enroll in PFFS select other MA plan options, over 1.2 million would enroll in traditional Medicare. Under this scenario, the overall impact of moving to 100 percent of FFS payments would be a reduction of approximately 3 million MA enrollees.

Reducing MA benchmarks would have significant differential impacts on rural areas and thus the beneficiaries and plans operating in those areas. Multiple congressional decisions have raised rates in rural areas above traditional FFS spending to expand access to MA plans to all Medicare beneficiaries<sup>7</sup>. Health plan options in rural areas, such as PFFS plans and regional PPOs, would face the largest reductions.

6 Atherly and Thorpe, "Value of Medicare Advantage to Low-Income and Minority Beneficiaries," Emory University, September 20, 2005.

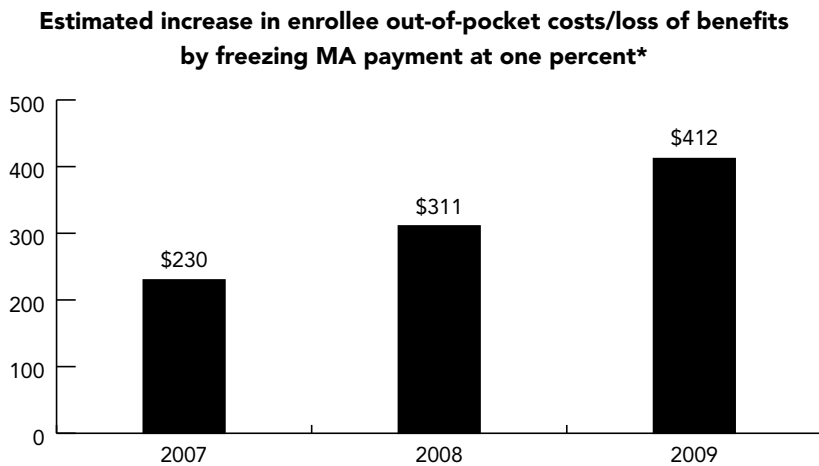
7 The Balanced Budget Act of 1997, The Benefits Improvement and Protection Act of 2000 and the Medicare Modernization Act of 2003 all raised rates in rural areas.

## b) Proposal: Freezing MA Benchmarks

We also analyzed the decline in benefits that would occur if Congress froze MA program annual payment increases to 1 percent annually. Our model estimates, with 5 percent increases in MA costs and 1 percent increases in payments, aggregate MA program funding would be at 100 percent FFS claims costs in approximately three years, depending on the underlying rate of medical inflation. Under this type of proposal, beneficiaries in urban areas would see greater dollar-value reductions in benefits. Because urban benchmarks are closer to FFS costs, simply freezing benchmarks would lead to MA rates below FFS and far below the cost of providing health care.

If MA payments increase at 1 percent per year each year (as they have in 2007) and underlying health care costs increase at 5 percent per year, the total dollar value of supplemental benefits would decline to \$2.2 billion in 2008 and to \$1.2 billion by 2009. If medical inflation is greater than 5 percent, supplemental benefits would decline even faster.

We estimate that freezing future MA payment increases at 1 percent would increase average beneficiary costs by a total of \$412 over the 2006-2009 time period, on average, for those who remain in the MA program. These higher beneficiary costs would come in the form of both higher premiums and benefit reductions. Beneficiaries who disenroll from the Medicare Advantage program would see even greater increases in out-of-pocket costs estimated at \$825 a year, the current value of per capita supplemental benefits in MA.



\* Assumes 5 percent increase in underlying health care costs and MA rates frozen at 1 percent, as in 2007. Greater medical inflation would result in greater benefit reductions and/or premium increases.

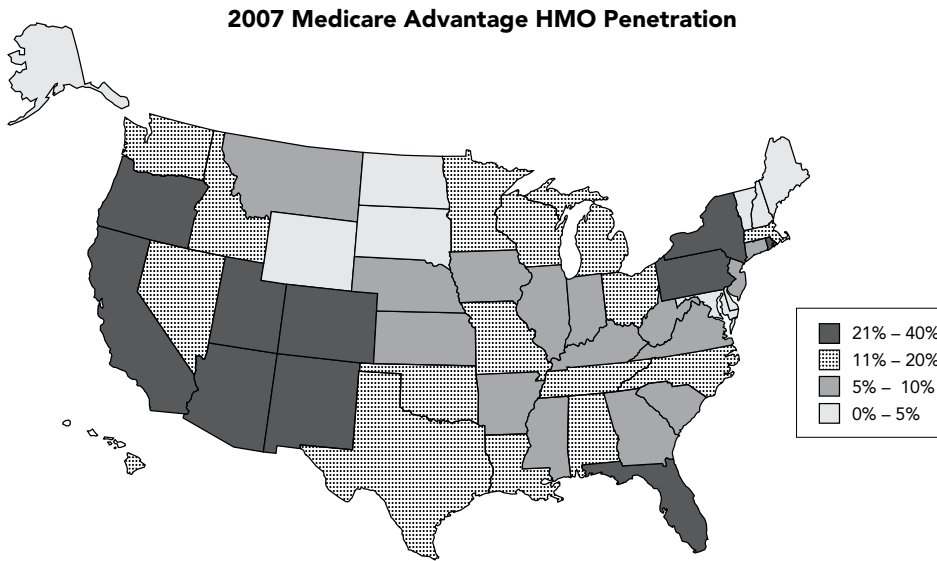
If plan payments increase at the same rate as health care costs, enrollment should remain the same or increase due to increases in efficiency, but enrollment is likely to decrease beginning in 2008 if plan payment increases rise slower than the increase in health care costs. Beyond 2008, enrollment will be highly dependent on MA payment rates. If MA payments do not keep pace with the rising health care costs, MA enrollment is projected to decline.

■ The Impact of Reductions in Medicare Advantage Funding on Beneficiaries

We modeled the decline in MA HMO enrollment over time with payment increases frozen at one percent conjoined with annual increases in health care costs of 5 percent. We estimate a steep decline in enrollment associated with the significant loss of supplemental benefits and eventual withdrawal of plans. We estimate approximately three million MA enrollees – one half of all HMO enrollees – would lose their coverage from 2006-2009 under this scenario.

### 3. Impact of Payment Reductions on State-level Enrollment

While beneficiaries now have access to MA options in every state, enrollment varies substantially by state. Arizona has the highest MA penetration of any state with 40 percent of all Medicare beneficiaries enrolled in an MA plan. Rhode Island, Oregon, Pennsylvania, and California are all above 30 percent penetration (see figure). In total, 26 states have MA penetration greater than 10 percent.



If Congress enacts reductions in MA payment rates, both the total number of enrollees and penetration rates are projected to decline. For example, if Congress sets MA rates at the level of county FFS spending, our model estimates that almost 196,000 enrollees each in Pennsylvania and Ohio would lose MA coverage and return to traditional Medicare. Michigan would lose MA coverage for 180,000 enrollees and Texas would lose 173,000 enrollees in MA HMO and PFFS plans. Enrollees who lose MA coverage and return to traditional Medicare would face increases in out-of-pocket costs and benefit reductions compared to what they were experiencing in MA.

Eleven states are predicted to lose more than 100,000 MA enrollees each including: California, Colorado, Oregon, Washington, Massachusetts, Wisconsin and Illinois. We estimate an additional 13 states would lose MA HMO and PFFS enrollees between 50,000 and 100,000 under the proposal to set all MA rates at FFS costs including: Missouri, North Carolina, New Jersey, Alabama, Georgia, Minnesota, Florida, New York, Louisiana, Kentucky, Virginia, Indiana and Tennessee.

## Conclusions

Medicare Advantage enrollment is at an all time high and HMO plans provided an estimated \$5.0 billion in additional benefits in 2006, up from about \$3 billion in 2005. Earlier work has shown that these benefits are provided disproportionately to lower-income and minority beneficiaries.

While MA plans increase costs for the Medicare program, in all circumstances, the size of the increase in cost will be less than the value of the supplemental benefits provided to beneficiaries. MA plans are able to combine the payment increases with cost containment strategies to provide \$5.0 billion in benefits to enrollees in 2006. Under current payment rules, most of the savings achieved by health plans are passed through to the beneficiaries instead of being recouped by Medicare.

Legislation that reduces future plan payments in the MA program could generate substantial savings for the Medicare program. The CBO estimates that paying plans at 100 percent of local FFS costs would save \$65 billion over the next five years and \$160 billion between 2008 and 2017.

On the other hand, legislation that reduces future plan payments would likely force MA plans to increase premiums, reduce benefits, reduce provider payments, and eventually lead MA plans to leave the program altogether or simply retrench in the markets where they have been able to maintain successful plans, such as Florida or Southern California.

We estimate that, if MA benchmarks were equalized with county-level FFS expenditures, enrollment in MA plans would decline by approximately 1.8 million MA HMO/PPO enrollees – and would also decline for many of the 2.3 million expected to enroll in PFFS. More than 700,000 of the 1.8 million HMO/PPO members who would lose coverage would go without any supplemental coverage

We estimate that freezing future MA payment increases at one percent would increase average beneficiary costs by a total of \$412 over the 2006-2009 time period, on average, for those who remain in the MA program. These higher beneficiary costs would come in the form of both higher premiums and benefit reductions. Beneficiaries who disenroll from the Medicare Advantage program would see even greater increases in out-of-pocket costs estimated at \$825 a year.

## Appendix A: Methodology

We modeled the impact of reduced funding on the availability of supplemental benefits using an update of a beneficiary choice model developed for the Blue Cross and Blue Shield Association in 2002 and published in *Health Affairs* later that year.<sup>8</sup> A statistical model of individual choice was used to predict the probability of Medicare Advantage enrollees dropping coverage for different levels of reductions in supplemental benefits.

Our analysis is based on CMS plan payment data and CMS plan benefits data. To calculate FFS costs we used CMS estimates of 2005-2007 FFS county level costs, then inflated them at either 4 or 5 percent for the various estimates. We also reduced FFS costs by 2 percent to adjust for indirect medical education (IME) payments that are included in the calculation of MA rates.

MA enrollment for 2006 is based on June and November 2006 CMS county level data. However, the data we used did not break down PFFS and HMO enrollment by county. To estimate the relative enrollment, we calculated the county level ratio of HMO/PFFS enrollment by county from prior years and applied that ratio to 2006 total MA enrollment.

To calculate the value of supplemental benefits provided by HMO plans, we took HMO plan level benefit data and estimated the cost of providing the base FFS benefits and the actual benefits provided by the plan for a typical HMO Medicare enrollee. The difference between the cost of the supplemental benefits and the FFS core benefits represents the dollar value of the plan's supplemental benefit package. We then projected that benefit to 2007 using HMO cost growth estimates and actual CMS payment rates. We then calculated a county level average supplemental benefit, weighted by 2005 HMO plan enrollment. We then projected changes in benefits under different cost growth scenarios and different HMO payment levels.

To project plan enrollment, we used our calculation of the change in the value of the supplemental benefits, net of any change in plan premiums, and used an actuarial estimate of the sensitivity of beneficiaries to changes in benefits to simulate the impact of the changes on enrollment.

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8 Thorpe, Kenneth E. and Atherly, Adam, "Medicare + Choice: Current Role And Near-Term Prospects," *Health Affairs Web Exclusive*, July 17, 2002, [http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.242v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=thorpe&fulltext=Medicare&andorexactfulltext=and&searchid=1124896732672\\_1213&stored\\_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff](http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.242v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=thorpe&fulltext=Medicare&andorexactfulltext=and&searchid=1124896732672_1213&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff)







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