

# **Medicare Overpayments to Private Plans, 1985-2012**

**Shifting seniors to private plans has already cost Medicare \$282.6 billion**

Ida Hellander, M.D.  
Steffie Woolhandler, M.D., M.P.H.  
David U. Himmelstein, M.D.

October 2012

*(Forthcoming, International Journal of Health Services)*

**Physicians for a National Health Program**  
29 E. Madison St., Suite 602, Chicago IL 60602-4406  
Telephone (312) 782-6006 • Fax (312) 782-6008 • [info@pnhp.org](mailto:info@pnhp.org) • [www.pnhp.org](http://www.pnhp.org)

# Contents

About the authors.....	1
Abstract.....	2
Background.....	3
How does Medicare overpay private plans?.....	3
Calculating the total Medicare overpayment to private plans.....	4
Results.....	5
Private plans and risk adjustment: no contest.....	6
Policy implications.....	7
Conclusion.....	7
Timeline of events discussed in this report.....	7
Figures and tables.....	9
Figure 1.....	9
Figure 2.....	10
Table 1.....	11
Table 2.....	12
Notes.....	13

## About the Authors

**Ida Hellander, M.D.**, is director of policy and programs at Physicians for a National Health Program. She is co-author of the book “Bleeding the Patient: The Consequences of Corporate Health Care” and co-editor of PNHP’s newsletter. Her health policy research has been published in JAMA and in the International Journal of Health Services. Dr. Hellander received her bachelor’s degree from Yale University and her medical degree from the University of Minnesota School of Medicine.

**Steffie Woolhandler, M.D., M.P.H.**, is professor in the City University of New York School of Public Health at Hunter College and visiting professor of medicine at Harvard Medical School, where she co-directed the general internal medicine fellowship program and practiced primary care internal medicine at Cambridge Hospital. Dr. Woolhandler earned her bachelor’s degree from Stanford University, Stanford, California; a medical degree from Louisiana State University; and a master’s degree from the University of California. She worked in 1990-1991 as a Robert Wood Johnson Foundation health policy fellow at the Institute of Medicine and the U.S. Congress. She is a frequent speaker and has written extensively on health policy, administrative overhead and the uninsured. She has authored more than 50 research articles on health care access and financing. Dr. Woolhandler is a co-founder and board member of Physicians for a National Health Program, co-editor of PNHP’s newsletter and is a principal author of PNHP articles published in the JAMA and the New England Journal of Medicine in conjunction with Dr. David Himmelstein.

**David U. Himmelstein, M.D.**, is professor in the CUNY School of Public Health at Hunter College and visiting professor of medicine at Harvard Medical School. He has served as chief of the division of social and community medicine at Cambridge Hospital, where he also practiced primary care internal medicine. Dr. Himmelstein received his medical degree from Columbia University and completed internal medicine training at Highland Hospital/University of California San Francisco and a fellowship in general internal medicine at Harvard. Dr. Himmelstein is a co-founder of Physicians for a National Health Program, co-edits PNHP’s newsletter and is a principal author of PNHP articles published in the JAMA and the New England Journal of Medicine in conjunction with Dr. Steffie Woolhandler.

## Abstract

Previous research has documented Medicare overpayments to the private Medicare Advantage (MA) plans (also known as Medicare Part C or Medicare HMOs) that compete with traditional fee-for-service Medicare. This research has assessed individual categories of overpayment for a single year, or at most a few years. However, no previous study has calculated the total Medicare overpayments to private plans since the inception of the Medicare program.

There are five ways in which private insurers systematically garner excess Medicare Advantage payments from the Medicare program.

Prior to 2004, the selective enrollment of healthier seniors by private plans – what we call “old cherry-picking” – was the major source of excess payments. We conservatively estimate that this old cherry-picking has added \$41 billion to Medicare’s costs since 1985. Medicare adopted a new risk-adjustment scheme in 2004 based on 70 medical diagnoses (“hierarchical condition categories”), but this scheme has not curbed, and may have increased, private plans’ ability to game Medicare’s payment system, albeit with a new strategy: now, plans seek to selectively enroll patients who have mild versions of the medical conditions that determine payment. This “new cherry-picking” has added \$122.5 billion to Medicare’s costs since 2004.

Congress mandated increased payment to private plans in the 2003 Medicare Modernization Act, adding \$84.4 billion to the cost of Medicare through 2012.

The Affordable Care Act (ACA) mandated a drop in these overpayments, but a new demonstration project on quality will offset one-third of the reductions called for by the ACA through 2014.

Another major way that private plans are overpaid is by enrolling persons who are eligible for Veterans Health Administration (VA) benefits. The VA has provided \$34.8 billion in care to MA enrollees since 1985.

In total, we find that Medicare has overpaid private insurers by \$282.6 billion, or 24.4 percent of all MA payments, since 1985. In 2012 alone, we find that MA plans are being overpaid by \$34.1 billion, or 6.2 percent of total Medicare spending.

In 2012, 13.5 million Medicare beneficiaries are in private plans, 27 percent of total enrollment. Some proposals would push millions more beneficiaries into private plans (e.g. voucher-type Medicare reform).

Risk adjustment does not and cannot work in the setting of for-profit MA plans, which have a strong financial incentive, and the data and ingenuity, to game whatever payment system Medicare devises. It is time to end Medicare’s long experiment with privatization and look toward proven-effective methods for controlling costs and improving coverage.

## Background

Commercial health insurance companies have been allowed to market private Medicare plans for three decades, over two-thirds of the duration of the program's existence. The number of enrollees in such plans, now known as Medicare Advantage (MA) plans, has grown rapidly in recent years (Figure 1).

As of mid-2012, 27 percent of all Medicare beneficiaries, 13.5 million people, are enrolled in private MA plans. This year, private plans participating in Medicare will receive an estimated \$136.2 billion from Medicare, \$10,123 per enrollee.<sup>1</sup> This money is drawn from Medicare Part A (the Hospital Insurance Trust Fund) and Medicare Part B, which in turn are funded primarily by a combination of general revenues, payroll tax contributions and beneficiary premiums.

While there are 3,300 different MA plans, two for-profit firms (UnitedHealth and Humana) enroll about one-third of all Medicare beneficiaries in private plans.

Numerous studies have found that private plans raise Medicare's costs, i.e. that Medicare pays private insurers more in premiums than the MA enrollees would have cost had they stayed in traditional (fee-for-service) Medicare.<sup>2-10</sup> However, private insurers have wielded sufficient political power over the years to resist most calls to end the overpayment – including advice from the Medicare Payment Advisory Commission (MedPAC) in 2001, 2002, 2004 and 2005.

The 2010 Affordable Care Act (ACA) changed the formula Medicare uses to pay the private plans to reduce their overpayment. This change accounts for \$145 billion of the \$716 billion in Medicare savings projected over the next decade under the ACA. The issue has turned into a political football in the 2012 presidential election.

However, implementation of the ACA's payment reductions has already been undermined by an \$8.35 billion demonstration project funded by the Centers for Medicare and Medicaid Services (CMS) that was intended to reward MA plans that provide particularly high-quality care but has awarded bonus payments to virtually all MA plans.<sup>11</sup> These bonuses will offset more than one-third of the ACA's payment reductions between 2012 and 2014. Private Medicare plan en-

rollment has grown dramatically since the passage of the ACA, indicating that the private Medicare plans remain highly profitable.

In this report, we review existing evidence on the Medicare overpayment to private plans, and calculate an overall estimate of the cost of such private plans to the taxpayers since 1985.

## How does Medicare overpay private plans?

Medicare pays each private plan a fixed amount for each Medicare beneficiary who chooses to enroll in a private plan. The formula for determining this amount has changed several times over the past three decades but MA plans have adapted to each change and have continued to take advantage of overpayments in new ways. Private plans are responsible for covering all care that would be covered by the traditional Medicare program, and may offer additional benefits, such as free eyeglasses.

The categories of systematic overpayment to private plans include:

**1. The selective enrollment of healthier beneficiaries before 2004, or what we will call “old cherry-picking.”**<sup>12</sup> Under the payment formula in effect until 2004, Medicare paid private plans a premium that was risk-adjusted only for a few demographic factors such as age, gender, and disability, whether an enrollee resided in a nursing home and Medicaid eligibility (a proxy for poverty). Hence a healthy 70-year-old man would bring the same premium as his sicker, 70-year-old neighbor. Private plans used marketing, benefit design, enrollment office location, and other techniques to recruit the healthy and discourage sicker seniors from enrolling.

**2. Gaming of Medicare's more complex risk-adjustment scheme, known as Hierarchical Condition Categories (HCCs).**<sup>13,14</sup> Since 2004, private plans have been selectively enrolling beneficiaries with very mild cases of the medical conditions included in the HCC risk-adjustment formula; such patients have, on average, substantially lower costs than the risk-adjust-

ed premium payment that Medicare pays the private plan on their behalf. We refer to this as “new cherry-picking.”

**3. Congressionally-mandated overpayments included in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA), including duplicate payments for indirect medical education.**<sup>15</sup> The provisions that generated this overpayment were tacked onto the MMA after heavy lobbying by the private insurance industry.

**4. Bonus payments from the \$8.35 billion CMS “Medicare Advantage Quality Bonus Payment Demonstration,” an expansion of the \$3 billion in quality bonuses contained in the ACA.** This demonstration will award bonuses to plans covering more than 90 percent of MA beneficiaries and offset more than one-third of the cuts to MA overpayments mandated by the ACA between 2012 and 2014. According to the General Accountability Office, the demonstration is so poorly designed that it will generate almost no useful findings to improve quality.<sup>16</sup>

**5. Duplicate payments for private plan members who receive all or part of their care at VA facilities.**<sup>17-19</sup> Medicare pays the private plan a full premium payment, no matter how much of the patient’s care is delivered (and paid for) by the VA. In an extreme case, a senior might receive all care at the VA, making the premium given to the private plan pure profit. In 2009, 8.3 percent of all MA enrollees were enrolled in the VA.

Private plans also garner overpayments through “upcoding,” or the practice of intensively recording additional diagnoses in enrollees’ charts, making them appear sicker than similarly ill patients in traditional Medicare. Although this might be considered a sixth category of overpayments, CMS is aware of the problem and has started applying a fixed-adjustment for it, reducing MA payments by \$2.7 billion in 2010.<sup>20</sup> Although a recent report by the General Accountability Office (GAO) suggests that CMS is continuing to overpay private plans by \$1-2 billion, we conservatively excluded upcoding from our calculations, and just focused on the five categories of overpayments above.

## Calculating the total Medicare overpayment to private plans

Although MedPAC, the GAO, the Congressional Budget Office, and researchers with The Commonwealth Fund, Urban Institute, and VA have published figures for individual categories of overpayment to private plans (generally for a single year), no previous study has compiled all the sources of overpayments since the beginning of the program.

To calculate total annual spending on private Medicare plans, we obtained figures on Medicare Part A and Part B contributions to private plan premiums between 1966 and 2012 from the CMS’ Office of the Actuary, Medicare and Medicaid Cost Estimates Group. We excluded the period between 1966 and 1979 when Medicare Part A spent nothing on private plans, and the period between 1980 and 1984 when total Medicare spending for private plans (from Part A and Part B) was under \$1 billion.

We used published research on Medicare overpayments for each of the five categories of overpayment to calculate excess Medicare spending (in each category) on private plans as a share of total spending on private plans for each year since 1985. Where overpayments were estimated as a share of “Medicare FFS payments,” we used data on annual Medicare spending on private plans (which is generally similar and readily available) as a proxy.

Most studies analyzed Medicare overpayments using data from a single year (the “data year”) or a few years. For years before and after the data year analyzed, we estimated each category of overpayment based on percentage figures (carried forward or backward) for the closest data year for which estimates were available, then adjusted for temporal changes in total Medicare spending for private plans. Figures are reported in current dollars, i.e. actual dollar costs in the year that the spending was incurred.

We calculated total Medicare overpayments to private insurers since 1985 by summing overpayments in the five categories using the sources described below.

1. A large body of research demonstrates that private plans selectively enroll healthier beneficiaries. Esti-

mates of overpayments due to old cherry-picking prior to 2004 range from 5.7 percent to 74 percent above what it would have cost to care for similar beneficiaries in fee-for-service (FFS) Medicare.<sup>21</sup> We used three conservative, widely cited estimates for our study: an estimate of 5.7 percent using 1992 data by Brown et al. for Mathematica; a peer-reviewed estimate by Riley et al. of 12 percent overpayment using 1994 data; and an estimate by the GAO of 13.2 percent overpayment using 1998 data.<sup>22</sup> We conservatively excluded studies with higher estimates, including a peer-reviewed 1997 study that suggested overpayments due to selective enrollment were 34 percent, and a 1996 study by the Physician Payment Review Commission that suggested overpayments were 37 percent.<sup>23</sup> (Both also found that private plans selectively disenroll sicker beneficiaries, which would further increase plans' overpayment.) Using the three studies cited above, we calculated the amount of the overpayment from the figure for the data year(s) given and the years surrounding it, using the lowest and earliest figure (5.7 percent, 1992 data year) to estimate overpayments back to 1985.

2. We used research by MedPAC to estimate overpayments from 2004 to 2012 related to new cherry-picking, i.e. gaming the complex risk-adjustment scheme. A 2012 MedPAC report using 2007-2008 data found that Medicare beneficiaries who subsequently switch to private plans have 15 percent lower costs than other beneficiaries with a similar risk score. (MedPAC also found that beneficiaries who leave MA plans to return to traditional Medicare have 16 percent higher costs than beneficiaries who stayed in traditional Medicare, a strategy that might be described as "cherry-picking and spitting out the pits.") A National Bureau of Economic Research (NBER) study estimates overpayments of \$15 billion to MA plans in 2006 from risk selection and overpayments mandated by the MMA, or a 23.2 percent combined overpayment (personal communication, Ilyana Kuziemko).<sup>24</sup> We used the published MedPAC figure of 15 percent since it was limited to risk selection, but note that the NBER figure is similar (subtracting the 11.2 percent share of mandated overpayments would leave a 12 percent overpayment from new cherry-picking in 2006).

3 and 4. We obtained figures on overpayments mandated by the MMA from two sources. For years between 2003 and 2008, we used research carried out by Brian Biles and colleagues for The Commonwealth

Fund.<sup>25</sup> For the years 2009-2012, estimates of the mandated overpayment were available from MedPAC's annual reports on the MA program.<sup>26</sup> MedPAC (appropriately) adjusted its 2012 figure to account for reductions contained in the ACA, and the fourth category of overpayment, demonstration project quality bonuses, which partially offset the ACA reductions.

5. Medicare overpayments for dually eligible VA patients enrolled in private plans have been known to exist for decades. However, they have only recently been quantified by Trivedi et al. at a national level.<sup>27</sup> We calculated overpayments from this source using figures on total VA spending on care for MA enrollees from 2004-2009 as a share of total MA spending during that period.

## Results

Table 1 displays each category of Medicare overpayment to private plans as a percentage of total Medicare payments to private plans for each year since 1985. Overpayments attributable to old cherry-picking ranged from 5.7 percent to 13.2 percent annually between 1985 and 2004. New cherry-picking since 2004 generated annual overpayments of 15 percent of total spending on private plans. Overpayments mandated by Congress rose from 9.9 percent in 2004 to 12 percent in 2010, and then fell to 7 percent in 2012. Overpayments due to care for Medicare private plans' enrollees delivered (and paid for) by the VA were 3 percent annually.

The dollar amounts of overpayments for each category are shown in Table 2. Overpayments nearly doubled with the implementation of the MMA, rising from \$6 billion in 2003 to \$11 billion in 2004. Prior to 2004 overpayments peaked at \$6.4 billion in 2000. The total overpayment was highest in 2009 at \$36.2 billion, just before passage of the ACA.

In 2012, the total Medicare overpayment to private plans was \$34.1 billion, 25 percent of all payments to private plans, or \$2,526 per MA enrollee.

Figure 2 displays the dollar amounts of overpayments in each category since 1985. New cherry-picking, plans' selective enrollment of healthier patients within each risk strata in the HCC risk-adjustment scheme since 2004, is currently the largest category of over-

payment, and is responsible for \$122.5 billion in overpayments to private plans since 1985.

Overpayments mandated by the MMA of 2003, including duplicate payments for indirect medical education, and the first year of quality bonuses to plans as part of a CMS demonstration project on quality, account for \$84.4 billion of overpayments to private plans since 1985.

The use of the VA for medical care by MA enrollees accounts for \$34.8 billion of total overpayments to private plans, while old cherry-picking (plans' selective enrollment of healthy beneficiaries prior to the adoption of the new risk-adjustment system in 2004) accounts for \$41 billion in overpayments to private plans since 1985.

In total, overpayments to private plans have cost taxpayers \$282.6 billion since 1985. That amount represents 24.4 percent of total Medicare spending of \$1,159.6 billion on private plans between 1985 and 2012.

In 2012 alone, the total Medicare overpayment to private plans will be an estimated \$34.1 billion, 25 percent of all payments to private plans, \$2,526 per MA enrollee, or 6.2 percent of all Medicare spending.

## **Private plans and risk adjustment: No contest**

Under Medicare's old "demographic" model of risk-adjustment, the most profitable beneficiaries to private plans were those who were the healthiest.

Under Medicare's new risk-adjustment scheme, the most profitable beneficiaries are those with a serious diagnosis (for which the plan receives a higher payment) but who, nonetheless, are actually not very sick (i.e. they have low severity of illness within that diagnosis). While serious cases of diseases like arthritis, diabetes, chronic bronchitis, and prostate cancer increase with age, so do very mild cases that require little or no specific treatment. Private plans have adapted to the HCC risk-adjustment formula by identifying and recruiting beneficiaries with mild cases of medical conditions who are now more profitable to insure than beneficiaries without any diagnoses. Such

gaming has been described as "cherry-picking conditional on diagnosis" or "selection along dimensions not included in the risk-adjustment formula."

The example of congestive heart failure (CHF) illustrates how private plans can game the risk-adjustment system.<sup>28</sup> Medicare beneficiaries at the 95th percentile of costliness with CHF had more than \$37,000 in Medicare spending in 2008, compared with just \$115 in spending for beneficiaries with CHF at the 5th percentile. Despite the cost differences, plans get the same bonus (about 41 percent of the premium for a healthy senior) for each patient who has CHF. Hence, plans can profit by encouraging physicians to perform echocardiogram tests used to diagnose CHF on seniors without symptoms, labeling the patients with this diagnosis when they have such mild cases that their costs of care would not be elevated.

While there are already calls to improve the accuracy of the HCC model, there is no evidence that risk adjustment works or can work in the dynamic reality of profit-seeking health care insurers.

Private plans have powerful financial incentives to design new strategies to game risk adjustment. The plans have access to much more detail about enrollees' health than does Medicare (i.e. there is information asymmetry), and as mentioned above, very mild cases of chronic conditions are common in the elderly. Each time Medicare adjusts its risk-adjustment formula, private plans will try to compensate by adjusting their cherry-picking. The most interesting part of the 2004 enhancement of Medicare Advantage's risk-adjustment formula is not that plans succeeded in gaming it, but that cherry-picking was at least as common after the enhanced risk adjustment as before.<sup>2</sup>

Without such cherry-picking, it seems unlikely that private plans could compete with traditional Medicare at all. Traditional Medicare is administratively efficient because it enrolls people using the Social Security system and uses a single set of rules and fees to pay doctors and hospitals. Hence, the overhead in traditional Medicare is quite low, under 2 percent, compared to 15 percent in private plans.<sup>29</sup> According to one estimate, overhead per enrollee in 2008 was \$147 in traditional Medicare versus \$1,450 in private plans.<sup>30</sup> Although private plans' higher overhead doesn't raise our estimate of overpayments, it does

imply significantly reduced amounts of clinical care actually delivered to patients by MA plans.

## Policy implications

Our findings indicate that the inclusion of private plans in the Medicare program has cost taxpayers \$282.6 billion, 24.4 percent of the total amount Medicare has paid private plans since 1985.

Our findings likely underestimate the magnitude of the overpayments. We used low-end estimates to calculate the cost of selective enrollment prior to 2004, and excluded the substantial cost of private plans' disenrollment of beneficiaries who subsequently have higher-than-average costs.<sup>31</sup> With private plans, "the healthy go in, and the sick go out," but our figures only include the first half of that formulation.

We also excluded the cost of the post-2004 upcoding that occurs after the first year of MA enrollment (payments for the first year are based on pre-enrollment data). CMS didn't make its first adjustment for upcoding until 2010, when it reduced MA payments by \$2.7 billion. The GAO estimates that Medicare could save another \$15 billion over the next decade on upcoding even after CMS' adjustment.

Recent technical and legislative attempts to reduce the two major drivers of overpayments have had little or no impact. The adoption of a new risk-adjustment scheme by Medicare in 2004 has not curbed cherry-picking by private plans, and may have increased it. In 2012 private plans garnered \$20.4 billion in overpayments by gaming the risk-adjustment scheme. Reductions in mandated overpayments by the ACA have been partially offset by inappropriate quality bonuses. Hence, the congressionally mandated overpayments fell only modestly this year to \$9.5 billion.

In addition, taxpayers pay twice for care provided (and paid for) by the VA for enrollees of private plans. In 2012 the VA will provide an estimated \$4.1 billion in care to the 8.3 percent of MA enrollees who are also receiving VA care.

In 2012 alone, we estimate that private insurers are being overpaid \$34.1 billion, \$2,526 per MA enrollee, 6.2 percent of total Medicare spending this year.

## Conclusions

Advocates of market-based Medicare reforms suggest that competition among private plans will induce greater efficiency and result in cost savings. Our findings indicate that the opposite is true. Private plans have drained over \$280 billion from Medicare since 1985, most of it in the last 8 years. Increasing private enrollment through voucher-type Medicare reform (as suggested by Republicans) or through quality bonuses and financial incentives to plans to enroll dual-eligible beneficiaries (as enacted by the Obama administration) will almost certainly raise Medicare's costs, not lower them.

Funds wasted on overpayments to private MA plans could instead have been used to improve benefits for seniors, extend the life of the Medicare Trust Fund by more than a decade, or reduce the federal deficit. Private insurers have enriched themselves at the expense of the taxpayers.

It is time to end Medicare's long and costly experiment with privatization. Alternative models of controlling costs that are proven-effective deserve a closer look.<sup>32,33</sup>

## Timeline of events discussed in this report

1972 – Congress passes legislation to authorize capitation payments for services covered under Part A and Part B. The goal initially was to avoid disrupting existing patient-provider relationships in staff-model HMOs, such as the nonprofit Kaiser plan in California.

1982 – Medicare Risk Program, Section 1876 of the Tax Equity and Fiscal Responsibility Act (TEFRA), passes. Medicare beneficiaries have the option to enroll in risk-contract HMOs in which the federal payment is set at 95 percent of the estimated fee-for-service cost as calculated at the county level (known as the average per capita cost, or AAPCC).

1985 – Medicare payments to private plans exceed \$1 billion annually for the first time.

1993 - 1999 – Private plans grow, increasing enrollment from 2.6 million to 7 million. Studies show that

because of cherry-picking the government is overpaying HMOs through the risk-contracting program, even with the 5 percent reduction from what it would have paid plans for the average FFS beneficiary.

1997 – Balanced Budget Act replaces TEFRA with Medicare+Choice. New method for paying plans adopted. Plans can choose the highest of three formulas: 2 percent increase (later increased to 3 percent) from previous year, blend of urban and rural counties, or blend of national and local rates.

1999 – 2003 – Because of the new payment formula, most big urban plans receive a premium increase of only 2 percent and start shedding benefits, enrollees, or both. Enrollment nationally declines to 5.3 million, although plans continue to be overpaid in this period.<sup>8</sup>

2000 – CMS experiments with adjusting a fraction of MA payments with inpatient claims data.

2003 – The Medicare Prescription Drug, Improvement, and Modernization Act (MMA), after heavy lobbying from the insurance industry, includes provisions that mandate raises in the premiums Medicare pays private plans. MMA explicitly directs CMS to pay plans for indirect medical education (IME), although plans do not pay hospitals for these costs, which are borne entirely by the traditional fee-for-service Medicare program.

2004 – Medicare starts risk-adjusting payments based on (initially 70) Hierarchical Condition Categories (HCC). In addition, Medicare gives plans temporary bonuses to aid their transition to the HCC, risk-adjusted payment system.

2008 – Medicare Improvement for Patients and Providers Act (MIPPA) legislation phases out duplicate indirect medical education (IME) payments by 0.6 percent annually starting in 2010. (In 2009, IME payments raised MA plan payments by 2.2 percent.) In 2010, the ACA exempted plans for beneficiaries eligible for both Medicare and Medicaid (dual-eligibles) from the IME phase-out.

2010 – The Patient Protection and Affordable Care Act (ACA) reduces the overpayments mandated in 2003 by aligning benchmarks (used to set MA payments) more closely with Medicare spending for enrollees in traditional Medicare. CMS Office of the Actuary estimates that this payment reform will reduce MA payments by \$145 billion over nine years and cut enrollment by half. ACA also provides \$3 billion in bonuses for plans that “achieve high star ratings” for quality. CMS begins applying a small adjustment for coding differences between MA plans and traditional Medicare, avoiding \$2.7 billion in excess payments in MA plans in 2010.

2010 – CMS announces revised \$8.35 billion “MA Quality Bonus Payment Demonstration” program with higher bonuses over a shorter time frame (2012 to 2014) for more plans (including those with lower star ratings, i.e. three, four or five stars) than the original bonus program included in the ACA. The bonuses offset more than one-third of the reduction in MA payments projected to occur under the ACA between 2012 and 2014. Private plan enrollment continues to increase, in contrast to the shrinkage previously predicted by CMS.

**Figure 1**

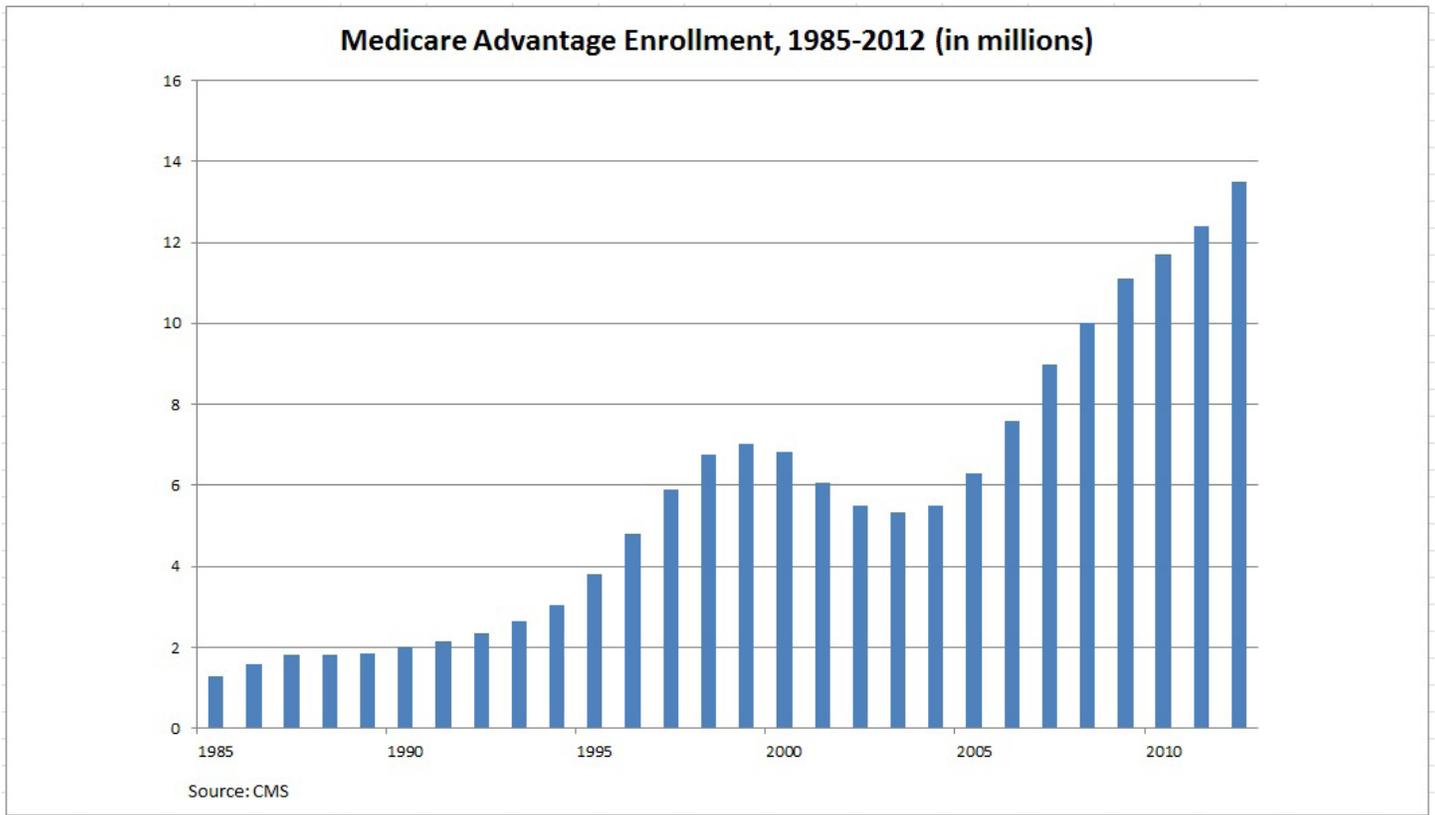
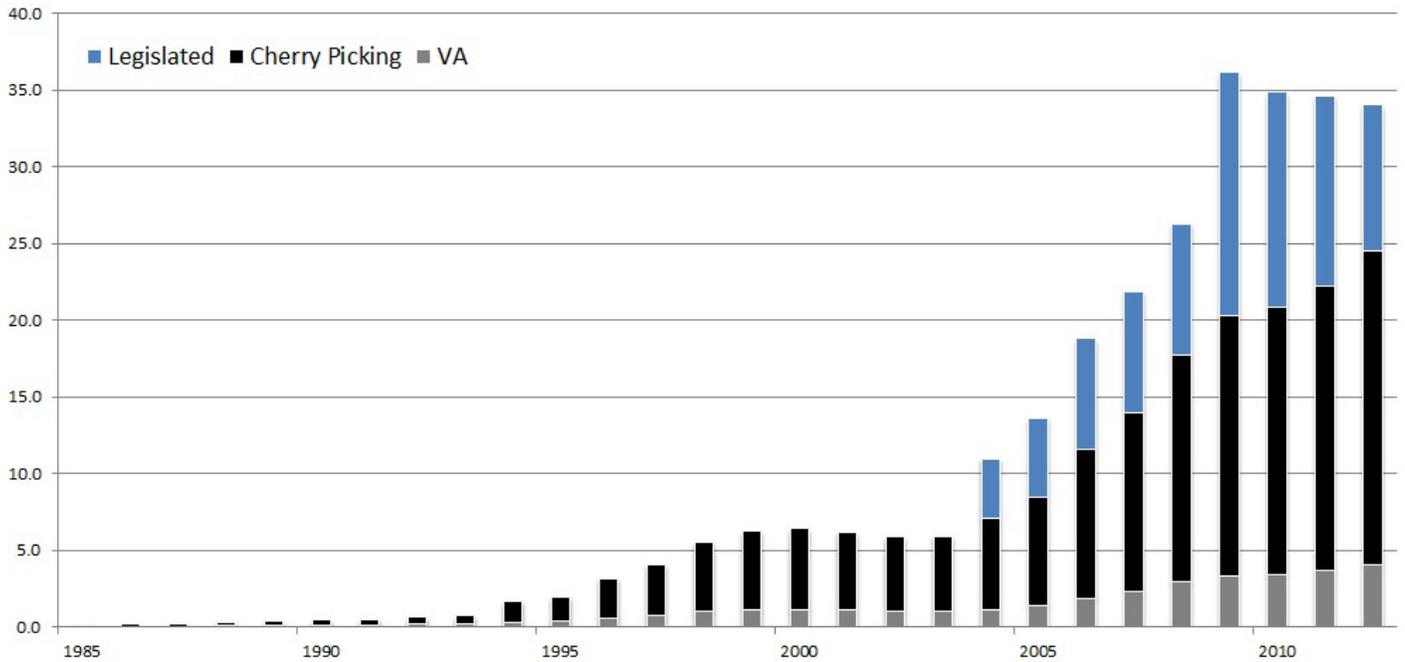


Figure 2

# Private Insurance Plans Cost Medicare More

Overpayments Total \$282.6 Billion Since 1985

Medicare Advantage overpayments as compared to Medicare F-F-S costs for similar patients (\$ billions)



Source: PNHP Report 10/2012 - based on data from MedPAC, Commonwealth Fund, Trivedi et al  
VA = Cost of VA uncompensated care provided to Medicare Advantage Enrollees  
Legislated = Congressionally-mandated excess payments to Medicare Advantage Plans

**Table 1**

Medicare Overpayments to Private Plans as a Percentage of Fee-for-Service Payments by Category, 1985-2012					
Year	Old Cherry Picking	New Cherry Picking <sup>d</sup>	Congressionally Mandated Overpayments	Care delivered by VA to Private Plan Enrollees <sup>j</sup>	Total Percentage Overpayments
1985	5.7 <sup>a</sup>	NA	NA	3	8.7
1986	5.7 <sup>a</sup>	NA	NA	3	8.7
1987	5.7 <sup>a</sup>	NA	NA	3	8.7
1988	5.7 <sup>a</sup>	NA	NA	3	8.7
1989	5.7 <sup>a</sup>	NA	NA	3	8.7
1990	5.7 <sup>a</sup>	NA	NA	3	8.7
1991	5.7 <sup>a</sup>	NA	NA	3	8.7
1992	5.7 <sup>a</sup>	NA	NA	3	8.7
1993	5.7 <sup>a</sup>	NA	NA	3	8.7
1994	12 <sup>b</sup>	NA	NA	3	15
1995	12 <sup>b</sup>	NA	NA	3	15
1996	12 <sup>b</sup>	NA	NA	3	15
1997	12 <sup>b</sup>	NA	NA	3	15
1998	13.2 <sup>c</sup>	NA	NA	3	16.2
1999	13.2 <sup>c</sup>	NA	NA	3	16.2
2000	13.2 <sup>c</sup>	NA	NA	3	16.2
2001	13.2 <sup>c</sup>	NA	NA	3	16.2
2002	13.2 <sup>c</sup>	NA	NA	3	16.2
2003	13.2 <sup>c</sup>	NA	NA	3	16.2
2004	NA	15	9.9 <sup>e</sup>	3	27.9
2005	NA	15	11.1 <sup>e</sup>	3	29.1
2006	NA	15	11.2 <sup>e</sup>	3	29.2
2007	NA	15	10.1 <sup>e</sup>	3	28.1
2008	NA	15	8.6 <sup>e</sup>	3	26.6
2009	NA	15	14 <sup>f</sup>	3	32
2010	NA	15	12 <sup>g</sup>	3	30
2011	NA	15	10 <sup>h</sup>	3	28
2012	NA	15	7 <sup>i</sup>	3	25

a Brown et al., 1993

b Riley et al., 1996

c GAO, 2000

d MedPAC 2012, Jun. page 101

e Biles et al., Commonwealth Fund, 2009

f MedPAC, 2009

g MedPAC, 2010

h MedPAC 2011

i MedPAC, 2012

j Trivedi et al., 2012

**Table 2**

Medicare Overpayments to Private Plans by Category, 1985-2012 (\$ billions)					
Year	Old Cherry Picking	New Cherry Picking	Congressional Mandated Overpayments	Care delivered by VA to Private Plan Enrollees	Total Percentage Overpayments
1985	0.1	0.0	0.0	0.0	0.1
1986	0.1	0.0	0.0	0.1	0.2
1987	0.2	0.0	0.0	0.1	0.3
1988	0.2	0.0	0.0	0.1	0.3
1989	0.3	0.0	0.0	0.1	0.4
1990	0.3	0.0	0.0	0.2	0.5
1991	0.4	0.0	0.0	0.2	0.5
1992	0.4	0.0	0.0	0.2	0.7
1993	0.5	0.0	0.0	0.3	0.8
1994	1.4	0.0	0.0	0.3	1.7
1995	1.6	0.0	0.0	0.4	2.0
1996	2.6	0.0	0.0	0.6	3.2
1997	3.3	0.0	0.0	0.8	4.1
1998	4.5	0.0	0.0	1.0	5.6
1999	5.1	0.0	0.0	1.2	6.2
2000	5.3	0.0	0.0	1.2	6.4
2001	5.1	0.0	0.0	1.2	6.2
2002	4.8	0.0	0.0	1.1	5.9
2003	4.9	0.0	0.0	1.1	6.0
2004	0.0	5.9	3.9	1.2	11.0
2005	0.0	7.0	5.2	1.4	13.7
2006	0.0	9.7	7.2	1.9	18.8
2007	0.0	11.7	7.9	2.3	21.9
2008	0.0	14.8	8.5	3.0	26.3
2009	0.0	16.9	15.8	3.4	36.2
2010	0.0	17.4	13.9	3.5	34.9
2011	0.0	18.6	12.4	3.7	34.6
2012	0.0	20.4	9.5	4.1	34.1
Total by Category	41.0	122.5	84.4	34.8	282.6

## Notes

1. Medicare Trustees Annual Report, Tables IV.C1-C3.
2. Brown R, Bergeron J, Clement D, et al. The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation Report to the Health Care Financing Administration. Princeton (NJ): Mathematica Policy Research, Inc.; 1993 Feb.
3. Riley G, Tudor C, Chiang YP, Ingber M. Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994. *Health Care Financ Rev.* 1996;17(4):65-76.
4. Physician Payment Review Commission. Risk Selection and Risk Adjustment in Medicare. Chapter 15, Annual Report to Congress. Washington (DC): 1996. Finds that spending by new HMO enrollees was 37 percent less than among fee-for-service beneficiaries in the six months prior to enrollment, while spending for those that disenrolled from HMOs was 60 percent higher in the six months after they dropped HMO coverage than it was for those in fee-for-service.
5. U.S. General Accountability Office. Medicare+Choice: Payments Exceed Cost of Benefits in Fee-for-Service, Adding Billions to Spending. Washington (DC): 2000 Aug. Pub. No GAO/HEHS—00-161.
6. Langwell, KM, Hadley, JP. Evaluation of the Medicare competition demonstrations, *Health Care Financ Rev.* 1989;11(2):65-80.
7. Morgan, RO, et al. The Medicare-HMO Revolving Door – The Healthy Go In and the Sick Go Out. *N Engl J Med.* 1997 Jul 17;337(3):169-175.
8. Berenson, R. Medicare Disadvantaged and the Search for the Elusive ‘Level Playing Field.’ *Health Aff (Millwood).* 2004;(Suppl Web Exclusives):W4-572–W4-585. Urban Institute.
9. Biles B, Pozen J, Guterman S. The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 billion in 2009. New York (NY): The Commonwealth Fund. Issue Brief. 2009 May 4.
10. Medicare Payment Advisory Commission (MedPAC). The Medicare Advantage Program: Status Report 2012. Washington (DC): p. 312. MedPAC. Medicare Advantage, 2011, p. 150. MedPAC. The Medicare Advantage Program, 2010, p. 266. MedPAC. Report to the Congress: Medicare payment policy, 2009 Mar.
11. U.S. General Accountability Office. Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings. Washington (DC):2012 Apr 23. Notes that after payment reductions mandated by the ACA, MA plan payment (including demonstration bonuses) is still about 7 percent higher than what the government would pay for similar beneficiaries in traditional Medicare.
12. Brown 1993, Riley 2006, Physician Payment Review Commission 1996, GAO 2000, Langwell and Hadley 1989.
13. Medicare Payment Advisory Commission. Chapter 4, page 101, 2012 Jun. Using data from 2007-2008, finds patients who enrolled in MA plans had 15 percent lower utilization in the year prior to joining the MA plan, and 16 percent higher utilization after returning from an MA plan to traditional Medicare.
14. Brown J, Duggan M, Kuziemko I, Woolston W. How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program. Cambridge (MA): National Bureau of Economic Research Working Paper 16977. 2011. [www.nber.org/papers/w16977](http://www.nber.org/papers/w16977) (under revision, personal communication, Ilyana Kuziemko, 2012 Aug 28)
15. Berenson 2004, Biles 2009, and MedPAC 2009-2012.
16. GAO, 2012.
17. Trivedi A, et al. Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Affairs Health Care System. *JAMA.* 2012;308(1):67-72.
18. Passman LJ, Garcia RE, Campbell L, Winter E. Elderly veterans receiving care at a Veterans Affairs Medical Center while enrolled in Medicare-financed

HMOs: Is the taxpayer paying twice? *J Gen Intern Med.* 1997;12(4):247-249.

19. DeVito CA, Morgan RO, Virnig, BA. Use of Veterans Affairs Medical Care by Enrollees in Medicare HMOs. *New Engl J Med.* 1997;337:1013-1014.

20. U.S. General Accountability Office. CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices. Washington (DC): 2012 Jan 12.

21. Brown 1993, and Langwell and Hadley 1989.

22. Brown 1993, Riley 2006, GAO 2000.

23. Morgan 1997, PPRC 2006.

24. Brown J, et al., 2011.

25. Biles, 2009.

26. MedPAC 2009, 2010, 2011, 2012.

27. Trivedi, 2012

28. MedPAC 2012, page 101.

29. Sullivan K. How to think clearly about Medicare administrative costs: Data sources and measurement. *Journal of Health Politics, Policy and Law*, forthcoming. Also U.S. Department of Health and Human Services. Administrative Costs Reflected on the Adjusted Community Rate Proposals are Inconsistent Among Managed Care Organizations. Washington (DC): 2000 Jan. (A-14-98-00210).

30. U.S. House of Representatives Committee on Energy and Commerce, Majority Staff. Profits, Marketing and Corporate Expenses in the Medicare Advantage Market. Washington (DC): 2009 Dec.

31. “We found that beneficiaries going into HMOs had cost 37 percent below average, but the beneficiaries leaving HMOs had costs 60 percent above average. With numbers like that, it seems pretty silly to debate whether or not there may be risk selection. The prudent question is, what are we going to do about it?” Christopher Hogan, in reference to PPRC’s 1996 study of selective enrollment, as quoted in “Policy Implications of Risk Selection in Medicare HMOs: Is the Federal Payment Rate Too High?” Washington (DC): Center for Studying Health System Change. Issue Brief. 1996 Nov;(4):1-7

32. Reinhardt UE. Why Does U.S. Health Care Cost So Much? Part III: An Aging Population Isn’t the Reason. *New York Times.* 2008 Dec. 5. <http://economix.blogs.nytimes.com/2008/12/05/why-does-us-health-care-cost-so-much-part-iii-an-aging-population-isnt-the-reason/> accessed on Sept. 21, 2012.

33. “In order to control costs effectively Americans should focus less on (re)inventing the latest delivery system or payment method, and instead pay more attention to what other countries do to slow health care spending. Global budgets, fee schedules, systemwide payment rules, and concentrated purchasing power may not be modern, exciting or ‘transformational,’ but they have the advantage of working.” Marmor T, Oberlander J. From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy. *J Gen Intern Med.* 2012 Mar 13. [www.springerlink.com/content/m86245k22018507n/fulltext.pdf](http://www.springerlink.com/content/m86245k22018507n/fulltext.pdf) accessed on Sept. 21, 2012.