AFFORDABLE HEALTH CARE FOR AMERICA ACT

RESTORING EQUITY BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE

BACKGROUND ON MEDICARE OVERPAYMENTS

When private insurance companies first petitioned to join Medicare in the 1980s, they asserted they could provide more care for less than it costs Medicare to provide its services and agreed to be paid 5 percent less than Medicare fee-for-service rates to prove that point. Even then, independent data suggested that private plans were making money because they tended to enroll healthier-than-average beneficiaries and their actual costs were closer to 10 percent less than Medicare fee-for-service. Today, these same companies – now called Medicare Advantage (MA) plans – are paid on average 14 percent more than it costs to provide care through the traditional fee-for-service Medicare program.

MA overpayments currently exceed $1,000 per MA enrollee per year, even though only a fraction is returned to beneficiaries through cost-sharing or benefit changes. MedPAC estimates that the national cost of MA overpayments is $12 billion a year. There is no dispute that MA overpayments exist or that they are projected to cost taxpayers and beneficiaries more than $170 billion over the next 10 years. CBO, MedPAC, and numerous independent experts validate these findings.

Affordable Health Care for America Act phases out these overpayments over three years, starting in 2011 (because the 2010 rates are already set), so that MA plans will be paid on a level playing field with traditional fee-for-service Medicare. Note that this position is still above the payment rates under which MA plans began participating in Medicare and continued operating for fifteen years. In addition, the legislation creates a quality bonus program for plans that meet quality benchmarks.

WHAT HAPPENS TO PEOPLE ENROLLED IN MA PLANS TODAY

Many MA plans will continue to offer their services under the new payment system. The plans that are able to operate efficiently and provide extra value to their enrollees through care coordination will continue to flourish. If MA plans choose to leave the market, people will be able to choose other MA plans in their area, or be guaranteed to receive the care they need by a strengthened, improved Medicare fee-for-service program. Traditional Medicare will no longer have a prescription drug donut hole, will offer free preventive health care, and will provide greater assistance for those with lower incomes – all reasons people have previously chosen MA plans. Plans will also be paid for and required to provide those benefits.

OVERPAYMENTS TO PRIVATE PLANS INCREASE COSTS TO ALL MEDICARE BENEFICIARIES AND TAXPAYERS

Medicare's Chief Actuary estimates that MA overpayments drain 18 months from the life of the Medicare Trust Fund; in other words, the Medicare Trust Fund is depleted by the excess payments. The Medicare Actuary and MedPAC also estimate that these overpayments increase premiums for all beneficiaries by almost $4 each month (even though only 24 percent of Medicare beneficiaries are enrolled in these plans).

In effect, more than 75% of Medicare beneficiaries – those who remain in the traditional fee-for-service program – are forced to pay higher premiums every month to subsidize payments to private plans. The rest of

the Medicare Advantage overpayment is paid by the American taxpayer. By eliminating these overpayments, Affordable Health Care for America Act protects the Medicare program so that it will be sustainable over time, restores equity in the program by putting plans on a level playing field with traditional Medicare, and requires MA plans to become more efficient competitors by refusing to continue to pad their payments. Under these reforms, plans will compete on price and quality, not by manipulating benefits or getting an unfair handout from senior citizens and taxpayers.

DESPITE OVERPAYMENTS, MA PLANS MAY CHARGE HIGHER COST-SHARING THAN TRADITIONAL MEDICARE

Medicare Advantage should be an "advantage," as the name implies. However, many MA plans charger higher cost-sharing than traditional Medicare for vital services like hospitalizations, chemotherapy, or home health care. Plans with these unfair cost-sharing practices discriminate against sicker Medicare beneficiaries. A Medicare beneficiary should never pay more under a private plan than he or she would under traditional Medicare. The legislation would hold MA plans true to their name by prohibiting plans from charging more than traditional Medicare would for any particular item or service.

OVERPAYING MEDICARE ADVANTAGE IS AN INEFFICIENT WAY TO PROVIDE EXTRA BENEFITS

Some have touted MA as a way to provide more benefits to people living in rural areas or those who have lower incomes. This is an inefficient way to provide increased benefits. First, those benefits only go to those people who find an MA plan that is acceptable to them. Second, taxpayers spend on average 14 percent more for MA beneficiaries. In some MA plans, the government spends $3 for every $1 of extra benefits offered, giving private insurance companies three times as much as they give to beneficiaries. Third, MA plans may provide extra benefits, but they also often charge more for certain services or items than the traditional Medicare fee-for-service program.

The more efficient way to provide new benefits for Medicare beneficiaries – and the only way to assure access for all Medicare beneficiaries who need the new benefits – is to add them to the traditional Medicare program. That's what this bill does. It is important to note that when benefits are added to Medicare, they automatically become part of the basic benefits in MA, but are no longer decided solely at the discretion of the private plan or only provided to people who happen to enroll in private plans. The bill follows a more equitable and efficient approach.

Under these reforms, all seniors and people with disabilities will obtain preventive services with no copayments, Medicare prescription drugs without a donut hole, better access to mental health providers, and improved financial help for those with low incomes.

MARKETING ABUSES

New enforcement resources are provided to prevent and prosecute marketing abuses by Medicare Advantage plans. State attorneys general and insurance commissioners would be allowed to enforce federal marketing standards to supplement federal resources devoted to combating marketing abuses.