

Payment and Participation: A Renaissance for Medicare's Private Health Plans?

By Reginald D. Williams II

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Public Law 108-173) provides about \$14 billion over 10 years in new federal funding to encourage private plans to participate in Medicare Advantage.¹ Historically, private plan participation in Medicare has fluctuated. Continuing changes in Medicare's funding policies and program requirements have hindered private health plans from meeting conflicting expectations. Over time, Congress established multiple goals for private plans: containing costs, improving benefits, and increasing plan participation and beneficiary enrollment in an effort to increase health care choices. Proponents of private plans tout the recent funding increase as the needed jumpstart to the program; skeptics claim that these new payments are excessive. Despite polarizing views about their potential, the history of Medicare's private health plans indicates that rising health care costs and constraints in Medicare payments result in private health plan withdrawal from Medicare. Early signs indicate that private health plans are interested in participating in Medicare Advantage, but only time will tell whether Congress will continue supporting higher payment levels to plans, and whether the plans' interest will be sustained. It also remains to be seen if the competitive bidding model adopted by the MMA will provide beneficiaries with more benefits at lower premiums.

History of Private Plans in Medicare

In 1965, when Medicare was enacted, it was modeled after employer-based health insurance, where a set amount was paid to providers for each encounter or service rendered (fee-for-service). However, from Medicare's beginning, it also contracted with health maintenance organizations (HMOs) on a limited basis. These early HMO contracts were designed for retirees in employer- or union-sponsored health plans as an alternative to the Medicare fee-for-service reimbursement system. Plans were paid based on either their charges or costs.

As private health insurance began evolving into a system of more managed care, where health plans were paid a fixed amount in advance for all services in an effort to contain costs and improve quality, Congress attempted to expand the role of private health plans in Medicare. The Social Security Amendments of 1972 ushered in the era of Medicare risk sharing.¹ However, the industry's response to the law was less than positive; only one HMO elected to contract with Medicare until changes were made to the law in 1982.

Reginald D. Williams II is an Associate at The Health Strategies Consultancy, LLC. At the time this brief was written, he was Health Policy Research Assistant at the National Academy of Social Insurance.

In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) incorporated changes designed to encourage more plans to contract with Medicare.² TEFRA also established two practices that have continued to dominate the discussion of private plans in Medicare: administrative price setting and allowing plans to provide additional benefits and/or to reduce cost-sharing requirements for beneficiaries. TEFRA also included a cost containment provision intended to ensure the government a savings of 5 percent by setting Medicare payments to private plans at 95 percent of the estimated amount Medicare would spend on a typical beneficiary in fee-for-service care. Although this provision reflected an expectation that private plans could provide a cost savings to the government, a study found that Medicare actually paid 5.7 percent more than it would have, had beneficiaries been enrolled in traditional Medicare. This occurred because private plans disproportionately enrolled healthier beneficiaries compared to traditional Medicare.³

Enrollment in private health plans soared from less than 1 million in 1986 to over 6 million by early 1997, as managed care and the virtues of coordinated care dominated America's health care landscape. At a time when Medicare's fee-for-service spending was rising more rapidly than private health insurance spending, the Medicare market proved profitable for private health plans. The plans offered reduced premiums and additional benefits, making the plans appealing to beneficiaries.

In the mid 1990s, Congress focused on balancing the federal budget, which would almost inevitably require a reduction in the rate of increase in Medicare, since it is second largest domestic social program. Congress succeeded in passing a balanced budget bill in 1995, but President Clinton vetoed it, partly because he considered the reductions in Medicare spending too great. In 1997, Congress and President Clinton agreed on a different framework for balancing the budget. The subsequent Balanced Budget Act (BBA) of 1997 reduced the rate of growth in Medicare spending by \$112 billion for FY 1998 to FY 2002, making it the single largest contributor to balancing the budget. The Congressional Budget Office (CBO) projected that the bulk of that savings, \$78.1 billion, would come from reducing payments to nearly all fee-for-service providers, and \$21.8 billion from net reductions to private plans.⁴

The BBA created a new name for the private health plan program, Medicare+Choice (M+C). The BBA also permitted new types of health plans, modeled on the private sector, to participate in the program and established education programs to inform beneficiaries about new health plan choices. The BBA also established a new payment formula for rates paid to Medicare's private plans. The revised payment formula considered geographic health care spending differences and risk adjustment.⁵ The law set a floor payment that boosted historically low payments in rural areas and guaranteed a minimum 2 percent annual increase for all Medicare+Choice plans in areas with higher-than-average costs, where the majority of beneficiaries in private plans enroll. Although some private plans received greater funding, the BBA's reductions in payment to providers in general yielded a net effect of reduction in government spending to private health plans.⁶

Before and after the passage of the BBA, there were disputes about the appropriate level of payments to private plans. To boost beneficiary enrollment and maintain plan participation, many proponents of private plans in Medicare argued for increased payments. They maintained

that private plans' participation in Medicare would give beneficiaries greater choices, access to coordinated care plans, and extra benefits not covered by traditional Medicare. Several published reports projected that if properly structured, Medicare's private plans could provide better care to beneficiaries and save money over the long-term.⁷

Opponents argued the private plans in Medicare were already paid too much relative to fee-for-service costs, and that continuing to provide higher payments would jeopardize Medicare's long-term financial sustainability. Opponents also argued that Medicare's private plans continued to benefit from favorable selection of healthier-than-average enrollees. The General Accounting Office (GAO) supported this assertion; in 1998, it reported that payments to Medicare+Choice plans were about 21 percent higher (\$5.2 billion, approximately \$1000 per beneficiary more) than if the plans' enrollees had received care in traditional Medicare.⁸

In 1998 and 1999, private plans dramatically reduced their participation in Medicare. When Congress enacted the BBA in 1997, it assumed that the private health plan market would continue growing. However, an industry-wide shift in strategies from growing enrollment and market share toward restoring profitability, combined with rising health care costs and Medicare reductions in plan payments, produced a different outcome. Plans withdrew from the Medicare market, reduced benefits, or increased cost-sharing and premiums.⁹ In 1999, 45 plans withdrew from Medicare, affecting more than 400,000 beneficiaries. Plans with the highest Medicare payment rates prior to the BBA, were less likely to withdraw from Medicare; likewise, the plans that received the highest payment updates from the BBA were least likely to withdraw.

In 1999, Congress passed the Balanced Budget Refinement Act (BBRA) in an effort to staunch plan withdrawals and provide greater protections to beneficiaries dropped by plans.¹⁰ However, the BBRA did little to prevent further reductions in plan participation. Responding to continuing pressure from Medicare providers to raise payment levels, Congress subsequently enacted the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) in 2000. The law provided modest increases in Medicare payments and relaxed some regulatory requirements for private plans. Despite the additional funding and regulatory changes, in 2001 and 2002, Medicare private plan participation and private plan enrollment dropped again.¹¹ Of the private plans that continued to participate in Medicare, the majority increased premiums and cost-sharing requirements, while reducing extra benefits.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Beginning in 2006, the law will provide Medicare beneficiaries with an optional outpatient prescription drug benefit. The MMA renamed the Medicare+Choice program the Medicare Advantage program and provided higher payments intended to stabilize and expand the Medicare private plan market. Beginning in 2004, Medicare's private plans are paid the highest of six calculations set at the county level, based on fee-for-service spending. The Medicare Payment Advisory Commission (MedPAC) estimated that payments averaged 107 percent of fee-for-service Medicare in 2004, up from a projected 103 percent for the previous year.¹² Another objective of the MMA was to expand the availability of Medicare private plans

to new areas. To this end, some rural Medicare Advantage plans will receive enhanced funding. In a few counties, plans could receive a 28 percent increase or \$1,257 more per enrollee than fee-for-service Medicare.¹³

Plans must use the additional funding in prescribed ways. According to the private plans' reports to the Centers for Medicare & Medicaid Services (CMS), 17 percent of the additional funds are being used to enhance benefits, 36 percent to lower beneficiaries' out-of-pocket spending, and 42 percent to increase plans' payments to providers. The remaining 5 percent will be put in a stabilization fund for later use in order to offset potential future premium increases or benefit cuts.¹⁴ These funds must be used by the end of 2005.

Implementation of the MMA provisions also coincides with the phase-in of an improved risk adjustment system, which uses claims data to account for the better health status of beneficiaries enrolled in Medicare Advantage plans. In 2004, 30 percent of the total payments to an individual Medicare Advantage plan are subject to the new risk adjustment system; in 2005, 50 percent of the payment will be adjusted by the new system. Risk adjustment was expected to reduce aggregate payments to Medicare private plans. However, CMS made an administrative decision to implement risk adjustment on a "budget neutral" basis by giving a portion of the risk-adjustment savings back to the plans. As a result, the plans continue to receive higher payments than fee-for-service by enrolling healthier and less costly beneficiaries.¹⁵ In 2004, the forgone savings represents about \$800 million, and in 2005, about \$1.5 billion in savings will be lost due to this interpretation of budget neutrality.¹⁶

In 2006, the way that Medicare pays private plans will change again. Under a new competitive bidding process, Medicare Advantage plans will submit bids that will be compared against a local benchmark calculated by CMS. If a Medicare Advantage plan bids above the benchmark, enrollees will be charged premiums to collect the difference. If a Medicare Advantage plan bids below the benchmark, 75 percent of the difference will be given to enrollees as extra benefits or premium reductions, and the remaining 25 percent retained by Medicare.

Beginning in 2006, the MMA also established a new type of Medicare Advantage plan, the regional preferred provider organization (PPO). Compared with HMOs, PPOs typically offer a broader choice of providers than HMOs. Regional PPOs must cover an entire region and may serve more than one or all regions.¹⁷ Twenty-six regions have been established. The MMA also created a \$10 billion stabilization fund to provide extra payments to regional PPOs as incentive to enter or stay in the Medicare Advantage market. Payments to regional PPOs will be calculated similarly to other Medicare Advantage Plans, but the benchmarks for regional PPOs are an average of the local benchmarks and the bids submitted by the regional PPOs in their region.

The MMA provides additional federal assistance to low-income beneficiaries for prescription drug benefits. Analyses have shown that Medicare private plans have provided significant assistance to low-income beneficiaries by acting as a safety net for beneficiaries whose income and assets are too high to qualify for Medicaid, but who do not have retiree health benefits, and cannot afford other supplemental coverage. Among Medicare beneficiaries who live in areas served by private plans and do not have retiree or individual Medigap coverage, low-income

beneficiaries disproportionately enroll in private plans. For example, among beneficiaries earning \$10,000 to \$20,000 a year (without Medicaid or employer insurance), nearly 78 percent in Southern California, 67 percent in Philadelphia, and 51 percent in Florida are enrolled in Medicare private health plans.¹⁸

Private health plans have long maintained that they improve the quality of health care provided to beneficiaries. Various initiatives have improved the quality of care for Medicare beneficiaries, but more needs to be done to assure that Medicare beneficiaries receive high quality health care services.¹⁹ The MMA included several quality improvement provisions. Medicare Advantage plans that offer the new prescription drug benefit are required to implement a medication therapy management program to ensure the appropriate use of prescription drugs to improve outcomes and reduce adverse drug interactions. The role of Quality Improvement Organizations (QIOs) will be expanded beyond oversight of fee-for-service to include Medicare Advantage plans. By 2006, Medicare Advantage plans are also required to have an ongoing quality improvement program that includes chronic care management. The programs must also include a method to monitor and identify health outcomes, enrollee satisfaction, and target improvements based upon those needs. In addition, Medicare Advantage plans will be required to collect, analyze, and report on health outcomes and other indices of quality.²⁰

The Goals of Medicare's Private Health Plans

Throughout the history of private health plans in Medicare, Congress has established several goals: containing costs, improving benefits, and increasing plan participation and beneficiary enrollment in an effort to increase health care choices. These goals have often been at odds with each other.

Containing Costs

Medicare's private health plans were designed to save the government money, but have ultimately cost Medicare more than fee-for-service. Analysis of the cost of private health plans should be divided into two periods: before and after the BBA. Before the BBA, payments were set at 95 percent of a county's per beneficiary spending in Medicare fee-for-service. However, studies have indicated that Medicare's private health plans were paid more on average than the healthier beneficiaries would have cost had they been enrolled in fee-for-service Medicare.²¹ The BBA sought to increase the role of Medicare's private health plans at the same time it constrained payments to plans. After the implementation of the BBA, the GAO estimated that spending for private plans continued to be higher than fee-for-service, as mentioned above.²² The payment increases of BBRA in 1999 and BIPA in 2000, combined with inadequate risk adjustment, continued to make payments to plans higher than fee-for-service Medicare.²³ The pattern of administered pricing, linking payments to private plans to the fee-for-service costs in an area, has led to unnecessarily high payments to private plans in parts of the country. Proponents of private plans view this as a distortion of a truly competitive market philosophy.²⁴

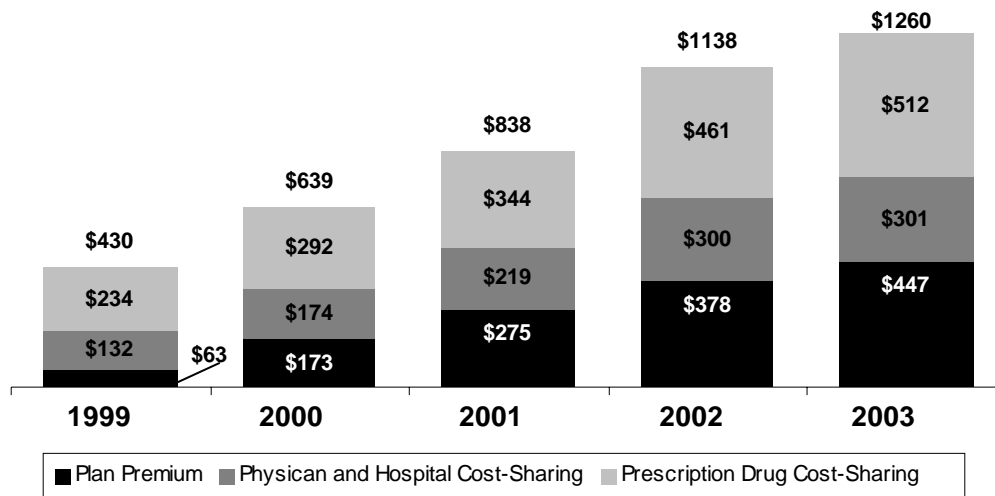
The MMA increased the cost of Medicare's private health plans compared with fee-for-service Medicare. In 2004, Medicare's private plans received higher payments than they were scheduled to receive before the enactment of the MMA. In 2004, various analyses have found that Medicare's private health plans have received an average increase of 10.6–10.9 percent over

2003 rates, which is about 7.4 percent higher than the increase originally announced for 2004.²⁵ According to one report, Medicare Advantage payments in 2004 averaged \$552 more than fee-for-service payments for each enrollee, for a total of about \$2.8 billion. In 2005, Medicare Advantage payments will average 7.8 percent more than fee-for-service payments (\$546 more for each enrollee, for a total of about \$2.7 billion).²⁶ Given the current payment policy, Medicare Advantage will simply not save money compared to fee-for-service Medicare.

Improving Benefits

Another goal of Medicare’s private health plans is improving benefits without increasing costs to beneficiaries. In the past, Medicare’s private health plans had offered extra benefits not covered by fee-for-service, but coverage of the extra services has eroded since the passage of the BBA, as health care costs rose and payments were constrained. The additional services offered with little or no premiums and reduced beneficiary cost sharing included outpatient prescription drugs, dental, vision, and preventive care. Since the late 1990s, benefit patterns and cost-sharing requirements have also changed for beneficiaries. In 1999, 85 percent of enrollees in Medicare’s private plans were not charged a premium; by 2003, only 29 were enrolled in plans that did not change a premium.²⁷ Many plans also began requiring enrollees to make out-of-pocket payments for Medicare-covered services. Private plans also began providing fewer supplemental benefits. In 2003, 31 percent of enrollees were in plans without prescription drug coverage, up from 16 percent in 1999.²⁸ As a result of these changes in premiums, in cost sharing, and in benefits, enrollees in Medicare’s private plan began spending more out-of-pocket for their health care. Figure 1 displays the out-of-pocket cost sharing for enrollees in private plans from 1999 to 2003.

Figure 1
Average Annual Out-of-Pocket Spending for Medicare Private Plan Enrollees, 1999-2003.²⁹



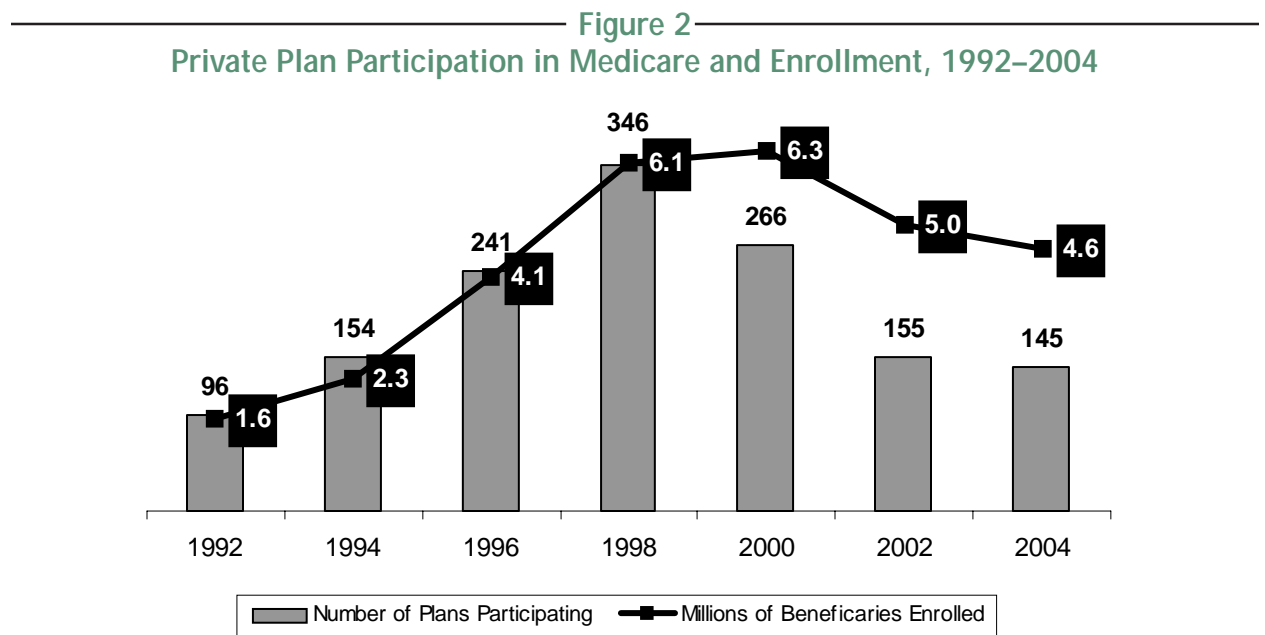
Source: Kaiser Family Foundation (KFF). 2004. Medicare Fact Sheet: Medicare Advantage. Menlo Park, CA: KFF.

In the past, prescription drug coverage may have drawn beneficiaries to Medicare’s private health plans. Under the MMA, all beneficiaries will have access to outpatient prescription drug coverage for the first time in 2006. Beneficiaries may continue to be drawn to Medicare’s private health plans for their simplicity. In 2006, a beneficiary could have fee-for-service Medicare, a Medigap plan, and a stand-alone Medicare prescription drug plan, while Medicare Advantage plans can offer all three in one package. The potential for the coordination of care offered by Medicare’s private health plans may also be attractive to beneficiaries.

The additional money provided to Medicare Advantage plans by the MMA requires them to enhance benefits for enrollees.³⁰ In 2004, plans reported that 53 percent of the additional funds were being used to enhance benefits and lower beneficiaries’ out-of-pocket costs.³¹ Initial analyses by the Secretary of HHS indicate that the decline in extra benefits and increases in premiums may be reversing in 2005 with plans continuing or reinstating benefits not covered by fee-for-service Medicare, including drugs, dental, vision, preventive services, and reduced out-of-pocket costs.³² For example, on average, overall enrollee out-of-pocket spending in 2004 was reduced to about the same level as 2003. Many plans reduced premiums and physician office co-payments, and, to a limited extent, improved drug and other supplemental benefit coverage.³³

Increasing Plan Participation and Beneficiary Enrollment

Medicare’s private health plans were charged with increasing plan participation and beneficiary enrollment, but projections that 35 percent of Medicare beneficiaries would enroll in plans have yet to become a reality. In 2000, enrollment reached a high of 16 percent (6.3 million). In 2004, only 11 percent (4.6 million enrollees) of beneficiaries were enrolled in private health plans. The number of plans participating has also decreased from a peak of 346 in 1998 to 145 in 2004.³⁴ Figure 2 shows the history of plan participation and enrollment in Medicare from 1992 to 2004. However, that trend may also be reversing.



Source: Kaiser Family Foundation (KFF). 2004. Medicare Fact Sheet: Medicare Advantage. Menlo Park, CA: KFF.

On October 6, 2004, HHS announced that 35 new private plans applied to participate (22 applied to expand their service areas) in Medicare Advantage. If approved, an additional 1.6 million beneficiaries would have access to Medicare Advantage plans, increasing the percentage of beneficiaries with access to Medicare's private health plans from 59 percent in 2003 to 66 percent in 2005.³⁵ Enrollment trends in the future are unclear. Projections by CBO and CMS offer conflicting pictures about the number of people who might enroll in Medicare Advantage.³⁶

Conclusion

The future of Medicare's private health plans is contingent on both beneficiaries' reactions and Congress. With no end to rising health care costs in sight, beneficiaries may see the new choices and benefits offered by Medicare's private health plans as incentives for switching to Medicare Advantage, or they may hesitate to enroll, given the history of instability in the program. The additional money provided to Medicare's private health plans gives them an opportunity to provide more benefits at reduced cost to beneficiaries, but questions of equity arise when fee-for-service beneficiaries cross-subsidize more services for private plan enrollees. Additionally, the higher payment levels seem unsustainable over the long-term, given the federal deficit. Congress may eventually regain interest in deficit reduction, and Medicare reductions, as in the past, will likely be a substantial component of any budget plan.³⁷

Endnotes

¹ In risk-sharing contracts, the price is fixed in advance. If costs are more than the amount Medicare pays, plans must absorb the losses or carry them over to the next year. If costs are less, plans share the savings with Medicare.

² These changes including dropping a requirement that plans share profits with Medicare, lowering the minimum enrollment to 5,000, and permitting new types of plans.

³ Brown, Randall, Jeanette Bergeron, Dolores Clement, Jerrold Hill, and Sheldon Retchin. 1993. *Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs*. Washington, DC: Mathematica Policy Research, Inc.

⁴ King, Kathleen and Mark Schlesinger, Eds. 2003. *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*. Washington, DC: National Academy of Social Insurance.

⁵ Congress subsequently delayed the phase-in of risk adjustment.

⁶ The payment amount for M+C plans is linked to FFS spending.

⁷ Dowd, Bryan, Roger Feldman, and Jon Christianson. 1996. *Competitive Pricing for Medicare*. Washington, DC: AEI Press and Thorpe, Kenneth. 1999. *Options for Reforming Medicare*, Testimony of Kenneth Thorpe before the Senate Finance Committee on May 26, 1999. Washington, DC.

⁸ General Accounting Office (GAO). 2000. *Medicare+Choice: Payments Exceed Costs for Fee-for-Service Benefits, Adding Billions to Spending*. Washington, DC: Government Printing Office.

⁹ The commercial health insurance underwriting cycle is a predictable pattern of gains and losses in which insurers maintain a stable level of financial risk over time. The cycle is characterized by two distinct periods. The first period is marked by health insurers' decreased profitability, increases in premiums below the rate of growth in health care costs, seeking to expanding

enrollment and increasing market share of for several years. In the second period of the cycle, health insurers switch strategies, seeking to restore profitability, increase premiums faster than the increases in health care costs for next several years, often resulting in decreased enrollment and reduced benefits, completing the cycle. For further discussion of the factors influencing plan withdrawal please see, King, Kathleen and Mark Schlesinger, Eds. 2003. *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*. Washington, DC: National Academy of Social Insurance.

¹⁰ The BBRA also included increases in payment to other types of providers.

¹¹ For further discussion of the factors influencing plan withdrawal please see, King, Kathleen and Mark Schlesinger, eds. 2003. *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*. Washington, DC: National Academy of Social Insurance.

¹² Medicare Payment Advisory Commission (MedPAC). 2004. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

¹³ Biles, Brian, Lauren Hersch Nicholas, and Barbara S. Cooper. 2004. *The Cost of Privatization: Extra Payments to Medicare Advantage Plans*. Commonwealth Fund Issue Brief. Washington, DC: The Commonwealth Fund.

¹⁴ CMS. 2004. *Press Release: Review Shows Beneficiaries in Medicare Advantage Plans Will See Better Benefits, Lower Costs*. Baltimore, MD: CMS

¹⁵ The budget neutral interpretation of risk adjustment is an administrative policy decision made by CMS that could continue indefinitely. MedPAC has recommended that this policy be reconsidered so that risk adjustment would achieve the goal of payment equity between Medicare fee-for-service and Medicare Advantage plans. Medicare Payment Advisory Commission (MedPAC). 2004. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC. The President's 2006 proposed budget of Department of Health and Human Services will "phase in over four years the savings from the full implementation of risk adjustment payments to account for different health status of beneficiaries in Medicare Advantage plans. The phase-in will begin in 2007 and will be completed by 2010." The Office of Management and Budget. *Budget of the United States Government, Department of Health and Human Services, Fiscal Year 2006*. Available at <http://www.whitehouse.gov/omb/budget/fy2006/hhs.html>. Last accessed March 15, 2005.

¹⁶ Berenson, Robert A. 2005. *Medicare Disadvantaged And The Search For The Elusive 'Level Playing Field.'* *Health Affairs*. Web Exclusive releases December 15, 2004.

¹⁷The MMA granted the Secretary of HHS the authority to establish between 10 and 50 regions. On December 6, 2004, 26 regions were established. The definition of the PPO regions has been controversial. Some advocated for larger regions in an effort to reach out to areas that have by and large not had access to Medicare private plans. Others advocated for smaller, state-based regions where commercial networks and regulatory requirements have already been established.

¹⁸ Thorpe, Kenneth, Adam Atherly, and Kelly Howell. 2002. *Medicare+Choice: Who Enrolls? A Study Commissioned by the Blue Cross and Blue Shield (BCBS) Association*. Washington, DC: BCBS Association.

¹⁹ For further discussion of quality of care in Medicare please see, King, Kathleen and Mark Schlesinger, Eds. 2003. *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*. Washington, DC: National Academy of Social Insurance.

²⁰ Regional PPOs will have separate rules.

- ²¹ Physician Payment Review Commission (PPRC). 1996. "Risk Selection and Risk Adjustment in Medicare." In *Annual Report to Congress*, Chapter 15. Washington, DC: PPRC. and Center for Studying Health System Change. 1996. Policy Implications of Risk Selection in Medicare HMOs: Is the Federal Payment Rate Too High? Issue Brief Number 4. Washington, DC: HSC.
- ²² General Accounting Office (GAO). 2000. Medicare+Choice: Payments Exceed Costs for Fee-for-Service Benefits, Adding Billions to Spending. Washington, DC: Government Printing Office.
- ²³ Medicare Payment Advisory Commission (MedPAC). 2001. Report to the Congress: Medicare Payment Policy. Washington, DC: MedPAC.
- ²⁴ Wilensky, Gail and Joseph Newhouse. 1999. Medicare: What's right? What's wrong? What's next? *Health Affairs* 18(1): 92-106.
- ²⁵ Berenson, Robert A. 2005. Medicare Disadvantaged And The Search For The Elusive 'Level Playing Field.' *Health Affairs*. Web Exclusive releases December 15, 2004.
- ²⁶ Biles, Brian, Lauren Hersch Nicholas, and Barbara S. Cooper. 2004. The Cost of Privatization: Extra Payments to Medicare Advantage Plans. Commonwealth Fund Issue Brief. Washington, DC: The Commonwealth Fund and Biles, Brian. 2004. Medicare Advantage: Extra Payments to Plans 2005. An Alliance for Health Reform Presentation on September 22, 2004.
- ²⁷ Achman, Lori and Marsha Gold. 2002. Trends in Medicare+Choice Benefits and Premiums, 1999-2002. New York: The Commonwealth Fund.
- ²⁸ Kaiser Family Foundation (KFF). 2004. Medicare Fact Sheet: Medicare Advantage. Menlo Park, CA: KFF
- ²⁹ Direct comparisons of out-of-pocket spending between FFS and MA are difficult because they cover different benefits. However, a Commonwealth Fund Issues Brief has estimated that 2003 out-of-pocket spending in FFS was about \$670 higher than in MA. (Gold, Marsha and Lori Achman. 2003. Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Ten Percent in 2003. New York: The Commonwealth Fund.)
- ³⁰ The revised 2004 payment rates were announced by CMS on January 16, 2004 and plans were obligated to submit their revised benefit packages by January 30, 2004.
- ³¹ CMS. 2004. Press Release: Review Shows Beneficiaries in Medicare Advantage Plans Will See Better Benefits, Lower Costs. Baltimore, MD: CMS.
- ³² CMS. 2004. Press Release: Medicare Advantage Plans Expand Coverage to Seniors, Lower Costs for Enrollees. Baltimore, MD: CMS.
- ³³ Achman, Lori and Marsha Gold. 2004. Are The 2004 Payment Increases Helping To Stem Medicare Advantage's Benefit Erosion? New York: The Commonwealth Fund.
- ³⁴ Kaiser Family Foundation (KFF). 2004. Medicare Fact Sheet: Medicare Advantage. Menlo Park, CA: KFF.
- ³⁵ U. S. Department of Health and Human Services. 2004. Press Release: Medicare Advantage Plans Expand Coverage to Seniors, Lower Cost for Enrollees on October 6, 2004.
- ³⁶ Foster, Rick to Dennis Smith, memorandum. 5 February 2004. Summary of Differences Between OACT and CBO Cost Estimates for P.L. 108-173, the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003"-Updated. Baltimore, MD: CMS.
- ³⁷ Center for Studying Health System Change (HSC). 2004. Wall Street Comes To Washington. Issue Brief Number 87. Washington, DC: HSC.

Available for download from the National Academy of Social Insurance website at www.nasi.org...

Medicare Brief No. 11 *Medicare and Communities of Color*
by Reginald D. Williams II, November 2004, 9pp. *FREE*

Medicare Brief No. 10 *The Unique Needs of Medicare Beneficiaries*
by Reginald D. Williams II, September 2004, 9 pp. *FREE*

Medicare Brief No. 9 *Restructuring Medicare: A Synthesis of the NASI Medicare Projects*
by Reginald D. Williams II, April 2003, 7 pp. *FREE*

Medicare Brief No. 8 *Costs and Financing of Medicare Enrollees Living with HIV/AIDS in California*
by June Eichner and James G. Kahn, August 2001. 9pp. *FREE*

Medicare Brief No. 7 *Coordination of Health Coverage for Medicare Enrollees: Living with HIV/AIDS in California* by June Eichner, June 2001. 11pp. *FREE*

Medicare Brief No. 6 *Supplemental Health Insurance for Medicare Beneficiaries*
by Thomas Rice and Jill Bernstein, November 1999. 15 pp. *FREE*

Medicare Brief No. 5 *The Financing Needs of a Restructured Medicare Program*
by Members of the National Academy of Social Insurance Study Panel on Medicare Financing, September 1999. 11 pp. *FREE*

Medicare Brief No. 4 *The Economic Status of the Elderly*
by Robert L. Clark and Joseph F. Quinn, May 1999. 11 pp. *FREE*

Medicare Brief No. 3 *Individualizing Medicare*
by Deborah J. Chollet, May 1999. 9 pp. *FREE*

Medicare Brief No. 2 *Should Higher Income Beneficiaries Pay More For Medicare?*
by Jill Bernstein, May 1999. 11 pp. *FREE*

Medicare Brief No. 1 *A Medicare Prescription Drug Benefit*
by Michael E. Gluck, April 1999. 11 pp. *FREE*

This brief is the twelfth in a series on Medicare. It is drawn from topics discussed in *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*, the final report of the Study Panel on Medicare and Markets convened by the National Academy of Social Insurance. The report was published in November 2003. This brief was supported by a grant from The Robert Wood Johnson Foundation.

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

1776 Massachusetts Avenue, NW
Suite 615
Washington, DC 20036-1904
(202) 452-8097
(202) 452-8111 Fax
nasi@nasi.org
www.nasi.org