WILL MEDICARE WITHER ON THE VINE? HOW CONGRESS HAS ADVANTAGED MEDICARE ADVANTAGE—AND WHAT'S A LEVEL PLAYING FIELD ANYWAY?

ROBERT A. BERENSON* AND MELISSA M. GOLDSTEIN**†

I. BACKGROUND

Congress is actively debating whether to reduce current overpayments to Medicare Advantage (MA) plans.[1] In 2007, overpayments, i.e., the amount that MA plans receive in aggregate over what it would otherwise cost to cover the same beneficiaries under the traditional fee-for-service Medicare program,[2] are estimated by government agencies to be 12%[3] and by an independent researcher to be 13.3%.[4] The Congressional Budget Office (CBO) estimates that reducing these overpayments to the level of local per capita spending in traditional Medicare would save $65 billion over the next five years and $160 billion over the next ten years.[5]

* M.D.; Senior Fellow, The Urban Institute.

** J.D.; Associate Research Professor, Department of Health Policy, School of Public Health and Health Services, Department of Health Sciences, School of Medicine and Health Sciences, The George Washington University Medical Center.

† The authors would like to extend their sincere gratitude to Lara Cartwright-Smith, J.D., whose contributions to this article have been substantial and very much appreciated.

1. Robert Pear, *Democrats Press House to Push to Expand Health Care Bill*, N.Y. TIMES, July 23, 2007, at A1.

2. *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 243 (2007), *available at* www.medpac.gov/documents/Mar07_Entire Report.pdf (last visited Sept. 19, 2007) [hereinafter MEDPAC, MEDICARE PAYMENT POLICY 2007] (discussing the concept of payment neutrality and that payments to MA programs are above FFS levels).

3. *Id.* at 243, 244 tbl.4.1; *The Medicare Advantage Program, Trends and Options: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. 4 (2007) [hereinafter *MA Hearing*] (statement of Peter R. Orszag, Director, Congressional Budget Office), *available at* http://waysandmeans.house.gov/media/pdf/110/Testimony 32107/OrszagTestimony.pdf (last visited Sept. 20, 2007).

4. BRIAN BILES & EMILY ADRION, THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS, UPDATED TABLES FOR 2007, tbl.1, (May 2007), *available at* www.ocpp.org/2007/Commonwealth_Brian_Biles_2007_Updated_tables.pdf (last visited Sept. 16, 2007).

5. *MA Hearing*, *supra* note 3, at 13.

Critics believe that these substantial overpayments to MA plans are unwarranted at a time of budget deficits and that this money can be used to fund other important programs, such as the Children's Health Insurance Program, and help forestall an anticipated 10% reduction in Medicare payments to physicians.[6] Recent criticism states that systematic overpayments undermine and threaten the future of the traditional Medicare program by enticing beneficiaries to leave the traditional program and enter into an MA plan.[7] Annually, MA plans receive approximately $1,000 per beneficiary in overpayments that they can use to offer extra benefits at no cost to beneficiaries.[8] Medicare rules require plans to use the overpayments to buy-down beneficiary cost sharing, provide catastrophic coverage, and offer extra benefits, e.g., prevention services, eye glasses, hearing aids, and supplemental prescription drug benefits.[9] Using part of the overpayments, MA plans provide more attractive prescription drug benefits than traditional Medicare, including substantially lower front-end premiums, some coverage in the infamous Part D "doughnut hole," and somewhat more generous brand-name drug coverage.[10]

6. Pear, *supra* note 1. *See generally* NAT'L COMM. TO PRESERVE SOC. SECURITY & MEDICARE, ATTACK ON MEDICARE: PRIVATE HEALTH PLAN SUBSIDIES WINDFALL FOR CORPORATE AMERICA (2007), *at* www.ncpssm.org/news/archive/vp_medicare_advantage/ (last visited Sept. 16, 2007) (discussing various perceived problems that result from plan overpayments, including the increase in Part B premiums for beneficiaries).

7. NAT'L COMM. TO PRESERVE SOC. SECURITY & MEDICARE, *supra* note 6.

8. *See* BRIAN BILES ET AL., THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS – UPDATED AND REVISED 2 (2006), *available at* www.commonwealthfund.org/usr_doc/Biles_costprivatizationextrapayMAplans_970_ib.pdf?section=4039 (last visited Sept. 16, 2007) (stating that the average 2005 overpayment per MA plan beneficiary was $992); BILES & ADRION, *supra* note 4, at 1 (stating that the average 2007 overpayment per MA plan beneficiary was $1,008); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE ADVANTAGE IN 2007, at 11 (2007) *available at* www.cms.hhs.gov/partnerships/downloads/MedicareAdvantage2007.pdf (last visited Nov. 21, 2007) [hereinafter CMS, MEDICARE ADVANTAGE IN 2007] (stating that in 2007, on average, MA beneficiaries will receive $86 worth of additional benefits per month).

9. CMS, MEDICARE ADVANTAGE IN 2007, *supra* note 8. *See generally* MEDICARE PAYMENT ADVISORY COMM'N, BENEFIT DESIGN AND COST SHARING IN MEDICARE ADVANTAGE PLANS (2004), *available at* www.medpac.gov/publications/congressional_reports/Dec04_CostSharing.pdf (last visited Sept. 16, 2007) [hereinafter MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT] (discussing the flexibility MA plans give managed care organizations in designing benefits packages).

10. MARSHA GOLD, THE HENRY J. KAISER FAMILY FOUND., THE MEDICARE DRUG BENEFIT: PREMIUMS AND COST-SHARING FEATURES IN MEDICARE'S NEW PRESCRIPTION DRUG PROGRAM 5, 11, 17 (2006), *available at* www.kff.org/medicare/upload/7517.pdf (last visited Sept. 19, 2007); *see also* MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2, at 253-59, 259 tbl.4.10.

The extra benefits that MA plans provide entice both low-income beneficiaries without Medicaid or retiree supplemental insurance and those who can afford a supplemental Medigap plan to choose an MA plan and leave traditional Medicare.[11] Indeed, of these beneficiaries who lack supplemental insurance (labeled active choosers), those with lower incomes and ethnic minorities are disproportionately likely to select MA plans, although the difference in enrollment compared with white and higher-income beneficiaries is not great.[12] MA plans are able to attract active choosers disproportionately because they can convert extra payments they receive into extra benefits, not because the plans are more efficient and thereby able to provide extra benefits.[13] In the aftermath of the Medicare

11. *See* ADAM ATHERLY & KENNETH E. THORPE, BLUE CROSS & BLUE SHIELD ASS'N, VALUE OF MEDICARE ADVANTAGE TO LOW-INCOME AND MINORITY MEDICARE BENEFICIARIES 6 (2005), *available at* www.bcbs.com/issues/medicaid/research/Value-of-Medicare-Advantage-to-Low-Income-and-Minority-Medicare-Beneficiaries.pdf (last visited Sept. 19, 2007).

12. *Id*. at 3-4; *see also* CMS, MEDICARE ADVANTAGE IN 2007, *supra* note 8, at 9. In criticizing these findings, others have analyzed the data without excluding beneficiaries on Medicaid and found that low-income and minority beneficiaries do not disproportionately enroll in Medicare plans. *See, e.g.*, EDWIN PARK & ROBERT GREENSTEIN, CTR. ON BUDGET & POLICY PRIORITIES, LOW-INCOME AND MINORITY BENEFICIARIES DO NOT RELY DISPROPORTIONATELY ON MEDICARE ADVANTAGE PLANS: INDUSTRY CAMPAIGN TO PROTECT BILLIONS IN OVERPAYMENTS RESTS ON DISTORTIONS 3-5 (2007), *available at* www.cbpp.org/4-3-07health.pdf (last visited Sept. 19, 2007).

13. There is confusion and disagreement over whether MA plans are more efficient than the traditional Medicare program. Using 2004 data from adjusted community rate filings, CBO found that MA plans required 103% of traditional Medicare spending to provide the statutory Medicare Part A and Part B benefits. CONG. BUDGET OFFICE, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE 11 (2006), *available at* www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf (last visited Sept. 19, 2007) [hereinafter CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE]. Using 2006 bids made by plans to provide Parts A and B benefits, MedPAC estimated that MA plans provide those benefits at 99% of Medicare's costs and that health maintenance organizations (HMOs), the predominant MA plan, are able to do so at 97%. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: PROMOTING GREATER EFFICIENCY IN MEDICARE 63 tbl.3-1, 64 (2007), *available at* www.medpac.gov/documents/Jun07_EntireReport.pdf (last visited Sept. 19, 2007) [hereinafter MEDPAC, PROMOTING GREATER EFFICIENCY IN MEDICARE]. As emphasized in the CBO's report, these analyses are sensitive to differences in beneficiaries' underlying health status. Therefore, the CBO tried to remove those differences by adjusting plan costs according to health risk. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra*. Another factor confounding the analysis of MA plan efficiency relative to traditional Medicare is that plans disproportionately serve counties where traditional Medicare spending is relatively high because payments to MA plans are based, at least to an extent, on traditional Medicare spending. *Id.* at 12. Nevertheless, until adjustments are made for the geographic distribution of plans, MedPAC's analysis will not be able to offer a conclusion about whether plans are actually more efficient at providing Parts A and B benefits than traditional Medicare.

Prescription Drug, Improvement and Modernization Act of 2003 (MMA),[14] which substantially increased payments made to MA plans, "[t]he number of Medicare enrollees in private health plans increased from 5.3 million (across 285 contracts) in 2003 to 8.7 million (across 602 contracts) as of June 2007."[15] MA enrollment rose slightly in July to 8.8 million, bringing the percentage of Medicare beneficiaries enrolled in private plans to exactly 20%.[16]

Observers have recently focused their criticisms on the possibility that the systematic overpayments and other advantages the MA plans enjoy, which this article discusses, will tilt the "playing field" in favor of private plans.[17] Their concern is that a long-term tilt could lead to the demise of the traditional Medicare program without Congress and the public ever debating the merits of this shift that would effectively privatize the program.[18] Giving beneficiaries the incentive to leave traditional Medicare for a private plan carries out former Speaker Gingrich's pronounced strategy to have traditional Medicare "wither on the vine" through the voluntary decisions of Medicare beneficiaries.[19] Ideological conservatives agree with liberal critics that the stakes involved in the political battle over Medicare Advantage are high. In an opposite editorial titled *How the GOP Won Health Care*, Holman Jenkins, a member of the *Wall Street Journal*'s editorial board,

14. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

15. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE ADVANTAGE 1 (2007), *available at* www.kff.org/medicare/upload/2052-10.pdf (last visited Sept. 19, 2007).

16. Stephanie Peterson & Marsha Gold, *Tracking Medicare Health and Prescription Drug Plans: Monthly Report for July 2007*, KAISER FAMILY FOUND., Aug. 3, 2007, at 1, *available at* www.kff.org/medicare/upload/medicaretracking0707.pdf (last visited Sept. 19, 2007).

17. *See, e.g.*, Trudy Lieberman, *The Medicare Privatization Scam*, THE NATION, July 16/23, 2007, at 14, 20 (contending that Congress is slowly draining Medicare to create a more privatized system and that, with some MA plans, seniors may pay more out of pocket than they would under traditional Medicare).

18. When the MMA was being debated, the issues that drew the most comments were those related to the structure and cost of the Part D drug benefit, including its "doughnut hole" in coverage, the "non-interference" clause precluding price negotiations between the government and the pharmaceutical companies, and its overall cost. *See id.* at 14; Paul Krugman, *The Plot Against Medicare*, N.Y. TIMES, Apr. 20, 2007, at A23; Robert A. Berenson, *Doctoring Healthcare II: Yo, Democrats! Medicare is Privatizing!*, 18 THE AMERICAN PROSPECT 13 (Jan./Feb. 2007) (discussing concerns that the un-level playing field could effectively privatize Medicare without receiving public attention).

19. On October 24, 1995, Gingrich explained the Republican strategy regarding Medicare. He said, "'Now, we don't get rid of it in round one because we don't think that's politically smart, and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine.'" Adam Clymer, *The Ad Campaign: Organized Labor Goes on the Offensive and the Republicans Cry Foul*, N.Y. TIMES, July 20, 1996, at A8.

argued that Democrats correctly accused Republicans of privatizing Medicare by turning it into a voucher program.[20]

The CBO's most recent projection calls for MA enrollment to "grow at an annual average rate of about 7 percent over the next 10 years, compared with a growth rate of about 2.5 percent for Medicare overall—reaching 21 percent of total enrollment in 2008 and 26 percent by 2017."[21] However, these projections might well be conservative. From July 2006 to July 2007, enrollment in MA increased from 7.3 million to 8.8 million, a growth of 20% in just one year.[22] Additionally, after the MMA was enacted, the CBO initially projected virtually no increase in MA plan enrollment.[23] Without changes in overpayments and the other advantages enjoyed by MA plans, MA enrollment growth might reach a "tipping point" where traditional Medicare will no longer be able to function in many areas. Critics predict that traditional Medicare's risk pool will be compromised "as those with greater health care needs remain in the traditional program, paying . . . higher Part B premiums to subsidize overpayments to [MA] plans."[24] Critics are also concerned that substitution of an array of private plans[25] will allow the program to alter its fundamental character from a social health insurance program providing a defined benefit to a voucher-like program offering beneficiaries a defined contribution to use in selecting among only private insurance plans.[26] A voucher-like program is a long-standing goal of ideologically conservative Medicare reformers.[27]

20. Holman W. Jenkins, Jr., *How the GOP Won Health Care,* WALL ST. J., May 9, 2007, at A16 (arguing that, with the extra payments provided to MA plans and the new Medicare drug benefit, "Republicans have usurped Democrats' role as Santa Claus to the middle class").

21. J. TIMOTHY GRONNIGER & ROBERT A. SUNSHINE, CONG. BUDGET OFFICE, MEDICARE ADVANTAGE: PRIVATE HEALTH PLANS IN MEDICARE 3 (June 2007), *available at* www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf (last visited Sept. 16, 2007).

22. Peterson & Gold, *supra* note 16.

23. Robert A. Berenson, *Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'* 2004 HEALTH AFF. (WEB EXCL.) w4-572, w4-576, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.572v1 (last visited Sept. 16, 2007) (discussing how most estimates were inappropriately conservative because they missed the dramatic increase in the enrollment in private fee-for-service (PFFS) option, which is the fastest growing MA option).

24. NAT'L COMM. TO PRESERVE SOC. SECURITY & MEDICARE, *supra* note 6.

25. This includes the PFFS option, which is the fastest growing MA plan and attempts to mirror traditional Medicare's open access to all providers.

26. *See* Stuart M. Butler & Robert E. Moffit, *The FEHBP as a Model for a New Medicare Program*, 14 HEALTH AFF. 47, 51-52 (1995), *available at* http://content.healthaffairs.org/cgi/reprint/14/4/47.pdf (last visited Sept. 16, 2007).

27. *See generally id.* at 47-61. A somewhat modified defined contribution approach, labeled "premium support," has been proposed by many since it was initially suggested in an influential *Health Affairs* article. *See* Henry J. Aaron & Robert D. Reischauer, *The Medicare*

Many healthcare system stakeholders have expressed increasing doubts about the ability of the market, generally, and private health plans, specifically, to address ongoing problems of escalating costs and mediocre quality and are looking for the government to serve a greater role as a steward of improving the system.[28] In the MMA, Congress ignored these views and moved the other direction, threatening the very survival of the relatively successful traditional Medicare program. This fundamental threat to the program comes as scholars increasingly are calling for expansion of traditional Medicare to serve either as a third-party administrator for self-funded employers[29] or as the basis for a national health system offering an array of private plans and a strong government-run program.[30] However, an un-level playing field in Medicare would undermine these promising proposals.

Whether within the context of the current Medicare program or in visions of a "Medicare for all" program, it is important to define what constitutes a level playing field.[31] Even some of the current proposals for moving Medicare to a premium support model call for an explicit and important role for traditional Medicare.[32] Although the current payment system for MA

Reform Debate: What is the Next Step?, 14 HEALTH AFF. 8, 20-22 (1995), *available at* http://content.healthaffairs.org/cgi/reprint/14/4/8.pdf (last visited Sept. 19, 2007). For a detailed exploration of how premium support would work, see CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 3-6.

28. Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFF. 8, 11-15 (2004), *available at* http://content.healthaffairs.org/cgi/reprint/23/2/8.pdf (last visited Sept. 16, 2007). Commenting on this paper, Alain Enthoven, one of the main architects of managed competition, lamented the failure of the market to address cost and quality concerns. Enthoven also stated that the country might have to move to "Medicare for all" by default. Alain C. Enthoven, *Market Forces and Efficient Health Care Systems*, 23 HEALTH AFF. 25, 25-27 (2004), *available at* http://content.healthaffairs.org/cgi/reprint/23/2/25 (last visited Sept. 16, 2007). Ironically, program developments resulting from the un-level playing field suggest Medicare for none.

29. *See* Joseph White, *Protecting Medicare: The Best Defense is a Good Offense*, 32 J. HEALTH POL., POL'Y & L. 221, 223-25 (2007), *available at* http://jhppl.dukejournals.org/cgi/reprint/32/2/221 (last visited Sept. 16, 2007).

30. Mark Schlesinger & Jacob S. Hacker, *Secret Weapon: The "New" Medicare as a Route to Health Security*, 32 J. HEALTH POL., POL'Y & L. 247, 271-84 (2007), *available at* http://jhppl.dukejournals.org/cgi/reprint/32/2/247 (last visited Sept. 16, 2007).

31. While some on the Right might prefer the elimination of a government-run program altogether, some on the Left seek a single-payor program that has no role for private health insurance, resembling the Canadian healthcare system.

32. Some advocates of major market-based reform in Medicare, based on premium support, have called for the traditional Medicare program to serve a major role as one of the competitors. Before the Senate Finance Committee, Dr. Stuart M. Butler from the Heritage Foundation testified,

plans and a premium support system share some elements, they differ significantly in that the current system treats private plans differently from the traditional program.[33] Under a premium support model, the traditional program's and private plans' payments would be established on the same basis.[34] The government's contribution would either be determined from the plans' bids, with the "bid" of the traditional program treated like a private plan bid, or set at a predetermined level.[35] Consequently, enrollees in traditional Medicare could be required to pay higher or lower premiums than they currently face, depending on the traditional program's bid.[36]

Whether the traditional program would be expected to be a passive payer, whose bid simply reflects its actual payments, or an active bidder, with an opportunity to use the bidding process to manage costs within

> Because of the statutory basis of the fee-for-service benefits package and the many requirements Congress places on HCFA [CMS], it is currently very difficult for the agency to make improvements in the fee-for-service program so that it becomes more competitive and modern. Thus, the fee for service [program] is inherently at a disadvantage when competing with the more flexible private plans now being made available to seniors.
>
> . . . .
>
> . . . Whenever a competitive market is introduced, the government-provided service must be given every opportunity to redesign itself to compete effectively.

Restructuring Medicare for the Next Century: Hearing Before the S. Comm. on Finance, 106th Cong. (1999) (statement of Stuart M. Butler, Vice President for Domestic and Policy Studies, The Heritage Foundation), *at* www.heritage.org/Research/HealthCare/Test052799.cfm?renderforprint=1 (last visited Sept. 16, 2007). The testimony did not address the issue of payment equity. At the time, payments to private plans were slightly less than traditional Medicare payments before considering the impact of favorable risk selection that plans experience. *See* Robert A. Berenson, *Medicare+Choice: Doubling or Disappearing?*, 2001 HEALTH AFF. (WEB EXCL.) W65, W76, W79, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w1.65v1 (last visited Nov. 17, 2007) (discussing the role of traditional Medicare in premium support proposals); *see also* Roger Feldman & Bryan Dowd, *Structuring Choice Under Medicare, in* MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 75-124 (Robert D. Reischauer et al. eds., 1998). Not all such proposals contemplate a role for traditional Medicare as a plan option. *See* THOMAS RICE & KATHERINE A. DESMOND, THE HENRY J. KAISER FAMILY FOUND., AN ANALYSIS OF REFORMING MEDICARE THROUGH A "PREMIUM SUPPORT" PROGRAM 8 (2002), *available at* www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14147 (last visited Sept. 16, 2007).

33. Currently, beneficiaries who receive their care in the traditional program pay a monthly premium for that coverage equal to a percentage of national per capita Medicare spending. 42 U.S.C. § 1395r (2000). Beneficiaries who enroll in private plans receive a rebate or pay a surcharge, depending on whether their selected plan's bid is below or above a benchmark that is constrained to be at least as high as local, county-level per capita traditional program spending. *See* 42 U.S.C. § 1395w-24 (2000 & Supp. IV 2004).

34. RICE & DESMOND, *supra* note 32.

35. *Id.*; CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 3.

36. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 2-3.

particular geographic areas, is unclear. Although the issues in permitting traditional Medicare to become an active value-based purchaser are beyond the scope of this article, there have been attempts to identify purchasing opportunities for the traditional program.[37]

This article attempts to analyze why the current playing field for competition between traditional Medicare and private health plans is severely tilted in favor of the plans. Current public debate has focused mostly on overpayments. This article begins with an exploration of how the payments can be modified to promote payment equity. However, other important but less-discussed factors contribute to the un-level playing field. In turn, this article considers the following issues: benefits flexibility, including the concept of actuarial equivalence that plans take advantage of; the opportunity plans have to market their products and abuses in marketing; and the unique advantages enjoyed by private fee-for-service (PFFS) plans. In each of these areas, this article offers suggestions for correcting the playing field imbalance. The article concludes with a brief discussion of the Centers for Medicare and Medicaid Services (CMS) "boosterism" of private plans, demonstrating the need for even-handedness in the administration of Medicare.

II. FINANCIAL NEUTRALITY

The Medicare Payment Advisory Commission (MedPAC), which explicitly and consistently has supported the concept of a level playing field competition between the array of private plans and traditional Medicare, has defined financial neutrality as follows: "the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses."[38] Recently,

37. There is growing literature on how the traditional Medicare program might be allowed to better manage costs and improve quality. MedPAC has issued many reports presenting ideas for value purchasing. For the author's contributions on the topic, see Robert A. Berenson, *Getting Serious About Excessive Medicare Spending: A Purchasing Model*, 2003 HEALTH AFF. (WEB EXCL.), W3-586, W3-591 to W3-602 (2003), *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.586v1 (last visited Sept. 16, 2007); Robert A. Berenson & Dean M. Harris, *Using Managed Care Tools in Traditional Medicare-Should We? Could We?*, 65 LAW & CONTEMP. PROBS. 139, 147-54 (2002), *at* www.law.duke.edu/shell/cite.pl65+Law+&+Contemp.+Probs.+139+(Autumn+2002) (last visited Sept. 24, 2007).

38. MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2. The actual payments made to plans are based on plans' bids against benchmark targets, a system that began in 2006. *Id.* at 243. Plans that want to participate as MA plans must submit bids indicating the per capita payment for which they are willing to provide Medicare Part A and Part B services. *Id.* Plans must also submit bids for the voluntary Part D prescription drug benefit and for premiums for any supplemental benefits they intend to offer. *Id.* at 253. Plans are paid their bids plus 75% of the amount by which the applicable benchmark exceeds their bid. *Id.* at

MedPAC clarified that their position on financial neutrality could be accomplished by payment equivalence in the aggregate, with variations in local rates, or by payment equivalence at the local level, which MedPAC has long-preferred.[39]

MedPAC initially adopted the payment neutrality provision in 2001 using the following rationale: "Because health care is delivered in local markets, payment neutrality needs to be pursued at the local level. Failure to make payments equal within a local market would give one sector—either M+C [the Part C program before MA] or traditional FFS—an advantage over the other."[40] First, this definition, which ignores overspending in the traditional program and the actual costs of providing Parts A and B services through MA plans, seems to accept the systematic, geographically-based overspending in the program[41] and essentially passes it through to the MA sector of Medicare; but, in so doing, the definition tries to maintain a level playing field.[42] MedPAC's preferred payment neutrality

246. Plans must return the 75% to beneficiaries as additional benefits or as a rebate on their Part B or Part D premiums. *Id.* Plans that bid above the benchmark are required to charge enrollees the full difference between the bid and benchmark as an additional premium. *Id.* at 243, 247. The 25% government retention, which is effectively a tax on low bids, explains why MedPAC estimates that benchmarks in 2006 were set 116% above traditional program spending and actual payments at 112%. *Id.* at 246-47. Independently, the CBO similarly concluded that the benchmarks for 2007 were 117% and payments 112% of traditional Medicare. *MA Hearing*, *supra* note 3.

39. MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2, at 252. Operationally, payment at the local level means at the county level because CMS collects well-defined, county-level, per-capita costs and can make other payment adjustments for beneficiary health status and for indirect medical education payments at the county level. *Id.* at 243, 252.

40. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 112-13 (2001), *available at* http://medpac.gov/publications/congressional_reports/Mar01%20Ch7.pdf (last visited Sept. 16, 2007). It is interesting to note that MEDPAC's predecessor, the Physician Payment Review Committee (PPRC), took a different position on financial neutrality at the local level. In its March 1997 Annual Report, PPRC stated,

> Many observers think current policies [financial neutrality at the country level] limit the growth of Medicare managed care by paying too little in some markets and promoting it in others by paying more than necessary to compensate plans fairly. In any case, these policies hamper Medicare's ability to benefit from the efficiencies of managed care. Moreover, they do not encourage beneficiaries to make cost-conscious choices.

PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS xxi (1997).

41. *See generally* John E. Wennberg et al., *Geography and the Debate Over Medicare Reform*, 2002 HEALTH AFF. (WEB EXCL.) W96, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1 (last visited Sept. 16, 2007) (showing that more than two-fold differences in spending does not produce important differences in quality of care).

42. An approach that would deviate from a level playing field would attempt to achieve savings from the potential efficiencies of private plans. For example, the competitive pricing demonstration model that CMS attempted to implement featured competitive bidding by health plans in a local area against each other. It did not refer to spending in the traditional

formulation would represent a substantial spending improvement over the current MMA payment formula, which pays MA plans 112% of traditional Medicare in aggregate and substantially more in some counties,[43] and would generate substantial program savings.[44]

Second, there is growing evidence that even traditional Medicare per capita spending, as calculated at the county level, provides payments that far exceed plan costs (including a reasonable profit), at least in those counties where plans are disproportionately represented (precisely because the payment levels have been so generous).[45] For many years, policy analysts have thought that plan costs do not vary the same way that traditional Medicare spending varies.[46] For example, over the many years when plans received formula-based payments, their benefits varied directly with their CMS payments, which were based on local traditional program expenditure levels.[47] This fact indicates that private plan costs do not vary as much as the traditional program spending.[48]

program, which might save substantially more as plans have an incentive to bid low to obtain business. Before the Denver demonstration of competitive pricing was cancelled by court order, the available bids "were found to be 24 to 38 percent below the prevailing payment rate at the time (which was set at 95 percent of the cost of care in [traditional] Medicare, adjusted for beneficiary risk)." Bryan E. Dowd et al., *Fee-for-Service Medicare in a Competitive Market Environment*, 27 HEALTH CARE FINANCING REV. 113, 117 (2005-2006). The health insurance industry argues, with some justification, that competitive bids from private plans without reference to traditional Medicare represents a tilted playing field, but, in this case, tilted to favor traditional Medicare, resulting in withdrawal of many plans from the program and an inability of plans to offer the additional benefits that many beneficiaries seek. Karen Ignagni, *Putting Principles First: A Better Way to Carry Out a Demonstration*, 19 HEALTH AFF. 44, 46 (2000), *available at* http://content.healthaffairs.org/cgi/reprint/19/5/44.pdf (last visited Sept. 16, 2007).

43. BILES ET AL., *supra* note 8, at 2; *see also* BILES & ADRION, *supra* note 4 (finding that, on average, MA plans were paid about 18% more than traditional programs costs in rural "floor" counties and 21% more in urban "floor" counties. Payments in some counties were substantially more than these averages).

44. *MA Hearing*, *supra* note 3, at 5. MedPAC further suggests the amount of overpayments will actually increase in the near term because enrollment trends toward MA plans are disproportionate in areas of the country with relatively high benchmarks in relation to traditional Medicare. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 58-64. However, this projection does not take into account the trend in health plan reporting of enrollee risk. *See infra* text accompanying notes 81-83.

45. Kenneth E. Thorpe & Adam Atherly, *Reforming Medicare: Impacts on Federal Spending and Choice of Health Plans*, 2001 HEALTH AFF. (WEB EXCL.) W51, W54, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w1.51v1 (last visited Sept. 16, 2007).

46. *See id.* at W51-52 ("Under the current system, payments for M+C plans are unrelated to plans' underlying costs. Instead, payments are derived from costs in the fee-for-service (FFS) sector."); Berenson, *supra* note 32, at W72-73.

47. Dowd et al., *supra* note 42, at 120.

48. *Id.*

CBO's recent study, *Designing a Premium Support System for Medicare*, confirms these analysts' suspicions and explains why payment neutrality *at the local level* is an analytically flawed recommendation.[49] In the study, CBO compared plans' projected per capita costs of providing Medicare Parts A and B benefits as reported in their adjusted community rate (ACR) submissions, which project plan per capita revenue requirements for delivering Medicare's covered benefits and the per capita costs adjusting for enrollees' health status using the standard CMS approach.[50] Put simply, the CBO data shows that plan costs do not vary geographically the same way traditional Medicare costs vary.

This lack of correlation between variations in plan costs and traditional Medicare spending should come as no surprise if one considers the major components of costs: administrative costs, price of services, and utilization of services. Health plan costs mainly consist of administrative costs, including profit and reserves, and payments to providers for medical care.[51] Medical care costs are determined by prices paid for services and the volume of services provided.[52]

CBO found that plans' "[a]dministrative costs . . . account for about 11 percent of private plans' costs of delivering Medicare benefits, whereas the administrative costs of the [traditional] Medicare program . . . account for less than 2 percent of its expenditures."[53] Although there may be some variable cost in the 11%, perhaps associated with the volume of services provided (e.g., costs of claims administration, medical management, or marketing in a competitive environment), a reasonable assumption is that most of the administrative costs do not vary in relation to geographic

49. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 5.

50. *Id.* at 10, 42 tbl.5-2 (finding the bids plans submitted for 2006 produced similar ratios of costs to FFS spending as ACR filings, so that the basic findings do not appear affected by the absence of ACRs, which provide detail on projected plan costs, and that plan bids appear to reflect plans' underlying costs in the same way that formal ACR submissions do).

51. *See* CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 12. Staff and group model HMOs, such as Kaiser-Permanente, typically employ or own some or all of the providers in the network and, therefore, demonstrate a different cost structure. Most MA enrollment is in other health insurance models in which the insurer pays contracting providers for medical care provided.

52. The Government Accountability Office developed a method for disaggregating medical expenses between prices paid to providers and the use of services by enrollees in the Federal Employees Health Benefits Program. This approach might be applied to determining benchmarks for MA plan bidding. GOV'T ACCOUNTABILITY OFFICE, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: COMPETITION AND OTHER FACTORS LINKED TO WIDE VARIATION IN HEALTH CARE PRICES app. I, at 32-48 (2005), *available at* www.gao.gov/new.items/d05856.pdf (last visited Sept. 16, 2007).

53. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 12.

variations in traditional program spending.[54] In other words, most of the administrative costs represent a fixed dollar commitment to supporting MA products, invariant of geographic factors.

With regard to payment rates for services, the prices paid by private plans to hospitals and physicians are actually "higher in rural and small metropolitan areas than in large metropolitan areas."[55] One study conducted for MedPAC found that "the rates paid to physicians by private plans are an average of 30 percent higher than Medicare's FFS rates in small metropolitan areas and rural areas, 10 percent higher in medium-sized metropolitan areas, and 1 percent higher in large metropolitan areas."[56]

This inverse relationship between size of geographic area and prices makes perfect sense based on the Center for Studying Health System Change (HSC) findings about market dynamics.[57] In recent years, hospitals, to a great extent, and physicians, to a lesser extent, have developed strategies, including restraining capacity growth, to gain bargaining leverage.[58] In comparison to providers in competitive urban areas, providers in rural and smaller urban areas with little provider competition have an upper hand in negotiating with plans.[59]

The situation is very different regarding service utilization. Health plans (except for group- and staff-model health maintenance organizations (HMOs) such as Kaiser) largely inherit the provider community's practice patterns.[60] Furthermore, plans have an enhanced opportunity to reduce spending in higher spending areas by applying managed care techniques, such as selective contracting based on physician profiling and prior authorization.[61] For purposes of this article, the main point is that it is

54. *Id*.

55. *Id*. at 13.

56. *Id*. (citing Dyckman & Associates, Medicare Payment Advisory Comm'n, Survey of Health Plans Concerning Physician Fees and Payment Methodology (2003), *available at* www.medpac.gov/publications/contractor_reports/Aug03_PhysPaySurvey(cont)Rpt.pdf (last visited Sept. 20, 2007) (Although this data is not specific to health plans' MA products, it is likely that prices vary similarly for these products as well, with the artificially produced PFFS prices.)).

57. *See* Paul B. Ginsberg, *Competition in Health Care: Its Evolution Over the Past Decade*, 24 HEALTH AFF. 1512, 1518-19 (2005), *available at* www.healthaffairs.org/RWJ/Ginsburg_05.pdf (last visited Nov. 18, 2007) (analyzing the HSC's observations of healthcare market forces).

58. *Id*. at 1518.

59. *Id*.

60. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 13.

61. *Id*.

reasonable to expect a positive correlation between plan and traditional Medicare utilization patterns, as the CBO has found.[62]

The CBO analysis showed that MA plans' bids vary less from county to county than does per capita traditional program spending.[63] As a result, in areas with high traditional program per capita costs, MA plans' costs are relatively low compared with traditional program spending and vice versa.[64] In particular, in areas with the highest traditional program spending, both the benchmarks against which plans bid and the plans' actual bids deviate from the idea of financial neutrality at the local county level.[65] In these areas, bids are about 8% above traditional Medicare spending, while in the lowest-cost traditional program areas, bids are about 21% above traditional program spending.[66]

The benchmarks against which MA plans bid do not reflect cost differences faced by local plans due to local market factors, but, rather, are artifacts of the specific cost factors faced by the traditional Medicare program.[67] By analyzing the variations in costs as represented by plan bids, benchmarks can be set that more closely replicate the actual costs plans face.

Although actual plans' bids might reflect strategic considerations in some cases, for purposes of the analyzing relative bids across geographic areas, plan bids reflect the costs of efficiently providing Medicare benefits. [68] By reviewing bids for all MA plans, except PFFS, for all counties, one can determine how plan costs vary geographically and how well that variation correlates with the variation in spending at the county level in traditional Medicare.[69]

If plan costs, as reflected in their bids, do in fact vary in the same way that traditional program county-level spending varies, but, say, are only half as much as traditional program costs, one could construct benchmarks

62. *Id*. at 11 tbl.2-1.

63. *Id*. at 11.

64. *Id*.

65. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 9, 11.

66. *Id*. at 11.

67. *See* Berenson, *supra* note 32, at W76-77 (discussing the linkage between M+C and the traditional program in determining payments to M+C plans).

68. *See* Bryan Dowd et al., *A Tale of Four Cities: Medicare Reform and Competitive Pricing*, 19 HEALTH AFF. 9, 10 (2000), *available at* http://content.healthaffairs.org/cgi/reprint/19/5/9.pdf (last visited Nov. 28, 2007) (explaining that the theory behind competitive pricing is that plans tell the government how much it costs to care for Medicare beneficiaries).

69. One would likely exclude PFFS plans from this calculation because of their legislated privilege of imposing Medicare prices on providers, thereby artificially altering the local market conditions—and costs—that all other MA plans face. See *infra* notes 204–12 and accompanying text for a discussion of deeming.

based 50% on the national per capita spending amount and 50% on county-level spending. The Balanced Budget Act of 1997 (BBA) used a blend in moving away from county-level payment neutrality, which was the basis for pre-BBA payments.[70] However, the BBA's 50-50 blend was selected arbitrarily and not based on the type of analysis proposed here.

Similarly, the county-level payment floors, which are embedded in benchmark calculations and have dramatically raised benchmarks and, thus, payments in low traditional Medicare payment areas, were set arbitrarily without reference to actual costs that plans in those areas face.[71] In the hypothetical 50-50 blend between national and county-level rates, the so-called floor counties would have benchmarks set above the pre-BBA payment equivalence levels but below the unjustifiably high levels the BBA produced.[72]

III. FAVORABLE SELECTION

Numerous studies over nearly two decades have documented that private plans attract healthier-than-average Medicare beneficiaries. The evidence comes from papers showing that Medicare beneficiaries in private HMOs used fewer services before enrolling and had lower mortality rates and imputed fee-for-service costs while in the plans; and beneficiaries who disenrolled from the plans had higher use and mortality rates than both people who remained in plans and those in traditional Medicare.[73] In general, if plans "attract healthier-than-average beneficiaries, the Medicare program pays more than these same beneficiaries would cost in the [traditional] program."[74]

70. Balanced Budget Act of 1997, 42 U.S.C. § 1395ww (2000). It is possible, although unlikely, that the kind of analysis recommended here would show an inconsistent relationship between health plan costs and traditional Medicare spending levels. If that were the case, any approach that tied plan bids to traditional program benchmarks, whether the current system, MedPAC's preferred approach, or the one proposed here, would be problematic. A different approach in which benchmarks were set as a function of plan bids only would seem to be indicated.

71. *See* CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 9.

72. This provides an analytic approach to accomplishing the objective that the Physician Payment Review Commission had in recommending a blended payment in their 1997 Report. PHYSICIAN PAYMENT REVIEW COMM'N, *supra* note 40, at 65-67.

73. *See, e.g.*, RANDALL BROWN ET AL., MATHEMATICA POLICY RESEARCH INC., THE MEDICARE RISK PROGRAM FOR HMOS: FINAL SUMMARY REPORT ON FINDINGS FROM THE EVALUATION (1993); U.S. GEN. ACCT. OFFICE, GAO/HEHS-00-161, MEDICARE+CHOICE: PAYMENTS EXCEED COST OF FEE-FOR-SERVICE BENEFITS, ADDING BILLIONS TO SPENDING (2000), *available at* www.gao.gov/archive/2000/he00161.pdf (last visited Dec. 4, 2007).

74. MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2, at 211 (also arguing that the opportunity to attract enrollees of varying health status is inequitable among competing plans).

The BBA authorized CMS to develop a risk-adjustment mechanism to adjust payments to plans not only for demographic factors such as age and gender, but also for the underlying health status of patients.[75] CMS chose to adopt the Hierarchical Condition Codes (HCC) model, which uses diagnoses recorded on claim forms and submitted by MA plans to CMS and a given year's demographic characteristics to assign each beneficiary a risk score measuring his or her predicted expenditures in the following year relative to the national average.[76]

Inadequate risk adjustment distorts competition between private plans and the traditional Medicare program because "spending is highly concentrated in a relatively small proportion of the beneficiary population."[77] While risk adjustment has helped level the playing field by making plan payments more appropriate for the level of health risk their enrollees manifest, there are ongoing concerns that the HCC model under-adjusts for health status disparity, and that, consequently, plans will still receive excessive payments as long as they continue to attract relatively healthy beneficiaries.[78] As discussed below, plans can do a number of things, such as engage in certain market strategies, to continue to attract relatively healthier beneficiaries or encourage sicker ones to leave the program.

Whether plans are now attracting a sicker population as they care for a larger percentage of beneficiaries is not clear. The CBO stated that between 2003 and 2004, "the average risk score for enrollees in private plans increased significantly relative to the average risk score for beneficiaries in the [traditional] program."[79] This increase happened "even though there was little change during that period in the composition of the

75. *Id.*

76. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 10.

77. *Id.* at 26. For example, in 2004, 43% of annual Medicare spending was attributable to the top 5% of beneficiaries and 15.5% of spending to the top 1% of beneficiaries. Gerald F. Riley, *Long-Term Trends in the Concentration of Medicare Spending*, 26 HEALTH AFF. 808, 810 (2007).

78. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM 43-44, 52-53 (2005), *available at* www.medpac.gov/documents/June05_Entire_report.pdf (last visited Sept. 21, 2007) [hereinafter MEDPAC, ISSUES IN A MODERNIZED MEDICARE PROGRAM]. This report found that although the current risk adjuster used by CMS is a major improvement over using demographic factors in adjusting payments to plans for the varying underlying health of enrollees, it still leaves room for improvement. The risk adjustment model that CMS uses "overpredicts the costliness of beneficiaries who are in good health and underpredicts for those who are in poor health," therefore maintaining the incentive for plans to seek to enroll relatively healthy Medicare beneficiaries disproportionately. *Id.* at 53.

79. CBO, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE, *supra* note 13, at 10.

private plans that participate in Medicare or in their enrollment."[80] Risk scores for MA plan "enrollees estimated from 2003 data were about 12 percent lower than risk scores for enrollees in the [traditional] program, on average," but using 2004 data the scores narrowed to approximately 6%.[81]

Why MA plan risk scores are increasing is unknown. As CBO and MedPAC stated, "[p]rivate plans may have become better at collecting and reporting diagnostic information on their enrollees" because they receive additional dollars in so doing.[82] If this is the case, the increasing risk scores and increased payments might not actually be justified; although, plans surely have a right to improve their documentation and data submissions to CMS.[83] The complexity of the risk adjustment mechanics requires CMS to make numerous operational policy decisions related to difficult issues of data collection and validity, statistical complexity, and potentially different coding practices among plans and providers in the traditional Medicare program,[84] which together determine the financial impact of risk adjustment on plans.[85]

In 2002, CMS made an administrative decision to not take savings from the phased-in implementation of risk adjustment in 2003 and to extend that policy for subsequent years when the savings to the government would have been more substantial as the risk adjustment was being phased in and more beneficiaries were enrolling in MA plans.[86] Such operational decisions can determine whether plan payments are adjusted to current risk adjustment

80. *Id.*

81. *Id.*

82. *Id.*; *see also* MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2, at 212 (suggesting that the risk adjustment may be higher than the true risk selection difference because of coding issues).

83. The Deficit Reduction Act of 2005 requires that CMS compare the diagnostic coding patterns of private plans and providers submitting claims in the traditional program, and if important differences are found, appropriately adjust the payments to plans. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 48 (to be codified at 42 U.S.C. § 1395w-23).

84. GRONNIGER & SUNSHINE, *supra* note 21, at 2.

85. For example, in calculating plan payments, "CMS has to decide what cohort of plans have submitted acceptable data on which to base risk scores; whether to adjust payment rates for trends in coding practices in traditional Medicare (so-called [fee-for-service] normalization); and whether to use lagged or nonlagged data to calculate risk scores." Berenson, *supra* note 23, at W4-578.

86. *Id.*; *see also*, MEDICARE PAYMENT ADVISORY COMM'N, MEDICARE ADVANTAGE BENCHMARKS AND PAYMENTS COMPARED WITH AVERAGE MEDICARE FEE-FOR-SERVICE SPENDING 3 (2006), *available at* www.medpac.gov/publications/other_reports/MedPAC_briefs_MA_relative_payment.pdf (last visited Sept. 20, 2007) [hereinafter MEDPAC, MEDICARE ADVANTAGE BENCHMARKS] (stating that this adjustment to not take savings from implementation or risk adjusted payments has now been "scheduled to fall over time as a result of the Deficit Reduction Act of 2005").

mechanisms' maximum potential or, rather, to constitute a discretionary source of plan overpayments, intentionally tilting the playing field.[87]

IV. GREATER FLEXIBILITY IN BENEFITS OFFERINGS

Decisions by beneficiaries to leave traditional Medicare for an MA plan are "driven primarily by the desire for lower premiums or more comprehensive benefits . . . not because [MA plans] are preferred as a system of care."[88] The attraction is related to the significant benefits gaps in Parts A, B, and now D of traditional Medicare. In particular, the traditional program has substantial cost sharing in the form of premiums, hospital deductibles, and co-insurance for Part B services, such as physician visits, and lacks coverage that limits beneficiary exposure to catastrophic expenses.[89] MA plans bidding below the applicable benchmark are able to provide benefits to enrollees by reducing Parts A and B cost sharing, reducing the Parts B and D premiums, enhancing Part D benefits, and providing other benefits, such as vision and hearing screening.[90]

Other parties attempt to provide complementary insurance to fill in the gaps in traditional Medicare. According to MedPAC, currently "[a]bout 90 percent of Medicare beneficiaries obtained supplemental coverage in 2003 through former employers (33 percent), [M]edigap policies (25 percent),

87. The administrative decision to forgo savings for favorable selection into plans from application of the risk-adjustment methodology was never subject to notice, comment rule-making, or even posted on the CMS Web site, but rather was announced by CMS Administrator Thomas Scully at a public meeting with health plans. Berenson, *supra* note 23, at W4-584 n.29. Called the budget neutrality or hold-harmless provision, the Republican Congress decided to ratify the administrative decision but to phase it out over four years beginning in 2007. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2117-19 (codified at 42 U.S.C. § 1395w-115). Some argue that authority for not taking the savings from plans for favorable selection derives from congressional report language for the Balanced Budget Refinement Act of 1999. MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2, at 211.

88. Karen Davis et al., *Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries*, 2005 HEALTH AFF. (WEB EXCL.) W5-442, W5-452, (citing CATHY SCHOEN ET AL., KAISER/COMMONWEALTH FUND 1997 SURVEY OF MEDICARE BENEFICIARIES (1998), *available at* www.commonwealthfund.org/usr_doc/medicare_survey97_308.pdf?section=4039 (last visited Sept. 20, 2007)).

89. *See* THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE AT A GLANCE (Feb. 2007), *available at* www.kff.org/medicare/upload/1066-10.pdf (last visited Sept. 20, 2007).

90. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: INCREASING THE VALUE OF MEDICARE 208 fig.9-2 (2006), *available at* www.medpac.gov/documents/Jun06_EntireReport.pdf (last visited Sept. 20, 2007) (showing that in 2006 MA plans used about 65% of what they retain from bidding below benchmarks to reduce Parts A and B cost sharing, 14% to provide additional benefits, 11% to reduce Part D premiums, 5% to enhance Part D benefits, and 4% to reduce Part B premiums).

Medicare Advantage plans (13 percent), Medicaid (16 percent), or other programs (2 percent)."[91]

The MMA partly addresses Medicare benefit gaps by providing a modest prescription drug benefit under Part D.[92] According to the authors of *Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries*,

> One of the key structural decisions made in enacting the law was to offer prescription drug coverage only through private plans, either stand-alone private drug insurance plans or . . . MA managed care plans. This decision marks the first time in the program's history that a Medicare benefit will not be available though the basic program. With the new, separate Part D drug benefit, beneficiaries wishing to remain in the traditional fee-for-service . . . program and still have comprehensive coverage will now need three separate plans: basic Medicare Parts A and B, for hospital and physician services; Part D, a private prescription drug plan; and supplemental private coverage to help cover Medicare's high cost sharing and protect against catastrophic costs.[93]

The patchwork of plans has the potential to create confusion and adverse selection as healthier beneficiaries select MA plans.[94] It can also lead to higher administrative expenses because of the multiple administrative entities involved and the lack of integrated claims administration.[95] By requiring beneficiaries to receive prescription drug coverage from a private insurer, the MMA replaced the previous "two-stop shopping" with "three-stop shopping" for beneficiaries who otherwise are satisfied to stay in traditional Medicare.[96] Under the MMA, Medigap insurers can renew policies providing prescription drug benefits only to beneficiaries who decline to enroll in Part D and cannot issue new prescription drug benefit policies.[97] Thus, these limitations on prescription drug coverage in the long-standing Medigap supplemental market actually reduce choice for beneficiaries.

Some architects of the MMA specifically worked to accentuate then-existing structural advantages given to private plans. In his 2003 State of

91. MEDPAC, MEDICARE PAYMENT POLICY 2007, *supra* note 2, at 6. Note that the percentage of beneficiaries in MA has increased from 13% in 2003 to 20% in July 2007. *See supra* text accompanying note 15.

92. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. §§ 1395w-101 – 152 (Supp. IV 2004).

93. Davis et al., *supra* note 88, at W5-442.

94. *Id.*

95. *Id.* at W5-442 to W5-443 (citing MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ASSESSING MEDICARE BENEFITS (2002), *available at* www.medpac.gov/documents/Jun02_Entire%20report.pdf (last visited Sept. 20, 2007)).

96. Berenson, *supra* note 23.

97. 42 U.S.C. § 1395ss(v) (Supp. IV 2004).

the Union address, President Bush proposed that beneficiaries could receive comprehensive prescription drug benefits only if they joined a private plan; those remaining in traditional Medicare would not receive as generous of coverage.[98] This proposal explicitly favored private plans. Although the tilt was politically unsustainable, the actual MMA language still provides a very real opportunity for private plans to exploit advantages the system's structure afforded them by offering one-stop shopping and using the overpayments they receive to offer extra benefits.

Because the same private plans offering Medicare Advantage also are offering the stand-alone drug benefit, including prominent insurers like UnitedHealth Group, WellPoint, and Humana, some beneficiaries will likely find it simpler to just let the same insurer provide all their care, including their basic Medicare benefits. Humana has forthrightly acknowledged this advantage. With its already large presence in both Parts C and D of Medicare, Humana has developed a "near national" strategy for reaching virtually all Medicare beneficiaries with a stand-alone drug plan.[99] Its goal is to "ultimately migrate those customers" to more profitable MA plans,[100] thereby promoting the simplicity of one-stop shopping.[101]

The obvious policy approach to leveling the playing field between MA plans and traditional Medicare in terms of benefit offerings would be to allow traditional Medicare to offer catastrophic coverage and a Part D plan directly and to improve coverage of beneficiary cost sharing so that beneficiaries could have one-stop shopping in the traditional program.[102] Even if premiums increased substantially to accommodate an expanded benefit package, allowing traditional Medicare to offer benefits comparable to what MA plans provide would present a "genuine market test" and fair choice.[103]

98. George W. Bush, U.S. President, State of the Union, (Jan. 28, 2003), *at* www.whitehouse.gov/news/releases/2003/01/20030128-19.html (last visited Sept. 30, 2007). President Bush subsequently proposed a plan that would have provided beneficiaries on traditional Medicare with an estimated 10% to 25% savings on prescription drugs and protection from high out-of-pocket prescription drug expenses. Press Release, White House, President Announces Framework to Modernize and Improve Medicare (Mar. 4, 2003), *at* www.whitehouse.gov/news/releases/2003/03/20030304-5.html (last visited Sept. 20, 2007).

99. MARSHA GOLD, THE HENRY J. KAISER FAMILY FOUND., PRIVATE PLANS IN MEDICARE: A 2007 UPDATE 10 (2007), *available at* www.kff.org/medicare/upload/7622.pdf (last visited Sept. 20, 2007).

100. Berenson, *supra* note 18, at 15 (quoting Humana's Chief Executive Officer Mike McAllister on the rationale for the aggressive strategy to sell Part D stand-alone products).

101. See *infra* notes 136-141 and accompanying text for evidence of marketing abuses associated with this migration strategy.

102. Davis et al., *supra* note 88, at W5-450.

103. *Id*. at W5-452.

Analysis suggests that a so-called Part E of Medicare, which represents a comprehensive benefit option and eliminates the need for beneficiaries to purchase a private drug plan and Medigap supplemental coverage, is reasonably economical and would not increase federal costs if supported by a budget-neutral beneficiary premium.[104] Yet, architects of the MMA, who created the extra payments and structural advantages that MA plans rely on, act as if the inadequate Medicare benefit package is immutable. This assumption underlies their arguments in favor of sustaining the un-level playing field. For example, Senator Charles Grassley, who was Chairman of the Senate Finance Committee when the MMA was enacted, recently argued why private plans should be favored. He stated,

> The original Medicare benefit is set up based on how medicine was practiced in 1964 . . . .
>
> . . . Traditional fee-for-service Medicare, the Medicare since 1964, by itself does not provide protection against the cost of catastrophic illness. Some beneficiaries then buy Medigap insurance for this catastrophic insurance. Medigap insurance can be expensive for those on fixed incomes. In contrast, . . . Medicare Advantage plans have catastrophic coverage for those seniors who want to choose it, and they do it for a much lower premium than the Medigap add-on to traditional fee-for-service Medicare.[105]

Noting that MA plans now serve rural areas and have helped rural beneficiaries, Senator Grassley commented that an important reason to favor private plans is to create "rural equity."[106] Yet, this entire argument assumes that traditional Medicare needs to remain in its original 1965 benefit structure. The obvious solution is not one that Republicans support, hence their self-fulfilling rationale for tilting the playing field.

V. ACTUARIAL EQUIVALENCE

As already discussed, MA plans are allowed to buy down beneficiary cost sharing with extra payments they receive above their bids. In addition, plan benefits do not have to strictly follow cost sharing amounts required in

104. *Id.* at W5-447 tbl.3. Although Part E could be constructed to not add incremental federal costs, more of the costs would be "on-budget," thereby contributing to political opposition to such an approach.

105. Senator Charles Grassley, Senate Floor Speech Following Passage of H.R. 976 Congressional Record article 21 of 83, at s10762-s10763 (Aug. 2, 2007), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?position=all&page=S10762&dbname=2007_record (last visited Jan. 19, 2008).

106. *Id.* at s10763.

the traditional program.[107] The benefit packages that plans offer must be "at least as good as Medicare's and cover everything Medicare covers, but they do not have to cover every benefit in the same way."[108] Rather, subject to CMS review, plans have some flexibility in making their benefits actuarially equivalent, but not identical, to traditional Medicare benefits so long as the cost sharing alterations do not result in discrimination on the basis of health status.[109] There have been a few notable instances of cost sharing that seemed designed to dissuade beneficiaries with particular costly health problems from enrolling in MA plans or to encourage enrollees to disenroll because of the substantial out-of-pocket liabilities associated with their health problems.[110] Less is known about whether plans use this flexibility to systematically determine actuarial equivalence in an attempt to attract and retain healthier beneficiaries.[111]

Out-of-pocket spending for plan enrollees with particular health problems seems to vary greatly from other enrollees' spending. A recent Commonwealth Study found that out-of-pocket costs for private plan members vary widely by health status and plan benefit package.[112] The report shows that in nineteen of eighty-eight MA plans reviewed, out-of-pocket costs for plan members in poor health would actually have been higher than in traditional Medicare.[113]

MedPAC's examination of the issue a few years earlier was inconclusive. On the one hand, MedPAC found that most of the time, the plans' ability to provide extra benefits resulted in reduced cost sharing compared with

107. MEDICARE RIGHTS CTR., TOO GOOD TO BE TRUE: THE FINE PRINT IN MEDICARE PRIVATE HEALTH PLAN BENEFITS 3 (2007), *available at* www.medicarerights.org/MA_care_problems.pdf (last visited Sept. 8, 2007).

108. *Id.*

109. MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT, *supra* note 9, at 4; *see* 42 U.S.C. § 1395w-22 (Supp. IV 2004).

110. *See, e.g.*, *Status of the Medicare+Choice Program: Hearing before the Subcomm. on Health of the H. Comm. on Ways and Means*, 107th Cong. 53 (2001) (Statement of Stephanie Sue Stein, Dir., Milwaukee County Dep't on Aging, Area Agency on Aging for Milwaukee County, Wis.) *available at* http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.181&filename=77455.pdf&directory=/diska/wais/data/107_house_hearings (discussing UnitedHealthcare's announcement that it would increase the inpatient hospital deductible from zero dollars to $350 per day for Milwaukee Medicare+Choice beneficiaries).

111. MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT, *supra* note 9, at 1 (noting that the MMA required MedPAC to conduct a study of the issue).

112. BRIAN BILES ET AL., THE COMMONWEALTH FUND, MEDICARE BENEFICIARY OUT-OF-POCKET COSTS: ARE MEDICARE ADVANTAGE PLANS A BETTER DEAL?, 2 (May 2006), *available at* www.commonwealthfund.org/usr_doc/927_Biles_MedicarebeneOOPcosts_MA_ib.pdf?section4039 (last visited Sept. 21, 2007).

113. *Id.* at 7.

traditional Medicare (e.g., for primary care visits).[114] However, MedPAC identified a pattern of plans charging higher cost sharing for self-labeled "non-discretionary" services associated with established serious conditions, such as chemotherapy,[115] or post-acute care services, such as home health and skilled nursing.[116] In one example, a colo-rectal cancer patient's charges for chemotherapy varied from $7,100 under one plan, to $1,990 under a second plan, and $6,500 under a third plan.[117] Furthermore, in a recent study, the American Medical Association found "[m]ore than half of the physicians report that their patients in a[n MA] HMO or PPO plan were denied coverage of services typically covered in the traditional Medicare plan."[118]

As one focus of its plan oversight activities, CMS reviews benefit packages with altered cost sharing. MedPAC recommended that CMS's review activities be increased and that CMS be given greater negotiation authority over the specific benefits provided in benefit packages and more resources to ensure that biased selection does not occur.[119] Nevertheless, beneficiary advocacy groups continue to argue that "[e]ven with enhanced payments, private health plans often fail to deliver coverage that a patient could obtain from Original Medicare."[120]

The issue of whether plans skimp on the care they provide because they are permitted to offer actuarially equivalent, but not identical, benefits is important primarily because of the need to protect beneficiaries from extraordinary costs during illnesses.[121] However, to the extent that plans are able to dissuade certain patients from enrolling in the first place or to encourage them to disenroll when they develop particularly expensive health problems, this flexibility in whom plans attract based on benefits they offer also tilts the playing field.[122] As noted, risk adjustment currently is an imperfect approach to addressing the problem.[123]

114. *See* MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT, *supra* note 9, at 24.

115. *See id.* at 12.

116. *See Medicare Advantage: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Congress 4 (2007) (statement of the Center for Medicare Advocacy, Inc.), *available at* www.medicareadvocacy.org/MA_03.26.07.TestimonyOnMAPlans.pdf (last visited Sept. 21, 2007).

117. MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT, *supra* note 9, at 12.

118. Press Release, Am. Med. Ass'n, AMA Calls for Financial Neutrality in Medicare Advantage (May 22, 2007), *at* www.ama-assn.org/ama/pub/category/print/17602.html (last visited Sept. 21, 2007).

119. *See* MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT, *supra* note 9, at 37.

120. MEDICARE RIGHTS CTR., *supra* note 107, at 9.

121. *See* MEDPAC, BENEFIT DESIGN AND COST SHARING REPORT, *supra* note 9, at 1.

122. *See id.* at 30 (noting that disenrollment rates typically have averaged between 10% and 13%; although, this data is from a period when beneficiaries could disenroll on a monthly basis). In 2002, the most common reason for disenrollment related to out-of-pocket costs for

VI. THE ABILITY TO MARKET THEIR PRODUCTS

The traditional Medicare program has an immeasurable and important advantage over private plans because it has been in operation since 1965, enjoys a good reputation with beneficiaries and the public, and is the "default" program that beneficiaries participate in if they do not enroll in MA. CMS provides a Handbook[124] to all beneficiaries, which includes the general choices between traditional Medicare and the variety of private plans and is supposed to provide a neutral presentation. Medicare's Web site contains detailed information that beneficiaries and their families can use as an aid in choosing between MA plans and traditional Medicare and among the various private plans that are available in specific geographic areas.[125]

Members of Congress have complained over the past few years that the materials provided by CMS are confusing and biased in favor of private plans.[126] For example, in 2005, several Congressmen expressed concern that the 2005 Handbook grouped PFFS plans and traditional Medicare in the same section and failed to accurately explain the differences between traditional Medicare and MA plans.[127] More recently, Senators complained of CMS bias in the 2007 Handbook, which states that traditional Medicare may be more expensive than MA plans but omits that MA plans may have

plan premiums, co-payments, and deductibles. (These data are from a period when plans were reducing benefits and do not reflect the recent increase in payments that permits more generous benefit packages.) *Id*.

123. *See* MEDPAC, ISSUES IN A MODERNIZED MEDICARE PROGRAM, *supra* note 78, at 53.

124. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., MEDICARE & YOU (2007), *available at* www.medicare.gov/Publications/Pubs/pdf/10050.pdf (last visited Sept. 21, 2007).

125. U.S. Dep't of Health & Human Servs., Medicare: Overview (Apr. 20, 2007), *at* www.medicare.gov/Choices/overview.asp (last visited Sept. 7, 2007).

126. Press Release, U.S. Cong., 'Medicare and You' Guide Skews Advice to Seniors (Oct. 25, 2006), *available at* www.senate.gov/~finance/press/Bpress/2005press/prb102506.pdf (last visited Sept. 21, 2007); Press Release, U.S. Senate, Comm. on Fin., Baucus Criticizes Agency Bias Toward Private Medicare Coverage (May 25, 2007), *available at* www.senate.gov/~finance/press/Bpress/2007press/prb052507.pdf (last visited Sept. 21, 2007) (noting that Senator Baucus recently reiterated these concerns).

127. Letter from Charles B. Rangel, Ranking Member, Comm. on Ways and Means, John Dingell, Ranking Member, Comm. on Energy and Commerce, Henry A. Waxman, Ranking Member, Comm. on Gov't Reform, Fortney Pete Stark, Ranking Member, Comm. on Ways and Means, Subcomm. on Health, & Sherrod Brown, Ranking Member, Comm. on Energy and Commerce, Subcomm. on Health to Mark B. McClellan, Adm'r, Ctrs. for Medicare & Medicaid Servs. (Apr. 26, 2005), *available at* www.house.gov/stark/news/109th/letters/2006%20Handbook%20Letter%20PDF.pdf (last visited Sept. 21, 2007).

higher cost sharing on a regular basis and significantly higher costs for critical services such as hospital care.[128]

Because of (1) the presumption of enrollment in traditional Medicare, (2) the supposed objectivity of the Handbook and other information provided by CMS to beneficiaries, and (3) the need for private plans to distinguish their own MA plans from those of competitors, it is understandable and reasonable that private plans actively market their plans and rely on media advertising and other outlets to inform beneficiaries of the potential advantages of plan enrollment. Yet, for a number of reasons, MA plans enjoy several advantages that go beyond the ability to encourage enrollment by informing beneficiaries about private plan options in general and the merits of their company's own plans.

As noted earlier, private plans offer two types of plans: stand-alone Part D prescription drug plans and Part C MA plans. Many insurers sponsor both[129] and, therefore, can gain special access to Medicare beneficiaries through their Part D offerings. Some companies specifically strategize to actively recruit beneficiaries for their prescription drug plans in the hope that they will later move to the company's more profitable MA plans.[130] The traditional program, on the other hand, remains a passive bystander because it is not permitted to offer a drug plan directly other than through private plans.[131]

The overpayments to MA plans create strong incentives for insurance companies to sell these plans instead of other Medicare products (including Part D plans). MA plans bring in more income than stand-alone drug plans[132] and have higher profit margins.[133] To encourage agents to sell MA plans, insurers pay commissions for MA plans that are five to eight times higher than what they pay for stand-alone drug plans.[134] The financial

128. *See* U.S. Cong., *supra* note 126; *see also* U.S. Senate, Comm. on Fin., *supra* note 126.

129. *See* GOLD, *supra* note 99, at 15.

130. Milt Freudenheim, *A Benefit for Insurers: Medicare Drug Plan Feeds More Profitable Managed Care*, N.Y. TIMES, Mar. 31, 2006, at C1 (noting Humana director's acknowledgement of his company's "springboard" policy, saying, "There's [sic] going to be a lot of people that are going to have Part D cards that are going to become interested in a Medicare Advantage plan.").

131. Lieberman, *supra* note 17, at 16.

132. *See id.* at 17 (noting that, on average, Humana's stand-alone drug plans cost beneficiaries about $100 a year, compared with about $800 for its MA plans).

133. Freudenheim, *supra* note 130 (noting that Humana estimated its profit margin for stand-alone drug plans was between 1% and 3%, while its profit margins for MA plans were between 3% and 5%).

134. DAVID LIPSCHUTZ ET AL., CAL. HEALTH ADVOCATES & MEDICARE RIGHTS CTR., AFTER THE GOLDRUSH: THE MARKETING OF MEDICARE ADVANTAGE AND PART D PLANS 5 (2007), *available at* www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-

incentive created by this commission structure, combined with lax government enforcement of regulations regarding the marketing and selling of these plans,[135] has created an environment conducive to deceptive practices bordering on fraud.

Shortly after marketing began in fall 2005 for MA plans that included the new prescription drug benefit, the government began to receive complaints about aggressive marketing.[136] A news article in January 2006, which described the financial incentives Humana gave its agents to sell MA plans instead of stand-alone drug plans, prompted Representative Pete Stark to ask CMS to enforce its own guidelines and prevent abusive marketing of the plans.[137] At that time, the guidelines prohibited the payment of a higher commission based on the value of the plan to the sponsor.[138] Now, however, the guidelines acknowledge that higher commissions are paid based on the volume or value of an agent's sales and require only that commissions be based on industry standards and related to the agent's time spent marketing the plan.[139] Nevertheless, the "rate of payment to a marketing representative should not vary based on the health status or risk-profile of a beneficiary."[140] These changed guidelines seem to imply that CMS no longer prohibits higher payments for plans that generate higher

01.pdf (last visited Sept. 21, 2007); Robert Pear, *Oklahoma Chides Insurer in Medicare Marketing Case*, N.Y. TIMES, May 15, 2007, at A14 (noting that Humana pays agents five times as much commission for selling an MA plan as for selling a prescription drug plan).

135. *See* LIPSCHUTZ ET AL., *supra* note 134, at 12.

136. Robert Pear, *Insurers' Tactics in Marketing Drug Plan Draw Complaints*, N.Y. TIMES, Nov. 27, 2005, at Section 1, 33.

137. Press Release, Pete Stark, U.S. Representative, U.S. House of Representatives, Stark Calls for Immediate Investigation of Humana and Other Medicare Drug Plans (Jan. 26, 2006), *at* www.house.gov/stark/news/109th/pressreleases/01-26Humana.htm (last visited Sept. 21, 2007).

138. Letter from Fortney Pete Stark, U.S. Representative, U.S. House of Representatives, to Mark McClellan, Adm'r, Ctrs. for Medicare & Medicaid Servs., and Daniel R. Levinson, Inspector General, U.S. Dep't of Health & Human Servs., (Jan. 26, 2005), *available at* www.house.gov/stark/news/109th/letters/20060126_McClellan_Levison_Humana.pdf (last visited Sept. 21, 2007) (according to Stark's January 26, 2005 letter to CMS Administrator Mark McClellan, the 2005 guidelines stated: "The commission rate (i.e., the percentage per enrollment) should not vary based on the value of the business generated for the Plan Sponsor paying the commission (e.g., profitability of the book of business)."); CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE MARKETING GUIDELINES FOR: MEDICARE ADVANTAGE PLANS (MAS), MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS (MA-PDS), PRESCRIPTION DRUG PLANS (PDPS), AND 1876 COST PLANS 129 (2006), *available at* www.cms.hhs.gov/PrescriptionDrug CovContra/Downloads/FinalMarketingGuidelines.pdf (last visited Sept. 21, 2007) [hereinafter CMS, MEDICARE MARKETING GUIDELINES].

139. CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138.

140. *Id.*

profits but does still forbid higher payments to agents based on the risk status of a beneficiary.

Recent congressional hearings included testimony from state officials who have received thousands of complaints concerning abusive marketing practices by insurers and their agents selling MA plans.[141] Beneficiaries have complained they were enrolled in MA plans without their knowledge or consent, threatened with loss of Medicare benefits unless they signed up for an MA plan, enrolled in an MA plan when they believed they had signed up for a stand-alone drug plan, or switched to an MA plan that was not appropriate for them, which sometimes led to higher premiums and cost sharing than under their previous coverage.[142] Insurance agents selling MA plans have used aggressive marketing tactics such as door-to-door visits and cold calling, misrepresenting themselves and their products, and selling to individuals with limited English proficiency or mental impairments despite not being able to adequately communicate with them. [143] In a recent

141. *See Predatory Sales Practices in Medicare Advantage: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 110th Cong. (2007), *available at* http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Medicare Advantage.shtml (last visited Sept. 21, 2007); *Medicare Advantage Marketing & Sales: Who Has the Advantage?, Hearing Before the Senate Special Comm. on Aging*, 110th Congress (2007), at http://aging.senate.gov/hearing_detail.cfm?id=274320& (last visited Sept. 21, 2007); *Medicare Advantage and the Federal Budget, Hearing Before the H. Budget Comm.*, 110th Congress (2007), *at* www.house.gov/budget_democrats/hearings.htm (last visited Sept. 21, 2007). For example, Lee Harrell, Deputy Commissioner of Insurance for the State of Mississippi, testified that his agency had "received over 1,000 complaints on Medicare Advantage alone . . . . These complaints represent at least twice as many complaints as we normally receive on all other topics combined." *Predatory Sales Practices in Medicare Advantage: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 110th Cong. 6 (2007), *available at* http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Harrell-Testimony.pdf (last visited Nov. 21, 2007) [hereinafter *Harrell, Predatory Sales Hearing*] (testimony of Lee Harrell, Deputy Commissioner of Insurance, State of Mississippi).

142. *Predatory Sales Practices in Medicare Advantage: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 110th Congress 6-7 (2007), *available at* http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Lipschutz-testimony.pdf (last visited Sept. 21, 2007) [hereinafter *Lipschutz, Predatory Sales Hearing*] (statement of David Lipschutz, California Health Advocates).

143. *See id.* at 5-9. CMS regulations prohibit door-to-door solicitation. 42 C.F.R. § 422.80(e)(1)(iii) (2007); 42 C.F.R. § 423.50(f)(1)(iii). Regulations also require that companies provide materials in a foreign language when there is a significant non-English speaking population in the community. 42 C.F.R. § 422.80(c)(5); 42 C.F.R. § 423.50(d)(5). There have been many complaints of agents going door-to-door, as well as soliciting on the street, at nursing homes and community centers, and asking Medicare beneficiaries whom they are visiting to introduce the sales agent to other beneficiaries. *See Medicare Advantage Marketing & Sales: Who Has the Advantage?, Hearing Before the Senate Special Comm. on Aging*, 110th Congress 4 (2007), *available at* http://aging.senate.gov/events/hr174sd.pdf (last

survey, thirty-nine states (out of forty-one respondents) said they had received reports of misrepresentation in the marketing of MA plans, and twenty-two states reported complaints of outright fraud, such as forged signatures on plan applications.[144]

PFFS plans, in particular, have been a magnet for fraud and abuse because they receive the highest overpayments (an average of 19% above traditional Medicare payments)[145] and because beneficiaries can enroll in PFFS plans without drug benefits any time of year.[146] The problems with PFFS plan marketing was so severe that seven sponsors signed an agreement with CMS in June 2007 to voluntarily suspend marketing those plans until corrective action was taken and fraud investigations were completed.[147] Despite evidence of widespread abuse in the marketing of non-PFFS plans, no immediate restrictions have been placed on the marketing of other types of MA plans.[148] CMS did propose new rules for voluntary reporting and enforcement of complaints,[149] but recently announced that the seven plan sponsors who had signed the voluntary suspension agreement in June have been approved to resume marketing.[150] According to CMS Acting Administrator Kerry Weems, the agency conducted a comprehensive review of the sponsors and found substantial improvements in both their internal controls and oversight processes that

visited Nov. 21, 2007) [hereinafter *Dilweg, Medicare Advantage Marketing Hearing*] (testimony of Sean Dilweg, Wisconsin Insurance Commissioner).

144. Pear, *supra* note 134.

145. MEDPAC, PROMOTING GREATER EFFICIENCY IN MEDICARE, *supra* note 13, at 64; *see also* MARISSA GORDON PICARD, CTR. FOR MEDICARE ADVOCACY, MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLANS: A PRIMER FOR ADVOCATES 25, *available at* www.medicareadvocacy.org/MA_PFFSPrimerForAdvocates.pdf (last visited Sept. 10, 2007); discussion of PFFS Plans *infra* Part VII.

146. JONATHAN BLUM ET AL., THE HENRY J. KAISER FAMILY FOUND., AN EXAMINATION OF MEDICARE PRIVATE FEE-FOR-SERVICE PLANS 2-3, www.kff.org/medicare/upload/7621.pdf (last visited Sept. 20, 2007).

147. Press Release, Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Plans Suspend PFFS Marketing: Plans Adopt Strict Guidelines in Response to Deceptive Marketing Practices (June 15, 2007), *available at* www.doi.ne.gov/notices/notc2007/nr0720.pdf (last visited Sept. 20, 2007).

148. Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Proposes Reforms of Compliance Requirements for Medicare Advantage Plans: Provisions Also Extend to Part D Prescription Drug Plans (May 21, 2007), *available at* www.cms.hhs.gov/apps/media/press_releases.asp (follow "May 21, 2007" hyperlink) (last visited Sept. 20, 2007).

149. *Id.*

150. Press Release, Ctrs. for Medicare & Medicaid Services, Seven Medicare PFFS Plans are Approved Following Rigorous Marketing Review (Sept. 24, 2007) *at* www.cms.hhs.gov/apps/media/press/release.asp?Counter=2474 (last visited Jan. 4, 2008).

were "consistent with regulations and guidance for Medicare private-fee-for-service plans."[151]

In addition, when marketing began for the 2008 benefit year on October 1, 2007, all PFFS plans became subject to the same standards, which include, inter alia, requirements that brokers and agents selling the product pass a written exam to demonstrate an understanding of Medicare PFFS policies and the products being marketed and that lists of planned marketing and sales events must be provided to CMS so that CMS can monitor these events.[152] The Agency has likewise promised more than a dozen new oversight activities of PFFS plans, including creation of a dedicated monitoring team and a comprehensive rapid-response plan, enrollment verifications by the Agency of new plan enrollees to ensure they were not subject to inappropriate marketing activities and understand the characteristics of a PFFS plan, and coordination with state insurance departments to share information about agent and broker complaints and license suspensions.[153] Yet, despite these ameliorative actions, complaints continue to arise regarding marketing of PFFS plans.[154]

CMS has issued regulations[155] and guidance[156] for marketing MA plans, and requires companies to submit marketing materials for approval before distributing them.[157] Insurers are also prohibited from discriminating, or "cherry-picking," among potential customers.[158] However, Medicare's structure gives them incentives to do exactly that, and the regulations and guidance allow practices that invite abuse and provide advantage. For example, companies that sell stand-alone drug plans are allowed to market MA plans and other products, including non-health products, to beneficiaries seeking stand-alone drug plans.[159] Therefore, when a beneficiary calls an agent or invites an agent into his or her home to discuss a prescription plan, the agent can take the opportunity to push an MA plan (which would result in a much higher commission for the agent) or any

151. *Id.*

152. *Id.*

153. *Id.*

154. *See* Robert Pear, *For Recipients of Medicare, the Hard Sell*, N.Y. TIMES, Dec. 17, 2007, at A1.

155. 42 C.F.R. § 422.80 (2007).

156. *See* CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138.

157. 42 C.F.R. § 422.80(a); 42 C.F.R. § 423.50(a).

158. 42 C.F.R. § 422.80(e)(1)(ii) (the regulations specifically ban discrimination); *see also* CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138 (discussing the fact that "[a]n individual performing marketing may be in a position to enroll healthier beneficiaries into specific health plans (or 'cherry-pick') . . . Therefore an individual performing marketing must not 'cherry pick'").

159. *See* CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138, at 112-113.

number of other products. Not only does this provide an opportunity for agents to use aggressive sales tactics,[160] but it could allow the agent to market selectively, both at the time of initial enrollment and during later open enrollment periods.

A potential advantage that plans have in offering both Part C and Part D products is the ability to "go to school" over the Part D data to better target Part C enrollment. The CMS marketing guidelines have an express anti-discrimination section that states that "[o]rganizations may not discriminate based on race, ethnicity, religion, gender, sexual orientation, health status, or geographic location within the service area."[161] However, there do not appear to be explicit prohibitions on plans taking advantage of prescription drug use patterns by beneficiaries to target enrollment. Plans, for example, could research whether potential Part C enrollees use particularly costly medications or whether they are compliant with their prescribed drug regimens in the Part D plans that the same organizations administer. Specifically, there are no "fire walls" between Part D and Part C staff to assure that Part C plans do not gain unfair advantages in targeting enrollment. Because CMS policing of this type of targeted marketing might be unrealistic in terms of the resources needed, a regulatory requirement that plans create such fire walls could be a workable solution to this particular problem.

As incentives for potential customers to seek information about their plans, insurance companies are allowed to offer gifts (of up to $15 in value) and conduct raffles or contests for larger prizes in locations such as Wal-Mart, as long as they are open to the general public.[162] The choice of prizes may even be tailored to appeal to a particular group of people that the company believes is less likely to use healthcare services.[163] Companies are also allowed to set up information booths at events such as health fairs,[164] and may choose which events to participate in based on the types of people likely to attend the event. Finally, companies may target a healthy population by including benefits that appeal to healthier seniors, such as discounts for health club memberships, or try to discourage sicker beneficiaries from enrolling by placing annual limits on coverage or

160. *See* LIPSCHUTZ ET AL., *supra* note 134, at 13 (noting that in-home sales visits have the highest closing rate for customer enrollments).

161. CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138, at 117.

162. *See* CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138, at 24, 124.

163. *See Lipschutz, Predatory Sales Hearing*, *supra* note 142, at 17.

164. CMS, MEDICARE MARKETING GUIDELINES, *supra* note 138, at 121-22.

imposing high cost sharing for expensive "nondiscretionary" services such as chemotherapy.[165]

CMS has been criticized for failing to curb MA marketing abuses until after Medicare advocacy groups and Congress brought the public's attention to the issue,[166] calling the Agency's enforcement capabilities as well as its neutrality into question. In recent months, however, CMS has taken action to address the aggressive and abusive marketing problems by entering into corrective action plans with some of the worst offenders and proposing new self-reporting requirements and plan-specific enforcement for companies who market MA plans.[167] Despite this promising action, the enforcement is uneven. For example, many reports of abuses by one insurer in Oklahoma did not result in corrective action by CMS.[168] State officials have found "chronic and blatant disregard for state regulation and for senior policyholders,"[169] but states' hands are tied by the federal preemption of all state regulatory authority over MA plans, except for licensing and solvency requirements.[170] As noted in recent congressional testimony, many of the misleading and fraudulent practices associated with the marketing of MA plans are tied to sales agents who are insufficiently trained and supervised[171] and have a significant financial incentive to sell MA plans instead of Part D drug and Medigap plans. Most recently, CMS revised the 2008 version of its Handbook in an effort to be less biased in favor of MA plans.[172] While the revisions do include information about cost sharing and

165. *See* MEDICARE RIGHTS CTR., *supra* note 107, at 3; *Medicare Advantage and the Federal Budget: Hearing Before the H. Comm. on the Budget*, 110th Congress (2007), *available at* www.house.gov/budget_democrats/hearings/2007/Hoven%20Testimony.pdf (statement of Ardis Hoven, Board of Trustees, American Medical Association) (last visited Sept. 22, 2007).

166. DAVID LIPSCHUTZ ET AL., CAL. HEALTH ADVOCATES & THE MEDICARE RIGHTS CTR, THE RELUCTANT REGULATOR: CENTERS FOR MEDICARE & MEDICAID SERVICES' RESPONSE TO MARKETING MISCONDUCT BY MEDICARE ADVANTAGE PLANS 1-3 (July 2007), *available at* www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Regulator-2007-07.pdf (last visited Sept. 28, 2007).

167. *Id.* at 2-3; *see also* Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 148.

168. LIPSCHUTZ ET AL., *supra* note 166, at 7.

169. *Predatory Sales Practices in Medicare Advantage: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 110th Cong. 4 (2007) (testimony of Kim Holland, Commissioner for the Oklahoma Insurance Department), *available at* http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Holland-Testimony.pdf (last visited Nov. 20, 2007) [hereinafter *Holland, Predatory Sales Hearing*].

170. 42 C.F.R. § 422.402 (2007).

171. *Harrell, Predatory Sales Hearing*, *supra* note 141, at 2.

172. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., MEDICARE & YOU (2008), *available at* www.medicare.gov/Publications/Pubs/pdf/10050.pdf (last visited Jan. 4, 2008).

the fact that MA plans may be more expensive, the Handbook might still be criticized as misleading because it presents traditional Medicare as a "plan" alongside MA plans and states that costs vary by plan without making clear that costs for certain services, such as hospital care, might be much higher under an MA plan than traditional Medicare.[173]

Medicare beneficiary advocacy groups have noted[174] that part of the solution to this problem is to restore state regulatory authority over the marketing of MA plans, as state insurance commissioners have requested.[175] As a result, on July 26, 2007, Senator Herb Kohl introduced legislation which would allow states to regulate the marketing and sales of MA plans and standardize marketing practices.[176] Another part of the solution could be to require training and supervision of sales agents, who are often short-term employees with little loyalty to the insurance company or to Medicare beneficiaries. As stated above, CMS took a step in this direction by requiring all PFFS-plan sales agents to pass a written exam to demonstrate their understanding of Medicare policies. Certainly, stronger enforcement of current regulations and guidelines would help, since prohibited sales practices continue to be reported.

Relying on CMS's regulatory and enforcement actions to stem the tide of MA marketing abuses would seem to be futile, despite the Agency's recent actions. As Representative Pete Stark, chair of the House Ways and Means Committee's Subcommittee on Health, has stated, the move by insurance companies to voluntarily suspend marketing PFFS plans "will do virtually nothing to protect Medicare beneficiaries and is a pathetic attempt to pre-empt Congressional *action*."[177] Indeed, some have criticized the agency for acting more as a cheerleader for MA plans than as a neutral regulatory agency overseeing them.[178] However, the structural factors of overpayments and insurers' ability to market MA plans form both the incentive for and the

173. *See* Jeffrey Young, *Medicare Pamphlet Now Includes Caveats on Private Plan Benefits*, THE HILL, Nov. 17, 2007, http://thehill.com/index2.php?option=com_content&do_pdf=1&id=69861 (last visited Jan. 4, 2008).

174. LIPSCHUTZ ET AL., *supra* note 166, at 9.

175. *See, e.g.*, *Holland, Predatory Sales Hearing*, *supra* note 169; *Predatory Sales Practices in Medicare Advantage: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 110th Cong. 8 (2007), *available at* http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Poolman-Testimony.pdf (last visited Oct. 20, 2007) (testimony of Jim Poolman, North Dakota Insurance Commissioner); *Dilweg, Medicare Advantage Marketing Hearing*, *supra* note 143 (recommending adopting the Medigap regulatory structure for MA plans).

176. Accountability and Transparency in Medicare Marketing Act of 2007, S. 1883, 110th Cong. (2007).

177. Lieberman, *supra* note 17, at 20 (emphasis added).

178. LIPSCHUTZ ET AL., *supra* note 166, at 2.

base of the abuse, indicating that congressional action may be the only true means of rectifying the problem.

VII. THE SPECIAL CASE OF PRIVATE FEE-FOR-SERVICE PLANS

In order to promote a variety of plan options, the MMA created a number of preferences for new forms of managed care other than the local HMO, which had been the staple of private plan contracting in Medicare for more than twenty years.[179] Initial attention was placed on the incentives for what the MMA called regional preferred provider organizations (R-PPOs).[180] To encourage R-PPOs, the "MMA allow[ed] Medicare to share financial risk with sponsors in 2006 and 2007, provides selected provisions to make it easier to establish networks in rural areas, and establishes a regional stabilization fund starting in 2007 to encourage entry of new plans and retention of existing ones."[181] Also, the MMA sets forth a somewhat different approach to establishing the benchmarks that plans bid against by basing the calculations partly on the actual bids submitted by the R-PPOs.[182] Despite these provisions, R-PPOs have attracted a relatively small share of MA enrollment.[183]

On the other hand, PFFS plans represent the greatest growth in the MA program despite receiving virtually no attention at the time the MMA was passed.[184] Although PFFS plans were first authorized by the BBA in 1997,[185] insurers had little interest in offering them, and beneficiaries had little interest in enrolling in them. Before the MMA was passed in 2003, PFFS plan enrollment hovered around 25,000.[186] Enrollment has since exploded,

179. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 created the initial risk-based program of contracting with private plans. 42 U.S.C. § 1395mm (2000).

180. The CBO and the CMS Office of the Chief Actuary's (OACT) 2003 disagreement over the predicted MA enrollment centered on the likely impact of R-PPOs on beneficiary choice. OACT believed that there would be substantial R-PPO enrollment, while CBO thought new R-PPO enrollment would be negligible. *See* GRONNIGER & SUNSHINE, *supra* note 21.

181. GOLD, *supra* note 99, at 3. R-PPOs must "serve large areas in the 26 defined regions comprising one or more states . . . [and] offer the same plan (with the same benefits and premiums) across the entire region." Furthermore, they must structure benefits to integrate cost sharing for Parts A and B and to include an annual out-of-pocket limit on cost sharing for these benefits. R-PPOs are to be distinguished from local PPOs that are coordinated care plans able to serve individual counties, not large geographic areas. *Id.*

182. MEDPAC, MEDICARE ADVANTAGE BENCHMARKS, *supra* note 86, at 1.

183. In July 2007, there were approximately 167,000 R-PPO enrollees. Although the number had doubled from a year earlier, R-PPO enrollment represented only 2% of MA enrollment. Peterson & Gold, *supra* note 16.

184. *Id.*

185. 42 U.S.C. §1395w-22 (2000).

186. *Medicare Advantage Private Fee-for-Service Plans: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. (2007), *at* http://waysand

increasing from about 42,000 in September 2004, to 120,000 in July 2005, to 764,000 in July 2006, to 1,661,000 in July 2007.[187] Current PFFS enrollment represents 19% of total MA enrollment and nearly 4% of the Medicare beneficiary population.[188] The CBO estimates that by 2017, enrollment in PFFS plans will reach 5 million and account for one-third of total MA enrollment.[189]

A PFFS plan is an MA plan that

> (i) Pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; (ii) Does not vary the rates for a provider based on the utilization of that provider's services; and (iii) Does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment.[190]

The advantages enjoyed by PFFS plans greatly exceed the advantages described in this article for MA plans in general. The same estimates that found 12% overpayment for MA plans in aggregate find that PFFS plans receive 19% more than the cost for covering the same beneficiaries under the traditional Medicare program, even though PFFS was designed to be a privately administered version of the traditional Medicare program.[191] From

means.house.gov/hearings.asp?formmode=view&id=5965 (last visited Oct. 20, 2007) [hereinafter *Neuman, Medicare Advantage Hearing*] (statement of Patricia Neuman, Vice-President, Henry J. Kaiser Family Foundation, Director, Medicare Policy Project). The first PFFS contract was approved by CMS in 2000 for Sterling Life Insurance, followed by PacifiCare in 2001 and Humana in 2003. Thirty-seven plan sponsors had entered the PFFS market by 2007. As of 2007, there were "482 unique plan designs and premium combinations in operation" and all beneficiaries now have access to at least one PFFS plan. BLUM ET AL., *supra* note 146, at 7-8.

187. Lindsay Harris, Lori Achman, & Marsha Gold, *Medicare Advantage and Medicare Beneficiaries: Monthly Tracking Report for September 2004*, THE HENRY J. KAISER FAMILY FOUND., Oct. 8, 2004, at 1, *available at* www.kff.org/medicare/upload/Medicare-Advantage-Monthly-Tracking-Report-September-2004.pdf (last visited Nov. 29, 2007); Marsha Gold & Lindsay Harris, *Tracking Medicare Health and Prescription Drug Plans: Monthly Report for July 2005*, THE HENRY J. KAISER FAMILY FOUND., Jul. 20, 2005, at 1, *available at* www.kff.org/medicare/upload/TrackingMedicareHealthandPrescriptionDrugPlans-July202005-2.pdf (last visited Nov. 29, 2007); Peterson & Gold, *supra* note 16.

188. *See* Peterson & Gold, *supra* note 16.

189. GRONNIGER & SUNSHINE, *supra* note 21.

190. 42 C.F.R §422.4(a)(3) (2007); *see also* PICARD, *supra* note 145, at 3.

191. BLUM ET AL., *supra* note 146, at 13. The benchmark rate for plan bidding is greater than the traditional Medicare rate and is derived from a formula set by the BBA and subsequent legislation that was meant to raise payment levels for private plans operating in rural areas and small urban markets. Consequently, for many counties, often referred to as floor counties, the benchmark payment rate is significantly higher than traditional Medicare county-level spending. Many PFFS sponsors have targeted their offerings toward these floor

an insurer's perspective, PFFS has a number of advantages compared with other MA plans. Unlike R-PPOs that are restricted to operating at the regional level, PFFS plans are permitted to operate at the county level and, therefore, can target high payment areas.[192] Because they are not required to have a provider network, PFFS plans enjoy much easier market entry and relatively low administrative costs.[193]

Additionally, "firms that currently offer Medigap policies may see [PFFS] plans as an attractive alternative for their Medigap policyholders, because they can now offer a government-subsidized source of supplemental coverage" to reduce monthly premiums.[194] Indeed, the PFFS option might become very popular with employers, both public and private, who offer health benefits to Medicare-eligible retirees because the plans without provider networks offer potential for better access for retirees who have relocated throughout the country.[195]

Whereas the MMA requires other MA plans to offer Part D prescription drug benefits, the legislation explicitly exempts PFFS plans from this requirement.[196] Furthermore, the MMA specifically exempts PFFS plans from provisions that permit CMS to negotiate with MA plans over whether their bid submissions "'reasonably and equitably' reflect the costs of health care services and supplies provided."[197] This exemption allows PFFS plans to retain more of their overpayments for administration and profit, rather than having to pass most of the overpayments on to beneficiaries in the form of lower cost sharing or extra benefits. Recent evidence finds that PFFS plans retain about half of the 19% overpayments, even though PFFS incurs much lower administration costs than a typical MA coordinated-care plan.[198]

The Tax Relief and Health Care Act of 2006[199] made an additional modification to the MA program for 2007 and 2008 to promote enrollment

counties, and most PFFS plan enrollees reside in these areas. *Id.* at 12-13; *see also* MEDPAC, PROMOTING GREATER EFFICIENCY IN MEDICARE, *supra* note 13, at 64.

192. *Neuman, Medicare Advantage Hearing*, *supra* note 186, at 2; *see also* BLUM ET AL., *supra* note 146, at 13 (stating that PFFS sponsors have targeted their products toward the higher paying floor counties and finding that 90% of PFFS plan enrollees reside in these areas).

193. *Neuman, Medicare Advantage Hearing*, *supra* note 186, at 2.

194. *Id*.

195. *Id*. However, as discussed *infra* at notes 216–18 and accompanying text, there are increasing reports of providers who are refusing to see PFFS patients, thereby undermining the intent of relying on PFFS plans to offer access equivalent to what traditional Medicare offers.

196. BLUM ET AL., *supra* note 146, at 2.

197. *Id*. at 13.

198. MEDPAC, PROMOTING GREATER EFFICIENCY IN MEDICARE, *supra* note 13, at 63 tbl.3-1, 64.

199. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, 120 Stat. 2922 (codified at 26 U.S.C. §§ 404(a), 405(a)).

in certain PFFS plans.[200] The new legislation allows "Medicare beneficiaries enrolled in traditional fee-for-service (Original) Medicare a one-time opportunity to enroll in an MA plan that does not offer the drug benefit at any time during the year rather than only during the open and annual enrollment periods from November 15 to March 31."[201]

PFFS plans are also exempt from statutory and regulatory patient-protection standards that apply to other MA plans. By virtue of the "deeming" provision discussed below, PFFS plans may be exempted from an assessment of whether they have an adequate number of providers in an area to ensure beneficiary access to care.[202] PFFS plans do not have to establish a program to improve the quality of care provided to enrollees, but, if they offer Part D, they must establish a drug utilization management program or medication therapy management program to reduce the risk of adverse events.[203]

The most fundamental advantage PFFS plans have over other MA plans, and the one that demonstrates congressional intent to effectively privatize Medicare,[204] is the "deeming" provision. Because providers in rural and small urban areas tend to have negotiating leverage over health plans,[205] the deeming provision apparently was created to give the plans a non-market advantage by effectively giving them regulatory authority over providers to set payment rates. By statute, a provider is deemed a contracting provider if, before furnishing services, the provider has been informed of the patient's enrollment in the plan and "[h]as either been informed of the terms and conditions of payment for the services under the plan, or [i]s given reasonable opportunity to obtain that information."[206] PFFS plans have the option of creating provider networks and may set payment at any level they agree on with providers participating in such a network.[207] Absent a network, a plan must pay at least the same payment

200. BLUM ET AL., *supra* note 146, at 2.

201. This provision specifically helps PFFS plans because they do not have to offer Part D benefits. *Id* at 2-3.

202. PICARD, *supra* note 145, at 15.

203. *Id.*; *see also,* BLUM ET AL., *supra* note 146 (providing comprehensive reviews of how the requirements for PFFS plans differ from other MA plans).

204. Berenson, *supra* note 18, at 14.

205. CONG. BUDGET OFFICE, CBO'S ANALYSIS OF REGIONAL PREFERRED PROVIDER ORGANIZATIONS UNDER THE MEDICARE MODERNIZATION ACT 3 (Oct. 2004), *available at* www.cbo.gov/ftpdocs/59xx/doc5997/10-27-PPOUnderMedicare.pdf (last visited Sept. 22, 2007).

206. PICARD, *supra* note 145, at 9-10 (noting that "[b]ecause the 'reasonable opportunity' bar is set very low, in practice, providers are generally considered 'deemed' if they have been informed of the patient's enrollment under the plan before providing treatment").

207. *Id*.

rate as under traditional Medicare, using the same payment methods.[208] Most PFFS plans have chosen to deem providers, rather than set up a network.[209]

The deeming provision represents an extraordinary opportunity for one set of private parties, namely health plans, to impose payment rates on other private parties, namely providers, outside of usual marketplace negotiations.[210] The deeming provision and the 19% overpayment combine to provide PFFS plans a unique arbitrage opportunity. That is, PFFS plans receive 19% more than Medicare would pay but are legislatively empowered to turn around and pay providers at Medicare rates.[211] They do not bear the same costs administering the program as coordinated care MA plans do because of all the special provisions enacted on their behalf. Therefore, PFFS plans can either apply most of the excess payments to offer extra benefits that entice beneficiaries to enroll or keep the extra payments as profit.[212]

At first blush from a beneficiary's point of view, the PFFS option seems very desirable because a beneficiary does not have to join a plan with a restricted provider network or one that performs utilization management to limit services, yet she receives extra benefits. It appears to be a no-lose opportunity for beneficiaries, and, indeed, insurers have marketed the PFFS option as a plan that is equivalent to the traditional Medicare program but with more benefits.[213] Thus, it is not surprising that enrollment skyrocketed once the MMA significantly increased the payments to PFFS plans.

208. *Id*. at 11-13.

209. MEDPAC, PROMOTING GREATER EFFICIENCY IN MEDICARE, *supra* note 13, at 65.

210. *See infra* notes 214–15 and accompanying text for limitations on the deeming authority.

211. Although PFFS plans are required to pay at least Medicare rates, some physician organizations allege that they actually pay less than Medicare would pay and may impose administrative compliance requirements that are more onerous than Medicare's, leading to additional practice costs on deemed physicians. *See* Sue U. Malone, *Executive Report: Physicians Be Aware: Educate Yourselves Regarding Medicare Advantage and Part D Plans*, ONLINE SAN MATEO COUNTY MEDICAL ASSOCIATION BULLETIN, Feb. 2007, www.smcma.org/Bulletin/BulletinIssues/Feb07issue/ExecutiveReport.html (last visited Dec. 28, 2007); AM. MED. ASS'N HOUSE OF DELEGATES, RESOLUTION 1001: DEEMED PARTICIPATION AND MISLEADING MARKETING BY MEDICARE ADVANTAGE PRIVATE FEE FOR SERVICE PLANS, *available at* www.ama-assn.org/ama1/pub/upload/mm/475/1001.doc (last visited Jan. 8, 2008).

212. *See supra* text accompanying notes 197–98 (explaining that because PFFS bids are not subject to CMS bid negotiation, PFFS plans can garner increased profits).

213. *See* PICARD, *supra* note 145, at 11-13. Furthermore, there is evidence that many PFFS-plan benefit structures impose greater out-of-pocket spending on sicker beneficiaries compared with other forms of MA plans and Medigap plans. Marsha Gold, *Medicare Advantage in 2006-2007: What Congress Intended?*, 2007 HEALTH AFF. (WEB EXCL.) W445, W453.

However, there is one limitation on the deeming provision that may put some breaks on the rapid migration of beneficiaries to PFFS plans. Although deemed providers do not get to negotiate the terms and conditions that plans impose on them, they do have the option of not providing services to a PFFS-enrolled patient seeking care.[214] Further, a provider that is deemed a contracting provider for an enrollee for one visit does not have to provide services to that enrollee during subsequent visits. Nor does the provider have to provide services to other enrollees in the same plan. In other words, a provider may accept the terms of the PFFS plan on an enrollee-by-enrollee and service-by-service basis.[215]

Recent reports from Medicare beneficiary advocacy groups[216] and anecdotal newspaper articles[217] suggest that providers are refusing to see PFFS enrollees, as is permitted under the deeming provision. For providers, the choice is a difficult one of feeling "forced into an unacceptable choice of either abandoning established patients who sign up for PFFS plans or having to accept the terms of participation."[218] In short, the deeming provision at the core of the PFFS model significantly advantages PFFS plans over other plans and, along with substantial overpayments, the traditional Medicare program. Yet, because PFFS plans cannot actually ensure beneficiaries access to deemed providers, it is still unstable in terms of access to care.

VIII. CONCLUSION

In 2007, the Medicare Advantage program is providing an affordable, high value choice for all Medicare beneficiaries. Enrollment is at an all-time

214. Gold, *supra* note 213, at W451.

215. PICARD, *supra* note 145, at 10.

216. *See, e.g.*, LIPSCHUTZ ET AL., *supra* note 166.

217. *See, e.g.*, Robert Pear, *Hard Sell Cited as Insurers Push Plans to Elderly*, N.Y. Times, May 7, 2007, at A1.

218. *Medicare Advantage Private Fee-for-Service Plans: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. (2007) (statement of David Lipschutz, California Health Advocates, Los Angeles, California), *available at* http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=5966 (last visited Sept. 29, 2007) (quoting American Medical Association House of Delegates, New Mexico Delegation, "Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans" Late Resolution: 1001 (I-06), received October 25, 2006); *see also* LIPSCHUTZ ET AL., *supra* note 134, at 7 (California Health Advocates, Medicare Rights Center) (Jan. 2007) ("Early experience with PFFS plans available in 2006, though, shows that enrollees have had difficulty finding doctors who will agree to treat them while in other cases providers have discovered retroactively that they are 'deemed' to be under contract to the plan and must accept the terms and payment of the plan. Similarly, many doctors are expressing frustration with these plans, including the fact that in some instances the plans can reimburse doctors at rates less than standard Medicare reimbursement rates.").

> high and plans are available in every region of the country, including rural areas. Medicare Advantage (MA) plans are a particularly important option for lower-income and minority beneficiaries.
>
> The value and availability of plans is a direct result of Congressional policies establishing minimum rates for MA plans in some regions where the MA option was not yet available. These policies were established to ensure wide availability of MA plans and to do so, in part, by providing extra benefits to enrollees.
>
> Beneficiaries should be able to have a choice of alternative delivery systems and MA plans have the flexibility to deliver innovative care management that is not encouraged in the FFS system. Eliminating the policies that have led to the wide-spread availability of MA plans could limit beneficiary access to these alternative delivery systems, and the care management services they can provide. While it is unclear how plans or beneficiaries would react, we know that before these policies were enacted, particularly those in the Medicare Modernization Act (MMA), far fewer beneficiaries had a choice of a private plan.[219]

It is not unusual for political leadership, including senior officials at an agency like CMS, to advocate in relation to the programs they have responsibility for administering. However, the quote cited here is from the introduction to an unsigned report on the state of Medicare Advantage in 2007, which, at the time of this writing, was featured on the home page of the CMS Web site. It is presented not as a viewpoint of political leadership but, rather, as an objective review of the state of the MA program as Congress considers partly leveling the playing field on which MA plans are thriving. The document continues at some length to present one-sided, misleading, or distorted information and some propaganda to support the policy status quo.[220]

The CMS Web site[221] is not directed specifically toward beneficiaries facing the choice of either staying in traditional Medicare or joining a private plan alternative. However, this fairly obvious attempt to influence congressional consideration of MA payment reductions suggests an unusual agency *boosterism* for private plans that contributes to an un-level playing field for competition between private plans and traditional Medicare. This article reviewed other less than even-handed implementation of what Congress authorized, including *spin* in Handbooks sent to all beneficiaries, lax oversight of marketing abuses, and decisions to use the risk adjustment system for modifying plan payments to send extra money to plans even after

219. CMS, MEDICARE ADVANTAGE IN 2007, *supra* note 8, at 3.

220. *Id.*

221. Medicare: The Official U.S. Government Site for People with Medicare, www.Medicare.gov (last visited Nov. 25, 2007).

Congress provided large increases to plans in their base payment rates under the MMA.

In the late 1990s, conservative advocates of market-based Medicare restructuring asserted that CMS could not evenhandedly administer the Medicare+Choice program because it had a basic conflict between operating the traditional program and "establishing and managing the market for the increasing range of plans that are offered to seniors at a monthly premium."[222] No organizational changes occurred at that time despite these concerns about CMS's will and ability to administer evenhandedly. Now, CMS boosterism threatens to undermine the traditional Medicare program by making operational policy that favor private plans.

Clearly, any attempt to formally define the element of level-playing-field competition among private plans and between private plans and traditional Medicare needs to again address the issue of where administrative responsibility should be lodged and what governance protections are needed to ensure that Congress's intent is being even handedly implemented.

This article has attempted to identify the major reasons why the playing field between private health plans and traditional Medicare is tilted and offer suggestions for correction. However, more fundamentally, there needs to be an immediate debate about whether there should even be a level playing field and, if so, how to achieve and maintain it. This debate would include issues that go beyond the scope of this article, such as the extent to which the traditional program should be permitted to manage care and costs as a competing plan, albeit with some restraints that might not apply to private plans. Additionally, this discussion needs to consider whether an array of private plan types should be promoted regardless of whether they offer important alternative choices to the traditional program or whether, as is the case for R-PPOs and the PFFS plans, private plans that are essentially traditional Medicare look-alikes are being advantaged primarily to undermine the government-administered traditional Medicare program. In the meantime, the quickest and most effective action Congress can take would be to reduce or eliminate the current overpayments that MA plans enjoy.

222. *Restructuring Medicare for the Next Century: Hearing Before the S. Comm. on Fin.*, 106th Cong. (1999) (statement of Stuart M. Butler, Vice President for Domestic and Policy Studies, The Heritage Foundation), *available at* www.heritage.org/Research/HealthCare/Test052799.cfm ("It is a very basic principle of economic organization in a market that those responsible for setting the rules of competition, and providing consumers with information on rival products, should have neither an interest in promoting any particular product nor even a close relationship with one of the competitors.").