

MEDICARE ADVANTAGE: WHAT ARE WE TRYING TO ACHIEVE ANYWAY?*

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By one summary measure, the Medicare Advantage (MA) plans created by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003¹ are a big success. Almost one in five Medicare beneficiaries elected to enroll in private MA plans in 2007.² Enrollment grew almost 40% in just two years, from 4.9 million persons in 2005 to 8.1 million in 2007.³ The MA Program, under Part C of the Medicare Program, is the latest reinvention of the original Medicare risk contract program, which was established initially in the 1970s and altered in 1997 by the legislation that created the Medicare+Choice (M+C) Program.⁴ The MA Program provides an alternative for Medicare recipients, who can choose between the traditional Medicare fee-for-service (FFS) program and an MA plan.⁵

* Editor's Note: Dr. McBride spoke on this topic at the 2007 Saint Louis University Health Law Symposium on Medicare After the Medicare Modernization Act. Other articles based on this symposium were published in the inaugural issue of the *Saint Louis University Journal of Health Law & Policy*.

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1. 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. & 26 U.S.C.).

2. CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICARE ADVANTAGE IN 2007*, at 8 (2007), at www.cms.hhs.gov/MCRAAdvPartDEnrolData/ (download Medicare Advantage 2007 Overview; then follow Medicare Advantage in 2007 icon) (last visited June 24, 2008) [hereinafter CMS 2007]; see also THE HENRY J. KAISER FAMILY FOUND., *MEDICARE ADVANTAGE (MA) PLAN PENETRATION 2007*, at www.statehealthfacts.org/comparetable.jsp?ind=329&cat=6 (last visited June 24, 2008) (listing percent enrollment in Medicare Advantage plans in each state as well as the national percent of Medicare Advantage enrollments).

3. MEDICARE PAYMENT ADVISORY COMM'N, *A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM 153* (2007), available at www.medpac.gov/documents/Jun07DataBook_Entire_report.pdf (last visited June 23, 2008) [hereinafter MEDPAC, A DATA BOOK].

4. STAFF OF THE COMM. ON WAYS & MEANS, U.S. HOUSE OF REPRESENTATIVES, *BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE HOUSE COMMITTEE ON WAYS AND MEANS*, app. E, at E-2 (2004), available at <http://waysandmeans.house.gov/media/pdf/greenbook2003/AppendixE.pdf> (last visited June 24, 2008) [hereinafter GREEN BOOK].

5. *Id.*

Congress explicitly established the goals of the M+C Program when it enacted the 1997 Balanced Budget Act (BBA), which replaced the Medicare risk contract program with the M+C Program.⁶ The two primary goals Congress identified for the M+C Program were to (1) “allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare” and (2) “enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.”⁷ In other words, the goals of the M+C Program, according to the legislators who created it, were to *expand choices and contain costs*.

This Article confronts the following question: What are we really trying to achieve with Medicare Advantage? Are we trying to achieve the expanded choice and cost containment goals, and, if so, how well does the current MA Program achieve these goals? Are there other goals implicit in the adoption of the MA legislation that Congress is trying to achieve? In particular, this Article asserts that an additional primary goal of the 1997 legislation was to increase *equity* among beneficiaries. Using legislative history and recent empirical evidence, this Article explores the extent to which the legislative and other goals for the MA Program have been achieved.

I. MEDICARE ADVANTAGE: HISTORY AND PROGRESS ON GOALS

The MA Program was created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)⁸ to replace the M+C Program, which was part of the Balanced Budget Act of 1997 (BBA) signed by President Clinton.⁹ The M+C Program’s creators designed M+C to manage the perceived problems of the Medicare risk contract program, which began in 1982 and primarily focused on Medicare health maintenance organizations (HMOs).¹⁰

At-risk and cost-based HMOs entered the Medicare program in the 1970s with payment rates set at 95% of adjusted average per capita cost (AAPCC), i.e., 95% of the total Medicare FFS expenses per person living in a given county.¹¹ By 1995, the HMO plans active in Medicare were

6. *Id.*

7. H.R. REP. NO. 105-149, at 1251 (1997), as reprinted in 1997 U.S.C.C.A.N. 176, 205-06).

8. See 42 U.S.C. §§ 1396w-21 to 1395w-29 (2000 & Supp. IV 2004).

9. CMS 2007, *supra* note 2, at 8.

10. *Id.*; GREEN BOOK, *supra* note 4, at E-2.

11. GREEN BOOK, *supra* note 4, at E-18 n.7; THE HENRY J. KAISER FAMILY FOUND., MEDICARE FACT SHEET: MEDICARE ADVANTAGE (2007), available at www.kff.org/medicare/upload/2052-10.pdf (last visited June 24, 2008) [hereinafter MEDICARE ADVANTAGE FACT SHEET].

concentrated in high AAPCC counties that had strong regional and urban bias.¹² Beneficiaries in those counties were able to purchase plans that provided extra benefits at little or no cost.¹³ This situation raised equity concerns across regions and between urban and rural areas.

The M+C Program established new forms of Medicare managed care plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), medical savings accounts (MSAs), and private fee-for-service plans (PFFS).¹⁴ In addition, the 1997 BBA set the rural floor payment at \$415 per member per month (pmpm), raising payments in some counties by more than \$100 pmpm.¹⁵ The Benefits Improvement and Protection Act of 2000 (BIPA)¹⁶ increased floor payments again from \$415 to \$475.¹⁷ The BIPA also created an urban floor payment of \$525.¹⁸

An important fact to recall is that creating the M+C Program was part of a larger debate in 1997 to balance the budget, which led to the BBA's passage.¹⁹ Thus, the larger goal of the BBA was to reduce the budget

12. See Timothy D. McBride, *Disparities in Access to Medicare Managed Care Plans and Their Benefits*, 17 HEALTH AFF. 170, 174 (1998); see also Carl Serrato et al., *Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?*, 17 HEALTH CARE FIN. REV. 85, 85-87 (1995) (discussing uneven distribution of HMOs between rural and urban areas).

13. See McBride, *supra* note 12, at 175 (explaining that "plans in areas with low AAPCC rates offer[ed] lower-cost preventive care benefits, while plans in counties with high AAPCC rates offer[ed] a much wider array of benefits"); see also MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 112 (2001), available at www.medpac.gov/documents/Mar01%20Entire%20report.pdf (last visited June 23, 2008) [hereinafter MEDPAC 2001]; see also Bryan Dowd & Roger Feldman, *Having It All: National Benefit Equity and Local Payment Parity in Medicare*, 21 HEALTH AFF. 208, 208 (2002) (stating that the "wide variation in HMO payments . . . resulted in wide variation in the availability of HMO plans and the benefits they offered"); Joan D. Penrod et al., *Geographic Variation in Determinants of Medicare Managed Care Enrollment*, 36 HEALTH SERVICES RES. 733, 748 (2001) (noting the 1999 amendments to the BBA that allowed "plans to vary the benefits and premiums within their service area to reflect variation in costs and Medicare payment").

14. GREEN BOOK, *supra* note 4, at E-3; MEDICARE ADVANTAGE FACT SHEET, *supra* note 11.

15. ANDREW F. COBURN ET AL., RURAL POLICY RES. INST., MEDICARE ADVANTAGE PLANS IN RURAL AMERICA 1 (2007), available at www.rupri.org/Forms/HealthPanelBrief3.pdf (last visited June 24, 2008).

16. Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763A-554 (codified as amended in scattered sections of 42 U.S.C.).

17. 42 U.S.C. 1396w-23(c) (2000); CMS 2007, *supra* note 2, at 6; COBURN ET AL., *supra* note 15.

18. 42 U.S.C. 1396w-32(c); CMS 2007, *supra* note 2, at 6; COBURN ET AL., *supra* note 15.

19. See H.R. REP. NO. 105-217, at 1, 21, 582-95 (1997), as reprinted in 1997 U.S.C.C.A.N. 176, 203-16 (Establishment of MedicarePlus/Medicare Choice Program, Conference Agreement); see also Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified in scattered sections of 26 U.S.C. & 42 U.S.C. (2000)).

deficit and growth in federal spending.²⁰ Medicare risk plans became a target for budget reduction, in part, because of studies showing that Medicare “overpaid” some HMOs.²¹

Why were Medicare risk plans perceived to be “overpaid”? First, because of “self-selection” into Medicare HMOs by younger, healthier Medicare recipients, the costs of the Medicare risk plan enrollees were lower than the costs of traditional Medicare FFS program enrollees.²² Second, payment to Medicare risk plans was based on an arcane reliance on prior Medicare FFS payments that perpetuated historical payment patterns based on prior utilization of Medicare benefits.²³ The prior utilization patterns were well known to be based on geographic and regional differences, and these differences in payment perpetuated.²⁴ As a result of these two factors, researchers estimated that, by 1996, Medicare was paying perhaps 7% more than cost to HMOs.²⁵

20. See MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 117 (2000), available at www.medpac.gov/documents/Mar00%20Entire%20report%20.pdf (last visited June 24, 2008) (stating that one of Congress’ explicit goals when it created M+C as part of the BBA was “to help control the growth in Medicare spending”).

21. Gerald Riley et al., *Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994*, 17 HEALTH CARE FIN. REV. 65, 73 (1996); see also Randall S. Brown et al., *Do Health Maintenance Organizations Work for Medicare?*, 15 HEALTH CARE FIN. REV. 7, 18 (1993) (“[T]he primary goal of the risk program—to reduce costs to HCFA [Health Care Financing Administration]—ha[d] not been realized . . . [because] capitation payments [to HMOs] for the month of June 1992 [were] about \$31 million more than HCFA would have spent in FFS reimbursements for the 1.4 million enrollees.”); Jonathan Gardner, *Study: Medicare Risk HMOs Overpaid*, 26 MOD. HEALTHCARE 8, 8 (Aug. 19, 1996) (discussing overpayments to HMOs discovered by the HCFA study and an evaluation by Mathematica Policy Research); Press Release, Health Care Fin. Admin., Medicare Risk HMOs Experiencing Favorable Selection (Aug. 13, 1996), at www.hhs.gov/news/press/1996pres/960813.html (last visited June 24, 2008) (stating that a study by HCFA found that “Medicare may be overpaying some health maintenance organizations because the current payment formula does not take into account enrollees’ better-than-average health status”).

22. Brown et al., *supra* note 21, at 8, 10; Riley et al., *supra* note 21, at 65-66, 73.

23. See Riley et al., *supra* note 21, at 73-74 (stating that “[w]hen several dimensions of health status were controlled for, the average predicted costs of HMO enrollees were only 85 percent of average predicted costs for respondents in FFS” and that the “use of models based on FFS data to impute costs for HMO enrollees may produce biased estimates if coefficients on the health-status variables used in the models are different for individuals choosing the HMO and FFS sectors”); Brown et al., *supra* note 21, at 10-11.

24. See GREEN BOOK, *supra* note 4, at E-13 (stating that enrollment patterns vary between urban and rural locations as well as by region).

25. Gardner, *supra* note 21, at 8 (reporting that an HCFA Office of Research and Demonstration study found that “Medicare may be overpaying HMOs by as much as 7% because the managed-care plans attract a healthier population”); Riley et al., *supra* note 21, at 73; Press Release, Health Care Fin. Admin., *supra* note 21.

In addition to perceiving that Medicare risk plans were overpaid, many also perceived a significant “equity” problem between rural and urban areas.²⁶ That is, persons living in urban areas were more likely to have access to Medicare risk plans, to be enrolled in them, and to receive more generous benefits.²⁷ For example, Medicare HMOs offered an array of benefits not offered by Medicare FFS. In 1996, 83% of risk-plan enrollees in urban counties had access to prescription drug coverage, 56% had access to dental coverage, 94% had access to eye exam coverage, and almost all had access to plans offering preventive care.²⁸ The evidence suggests that these disparities were due almost entirely to higher payment rates in urban areas than in rural areas.²⁹ This perceived “equity” problem in Medicare’s risk contract program led to a huge lobbying campaign on behalf of rural interests to fix the problem.³⁰

The policy prescription Congress chose to include in the 1997 BBA was to create a Byzantine and complicated policy proposal that would reduce payments to higher payment areas over time by “blending” national and local rates.³¹ By blending (or averaging) the rates, the BBA raised the payment rates in areas where the local rate was lower than the national average and lowered the rates in areas where the local rate was higher than the national average.³² In addition, the 2000 BIPA legislation created artificial “floor” rates based on population and location, not on prior

26. See MEDPAC 2001, *supra* note 13, at 112, 114 (describing the inequality existing between rural and urban areas); see also Dowd & Feldman, *supra* note 13, at 209, 211 (describing the geographic inequities); McBride, *supra* note 12 (discussing how the risk plans, premium amounts, and benefits offered to Medicare beneficiaries vary according to areas of residence); Penrod et al., *supra* note 13 (discussing geographic variations in Medicare HMO availability and enrollment).

27. McBride, *supra* note 12, at 174-75.

28. *Id.* at 176 tbl.2.

29. See *id.* at 177; CMS 2007, *supra* note 2, at 6.

30. See, e.g., Serrato et al., *supra* note 12, at 95-97 (examining why “so few HMOs offer a Medicare risk plan in rural counties” and suggesting proposals for how HCFA could increase the offerings of risk plans in rural areas); JEANNE M. LAMBREW & BECKY BRIESACHER, CTR. FOR AM. PROGRESS, MEDICARE PRESCRIPTION DRUG LEGISLATION: WHAT IT MEANS FOR RURAL BENEFICIARIES (2003), available at www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/ruralreport.pdf (last visited June 24, 2008) (advocating for rural beneficiaries prior to the passage of the 2003 MMA); THOMAS C. RICKETTS, N.C. RURAL HEALTH RESEARCH & POLICY ANALYSIS CTR., ARGUING FOR RURAL HEALTH IN MEDICARE: A PROGRESSIVE RHETORIC FOR RURAL AMERICA 5, 10, 12 (2002), available at www.shepscenter.unc.edu/research_programs/rural_program/wp75.pdf (last visited June 24, 2008) (discussing the role of effective advocacy in developing rural policy).

31. GREEN BOOK, *supra* note 4, at E-19 to -20.

32. See *id.*

Medicare costs, that ended up being operative in most rural areas in the United States.³³

II. WE RAISED RATES, BUT DID THEY COME? THE MEDICARE+CHOICE EXPERIENCE

As noted above, the 1997 BBA provisions that created the M+C Program restructured the method for computing capitation rates paid to M+C plans beginning in January 1998.³⁴ The changes to the policy for setting plan payment rates were much anticipated partly because of the new rates' potential to spur managed care growth in areas that previously had lower rates, especially rural areas.³⁵ Despite this expectation, the number of M+C plans started to decline dramatically, falling from 346 plans in 1998 to 145 plans in 2004.³⁶ Nevertheless, beneficiary enrollment in M+C plans still increased until 2000 because the plans that exited the program tended to have low enrollment.³⁷ In 2000, however, enrollment started to decline when plans with larger enrollment started to withdraw.³⁸ By December 2003, enrollment had dropped to 4.6 million (from its peak of 6.4 million in 1999).³⁹ Rural M+C enrollment declined precipitously as well during this period—after peaking at just over 260,000 in 1999, enrollment fell to 176,058 in December 2003.⁴⁰

Should policy makers have been able to predict these withdrawals from M+C plans? Well, yes. It was not surprising that plans exited M+C in urban areas, where the 1997 BBA slowed growth in payment rates. Part of the decline in M+C enrollment stemmed from nonrenewal by plans.⁴¹ From 1999 through early 2001, “[a] considerable number of M+C plans either dropped out of Medicare completely or reduced their service areas,” affecting a reported 2.4 million enrollees (about 407,000 in 1999, about 327,000 in 2000, about 934,000 in 2001, about 536,000 in 2002, and

33. *Id.* at E-20.

34. *Id.* at E-18 to -20; COBURN ET AL., *supra* note 15.

35. Penrod et al., *supra* note 13, at 733-34.

36. THE HENRY J. KAISER FAMILY FOUND., MEDICARE FACT SHEET: MEDICARE ADVANTAGE (2004), available at www.kff.org/medicare/upload/Medicare-Advantage-Fact-Sheet.pdf (last visited June 24, 2008).

37. MEDPAC, A DATA BOOK, *supra* note 3, at 153 fig.10-3.

38. *See id.*

39. *Id.*

40. THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN TRACKER, UNITED STATES – RURAL COUNTIES: ENTIRE MEDICARE ADVANTAGE PROFILE, MEDICARE ADVANTAGE PLAN ENROLLMENT, at www.kff.org/medicare/healthplantracker/georesults.jsp?r=2&pt=8&yo=2&c=&i=&n=1#6 (last visited June 20, 2008); COBURN ET AL., *supra* note 15, at 2.

41. Timothy D. McBride & Courtney Andrews, *An Update on Medicare+Choice: Rural Medicare Beneficiaries Enrolled in Medicare+Choice Plans Through October 2000*, RURAL POLICY BRIEF (RUPRI Ctr. for Rural Health Policy Analysis, Omaha, Neb.), Mar. 2001, at 1, 3.

about 215,000 in 2003).⁴² However, in rural areas, the payment rates to the M+C plans did increase due to implementation of the national payment floor, but the plans did not come.⁴³ Although plans attributed their departure from M+C to sluggish growth in payment rates, other factors, such as a weakening HMO market in general, most likely contributed to these declines.⁴⁴ The nonrenewals had a disproportionate impact on rural beneficiaries. For example, “[w]hile only about 3.7% of M+C enrollees lived in rural areas, a much larger proportion of rural persons were affected by exits in the 1999-2001 period: 14% [of the nonrenewals were in rural areas] in 1999, 12% in 2000, and 7% in 2001.”⁴⁵ Only in 2002 did the nonrenewals “seem to fall proportionately on rural residents, when 3.5% of persons affected by [nonrenewals] were from rural areas.”⁴⁶

III. THE LEGISLATIVE RESPONSE TO M+C: MEDICARE ADVANTAGE UNDER THE 2003 MMA

Despite the turmoil in the M+C Program, President Bush and Republicans in Congress decided they could not simply let private plans die because they had a long-term goal of enhancing private choices as alternatives to traditional Medicare.⁴⁷ In 2003, President Bush said, “Medicare beneficiaries should be given more choices in how they receive their health care . . . [and] seniors who want more choices and better benefits . . . will have the right to select the health plan that fits their needs

42. *Id.*; CTRS. FOR MEDICARE & MEDICAID SERVS., M+C ENROLLEES BY COUNTY FOR CY 2002, at www.cms.hhs.gov/NonRenewal/ (last visited June 24, 2008) (download Non-Renewal Reports, follow Affected Enrollees by State, County, and Plan – CY2002 icon, follow markprintoutnew icon); CTRS. FOR MEDICARE & MEDICAID SERVS., M+C ENROLLEES BY COUNTY FOR CY 2003, at www.cms.hhs.gov/NonRenewal/ (last visited June 24, 2008) (download Non-Renewal Reports, follow Affected Enrollees by State, County, and Plan – CY2003 icon).

43. See CMS 2007, *supra* note 2, at 6 (discussing rate increases); see also Joseph R. Antos, *Medicare+Choice: Where Did the Scorekeepers Go Wrong?*, 2001 HEALTH AFF. (WEB EXCL.) w83 (discussing the reasons for the lack of increased plans after the rate increases).

44. See Antos, *supra* note 43, at w83-84 (saying that plans consider the conditions of the commercial market as one of several factors when deciding whether to participate in M+C); Penrod et al., *supra* note 13, at 747 (explaining that market characteristics such as enrollment in non-Medicare HMOs influence payment rates).

45. Timothy McBride et al., *An Update on Medicare+Choice: Rural Medicine Beneficiaries Enrolled in Medicare+Choice Plans Through September 2001*, RURAL POLICY BRIEF (RUPRI Ctr. for Rural Health Policy Analysis, Omaha, Neb.), Aug. 2002, at 1, 4, available at www.unmc.edu/ruprihealth/Pubs/pb2002-4.pdf (last visited June 23, 2008).

46. *Id.*

47. See AMERICA’S HEALTH INSURANCE PLANS, THE VALUE OF PRIVATE HEALTH CARE CHOICES IN MEDICARE 17 (2005), available at www.medicarechoices.org/files/ValueofPrivateHealthCareChoicesinMedicareOct2005.pdf (last visited June 24, 2008) (showing that both Republicans and Democrats “worked together to win congressional approval of reforms to stabilize private health care choices in Medicare”).

best-rather than a one-size-fits-all government plan.”⁴⁸ While the need to address the M+C Program’s problems afforded an opportunity to promote more private choices in Medicare, the idea was not new. In 1995 while serving as Speaker of the House, Newt Gingrich said, “Now let me talk a little bit about Medicare . . . We believe it’s going to wither on the vine because people are voluntarily going to leave it.”⁴⁹

Thus, in 2003, Congress passed the MMA.⁵⁰ Among other provisions, the MMA (1) renamed the M+C Program as the Medicare Advantage (MA) Program, (2) created a new MA option (regional PPOs that offered a new plan anywhere in the region in 2006 or 2007 were required to offer the same plan everywhere in the region), (3) created MA Prescription Drug Plans, and (4) raised the MA plan payment rates.⁵¹ The MMA affected plan payment rates in several ways. It increased payments for MA plans across the board through provisions guaranteeing plan payment rates equal to at least 100% of the payment that would be made under the fee-for-service program.⁵² The MMA also increased floor rates again to \$613 for urban counties and \$555 for all other counties.⁵³ “The MMA established a new payment adjustment for risk by using risk corridors around the benchmark payment so that aggregate losses and gains are shared between the Medicare program and the plan.”⁵⁴ Additionally, the MMA repealed the BBA’s “budget neutrality” provisions,⁵⁵ which had reduced growth of payment rates over time to M+C plans.⁵⁶ Collectively, the payment changes in the MMA led to significant increases in payments to MA plans. Based on January 2004 data, in most areas of the country payment increases would exceed 8% and the average increase would be 11.5%.⁵⁷ In

48. THE WHITE HOUSE, FACT SHEET: FRAMEWORK TO MODERNIZE AND IMPROVE MEDICARE, at MORE CHOICES-INCLUDING THE CHOICE TO STAY IN TRADITIONAL MEDICARE (2003), at www.whitehouse.gov/news/releases/2003/03/20030304-1.html (last visited June 24, 2008).

49. *Gingrich on Medicare*, N.Y. TIMES, July 20, 1996, § 1, at 8 (citing House Speaker Newt Gingrich, speech at a Blue Cross/Blue Shield conference on Oct. 24, 1995).

50. 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. & 26 U.S.C.).

51. CMS 2007, *supra* note 2, at 5-7; COBURN ET AL., *supra* note 15, at 2; MEDICARE ADVANTAGE FACT SHEET, *supra* note 11.

52. CMS 2007, *supra* note 2, at 6.

53. *Id.*

54. COBURN ET AL., *supra* note 15, at 2.

55. CMS 2007, *supra* note 2, at 6.

56. See *id.* at 5, 6, & 22; McBride et al., *supra* note 45.

57. The author calculated these increases from data contained in the Centers for Medicare & Medicaid Services MA ratebook for January and February 2004. This ratebook can be downloaded at Ctrs. For Medicare & Medicaid Servs., Ratebooks & Supporting Data, www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage (last visited June 22, 2008).

the counties where the rate is now set by the fee-for-service rate, the payment rate would rise by an average of 17.7%.⁵⁸

Congressional reformers expected the payment rate increases to lead to new MA plan activity—e.g., the creation of new MA plans, or the expansion of service areas for existing MA plans—across the United States, including rural areas.⁵⁹

A. *Response to the MMA: Growth in the MA Program from 2005 to 2007*

During the first three quarters of 2007, MA plan enrollment grew over 50% and has more than tripled since the program's launch in early 2006.⁶⁰ In September 2007, more than 845,000 rural Medicare beneficiaries were enrolled in an MA plan, which represents a 56% increase since December 2006 and a 230% increase since December 2005.⁶¹ Furthermore, as shown in Figure 1, MA plan enrollment in all counties rose to about 8.3 million, an increase of 42% since December 2005.⁶²

58. *See id.*

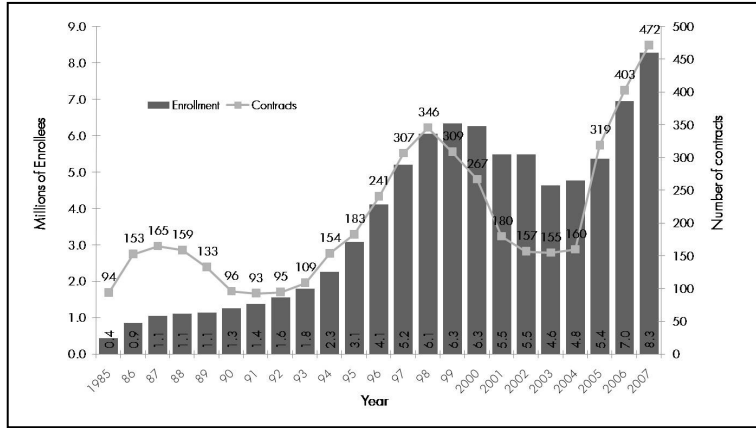
59. H.R. REP. NO. 108-391, at 524, 527, as reprinted in 2004 U.S.C.C.A.N. 1808, 1896, 1899 (stating that Title II of the MMA "modernizes and revitalizes private plans under Medicare"); see also AMERICA'S HEALTH INSURANCE PLANS, *supra* note 47, at 9 ("Medicare Advantage plans have been using these new funds to reduce costs and enhance benefits for beneficiaries."); Robert H. Bradner, *The New Medicare: A Detailed Guide to the Just-Enacted Prescription Drug Legislation*, ABA HEALTH ESOURCE, June 2004.

60. Timothy D. McBride & Keith J. Mueller, *Update on Rural Enrollment in Medicare Advantage: Growth Continues*, RURAL POLICY BRIEF (RUPRI Ctr. for Rural Health Policy Analysis, Omaha, Neb.), October 2007, at 1, available at www.unmc.edu/ruprihealth/Pubs/PB2007-7%20110507.pdf (last visited June 24, 2008).

61. *Id.*

62. *Id.*

Figure 1: MA Plan Enrollment and Contracts, 1985–2007⁶³
(as of December of Year Shown)



However, despite significant growth in MA plans, from 160 in 2004 to 472 in 2007 (see Figure 1), as Figure 2 shows, only 9.3% of Medicare eligibles in *rural* areas were enrolled in MA plans in September 2007, compared to 19% of *all* Medicare eligibles.⁶⁴

Figure 2: MA Enrollment by Area of Residence, September 2007⁶⁵

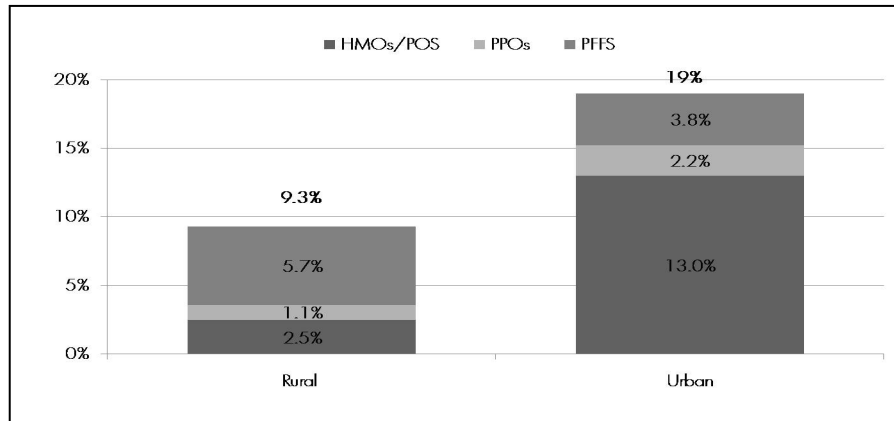


Figure 3 shows that, as of September 2007, “[o]ver half (56%) of rural persons enrolled in MA or prepaid plans were in private fee-for-service

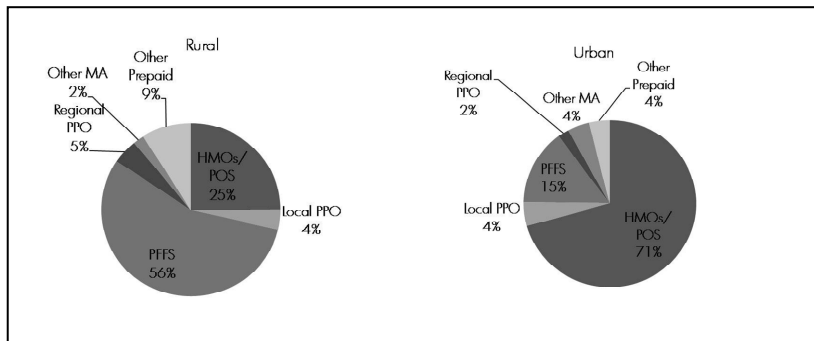
63. The information in this graph comes from the Medicare Advantage Monthly Reports and includes risk plans prior to 1997 and CCP and PFFS plans only after 1997. See Ctrs. for Medicare & Medicaid Servs., *Monthly Enrollment and Contract Summary Reports*, available at www.cms.hhs.gov/MCRAAdvPartDEnrolData/MCESR/list.asp#TopOfPage (last visited Aug. 24, 2008).

64. McBride & Mueller, *supra* note 60, at 1.

65. *Id.* at 3 tbl.1, 4 tbl.2.

(PFFS) plans, compared to only 15% of urban persons.⁶⁶ Conversely, urban persons are much more likely to enroll in HMO plans. In September 2007, 71% of urban area enrollment was in HMO plans, a high rate despite having fallen from 84% in 2005 (see Figure 3).⁶⁷

Figure 3: Enrollment in MA and Other "Prepaid" Plans, September 2007⁶⁸



IV. MEDICARE ADVANTAGE: HAVE WE ACHIEVED PROGRAM GOALS?

Has the United States achieved the MA Program's original goals to (1) expand healthcare delivery options for seniors by giving them access to private plan choices, (2) contain the growth of Medicare costs through these options, and (3) reduce equity problems (the implicit goal of the 1997 BBA, as described above)?

A. Do MA Plans Expand Choice?

The choice expansion goal has been met by one measure because, as of 2007, essentially every Medicare beneficiary in the country can choose an MA plan.⁶⁹ In 2005, only 84% of beneficiaries had an MA plan option.⁷⁰ In 2007, however, every urban beneficiary could choose an MA plan, and over 94% of beneficiaries living in rural areas had at least one MA plan they could choose.⁷¹ However, is the mere availability of an MA plan the right measure for determining whether seniors have access to

66. *Id.* at 1.

67. *Id.*

68. RUPRI Ctr. for Rural Health Policy Analysis, Table 3. Enrollment in Medicare Advantage and Other Prepaid Plans by Location, 2005-2007, available at www.unmc.edu/ruprihealth/Pubs/PB2007-7%20Tables%20110507.pdf (last visited Aug. 24, 2008).

69. MEDPAC, A DATA BOOK, *supra* note 3, at 151 fig.10-1.

70. *Id.*

71. Marsha Gold, *Medicare Advantage in 2006-2007: What Congress Intended?* 2007 HEALTH AFF. (WEB EXCL.) w445, w447; Press Release, Health Affairs, Growth in Private Fee-for-Service Plans Accounts for Much of the Increase in Choice Among Medicare Advantage Plans (May 1, 2007), at www.healthaffairs.org/press/mayjun0703.htm (last visited June 24, 2008).

“expanded delivery options”? This increased plan availability is illusory for at least three reasons.

First, beneficiaries have an increased choice offered among different types of insurance plans with different financial structures,⁷² but not necessarily an expanded choice of providers. In fact, the greatest freedom to choose providers is offered in traditional Medicare FFS. MA plans (especially HMOs) actually restrict choice because beneficiaries must choose from a provided list of doctors and hospitals. Thus, beneficiaries have the option of choosing among plans with more benefits offered, as opposed to a choice of more providers. An estimate from the Centers for Medicare & Medicaid Services shows that the extra benefits from MA plans amount to almost \$108 per member per month and that \$86 of that extra benefit is financed by payments from the Medicare Program and \$22, on average, is financed by extra premiums levied on recipients.⁷³ The extra benefits offered include routine physical exams (offered by 96% of plans), additional acute care (87%) or long-term skilled nursing facility days covered in the hospital (90%), eye exams (77%), ear exams (76%), eyeglasses (64%), and hearing aids (61%).⁷⁴ In addition, 70% of MA plans offer access to a prescription drug plan that does not require beneficiaries to pay a premium for the coverage.⁷⁵

72. See Timothy D. McBride et al., *Rural Enrollment in Medicare Advantage Is Concentrated in Private Fee-for-Service Plans*, RURAL POLICY BRIEF (RUPRI Ctr. for Rural Health Policy Analysis, Omaha, Neb.), Apr. 2007, at 1, 2, 4 tbl.3, available at www.unmc.edu/ruprihealth/Pubs/PB2007-2.pdf (last visited June 20, 2008) (stating that “MA and prepaid enrollment in rural areas is concentrated in a few organizations holding contracts with CMS” and “[t]he top three contracts in rural areas are PFFS contracts, enrolling 38% of the rural enrollees in MA and prepaid plans”).

73. CMS 2007, *supra* note 2, at 11; CTRS. FOR MEDICARE & MEDICAID SERVS., OVERVIEW OF THE MEDICARE ADVANTAGE PROGRAM 2 (2007), at www.cms.hhs.gov/MCRAAdvPartDEnrolData/ (download Medicare Advantage 2007 Overview; then follow MA Backgrounder icon) (last visited June 23, 2008); see also CTR. FOR HEALTH POLICY STUDIES, THE HERITAGE FOUND., A MEDICARE ADVANTAGE PRIMER 5 (2007), available at www.heritage.org/research/HealthCare/upload/HeritageMedicareAdvantageprimer.pdf (last visited June 24, 2008).

74. CMS 2007, *supra* note 2, at 14.

75. Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare Advantage Plans Provide Lower Costs and Substantial Savings: CMS Announces Increased Payment Rates for Medicare Advantage Plans in 2007 (Apr. 3, 2006), at www.cms.hhs.gov/apps/media/press/release.asp?Counter=1825 (last visited June 24, 2008); see also BRIAN BILES ET AL., THE COMMONWEALTH FUND, MEDICARE BENEFICIARY OUT-OF-POCKET COSTS: ARE MEDICARE ADVANTAGE PLANS A BETTER DEAL? 3 (2006), available at www.cmwf.org/usr_doc/927_Biles_MedicarebeneOOPcosts_MA_ib.pdf (last visited June 24, 2008) (citing prescription drug plan availability as evidence that additional payments to MA plans has allowed them to offer more benefits).

Second, in most of the country (especially in rural counties), the “predominant” alternative to traditional Medicare FFS is the private fee-for-service (PFFS) MA plan.⁷⁶ The PFFS plan is a type of FFS plan, so it does not differ much in terms of provider choice from traditional Medicare FFS. In 2003, the majority of counties had zero or one private plans.⁷⁷ As of 2007, most counties have several PFFS plans.⁷⁸ However, while 87% of urban persons have access to an HMO plan, only 35% of rural persons have access to an HMO plan.⁷⁹

Third, the recent passage of the MMA is limited in its provisions of expanded prescription drug coverage. Since prescription drug coverage under Medicare was previously only available previously through M+C plans,⁸⁰ the coverage expansions creating the Medicare Part D program amount to an expansion that was tried already through M+C. However, drug coverage as an additional “choice” offered by MA plans is becoming obsolete because prescription drug coverage is now available to all Medicare recipients.

B. Do MA Plans Contain Costs?

Although the MA plans were designed to reduce Medicare spending, especially the growth in Medicare spending, evidence emerged in 2007 showing that, on average, MA plans were paid 112% of the mean costs of

76. MEDPAC, A DATA BOOK, *supra* note 3, at 246; see THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN TRACKER, UNITED STATES – RURAL COUNTIES: MEDICARE BENEFICIARIES WITH ACCESS TO MA CONTRACTS, BY PLAN TYPE, at www.kff.org/medicare/healthplantracker/georesults.jsp?r=2&yo=2&n=1&i=3&pt=8 (last visited June 16, 2008) (showing that, as of 2007, 100% of rural beneficiaries have access to a PFFS plan); see also McBride et al., *supra* note 72, at 2 (“Despite the new option of a regional PPO, virtually all growth in MA plans in rural areas in 2006 was in PFFS plans.”).

77. See GREEN BOOK, *supra* note 4, at E-9, E-10 tbl.E-3 (stating that in January 2003, “41 percent of all Medicare beneficiaries lived in an area that had no access to an M+C plan” and 19% had access to only one M+C plan).

78. See Timothy McBride et al., *supra* note 72, at 2, 4.

79. THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN TRACKER, UNITED STATES – RURAL COUNTIES: ENTIRE MEDICARE ADVANTAGE PROFILE, MEDICARE BENEFICIARIES WITH ACCESS TO MA CONTRACTS, BY PLAN TYPE, at www.kff.org/medicare/healthplantracker/georesults.jsp?r=2&pt=8&yo=2&c=&i=&n=1#6 (last visited June 16, 2008); THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN TRACKER, UNITED STATES – URBAN COUNTIES: ENTIRE MEDICARE ADVANTAGE PROFILE, MEDICARE BENEFICIARIES WITH ACCESS TO MA CONTRACTS, BY PLAN TYPE, at www.kff.org/medicare/healthplantracker/georesults.jsp?r=3&n=&i=&c=&pt=8&yo=2&x=9&y=11 (last visited June 20, 2008).

80. See GREEN BOOK, *supra* note 4, at E-39 (explaining that one advantage of Medicare managed care over traditional FFS Medicare is that most plans offer some prescription drug coverage).

covering a traditional Medicare recipient.⁸¹ PFFS plans were the most overpaid, receiving payments equal to 119% of traditional Medicare FFS costs.⁸² In addition, the Congressional Budget Office (CBO) estimates that if MA plans were paid at 100% of FFS costs, then Medicare spending would be reduced by "\$54 billion over the 2009-2012 period and \$149 billion over the 2009-2017 period."⁸³ This potential for cost savings inspired Representative Pete Stark and others to propose this legislative change in 2007.⁸⁴

As indicated in the discussion above, the higher payment to MA plans results from a series of payment policy changes, the most recent changes being made by the MMA. Before the MMA, private Medicare plans were paid, on average, 4% above traditional FFS costs.⁸⁵ However, the MMA led to significant payment increases to MA plans that exceeded 8% in most areas of the country and eventually to an average increase of about 12%.⁸⁶

81. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 244 tbl.4-1 (2007), available at www.medpac.gov/documents/Mar07_Entire_Report.pdf (last visited June 24, 2008) [hereinafter MEDPAC 2007].

82. *Id.*; see also *Medicare Payment Advisory Commission's Annual March Report: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Cong. 13 (2007) (statement of Glenn M. Hackbarth, Chairman of the Medicare Payment Advisory Commission), available at www.medpac.gov/documents/030107_Testimony_Mar07_report.pdf (last visited Aug. 24, 2008) [hereinafter Hackbarth Testimony].

83. J. TIMOTHY GRONNIGER & ROBERT A. SUNSHINE, CONGRESSIONAL BUDGET OFFICE, MEDICARE ADVANTAGE: PRIVATE HEALTH PLANS IN MEDICARE 6 (2007), available at www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf (last visited June 24, 2008); *Medicare Advantage and the Federal Budget: Hearing Before the H. Comm. on the Budget*, 110th Cong. 13 (2007) (testimony of Peter Orszag, Director of the Congressional Budget Office), available at www.budget.house.gov/hearings/2007/06.27orszag_testimony.pdf (last visited June 24, 2008).

84. *Rep. Stark to Introduce Bill to Reduce Reimbursements for Medicare Advantage Plans*, KAISER DAILY HEALTH POL'Y REP. (The Henry J. Kaiser Family Found.), Apr. 26, 2007, at www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=44518 (last visited June 24, 2008); see Press Release, Congressman Pete Stark, Stark Floor Remarks on Medicare Legislation (Dec. 19, 2007), at www.house.gov/stark/news/110th/pressreleases/2007/2007-12/19-medicare.htm (last visited Aug. 24, 2008) (discussing the CHAMP bill and its proposals to reduce overpayments to private plans).

85. MEDPAC 2001, *supra* note 13, at 117 tbl.7-2 (stating that the average M+C payment rate as a percent of Medicare FFS spending in 2000 was 104%); see also MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 210, 210 tbl.4.3 (2004), available at www.medpac.gov/documents/Mar04_Entire_reportv3.pdf (last visited June 23, 2008) (stating that in 2004, "before MMA . . . Medicare would have paid M+C plans an average of 103 percent of what it would cost to cover the current demographic mix of M+C enrollees under the traditional FFS Medicare program") [hereinafter MEDPAC 2004].

86. These percentages are based on the author's analysis of MA plan payment rates as of January 2004. The ratebooks are available on the Centers for Medicare & Medicaid Services

Medicare's private plans were expected originally to lower Medicare costs because, at the time they were introduced, the costs of managed care plans were lower than the costs of traditional FFS plans.⁸⁷ This expectation was based on the theory established when Congress created the Medicare risk contract program, namely to pay Medicare HMOs at 95% of the adjusted average per capita cost (AAPCC).⁸⁸ Thus, the expectation was that these plans would cost 5% less than traditional Medicare FFS. However, the current payment rate, 112%⁸⁹ of traditional Medicare FFS, indicates that managed care is not leading to 5% savings but, instead, to 12% higher costs. The Medicare Trustees also confirm that shifting Medicare beneficiaries to MA plans does not lead to considerable savings, since they currently are assuming that shifting beneficiaries from traditional Medicare FFS to MA plans will save just 0.03% annually in the long run.⁹⁰

C. Do MA Plans Increase Equity?

Recall that before the 1997 BBA created the M+C Program, rural areas complained that they did not have access to benefit-rich Medicare HMOs.⁹¹ Now essentially every Medicare beneficiary has access to Medicare PFFS plans, and enrollment in these plans is growing rapidly.⁹² However, in terms of the equity goal, there are several issues PFFS plans raise. For example,

Web site, www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage (last visited June 24, 2008); see also MEDPAC 2004, *supra* note 85, at 210-11, 210 tbl.4-2 ("For 2004 under the new MMA rates . . . Medicare is paying M+C plans an average of 107 percent of what it would cost to cover the current demographic mix of M+C enrollees under the traditional fee-for-service Medicare program").

87. See BRIAN BILES ET AL., THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS-2005 UPDATE 1-2 (2004), available at www.cmf.org/usr_doc/750_Biles_costofprivatization_update_ib_pdf.pdf (last visited June 24, 2008).

88. See *id.* at 2; see GREEN BOOK, *supra* note 4, at E-18 n.7.

89. MEDPAC 2007, *supra* note 81, at 244 tbl.4-1.

90. THE BD. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, THE 2007 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 68-69 (2007), available at www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf (last visited June 24, 2008) [hereinafter THE BD. OF TRS. 2007].

91. See *supra* text accompanying notes 26-30; Dowd & Feldman, *supra* note 13, at 209, 211; McBride, *supra* note 12; Penrod et al., *supra* note 13; Serrato et al., *supra* note 12, at 95-97.

92. MEDPAC 2007, *supra* note 81, at 248; McBride & Mueller, *supra* note 60; see also MEDPAC, A DATA BOOK, *supra* note 3, at 154 (stating that "enrollment in PFFS plans accounted for nearly half the growth in Medicare Advantage" between July 2006 and February 2007).

PFFS plans generally do not offer an array of additional benefits⁹³—they are essentially Medigap plans.⁹⁴ In addition, both providers and consumer advocates lodged a significant number of complaints about PFFS plans between 2004 and 2007. Providers complained about reimbursement issues and about “deeming” provisions,⁹⁵ while consumer advocates complained about possible deceptive marketing techniques.⁹⁶ Furthermore, PFFS plans are concentrated in just a few organizations,⁹⁷ which, in the long run, raises concerns about market power.

In 2007, a new view of equity in MA plans emerged. Instead of looking at horizontal equity across geographical areas, the new view focuses on increased vertical equity among recipients⁹⁸ and concludes that MA plans do increase vertical equity because they help lower-income Medicare beneficiaries.⁹⁹ In particular, evidence shows that 49% of MA enrollees had incomes of less than \$20,000 in 2004¹⁰⁰ and that “racial and ethnic

93. See MEDPAC, A DATA BOOK, *supra* note 3, at 156 (showing that PFFS plans, for example, are not required to offer drug coverage).

94. In other words, PFFS plans offer coverage similar to that of plans designed to supplement traditional Medicare FFS.

95. See, e.g., Patricia Barry, *Don't Fall for the Hard Sell*, AARP BULLETIN, October 2007, at www.aarp.org/health/insurance/articles/beneficiaries_have.html (last visited June 24, 2008) (stating that “a doctor or hospital that agrees to treat an enrollee is automatically ‘deemed’ to have agreed to the plan’s terms and payment conditions—without any negotiation” between the provider and the plan having taken place).

96. Robert A. Berenson & Melissa A. Goldstein, *Will Medicare Wither on the Vine? How Congress Has Advantaged Medicare Advantage—And What's a Level Playing Field Anyway?*, 1 ST. LOUIS U. J. HEALTH L. & POLY 5, 30-33 (2007).

97. McBride & Mueller, *supra* note 60, at 5 (stating that in 2007 “over 43% of rural overall MA enrollment [was] in just five organizations serving about 2,000 counties in the United States”); see also McBride et al., *supra* note 72, at 4 tbl.3 (showing that the three plans with the highest enrollment in rural areas are PFFS plans).

98. See ROBERT A. BERENSON & BRYAN E. DOWD, AARP PUB. POLICY INST., THE FUTURE OF PRIVATE PLAN CONTRACTING IN MEDICARE 6-7 (2002), available at http://assets.aarp.org/rgcenter/health/2002_12_medicare.pdf (last visited June 24, 2008) (stating that “vertical equity means that people with different resources should be treated differently”).

99. CMS 2007, *supra* note 2, at 3, 9 (“Fifty-seven percent of MA beneficiaries have income between \$10,000 and \$30,000 as compared to 46 percent of FFS beneficiaries.”).

100. *An Examination of the Medicare Advantage Program: Hearing Before the S. Comm. on Finance*, 110th Cong. 4 (2007) (presentation by the Members of the Health Policy Consensus Group), available at www.senate.gov/~finance/hearings/statements/041107cg2.pdf (last visited June 24, 2008) [hereinafter Health Policy Consensus Group testimony]; see also ADAM ATHERLY & KENNETH E. THORPE, VALUE OF MEDICARE ADVANTAGE TO LOW-INCOME AND MINORITY MEDICARE BENEFICIARIES, BLUE CROSS & BLUE SHIELD ASS'N 4 tbl.2 (2005), available at www.bcbs.com/issues/medicaid/research/Value-of-Medicare-Advantage-to-Low-Income-and-Minority-Medicare-Beneficiaries.pdf (last visited June 24, 2008) (showing that in 2003, 35.6 % of Medicare beneficiaries with incomes under \$10,000 enrolled in MA (slightly lower than the 40.3% of beneficiaries with incomes under \$10,000 who only enrolled

minorities represent 27 percent of total MA enrollment, compared with 20 percent in fee-for-service."¹⁰¹ One study predicts that if MA coverage ceased to exist, "59% of African-American beneficiaries in counties that have MA plans would go without supplemental coverage."¹⁰² As a result of these studies, the NAACP opposed reducing funding for MA plans, saying they "disproportionately provide coverage to low-income and racial and ethnic minority beneficiaries."¹⁰³ In addition, a gaggle of policy experts concluded that MA plans are "offering more choices of plans, more generous benefits, and lower cost-sharing for . . . [s]eniors . . . with modest incomes who do not have supplementary coverage."¹⁰⁴ However, subsequent analysis showed that this research was misleading and that low-income and minority Medicare beneficiaries were not more likely to benefit from MA plans.¹⁰⁵

V. IS IT POSSIBLE TO ACHIEVE THE GOALS OF MEDICARE ADVANTAGE?

The conclusions described above create a rather perplexing story. The goals for Medicare private plans were to increase choices, contain costs, and increase equity, but, arguably, MA has not achieved any of these goals. First, while MA plans expanded choices of insurance plans and some plans (especially HMO and PPO plans) offer expanded benefit options, few plans expand choice of providers. Furthermore, the additional choices offered to most beneficiaries are PFFS plans, which are not that much unlike traditional Medicare FFS in terms of provider choice. Second, by almost any measure, MA plans have not met the cost containment goal. Finally, the evidence is

in Medicare) and 37.8% of Medicare beneficiaries with incomes from \$10,000 to \$20,000 enrolled in MA (slightly higher than the 29.2% of beneficiaries with incomes from \$10,000 to \$20,000 who only enrolled in Medicare)).

101. Health Policy Consensus Group testimony, *supra* note 100.

102. ATHERLY & THORPE, *supra* note 100, at ii, 8.

103. *Minority Groups Oppose Proposed Reduction in Funds for Medicare Advantage Plans*, KAISER DAILY HEALTH POL'Y REP., Mar. 16, 2007, at www.kaisernetwork.org/Daily_reports/rep_index.cfm?DR_ID=43645 (last visited June 24, 2008); see also Health Policy Consensus Group testimony, *supra* note 100 ("The NAACP, as well as the League of United Latin American Citizens, have called upon congressional leaders to oppose reductions in funding for Medicare Advantage plans.").

104. Health Policy Consensus Group testimony, *supra* note 100, at 6; see also DEP'T OF HEALTH & HUMAN SERVS., HHS BUDGET IN BRIEF 51-52 (2008), available at www.hhs.gov/budget/08budget/2008BudgetInBrief.pdf (last visited June 24, 2008).

105. 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 (2007), available at www.cbpp.org/4-3-07health.pdf (last visited June 24, 2008) (stating that many of the calculations fail "to include Medicaid and employer-based retiree coverage as options that provide supplemental coverage, which distorts the data").

overwhelming that MA plans still have not achieved horizontal equity across geographic areas, especially between urban and rural areas. Met with these concerns, the MA Program's defenders invented a goal of achieving vertical equity among recipients, even though it was never a stated goal of the program and evidence shows that MA plans do not actually achieve vertical equity.

This history raises a question: Is it really possible to achieve the goals set out for the MA Program? As is often the case in healthcare policy, everyone wants everything, everywhere without having to pay additional money for it. So what people were really saying in 1982, 1997, and 2003 was, "We want a better Medicare plan covering more services with less out of pocket costs, like those Medicare HMOs, and, especially, covering outpatient drugs at lower costs, like those zero-premium plans offered in Florida." And, in 1997, Congress attempted to achieve these goals through the BBA's "budget neutrality" provisions.

This expectation's obviously unrealistic nature leads to the conclusion that achieving these illusory goals is simply not feasible. Since evidence now shows that MA plans cost 112% of Medicare FFS, consider what would happen if all Medicare beneficiaries, not just 20% of them, as was the case in 2007,¹⁰⁶ were enrolled in these plans and receiving coverage for more of their copayments, deductibles, and, perhaps, prescription drugs, with reasonable additional premiums. This scenario would obviously not save money because the costs of providing coverage to the traditional Medicare FFS recipients would also rise, perhaps by 15% as already projected.¹⁰⁷ People fight so hard against payment cuts to private plans (in urban areas) or to raise payments to private plans (in rural areas) because they want the additional benefits. However, the recent evidence demonstrates that even these changes would not achieve the equity goals, either vertical or horizontal.

Regardless of these other goals, we must return to the goal of containing aggregate Medicare costs, especially in the long run. What about the Medicare trust funds and the future costs of Medicare? The future costs of the entitlement programs that benefit the elderly—Medicare, Medicaid, and Social Security—are projected to more than double, rising

106. MEDPAC 2007, *supra* note 81, at 244 tbl.4-1; MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 153 (2008), available at www.medpac.gov/documents/Mar08_EntireReport.pdf (last visited June 24, 2008).

107. See THE BD. OF TRS. 2007, *supra* note 90, at 52 tbl.III.B.5 (predicting that the total expenditures of the Hospital Insurance Trust Fund will increase from \$208.2 billion in 2007 to \$385.4 billion in 2016); BD. OF TRS. OF THE FED. OLD-AGE & SURVIVORS INS. & FED. DISABILITY INS. TRUST FUNDS, STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2007 ANNUAL SOCIAL SECURITY AND MEDICARE TRUST FUND REPORTS (2007), available at www.ssa.gov/OACT/TRSUM/tr07summary.pdf (last visited June 24, 2008).

from 7.6% of GDP in 2000 to 15% of GDP in 2035.¹⁰⁸ Estimates from Social Security and Medicare actuaries are that the projected growth in MA enrollment, as a percent of beneficiaries, will increase from the current 20% to 26% by 2017.¹⁰⁹ Since MA enrollees currently cost Medicare an additional 12%, this enrollment increase may lead to overall Medicare spending being about 3% higher than it otherwise would be,¹¹⁰ especially considering that Medicare actuaries are assuming that the shift to managed care will not lower costs substantially in the long run.¹¹¹ MA expenditures also result in higher premiums charged to traditional Medicare FFS recipients—in 2008, increased spending on MA plans accounted for a large portion of the increase in Part B premiums (roughly \$3 per month)¹¹²—since under current law, a portion of Part B cost increases (25%)¹¹³ must be passed on to recipients in the form of higher premiums.

108. DAVE KOITZ ET AL., CONG. BUDGET OFFICE, A 125-YEAR PICTURE OF THE FEDERAL GOVERNMENT'S SHARE OF THE ECONOMY, 1950 TO 2075, at 2 (2002), available at www.cbo.gov/ftpdocs/35xx/doc3521/125RevisedJuly3.pdf (last visited June 24, 2008).

109. THE BD. OF TRS. 2007, *supra* note 90, at 148 tbl.IV.B6; GRONNIGER & SUNSHINE, *supra* note 83, at 3, 4 fig.1.

110. THE BD. OF TRS. 2007, *supra* note 90, at 126 tbl.IV.A1.

111. *Id.* at 68-69.

112. David Glendinning, *Medicare 2008 Premium Hike Low, but Doctor Pay Remains Unresolved*, 50 AM. MED. NEWS, Oct. 22/29, 2007, at 1, at www.ama-assn.org/amednews/2007/10/22/gvl11022.htm (last visited June 24, 2008).

113. 42 U.S.C. § 1395w-24(b)(1)(C) (Supp. IV 2004); Glendinning, *supra* note 112.

