THE COMMONWEALTH FUND

December 2009

Issue Brief

Medicare Advantage Reforms: Comparing House and Senate Bills

Brian Biles and Grace Arnold

ABSTRACT: The Medicare Advantage (MA) program, which enables Medicare beneficiaries to enjoy private health plan coverage, is a major element of the current health care reform discussion on Capitol Hill—in large part because payments to MA plans in 2009 are expected to run at least $11 billion more than traditional Medicare would have cost. While the pending Senate and House bills both endeavor to reduce these extra MA payments, their approaches are different. The bills also differ on other aspects of reforming the MA program, such as plans' allowable geographic areas, their risk-adjustment systems and reporting requirements, their potential bonuses for achieving high-quality care and providing good management, and their beneficiary protections. This issue brief compares the above and other provisions in the House and Senate bills, which have a common overall goal to improve the value that Medicare obtains for the dollars it spends.

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OVERVIEW

The Medicare Advantage (MA) program, which enables Medicare beneficiaries to enjoy private health plan coverage, is a major element of the current health care reform discussion on Capitol Hill. Because payments to MA plans in 2009 are expected to run at least $11 billion more than traditional Medicare would have cost, such excesses were identified early in the development of health care reform proposals as a possible source of savings that would help make the final legislation deficit-neutral. In the House of Representatives bill, the savings over 10 years are expected to total $170 billion; in the Senate bill, $118 billion.

The Senate and House approaches to reducing MA extra payments, as might be surmised, are markedly different. The House system would base MA plan payments on average Medicare fee-for-service costs in each county. The Senate system would be based on plan bids (reflecting actual plan costs, as opposed to statutorily set rates); payments would reflect the averages of bids, weighted by the numbers of MA plans' enrollees in a state's metropolitan areas and individual rural counties. Both the House and Senate bills would provide additional payments to MA plans that have higher quality-rating scores.

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For more information about this study, please contact:

Brian Biles, M.D., M.P.H.
Department of Health Policy
School of Public Health
and Health Services
The George Washington University
bbiles@gwu.edu

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Commonwealth Fund pub. 1357
Vol. 74

This issue brief analyzes the MA payment policy provisions in the House and Senate bills. In addition, it discusses their other MA provisions, including those related to risk adjustment, beneficiary protections, and Special Needs Plans.

MEDICARE ADVANTAGE PAYMENT POLICY

Since 1971, the basic rationale for including health maintenance organizations (HMOs) and other private plans as options in Medicare has been that they can provide care more efficiently than the unorganized fee-for-service (FFS) health care system.[1] Under policies proposed by the Reagan administration and adopted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare HMOs were paid 95 percent of the projected average costs of traditional FFS Medicare in each county (average adjusted per-capita cost, or AAPCC), with the federal government realizing as savings the remaining 5 percent.

The approach to paying private plans in Medicare was that if they could provide care more efficiently than the AAPCC-based payment rate, they would succeed in attracting enrollees, and if they could not match that rate, they would be unable to compete. The TEFRA policy also required plans with estimated costs below their payment rate to apply that difference toward the provision of additional benefits not available in traditional Medicare—including lower deductibles or copayments. These additional benefits were understood to make enrollment in plans financially attractive to beneficiaries compared with FFS Medicare plus Medigap supplemental coverage—at least with regard to deductibles and coinsurance.

In an effort to encourage more widespread use of private plans in Medicare, the Congress enacted policies to pay private plans more than local FFS costs in 1997, 2003, and 2006. As a result, private MA plans are now paid 114 percent—over $11 billion—more in 2009 than it would have cost the federal government had those 10 million MA enrollees participated in traditional Medicare.[2]

Over the past two years, Barack Obama, first as a presidential candidate and now as president, has consistently stated that these extra payments to Medicare private plans constitute wasteful federal spending and

Exhibit 1. Medicare Advantage Payment Proposals as of November 2009

	House of Representatives (HR 3962)	Senate (HR 3590)
MA Payment	MA payment policy transitions from the current approach to a fee-for-service cost system that pays plans 100 percent of average Medicare FFS costs in each county.	MA payment policy transitions from the current approach to a system that pays plans based on the area-wide average of plan bids, reflecting their actual costs.
Transition to New Payments	Payments transition to the new FFS cost system from 2011 to 2013. In 2011, one-third of the county benchmark will be set at local FFS costs while two-thirds reflect current policy. In 2012, two-thirds of the benchmark are to be set at local FFS costs and one-third reflect current policy. In 2013 and subsequently, local benchmarks will equal FFS Medicare costs in each county.	Payments transition to the plan-bid system from 2011 to 2014. In 2011 only, the MA per-capita-growth percentage will be reduced by 3 percent. In 2012, one-third of the benchmark will be set using the enrollment-weighted area average of plan bids for 2012 and two-thirds reflect current law. In 2013, two-thirds will be set using the enrollment-weighted area average of plan bids for 2013 and one-third of the benchmark reflect current law. In 2014, the benchmark will be set using enrollment-weighted area average of plan bids from the previous year, increased by the per-capita-growth percentage. In 2015 and subsequently, the benchmark will be set using enrollment-weighted area average of plan bids for the current year. Benchmarks based on the weighted average of plan bids may not exceed benchmarks provided under the current law's formula.
Rebates	No provision.	Plans receive rebates equal to 100 percent of the difference between their plan costs and the benchmark, beginning in 2014. Rebates must be used to provide extra benefits. Plans with costs above the benchmark must charge enrollees an additional premium for benefits.

should be eliminated.[3] Members of Congress have made similar observations in recent years.

Thus, provisions that would reduce or eliminate extra payments to MA plans have been included both in the House bill and Senate bills (Exhibit 1), and they serve not only to correct the current policy but also to provide a source of savings that would help offset the costs of expanded health insurance coverage and other health care reform initiatives.

The current method of setting payment rates for MA plans involves a benchmark rate for each county (set by law) and a bid amount, submitted by each plan, that represents the expected cost of providing basic Medicare benefits to its enrollees. A plan with a bid less than the benchmark rate for the area it serves receives a payment rate equal to its bid plus a "rebate" equal to 75 percent of the difference between the benchmark rate and its bid; the plan must provide additional benefits equal in value to the rebate amount. A plan with a bid greater than the benchmark rate for the area it serves must charge beneficiaries a premium equal to the difference between its bid and the benchmark rate.

The House bill would set MA benchmark rates at 100 percent of FFS costs in each county and thus would pay plans approximately 100 percent of county FFS costs throughout the United States. This approach, supported by the Medicare Payment Advisory Commission (MedPAC),[4] is projected by the Congressional Budget Office (CBO) to reduce federal spending by $154 billion over 10 years (2010–2019).[5]

The Senate bill would base the calculation of MA benchmarks on actual plan costs, as reflected in plan bids, rather than on statutorily set rates.[6] MA plan bids in 2009 are estimated by MedPAC staff to average 101 percent of FFS costs nationwide, but because MA plans' efficiency relative to local FFS costs varies greatly across the nation, this provision would set plan-payment rates in some areas above the local average FFS costs and in other areas pay plans less than those local averages.[7] The Senate bill also changes the rebate for each plan to 100 percent of the difference between the benchmark rate and the plan's bid. CBO estimates that this approach would save the federal government $118 billion over 10 years.[8]

One concern about the modification of MA payment rates is that people who are enrolled in MA plans (almost 25 percent of all Medicare beneficiaries in 2009) might lose some or all of the additional benefits that are currently funded by the extra payments that plans receive.[9] CBO projects that the House provision would decrease these additional benefits by about 60 percent by 2019, with substantial variation across areas depending on their FFS costs, while the Senate provision would essentially eliminate additional benefits.[10]

GEOGRAPHIC UNIT OF PAYMENT

While payments to MA plans have been determined at the county level since 1982, such plans are often available in geographic areas that include (at least parts of) multiple counties. As a result, MedPAC and others have suggested expanding MA payment areas to such broader geographic areas, which could more accurately reflect the markets in which MA plans operate.

Thus the House bill, though it retains the county-based system of payments, directs the secretary of Health and Human Services (HHS) to study the effects of paying plans based on larger geographic units. The Senate bill changes the MA geographic payment unit to core-based statistical areas (CBSAs).* Plans in rural areas not included in a CBSA would be paid the enrollee-weighted average of plan bids at the county level (Exhibit 2).

The major consideration in determining the appropriate definition of payment areas involves a tradeoff: the desire to establish uniform payment rates across a given market area (such as the Washington, D.C. metropolitan area) versus the recognition that utilization and spending patterns vary substantially across

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* These areas include metropolitan and micropolitan areas. Metro areas have a core urban area of at least 50,000 people, while micro areas have a core urban area of 5,000–10,000 people. Outlying counties included in the CBSA are determined by of the degree to which the outlying county population commutes to the core area.
Source: U.S. Bureau of Labor Statistics

Exhibit 2. Geographic Unit of Medicare Advantage Plan Payment

	House of Representatives (HR 3962)	Senate (HR 3590)
Geographic Unit of Payment	The secretary of HHS is directed to study the effects of calculating MA benchmarks on a broader geographic basis within one year of the law's enactment.	Payments in urban areas change to a system of multi-county core-based statistical areas (CBSAs). Benchmarks, bids, and payments continue to be made at the county level in rural areas. CBSA-based payments do not cross state lines. Beginning in 2012, payments in urban areas will be made by CBSAs within a state. Beginning in 2012, bidding and service areas will be the same. Plans will be allowed to choose which payment areas they would like to serve, and in each case they must serve the entire area. The secretary is granted authority to adjust payment areas based on actual health care use and may make limited exceptions to plans with historical licensing agreements or historical capacity limits that preclude them from serving an entire payment area.

the counties of a metropolitan area (such as between the District of Columbia, Maryland's Prince George's County, and Virginia's Arlington County). If the same rate were paid across all of the counties in a given metropolitan area, plans could pursue various policies to encourage enrollment in low-cost areas while discouraging enrollment in high-cost areas.

RISK ADJUSTMENT, OTHER ADJUSTMENTS, AND REPORTING REQUIREMENTS

MA payments are risk-adjusted to account for the health status of enrollees, but the current risk-adjustment system slightly overpays for low-cost healthy enrollees and significantly underpays for high-cost sick enrollees.[11] Because MA plans have perennially resisted providing additional data to the Centers for Medicare and Medicaid Services (CMS) that might improve the risk-adjustment system, the House bill includes a provision that directs the secretary of Health and Human Services to update the MA risk-adjustment mechanism.

MA benchmarks are adjusted for differences in care utilization that result from MA plans' extra benefits and "aggressive coding." Coding adjustments, though allowed under the Deficit Reduction Act of 2005, had not been made prior to 2009, and the secretary's current authority to adjust for coding intensity expires in 2010. Both the House and Senate bills extend or modify this authority. This provision is expected to save $15.5 billion in the House bill and $1.9 billion in the Senate bill over 10 years.

In addition, the Government Accountability Office has reported that CMS's current authority to conduct audits is not adequate.[12] The House bill increases the secretary's audit authority.

The House bill also expands the secretary's authority and requirements to report plans' medical loss ratios (MLRs). While MLR data is available to analysts because it is reported to the states and the Securities and Exchange Commission, it is not readily available to beneficiaries during open-enrollment periods. The House bill penalizes plans with MLRs lower than 85 percent by forbidding them to enroll new beneficiaries. If a plan has an MLR lower that 85 percent for five consecutive years, the secretary can disallow the plan from participating in the program.

Exhibit 3 summarizes the above and other proposed changes.

Exhibit 3. Medicare Advantage Payment Process

	House of Representatives (HR 3962)	Senate (HR 3590)
Plan Bid Process	No provision.	Plan bids, reflecting their costs, must be certified by a member of the American Academy of Actuaries (beginning in 2012). The secretary of HHS retains current authority to review, reject, and negotiate plan bids and to set actuarial standards for bids (beginning in 2012). The secretary is required to report plan actuaries who repeatedly do not comply with bidding rules and standards to the Actuarial Standards Board (beginning in 2012). In areas where only one plan is offered, its costs will be paid (the bid will equal the benchmark). In areas where no plans are offered the previous year and multiple plans are offered the next year, the benchmark is a simple average of plan bids. Benchmarks do not include the costs of regional, PACE, or 1876 cost plans.
Grandfathering of Benefits in Low-Bid Areas	No provision.	Beginning in 2012, plans will be able to grandfather extra benefits at the 2011 levels for enrollees in areas where average plan bids are at or below 75 percent of local FFS costs. Plans choosing to grandfather benefits can only offer them to the enrollees enrolled when legislation is enacted. Plans submit one bid for all enrollees. Plans with grandfathered enrollees receive rebates equal to the value of those enrollees' 2011 benefits. Extra benefits in grandfathered plans will be reduced by 5 percent each year, beginning in 2013. Quality or bonus payments will not be available to enrollees with grandfathered benefits. Bidding and risk adjustment occur as if there were no grandfathering policy, except that differences in utilization due to extra benefits—of up to 0.5 percent of the benchmark—can be factored into the risk adjustments.
Transitional Benefits	No provision.	Beginning in 2012, the secretary is required to provide transitional benefits to certain enrollees if they would experience a significant reduction in benefits. These enrollees include: • Individuals in the country's two largest metropolitan areas (New York and Los Angeles) if extra benefits are greater than $100 per member per month. • People in plans where the 2011 benchmark is the legacy urban floor, MA penetration is greater than 30 percent, and MA plan bids are below local FFS costs. • Plan members in counties that are contiguous to counties previously described, as determined by the secretary. The total funds available for transitional benefits would be $5 billion through 2019.
Risk Adjustment	The secretary is directed to evaluate the MA risk-adjustment system and report the findings to Congress within one year of enactment. Changes to the risk-adjustment system recommended by the secretary will be implemented by January 1, 2012.	No provision.

Exhibit 3. Medicare Advantage Payment Process

	House of Representatives (HR 3962)	Senate (HR 3590)
Coding Intensity	The secretary is given permanent authority to adjust payments for coding intensity.	Authority to adjust payments for coding intensity is extended through 2013. The secretary is allowed to incorporate coding intensity adjustments into risk adjustments beginning in 2014.
Audit Authority	The secretary is authorized to take action, including financial recovery, if overpayments to plans are discovered in audits beginning in 2011.	No provision.
Authority to Deny Plan Bids	The secretary is granted authority to deny plan bids beginning in 2011.	No provision.
Medical Loss Ratios	Beginning in 2011, the secretary is required to publish each plan's medical loss ratio. Beginning in 2012, the secretary, in consultation with the Health Choices commissioner, will establish standards for MLR reporting. Beginning in 2014, plans with MLRs lower than 85 percent must give the excess loss (below 85 percent) back to enrollees as a rebate premium the following year. Plans with MLR lower than 85 percent are not allowed to enroll new beneficiaries for three years. The secretary is given the authority to terminate the contracts of plans with MLRs below 85 percent for five consecutive years.	No provision.

BONUSES FOR QUALITY AND MANAGEMENT

Medicare Advantage plans vary in the quality of services and care provided to their members. Currently, CMS uses a composite of the scores of the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the Medicare Health Outcomes Survey (HOS) in order to determine a star rating for plans, with five stars representing the highest quality and one star the lowest.

MedPAC has indicated that measures of the quality of care provided by MA providers need to be improved, as they differ in comparison with other types of plans and also with FFS Medicare. In addition, MedPAC has recommended that MA plan payments should reflect plan performance on quality measures. If quality-related payments are indeed used to provide additional benefits to plan enrollees, plans with higher-quality scores could prove more attractive. As shown in Exhibit 4, both the House and Senate bills include provisions to improve quality measures and offer bonus payments based on plan performance.

Exhibit 4. Quality Measures and Bonuses

	House of Representatives (HR 3962)	Senate (HR 3590)
Quality Measures	Quality measures, determined by the secretary of HHS, are based on a star system that reflects a composite of HEDIS, CAHPS, and other clinical quality scores. The secretary is directed to report on the following as well: • admission and readmission rates • prevention quality (i.e., measures established by AHRQ) • patient morbidity and mortality following surgery • measures of health, functioning, and survival of chronic-disease patients. • patient safety • other outcomes and quality-of-life measures. The secretary is given the authority to determine when and how the transition to new quality measures would occur.	Quality measures are determined by the secretary, who is given the authority to determine whether a five-star or other scale is appropriate. Quality measures are demographic and health status-adjusted. Bonuses must be used to provide additional benefits to enrollees. Plans can receive a maximum of 6 percent of U.S. per capita costs of Medicare (USPCC) in bonuses. The secretary may convert low-enrollment plans not otherwise eligible for bonuses into eligible plans, based on the regional or local-plan quality mean.
Care Coordination and Management Bonuses	No provision.	Plans are eligible for bonuses of 0.5 percent of USPCC per activity, with a maximum of 2 percent, for offering any of the following eight care, coordination, and management activities beginning in 2014: • chronic-care management • patient education and disease self-management • transitional care interventions to coordinate care around a hospital inpatient episode • patient safety • financial policies to promote care coordination by primary care providers • medication management • health information technology • programs that address health disparities.
Quality Bonuses	Plans rated with four or more stars are eligible for quality bonuses of 1.5 percent of the benchmark in 2011, 3.0 percent in 2012, and 5 percent in 2013 and beyond. Only plans offered in counties with the lowest one-third of FFS costs, and with at least 20 percent of Medicare beneficiaries enrolled in an MA plan, are eligible for bonuses. Beginning in 2010, the secretary notifies plans if they are eligible for bonuses in the coming year.	Plans are eligible to receive a 4-percent bonus if they achieve a four- or five-star rating. Plans are eligible to receive a 2-percent bonus if they achieve a three-star rating (beginning in 2014). Plans are eligible to receive a 1-percent bonus if their rating is below three stars and their rating improves form the previous year (beginning in 2014). New plans are eligible for a 2-percent bonus if they have certain structural measures of quality and network adequacy (beginning in 2014).

BENEFICIARY PROTECTIONS AND ENROLLMENT-PROCESS SIMPLIFICATION

MA plans have an incentive to enroll healthier individuals, given that the MA risk-adjustment system slightly overpays for healthy beneficiaries and underpays considerably for high-cost beneficiaries. Some MA plans may design out-of-pocket costs for benefits in ways that could discourage the enrollment of high-cost beneficiaries. In response, both the House and Senate bills include provisions to limit MA plan out-of-pocket costs for enrollees who use health services, especially high-cost services (Exhibit 5).

The health insurance open-enrollment periods in the Federal Employees Health Benefits Program and also in many other employee plans occur in the late fall. The House and Senate bills reduce the MA annual open-enrollment period to six or seven weeks each fall and eliminate a current open-enrollment period in January through March.

State insurance commissioners have documented marketing and advertising abuses by MA plans.[13] The House bill explicitly allows states to investigate and enforce federal MA marketing requirements.

Exhibit 5. Beneficiary Protections and Enrollment-Process Simplification

	House of Representatives (HR 3962)	Senate (HR 3590)
Benefits, Cost-Sharing, and Out–of-Pocket Costs	Beginning in 2011, MA plans must not impose a cost-sharing regime for traditional Medicare benefits that imposes higher beneficiary costs than the cost-sharing system for the same benefits in FFS Medicare. Cost-sharing is allowed to take the form of coinsurance, copayments, or per-diem rates, provided the cost-sharing does not exceed that of FFS Medicare. "Actuarially equivalent" cost-sharing is not allowed. Plans must not impose on dually eligible or qualified Medicare beneficiaries cost-sharing that is greater than the cost-sharing the enrollee would face if enrolled in his or her state's Medicaid.	Beginning in 2011, cost-sharing greater than in FFS Medicare is prohibited for selected services such as chemotherapy, renal dialysis, and skilled nursing care. The secretary has authority to identify the services to be included in this provision. Cost-sharing includes copayments, coinsurance, deductibles, and out-of-pocket caps on total beneficiary spending. Plans are permitted to charge cost-sharing for Medicare-covered services when FFS Medicare does not charge cost-sharing. Any out-of-pocket spending limits must apply to all Part A and B benefits with no exclusions. Beginning in 2012, plans must spend their rebates, premiums, and bonuses by first providing a "meaningful reduction" in Part A, B, and D cost-sharing. Plans must use the next share of rebates to add preventive and wellness benefits, and plans may use any remaining share to add benefits not covered by FFS Medicare. The current authority to reduce the Part B premium as an additional benefit is eliminated. Beginning in 2011, the secretary is required to categorize plans according to the share that rebates, bonuses, and supplemental premiums represent in each plan's bid. Any marketing materials must reflect the plan's category, such gold, silver, or bronze. Plans are required to develop uniform exceptions and appeals processes by 2012. The secretary is required to: develop and maintain a complaint-tracking system—regarding complaints originated by MA and Part D enrollees—through resolution; and produce associated reports.
Annual Enrollment Process	Beginning in 2011, the annual enrollment period changes to November 1 to December 15. The three-month additional enrollment period, from January 1 to March 31, is eliminated. If enrollment in a plan is suspended, enrollees are allowed to opt out of the plan at any time and return to FFS Medicare. The secretary has the authority to allow enrollees in exceptional circumstances to change plans at any time.	Beginning in 2012, the annual enrollment period changes to October 15 to December 7. The three-month additional enrollment period is eliminated. Enrollees have 45 days (January 1 to February 15) to disenroll from the MA program and return to FFS Medicare.
State Enforcement of Marketing Requirements	States are allowed to enforce federal marketing requirements for MA plans and recommend further sanctions to the secretary. Plans may not be penalized twice for the same violation.	No provision.

SPECIAL NEEDS PLANS AND COST-BASED PLANS

MA Special Needs Plans (SNPs), which were established by the Medicare Modernization Act of 2003 (MMA), are extended and modified under both the House and Senate bills, as shown in Exhibit 6. The Senate bill provides for SNP payments to be set by its bid-based mechanism (described above, but the bill does not allow a SNP to charge premiums to enrollees if its bid is above the benchmark.

Employer-sponsored group plans now operate under broad waiver authority included in the MMA. The House bill limits employer-sponsored MA plans in the following way: 90 percent of the MA-eligible individuals enrolled in the plan must reside in a county in which the MA organization offers a local MA plan. The Senate bill provides that the network requirement for

Exhibit 6. Special Medicare Advantage Plans

	House of Representatives (HR 3962)	Senate (HR 3590)
Program of All-Inclusive Care for the Elderly (PACE) Plans	PACE plans are exempt from payment reductions. Benchmarks and payments follow current law.	PACE plans are exempt from the changes to MA benchmarks beginning in 2012. PACE plans are paid in accordance with the new CBSA-based geographic unit of payment.
Special Needs Individuals	Authorization for SNP plans is extended until January 1, 2013—or until January 1, 2016, for grandfathered plans, which are those that had contracts with state Medicaid agencies for "demonstrations serving those dually eligible for Medicare and Medicaid" and that have a current contract with a state Medicaid agency. Beginning in 2011, SNP enrollment is limited to the annual enrollment period or to when the beneficiary is first diagnosed with a disease or condition that qualifies him or her for a SNP. The secretary is directed to evaluate and report to Congress on the impact of SNP plans on cost, quality of care, patient satisfaction, and other subjects by December 31, 2011.	Authorization for SNP plans is extended through December 31, 2013. Starting in January 1, 2010, and by January 1, 2013, SNP plans must have only those beneficiaries enrolled that meet the definition for its type of SNP. By 2013, enrollees in plans that do not meet the definition established for a SNP plan will be transitioned to a non-SNP MA plan or to FFS Medicare. Exceptions are made for individuals who are no longer eligible for Title XIX medical assistance. By January 1, 2013, all dual-eligible SNPs will need to have contracts in place with state Medicaid programs in order to serve dual-eligibles. All plan payment changes will apply to SNPs, though they may not be able to charge premiums if their bids exceed the new benchmark. SNPs that are fully integrated under Titles 18 and 19 of the Social Security Act are eligible to receive frailty adjustments similar to those used for PACE plans. In 2011 and periodically afterward, the secretary must create a new budget-neutral risk adjustment for SNPs to replace the default risk score of other MA plans. Beginning in 2013, SNPs must be certified by the NCQA.
Reasonable Cost Contract Plans	Authority for reasonable cost contract plans is extended until January 1, 2012. The meaning of "service area" is clarified.	Authority for reasonable-cost contract plans is extended until January 1, 2013, regardless of any other MA plans serving the area.
Private Fee-For-Service Plans	No provision.	When specifying areas where PFFS must establish contracts, "network area" is defined as on that is served by two or more MA organizations.
Erickson Demonstrations	A Medicare Senior Housing program is created. Entities that qualify to offer Senior Housing program plans include those that offered a plan under the Erickson demonstration to individuals residing in continuing care communities (which provide onsite primary care services, offer transportation to providers outside the facility, and use health information technology). Payments to these plans are capped at either current MA payments or the cost of caring for the same enrollees under FFS Medicare, whichever is greater.	Beginning in 2011, Erickson demonstration plans are allowed to become a type of SNP if they serve beneficiaries who reside in continuous care environments, have a sufficient number of on-site primary care providers (as determined by the secretary), supply transportation benefits to other providers, and have been in existence under a demonstration for at least one year.
Employer Group Plans	The authorization for waivers for employer-sponsored group plans that offer coverage outside their service area is limited as follows: 90 percent of the MA-eligible individuals enrolled in the plan must reside in a county in which the MA organization offers a local MA plan.	The secretary may waive private FFS network requirements for employer-sponsored private FFS plans in a manner similar to the waiver of requirements for employer-sponsored coordinated care plans.

employer-sponsored private-fee-for-service plans may be waived in a manner similar to the waiver of requirements for employer-sponsored coordinated-care plans. Provisions in both bills also deal with other types of plans, such as reasonable-cost contract plans.

The bills contain several other provisions that affect special MA plans, including Program of All-Inclusive Care for the Elderly (PACE) plans—which are intended to help keep frail elders in the community and out of nursing homes—and plans that provide on-site health care for residents of continuing-care communities.

MA private fee-for-service (PFFS) plans are MA plans authorized to operate without contracts with physicians and other providers. The Medicare Improvements for Patients and Providers Act of 2008 requires PFFS plans in counties with other MA plans to establish provider networks by 2011. The Senate bill clarifies that such counties are those with two or more MA organizations. It also allows waiver of these provider-network requirements for employer PFFS plans.

CONCLUSIONS

Although the House and Senate bills take somewhat different approaches to changing the MA program, they both attempt to achieve the same goal of eliminating the extra payments to private plans. They are motivated by the fact that these monetary supplements presently increase Medicare spending, provide additional benefits to some but not all beneficiaries, and diminish the incentive for private plans to provide care more efficiently than traditional Medicare—the original purpose of including private plans as an option for Medicare beneficiaries. These bills' common strategy is to encourage MA plans to provide coordinated care for their enrollees more efficiently and effectively than could be provided under the traditional Medicare program, with its reliance on fee-for-service payment. While the specifics of the bills differ, they both intend to improve the value that Medicare obtains for the dollars it spends.

Notes

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About the Authors

Brian Biles, M.D., M.P.H., is a professor in the Department of Health Policy in the School of Public Health and Health Services at The George Washington University. He served for five years as the senior vice president of The Commonwealth Fund and for seven years as staff director of the Subcommittee on Health of the House Ways and Means Committee. Dr. Biles received his medical degree from the University of Kansas and his master's degree in public health from the Johns Hopkins Bloomberg School of Public Health. He can be e-mailed at bbiles@gwu.edu.

Grace Arnold is a research assistant in the Department of Health Policy at George Washington University. She previously worked at Oregon Health and Science University researching Parkinson's disease and amyotrophic lateral sclerosis (ALS). Ms. Arnold has an undergraduate degree in biology from Macalester College.

Editorial support was provided by Steven J. Marcus.

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