

**MEDICARE OVERPAYMENTS TO PRIVATE PLANS,
1985–2012: SHIFTING SENIORS TO PRIVATE PLANS
HAS ALREADY COST MEDICARE US\$282.6 BILLION**

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Previous research has documented Medicare overpayments to the private Medicare Advantage (MA) plans that compete with traditional fee-for-service Medicare. This research has assessed individual categories of overpayment for, at most, a few years. However, no study has calculated the total overpayments to private plans since the program's inception. Prior to 2004, selective enrollment of healthier seniors was the major source of excess payments. We estimate this has added US\$41 billion to Medicare's costs since 1985. Medicare adopted a risk-adjustment scheme in 2004, but this has not curbed private plans' ability to game the payment system. This has added US\$122.5 billion to Medicare's costs since 2004. Congress mandated increased payment to private plans in the 2003 Medicare Modernization Act, which was mitigated, to a degree, by the subsequent Affordable Care Act. In total, we find that Medicare has overpaid private insurers by US\$282.6 billion since 1985. Risk adjustment does not work in for-profit MA plans, which have a financial incentive, the data, and the ingenuity to game whatever system Medicare devises. It is time to end Medicare's costly experiment with privatization. The U.S. needs to adopt a single-payer national health insurance program with effective methods for controlling costs.

Commercial health insurance companies have been allowed to market private Medicare plans for 36 years, more than two-thirds of the duration of the program's existence. The number of enrollees in such plans, now known as Medicare Advantage (MA) plans, has grown rapidly in recent years (Figure 1).

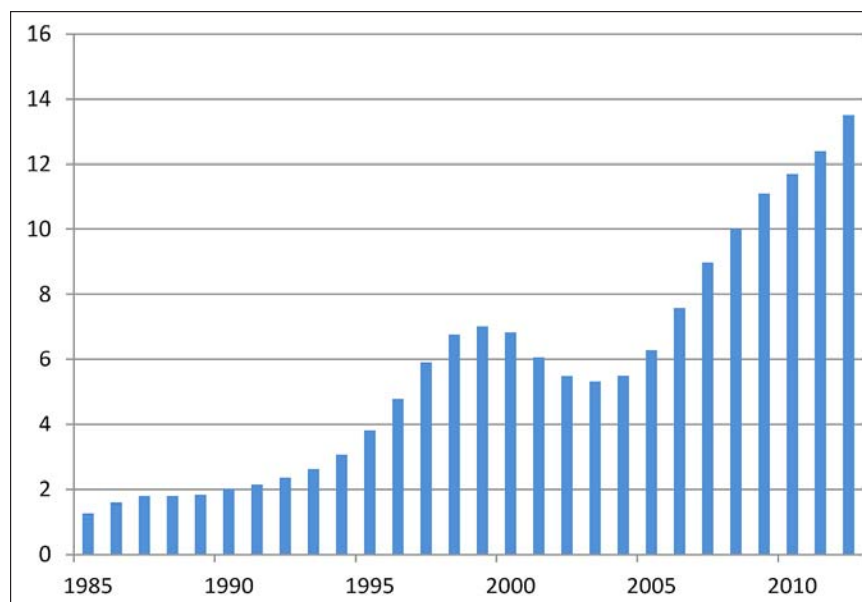


Figure 1. Medicare Advantage enrollment, 1985–2012 (in millions). *Source:* Centers for Medicare & Medicaid Services.

As of mid-2012, 27 percent of all Medicare beneficiaries, or 13.5 million people, are enrolled in private MA plans. This year, private plans participating in Medicare will receive an estimated \$136.2 billion (all dollar amounts in U.S. dollars) from Medicare, or \$10,123 per enrollee (1). This money is drawn from Medicare Part A (the Hospital Insurance Trust Fund) and Medicare Part B, which in turn are funded primarily by a combination of general revenues, payroll tax contributions, and beneficiary premiums.

While there are 3,300 MA plans, two for-profit firms (United Health and Humana) enroll about one-third of all Medicare beneficiaries in private plans.

Numerous studies have found that private plans raise Medicare's costs, that is, Medicare pays private insurers more in premiums than the MA enrollees would have cost had they stayed in traditional (fee-for-service [FFS]) Medicare (2–10). However, private insurers have wielded sufficient political power over the years to resist most calls to end the overpayment—including advice from the Medicare Payment Advisory Commission (MedPAC) in 2001, 2002, 2004, and 2005.

The 2010 Affordable Care Act (ACA) changed the formula Medicare uses to pay the private plans to reduce their overpayment. This change accounts for \$145 billion of the \$716 billion in Medicare savings projected over the next decade under the ACA. The issue turned into a political football in the 2012 presidential election.

However, implementation of the ACA's payment reductions has already been undermined by an \$8.35 billion demonstration project funded by the Centers for Medicare and Medicaid Services (CMS) that was intended to reward MA plans that provide particularly high-quality care but, instead, has awarded bonus payments to virtually all MA plans (11). These bonuses will offset more than one-third of the ACA's payment reductions between 2012 and 2014. Private Medicare plan enrollment has grown dramatically since the passage of the ACA, indicating that private Medicare plans remain highly profitable.

In this report, we review existing evidence on the Medicare overpayment to private plans and calculate an overall estimate of the cost of such private plans to the taxpayers since 1985.

HOW DOES MEDICARE OVERPAY PRIVATE PLANS?

Medicare pays each private plan a fixed amount for each Medicare beneficiary who chooses to enroll in a private plan. The formula for determining this amount has changed several times over the past three decades, but MA plans have adapted to each change and have continued to take advantage of overpayments in new ways. Private plans are responsible for covering all care that would be covered by the traditional Medicare program and may offer additional benefits, such as free eyeglasses.

The categories of systematic overpayment to private plans include:

1. The selective enrollment of healthier beneficiaries before 2004, or what we will call "old cherry-picking" (2–6). Under the payment formula in effect until 2004, Medicare paid private plans a premium that was risk-adjusted only for a few demographic factors, such as age, gender, disability, whether an enrollee resided in a nursing home, and Medicaid eligibility (a proxy for poverty). Hence a healthy 70-year-old man would bring the same premium as his sicker, 70-year-old neighbor. Private plans used marketing, benefit design, enrollment office location, and other techniques to recruit the healthy and discourage sicker seniors from enrolling.
2. Gaming of Medicare's more complex risk-adjustment scheme, known as Hierarchical Condition Categories (HCCs) (12, 13). Since 2004, private plans have been selectively enrolling beneficiaries with very mild cases of the medical conditions included in the HCC risk-adjustment formula; such patients have, on average, substantially lower costs than the risk-adjusted premium payment that Medicare pays the private plan on their behalf. We refer to this as "new cherry-picking."
3. Congressionally-mandated overpayments included in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA), including duplicate payments for indirect medical education (8–10). The

provisions that generated this overpayment were tacked onto the MMA after heavy lobbying by the private insurance industry.

4. Bonus payments from the \$8.35 billion CMS Medicare Advantage Quality Bonus Payment Demonstration, an expansion of the \$3 billion in quality bonuses contained in the ACA. This demonstration will award bonuses to plans covering more than 90 percent of MA beneficiaries and offset more than one-third of the cuts to MA overpayments mandated by the ACA between 2012 and 2014. According to the General Accountability Office (GAO), the demonstration is so poorly designed that it will generate almost no useful findings to improve quality (5).
5. Duplicate payments for private plan members who receive all or part of their care at Veterans Health Administration (VA) facilities (14–16). Medicare pays the private plan a full premium payment, no matter how much of the patient’s care is delivered (and paid for) by the VA. In an extreme case, a senior might receive all care at the VA, making the premium given to the private plan pure profit. In 2009, 8.3 percent of all MA enrollees were enrolled in the VA.

Private plans also garner overpayments through “upcoding,” or the practice of intensively recording additional diagnoses in enrollees’ charts, making them appear sicker than similarly ill patients in traditional Medicare. Although this might be considered a sixth category of overpayments, CMS is aware of the problem and has started applying a fixed adjustment for it, reducing MA payments by \$2.7 billion in 2010 (17). Although a recent report by the GAO suggests that CMS is continuing to overpay private plans by \$1 billion to \$2 billion, we conservatively excluded “upcoding” from our calculations and focused on the five categories of overpayments above.

CALCULATING THE TOTAL MEDICARE OVERPAYMENT TO PRIVATE PLANS

Although MedPAC, the GAO, the Congressional Budget Office, and researchers with The Commonwealth Fund, Urban Institute, and VA have published figures for individual categories of overpayment private plans (generally for a single year), no previous study has compiled all the sources of overpayments since the beginning of the program.

To calculate total annual spending on private Medicare plans, we obtained figures on Medicare Part A and Part B contributions to private plan premiums between 1966 and 2012 from the CMS’ Office of the Actuary, Medicare and Medicaid Cost Estimates Group. We excluded the period between 1966 and 1979 when Medicare Part A spent nothing on private plans and the period between

1980 and 1984 when total Medicare spending for private plans (from Part A and Part B) was under \$1 billion.

We used published research on Medicare overpayments for each of the five categories of overpayment to calculate excess Medicare spending (in each category) on private plans as a share of total spending on private plans for each year since 1985. Where overpayments were estimated as a share of “Medicare FFS payments,” we used data on annual Medicare spending on private plans (which is generally similar and readily available) as a proxy.

Most studies analyzed Medicare overpayments using data from a single year (the “data year”) or a few years. For years before and after the data year analyzed, we estimated each category of overpayment based on percentage figures (carried forward or backward) for the closest data year for which estimates were available, then adjusted for temporal changes in total Medicare spending for private plans. Figures are reported in current dollars, that is, actual dollar costs in the year the spending was incurred.

We calculated total Medicare overpayments to private insurers since 1985 by summing overpayments in the five categories using the sources described below:

1. A large body of research demonstrates that private plans selectively enroll healthier beneficiaries. Estimates of overpayments due to “old cherry-picking” prior to 2004 range from 5.7 percent to 74 percent above what it would have cost to care for similar beneficiaries in FFS Medicare (2, 6). We used three conservative, widely-cited estimates for our study: an estimate of 5.7 percent using 1992 data by Brown and colleagues for Mathematica; a peer-reviewed estimate by Riley and colleagues of 12 percent overpayment using 1994 data; and an estimate by the GAO of 13.2 percent overpayment using 1998 data (2, 3). We conservatively excluded studies with higher estimates, including a peer-reviewed 1997 study that suggested overpayments due to selective enrollment were 34 percent and a 1996 study by the Physician Payment Review Commission that suggested overpayments were 37 percent (4, 7). (Both also found that private plans selectively dis-enroll sicker beneficiaries, which would further increase plans’ overpayment.) Using the three studies cited above, we calculated the amount of the overpayment from the figure for the data year(s) given and the years surrounding it, using the lowest and earliest figure (5.7 percent, 1992 data year) to estimate overpayments back to 1985.
2. We used research by MedPAC to estimate overpayments from 2004 to 2012 related to “new cherry-picking,” or gaming the complex risk-adjustment scheme. A 2012 MedPAC report using 2007–2008 data found that Medicare beneficiaries who subsequently switch to private plans have 15 percent lower costs than other beneficiaries with a similar risk score. (MedPAC also found that beneficiaries who leave MA plans to return to

traditional Medicare have 16 percent higher costs than beneficiaries who stayed in traditional Medicare, a strategy that might be described as “cherry-picking and spitting out the pits.”) A National Bureau of Economic Research study estimates overpayments of \$15 billion to MA plans in 2006 from risk selection and overpayments mandated by the MMA, or a 23.2 percent combined overpayment (13). We used the published MedPAC figure of 15 percent since it was limited to risk selection, but note that the National Bureau of Economic Research figure is similar (subtracting the 11.2% share of mandated overpayments would leave a 12% overpayment from “new cherry-picking” in 2006).

- 3 and 4. We obtained figures on overpayments mandated by the MMA from two sources. For years between 2003 and 2008, we used research conducted by Brian Biles and colleagues for the Commonwealth Fund (9). For the years 2009 to 2012, estimates of the mandated overpayment were available from MedPAC’s annual reports on the MA program (10). MedPAC (appropriately) adjusted its 2012 figure to account for reductions contained in the ACA and the fourth category of overpayment, demonstration project quality bonuses, which partially offset the ACA reductions.
5. Medicare overpayments for dually eligible VA patients enrolled in private plans have been known to exist for decades. However, they have only recently been quantified by Trivedi and colleagues at a national level (14). We calculated overpayments from this source using figures on total VA spending on care for MA enrollees from 2004 to 2009 as a share of total MA spending during that period.

RESULTS

Table 1 displays each category of Medicare overpayment to private plans as a percentage of total Medicare payments to private plans for each year since 1985. Overpayments attributable to “old cherry-picking” ranged from 5.7 percent to 13.2 percent annually between 1985 and 2004. “New cherry-picking” since 2004 generated annual overpayments of 15 percent of total spending on private plans. Overpayments mandated by Congress rose from 9.9 percent in 2004 to 12 percent in 2010 and then fell to 7 percent in 2012. Overpayments related to care for Medicare private plans’ enrollees delivered (and paid for) by the VA were 3 percent annually.

The dollar amounts of overpayments for each category are shown in Table 2. Overpayments nearly doubled with the implementation of the MMA, rising from \$6 billion in 2003 to \$11 billion in 2004. Prior to 2004, overpayments peaked at \$6.4 billion in 2000. The total overpayment was highest in 2009 at \$36.2 billion, just before passage of the ACA.

In 2012, the total Medicare overpayment to private plans was \$34.1 billion, 25 percent of all payments to private plans, or \$2,526 per MA enrollee.

Table 1

Medicare overpayments to private plans as a percentage of fee-for-service payments by category, 1985–2012

Year	Old cherry-picking	New cherry-picking ^d	Congressionally-mandated overpayments	Care delivery by VA to private plan enrollees	Total percentage overpayments
1985	5.7 ^a	NA	NA	3.0	8.7
1986	5.7 ^a	NA	NA	3.0	8.7
1987	5.7 ^a	NA	NA	3.0	8.7
1988	5.7 ^a	NA	NA	3.0	8.7
1989	5.7 ^a	NA	NA	3.0	8.7
1990	5.7 ^a	NA	NA	3.0	8.7
1991	5.7 ^a	NA	NA	3.0	8.7
1992	5.7 ^a	NA	NA	3.0	8.7
1993	5.7 ^a	NA	NA	3.0	8.7
1994	12.0 ^b	NA	NA	3.0	15.0
1995	12.0 ^b	NA	NA	3.0	15.0
1996	12.0 ^b	NA	NA	3.0	15.0
1997	12.0 ^b	NA	NA	3.0	15.0
1998	13.2 ^c	NA	NA	3.0	16.2
1999	13.2 ^c	NA	NA	3.0	16.2
2000	13.2 ^c	NA	NA	3.0	16.2
2001	13.2 ^c	NA	NA	3.0	16.2
2002	13.2 ^c	NA	NA	3.0	16.2
2003	13.2 ^c	NA	NA	3.0	16.2
2004	NA	15.0	9.9 ^e	3.0	27.9
2005	NA	15.0	11.1 ^e	3.0	29.1
2006	NA	15.0	11.2 ^e	3.0	29.2
2007	NA	15.0	10.1 ^e	3.0	28.1
2008	NA	15.0	8.6 ^e	3.0	26.6
2009	NA	15.0	14.0 ^f	3.0	32.0
2010	NA	15.0	12.0 ^g	3.0	30.0
2011	NA	15.0	10.0 ^h	3.0	28.0
2012	NA	15.0	7.0 ⁱ	3.0	25.0

^aBrown et al., 1993.

^bRiley et al., 1996.

^cGeneral Accounting Office, 2000.

^dMedPAC June 2012, page 101.

^eBiles et al., Commonwealth Fund, 2009.

^fMedPAC, 2009.

^gMedPAC, 2010.

^hMedPAC, 2011.

ⁱMedPAC, 2012.

^jTrivedi et al., 2012.

Table 2

Medicare overpayments to private plans by category, 1985–2012
(in billions of dollars)

Year	Old cherry- picking	New cherry- picking	Congressionally- mandated overpayments	Care delivery by VA to private plan enrollees	Total overpayments
1985	0.1	NA	NA	0.0	0.1
1986	0.1	NA	NA	0.1	0.2
1987	0.2	NA	NA	0.1	0.3
1988	0.2	NA	NA	0.1	0.3
1989	0.3	NA	NA	0.1	0.4
1990	0.3	NA	NA	0.2	0.5
1991	0.4	NA	NA	0.2	0.5
1992	0.4	NA	NA	0.2	0.7
1993	0.5	NA	NA	0.3	0.8
1994	1.4	NA	NA	0.3	1.7
1995	1.6	NA	NA	0.4	2.0
1996	2.6	NA	NA	0.6	3.2
1997	3.3	NA	NA	0.8	4.1
1998	4.5	NA	NA	1.0	5.6
1999	5.1	NA	NA	1.2	6.2
2000	5.3	NA	NA	1.2	6.4
2001	5.1	NA	NA	1.2	6.2
2002	4.8	NA	NA	1.1	5.9
2003	4.9	NA	NA	1.1	6.0
2004	NA	5.9	3.9	1.2	11.0
2005	NA	7.0	5.2	1.4	13.7
2006	NA	9.7	7.2	1.9	18.8
2007	NA	11.7	7.9	2.3	21.9
2008	NA	14.8	8.5	3.0	26.3
2009	NA	16.9	15.8	3.4	36.2
2010	NA	17.4	13.9	3.5	34.9
2011	NA	18.6	12.4	3.7	34.6
2012	NA	20.4	9.5	4.1	34.1
Total by category	41.0	122.5	84.4	34.8	282.6

Figure 2 displays the dollar amounts of overpayments in each category since 1985. “New cherry-picking,” plans’ selective enrollment of healthier patients within each risk strata in the HCC risk-adjustment scheme since 2004, is currently the largest category of overpayment. This is responsible for \$122.5 billion in overpayments to private plans since 1985.

Overpayments mandated by the MMA of 2003, including duplicate payments for indirect medical education and the first year of quality bonuses to plans as part of a CMS demonstration project on quality, account for \$84.4 billion of overpayments to private plans since 1985.

MA enrollees’ use of the VA for medical care accounts for \$34.8 billion of total overpayments to private plans, while “old cherry-picking” (plans’ selective enrollment of healthy beneficiaries prior to the adoption of the new risk-adjustment system in 2004) accounts for \$41 billion in overpayments to private plans since 1985.

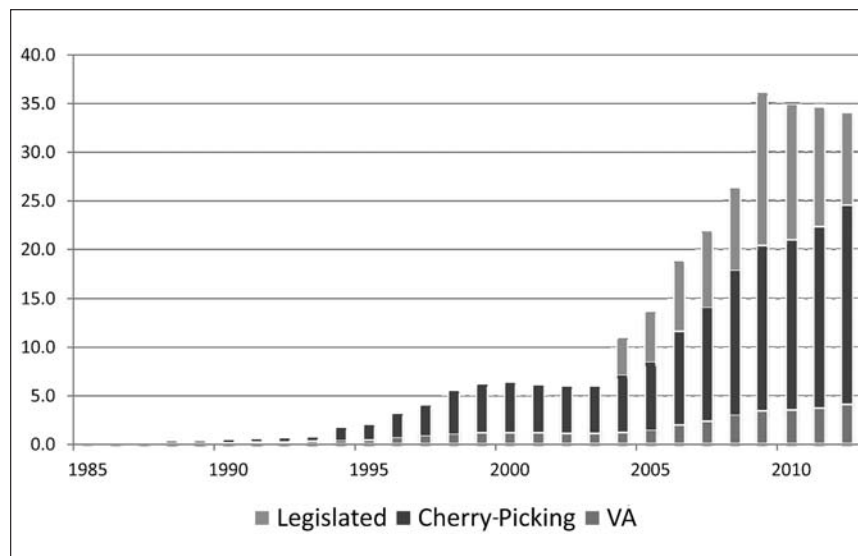


Figure 2. Private insurance plans cost Medicare. Medicare Advantage overpayments as compared to Medicare FFS costs for similar patients (dollars amounts in billions). *Note:* VA is cost of VA uncompensated care provided to Medicare Advantage enrollees. Legislated is Congressionally-mandated excess payments to Medicare Advantage plans. *Source:* PNHP Report October 2012, based on data from MedPAC, Commonwealth Fund, and Trivedi et al.

In total, overpayments to private plans have cost taxpayers \$282.6 billion since 1985. That amount represents 24.4 percent of total Medicare spending of \$1,159.6 billion on private plans between 1985 and 2012.

PRIVATE PLANS AND RISK ADJUSTMENT: NO CONTEST

Under Medicare's old "demographic" model of risk-adjustment, the most profitable beneficiaries to private plans were those who were the healthiest.

Under Medicare's new risk-adjustment scheme, the most profitable beneficiaries are those with a serious diagnosis (for which the plan receives a higher payment) but who, nonetheless, are actually not very sick (i.e., they have low severity of illness within that diagnosis). While serious cases of diseases like arthritis, diabetes, chronic bronchitis, and prostate cancer increase with age, so do very mild cases that require little or no specific treatment. Private plans have adapted to the HCC risk-adjustment formula by identifying and recruiting beneficiaries with mild cases of medical conditions who are now more profitable to insure than beneficiaries without any diagnoses. Such gaming has been described as "cherry-picking conditional on diagnosis" or "selection along dimensions not included in the risk-adjustment formula."

The example of congestive heart failure (CHF) illustrates how private plans can game the risk-adjustment system (18). Medicare beneficiaries at the 95th percentile of costliness with CHF had more than \$37,000 in Medicare spending in 2008, compared with just \$115 in spending for beneficiaries with CHF at the 5th percentile. Despite the cost differences, plans get the same bonus (about 41 percent of the premium for a healthy senior) for each patient who has CHF. Hence, plans can profit by encouraging physicians to perform echocardiogram tests used to diagnose CHF on seniors without symptoms, labeling the patients with this diagnosis when they have such mild cases that their costs of care would not be elevated.

While there are already calls to improve the accuracy of the HCC model, there is no evidence that risk adjustment works or can work in the dynamic reality of profit-seeking health care insurers.

Private plans have powerful financial incentives to design new strategies to game risk adjustment. The plans have access to much more detail about enrollees' health than does Medicare (i.e., there is information asymmetry) and, as mentioned above, very mild cases of chronic conditions are common in the elderly. Each time Medicare adjusts its risk-adjustment formula, private plans will try to compensate by adjusting their cherry-picking. The most interesting part of the 2004 enhancement of Medicare Advantage's risk-adjustment formula is not that plans succeeded in gaming it, but that cherry-picking was at least as common after the enhanced risk adjustment as before (13).

Without such cherry-picking, it seems unlikely that private plans could compete with traditional Medicare at all. Traditional Medicare is administratively efficient because it enrolls people using the Social Security system and uses a single set of rules and fees to pay doctors and hospitals. Hence, the overhead in traditional Medicare is quite low, under 2 percent, compared to 15 percent in private plans (19). According to one estimate, overhead per enrollee in 2008 was \$147 in traditional Medicare versus \$1,450 in private plans (20). Although private plans' higher overhead does not raise our estimate of overpayments, it does imply significantly reduced amounts of clinical care actually delivered to patients by MA plans.

POLICY IMPLICATIONS

Our findings indicate that the inclusion of private plans in the Medicare program has cost taxpayers \$282.6 billion, or 24.4 percent of the total amount Medicare has paid private plans since 1985.

Our findings likely underestimate the magnitude of the overpayments. We used low-end estimates to calculate the cost of selective enrollment prior to 2004, and we excluded the substantial cost of private plans' disenrollment of beneficiaries who subsequently have higher than average costs (21). With private plans, "the healthy go in, and the sick go out," but our figures only include the first half of that formulation.

We also excluded the cost of the post-2004 "upcoding" that occurs after the first year of MA enrollment (payments for the first year are based on pre-enrollment data). CMS did not make its first adjustment for upcoding until 2010, when it reduced MA payments by \$2.7 billion. The GAO estimates that Medicare could save another \$15 billion over the next decade on upcoding even after CMS' adjustment.

Recent technical and legislative attempts to reduce the two major drivers of overpayments have had little or no impact. The adoption of a new risk-adjustment scheme by Medicare in 2004 has not curbed cherry-picking by private plans and may have increased it. In 2012, private plans garnered \$20.4 billion in overpayments by gaming the risk-adjustment scheme. Reductions in mandated overpayments by the ACA have been partially offset by inappropriate quality bonuses. Hence, the Congressionally-mandated overpayments fell only modestly this year to \$9.5 billion.

In addition, taxpayers pay twice for care provided (and paid for) by the VA for enrollees of private plans. In 2012, the VA will provide an estimated \$34.8 billion in care to the 8.3 percent of MA enrollees who are also receiving VA care.

In 2012 alone, we estimate that private insurers are being overpaid \$34.1 billion, or \$2,526 per MA enrollee.

CONCLUSIONS

Advocates of market-based Medicare reforms suggest that competition among private plans will induce greater efficiency and result in cost savings. Our findings indicate that the opposite is true. Private plans have drained more than \$280 billion from Medicare since 1985, most of it in the last eight years. Increasing private enrollment through voucher-type Medicare reform (as suggested by Republicans) or through quality bonuses and financial incentives to plans to enroll dual-eligible beneficiaries (as enacted by President Barack Obama's administration) will almost certainly raise Medicare's costs, not lower them.

Funds wasted on overpayments to private MA plans could instead have been used to improve benefits for seniors, extend the life of the Medicare Trust Fund by more than a decade, or reduce the federal deficit. Private insurers have enriched themselves at the expense of the taxpayers.

It is time to end Medicare's long and costly experiment with privatization. The U.S. needs to adopt a single-payer national health insurance program with proven, effective methods for controlling costs (22, 23).

TIMELINE OF EVENTS DISCUSSED IN THIS REPORT

1972—Congress passes legislation to authorize capitation payments for services covered under Part A and Part B. The goal initially was to avoid disrupting existing patient-provider relationships in staff-model health maintenance organizations (HMOs), such as the non-profit Kaiser plan in California.

1982—Medicare Risk Program, Section 1876 of the Tax Equity and Fiscal Responsibility Act (TEFRA), passes. Medicare beneficiaries have the option to enroll in risk-contract HMOs in which the federal payment is set at 95 percent of the estimated fee-for-service cost as calculated at the county level (known as the average per capita cost, or AAPCC).

1993–1999—Private plans grow, increasing enrollment from 2.6 million to 7 million. Studies show that because of cherry-picking, the government is overpaying HMOs through the risk-contracting program, even with the 5 percent reduction from what it would have paid plans for the average FFS beneficiary.

1997—Balanced Budget Act replaces TEFRA with Medicare+Choice. New method for paying plans adopted. Plans can choose the highest of three formulas: 2 percent increase from previous year, blend of urban and rural counties, or blend of national and local rates.

1999–2003—Because of the new payment formula, most big urban plans receive a premium increase of only 2 percent and start shedding benefits, enrollees, or both. Enrollment nationally declines to 5.3 million, although plans continue to be overpaid in this period.

2000—CMS experiments with adjusting a fraction of MA payments with inpatient claims data. MedPAC estimates that Medicare+Choice plans are overpaid by 4 percent in 2001 before risk-adjustment.

2003—The Medicare Prescription Drug, Improvement, and Modernization Act (MMA), after heavy lobbying from the insurance industry, includes provisions that mandate raises in the premiums Medicare pays private plans. MMA explicitly directs CMS to pay plans for indirect medical education (IME), although plans do not pay hospitals for these costs, which are borne entirely by the traditional fee-for-service Medicare program.

2004—Medicare starts risk-adjusting payments based on (initially 70) HCCs. In addition, Medicare gives plans temporary bonuses to aid their transition to the HCC, risk-adjusted payment system.

2008—Medicare Improvement for Patients and Providers Act (MIPPA) legislation phases out duplicate IME payments by 0.6 percent annually starting in 2010. (In 2009, IME payments raised MA plan payments by 2.2 percent.) In 2010, the ACA exempted plans for beneficiaries eligible for both Medicare and Medicaid (dual-eligibles) from the IME phase-out.

2010—The ACA reduces the overpayments mandated in 2003 by aligning benchmarks (used to set MA payments) more closely with Medicare spending for enrollees in traditional Medicare. CMS Office of the Actuary estimates that this payment reform will reduce MA payments by \$145 billion over nine years and cut enrollment by half. ACA also provides \$3 billion in bonuses for plans that “achieve high star ratings” for quality. CMS begins applying a small adjustment for coding differences between MA plans and traditional Medicare, avoiding \$2.7 billion in excess payments in MA plans in 2010.

2010—CMS announces a revised \$8.35 billion MA Quality Bonus Payment Demonstration program with higher bonuses over a shorter time frame (2012 to 2014) for more plans (including those with lower star ratings, i.e., three, four, or five stars) than the original bonus program included in the ACA. The bonuses offset more than one-third of the reduction in MA payments projected to occur under the ACA between 2012 and 2014. Private plan enrollment continues to increase, in contrast to the shrinkage previously predicted by CMS.

REFERENCES

1. Centers for Medicare & Medicaid Services. *Medicare Trustees Annual Report, Tables IV.C1-C3*. Washington, DC, 2012.
2. Brown, R., et al. *The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation Report to the Health Care Financing Administration*. Mathematica Policy Research, Inc., Princeton, 1993.
3. Riley, G., et al. Health status of Medicare enrollees in HMOs and fee-for-service in 1994. *Health Care Financ. Rev.* 17(4):65–76, 1996.

4. Physician Payment Review Commission. *Risk Selection and Risk Adjustment in Medicare. Chapter 15, Annual Report to Congress*. Washington, DC, 1996.
5. U.S. General Accountability Office. *Medicare+Choice: Payments Exceed Cost of Benefits in Fee-for-Service, Adding Billions to Spending*. Pub. No. GAO/HEHS—00–161. Washington, DC, August 2000.
6. Langwell, K. M., and Hadley, J. P. Evaluation of the Medicare competition demonstrations. *Health Care Financ. Rev.* 11(2):65–80, 1989.
7. Morgan, R. O., et al. The Medicare-HMO revolving door—The healthy go in and the sick go out. *N. Engl. J. Med.* 337(3):169–175, 1997.
8. Berenson, R. Medicare disadvantaged and the search for the elusive ‘level playing field.’ *Health Aff.* (Suppl. Web Exclusives):W4-572–W4-585, 2004.
9. Biles, B., Pozen, J., and Guterman, S. *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 billion in 2009*. Issue Brief. The Commonwealth Fund, New York, 2009.
10. Medicare Payment Advisory Commission. *The Medicare Advantage Program: Status Reports, 2010–2012, and Report to the Congress: Medicare Payment Policy, 2009*. Washington, DC.
11. U.S. General Accountability Office. *Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*. Washington, DC, 2012.
12. Medicare Payment Advisory Commission. *The Medicare Advantage Program, Chapter 4*. Washington, DC, June 2012.
13. Brown, J., et al. How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program. Working Paper 1697. National Bureau of Economic Research, Cambridge, 2011. (under revision, personal communication, Ilyana Kuziemko, August 28, 2012)
14. Trivedi, A., et al. Duplicate federal payments for dual enrollees in Medicare Advantage Plans and the Veterans Affairs health care system. *JAMA* 308(1):67–72, 2012.
15. Passman, L. J., et al. Elderly veterans receiving care at a Veterans Affairs Medical Center while enrolled in Medicare-financed HMOs: Is the taxpayer paying twice? *J. Gen. Intern. Med.* 12(4):247–249, 1997.
16. DeVito, C. A., Morgan, R. O., and Virnig, B. A. Use of Veterans Affairs medical care by enrollees in Medicare HMOs. *N. Engl. J. Med.* 337:1013–1014, 1997.
17. U.S. General Accountability Office. *CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*. Washington, DC, 2012.
18. Medicare Payment Advisory Commission. *The Medicare Advantage Program*. Washington, DC, June 2012.
19. Sullivan, K. How to think clearly about Medicare administrative costs: Data sources and measurement. Forthcoming, *J. Health Polit. Policy Law*. Also U.S. Department of Health and Human Services. *Administrative Costs Reflected on the Adjusted Community Rate Proposals are Inconsistent Among Managed Care Organizations*. A-14-98-00210. Washington, DC, 2000.
20. U.S. House of Representatives Committee on Energy and Commerce, Majority Staff. *Profits, Marketing and Corporate Expenses in the Medicare Advantage Market*. Washington, DC, 2009.
21. Center for Studying Health System Change. *Policy Implications of Risk Selection in Medicare HMOs: Is the Federal Payment Rate Too High?* Washington, DC. Issue Brief. (4):1–7, 1996.

22. McCanne, D. A national health insurance program for the United States. *PLoS Med.* 1(2):115–118, 2004.
23. Marmor, T., and Oberlander, J. From HMOs to ACOs: The quest for the Holy Grail in U.S. health policy. *J. Gen. Intern. Med.* March 13, 2012. www.springerlink.com/content/m86245k22018507n/fulltext.pdf (accessed September 21, 2012).

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