Medicare Rights Center

Medicare Private Health Plans vs. Medicare Savings Programs:

Which Is the Better Way to Help People with Low Incomes Afford Health Care?

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Executive Summary

As Congress debates whether to cut the extra payments Medicare makes to private health plans, the insurance companies offering these plans have argued that the overpayments they receive help lower the out-of-pocket costs (premiums, copayments and deductibles) for low-income people with Medicare, especially African Americans and Latinos.

But an analysis by the Medicare Rights Center of Medicare private fee-for-service plans reveals that often people with low incomes and minority communities pay *more* compared to their wealthier neighbors and get fewer benefits when they join these private plans. The payment rates for Medicare private health plans (known as Medicare Advantage plans) are set county by county using a complex set of formulas that do not take into account whether the county has a high proportion of people with low incomes that need assistance. That has led to plans with higher per member reimbursement in some of the nation's most affluent counties.

In Ohio, for example, one plan is absolutely free in one wealthy county and costs $69 a month in a county with almost double the proportion of families living in poverty and median household income that is 24 percent lower. In Colorado, a leading plan costs $35 a month in one county but twice as much in a county with three times the proportion of families living in poverty and where the median household is 61 percent lower.

As our review of county private plan payment rates and private fee-for-service plan benefits shows, a far better health care deal for low-income people with Medicare is the Medicare Savings Programs, which subsidize premiums, copayments and other out-of-pocket expenses. In addition, no private health plan alone matches what the federal low-income assistance program "Extra Help" offers: copayments of $5.35 of less for each prescription, no monthly premiums, no deductible and no gap in coverage. People enrolled in a Medicare Savings Program automatically get Extra Help.

A better way to spend the $65 billion in overpayments the insurance companies will be getting over the next five years would be to expand enrollment in the Medicare Savings Programs (MSPs). Income and asset eligibility criteria for MSPs should be raised to match those of the Extra Help program. In this way lawmakers can target financial assistance to those who need it most.

Introduction

The Medicare Payment Advisory Commission (MedPAC) reports that in 2006, Medicare Advantage plans were paid an average of 12 percent more than the average cost of caring for an individual in the same locality under Original Medicare.[1] Private fee-for-service (PFFS) plans, which have experienced a surge in enrollment far above growth in traditional health maintenance organizations (HMOs) and preferred provider organizations (PPOs), receive payments that average 19 percent above Original Medicare costs.[2] New research shows Medicare Advantage overpayments have grown and now average around $1,000 extra per enrollee per year.[3] The Congressional Budget Office (CBO) estimates that setting MA payment benchmarks to costs under Original Medicare would save $54 billion over four years, starting in 2009.

In trying to protect their overpayments, plans have exaggerated the proportion of low-income and minority people with Medicare that they cover. Private plans argue that curbing the overpayments would harm low-income and minority people with Medicare, whom they claim rely disproportionately on Medicare Advantage for supplemental coverage. Analysis by the Center on Budget and Policy Priorities, however, found those claims to be based on misleading use of data.[4]

This report analyzes whether the current payment structure for Medicare Advantage plans is an effective way to provide financial assistance to low-income people with Medicare, and African Americans and Latinos in particular.

We will also investigate whether enrollment in Medicare Savings Programs, which pay Medicare cost-sharing and/or premiums, is a better alternative to improve access to health services for low-income people with Medicare, and whether it should be expanded.

How Are Plan Payment Rates Set?

Nearly 90 percent of Medicare Advantage enrollment is in local HMOs, PPOs and PFFS plans that are paid for each enrollee based on county payment benchmarks.[5] Plans submit a bid based on their estimates of how much it will cost them to provide standard Medicare benefits in comparison to the county benchmark.[6]

The amount the county benchmark exceeds the average local cost of care under Original Medicare and the amount the plan bids under the benchmark determines the amount of extra money available to the plan (the "rebate") to provide additional benefits and reduce enrollee cost-sharing.[7]

County benchmarks for Medicare Advantage plans are set annually according to one of a choice of statutory formulas—a minimum update, a peg to local Original Medicare costs or floors set for certain urban and rural counties. The rate is set according to whichever formula that applies to the county results in the highest benchmark. Therefore, the benchmarks vary greatly between counties, ranging from around 104 percent of Original Medicare costs on the low end, to well over 120 of Original Medicare costs at the upper extreme.

For example, in counties where benchmarks are set by urban floors, Medicare pays plans over 21 percent above local costs under Original Medicare. These counties account for over 42 percent of overpayments although they have just over 26 percent of the Medicare population.[8] These high urban floor rates are not designed to target extra payments to impoverished inner-city communities. In fact, these counties include some of the wealthiest suburban counties in the country. Nationwide, among the 20 counties with the highest median household income, Loudoun County, Virginia, has a benchmark for Medicare Advantage payments set 18 percent higher than local costs under Original Medicare. The benchmark in Collin County, Texas, is 27 percent higher; in Fayette County, Georgia, it is 24 percent higher; and in Hamilton County, Indiana, it is 19 percent higher.

What Do the Overpayments Pay For?

Not all the overpayments that Medicare Advantage plans receive go into additional benefits for plan members. Some of the overpayments pay for standard Medicare benefits because it costs many of the plans more than Original Medicare to provide them. In addition, the Centers for Medicare & Medicaid Services (CMS) allows plans to include additional costs for overhead in the supplemental benefits that are funded by overpayments.[9] In fact, there is no legal requirement on how much of these payments the companies must spend on health care.

The bids submitted by the most restrictive type of private health plan, HMOs, for providing standard Medicare benefits average 3 percent below local costs under Original Medicare.[10] Because their costs are lower, these plans, which account for 75 percent of Medicare Advantage enrollment, should be able to provide some enhanced benefits even if payment benchmarks are put on par with Original Medicare costs. But it costs local PPOs, regional PPOs and PFFS plans more to provide standard Medicare benefits.

For PFFS plans, the fastest growing type of Medicare Advantage plan, roughly half the overpayment is due to the plans' higher cost of providing standard Medicare services than Original Medicare. For every dollar in overpayment, only 45 cents is returned as a rebate used to improve benefits or lower cost-sharing for plan enrollees.[11]

Even with the overpayments they receive, members of Medicare Advantage plans sometimes pay more for medical services above what they would have paid under Original Medicare. Numerous Medicare Advantage plans charge members more than Original Medicare for stays in hospitals, skilled nursing facilities and mental health facilities, as well as for home health care and wheelchairs and other medical equipment.[12] The varying copayments or other fees imposed by Medicare Advantage plans can translate into much higher out-of-pocket spending for people with Medicare suffering from serious illnesses.[13]

Who Benefits from the Overpayments?

Lawmakers must determine whether overpayments for Medicare Advantage plans, which are based on county benchmarks, are an effective way of targeting extra benefits and reduced cost-sharing to low-income people with Medicare.

None of the formulas used to set payments for Medicare Advantage plans take into account whether the locality has a high- or low-median income, high or low rates of poverty or any other indicator of relative wealth. As a result, even if the Medicare Advantage plans did not absorb a percentage of overpayments in profit and administrative overhead, there is no guarantee that this excess Medicare spending is received by or even available to low-income people with Medicare.

As our survey of Medicare Advantage benchmarks and benefit packages from around the country demonstrated, low-income, minority communities in many instances are worse off than their more affluent neighbors under the Medicare Advantage program.

Our research focuses on the premiums and benefit packages offered by PFFS plans across the country. PFFS plans can flourish because of the difference between county benchmarks and local costs under Original Medicare. Targeting counties with the highest benchmarks (averaging 122 percent of costs under Original Medicare), PFFS plans pay providers at Medicare rates and utilize the difference to fund their overhead and marketing costs, their profit margins and the additional benefits they provide enrollees (what economists call "arbitrage).[14] By looking at the PFFS plans, we can determine whether county benchmarks, and therefore plan payments, are structured in a way to deliver the lowest cost-sharing and premiums to the consumers who need them the most—low-income people with Medicare.

How Do the Medicare Savings Programs Work?

In contrast to the payment system for Medicare Advantage plans, the Medicare Savings Programs provide a straightforward and efficient means of lowering out-of-pocket spending for medical services and prescription drugs for people with Medicare who have difficulty affording their health care costs. Eligibility for Medicare Savings Programs is determined on the basis of income and financial assets. The federal government sets minimum levels for income and asset eligibility criteria, but the states can expand eligibility, such as by removing the asset test. Benefits under the MSPs are uniform nationwide, regardless of the county of residence.

There are three Medicare Savings Programs. (Note: All dollar figures below are for 2007.)

1. The **Qualified Medicare Beneficiary** (QMB) program covers people with incomes below 100 percent of the federal poverty line ($850.83 per month for an individual) and limited assets. QMB pays all medical cost-sharing under Medicare Parts A and B, including the Part A deductible for a hospital visit ($952), the Part B deductible ($131), and cost-sharing for doctor visits and other Part B services (generally 20 percent). QMB also pays the Part B monthly premium ($93.50 per month).

2. The **Specified Low-Income Medicare Beneficiary** (SLMB) program covers individuals between 100 percent and 120 percent of the federal poverty line ($1,021 per month for an individual) with limited financial assets. SLMB pays the monthly Part B premium.

3. The **Qualified Individual** (QI) program covers individuals between 120 percent and 135 percent of the federal poverty line ($1,148.63 per month for an individual). Unlike the QMB and SLMB programs, which are Medicaid entitlements and funded jointly by states and the federal government, the QI program is a grant to states that must be renewed on an annual or biannual basis. It expires September 30, 2007. QI pays the monthly Part B premium.

Enrollment in any of the three Medicare Savings Programs automatically qualifies the individual for the Low-Income Subsidy (LIS) under Part D, commonly called Extra Help. Under the Extra

Help program, copayments are set at $5.35 for a brand-name drug and $3.10 for a generic medicine. There is no annual deductible or coverage gap (doughnut hole) in the drug benefit, and premiums are fully subsidized up to the average plan premium in the region. (Individuals can apply for Extra Help directly through the Social Security Administration.)

These benefits far exceed the benefits provided by Medicare Advantage plans. No MA plan alone matches what the federal low-income assistance program "Extra Help" offers: copayments of $5.35 of less for each prescription, no monthly premiums, no deductible and no gap in coverage. No Medicare Advantage plan covers all cost-sharing for medical services like the QMB program. In fact, QMB and Medicaid enrollees can pay higher cost-sharing under a Medicare Advantage plan than under Original Medicare with the Medicaid supplement.

CMS estimates that the average value of extra benefits provided by Medicare Advantage plans is $86 per month for each member (a figure that includes "allowable overhead" for plans)[15], although the agency does not collect data on how often plan enrollees actually use these benefits.[16] By contrast, every enrollee in the Medicare Savings Programs has $93.50 per month added back into their Social Security check.

Four States, Eight Counties:
Differential Medicare Private Fee-for-Service Plan Benefits and the Potential for Expansion of Medicare Savings Programs

In this section, we analyze how the premiums charged and benefit packages offered by specific Medicare Private Fee-for-Service (a type of Medicare Advantage plan) correlate with demographic criteria for the counties where they are offered. The extent that Medicare Advantage payment benchmarks exceed local costs under Original Medicare is drawn from CMS data.[17] It does not subtract payments for medical education made by Original Medicare but not by Medicare Advantage plans and, as a result, understates the amount of overpayment allowed by the benchmarks. Data on median household income, the percentage of county residents living in poverty and the ethnic makeup of the counties is drawn from data from the U.S. Census.[18]

We also provide conservative estimates of the number of low-income people with Medicare in the areas surveyed who could benefit if income and asset eligibility criteria for Medicare Savings Programs were brought in line with thresholds for the Part D Extra Help program. These estimates are drawn from county level target data developed by CMS actuaries on the number of persons eligible for, but not enrolled in, Extra Help.[19] These estimates understate the number of residents who could benefit, since they do not include the 2.2 million who are enrolled in Extra Help but not in a Medicare Savings Program.

Ohio

The table below compares Cuyahoga County (which includes Cleveland) to Clermont County (which is outside of Cincinnati). Residents of Clermont County, the wealthier of the two localities, can enroll in Humana Gold Choice at no premium, while those who live in Cuyahoga County,

with over twice the number of impoverished residents, pay $69 a month for the same benefit package.

	Clermont County	Cuyahoga County
Median Household Income	$52,951	$40,457
Residents Living Under the Poverty Line	7.8%	15%
Residents Who Are African American	1.3%	29%
Humana Gold Choice's Monthly Premium	$0	$69
Amount MA Benchmark Exceeds Average Local Costs Under Original Medicare	$135.31 (21%) per month	$80 (12%) per month

There are at least 15,500 Cuyahoga County residents and over 1,700 Clermont County residents who could qualify for a Medicare Savings Program, if income and asset criteria were fully aligned with the Extra Help program under Part D. Under the QMB program, they would have all their cost-sharing under Medicare Parts A and B paid for—a benefit far superior to Humana Gold Choice plan or any other Medicare Advantage plan. The QMB, SLMB and QI programs pay the full Part B premium ($93.50 per month in 2007) and automatically enroll individuals in Extra Help, providing prescription drug coverage with lower cost-sharing than Humana Gold Choice or any other Medicare Advantage plan.

Colorado

Douglas County, outside Denver, Colorado, is one of the wealthiest counties in the country. The high payment rates for Medicare Advantage plans in this county allow Universal American to charge $35 for its Today's Options Premier PFFS plan. Residents of nearby Morgan County pay more than twice as much for the same plan, even though the area is far poorer.

	Douglas County	Morgan County
Median Household Income	$94,658	$36,507
Residents Living Under the Poverty Line	3.7%	12.6%
Residents Who Are Latino	6.5%	33%
Universal American's Today's Options Premier Monthly Premium	$35	$72
Amount MA Benchmark Exceeds Average Local Costs Under Original Medicare	$122 (19%) per month	$29 (4%) per month

Under the Medicare Savings Program, however, low-income Colorado residents would receive the same benefits whether they live in Douglas County, Morgan County or any other area of the state. If income and asset eligibility criteria for the Medicare Savings Program were aligned with those used for the Part D Extra Help program, more than 1,000 residents in those two counties, plus at least 3,000 Denver residents, could receive help with their Medicare cost-sharing.

Utah

While some Medicare Advantage plans raise or lower their premiums, depending on the amount they are overpaid in a particular county, other plans alter the benefit structure to reflect different

payment levels. For example, UnitedHealth Group offers radically different PFFS plans in two different counties in Utah under its Secure Horizons Medicare Direct brand. While neither plan charges a premium to enrollees, the plan offered in San Juan County charges much more for acute care than the plan sold in Morgan County, which is one of the wealthier counties in the state.

In Morgan County, Secure Horizons charges $200 per day, for days one through 90 for a hospital stay. In San Juan County, the charge is $275 per day, for days one through 90. Both charges would saddle enrollees with a higher bill for six days—the average length of stay in a hospital—than Original Medicare, under which the charge would be $992.

In Morgan County, Secure Horizons charges $80 per day for the first 10 days in a skilled nursing facility; in San Juan County, the charge is $100 per day. Under Original Medicare, there is no charge for the first 20 days in a skilled nursing facility. Since the average length of stay in a skilled nursing facility is 26 days, enrollees in Secure Horizons would generally pay more than under Original Medicare, especially if they lived in San Juan County.

Secure Horizons does limit annual out-of-pocket spending on medical care for its enrollees, a benefit that does not exist under Original Medicare without a supplemental "Medigap" plan. The limit is considerably higher in San Juan County, however.

The table below illustrates the potential pitfalls to people with Medicare enticed by zero-premium coverage from a Medicare Advantage plan if they should fall ill. The version of the plan sold in San Juan County, the poorer of the two localities, has a higher cost-sharing.

	Morgan County	**San Juan County**
Median Household Income	$58,865	$28,751
Residents Living Under the Poverty Line	5%	25%
Residents Who Are American Indian	0.2%	56%
UnitedHealth Group's Secure Horizons Medicare Direct Monthly Premium	$0	$0
Cost of Hospital Stay for Average Six-Day Stay	$1,200	$1,650
Cost of Skilled Nursing Facility Stay for 10-Day Stay	$800	$1,000
Amount MA Benchmark Exceeds Average Local Costs Under Original Medicare	$198 (35%) per month	$120 (21%) per month
Annual Out-of-Pocket Limit	$3,200	$3,900

Over 10,000 Utah residents could benefit from the Medicare Savings Programs if income and asset eligibility criteria were brought in line with the Part D Extra Help program. Those below the poverty level would have all their cost-sharing under Medicare paid for through the QMB program. Enrollees in the SLMB or QI program would have their $93.50 Part B premium paid, providing them with funds to buy a Medigap or Medicare Advantage plan that provided real protection against high medical bills.

California

One of the most fundamental changes enacted through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was the means testing of the Part B premium. Starting in 2007, individuals earning more than $80,000, and couples making more than $160,000, began paying higher monthly Part B premiums. Medicare no longer provides the full 75 percent subsidy for Part B for individuals in these higher income brackets.

Opponents of this provision—including the Medicare Rights Center—argue it undermines the universal nature of the Medicare benefit, taking a step toward making Medicare a means-tested, welfare program. Supporters argue that people who can afford to pay more for their Medicare coverage should do so and that scarce resources should not be used to subsidize health care for those who can afford to pay a greater share of the cost. Means testing (or "income-relating) of the Part B premium was estimated by the Congressional Budget Office (CBO) to save Medicare $2.7 billion over seven years.

Ironically, overpayments to Medicare Advantage plans, which are supported by the same lawmakers who supported means testing of the Part B premium, create a situation where wealthier people with Medicare may actually pay lower Part B premiums than some impoverished older adults and people with disabilities. That is because one of the "extra" benefits offered by some Medicare Advantage plans is a reduction or elimination of the Part B premium for plan members.

Universal American's Today's Options Value plan, for example, will reduce enrollees' Part B premium by up to $21.50 and provide coverage at no additional premium if they happen to live in a county with a very high benchmark for Medicare Advantage payments. This is true of individuals who live in Napa County, California—wine country. Further south, in Los Angeles County, the same plan costs members $48 a month, with no reduction in the Part B premium. (Note that that the Part B premium is higher for everyone with Medicare—by $2 a month—because of the overpayments to Medicare Advantage plans.)

	Napa County	**Los Angeles County**
Median Household Income	$53,184	$43,518
Residents Living Under the Poverty Line	7.8%	17%
Residents Who Are African American or Latino	29%	56.5%
Universal American's Today's Options Value Plan Monthly Premium	$0	$48
Monthly Part B Premium (2007)	$72	$93.50
Amount MA Benchmark Exceeds Average Local Costs Under Original Medicare	$182.38 (25%) per month	$60.14 (7%) per month

Medicare Savings Programs, on the other hand, pay the full Part B premium for low-income people with Medicare, whether they live in Napa County or Los Angeles County or anywhere else in the country. Wealthy retirees cannot enroll in these programs, but many low-income people with Medicare also miss out because income and asset criteria are so restrictive and outreach efforts have been lacking.

If income and asset eligibility criteria were set at current levels for the Part D Extra Help program, over 58,000 people with Medicare in Los Angeles County could be newly enrolled in an MSP and

receive the help they need, and in Napa County almost 1,000 individuals could qualify and receive this assistance.

Who Pays the Part B Deductible?

The Bush administration argues that Congress should not eliminate the overpayments to Medicare Advantage plans because a portion of those payments are used by the plans to reduce cost sharing for plan members. Interestingly enough, the administration's support for reducing cost-sharing for people with Medicare does not extend to people not in private plans—those who opt to stay in Original Medicare. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the law that funneled billions in subsidies to Medicare private health plans—changing their name to Medicare Advantage plans in the process—also raised cost-sharing for people in Original Medicare.

In the MMA, Congress extracted $11.6 billion in savings from people with Medicare, including those with low and moderate incomes, by increasing the Part B deductible. Set at a fixed $100 since 1991, the deductible was hiked to $110 and then set to be raised each year by the same percentage used to determine the annual Part B premium increase. Rising Part B spending, as well as the growth in overpayments to Medicare Advantage plans, are factors in determining the yearly increase in the Part B deductible ($131 in 2007).

Many enrollees in Medicare Advantage plans, however, do not pay a Part B deductible. One of the most common enticements offered by Medicare Advantage plans—and funded by overpayments—is the absence of a deductible for Part B services.

No-deductible plans have proven to be popular for the Medicare population, even if they provide no savings on an annual basis because of higher premiums and copayments. They are an attractive benefit feature for plans as well, since the added expense per enrollee is modest and predictable.[1]

In effect, Congress saved over $10 billion over 10 years by making people in Original Medicare pay a higher Part B deductible, but is spending tens of billions of dollars so that the fraction that chooses Medicare Advantage pays no Part B deductible. This dichotomy raises two questions: Does Congress want to allocate scarce resources to eliminate the Part B deductible? And who should receive this additional benefit, if it is too expensive to provide it to every person with Medicare?

The sensible answer is: Congress should reduce Medicare cost-sharing, including eliminating the Part B deductible, for the people with Medicare who can least afford it. That requires targeting assistance to people with Medicare whose incomes are low through the Medicare Savings Programs. The QMB program, for people living below the poverty line with limited assets, pays the annual Part B deductible, monthly premium and all cost-sharing under Parts A and B. The SLMB and QI programs pay the monthly Part B premium, set in 2007 at $93.50. Two months of assistance under these programs is worth more than the Part B deductible.

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[1]Some Medicare Advantage plans charge a higher deductible than Original Medicare, even though the plans receive more in subsidies than it would cost to provide benefits for their members under Original Medicare. Over 100,000 retired government workers in Michigan, for example, saw their deductible rise from $131 to $250 when their retirement coverage was switched to a PFFS plan operated by Blue Cross Blue Shield of Michigan.

Conclusion

Private plans were brought into the Medicare program with the promise that they would reduce costs by injecting competition into the program. Instead they have consistently been proven to cost more than Original Medicare.

As a result, the insurance companies offering Medicare Advantage plans have settled on a new argument to justify continued overpayments—the extra benefits that overpayments fund for plan members with low incomes, particularly African Americans and Latinos. This after-the-fact rationalization, however, is contradicted by the very payment structure it was designed to protect.

As our analysis shows, overpayments to Medicare Advantage plans are not targeted to low-income communities, and can, in fact, fund more generous benefits for higher-income people with Medicare than they do for lower-income individuals. The payment structure of county-based benchmarks, coupled with the share of overpayments that private plans use for administrative overhead, marketing costs and profit, makes the Medicare Advantage program an inefficient and ineffective tool to reduce the cost of medical care for low-income people with Medicare.

As the chart below illustrates, lawmakers interested in reducing the financial burden of medical care for low-income people with Medicare should instead look at the Medicare Savings Programs.

Program Benefits	**Medicare Advantage Plans**	**Medicare Savings Programs**
Targeted to People with Low Incomes	No	Yes
Pays Part B Premium	Maybe	Yes
Pays 100 percent of cost-sharing under Parts A and B	No	Yes: QMB No: SLMB, QI
Pays Part D premium	Maybe	Yes
Covers all Part D-covered drugs during coverage gap	Rarely	Yes[20]
Caps copayments for Part D-covered brand-name drugs at $5.35	No	Yes[20]
Raises cost of Part B premium for everyone with Medicare	Yes	No

Congress recognized, in establishing the Part D Extra Help program, that people with Medicare with incomes below 150 percent of the poverty line needed additional assistance with their prescription drug costs. Individuals with such limited incomes can also face hardship paying their Part B premiums and medical bills, but may not receive assistance from Medicare Savings Programs because of their more restrictive eligibility criteria.

Congressional action is needed to ensure that all low-income people with Medicare who need this assistance are enrolled in the Medicare Savings Programs.[21] The income and asset limits for the Medicare Savings Programs are set below the thresholds Congress established for the Extra Help program under Part D. The asset test for Medicare Savings Programs has been set at $4,000 for an

individual and $6,000 for a couple since 1997, well below the levels allowable under Extra Help ($11,710/$23,410 in 2007). The asset ceilings for Medicare Savings Programs do not rise with inflation like those used for Extra Help. Individuals with incomes up to 150 percent of poverty level ($1,276.25 a month in 2007) qualify for a partial subsidy under Extra Help, but the maximum income allowed for the Medicare Savings Program is $1,148.63 (135 percent of poverty level).

If eligibility criteria for Medicare Savings Programs were aligned with the income and asset thresholds for Extra Help, the 2.2 million enrollees in the Extra Help program could automatically be enrolled in the Medicare Savings Programs. In addition, the 3.2 million low-income people with Medicare who qualify but still have not enrolled in the Extra Help program would also qualify. People with Medicare could receive the benefits of the Medicare Savings Programs when they seek assistance from the Social Security Administration.

By aligning income and asset thresholds for the Medicare Savings Programs with the Extra Help program, lawmakers can target financial assistance to those who need it most and rationalize the two programs proven to lower out-of-pocket spending for low-income people with Medicare.

Congress can expand those programs by eliminating the overpayments to the private health plans. Putting those billions of dollars into the MSPs and Extra Help program is a much more efficient and evenhanded way of ensuring all people with Medicare can afford to get the health care they need.

Endnotes

[1] "The Medicare Advantage Program and MedPAC Recommendations," statement of Mark E. Miller, PhD, executive director, Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.
[2] "The Medicare Advantage Program and MedPAC Recommendations"
[3] "The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised," Commonwealth Fund, Brian Biles and Emily Adrion, November 30, 2006.
[4] "Low-Income and Minority Beneficiaries Do *Not* Rely Disproportionately on Medicare Advantage Plans: Industry Campaign to Protect Billions in Overpayments Rests on Distortions," Center on Budget and Policy Priorities, Edwin Park and Robert Greenstein, April 12, 2007.
[5] The other 10 percent are enrolled in regional PPOs, PACE programs, and Cost Plans, etc.
[6] "Medicare Advantage Overview," Kaiser Family Foundation.
[7] Seventy-five percent of the rebate is used to fund supplemental benefits, 25 percent is returned to the Treasure. "The Medicare Advantage Program and MedPAC Recommendations," statement of Mark E. Miller, PhD, executive director, Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.
[8] "The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised," Commonwealth Fund, Brian Biles and Emily Adrion, November 30, 2006.
[9] "Overview of Medicare Advantage," Centers for Medicare & Medicaid Services, May 2007.
[10] "The Medicare Advantage Program and MedPAC Recommendations," statement of Mark E. Miller, PhD, executive director, Medicare Payment Advisory Commission, before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.
[11] "The Medicare Advantage Program and MedPAC Recommendations."
[12] "Beneficiary Cost-Sharing in Medicare Advantage Varies from Traditional Medicare," Representative Pete Stark, Democrat of California, June 27, 2007.
[13] "Benefit Design and Cost-Sharing in Medicare Advantage Plans," Medicare Payment Advisory Commission (MedPAC), December 2004, and "Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?," Commonwealth Fund, May 2006.
[14] HMOs and PPOs, on the other hand, can construct networks of providers and more closely manage the utilization of services. These tools can enable some plans to cover enrollees at less cost than Original Medicare, providing funding for extra plan benefits even if benchmarks do not exceed costs under Original Medicare.
[15] "Overview of Medicare Advantage," Centers for Medicare & Medicaid Services, May 2007.
[16] Exchange between Ways and Means Health Subcommittee Chairman Pete Stark, Democrat of California, and Acting CMS Administrator Leslie Norwalk, June 21, 2007.
[17] "Medicare Advantage 2008 Ratebook," Centers for Medicare & Medicaid Services, April 2007.
[18] "USA State and County QuickFacts," U.S. Census Bureau,
[19] "LIS Targeting Data," Centers for Medicare & Medicaid Services, 2006.
[20] People enrolled in an MSP automatically qualify for the Extra Help program.
[21] The Congressional Budget Office estimates that only one-third of eligible individuals are enrolled in the Medicare Savings Programs.