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Summary of NRLN Positions on Medicare and Medicare Advantage

For the past several years NRLN has been lobbying with Congressional representatives and staffers about the relative costs and disparities between traditional Medicare and privately administered Medicare Advantage plans. Now the Medicare administrator (CMS) has requested opinions on its proposal to replace the traditional Medicare fee-for-service (FFS) payment system with a new "capitation" system where payments are determined by the cost incurred by private organizations to maintain the overall health of the covered population. So, there are two policy areas to examine.

Original Medicare (OM) vs. Medicare Advantage (MA)

Original Medicare is a fee-for-service model where CMS reimburses medical professionals for services performed. This is covered by Part A and Part B of Medicare. Seniors using Original Medicare (OM) often also purchase drug cost insurance (Part D) and/or a Medigap or Supplemental insurance plan to pay for what Medicare does not cover. These two options are provided by private insurers. 54% of seniors use Original Medicare (OM).

Medicare Advantage (Part C of Medicare) offers plans where the senior contracts with a private insurer for medical coverage, and the private insurer contracts with Medicare to be reimbursed for the costs of coverage, including Parts A, B, and D, and sometimes additional features like eyecare, hearing, dental, and vision. This is what TV spokespersons like Joe Namath are selling.

The government's purpose in creating Medicare Advantage (MA) was to reduce its Medicare costs by the efficiencies of private management, such as negotiated pricing with providers, modern systems of claims processing and fraud control,

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competitive labor rates, employee incentives, and modern management techniques. It was believed that such cost reductions would more than compensate for a 10-15% profit earned by the private insurers, while quality would be assured through competition.

The NRLN has used government reports to show that this belief has turned out to be false, because Medicare Advantage (MA) costs are 4% higher than Original Medicare (OM), and have never been less than OM. The quality of MA care cannot be measured with the tools being used today and the quality of care may be worse due to MA limitations on covered procedures, their networks of authorized providers, co-pays, and caps on payouts.

NRLN's positions are that:

1. Original Medicare (OM) should provide the same benefits as Medicare Advantage (MA). It should include additional features, such as eyecare, dental, etc., or the subsidies that enable these features under MA should be eliminated.
2. MA subsidies, rebates, and bonuses to insurance companies should be eliminated or revised so that MA plans actually cost less than OM for the same populations.
3. MA quality should be measured from the patient's point of view, and financial penalties for poor MA quality should be enforced.

Fee-for-Service (FFS) vs Capitation

Capitation is fee-per-person within a covered group, regardless of the healthcare services provided. It is sometimes called Value Based Healthcare. The fee rises if the group's health quality exceeds the target at year-end, but the fee falls if the quality falls, regardless of how many medical services were provided. So, measuring the quality of health and how it changes is crucial to making the capitation approach work. It is intended to correct the biggest problem with Fee for Service (FFS), which is provider focus on performing billable services without considering their combined effect on the overall health of the patient ("coordination of care"), or maybe whether they are needed at all.

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However, capitation can be effective only if an entity or organization controlling multiple medical specialties becomes responsible for the overall health of the patient. Such middleman entities are called Accountable Care Organizations (ACOs). This entity receives the Medicare payments, compensates the doctor or other professional, and keeps the remainder to cover administrative costs and profit.

In previous trials of capitation, the ACOs were either insurance companies or groups of doctors such as a hospital network. Now Medicare (CMS) proposes that other private entities – such as a group of investors -- can own an ACO, and that patients will be assigned to an ACO by CMS, based on which ACO their doctor has joined. **This would apply even to patients who have chosen to use Original Medicare rather than Medicare Advantage. CMS calls these private entities Direct Contracting Entities, and this new proposal is called "ACO Reach."**

NRLN is opposed to ACO Reach because they see it as eliminating Original Medicare, which will increase Medicare costs. This belief is based on the data showing that privately insured MA costs 4% more than OM despite Medicare Advantage serving a healthier patient population than Original Medicare. The ultimate design of ACO Reach is not clear yet, so it is possible that excess costs we now see in MA may be prevented in its final structure, but NRLN doubts that the same players in a similar game will produce different results.

AASBCR supports NRLN efforts to develop consensus with other organizations on these two issues.

For more details, go to https://nrln.org/ or view these links:

https://www.nrln.org/wp-content/uploads/2022/07/NRLN-FOCUS-2022-Summer-Website-Post.pdf

https://nrln.org/wp-content/uploads/2022/09/HHS-RFI-Response-Final-with-Attachment-082522.pdf

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https://nrln.org/presidents-forum-138-discussion-with-senators-medical-staff-member/

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