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Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices

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ABSTRACT The policy community generally has assumed Medicare Advantage (MA) plans negotiate hospital payment rates similar to those for commercial insurance products and well above those in traditional Medicare. After surveying senior hospital and health plan executives, we found, however, that MA plans nominally pay only 100–105 percent of traditional Medicare rates and, in real economic terms, possibly less. Respondents broadly identified three primary reasons for near–payment equivalence: statutory and regulatory provisions that limit out-of-network payments to traditional Medicare rates, de facto budget constraints that MA plans face because of the need to compete with traditional Medicare and other MA plans, and a market equilibrium that permits relatively lower MA rates as long as commercial rates remain well above the traditional Medicare rates. We explored a number of policy implications not only for the MA program but also for the problem of high and variable hospital prices in commercial insurance markets.

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Fundamental Medicare restructuring, featuring competition among private health plans, either with or without traditional Medicare as a competitor, has emerged as an important health policy topic and will likely receive increased attention from the Republican-controlled Congress.[1] Integral to such a policy discussion is the assessment of the cost containment performance of Medicare Advantage (MA) plans compared to traditional Medicare.

MA plans submit bids to offer coverage to Medicare beneficiaries. These bids are based on the plans' estimates of the cost of providing required Medicare Part A, which covers most medically necessary hospital; skilled nursing facility; home health and hospice care; and Part B services, which cover medically necessary services by providers and other services deemed medically necessary, to cover an average beneficiary. The Medicare payment that the MA plans receive is then determined by how these bids compare to benchmarks, which reflect the maximum amount that Medicare will pay MA plans in a given area.[2] When benchmarks exceed bids—the usual situation—MA plans are able to offer additional benefits with the extra payments. The Medicare Payment Advisory Commission (MedPAC) uses MA plan bid projections as a proxy for cost to annually compare the Medicare program's projected MA spending with projected traditional Medicare spending. MedPAC's most recent estimate for 2015 bids found that for all MA plans, bids were 94 percent of traditional Medicare spending.[3]

It is known that MA plan costs for administration and profit are approximately 11–13 percent of plans' total costs of providing benefits to Medicare beneficiaries compared to traditional Medicare administrative costs of 1.5–5.0 percent of the total program budget.[4–7] However, much less is known about how MA plans and traditional Medicare compare on prices paid to providers and on service use, the main factors that deter-

mine total spending for MA plans. In fact, a number of policy analysts, including the lead author of this article, had assumed that MA plans were subject to the same market dynamics that result in commercial insurers' paying nationally about 40 percent higher prices than traditional Medicare prices for hospital services.[4,8,9]

Recently, research has suggested that MA plans actually pay at or near traditional Medicare levels for both inpatient and outpatient hospital services,[10–12] instead of the substantially higher commercial insurance rates. In a recent analysis, the Congressional Budget Office (CBO) reported that provider payment rates for MA enrollees are similar to those that Medicare pays for traditional Medicare patients' care, even though providers receive higher amounts from the same payers for the same services for nonelderly patients in their commercial plans. The CBO noted that the "exact cause of the difference is not known."[11(p39)]

By interviewing contracting experts at both MA plans and hospitals, we sought to understand the negotiating dynamics between MA plans and hospitals, first to confirm that MA plans do pay hospitals at or near traditional Medicare payment rates and then to explain why. We also sought to understand other aspects of contract negotiations between MA plans and hospitals that might provide insight about Medicare restructuring proposals designed to reduce Medicare program spending.

Through these interviews, we found with rare exception, in our sample of MA plans and hospitals, that MA inpatient and outpatient prices were at or slightly above traditional Medicare payment levels and that the cited explanations for these much-lower-than-commercial payment rates included Medicare statute [section 1866(a)(1)(o) of the Social Security Act], de facto budget constraints, and market equilibrium related to how insurance markets historically work across different product lines. We then present other findings, including the view expressed by some of the hospitals in our sample that in economic terms, MA plans pay less than 100 percent of Medicare levels, despite paying nominal prices at about traditional Medicare levels. We conclude by reviewing the policy implications both for the debate over Medicare restructuring and for the problem of high and variable hospital prices in commercial insurance markets.

Study Data And Methods

METHODS We conducted structured, hour-long interviews with senior personnel from ten independent hospitals or hospital systems and eleven health plans. The telephone interviews were conducted between February and October 2014. Before these formal interviews, we conducted six semistructured interviews with experts with broad knowledge of the field, to enhance our understanding of Medicare Advantage plan and hospital contracting. These and other experts directed us to senior hospital and health plan personnel who were especially knowledgeable about our study topic, whom we then formally interviewed.

Because MA plan and hospital contracting dynamics may differ by organization characteristics, including size and organization type and by variations in market dynamics, our sample was designed to include respondents from different geographic areas and various sizes and types of hospitals and hospital systems and MA health plans. These variations in respondent characteristics include a range of health plans that differ in their number of lines of business, including Medicare, commercial, and Medicaid insurance products. In addition, we sought diversity in the total and relative sizes of their MA business lines compared to the rest of their product lines and the size of their MA business compared to that of competitors in their area. Our sample also included hospitals that differed in their payer mix and their overall market share within their service area.

The interview protocol permitted respondents not only to comment on the contracting experience of their own organizations but also to reflect on market dynamics in general and on their experiences in other organizations and other markets. The twenty-nine-item interview protocols—one protocol for hospitals and another one for health plans—were approved by the Urban Institute's Institutional Review Board and are available from this article's corresponding author. Interviews were conducted by a senior member of the project team. They were recorded and transcribed verbatim. To promote candor, interviewees were guaranteed confidentiality as to their and their organization's identity. The interview responses were analyzed in Microsoft Excel and were supplemented by a reading of the interview transcripts as a double check on the determination of key findings.

INTERVIEWEE AND ORGANIZATION CHARACTERISTICS

▶ **HOSPITALS:** For the most part, the interviewees from hospitals were chief financial officers. The sample included two solo hospitals and eight hospital systems ranging in size from a few hospitals to multiple dozens of hospitals. Interviewees included for-profit and nonprofit systems, one public hospital, and more than one system with an academic health center. Some hospital systems have facilities in more than

one of the four US census regions (Northeast, Midwest, South, and West). All four regions were represented, each by at least three interviewees.

Estimates of the percentage of all Medicare patients in a hospital system who were MA patients ranged from 15 percent (approximately half the national average) for one system to approximately two-thirds for another. About half of the sampled hospital organizations had an ownership interest in a health plan, and a number of the other hospital organizations were currently developing a health plan. Hospitals typically have contracts with a variety of MA plan types, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and Special Needs Plans.

▶ **HEALTH PLANS:** Most commonly, the interviewees were the head of provider contracting or network management. Seven of the eleven health plan interviewees represented nonprofit health plans, three of which were Blue Cross and Blue Shield plans. The remaining four health plan interviewees represented large, for-profit plans. With the exception of one health plan that only does Medicare business, the plans have multiple lines of business, including Medicare Advantage, commercial, and, sometimes, Medicaid. The plans' MA line of business ranged from very small to a substantial portion of their overall business. The plans also ranged from dominant payers in their given market area to those with a small market presence of only a few thousand people. The geographic areas these health plans covered ranged from a single area in one state to covering most of the United States. In each census region, at least three of the interviewed health plans were active.

Among the health plans we included, it was uncommon for a hospital system to have a direct ownership interest in the given health plan. The MA plans ranged from encompassing a small percentage of the total Medicare-covered lives in the area to encompassing a majority. Within the MA product line, health plans typically operate a variety of types of MA plans, including HMOs and local and regional PPOs.

LIMITATIONS Our study had several limitations. Our initial objective was to pair this interview study with a quantitative analysis of the MA plan bids submitted to the Centers for Medicare and Medicaid Services (CMS), permitting a direct comparison of contracted MA hospital rates with traditional Medicare rates. Unfortunately, we were not allowed access to the data CMS collects on health plans' proposed bid prices. The principal and inherent limitation of our interview study is that it relies on a small convenience sample. Thus, it might not be fully representative, although all four census regions are covered and the sample is diverse in other key organization characteristics. Finally, some findings reflect important, non-protocol-based observations from respondents. Because these topics were not part of the protocols, we were not able to obtain views on these topics from the entire sample of interviewees.

Study Results

MEDICARE ADVANTAGE PAYMENT COMPARED TO TRADITIONAL MEDICARE PAYMENT With rare exceptions, we found that respondents from MA plans reported that they were currently paying at or slightly more than 100 percent of the traditional Medicare payment for hospital services. Indeed, the most common report, by both hospitals and health plans, was an agreement to pay exactly 100 percent, although the precision in determining "exactly 100 percent" varied, as discussed below. In addition, respondents from almost all remaining health plans said that they were only slightly above 100 percent—typically, in the 101–105 percent range—and were striving, generally successfully, to bring payments down toward 100 percent. Rates above 100 percent were sometimes the case in new MA plans, in which new entrants pay slightly more to "get into the game" with the expectation that rates would subsequently decline. Where MA rates were not exactly at 100 percent, hospital outpatient rates occasionally were paid at a greater percentage above traditional Medicare than inpatient rates.

A few respondents observed that in the relatively recent past, MA contracts sometimes included prices pegged to commercial insurance rates. However, with greater attention accompanying the growth in MA business and because the Affordable Care Act reduces benchmark levels, insurers quickly were able to establish a negotiating strategy to get to the 100 percent traditional Medicare norm. Currently, 110 percent of traditional Medicare seems to be the rate ceiling in markets with powerful hospitals that use "more of their muscle" to get the higher payments, while 100 percent of traditional Medicare is generally the floor, with the majority reporting in the 100–105 percent range.

Consistent with the finding that 100 percent of traditional Medicare is the peg for determining contracted MA rates, we did not find much rate variation within or across geographic areas based on market or other factors. A number of respondents pointed out that negotiations over even a few percentage points' difference in rates sometimes is viewed as important, especially to hospitals. Hospitals with "pretty solid footholds and solid reputations" or rural hospitals with no competition might be positioned to obtain a

price a few percentage points above the traditional Medicare standard. However, MA plans also indicated a willingness to exclude small-population counties from their service areas to avoid paying much more than traditional Medicare levels.

Commercial insurance rates for hospitals are much above those of MA. With one exception of a hospital reporting being paid commercial rates of 105–112 percent of traditional Medicare, commercial rates were reported to be at least 130 percent those of Medicare Advantage. Commercial rates averaging 175 percent, 250 percent, 300 percent, and even 350 percent of the MA rate are cited. These findings are consistent with other literature finding high and highly variable hospital rates negotiated for commercial insurance products.[13,14]

REASONS FOR 100 PERCENT EQUIVALENCE We asked why hospitals were willing to accept MA payment rates that were very close to traditional Medicare rates although they were successful in obtaining much higher rates from commercial insurers. Respondents often gave multiple reasons, which were not mutually exclusive and often complementary. Overall, the frequently cited reasons can be classified into three categories: regulatory limits, de facto budget constraints, and market equilibrium.

▶ **REGULATORY LIMITS:** "The MA plan never has to pay more than [traditional] Medicare," said one hospital interviewee. Most prominently mentioned was section 1866 of the Social Security Act and CMS's implementing regulation (42 CFR 422.214) that stipulate that providers must accept payment for out-of-network hospital care for MA plan members at the rate applicable under traditional Medicare. Thus, unlike the situation with commercial insurance, in which hospitals generally can bill patients or their insurer their full charges for out-of-network services, most respondents thought that hospitals have little bargaining power to obtain negotiated rates above 100 percent of traditional Medicare. In practice, this statutory provision means that hospitals can be out of network yet constrained to be paid 100 percent of traditional Medicare, or in network and paid at a negotiated rate approximating 100 percent. About half of all respondents spontaneously provided this explanation without prompting. Most of the others agreed on its importance when we asked about this explanation, having heard it from others.

▶ **DE FACTO BUDGET CONSTRAINTS:** "We need to be competitive. [Hospitals] understand that," one health plan interviewee stated. This second explanation notes that MA plans effectively operate with fixed budgets constrained by the benchmarks against which MA plans submit bids. Thus, the explanation goes, MA plans cannot afford to pay hospitals much more than Medicare rates in order to be competitive with traditional Medicare and with other MA plans. A few respondents observed that as more vertically integrated hospital systems have developed their own MA plans, hospitals' recognition and acceptance of this constraint on the ability of MA plans to pay more than traditional Medicare has grown.

Because of current financial pressure on benchmarks, respondents agreed that MA plans have additional motivation to drive down provider payment rates. However, respondents also agreed that this financial pressure likely would not lead to negotiated payment rates below 100 percent of traditional Medicare, largely because of MA network adequacy requirements, which specify criteria, such as a minimum number of providers and maximum travel time and distance for beneficiaries, that MA plans' networks must meet. These requirements provide a counter source of leverage for hospitals. In short, traditional Medicare rates act as both a ceiling and a floor in negotiations. In the words of a health plan respondent, "When we request decreased prices [below 100 percent] because of pressure on our rates, the fist goes down on the table. 'Absolutely not! It's off the table. We're not doing that. End of story.'"

▶ **MARKET EQUILIBRIUM:** "[Rates] reflect a balance for all business," a health plan interviewee stated. Numerous respondents spontaneously offered an explanation that they called "equilibrium" and considered "historically, how the market works." Prominent in this category is the idea that "it's all a big bucket of money." That is, hospitals are able to trade off the lower-than-desired payments in Medicare Advantage for substantially higher rates on commercial insurance. Accordingly, respondents generally agreed that the negotiations over MA rates are straightforward—pegged to traditional Medicare rates—in contrast to the sometimes contentious negotiations over commercial insurance rates.

Respondents also suggested there is an acceptance on both sides that MA rates will be at or close to traditional Medicare rates, in part because MA is viewed as a part of Medicare, with traditional Medicare setting the pricing norms for all Medicare. An additional, service-centered explanation, voiced by a hospital interviewee, was that "hospitals largely exist to serve seniors.... You don't really have a choice."

Medicaid also is important to the historical market equilibrium explanation. Most respondents identified low Medicaid payment rates as the primary reason for what some respondents

call "cost shifting," although a more precise term might be "price discrimination." We heard from a number of hospital respondents that Medicaid pays far below costs. Hospital respondents estimated Medicaid payment rates were mostly in the 70 percent of Medicare range for hospitals that did not receive other payments through Medicaid such as the disproportionate-share hospital payment that goes to hospitals with a high percentage of patients who are on Medicaid or uninsured. The range includes well-known state-by-state variation.[15] Hospital respondents think that Medicare pays close to their costs for inpatient care and somewhat below costs for outpatient care, so commercial insurance has to make up for the Medicaid loss, for uncompensated care, and for Medicare's marginally low payments. In essence, those espousing this notion of market equilibrium explain that hospitals can accept MA payments at traditional Medicare levels as long as there is the safety valve of substantially higher prices on commercial insurance as a cushion.

CONTRACT NEGOTIATIONS Negotiations between hospitals and health plans over MA contracts most often take place as part of negotiations over the full range of health insurance products, including commercial insurance. For some hospitals the negotiations over MA, commercial, and Medicaid-managed care products are done separately. However, even then, often the same individuals are involved, and negotiators are "mindful" of the rates negotiated for the other products.

A few respondents noted that in MA contract negotiations, MA-specific issues might involve quality incentives associated with the MA star ratings of health plan quality and service and diagnosis coding on claims. (Diagnosis coding determines risk-adjustment scores.) Since both star-rating and risk-adjustment calculations depend on data from providers, contracts can include incentives for more complete data submissions, resulting in payment of slightly more than 100 percent of traditional Medicare.

Hospital systems predominantly negotiate as a system on behalf of all the system's constituent hospitals at once, instead of hospital by hospital. Respondents agreed that this approach increases hospitals' negotiating leverage in commercial insurance negotiations but to a much lesser degree in MA negotiations—perhaps achieving rates at the higher end of the 1–5 percent above traditional Medicare rates window. For health plans with a broad geographic scope, including national insurers, MA negotiations typically are conducted regionally or locally, with central office oversight. Most MA contracts extend two to three years. But a few run up to ten years or are "evergreen" (automatically renewed) with annual inflators and "material impact" language to open them up for renegotiation.

PAYMENT METHODS By far the most common payment method used in MA plans is traditional Medicare's diagnosis-related group (DRG) system, or MS-DRGs, for inpatients and traditional Medicare's ambulatory payment classification for hospital outpatients. For the most part, the MA plan's payments fully follow traditional Medicare's, having the same adjustments—for example, for area wage index and graduate medical education. In some cases, the payments are administered by a third-party vendor following the instructions of the Medicare administrative contractors, which are private organizations that carry out administrative responsibilities, including paying claims to providers, for traditional Medicare, because the MA plan itself does not have the computational systems needed to replicate the full complexity of the traditional Medicare payment system. However, some MA DRG payment systems do not include all of the traditional Medicare refinements. Indeed, we heard some hospital complaints that while their contracts call for payment at Medicare levels, some MA plans do not provide the detailed payment adjustments required, thus sometimes paying marginally below true traditional Medicare levels.

There are exceptions to the dominant pattern of using MS-DRGs and ambulatory payment classifications. Most importantly, a few respondents indicated that some health systems are paid a percentage of the total "premium" that the MA plans receive from Medicare. In the relatively few percentage-of-premium instances in our sample, the per member per month MA plan payments are roughly the payments traditional Medicare would generate. This occurs because the MA payments to plans are based on the costs enrollees would be expected to generate if they enrolled in traditional Medicare. However, by their nature, per member per month payments can produce allocations that produce price equivalents deviating somewhat from the traditional Medicare levels. For example, if MA plans succeed in curbing use in part by placing providers at risk, the traditional Medicare price equivalent in effect would be higher than what traditional Medicare pays. We also found recent occasional inclusion of risk sharing and shared-savings arrangements on top of traditional Medicare-based DRG payments.

A few MA plans prefer to pay using per diems instead of DRGs because of comparatively short lengths-of-stay, such as in California, or because the MA plan has in place what it considers a

strong approach, using transitions-of-care programs, to promote early discharge, thereby reducing lengths-of-stay. In these cases, the MA plans want to avoid paying DRGs, which are based on national lengths-of-stay data, because using DRGs would result in excessive payments.

WHEN IS 100 PERCENT NOT 100 PERCENT? A number of hospital respondents on their own raised concerns that are captured well in this comment from one respondent: "From an economic perspective, MA rates are even below traditional Medicare rates." The cited reasons include the following: Medicare Advantage more frequently than traditional Medicare rejects payment for stays on the grounds that the stays are not medically necessary; Medicare Advantage more frequently than traditional Medicare downgrades stays to "observational" status, with payment at lower outpatient hospital rates; Medicare Advantage requires hospitals to incur increased administrative expenses because of the separate information requirements of each separate MA plan, compared to the unitary requirements of traditional Medicare; MA plans do better prehospital screening and prior authorization than traditional Medicare to limit hospitalizations—thus, within any DRG category, MA inpatients are sicker than traditional Medicare patients and require more resources; the costs of collection from patient cost-sharing obligations are higher in Medicare Advantage; often there is no "back end" reconciliation such as traditional Medicare conducts, providing additional payments for bad debt, graduate medical education, and disproportionate-share hospital payments; and traditional Medicare typically pays more promptly than MA plans.

Four of the ten hospital respondents raised these concerns on their own without prompting. We reemphasize that we did not have the opportunity to ask MA plan respondents or other hospital respondents to address these concerns.

PRICE EFFECT OF NARROW/TIERED MEDICARE ADVANTAGE NETWORKS We asked respondents what they thought would be the effect on MA payment rates of substantially narrower networks than the mostly broad MA networks that now predominate. The consensus was that little change would result, as long as out-of-network prices are constrained as by current statute. Moreover, health plans and hospital systems saw the possibility of greater reliance on narrow networks in Medicare Advantage not primarily as a matter of price but mostly as related to quality and use. For example, a health plan respondent suggested, "[In MA], we would do [narrow networks] more on the clinical side. It's better care.... But on the commercial side, it's more about costs." A hospital respondent added, "In MA, [narrow networks are] really not a cost game at all, [that is,] pricing. It's a utilization and site-of-care issue."

Discussion

Our study confirms earlier reports that Medicare Advantage plans and hospitals peg their MA payment rates not to commercial insurance rates but instead to rates used by traditional Medicare. In some cases, rates are exactly the same as the rates that Medicare administrative contractors would determine. In other cases, rates are slightly above or without a commitment to all of the traditional Medicare payment adjustments. We heard three predominant, complementary explanations for this payment equivalence: statutory provisions that constrain out-of-network payments to traditional Medicare rates, de facto budget constraints that MA plans face because of the need to compete with traditional Medicare and other MA plans, and a market equilibrium that permits relatively lower MA rates as long as commercial rates remain well above traditional Medicare rates. Market characteristics, such as market share enjoyed by health plans or hospitals, had little effect on the equivalence of MA hospital payment rates to rates in traditional Medicare.

We have more firmly established that MA plans do not face a significant price disadvantage compared to traditional Medicare for the largest component of their payments—hospital care. In economic terms, they may actually achieve prices lower than traditional Medicare prices.

Our findings suggest that letting MA plans benefit from traditional Medicare's administered pricing helps constrain MA plans' costs, thereby making MA a more advantageous option for Medicare beneficiaries. Indeed, the CBO recently concluded that maintaining the traditional Medicare program as a competing plan in the establishment of a premium support system for Medicare would boost federal savings partly because the rates that traditional Medicare pays providers would serve to hold down the rates paid by the competing private insurers—consistent with our findings.[11]

The CBO also argued that over time, premium-support restructuring would likely reduce the market share of traditional Medicare and as a result would boost the rates that private insurers would pay to providers, forcing them to raise their bids, which would lead to greater government contributions. In contrast, in our interviews we did not find evidence that MA market share affects the parties' basic agreement to use the traditional Medicare price standard as the price peg. Many of our respondents agreed with

the CBO analysis that prices would migrate up toward commercial insurance price levels if traditional Medicare totally disappeared but doubted they would rise much from the 100 percent equivalence as long as the requirement that out-of-network hospitals have to accept traditional Medicare rates remains in effect.

Given the central role that the statutory limitation on out-of-network charges plays on negotiated rates, some might suggest raising the current limit—for example, to 125 percent of traditional Medicare—which could strengthen hospitals' weak contracting leverage in their negotiations with MA plans. We observed, however, that respondents generally saw the three explanations for traditional Medicare payment equivalence as intertwined. In this scenario, the need for MA plans to compete with traditional Medicare and each other would likely act as a constraint on the willingness of MA plans in some MA markets to accede to hospitals' higher price requests. And, of course, permitting an out-of-network billing limit that was higher than traditional Medicare would counter the purpose of the current policy protecting beneficiaries from out-of-network charges exceeding those in traditional Medicare.

Indeed, we heard from a few respondents that the nature of competition changes—seemingly for the better—when provider prices are constrained. They noted that with Medicare's statutory control over hospital prices, active competition in Medicare emphasizes "better care" and "utilization and site of service," not the ability to garner price advantages, a major characteristic of competition in commercial insurance markets. Arguably, the current statutory ceiling permits MA plans to worry less about how to gain negotiating leverage over prices and more about service use, quality, and customer service.

Finally, we suggest that placing an upper limit on out-of-network billing might discipline commercial insurance market negotiations, where negotiated hospital prices are as much as 2.5 times Medicare prices or even more. Placing an upper limit on what a hospital or physician can charge as a percentage above Medicare prices might provide a regulatory alternative to actually setting the commercial rates themselves, likely a less intrusive and less resource-intensive endeavor, especially if the out-of-network ceilings were set initially to affect only a small number of especially high-price hospitals.[16] ■

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