In the Literature

MEDICARE ADVANTAGE: DÉJÀ VU ALL OVER AGAIN?

Brian Biles, M.D.
Geraldine Dallek
Lauren Hersch Nicholas

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For more information about this study, contact:

Brian Biles, M.D.
Professor, Department of Health Policy
George Washington University
TEL 202-416-0066
E-MAIL bbiles@gwu.edu

or

Mary Mahon
Public Information Officer
The Commonwealth Fund
TEL 212-606-3853
E-MAIL mm@cmwf.org

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THE COMMONWEALTH FUND
ONE EAST 75TH STREET
NEW YORK, NY 10021-2692
TEL 212.606.3800
FAX 212.606.3500
E-MAIL cmwf@cmwf.org
http://www.cmwf.org

In 1997, Congress established Medicare+Choice (M+C) as a strategy to reduce Medicare program costs by encouraging beneficiaries to switch from standard fee-for-service Medicare into privately managed health plans. In the subsequent six years, from 1997 to 2003, the M+C program achieved less-than-projected results, prompting Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), to revamp and rename the program, now called Medicare Advantage. But now a new study conducted with support from The Commonwealth Fund raises questions about whether Medicare Advantage will achieve its goals or, instead, will repeat the pattern of its predecessor.

In "Medicare Advantage: Déjà Vu All Over Again?" (*Health Affairs* Web Exclusive, Dec. 15, 2004), researchers Brian Biles, M.D., Geraldine Dallek, and Lauren Hersch Nicholas examine benefits, cost-sharing, provider access, and enrollment outcomes of the standard Medicare fee-for-service plan and the participating private Medicare plans. The researchers find that private plans add complexity to the Medicare program. In addition, private plans now cost the federal government more than standard fee-for-service Medicare. Medicare Advantage is not likely to grow, say the researchers, if beneficiaries do not understand their choices and if challenges encountered in M+C are not addressed.

Challenge 1: Plan Choices Are Complicated

Under M+C, elderly and disabled Medicare beneficiaries were offered the option to choose from an array of participating private health plans. The new prescription drug benefit only adds to the complexity.

It would be difficult for anyone, but perhaps especially the elderly, to make a prudent plan choice under these circumstances. Private plans will cover a variety of different medications, charge varying out-of-pocket costs, and have different participating pharmacies in their networks. Research has shown that one-half of the Medicare population does not have the consumer skills necessary to compare critical health plan information.

Challenge 2: Efforts to Avoid Enrollment of High-Cost Beneficiaries

Historically, Medicare private plans have enrolled healthier, lower-cost individuals than did traditional Medicare. The Centers for Medicare and Medicaid Services (CMS) estimates that Medicare spent about 8 percent more in 2003 for private plan enrollees than if these beneficiaries had remained in fee-for-service Medicare. Meanwhile, private plans increasingly designed benefit packages to discourage sicker enrollees by increasing costs for services associated with chronic care. As a result, sicker enrollees spent substantially more on out-of-pocket costs than did enrollees in good health. The new prescription drug program will require strong oversight to deter plans from using flexibility in benefit package design to avoid high-cost enrollees.

Challenge 3: Benefits, Provider, and Plan Stability

Compared with traditional Medicare, which has enjoyed remarkable stability for 38 years, there were considerable changes in

Medicare+Choice. From 1997 to 2003, sharp premium increases and benefit reductions, provider turnover, and plan withdrawals resulted in significant program instability.

Challenge 4: Beneficiary Plan Lock-In

MMA provides for an annual lock-in to private plan enrollment beginning in 2006, with a limited option for Medicare Advantage enrollees to change plans once during the first three months of the year. This provision may leave some enrollees vulnerable. Physicians or hospitals may choose to leave a particular plan, a plan may drop a key prescription drug, or enrollees may find they have made an unsuitable choice. A policy to allow beneficiaries to change plans for good cause during the year would address these concerns about plan lock-in.

Challenge 5: Geographic Inequity in Plan Choice and Benefits

In contrast to traditional Medicare, which offers beneficiaries identical premiums and benefits no matter where they live, M+C plans offered different premiums and benefits in different areas, resulting in wide geographical variations in costs to plan enrollees. While MMA has increased funding to Medicare Advantage plans, geographic differences in plan payments remain. Prescription drug plans may very well face the same challenges.

Challenge 6: Private Plans and Savings to Medicare

One goal of the private plan approach is to control costs through competition. However, analysis has shown that payments to private plans have increased Medicare spending. In 2004, Medicare will pay Medicare Advantage plans 8.4 percent more than for enrollees in traditional Medicare. The prescription drug benefit will add an additional challenge, as plans seek to limit the increase in drug costs while providing the wide range of drugs needed by elderly and disabled beneficiaries.

Conclusions

Medicare may face major challenges in its goal of making prescription drugs affordable and available to beneficiaries. Relying on private plans to provide benefits could lead to many of the same issues that have troubled the M+C program, including program instability, geographic inequities, plan lock-in, and rising costs. Additionally, the program may be too complex and intricate for many beneficiaries to understand.

In establishing the new prescription drug and Medicare Advantage programs, MMA had an opportunity to draw on the lessons learned by M+C. If the challenges are not addressed, observers six years from now may attest to a classic case of "déjà vu all over again."

Facts and Figures

- Five percent of Medicare beneficiaries account for 47 percent of program costs, making the enrollment of healthier individuals more financially attractive to Medicare health plans.
- CMS plans to establish an online database to help beneficiaries compare drug packages, but only 19 percent of seniors currently have access to the Internet. Given the complexity of plan comparisons, many will need individual assistance to make informed decisions.
- From 1997 to 2003, the number of private M+C plans decreased by more than half, from 346 plans in 1998 to 155 plans in November 2003.