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MEDICARE DISADVANTAGED AND THE SEARCH FOR THE ELUSIVE "LEVEL PLAYING FIELD"

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Throughout its history, the Medicare program has tested various models designed to gradually integrate the participation of private health insurance organizations. Most recently, in an effort to expand the role of private insurers, the government has been paying these plans more per-enrollee compared with similar enrollees in traditional, fee-for-service Medicare.

In his article, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,' " (*Health Affairs* Web Exclusive, Dec. 15, 2004), the Urban Institute's Robert A. Berenson questions whether the federal government can fiscally justify and sustain private plan overpayments amid strong pressure to reduce the federal budget deficit. And if overpayments are reduced next year, he asks, will plans that withdrew from the Medicare market earlier in the decade be reluctant to jump back in?

The History of Private Health Plans in Medicare

For some time, health maintenance organizations and other types of private health plans have been encouraged to participate in Medicare as a way to increase cost savings and expand beneficiary choices. Private plans were paid a pre-set, capitated rate for each enrollee, regardless of individual services utilized or costs incurred. From 1993 to 1999, the plans thrived, with enrollment increasing from 1.8 million to nearly 7 million. However, because plans were able to attract a healthier, less costly beneficiary population than that enrolled in traditional Medicare, the government, Berenson notes, was actually losing money.

In order to address large discrepancies in payments to plans based on geographic variations in traditional Medicare spending, the Balanced Budget Act of 1997 introduced a new method for determining payment rates, under which Medicare+Choice plans received the highest of three calculations. The legislation also mandated a system for adjusting payments based on enrollees' health status.

But the advent of these changes created problems for Medicare managed care. Plans began either leaving the program or cutting back on the benefits provided to beneficiaries. As a result, enrollment in private plans dropped from 7 million in 1999 to 5.3 million by the end of 2003.

The Medicare Advantage Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created two types of Medicare Advantage (formerly Medicare+Choice) managed care plans—regional and local—with the initiation of regional health plans scheduled to coincide with the new Medicare drug benefit plan, beginning in January 2006. Once implemented, plan payments will be based on a newly conceived competitive bidding process, a major departure in how Medicare pays providers and plans.

Under MMA bidding, the government will compare a plan's bid for Medicare

Parts A and B with a benchmark amount. If the bid is lower than the benchmark, 75 percent of the difference will be made available to the plan to provide supplemental benefits or reduce prescription drug or Part B premiums. The government will retain 25 percent of bids below the benchmark.

Bidding against a fixed benchmark, however, can create challenging dynamics. In the MMA model, with all plans bidding against a known or fixed benchmark, bids may cluster closer to the external benchmark than they would in a competitive pricing model. In addition, the government's 25 percent take of low bids may serve as a "tax" and could reduce the likelihood of aggressively low bids. This method creates the potential to perpetuate a gap between plan costs and Medicare payments in many areas.

The MMA sets up a tremendous expansion of beneficiary options but also increases the complexity of those options. In all, there will be at least 15 categories, with several different companies offering competing options within the individual categories. The array of products and organizations will add to the bewildering complexity, says Berenson. Nonetheless, private plans will have the edge—based, ironically, on simplicity. Beneficiaries remaining in traditional Medicare will have to purchase two additional supplemental policies to achieve comprehensive coverage, whereas private plans will offer "one-stop shopping" for comprehensive benefits.

Conclusions

Whether widespread restructuring of the Medicare program will occur depends in large part on decisions still pending. But the MMA legislation sowed the seeds for massive changes, Berenson says. How much health plans are paid under the new bidding approach, whether payments are appropriately risk-adjusted for enrollee health status, and whether there will be new preferred provider organizations (PPOs) to substitute for traditional Medicare remains to be seen.

The bidding model adopts a payment method that has never been tested. Many claim that traditional Medicare, which already functions much like a PPO, has enough market power to impose prices on providers at rates that are generally lower than those of commercial PPOs. Therefore, the main virtues of the PPO model, Berenson asserts, do not apply to Medicare.

Although the MMA has mandated that Medicare Advantage local plans receive an average of 107–109 percent of traditional Medicare payment levels, plans actually are receiving about 116 percent more than the costs to care for the same patients in traditional Medicare because the plans serve healthier than average enrollees. Yet, CMS has adopted a policy of not taking budget savings from the phased-in implementation of risk-adjusted payments to health plans. Faced with growing budget deficits, Congress will have to decide whether these calculated overpayments are sustainable. Most importantly, Congress must consider whether the extra payments to private plans constitute the best use of federal budget resources for all Medicare beneficiaries, especially those with the greatest health needs.

Facts and Figures

- Medicare Advantage local plans receive, on average, 107 to 109 percent of what would have been spent for the same beneficiaries in traditional Medicare.
- Data for 2003 that health plans submitted to CMS show that the enrollees they served had predicted costs 8 percent lower than those for the average fee-for-service beneficiary.
- A proposed MMA competitive bidding model uses an untested, fixed benchmarking method in which the government retains 25 percent of bids below the benchmark.