



APRIL 2002

Issue Brief

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Medicare Managed Care: Medicare+Choice at Five Years

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Introduction

The U.S. Congress created the Medicare+Choice (M+C) program in 1997 through the Balanced Budget Act (BBA) to broaden opportunities for elderly Americans to enroll in managed care. The architects of the program hoped that expanded plan choice would increase efficiency and lower costs by sparking competition among plans. Currently, about 5.6 million people, or 14 percent of the nation's 40 million Medicare beneficiaries are covered under M+C. While the Administration and some key members of Congress remain committed to expanding private Medicare options, the program has experienced some instability from health plan withdrawals in recent years.

Trends in Enrollment and Plan Participation

The opportunity to enroll in health maintenance organizations (HMOs) has existed since Medicare's creation in 1965. Yet, only a few beneficiaries took advantage of these options prior to the 1990s when managed Medicare began to grow rapidly. Between 1993 and 1999, Medicare HMO enrollment increased from 1.8 to 6.3 million beneficiaries. By creating M+C, policymakers hoped to facilitate this trend toward increased enrollment. The law expanded the health plan options potentially available to beneficiaries by allowing enrollment in alternative insurance arrangements, including preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and private fee-for-service organizations (PFFS). In addition, the program permitted beneficiaries to enroll on a limited basis (capped by law at 390,000 participants) in high

This *Issue Brief* was prepared for The Commonwealth Fund/John F Kennedy School of Government, Harvard University Bipartisan Congressional Health Policy Conference, January 17-19, 2002.

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deductible medical savings accounts (MSAs).¹ It also restructured plan reimbursement in an effort to enhance equity in regional payments, encourage performance measurement, and improve overall quality.²

Since 1999, however, enrollment has declined and the share of beneficiaries with an HMO available in their area has decreased from 72 to 64 percent. Only 14 percent of beneficiaries in rural areas reside in a location where an HMO is offered. Enrollment remains concentrated in highly populated areas and in a few states with historically high managed care penetration.

Declining enrollment results from withdrawals of managed care plans from the Medicare market. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) announced that in 2002, 58 plans would withdraw or cut back services, affecting 536,000 seniors nationwide.³ Approximately 38,000 of these beneficiaries live in regions where no other managed care plans exist; they will return to traditional Medicare. Another 50,000 beneficiaries will be limited to private fee-for-service coverage. The majority of involuntarily disenrolled beneficiaries reside in suburban and urban areas. These plan withdrawals follow similar pullouts in 1999, 2000, and 2001 that affected 400,000, 327,000, and 934,000 beneficiaries, respectively.⁴ Beneficiaries affected by withdrawals or benefits cuts have expressed anger, frustration, and concern regarding the future stability of their Medicare coverage. These beneficiaries appear particularly confused about remaining options, changes in provider networks, and the rules regarding the purchase of a Medigap policy.⁵

Stakeholders suggest that declining plan participation results from federal payments changes enacted through the BBA. Burdensome administrative requirements and other profitability issues are also cited as contributing to these declines. Finally, a Commonwealth Fund analysis suggests that a variety of local factors have affected health plans' decisions to withdraw from the M+C market.⁶ Such factors include increases in utilization and costs of medical care including prescription drugs, variation in provider willingness to accept capitated payment rates, and concerns about adverse selection and market share. According to early research, plan withdrawals may disproportionately affect the under-65 disabled,

the oldest-old, and the near poor.⁷ Policymakers have taken various steps to stem plan withdrawal. Both the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 increased payments to the plans. Administrative requirements were also adjusted by the CMS to ease plan burden. The BBRA lowered the reentry bar for terminated plans from five years to two years, and established a new entry bonus.

While media attention has focused on recent plan withdrawals, some evidence suggests that physician withdrawals from the M+C program constitute another, less visible source of instability in this market. The Commonwealth Fund recently examined provider turnover rates in the program.⁸ While these rates vary substantially, a number of states had rates of 20 percent or more. This analysis also observed variation in provider turnover rates within the same M+C market area. The report identifies both provider payment and network financial problems as the source of this instability.

Despite governmental efforts to expand enrollee choice to a wider range of managed care products, the primary alternative to traditional Medicare continues to be HMOs. Two companies, Sterling Life and Humana, have gained approval to offer a PFFS option. Sterling Life operates PFFS Medicare plans in 25 states and is available to about 38 percent of all beneficiaries while Humana operates only in Illinois in DeKalb County.⁹ Under the PFFS option, an insurer receives payments for each enrollee and contracts with providers on a negotiated fee-for-service basis. The development of a PFFS product represents a possible source of competition for traditional Medicare beneficiaries. Sterling Life primarily serves counties where payments were increased by the BBA's floor on payments (see below) and that were previously without an M+C option.

The government has received no applications for plans to offer MSA products. In a November 2000 report, the Medicare Payment Advisory Commission (MedPAC) concluded that the private sector's reticence in offering Medicare MSAs results from two market characteristics. First, little demand for this product exists among risk-averse Medicare enrollees. Second, the financial cost of marketing this kind of complex product to geographically scattered population of customers is high.¹⁰

Benefits and Premiums Under M+C

Managed Medicare plans are obligated to provide the same benefits covered by traditional Medicare. Plans with lower costs must distribute savings to beneficiaries through either lower plan premiums or enhanced benefits unless they opt to return these excess funds to the government. As government payments rose during the 1990s, many HMOs substantially reduced beneficiary plan premiums (other than the monthly Part B premiums), often to zero, and added additional benefits such as outpatient prescription drugs, vision care, and preventive dental care. Enhanced benefits meant that Medicare managed care plans had the potential to be a good financial alternative in comparison with high-cost Medigap supplemental policies. In particular, lower-income beneficiaries unable to afford Medigap coverage might particularly benefit from these extra benefits. Starting in 2003, M+C plans can begin to offer reduced Part B premiums as an additional benefit to enrollees.

The availability of enhanced benefits in M+C plans has declined somewhat in recent years. For example, the proportion of M+C enrollees with additional drug coverage dropped from 84 to 70 percent over the last three years, and other plans are scaling back their drug benefit by imposing annual caps on coverage.¹¹ The share of Medicare HMOs charging zero premiums also declined from 80 to 46 percent while the proportion of enrollees with monthly premiums of \$50 or more increased from 3 to 19 percent between 1999 and 2001.¹² Among managed care companies that charged a premium, average monthly charges increased from \$32.11 to \$42.52 during this period.¹³

In addition, out-of-pocket spending for beneficiaries in M+C plans appears to vary substantially by health status. A recent Commonwealth Fund report found that the average M+C enrollee in good health spent \$1,195 annually in out-of-pocket health costs in 2001.¹⁴ In contrast, an average enrollee in poor health spent \$3,578. The report also found that growth in out-of-pocket spending among M+C enrollees in poor health is greater than healthy enrollees. Between 1999 and 2001, costs increased \$358 (43%) among enrollees in good health, \$639 (53%) among those in fair health, and \$1367 (62%) among those in poor health.

In markets with a variety of M+C plan options, seniors may face a complex array of dif-

ferent benefit design choices across plans from year to year.¹⁵ Some research suggests that the lack of benefit standardization in the M+C program may undermine some of the goals of a competitive market because beneficiaries may be unable to systematically compare plan benefits and costs.¹⁶

M+C Plan Payments

Historically, the government reimbursed Medicare HMOs on a fee-for-service (FFS) basis until the Congress approved the use of risk contracting under the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). An adjusted average per capita cost (AAPCC) system was established to reimburse plans a fixed amount per member per month. The amount is based on 95 percent of traditional Medicare's average payment within a beneficiary's county of residence. As a result, payments to participating plans varied substantially by county, and HMOs concentrated in large metropolitan areas where payments tended to be higher. Increased visibility of geographic variation in reimbursement levels prompted demands for greater equity.

The BBA of 1997 established minimum monthly payment floors for plans serving rural areas with fewer than 250,000 beneficiaries, and the BIPA of 2000 added a somewhat higher floor for plans in more populated areas.¹⁷ In 2002, these floors are \$500.37 and \$553.04 respectively.¹⁸ The BBA also limited increases for areas with payments levels above this threshold to 2 percent; the BIPA increased this to 3 percent in 2001.¹⁹ The BBA also established a phased-in blend of national and county payments in an effort to decrease regional variation. Each year for five years the weight on the national average payment would increase 10 percentage points until by 2003 it reached 50 percent. Plans now receive the greater of the phased in blend of local and national rates, the floor rate, or the 3 percent update. While payment differences across counties have been slightly reduced, substantial variation remains.²⁰

Plan choice in rural and other low-payment regions remains quite limited, despite the creation of floor payments to induce plans to enter these areas. While 78 percent of rural beneficiaries had no managed care option in 1997, this proportion increased to 79 percent in 2000 and 85 percent in 2001. Beyond payment issues,

many rural areas operate with single-provider systems that render plan contract negotiations more difficult. A recently released Medicare Payment Advisory Commission (MedPAC) report concludes that lack of competition among providers and hospitals has dissuaded M+C managed companies from entering rural areas.²¹

Risk Adjusting Plan Payments

Traditionally, AAPCC fixed payments were risk-adjusted for beneficiary age, sex, Medicaid enrollment, and institutional status. Critics assert that this payment methodology does not sufficiently take into account the mix in health status of enrollees. Indeed, various research analyses suggest that favorable selection of Medicare beneficiaries into managed care plans has occurred. HMOs attract younger, healthier-than-average enrollees compared with the population enrolled in traditional Medicare. Rather than generating savings, favorable risk selection has meant that the federal government pays more by enrolling beneficiaries in HMOs than it would have paid for them in traditional Medicare. Precise estimates of these losses have prompted some controversy. The most widely cited estimates fall in the 6 to 8 percent range, even accounting for the 5 percent taken off the top in accordance with the AAPCC.²² As a result, selection problems may create a tradeoff between the efficiency gains achieved through plan choice and the drawbacks of sorting by health status with insufficient risk adjustment.

A new risk-adjustment system that started phasing in 2000 should help adjust for favorable risk selection, but objections by health plans have kept its scope limited. (Adjustment for the favorable selection would have meant that most plans would be reimbursed less.) The new system uses prior year individual-level inpatient hospital spending data to adjust rates for the health status of enrollees. A more complex risk adjustment system that also incorporates ambulatory data is scheduled to be in place by 2007. Improved risk adjustment is crucial for accurately capturing the health needs of beneficiaries and encouraging plans to enroll more high-cost enrollees. Legislators also have taken steps to lengthen the lock-in period for plan enrollment in an effort to curb selection. Historically, Medicare permitted beneficiaries to change enrollment at any time throughout the year. Beginning in 2002,

beneficiaries' opportunities to change their enrollment status will be limited, decreasing opportunity for selection.

Evidence on Quality and Satisfaction

It remains unclear whether quality of care and degree of satisfaction improve under managed Medicare with studies reaching conclusions on all sides of the issue. One research study found that elderly cancer patients in HMOs were more likely to be diagnosed early than those in traditional Medicare.²³ Other studies report heightened problems with access and poorer outcomes for managed Medicare beneficiaries with chronic conditions compared with similar enrollees in fee-for-service.²⁴ A review of studies on the effects of managed care on quality found that on balance no clear conclusion could be drawn with respect to quality of care.²⁵ In terms of satisfaction, most Medicare HMO enrollees appear satisfied with their care. However, those with health problems, under-65 disabled enrollees, and the chronically ill all report greater barriers to care under managed Medicare.

The Quality Improvement System for Managed Care (QISMC), established in 1996, sets quality standards for managed care plans that serve Medicare and Medicaid populations. Under the BBA of 1997, efforts were made to improve quality monitoring of participating plans by requiring standardized reporting through Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Survey (CAHPS). By increasing the availability of information on quality, the aim of the federal government is to improve the ability of beneficiaries to make informed decisions about their health plans without unduly increasing the administrative burden on plans.

Recent Developments

The Administration supports development of the M+C program, and the CMS established a goal of enrolling at least 30 percent of beneficiaries in M+C. The Congressional Budget Office (CBO) projects that enrollment in M+C will reach 22 percent of all Medicare beneficiaries by 2005 and 31 percent by 2010.²⁶ Given plan withdrawals over the last three years, these targets may appear ambitious. However, Administration officials suggest that increasing plan reimbursement rates while easing regulatory burdens can

substantially encourage enrollment. Legislation pending before Congress aims at encouraging the development of managed Medicare. Proposals to restructure Medicare include provisions that address enrollment in the M+C program. Other reform options focus on increasing reimbursement rates for health plans that participate in the program and creating incentives to beneficiaries to make cost-conscious choices. MedPAC has recommended equalization of payment rates between M+C plans and the traditional FFS program within a local market, taking into account beneficiaries' health status.²⁷ This recommendation would encourage plan choice in areas where competition between plans is viable while controlling spending.

Conclusion

While most Americans under age 65 obtain health insurance through some form of managed care, the majority of the nation's elderly remain in the traditional fee-for-service Medicare program. Achieving the goals of the M+C program present significant challenges in a climate of persistent medical care cost pressure, and widespread provider consolidation has rendered plan negotiations with providers more difficult. Lack of both managed care penetration and provider competition present unique hurdles in developing managed Medicare in rural America. Despite substantial legislative adjustments to the program under the BBRA and BIPA laws, plans continue to withdraw from the market. Such dislocations make managed care appear less secure and stable to beneficiaries.

Yet, the Administration and key leaders on Capitol Hill remain committed to expanding enrollment and correcting shortcomings of the program. Indeed, many argue that a successful managed Medicare program has the potential to create substantial market efficiencies and augment choices among elderly beneficiaries. The M+C program promises to make the health care options available to Medicare eligible individuals more closely resemble those of the insured working population. Over the next few years, researchers and policymakers will continue to gauge the success of the M+C program in providing cost-effective, high quality health care to the nation's elderly.

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