Medicare+Choice Becomes Medicare Advantage: Will Past Be Prologue?

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Policy Context

- Medicare+Choice aimed to expand private plan options and encourage individuals to be informed consumers but few new options were created and the share of Medicare beneficiaries in private plans decreased rather than increased.

- Medicare Advantage has now been created under the Medicare reform legislation. Current private plan options will be maintained as “local plans” and paid more effective in 2004 to stabilize the market. In 2006, regional plans will be added along with prescription drug benefits and pricing changed.

- We need to understand the past to anticipate the future. Will past be prologue or will the changes Congress has introduced in Medicare Advantage yield a new experience?
Organization of Presentation

- Context: Important Attributes of Medicare Beneficiaries
- Medicare+Choice: What Happened
- Drawing Lessons from Medicare+Choice
- Speculating on the Future under Medicare Advantage
Basis for Presentation

- Over five years experience monitoring the Medicare+Choice program and its effects on beneficiaries

- Core funding from the Robert Wood Johnson Foundation, complemented by The Commonwealth Fund.

- Related work funded by the Kaiser Family Foundation, AARP and Medicare Payment Advisory Commission
Major Data Sources

- Administrative data used to develop longitudinal research files with information on Medicare beneficiaries, available M+C plans and enrollment in each county, with county and plan characteristics.

- Complementary database on plan premiums and benefits based on Medicare Compare.

- 2000 survey of Medicare beneficiaries nationally and in six communities that also were monitored on an annual basis by initial site visits and annual calls.

- Targeted work on special topics (e.g. national firm analysis, the PPO demonstration and private fee-for-service plan option)
Context: Important Attributes of Medicare Beneficiaries
Medicare Beneficiaries Have Limited Managed Care Experience; Few Find Choice of Plan Salient

Source: MPR Survey of Medicare Beneficiaries for RWJF, 2000

Share of Beneficiaries for Whom Choice Was Salient, 2000
The Context of Choice Varies Greatly Because of the Complexity of the Supplemental Market

<table>
<thead>
<tr>
<th>Supplemental Coverage</th>
<th>All Beneficiaries</th>
<th>All Beneficiaries in Counties with Medicare+Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any group coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>38%</td>
<td>40%</td>
</tr>
<tr>
<td>Self</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>Spouse</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>Military</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Any Medicaid</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Any Medigap</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Any Medicare HMO</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Any other</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>None</td>
<td>17</td>
<td>13</td>
</tr>
</tbody>
</table>

Subgroups of Medicare Beneficiaries are Particularly Vulnerable in Ways that Complicate Choice

Percent of Medicare Beneficiaries

- Under 65 and Disabled: 12%
- 85 and Older: 11%
- Fair/Poor Health: 36%
- Needs Help 1+ Areas: 37%
- Less Than High School: 26%
- African-American: 9%
- "Other" Non-White Races: 5%
- Hispanic: 4%
- $20,000 Income or Less: 60%

Medicare+Choice: What Happened and Why?
What Medicare+Choice Did

- Folded the Medicare risk contracting program (for HMO plans) in Medicare+Choice.

- Expanded authorized coordinated care options to include preferred provider organizations, provider sponsored plans, and point of service plans.

- Authorized private fee-for-service plans and, on a demonstration basis, Medical Savings Accounts.

- Modified risk-based payment to encourage development of plans in rural and less served areas and to reduce disparities in payment across the country, subject to budget neutrality.

- Expanded efforts to educate beneficiaries and encourage them to consider choice, with transition to an annual enrollment period (delayed).

- Part of a complex bill with many components and provisions for containing Medicare costs.
### Percent of Medicare Beneficiaries in Private Plans 1999 and 2003

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>1999 N</th>
<th>1999 %</th>
<th>2003 N</th>
<th>2003 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Private Plan</td>
<td>6,893,765</td>
<td>17.3%</td>
<td>5,228,349</td>
<td>12.2%</td>
</tr>
<tr>
<td>Coordinated Care Plan*</td>
<td>6,347,434</td>
<td>15.9%</td>
<td>4,622,664</td>
<td>10.8%</td>
</tr>
<tr>
<td>Cost Plan</td>
<td>341,022</td>
<td>0.9%</td>
<td>355,231</td>
<td>0.8%</td>
</tr>
<tr>
<td>PPO Demonstration</td>
<td>--</td>
<td>--</td>
<td>75,431</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other Demonstration</td>
<td>205,309</td>
<td>0.5%</td>
<td>150,563</td>
<td>0.4%</td>
</tr>
<tr>
<td>Private FFS</td>
<td>--</td>
<td>--</td>
<td>24,400</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

**Source:** MPR Analysis of CMS Data.  Medicare Managed Care Reports October 2003, December 1999

*Include HMOs, PPOs and provider sponsored plans.
Medicare Managed Care Enrollment, 1990-2003

Source: HCFA/Center for Health Plans and Providers data, MPR analysis for RWJF.

Note: All data as of December. Data from 1999 on are for coordinated care plans (CCPs). Data for prior years are for enrollees in Medicare risk plans.
## Enrollees Affected by M+C Withdrawals 1999-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>M+C Enrollees Affected</th>
<th>M+C Enrollees with No Other M+C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>407,000</td>
<td>47,000</td>
</tr>
<tr>
<td>2000</td>
<td>327,000</td>
<td>79,000</td>
</tr>
<tr>
<td>2001</td>
<td>934,000</td>
<td>159,000</td>
</tr>
<tr>
<td>2002</td>
<td>536,000</td>
<td>38,000</td>
</tr>
<tr>
<td>2003</td>
<td>217,000</td>
<td>29,000</td>
</tr>
<tr>
<td>2004</td>
<td>41,000</td>
<td>3,100</td>
</tr>
</tbody>
</table>

Source: CMS, various years.
### Trends in Premiums and Benefits in Coordinated Care Plans, 1999-2003*

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero Premium Plan</td>
<td>80</td>
<td>59</td>
<td>46</td>
<td>41</td>
<td>38</td>
</tr>
<tr>
<td>Average Premium</td>
<td>$6</td>
<td>$14</td>
<td>$23</td>
<td>$32</td>
<td>$37</td>
</tr>
<tr>
<td>Average Percent of Enrollees with Any Drug Coverage</td>
<td>84</td>
<td>78</td>
<td>70</td>
<td>72</td>
<td>69</td>
</tr>
<tr>
<td>Estimated Average Out of Pocket Spending</td>
<td>$976</td>
<td>$1,185</td>
<td>$1,438</td>
<td>$1,786</td>
<td>$1,964</td>
</tr>
</tbody>
</table>

**Source:** MPR Analysis for The Commonwealth Fund.

*Basic Plans only

**Includes a few plans that offer premium rebates as well.
Coordinated Care Plans are Geographically Concentrated

<table>
<thead>
<tr>
<th>State</th>
<th>CCP Enrollees</th>
<th>Penetration (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island</td>
<td>57,203</td>
<td>32</td>
</tr>
<tr>
<td>California</td>
<td>1,266,466</td>
<td>30</td>
</tr>
<tr>
<td>Arizona</td>
<td>200,682</td>
<td>27</td>
</tr>
<tr>
<td>Oregon</td>
<td>121,779</td>
<td>23</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>491,068</td>
<td>23</td>
</tr>
<tr>
<td>Colorado</td>
<td>109,945</td>
<td>22</td>
</tr>
<tr>
<td>Florida</td>
<td>524,545</td>
<td>18</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>164,229</td>
<td>17</td>
</tr>
<tr>
<td>Washington</td>
<td>125,537</td>
<td>16</td>
</tr>
<tr>
<td>New York</td>
<td>424,700</td>
<td>15</td>
</tr>
<tr>
<td>All Other States</td>
<td>1,053,655</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: MPR Analysis of CMS data.
A Small Number of Firms Dominate the Market

M+C Coordinated Care Enrollment by Firm or Affiliate 2003

Source: Enrollment information from CMS October 2003 Geographic Service Area File. Information on plan affiliation from Interstudy 13.2 with data as of January 1, 2003.
The PPO Demonstration Expanded Options but in Areas Already Served

- Only five percent of beneficiaries in PPO demonstration had no existing PPO option
- Premiums for PPOs vary but typically are substantially higher than for HMOs
- High cost sharing typically applies to out of network benefits
- Only one of the firms did not already participate in M+C
- Risk sharing and 100% FFS option applied to demonstration and were variably used.
The Private Fee-For-Service Option is Small but Has been Evolving

- Less than 25,000 nationwide
- Enrollment is geographically dispersed
- The largest and oldest plan, Sterling, withdrew in 2004 from 502 counties in 13 states, with most of the 2,543 affected enrollees having no other choice
- New entries by UniCare and Humana suggest plans are using this option to diversify products

Source: MPR analysis of Centers for Medicare and Medicaid Services geographical Service area file and contract withdrawal reports
*Projected based on 2004 withdrawal reports and 2003 plan offerings.
Trends in Availability of Medicare Private Plans, Rural, 1999-2004

Source: MPR analysis of Centers for Medicare and Medicaid Services geographical Service area file and contract withdrawal reports
*Projected based on 2004 withdrawal reports and 2003 plan offerings.
Some Reasons for Experience Under M+C

- Rapid expansion in competitive market will result in some failures

- Plans won’t develop new products they don’t think are viable in the market (structures, requirements).

- Managed care backlash and experience limited provider’s willingness to accept risk and lower payments (provider pushback).

- Plans serving most enrollees got only 2 percent increases annually, less than inflation.

- Reduced benefits and instability in plans and networks made plans less attractive to beneficiaries.

- Initial expectations were overly optimistic even with “best case” scenario.
Lessons From M+C
Lessons From M+C

- Can’t legislate a market if underlying conditions unfavorable
- Price matters (and so does stability, predictability)
- The private sector is not necessarily less expensive and additional benefits may be needed to make people want to voluntarily join
- Private plans, especially risk based managed ones, are not equally viable everywhere
- Providers are critical and need to want to play or feel they have no choice
- Private plans are less likely to yield uniform benefits because of geographical variation in practice.
Speculating on the Future Under Medicare Advantage
Short Term Changes (2004-2005)

- M+C become MA, all options continue (including MSAs)

- Current payment policy of floor, blend (if budget neutral), or 2 percent payment changed:
  - Fourth alternative, 100% FFS in county excluding DME, including DOD/VA
  - Blend not subject to budget neutrality
  - Minimum increase the GREATER of 2 percent or prior year’s increase in national growth rate with no retrospective adjustments for errors pre 2004

- 2005 payment is 2004 by greater of 2 percent or NGR per above
2006 Changes

- Pharmacy benefit either through private drug plans or MA.

- Current MA options maintained as “local plans” but two year moratorium on new PPOs or service area expansions.

- Regional plans offered nationally in 10 to 50 regions.

- Regional plans include a single deductible and out of pocket limit (may vary in and out of network).

- Short term risk sharing and a regional stabilization fund to encourage participation, certain other regulatory requirements waived.

- “Blended payment” by based on plan bids and local/ regional/national benchmarks
Speculations on Immediate Effects

- Payment increases substantial but variable in 2004
- Full increase won’t be translated into benefits but plans will use money strategically.
- Market should stabilize though benefits won’t reach back to past
- Plans will modify offerings in anticipation of 2006
- Penetration won’t increase much in the short run
- M+C experience will keep beneficiaries, providers, and, to an extent, plans leery of the private plan option
2006 and Intermediate

- MA may become more attractive if higher payments and integrated structure lead to more appealing drug benefit.

- Development of MA limited by entry costs for new sponsors and potential problems of serving large regions.

- Congress included many features to enhance flexibility for Medicare’s negotiations to attract private plans but use of these options will be challenging and require much savvy.

- Private firm participation will be key but so will changing the negative perceptions of M+C among beneficiaries and physicians.

- Experience will show whether government has the flexibility, savvy, and discretion to develop stable, attractive products.

- There are likely to be trade-offs between developing private options rapidly and protecting beneficiaries.