Order Code RS21761
Updated April 20, 2004

Medicare Advantage: What Does It Mean For Private Plans Currently Serving Medicare Beneficiaries?

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Summary

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173) added a voluntary prescription drug benefit to Medicare and established the Medicare Advantage program to replace the Medicare+Choice program. The act increases payments to private plans beginning in March 2004, creates a new competitive program in 2006, adds a regional program also in 2006, and creates a temporary program that requires traditional Medicare to compete with private plans in 2010. These changes were designed to increase private plan participation and to increase competition in Medicare. Although plan participation is likely to increase in the short-term, long-term participation is unknown. This paper outlines major changes to the managed care program and indicates how these changes may affect participation. This report will not be updated.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) added a voluntary prescription drug benefit to Medicare and made many changes to the Medicare+Choice (M+C) program, now called Medicare Advantage (MA). Changes to MA include (1) increased payment rates, (2) a competition program in 2006, (3) the addition of regional plans beginning in 2006, and (4) a six-year comparative cost adjustment program in 2010 that enhances competition between MA plans and requires traditional Medicare to compete with MA plans. Although plan participation is likely to increase due to the increased payments, long-term plan participation is unknown.

Prescription Drugs

MMA added a voluntary prescription drug benefit to Medicare. Starting in 2006, beneficiaries will have access to a drug plan whether they are in traditional fee-for-service (FFS) Medicare, or enrolled in managed care. The prescription drug coverage will be provided through either newly created prescription drug plans or for those beneficiaries in MA, Medicare Advantage Prescription Drug (MA-PD) plans. Managed care

organizations will be required to offer at least one plan that includes the standard prescription drug benefit, or an actuarially equivalent drug benefit, but may offer additional plans without a drug benefit, or with a more generous benefit. Generally, organizations offering MA-PD plans will be required to comply with the rules and procedures required of companies offering a prescription drug plan to beneficiaries in the FFS Medicare program under the new Part D. Similar rules and procedures will be established for the prescription drug plans and MA-PD plans with respect to: enrollment, dis-enrollment, termination, coverage periods, appeals, information dissemination and the procedure of submitting a bid for the cost of providing the drug benefit.

Historically Medicare managed care plans were able to attract enrollees by offering additional benefits, one of the most popular being prescription drugs. Beneficiaries who enrolled in these plans were willing to accept some of the restrictions of managed care, such as limitations on provider choice, in order to have the additional benefits. Beginning in 2006, beneficiaries will be able to get prescription drugs whether they are in traditional FFS Medicare or an MA-PD plan. To compete with traditional Medicare, some plans may redesign their benefit packages to remain attractive to their enrollees. For example, they may consider adding vision or dental services, if they do not already include them, reducing cost sharing, or enhancing the prescription drug benefit.

In 2004, 36% of Medicare Advantage enrollees are enrolled in a plan that includes prescription drugs with no additional premium.[1] These plans are providing prescription drug coverage to enrollees because their cost of providing all benefits covered by Medicare under Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) is less than the current payment rate. Starting in 2006, MA-PD plans will receive additional money from Medicare to pay for the prescription drug benefit. If a plan can continue to provide the standard Part A and B benefits at a lower cost (i.e., if its bid for covering Part A and B benefits is less than the benchmark, explained in more detail below), then it can provide other additional benefits with some of the savings that might, in previous years, have gone towards providing prescription drugs.

What can plans do to compete with traditional FFS Medicare? Managed care organizations will be allowed to make their plans more attractive to beneficiaries by reducing out-of-pocket expenses (copayments for Part A and Part B benefits, the premium for Part B coverage, or the premium for the prescription drug coverage) or by adding benefits such as eyeglasses and earing aids. Plans may also add additional drug coverage beyond the basic Medicare benefit, but there is a disincentive for them to do this. Once an enrollee reaches the annual out-of-pocket threshold for catastrophic drug coverage ($3,600 in 2006, which would be reached with $5,100 in total drug spending under a standard plan) Medicare provides reinsurance — paying the plan a portion of the enrollee's additional drug costs. Third party payments, including MA payments, do not count toward the beneficiary's out-of-pocket threshold. Additional drug coverage would reduce the enrollees' out-of-pocket expenses, so that fewer enrollees would reach the out-of-pocket threshold, and those who did would reach it later in the year. The additional coverage would thus reduce the money a plan would receive from Medicare.

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[1] Centers for Medicare and Medicaid Services, personal communication, Jan. 2004.

Alternatively, plans may decide to add or enhance a drug benefit in 2004 to increase enrollment and gain a competitive advantage in the managed care market prior to the beginning of the Medicare drug benefit in 2006. Some plans have enhanced their drug benefits for 2004, as discussed below. Plans may also offer Medicare-endorsed drug discount cards to their own enrollees through the newly established drug discount card program under MMA. The cards could provide discounts on drug prices even if the plan does not have a drug benefit, or if the plan benefit cap is reached.[2] Beneficiaries who enroll in a plan in 2004 may be more likely to remain with the plan when the Medicare drug benefit is added to the program in 2006.

Payment Rate Changes

For 2004, MMA changed the payment rate calculation for Medicare managed care plans, resulting in increased payment rates for all counties.[3] Previously, plans received the highest of three possible rates — a floor rate, a minimum increase above the previous year's rate, or a blend of local and national rates — subject to a budget neutrality provision.[4] MMA made three major changes to the payment formula for 2004, all designed to increase payment rates. First, a fourth payment type was added: 100% of per capita fee-for-service Medicare costs.[5] Second, the budget neutrality adjustment was eliminated, allowing a blend payment to be paid when it is the highest of the four rates, even when that would increase total expenditures. The blend payment uses a combination of local and national rates, and is designed to reduce variance in payments across counties. Third, the minimum increase was changed from a 2% increase above the previous year's rate to the greater of 2% or the percentage by which per capita Medicare expenditures grew nationally in the previous year. In 2005 and beyond, payments will be annually updated by the new minimum increase or, at the Secretary's discretion, but at least once every three years, the higher of either the new minimum increase or 100% of the updated (rebased) FFS per capita payment.

Payment rate increases beginning in March 2004 vary from county to county. The average increase (weighted by the number of enrollees) relative to the 2003 rate is 10.8%. The smallest increase for the same period is approximately 6.3%. Approximately 94% of enrollees live in counties where the increase is 20% or less. A small number of plans will receive increases of more than 45%. The higher payment rates may encourage organizations to stay in Medicare, and may attract other organizations, increasing

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[2] See [http://www.cms.hhs.gov/discountdrugs/overview.asp]

[3] For 2004, the Centers for Medicare and Medicaid Services updated the national growth percentage to reflect "adjustments for prior year's over/under estimates" and the impact of MMA. The update increased the floor payments, even though they were not explicitly changed by MMA.

[4] For a more detailed discussion of payments under the M+C program, see CRS Report RL30587, *Medicare+Choice Payments*, by Hinda Ripps Chaikind and Paulette Morgan.

[5] Per capita FFS payment would be adjusted to (1) include risk adjustment, (2) remove payments for direct medical education costs, and (3) include the additional payments that would have been made if Medicare beneficiaries entitled to benefits from the Department of Veterans Affairs (VA) and the Department of Defense (DOD) had not used those services. Risk adjustment is a method of controlling for the variation in the cost of providing health care among beneficiaries. CMS is currently unable to obtain the data it needs to properly adjust for VA and DOD benefits.

competitive pressures on existing plans. It may also encourage plans to expand their service areas. Approximately 21% of counties not currently served by a managed care plan qualify for an average payment increase of 15% or greater. For six consecutive years private plans have withdrawn from Medicare or reduced their service areas citing low payment rates as the primary cause. CMS indicates that plans are using the increases to 2004 payments to: (1) strengthen provider networks with 43% of the funds; (2) reduce premiums with 31% of the funds; (3) enhance benefits, including prescription drug cards, with 17% of the funds; and (4) reduce cost sharing with 5% of the funds. Five percent of the additional funds are being held in the stabilization fund for use before the end of 2005.

Competition Program Starting in 2006

Until 2006, organizations participating in Medicare managed care must submit to CMS an estimate of the cost of providing Part A and B benefits to the average beneficiary. This estimate is called an Adjusted Community Rate (ACR) proposal and it is submitted each year for each plan the organization offers. The ACR is compared to the payment the plan would receive for serving beneficiaries. If the payment is larger than the cost of serving beneficiaries, the plan is required to return the full amount of the difference to the beneficiary in the form of additional benefits, reduced cost-sharing or a reduction in the Part B premium. The organization may also save the difference in a "stabilization fund" to defray future costs.

Starting in 2006, plans will no longer file ACRs. Instead, their estimate of the cost of providing benefits to beneficiaries will be called a bid. The bid will be compared to a per capita benchmark for the area that is similar to a payment rate prior to 2006. If the benchmark is higher than the bid, the plans must return 75% of the difference to the beneficiaries in the form of reduced cost-sharing for Part A and B benefits, additional MA benefits, or a credit towards any monthly MA premium, prescription drug premium, or Part B premium. If the bid is above the benchmark, Medicare will pay the plan the benchmark and the beneficiary will pay the difference between the bid and the benchmark.

The bid portion of the competition program starting in 2006 differs from the ACR process in two ways. First, MMA grants the Secretary the authority to negotiate plan bids. Second, prior to 2006, plans return 100% of the difference to beneficiaries if the payment exceeds the ACR; after 2006, plans will return only 75% of the difference if the benchmark exceeds the bid, and the remaining 25% will be returned to the government as savings.

It is unclear whether the Secretary's ability to negotiate will have an impact on plans currently in Medicare. It is also unclear whether returning 25% of plan savings to the government instead of providing that amount to the beneficiary will have an effect on plans. Some observers expect plan bids to be close to the benchmark with little savings returned to either the beneficiary or the government. Others, including the Congressional Budget Office, estimate plan bids will be below the benchmarks, resulting in savings for both beneficiaries and the government. Sharing savings with the government could result in plans providing less generous supplemental benefits than they otherwise would have, which could make it more difficult to compete with traditional Medicare

It is possible that the bid process may be less burdensome than the ACR process, though that will depend on details of how the implementing regulations are written. The ACR process, in effect until 2006, requires a comparison that is not required in the bid. Under the Medicare+Choice program, plans are not allowed to earn a higher return from their Medicare business than their commercial market. One section in the ACR requires a calculation of the plan's expected returns from providing Medicare-covered benefits to Medicare beneficiaries versus providing the same benefits to their non-Medicare business. No such calculation is required under the bid process beginning in 2006.

Regional Plans Starting in 2006

Private plans participating in Medicare specify the areas they want to serve. They define their service areas as sets of counties and county parts. Starting in 2006, plans will be encouraged (but not required) to serve entire regions designated by the Secretary as part of a new regional program. The regional program is designed to encourage plans, specifically preferred provider organizations (PPOs), to serve areas they had not previously served, particularly rural areas, in an effort to make Medicare managed care more closely resemble the Federal Employees Health Benefits Program (FEHBP). A plan participating in the new regional program will (1) have a network of providers who agree to a contractually specified reimbursement for covered benefits, (2) provide for reimbursement for all covered benefits, regardless of whether the benefits are provided within the network, and (3) serve one or more regions.

The Secretary will establish between 10 and 50 regions throughout the country based on analyses of current insurance markets. Plans offered in the regional program will be called MA regional plans, while non-regional plans will be called MA local plans. An MA regional plan may choose to serve more than one region, or may serve the entire nation, but it can not segment its service area to offer different benefits or cost sharing requirements to beneficiaries within the same region.

In addition to the difference in service areas, MA regional plans will differ from MA local plans in (1) benefit package, (2) access to risk-sharing arrangements and incentive payments, and (3) potential additional payments to hospitals that join managed care networks. First, the benefit package for MA regional plans must include a single deductible for Part A and B services, and it must include a catastrophic limit on expenditures. The conference report for MMA (H.Rept. 108-391) indicates these requirements will make the regional plans more closely resemble the private plans for the under-65 population. The amount of the catastrophic limit is not specified in the law. Second, to encourage plans to participate in the regional program and serve areas they have not previously chosen to serve, Medicare will initially share risk with MA regional plans in 2006 and 2007 if a plan's costs fall outside of a specified range or "risk corridor"; plans will assume only a portion of the risk for unexpected high costs and plans will be required to return a portion of the savings to Medicare for unexpected low costs. Another incentive to participate in the regional program is a stabilization fund that can be used to encourage plans to serve one or all regions, or to encourage plans to stay in regions they might otherwise leave. Initially $10 billion will be available to the fund, but additional funds will be available from any savings from regional plans with bids below the regional benchmark. Third, since establishing networks can be difficult in less-populated areas, MMA includes a provision whereby hospitals can receive a payment from CMS to join an MA regional plan's network if the hospital can prove that the costs of serving the

plan's enrollees exceed the Medicare Part A payment. In such cases, the plan must also pay the hospital at least the Medicare Part A payment for services provided to enrollees.

What does this mean for plans currently in Medicare? All areas of the country will be part of a region in the regional program, including areas currently served by local MA plans. It is unclear whether the incentives to participate in the regional program will be (1) enough to encourage plans to participate, or (2) so great that regional plans can offer more generous benefits than local MA plans and attract beneficiaries away from the local plans within the region. Moreover, some plans may choose to participate in the regional program in addition to, or instead of participating as local MA plans. How local MA plans react to the regional program will be based on business decisions about risk, profit and competition.

Comparative Cost Adjustment Starting in 2010

The Secretary is to establish a six-year comparative cost adjustment (CCA) program beginning on January 1, 2010, and ending on December 31, 2015. The CCA program is designed to enhance competition between local private plans in the Medicare program and to compare the overall efficiency of these plans with respect to traditional Medicare. MA plans in CCA area can only be local plans, as regional plans can not participate in the program. An area can qualify for the program if it is a metropolitan statistical area (MSA) with at least two MA organizations and has at least 25% of Medicare beneficiaries enrolled in MA local plans. Of those MSAs that qualify, no more than 6 areas, or 25% of the areas that meet the requirements will participate.

There are two major differences between comparative cost adjustment areas and non-CCA areas. First, in a CCA area, payments to local MA plans will be based on competitive bids, similar to payments for the regional MA plans. The benchmark that is compared to each plan's bid is not strictly an increase over the previous year's benchmark (as in non-CCA areas), but rather a weighted average of plan bids and the cost of traditional FFS Medicare in an area. (There is a five-year phase-in of CCA benchmarks.) Second, in a CCA area, traditional Medicare will compete with local MA plans. While FFS beneficiaries in non-CCA areas will continue to pay the standard Medicare Part B premium, beneficiaries in CCA areas could have their Part B premium either increased or decreased. FFS beneficiaries in CCA areas would pay higher Part B premiums if the cost of providing the standard Medicare benefit package was more expensive in FFS than the cost in the local MA plans. Conversely, FFS beneficiaries in a CCA area would paid lower Part B premiums if the FFS costs are less expensive the MA costs. The premium is phased-in over five years, and additionally, cannot exceed 105% of what it would have been for beneficiaries in the CCA area.

Proponents of the CCA program anticipate that competition in CCA areas would decrease costs to the Medicare program, perhaps through such strategies as steeper negotiations with providers or more attention to disease management. Opponents of the CCA program argue that beneficiaries who want to remain in traditional Medicare may be financially penalized with increased Part B premiums.