Medicare Advantage – Past, Present, and Future

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Introduction

"Prepaid Medicare," known today as Medicare Advantage but with a number of important antecedents, is a program in search of a stable mission. As we will discuss, the goals of Prepaid Medicare have changed repeatedly over the roughly 40 years of its existence paralleling Traditional Medicare (TM). For the future, the questions are what are the gains to be achieved from continuing a Prepaid Medicare program, and how can they best be accomplished?

Early History (1965-85)

Before the Prepaid Medicare program was given its first formal name and formally designed, Medicare prepayment came into being within the context of integrated delivery systems like Kaiser Permanente. At the onset of the Medicare program, group/staff model plans (later to become early "Health Maintenance Organizations" (HMOs)) were paid either FFS or 80% of costs, with the balance paid by beneficiaries. However, FFS payment, as well as substantial co-insurance, conflicted with these plans' prospective (capitated) commercial payment methodology, mission to provide comprehensive coverage and prepayment to the delivery system. In addition, many felt that there was no opportunity for the Medicare program to participate in the savings potential created by prospective payment. So by the late 1970s there were several Medicare prepayment pilot programs in place.

TEFRA 1985

In the Tax Equity and Fiscal Responsibility Act of 1985 (TEFRA), the Centers for Medicare and Medicaid Services (CMS), at the time called the Health Care Financing Administration (HCFA) was told to experiment further with risk-based payment systems. Based on the experience of subsequent "TEFRA Risk" pilots, a growing Prepaid Medicare industry began to gain a foothold. The basic design was per-beneficiary capitation based on 95% of the local county FFS payment rates. At a time when FFS expenditures were seen as robust, the intent was to return at least 5% in savings relative to FFS costs to the Medicare Trust Funds. In addition, the payment methodology included the potential for added benefits, especially lower out-of-pocket payments for beneficiaries, a design that was quite appealing to low income beneficiaries lacking supplemental insurance. Payments were risk adjusted to a limited extent, using limited demographic and institutional status.

Initial Issues (1985-1996)

After the passage and implementation of TEFRA, enrollment in Prepaid Medicare, then known as "Medicare Risk", grew steadily, increasing nearly ten-fold between 1985 and 1996 (see Figure #1)[2]. But some experienced growing concerns with the direction of

the program. The county-based payment system created geographic disparities in payments and in the level of additional benefits that were available to beneficiaries. Medicare Risk contractors tended to concentrate in higher paid (and more densely populated) counties, such as urban and suburban counties, to the exclusion of some more rural parts of the country. Many Medicare Risk plans were able to use "savings" to provide beneficiaries with at least some pharmaceutical coverage, a benefit not available in TM.

By 1996, policymakers had begun to discuss issues of risk selection leading to some Medicare Risk plans potentially being overpaid. There was evidence that some plans were receiving 10-11% beyond their costs, primarily as a consequence of attracting an average lower risk beneficiary profile than existed in TM. Some plan marketing practices appeared geared to promote favorable risk selection. Many felt that the risk adjustment mechanism was inadequate and needed more clinical data elements.

BBA - 1997

In reaction to the concerns expressed above, Congress, in the Balanced Budget Act of 1997 (BBA) decided to both expand the geographic availability of Medicare Risk and improve the accuracy of payment thought the implementation of a more sophisticated risk adjustment methodology. The name "Medicare Risk" was changed to "Medicare+Choice". Several new types of plans were authorized including "Preferred Provider Organization (PPO) plans, characterized by larger, more open provider networks than the earlier HMO-based plans, and Private Fee-for-Service plans (PFFS) which ultimately had the effect of creating incentives for plans to service more rural areas. Of course, the PFFS plans changed the nature of prepayment by limiting it to the health plan itself, with the health plan adopting the fee-for-service provider payment system.

However, due to its underlying deficit reduction motivation, the BBA significantly reduced payment updates to Medicare+Choice plans. It also improved the risk adjustment methodology by including health status-based adjustment factors. As a result of the subsequent changes in payment levels, many Medicare+Choice plans quit or reduced geographic coverage; premiums paid by beneficiaries rose; some tangible benefits were reduced; enrollment dropped; and beneficiaries complained (see Figure #1). For example, in an attempt to constrain geographic variation, the payment methodology was changed to "squeeze down" high payment levels to the national average over time, while increasing payments in the lowest paid counties. A minimum payment update of 2% was also included in the new methodology. So although counties with high payment rates faced an indefinite period of 2% payment increases, this was much less than medical inflation (around 4-5% during that period) and much less than comparable commercial trends of 8% to 12%.

BBRA-1999, BIBA-2000, MMA-2003

As the effects of the BBA were being felt, Congress reacted to plan withdrawals and beneficiary complaints with incremental changes over the next few years mitigating some payment reductions, until the major changes of the Medicare Modernization Act of 2003 (MMA). These included:

- Another name change for Prepaid Medicare, now to "Medicare Advantage" (MA).

- Increased payments to plans by adding minimum "floor" payment levels in rural and then some urban counties which were not directly related to the original TM county payment rates.
- Creation of protections for newer plan types, especially PFFS plans, using special contracting provisions, such as the ability of PFFS plans to "deem" a provider into its network if any Medicare beneficiary was served by that provider, even once, under the TM program. PFFS plans were allowed to enforce payment to hospitals at TM prospective payment rates, and to physicians at the Medicare RB/RVS payment schedule rates.
- Changed the update formula (removing the BBA-induced pressure on rates) and established in Medicare Advantage a new quasi-competitive bidding process against county "benchmarks."

Following these changes Medicare Advantage enrollment began to grow rapidly, mostly in the new PFFS program, with membership increasing from a nadir of around 5 million members in 2002 (See Figure #2)[3] to the current 10.5 million in 2010. But concerns about "over-payment" reemerged, because the Medicare program was spending more on Prepaid Medicare, rather than achieving savings, and this became a point of controversy between Republicans and Democrats.

<u>Current State of Medicare Advantage</u>

It may be useful to look at several snapshots of Medicare Advantage as it exists today, before changes from the new health care reform legislation, now commonly referred to as "The Affordable Care Act" (ACA).

i. Enrollment by type of MA plan (as of 4/10)
   - HMO ~ 7.3 million seniors
   - PPO ~ 2.1 million
   - PFFS ~ 1.7 million
   - MSA ~ 600

ii. Average Estimated Payments in 2010 (assuming SGR cuts do not occur)
   - Ratebook = 112%
   - Rebates to Treasury = <3%>
   - Net pay = 109%

iii. Benchmarks by type of plan (MedPAC March 2010 report, p. 266))
   - HMOs ~ 112% of FFS Medicare; (bids 97% of FFS)
   - PPOs ~ 109-115%; (bids regional-104%, local-108%-of FFS)
   - PFFS ~ 114%; (bids 111% of FFS)

Bids are now based on "benefit competition" under which MA plans try to have the most attractive package of "extra benefits" with as small a premium to beneficiaries as possible, and in many areas, no premium. The formula works as follows:

- Ratebook rate - Plan bid = Payment difference
- Rebate = 75% of payment difference and is used by plans to provide additional benefits and reduced cost-sharing, 25% is returned to the Medicare Trust Funds.

The "Ratebook" is the Congressionally legislated set of rates that are somewhat based on county FFS Medicare spending, but county rates have been increased relative to FFS by other Congressional action to provide minimum "floors" or to receive the greater of the county rate or the floor. A plan's "bid" is submitted for the TM package of Medicare benefits (e.g., the 2010 $1100 Part A deductible, $155 Part B deductible with 80/20% coinsurance, etc.). If the plan bid is less than the county rate (which it almost always is), then MA plans can use 75% of the difference (the "rebate") to enhance their products for potential enrollees.

This rebate can be used for:

- Supplemental benefits (dental, vision, etc.)
- Reduced cost-sharing (deductibles, co-payments, etc.)
- Reductions in Part B or Part D premiums
- Increased payment to network providers

The greater the rebate is (as is the case in high payment counties in South Florida and Southern California), the more extra benefits that can be offered. In other regions with lower county rates (e.g., the Midwest), only modest benefit enhancements are possible.

<u>Changes in ACA for MA Plans</u>

ACA greatly changed the payment methodology, while keeping it as an administered pricing system with plans bidding against set county-level benchmarks. Starting in 2011, there are numerous changes including:

i. A freeze on county payment rates for 2011, then a multi-year transition to the new system

ii. Payments will now be scaled based on the quartile in which a county's rate falls:

- Highest ~ 95% of FFS actual payments
- 2nd ~ 100% of FFS actual payments
- 3rd ~ 107.5% of FFS actual payments
- Lowest ~ 115% of FFS actual payments
- The quartiles are established by creating a simple, unweighted list of counties in order of local FFS costs, dividing the list into four equal segments.
- The amount of rebate savings that plans may use to enhance benefits or lower premiums is reduced to 50%, except that plans with relatively high quality scores may retain up to 70% of the savings resulting from bidding below the local county benchmark.
- In total, these new rates will be lower for each quartile than the status quo and the savings for the U.S. Treasury will, according to CBO, amount

to about $140 billion over the 2010-2019 "scoring window, assuming a substantial reduction in MA enrollment.
- The rate of reduction in each county will be over either 2, 4 or 6 years, with the length of implementation time directly related to the degree of change of the benchmark.

Quality measures will now explicitly become a part of the payment methodology. In deriving the amount of "extra payments" that MA plans can return in the form of extra benefits, the rebate percentage used will be reduced from the current 75% to either 70%, 65%, or 50% based on quality "star" ratings (i.e., MA plans earning more stars for quality metrics will retain a high percentage of the extra payments).

A quality bonus (actually an increase in the benchmark against which plans will bid) has also been added. A plan's county level benchmark will be increased by 5% if plans reach certain quality scores on specified measures. In theory, this allows the counties in the highest rate quartile an increase in their payments from the new 95% level up a maximum of 5%, thus returning to the 100% of the Ratebook currently in place.

Also, "qualifying county" bonuses are provided for certain counties. High scoring plans in counties that have 250,000 people, 25% of all Medicare beneficiaries enrolled in MA plans and county FFS Medicare payments that are less than the national average will receive a double bonus (that is, the benchmark against which they bid will be increased by an additional 5% for a possible total bonus of 10%.)

Another significant change is unrelated to the administrative payment methodology, but follows a similar requirement for insurers in commercial markets under the new health reform law. A minimum 85% Medical Loss Ratio (MLR) is required in 2014, with rebates to beneficiaries if the MLR is lower.

Possible Reactions to ACA

Since ACA is a "big change" rather than an incremental fix to the payment methodology, there are likely to be multiple reactions by MA plans and beneficiaries. Effects are likely to differ across regions of the country, with smaller effects on the "extra benefits" for seniors in higher-paid regions and larger effects in other regions, including possible withdrawal by MA plans from some lower payment counties.

First, it is likely that MA plans will start by "tightening their belts" by reducing benefits and accepting lower profit margins to retain membership. Such reductions could come in the form of narrower supplemental benefits (e.g., dental and vision non-TM benefits) and greater cost-sharing for beneficiaries (i.e., larger co-payments and deductibles than in 2010). Plan payment of Part B premiums and some Part D premiums may also diminish.

Second, there are likely to be some counties where the combination of low payment rates (even at the 115% of FFS rate in the lowest quartile where payments in dollar terms are significantly below the national average, plus high required payments to providers will result in withdrawals from certain geographic areas by MA plans. In addition, some existing "efficient" (i.e., Tier 2 or Tier 3 lower payment) counties may see reductions in the number of MA plans, reduced benefits or additional premiums.

The "qualifying county" bonus and varying county-by-county phase-in periods aim to minimize this disruption for these types of counties.

Overall, plans will be forced to become more efficient, to have tighter networks and are likely to aim for obtaining the 5% quality bonus. Some current MA plans that now prosper mostly because of high payment rates will likely exit many markets or the program as a whole, but major, organized plans are likely to continue in the program. .

Why Have "Prepaid Medicare" Options?

With such big changes coming (similar in impact to the BBA changes—in terms of direct reductions to MA payment and reductions in the underlying TM FFS growth rate), as well as the potential for further impacts on MA from follow-on legislation, it will be important to crystallize the value of retaining a "Prepaid Medicare" option. Among other considerations, such clarity would contribute to the stability of the future MA program for both beneficiaries and plans. Such stability could, in turn, provide incentives for MA plans to make longer term investments in such things as care coordination, with resulting improvements in the quality and efficiency in Medicare and potentially in the larger health care environment.

What are the public policy goals that should be considered for "Prepaid Medicare?" These could include:

- Support capitated systems and provide access to alternative delivery systems that are not available through the traditional Medicare fee-for-service program. As the nation aims to "bend the cost curve," most analysts believe that increased integration of care driven by payments through fully or partially capitated systems will be important. Support for Medicare capitated systems is an existing starting place. Such payments could be made to plans, as in MA currently or potentially directly to integrated delivery systems on a shared risk basis. Such an idea was actually incorporated into MA as part of the BBA, but never successfully implemented, because of administrative complexity and provider reluctance. In any event, pre-paid systems need some pre-paid Medicare option in order to support the social policy, clinical model and alternative set of financial incentives that are characteristic of such organizations.

- Added benefits for low income beneficiaries
  Low income beneficiaries who are in the gap between being "dual-eligible " individuals (those qualifying both for Medicare and Medicaid), wealthy enough to afford supplemental (Medigap) insurance or covered by retiree health insurance can benefit greatly from the reduced cost-sharing and supplemental benefits available to them through some appropriately designed MA plans. Some have argued that MA "overpayment" is an inefficient way to address this problem. Nevertheless, any approach to substantially altering MA should consider how to provide for the needs of this vulnerable population.

- A venue for using managed care or coordinated care tools
  One of the major criticisms of TM is that it simply pays claims and has few, if any, tools to manage the volume of services or to direct beneficiary care to high quality, efficient providers. MA offers a way for CMS to gain experience with the

relative value of private-payer approaches to these problems and to consider their potential applicability to the larger TM program.

- Potential "Halo effect" on FFS costs
  Several analysts have documented a possible "halo" or "spillover" effect of lower TM costs in regions of the country with high managed care penetration, especially where earlier HMO model plans have a significant presence. It is possible that HMO-based MA actually saves the Trust Funds money by establishing a community-wide "culture" of relative efficiency that affects the practice patterns of physicians and other providers in general, with a salutary effect on TM costs (and health care costs overall). If this is the case, then such an impact should be considered in evaluating policy ideas for the future of the MA program.

- A venue for care innovation and data
  MA plans have more latitude in designing benefits for Medicare members. They can quickly adopt new care innovation ideas and can make better and quicker use of emerging data. Such data and data analysis can prove valuable in the future as TM continues to wrestle with the steady increase in utilization and costs. Retaining the program for this goal would return to one of the original goals of "Prepaid Medicare."

<u>Possible Futures for "Prepaid Medicare"</u>

In the next few years the future of MA will become clearer. This future will likely be shaped by policy considerations leading to legislation, regulatory changes created within CMS and the evolution of the marketplace as the health care industry adjusts to ACA and later changes. Nevertheless it is tempting to speculate about a few possible scenarios.

- A "niche" program
  It is possible, albeit unlikely, that ACA reductions in MA revenue combined with further reductions by Congress could make MA a poor business proposition for all but the most robust MA plans. This could include larger enrollment in the "original" HMO design plans, which may be the long term beneficiaries of the quality bonus provisions of ACA. In such a scenario, MA would shrink down to become a useful but marginal part of the Medicare program.

- A move to true competitive bidding model
  Further legislation could propose again a model which has been rejected in the past. That is a model which bases MA payment rates not on local benchmarks but on open competitive bidding between plans. Based upon an analysis of recent plan bidding behavior within the current benchmark based system, there is reason to believe that such a model would result in lower MA expenditures. However, this dynamic could well have unintended effects. It would very likely compel plans to lower provider reimbursements and potentially lead to physicians withdrawing from participation in MA plans, least in some parts of the country.

- MA-Accountable Care Organization (ACO) contracting

As mentioned briefly above, it is possible for CMS, through the activities of its new Center for Medicare and Medicaid Innovation, to develop a robust direct contracting arrangement with large integrated delivery systems in the form of ACOs. Reimbursement could be provided on a shared risk or global payment basis depending on the sophistication of the delivery system. This process could take place in parallel with a continued robust MA program or as a substitute for MA, in the event that plans substantially abandon the MA program.

- Political changes in 2012 that again reverse program direction
  As we have described earlier in the paper, the course of the journey of Prepaid Medicare has been affected continually by political change. It is conceivable that political realignments in subsequent national elections could once again shape the future of MA in ways unforeseen at the moment. What seems pretty sure, however, is that the need for cost control, especially in the face of the new coverage and access provided by ACA will be the prime directive for the federal government as a whole, whatever changes in political philosophy evolve.

Conclusion

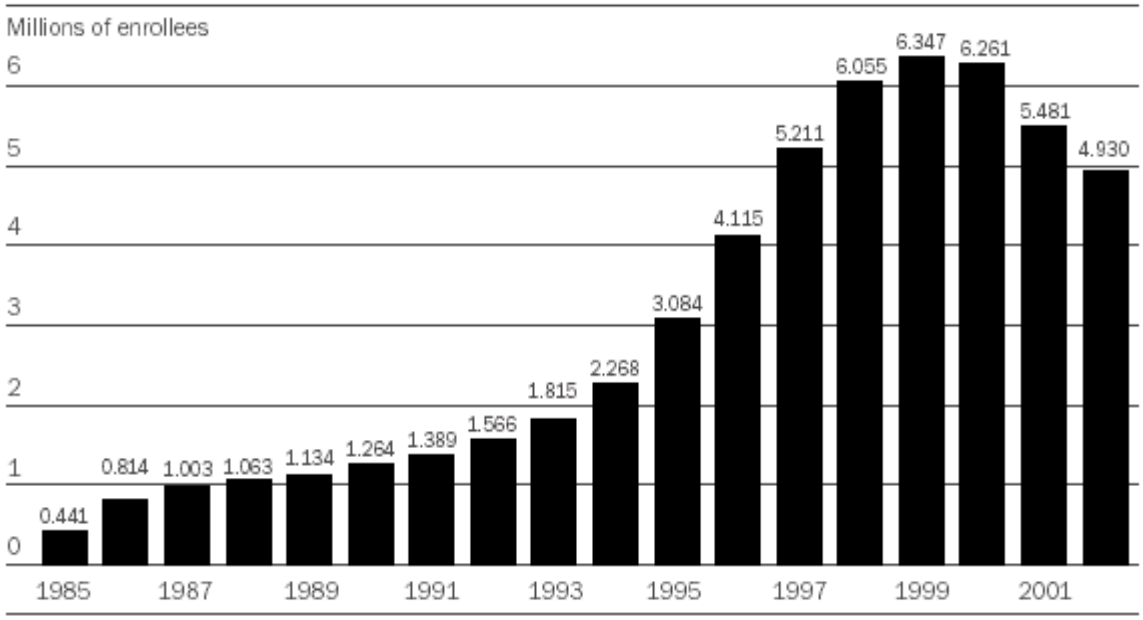
Prepaid Medicare has gone through many permutations since the need for it was first conceived forty years ago. It has clearly provided some tangible benefits, including helping to preserve the integrity of the alternative care delivery system with different internal financial incentives that are characteristic of HMO-based plans, providing financial assistance to a segment of low income beneficiaries, and acting as a source of innovation for the larger TM program. In its current form, however, MA has not solved the problem of cost escalation in the Medicare program, as some hoped that it would. The next few years will determine the future of Prepaid Medicare. The original promise still remains, we believe. It will require cooperation between and vision from both public and private health care leaders to see that the promise is fulfilled this time.

The opinions expressed in this article are those of the authors and not necessarily those of their respective organizations.

Figure #1

EXHIBIT 1

Enrollment In Medicare Risk/Medicare+Choice Plans, 1985–2002



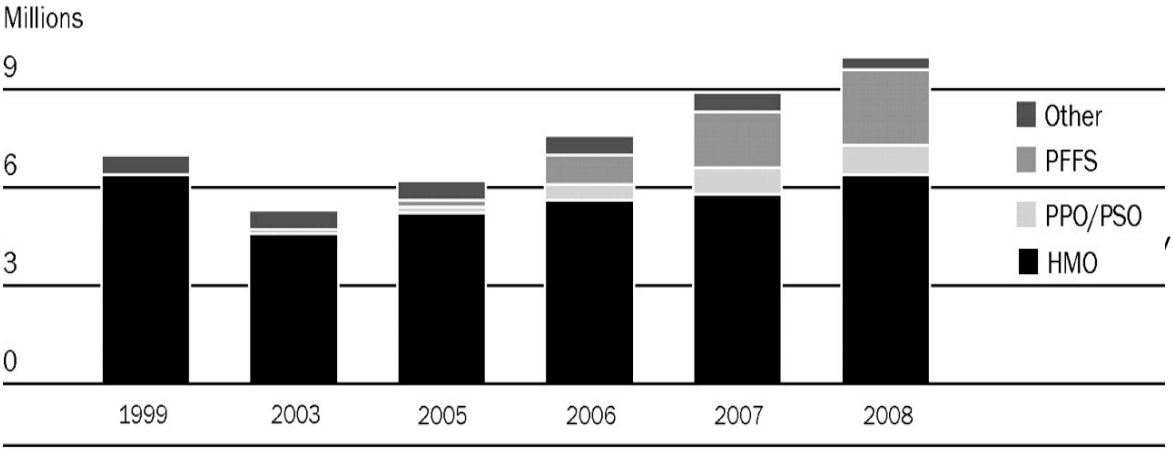
SOURCE: Mathematica Policy Research analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Contract Plans Monthly Summary Report, various years.

NOTES: Data for 1999–2002 are for enrollees in M+C coordinated care plans. Data for prior years are for enrollees in Medicare risk contracts. All data are for December of the given year.

Figure #2

EXHIBIT 1

Medicare Private-Plan Enrollment, By Contract Type, Selected Years 1999–2008



SOURCE: Centers for Medicare and Medicaid Services (CMS) Monthly Summary Report, various years (December), and June 2008.

NOTES: Totals exclude "pilots." Health maintenance organization (HMO) counts for 2003 and 2005 include a few enrollees in preferred provider organizations (PPOs) or provider-sponsored organizations (PSOs). "Other" includes Medicare 1876 Cost Plans, 1833 Cost Plans (HCPPs), Program of All-Inclusive Care for the Elderly (PACE), and demonstrations. HMO enrollment increased in 2008 as the CMS reclassified several demonstrations as HMO-SNPs (Special Needs Plans). PFFS is private fee-for-service.

References

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