

Has Medicare Been Privatized? Implications of the Medicare Modernization Act, Beyond the Drug Benefit

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President Bush called the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) “a landmark achievement in American health care.”¹ This legislation created Medicare Part D, a new outpatient prescription drug program, which truly is a significant development. However, this law may have set in motion an even more profound change in Medicare’s structure. The MMA redesigned the payments and rules for private health plans, which are an alternative to traditional Medicare, and renamed this program “Medicare Advantage”. These changes, the nature of the drug benefit, and their effects on coverage that supplements Medicare could result in a large shift in enrollment to Medicare Advantage plans. In other words, it is possible that many, if not most, Medicare beneficiaries could be enrolled in private plans within the decade. This issue brief explains why this may occur and raises questions about its implications on costs, satisfaction, and access to care.

Historical Context: Medicare and Private Health Plans

Medicare is the nation’s largest Federal health program. In 2005, its gross spending totaled \$333 billion. With the implementation of the Medicare drug benefit, program spending is projected to grow to \$391 billion in 2006 and \$543 billion in 2010, increasing at an average annual rate of more than a 10 percent.² Medicare covers about 42 million people: 35.4 million seniors and 6.3 million people with permanent disabilities under the age of 65.³

Pre-1997: For several decades, Medicare beneficiaries have been able to choose between two different delivery systems to obtain benefits. Most individuals have received coverage through traditional, fee-for-service Medicare; this system pays all participating providers under a specific set of payment rules, and covers a defined set of benefits. A minority of beneficiaries have obtained coverage through private health plans. These health plans, typically HMOs, provide Medicare’s benefits, with some variability in cost sharing, premiums and supplemental benefits, to enrollees through networks of providers. They are paid a fixed amount per person, or capitation rate. Before 1997, Medicare paid risk-contracting health plans based on the average spending per person for fee-for-service Medicare in each county, known as the adjusted average per capita cost (AAPCC). Medicare’s fixed capitation payment was calibrated to equal 95 percent of the AAPCC for each enrollee, adjusted by a limited set of demographic characteristics to account for the specific risk profile of plan enrollees.

The original intent of allowing managed care plans to offer Medicare benefits was to reduce costs (thus the 5% reduction in average payments to plans). However, this private plan payment system resulted in overpayments since enrollees were significantly healthier than the average beneficiaries in the traditional program. Thus, their average costs were well below the capitation payment.⁴ Because the rules required that private plans return overpayments to beneficiaries,

most did this through reduced premiums and supplemental benefits such as prescription drugs. Enrollment rose gradually to 5.4 million by 1997.

1997-2003: In the Balanced Budget Act of 1997 (BBA), Congress replaced the risk contract program with the Medicare+Choice program in an effort to increase Medicare enrollment in managed care plans. Medicare+Choice allowed additional types of managed care plans to participate in Medicare – preferred provider organizations, provider-sponsored organizations, private fee-for-service plans and high-deductible plans linked with medical savings accounts. Medicare+Choice also changed the payment formula for Medicare-contracting health plans. Per capita payments were set at the highest of three amounts – a minimum payment rate, a blended rate based on area-specific and national rates, or a rate that reflects a minimum increase – typically 2 percent – from the previous year’s rate. These changes were intended to expand enrollment by creating new incentives for private plans to provide services in counties with comparatively low Medicare fee-for-service costs.

In practice, these changes resulted in slow growth rates in the payments to private plans. Most plans received a 2 percent increase in their Medicare payments each year, and few (if any) expanded coverage into new markets. Private plan participation in Medicare fell from 346 plans in 1998 to 151 in 2003.⁵ Consequently, private plan enrollment among Medicare beneficiaries declined by 26 percent from 1998 to 2003 (from 6.2 to 4.6 million). Satisfaction with the program, generally below that for the traditional program, dropped.⁶ In addition, concerns about risk selection grew. One study found that estimated out-of-pocket cost sharing for enrollees in good health increased by 87 percent while that for enrollees in poor health increased by 140 percent from 1999 to 2003.⁷ Even with the program downsizing, the Medicare Payment Advisory Commission reported that Medicare spent about 4 percent more for enrollees in private plans than it would have had the enrollees stayed in traditional Medicare in 2003.⁸

Private Plan Expansion as Part of the Drug Benefit Legislation

President Bush, beginning with his campaign in 2000, made “provid[ing] better health insurance options” through Medicare one of his goals.⁹ In 2002, he stated, “What’s important to understand is that almost none of the treatments that I described ... are part of Medicare’s defined benefits. Many are only available through Medicare’s private plans.... As we discuss Medicare ... the defined benefit plan in Medicare limits the capacity of seniors to meet their needs. And that doesn’t seem right to me.”¹⁰ Rather than promoting private plans to reduce costs (pre-1997) or promote choices (1997 law), the President viewed private plans as the only way to update and expand Medicare benefits. This emphasis, and the means to achieving it (greater payments and flexibility for private plans compared to traditional Medicare), became a Congressional priority in its consideration of a Medicare drug benefit.

The Medicare Modernization Act of 2003 (MMA) is primarily known for creating Part D. This part of the program entitles Medicare beneficiaries to a choice of prescription drug plans. For the first time, the benefit is delivered entirely through private plans, without a traditional Medicare fee-for-service alternative. The cost sharing and formulary parameters for the basic drug benefit are set in law, but private plans offering the benefit may vary these key benefit design features within limits. The average drug plan will be subsidized by an estimated 75

percent, although its design means that it covers only about half of the average drug costs of Medicare beneficiaries.¹¹ Drug coverage began on January 1, 2006 after a temporary drug discount card program. The MMA also created the Medicare Advantage (MA) program to replace the Medicare+Choice program. The law made three major changes.¹²

Different Payment System for Local Plans: The MMA scrapped the Medicare+Choice payment system and re-established the link between Medicare fee-for-service costs and managed care payments. The legislation specified that in 2004, MA plans would be paid at least the fee-for-service per capita amount in their contract area per enrollee, with yearly increases tied to increases in fee-for-service Medicare. In many counties, particularly in rural areas, the rates were considerably above average fee-for-service amounts because of payment “floors” enacted to entice plans to underserved areas. In 2005, rates were, on average, 7 percent higher than the cost for the same beneficiaries in the traditional program.¹³ Beginning in 2006, plans submit bids that will be compared to the county benchmark rate. Medicare will pay the full bid if it is equal to the benchmark, beneficiaries will pay the excess amount if the bid is higher than the benchmark, and the plan can keep 75 percent of the savings if the bid falls below the benchmark. This system is designed to increase competition based on premiums.

New Regional Plans: The 2003 law created, for the first time, a regional private preferred provider organization (PPO) option. The intent is two-fold: (1) to provide payment incentives for plans to serve regions that include rural areas that historically have been ignored by private plans; and (2) to offer an integrated private plan option to replace traditional Medicare and Medigap. The new program allows PPOs to operate in at least one of 26 Federally-established service areas. These service areas are no smaller than one state; in one case, it includes 7 states. These incentives include: shared financial risk between Medicare and the plans, in the form of risk corridors for 2006 and 2007; a network adequacy fund to finance payments to critical regional hospitals not included in the plan network; a blended payment rate that depends on plans’ actual bids in the region; and a regional stabilization fund. The regional plan stabilization fund will make \$10 billion available, from 2007 through 2013, for incentives to promote plan entry and plan retention in regions with below-average private plan penetration. These incentives may include annual bonus payments to organizations that offer plans in every region, or multi-year regional payment adjustments to regional plans.

Premium Support Demonstration: Lastly, the 2003 drug law created a “premium support” demonstration. Premium support refers to a proposal to capitate payments for both private plans and the traditional program, assuming that competition between the two delivery systems will result in lower costs and higher quality.¹⁴ This proposal has proven controversial because of its potential to raise premiums in the traditional program and result in adverse selection.¹⁵ As a result, the final law limited premium support to a demonstration project in six metropolitan areas that begins in 2010.

Interaction with Drug Benefit: Virtually all Medicare Advantage plans must offer a drug benefit that meets the new Part D standards. Private plans have the option of cross-subsidizing their drug benefit with any savings or overpayments on the non-drug part of Medicare’s benefit. Similarly, plans reap the savings of lower hospitalization and other costs due to a well-managed drug benefit (stand-alone prescription drug plans do not capture such savings). And, private

plans can present to beneficiaries one premium for all of their benefits, including prescription drugs.¹⁶

Estimated Private Plan Enrollment in 2003

At the time that the Medicare Modernization Act of 2003 passed, the Congressional Budget Office (CBO) estimated that the Medicare Advantage changes would increase Federal spending by \$14 billion over 10 years. The regional PPO stabilization fund would account for most of these costs (\$10 billion), while another \$4 billion would result from payments per person that would still be higher than what Medicare would have paid had plan enrollees been in the traditional program. CBO assumed that 13 percent of Medicare beneficiaries would enroll in private plans under the law, ending the projected decline in enrollment. It did not anticipate that the regional PPO option would be viable, and calculated that few people would switch to local plans.¹⁷

The Medicare Actuaries' estimates of the Federal cost of the MMA were \$139 billion higher than those of CBO (\$534 billion vs. \$395 billion for FY2004-13).¹⁸ Over 20 percent (\$32 billion) of this difference related to Medicare Advantage. The Actuaries projected that enrollment in local private plans would reach 16 percent of the Medicare population by 2013. Another 16 percent would be enrolled in regional PPOs (Chart 1). In other words, over twice as many beneficiaries would shift to private plans under the Medicare Actuaries' versus CBO's estimates. This large difference of opinion was not a particular focus at the time, given the focus on the drug benefit's cost estimates.

What Has Changed

Nearly three years have passed since these preliminary estimates of the cost and coverage implications the MMA. Experience with the law, plus other trends, suggest that private plan enrollment in Medicare may grow faster than CBO's projections, and even potentially faster than the Medicare Actuaries' expectations.

The President's budget reports that enrollment in private plans rose to 5.7 million in 2005, or nearly 13 percent of the Medicare population.¹⁹ Between 2003 and 2006, plan participation in Medicare more than doubled, rising from 151 to 360 plans according to budget documents. This is the highest level of private plan participation in the program's history (Chart 2). And, the Administration reports that 98 percent of Medicare beneficiaries will have access to some type of local private plan in 2006, while regional PPOs will be an option for more than 80 percent of beneficiaries. These numbers exceed expectations and, arguably, will continue to do so in the future for several reasons.

Favorable Regulations for Private Plans: The 2003 law explicitly built in payment incentives for private plans in Medicare. The Administration used regulation and administrative actions to advance the goal as well. For example, regulations on plan payments proposed a method for calculating the regional benchmarks for Medicare PPOs that significantly increased payments to such plans – by \$60 billion over 10 years, according to one study.²⁰ Private plans have also been given greater flexibility to increase as well as reduce Medicare's specified levels of cost sharing.

More – and More Complex – Drug Plans: Another surprise is the large number of participating prescription drug plans (plans that offer only prescription drugs to traditional Medicare enrollees). The number of stand-alone drug plans available to beneficiaries ranges from 27 in Hawaii to 52 in Pennsylvania and West Virginia.²¹ This degree of choice is larger than anticipated by Congress which labored over policies to ensure at least two choices in each area. Each plan can, and typically does, differ on (a) cost sharing; (b) formulary (i.e., which drugs are covered); (c) pharmacy network; and (d) premiums. This set of choices has proven confusing to beneficiaries.²² In some cases, this may mean that seniors mistakenly join private plans for all benefits rather than prescription drug plans. It could also make the option of a single private plan that covers everything more appealing. Lastly, insurers may be offering drug-only products as a way to market for their private plan options. For example, Humana offers both types of plans and aims to “enroll and migrate” enrollees from its drug plan to its full benefit plan.²³

Decline in Supplemental Coverage: Historically, most beneficiaries had retiree coverage or Medigap insurance to fill in Medicare’s benefit gaps and cost sharing. The availability of such supplemental coverage has been declining, and could be exacerbated by the MMA. If trends continue, beneficiaries who want to supplement their Medicare coverage may have to join a private plan to do so.

The 2003 law has caused employers to re-think their retiree health benefits. It allows employers offering drug coverage to their Medicare-eligible retirees to receive a subsidy for doing so under most circumstances. Most employers report taking this option, but the erosion of retiree coverage continues. Between 2003 and 2005 alone, the percent of large firms offering retiree coverage dropped from 38 to 33 percent.²⁴ Looking forward, while 8 out of ten employers reported that they will continue drug coverage in their plans in 2006, only half reported that they would do so in 2010.²⁵ For example, Nissan has announced that it will replace Medicare retiree coverage with a defined contribution to limit its liability.²⁶ People with retiree coverage who go into either a drug plan or full-benefit private plan may not have the option of returning to their retiree plan. About 44 percent of employers reported that a retiree who opts for a Medicare drug plan cannot return to the retiree plan for drug coverage, and 29 percent will drop all supplemental coverage for the retiree who chooses a Medicare drug plan.²⁷ On top of this, the Administration has made it easier for employers to wrap around drug plans and enroll their retirees in specially-designed full-benefit private plans.²⁸ In short, the availability of drug coverage – and all supplemental coverage – through former employers is likely to decline.

A similar fate may be in store for the one in five beneficiaries with Medigap supplemental coverage. This private health insurance relies on enrollment of a large and diverse group of seniors to make premiums affordable and plans viable. However, with the introduction of the drug benefit, such seniors will have three different premiums and insurance policies: traditional Medicare, a prescription drug plan, and Medigap. If a large fraction of seniors join Medicare Advantage plans as a result of this complexity, the premiums for those remaining in Medigap may rise, causing these policies to become unaffordable and unviable. As with the erosion of retiree coverage, this could leave beneficiaries interested in supplemental coverage with no alternative to Medicare Advantage private plans.

Future and Questions

The incentives for private plan participation, the complexity of the drug benefit, and vanishing supplemental coverage options may create a dynamic that propels people with Medicare to enroll in private plans at an unexpected and unprecedented rate. This raises important questions for Medicare's future:

- Will the advantages of private plans be enough to overcome seniors' historical hesitancy at accepting a limited network of providers? Do Medicare beneficiaries prefer: a choice of plans, variable benefits, and reduced cost sharing available in Medicare Advantage, or stability of coverage, predictable benefits, and access to providers, characteristic of traditional Medicare?
- What does a spike in private plan enrollment mean for Medicare benefits? Has Medicare become a *de facto* defined contribution program?
- What implications does growth in private plan enrollment have for access to care in rural and underserved areas? What is the impact on the chronically ill, people with mental health problems, and people with long-term care needs?
- How will the provider community – particularly physicians – react to the growth of Medicare Advantage plans? Will they prefer and potentially participate only in private plans or continue to provide services through traditional Medicare?
- How will an increase in enrollment in private plans affect the politics of Medicare payment policy? As Medicare Advantage enrollment increases, will plans wield even greater negotiating power with Congress over payment formulas? Or will fiscal pressures force down excess payments, at the risk of reducing supplemental coverage for beneficiaries? Does the President's proposal of automatic cuts if Medicare spending exceeds a certain threshold change these dynamics?

Notes:

¹ G.W. Bush, February 11, 2005, available at: <http://www.whitehouse.gov/news/releases/2005/02/20050211-3.html>

² CBO, Budget Projections, January 2006, available at: <http://www.cbo.gov/budget/budproj.pdf>

³ Kaiser Family Foundation, Medicare at a Glance, September 2005, available at: <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=52974>

⁴ R. Brown et al., Do HMOs work for Medicare? Fall 2003, available at: http://www.findarticles.com/p/articles/mi_m0795/is_n1_v15/ai_15268427

⁵ Kaiser Family Foundation. Medicare Advantage Fact Sheet, September 2005, available at: www.kff.org/medicare/2052-07.cfm

⁶ Medicare Current Beneficiary Survey, Tables 5.14, available at: <http://new.cms.hhs.gov/apps/mcbs/PubIDT.asp>

⁷ M. Gold and L. Achman, Commonwealth Fund, August 2003, available at: http://www.cmwf.org/publications/publications_show.htm?doc_id=221566

⁸ Medicare Payment Advisory Commission, March 2003, available at: http://www.medpac.gov/publications/congressional_reports/Mar03_Ch5.pdf

⁹ G.W. Bush, Medicare Principles, 2003, available at: <http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html>

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- ¹⁰ G.W. Bush, Speech, May 17, 2002, available at: <http://www.whitehouse.gov/news/releases/2002/05/20020517-8.html>
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- ¹³ Medicare Payment Advisory Commission, June 2005, available at: http://www.medpac.gov/publications/congressional_reports/June05_Table_of_Contents.pdf
- ¹⁴ R.D. Reischauer and H. Aaron, Medicare Reform, Winter 1995, available at: <http://content.healthaffairs.org/cgi/content/abstract/14/4/8>
- ¹⁵ T. Rice and K.A. Desmond, Distributional Consequences of Premium Support, 2004, available at: <http://jhpppl.dukejournals.org/cgi/content/abstract/29/6/1187>
- ¹⁶ R. Berenson, Medicare Disadvantaged, 2004, available at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.572/DC1>
- ¹⁷ D. Holtz-Eakin, CBO, Testimony, March 24, 2004, available at: <http://www.cbo.gov/showdoc.cfm?index=5252&sequence=0>
- ¹⁸ R. Foster, Chief Actuary, Testimony, March 24, 2004, available at: <http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=1303>
- ¹⁹ U.S. Department of Health and Human Services, Budget in Brief, 2006, available at: <http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf>
- ²⁰ Pizer, Feldman & Frakt, PPO Payments, 2006, available at: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.399>
- ²¹ Kaiser Family Foundation, Plan Tracker, available at: <http://www.kff.org/medicare/healthplantracker/topicresults.jsp?i=30&rt=2>
- ²² See for example, <http://select.nytimes.com/gst/abstract.html?res=F00C15F7395B0C718EDDA80894DE404482>
- ²³ S. Lueck and V. Fuhrmans, January 25, 2006, available at: <http://www.postgazette.com/pg/06025/644020.stm>
- ²⁴ Kaiser Family Foundation / HRET, Health Benefits 2005. <http://www.kff.org/insurance/7315/sections/ehbs05-11-1.cfm>
- ²⁵ Kaiser/Hewitt 2005 Survey on Retiree Health Benefits 2005, available at: <http://www.kff.org/medicare/med120705pkg.cfm>
- ²⁶ Associated Press, "Nissan Switches Retiree Medical Coverage," available at: <http://www.latimes.com/business/investing/wire/sns-ap-nissan-medical-coverage,1,5492804.story?coll=sns-ap-investing-headlines&ctrack=1&cset=true>
- ²⁷ Kaiser/Hewitt 2005 Survey on Retiree Health Benefits.
- ²⁸ Centers for Medicare and Medicaid Services, Employer Waivers, available at: <http://www.cms.hhs.gov/EmpGrpWaivers/>