Medicare Managed Care: Preserving An Option For The Future

Some reforms that are designed to be defensible from a public policy perspective while improving the survival prospects of Medicare managed care.

by John Bertko

The Bush administration and Congress have begun the most recent debate over Medicare reform. Although recent tragic events may push comprehensive reform to a back burner, swift congressional action is essential to retaining Medicare managed care. Without significant change in the administrative payment methodology, I predict continued shrinking of enrollment and reduction in the number of markets in which Medicare managed care is available.

Robert Berenson has proposed two interesting options for modifying administrative payments to Medicare+Choice (M+C) plans. Why not consider a broader range of options to find an interim solution? If the nation waits for comprehensive reform (and the subsequent regulations and processes), there may not be any Medicare managed care plans remaining to offer.

Why preserve a managed care option? Medicare managed care plans offer many benefits, including choice among delivery systems, coordinated care programs that offer better care for many chronic conditions, and a more affordable option than Medigap coverage. M+C plans limit beneficiaries’ out-of-pocket costs for catastrophic illnesses through cost-sharing limitations that are an integral part of the contract with the federal government. In contrast, enrollees in traditional fee-for-service (FFS) Medicare face unlimited cost-sharing liability for physician and subacute institutional care, unless they can afford Medigap policies, which many cannot.

If Congress does not act now, it may be difficult to entice insurers to participate in reform programs in the future. Many insurers will have reoriented their strategy to offer different, more financially viable products and may be reluctant to reverse course after their adverse Medicare managed care experience.

The ubiquitous problem of rapidly increasing costs. The problem of rapidly rising health care costs for government programs, private employers, and consumers is one of the crucial issues of this decade. With FFS costs rising (10.7 percent for fiscal year 2001), FFS Medicare appears to be suffering from the same malady as other health plans: high cost-trend rates. M+C plans, like private-sector plans, are experiencing these as well. The current trend is driven strongly by much higher hospital costs, as confirmed recently. As a measure of the magnitude of increasing costs, premiums for plans in the Federal Employees Health Benefits Program (FEHBP) have risen 50 percent since 1998, and rates are increasing 13.3 percent for 2002.

Although insurers’ decisions to continue participating in M+C include other considerations, low reimbursement in an era of high cost trends is by far the predominant factor. Berenson minimizes the impact of the Balanced Budget Act (BBA) of 1997 and its accompanying update legislation on counties that have the most M+C enrollees. By our estimates (confirmed by the Centers for Medicare and Medicaid Services, or CMS), approximately 66 percent of M+C enrollees live in...
counties that will receive increases of only 2 percent in 2002. It is likely that nearly all of these counties have been receiving only the 2 percent minimum increase since 1998.

Without payment adjustment to remedy this situation, it appears likely that nearly all M+C plans will cease to participate after 2004. With high cost trends likely to continue, perpetuation of the current 2 percent annual reimbursement increase in M+C plan counties (accounting for the majority of enrollees), as is likely under the BBA provisions, will drive M+C plans out of these contracts. With such low reimbursement, it appears to be impractical to pass along premium increases of 5–10 percent of total federal and beneficiary payments to enrollees. This would be in a $40–$80 range in additional monthly premiums per year in many counties to make up the difference between a 2 percent reimbursement and a 10 percent (or higher) cost trend.

**Response to the proposed options.** Berenson proposes two interesting revisions to the current payment methodology. In the first, he proposes to sever the payment linkage between FFS Medicare and M+C. His suggestion to pay M+C plans as “another provider type” is appealing in theory but would be difficult to apply. For example, if only input prices were considered, then the major impact of changes in utilization, intensity, and technology would not be reflected. Furthermore, if Congress is asked to provide a periodic update, then political factors will contribute to the volatility of payment rates. The second suggestion—rewarding quality by paying plans differentially based on quality measures—requires, as Berenson acknowledges, that Congress grant an “unprecedented amount of autonomy” to the CMS. Also, quality measurement is in its infancy.

**More options to consider.** With assistance from a group of colleagues, I have developed a short list of options for addressing the reimbursement issue. All of the options are consistent with the recent Medicare Payment Advisory Commission (MedPAC) recommendation to Congress that federal policy should be “neutral” between Medicare FFS and Medicare managed care. All are intended to be defensible from a public policy perspective while improving the “survival” prospects of Medicare managed care.

The options are classified by major type of change: (1) “cleaning up” methodological flaws in the computation of rates; (2) updating M+C plan payments at the same rate as local Medicare FFS rates; (3) introducing more limited risk contracts (like the “risk corridor” approach used by the Department of Defense in its TriCare program); and (4) moving in a “half-step” toward a competitive payment model (but without affecting costs or benefits to beneficiaries for FFS Medicare).

The first option involves reviewing many of the past “shortcuts” and errors in the adjusted average per capita cost (AAPCC) payment mechanism that underlies the BBA rates. If missing costs paid by the Veterans Administration or the Department of Defense were recognized, payment rates in some counties would increase greatly. A full discussion of these options is beyond the scope of this Perspective, but each of these options should be considered if the decision is made to preserve Medicare managed care.

**NOTES**

1. Congressional Budget Office, “Monthly Budget Review, Fiscal Year 2001” (Washington: CBO, 14 November 2001). “Health care cost trend” is used to encompass all components of cost increases, including unit cost increases (inflation), changes in utilization and intensity, cost increases due to aging, changes in technology, and all other residual factors.


6. A demonstration of a “risk corridor” approach in DuPage County, Illinois, has been approved for Humana Inc. by the CMS under current M+C program rules.