The Future of Medicare Advantage: Will Past Be Prologue?

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Quick Review: What Medicare Advantage Is:

- Absorbs previous M+C options for county by county risk-based private health plans (HMO, PPO, private fee-for-fee service) effective 2004.
- Authorizes new regional MA PPO option in 2006 concurrent with the introduction of a voluntary Medicare drug benefit via private prescription drug plans (PDPs). Short term risk sharing and bonuses to encourage entry.
- Both local and private regional plans will provide integrated Medicare A/B and drug benefits which serve as alternative to traditional Medicare with or without PDP. Rates reflect a blend of bids and FFS benchmarks.

Quick Review: What Medicare Advantage Is: *(continued)*

- Regional plans must reconfigure Medicare cost sharing on A/B benefits and include an out-of-pocket maximum (can be higher for out-of-network benefits)
- Higher rates in 2004 and 2005 to stabilize the market via minimum payment of 100 percent FFS and higher annual minimum increase than previous two percent

My Interpretation of What MMA Seeks To Do With Medicare Advantage

- Give all Medicare beneficiaries a choice to enroll in a private Medicare plan regardless of where they live (finally)
- Use regional MA options to create a reconfigured Medicare benefit package that could ultimately replace traditional Medicare benefits
- Reduce county by county variation in private plan benefits and premiums (at least within regions for MA plans)
- Position private plans in Medicare so that they ultimately will compete, or even replace, the traditional Medicare program

What is Underlying Policy Motivation—the "Why"

- Private plans and more choice are perceived as better by influential legislators.
- Regional plans address perceived inequity because some beneficiaries (e.g., in rural states) are not able to benefit from private plan options (which come with expanded benefits at a competitive price.)

What is Underlying Policy Motivation—the "Why" *(continued)*

- Potential effects on Medicare costs unclear:
  - Short term costs to Medicare cannot be lower (because of how rates are set and what it takes to attract plans.)
  - Potential for gains in care management are gains unclear if products are loosely managed or not managed at all.
  - There could be potential or long term savings (if competitive savings are generated; if shift allows Medicare to shift from a defined benefit to a defined contribution program and private plans stick with the program).

Will It Happen?

- We don't know. Nothing as expansive as this has been tried before.
- Congress is asking private plans to have faith that they will be a better business partner than they have in the past—rates sufficiently high and stable to maintain participation; requirements consistent with firms' business models.
- Model assumes that private plans will overcome market-based barriers to managed care in some areas of the country and in rural areas—or that a private fee-for-service or similar product that is more feasible can be supported.

Will It Happen? *(continued)*

- **Model assumes that many beneficiaries will find MA attractive if it is offered.**

  + Potential for competitive benefits and premiums especially for those with no other subsidized Medicare supplement (integrated product, higher payments on average than FFS).

  + Ability to make a single choice and receive integrated benefits versus Medicare, Medigap and PDP

Will It Happen? *(continued)*

- Traditional Medicare is well regarded and trusted by many beneficiaries

- In contrast, prior history of MA instability, withdrawals has left a sour taste (especially in some markets)

- Out-of-pocket costs could be high especially if providers are not “in network”

Salient Facts: What We Do Know

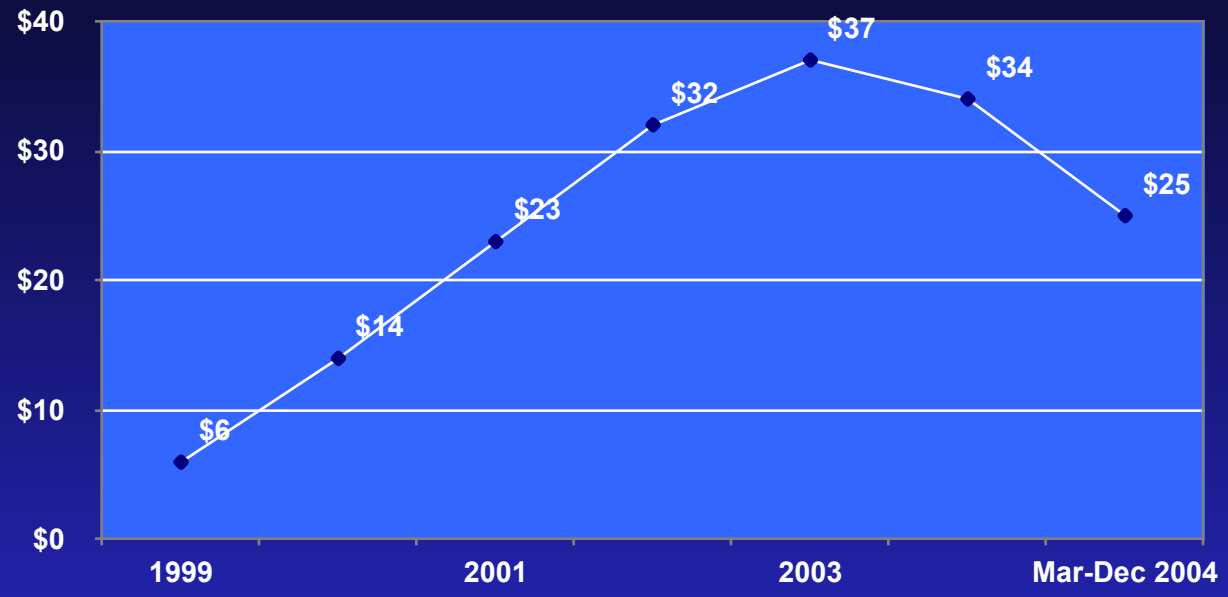
MMA Helped Stabilize MA in 2004-2005

- 2004 average rate increase was 10.9 percent (15.3 percent in markets previously below 100 percent of FFS). In 2005, plans received at least a 6.6 percent increase.
- About half of higher 2004 payments went to benefits and premiums with most of the rest going to providers (CMS)
- MA premiums dropped an average of $9 per month versus 2003. The share of private plans covering brand name drugs (versus generics only) increased. Some decrease in copayments for physician services. Out-of-pocket costs in post MMA 2004 costs returned to pre-MMA 2003 levels (Achman and Gold 2004).

MMA Helped Stabilize MA in 2004-2005 *(continued)*

- Slow growth in number of MA contracts, especially the second half of 2004/2005.
- Enrollment slowly increasing now, but penetration still low (12.3 percent).

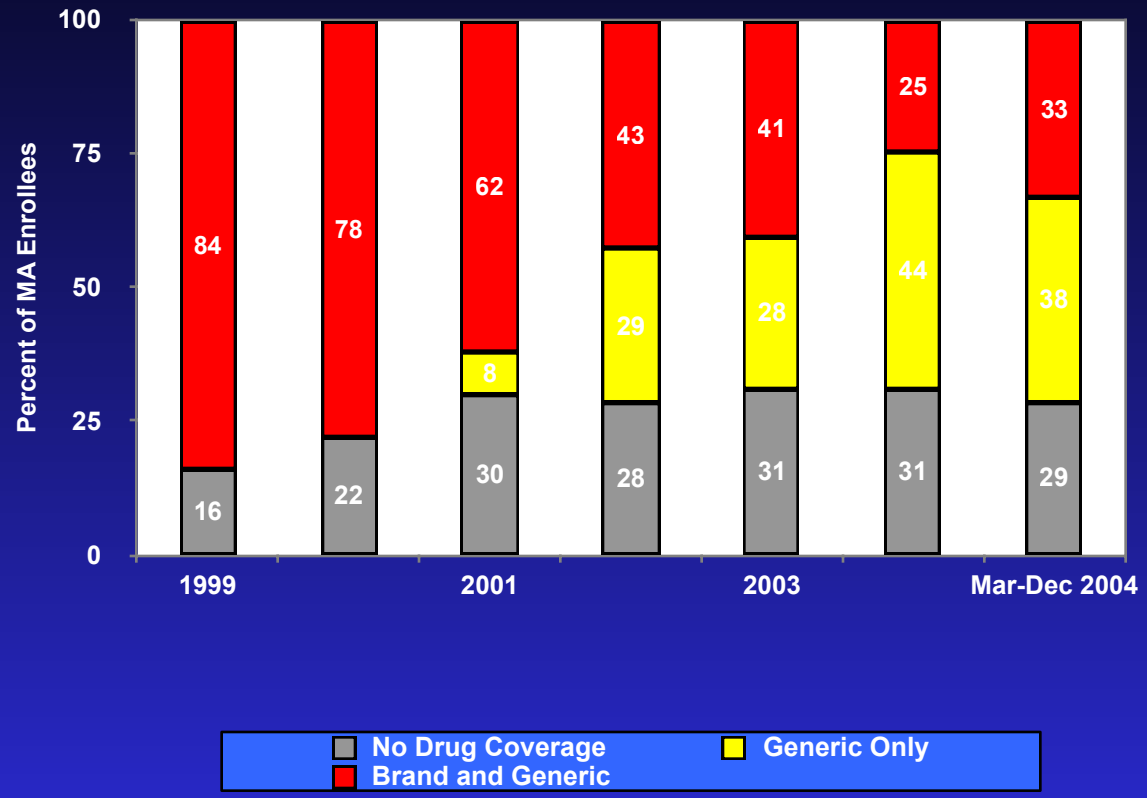
Average Medicare Advantage Premiums, 1999-2004



Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

Note: With the exception of the January-February 2004 data, all other data is weighted by March enrollment of each year. January-February 2004 data is weighted by February 2004 enrollment.

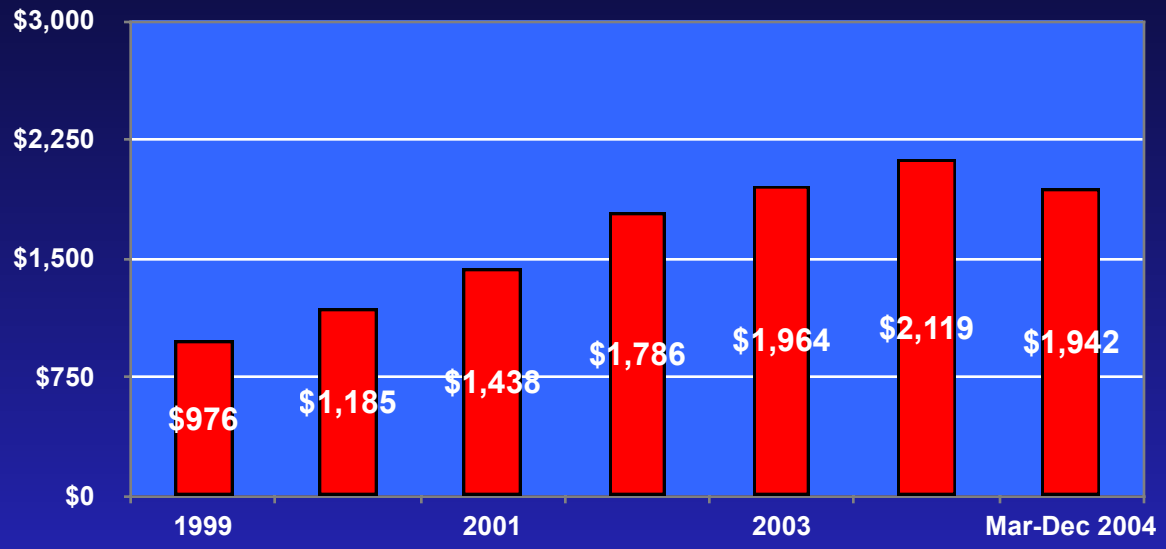
Changes in Type of Drug Coverage in Medicare Advantage Plans, 1999-2004



Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

Note: With the exception of the January-February 2004 data, all other data is weighted by March enrollment of each year. January-February 2004 data is weighted by February 2004 enrollment. Information on generic-only prescription drug coverage was not tracked in 1999 and 2000. The number of enrollees with generic-only coverage during those two years is assumed to be neglible.

Average Enrollee Out-of-Pocket Costs in MA Plans, 1999-2004

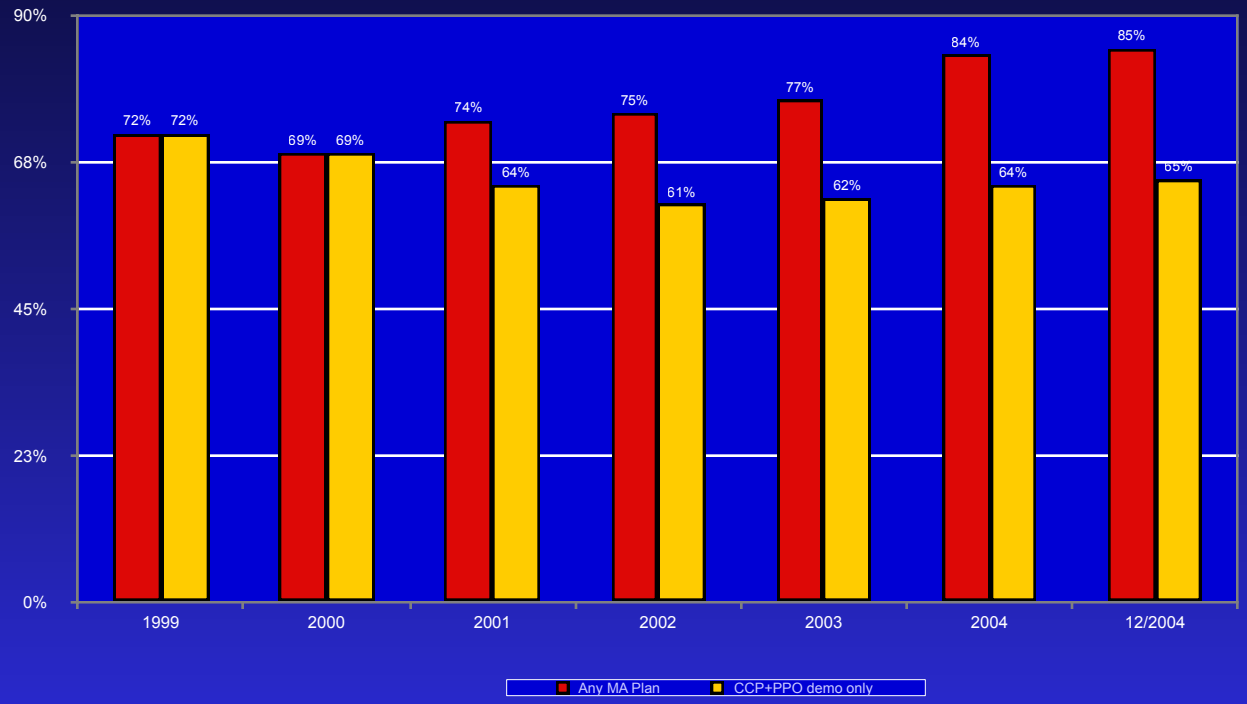


Source: MPR analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

Notes: With the exception of the January-February 2004 data, results are weighted by March enrollment of each year. January-February 2004 data is weighted by February 2004 enrollment. Average costs assume 79 percent of enrollees are in good health, 15 percent in fair health, and 6 percent in poor health. This distribution corresponds to the distribution of self-reported health status among Medicare managed care enrollees in the 1999 Medicare Current Beneficiary Survey (Liu and Sharma 2003).

MA Presence Still Very Uneven

Percent of Medicare Beneficiaries with Access to an MA Private Plan, 1999-2004*

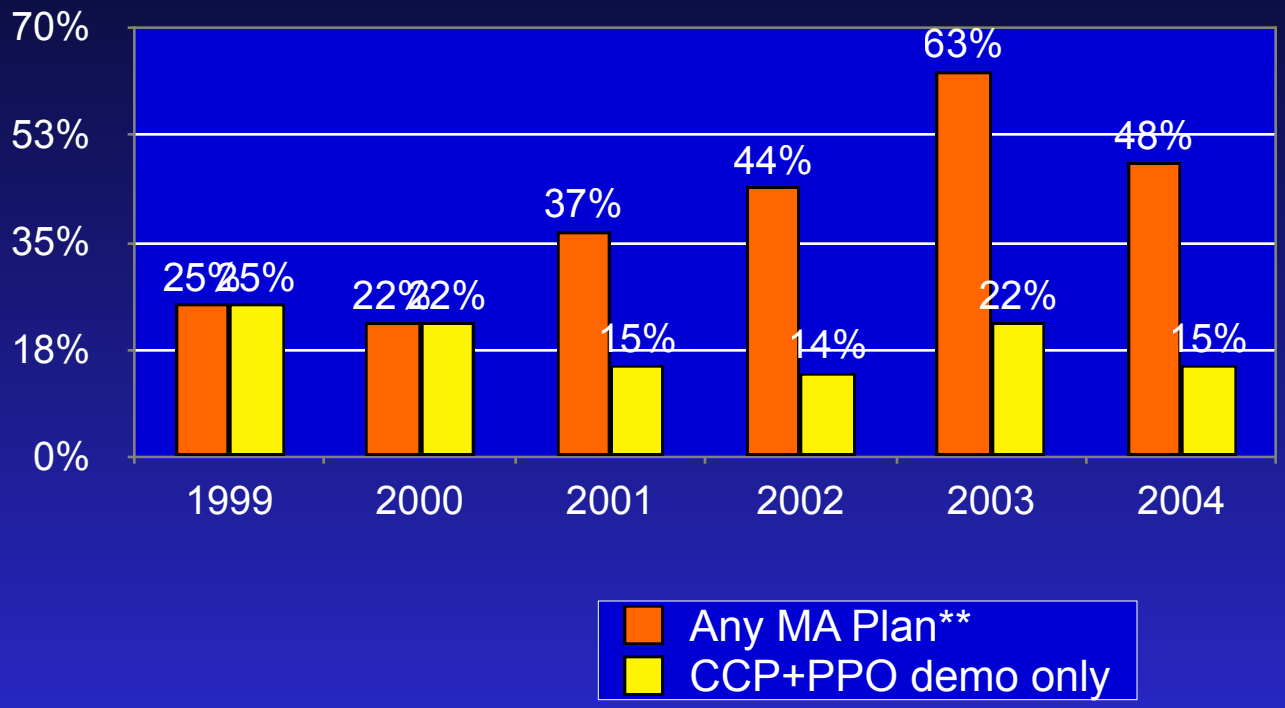


Source: MPR Analysis of CMS data for The Kaiser Family Foundation

*Data for March of that year, unless otherwise indicated

MA Availability in Rural Areas Very Limited

Percent of Rural Beneficiaries with MA Plan Access, 1999-2004*



Source: MPR Analysis of CMS data for The Kaiser Family Foundation

*Data for March of each year.

**All includes PFFS; offerings have been highly unstable over the period as Sterling has withdrawn from many markets

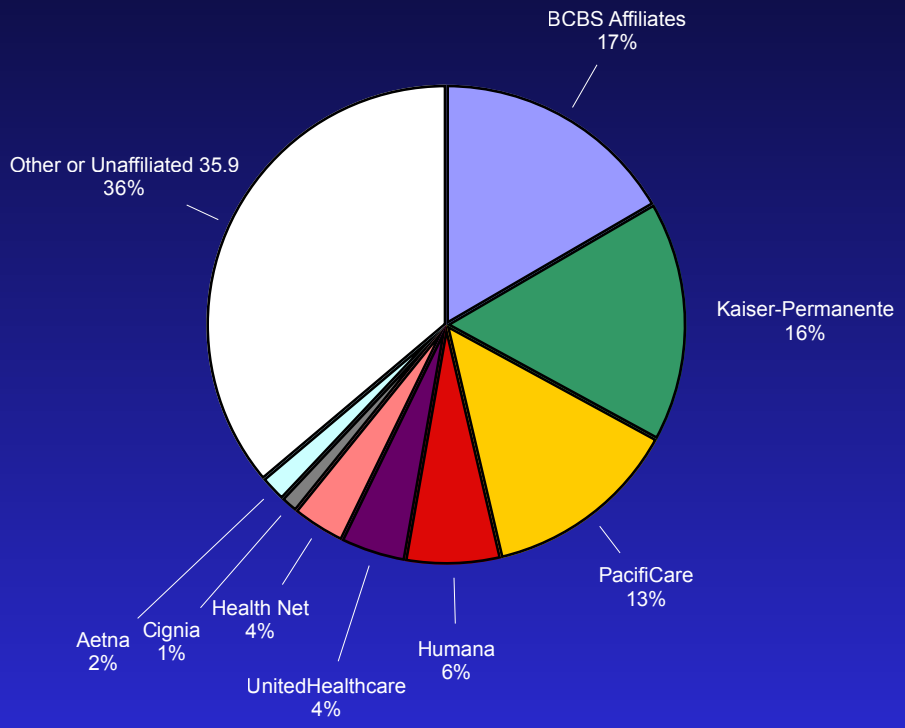
Enrollment in non-HMO MA Plans Remains Low

	December 2004
All	5,300,903
CCP	4,672,514
PPO Demo	107,730
PFFS	47,639

Source: MPR Analysis of CMS data for The Kaiser Family Foundation

A Small Number of Firms Dominate the Market

Distribution of By Firm or Affiliation, 2004



Source: MPR Analysis of CMS data for The Kaiser Family Foundation

Regions Vary Substantially in Size and Urban/Rural Mix

- 47 percent of beneficiaries are in seven of the 26 regions with more than 2.0 million (another 32 percent are in eight regions with 1.5-2.0 million)
- At least 20 percent of beneficiaries are in rural counties in 16 of the 26 regions.
- In three regions rural beneficiaries outnumber urban beneficiaries.
  - #19 (seven states in north central US) 55 percent
  - #1 (Maine, NH) 54 percent
  - #26 (Alaska) 51 percent

Some Regions are Very Heterogeneous

For example:

- Region 2 includes Vermont (no MA) with MA, RI, CT.
- Region 6 includes WV (almost no MA) with Pennsylvania.
- Region 16 includes MS (no MA) with Louisiana.
- Region 19 includes seven states of whom two have no MA (MT, WY), and two have only PFFS (ND, SD) along with Minnesota where MA has a long history. (The other states—Nebraska and Iowa—have limited MA penetration.)

Current MA Availability is Much Less than MA Intends

	Percent of Beneficiaries with MA Plan Available 2004*		
	67%+	30-66%	30%
Number of Regions	11	10	7
Percent of Medicare Beneficiaries#	46%	31%	21%
Percent of the nation's rural beneficiaries#	22%	35%	40%
Regions included	#3 (NY), #4 (NJ), #8 (FL) #12 (OH), #20 (CO, NM) #21 (AZ), #22 (NV) #24 (CA), #25 (HA)	#10 (AL, TN), #11 (MI) #14 (IL, WI), #15 (AK, MO), #17 (TX) #18 (KS, OK)	#1 (ME, NH), #7 (NC, VA) #8 (GA, SC),#13 (IN, KY) #26 (Alaska)
	Highly Uneven	Highly Uneven	Highly Uneven
	#2 (CT, MA, RI, VT) #6 (PA, WV)	#23 (ID, OR, UT, WA)	#16 (LS, MS)
Source: Author's analysis based on a variety of information sources.			#19 (IA, MN, MT, NE, ND, SD, WY)

*Highly Uneven – in multiple state regions includes a state that no CCP choice (or less than 10 percent with it) for regions in the substantial or some categories. In states with limited choice, means that the region includes a state that would qualify as moderate choice.

Challenges to Entry and Retention Vary By Type of Region

- Limited MA history—why did the market not support it before? Can it now?
- Intra-regional variation in MA—will plans find it feasible to serve the entire region?
- Substantial local MA market share—will plans be concerned about the impact of regional entry on their local product?
- Past history of instability—will it scare plans or beneficiaries away, signal future instability?

Looking to the Future

- History suggests regional MA plan entry will be limited and retention could be a problem.
- History also suggests that PFFS type products will dominate any offerings in at least some regions if they are allowed: What is a PFFS?
- But past is not necessary prologue.
- Medicare is an enormous program. If industry believes that Congress truly will support an enlarged private role over time, they may try to make it work.

Looking to the Future *(continued)*

- "One stop choice" an attractive package made possible by higher payments, and pharmacy experience could make private plans more attractive to beneficiaries.
- Whether this will be in regional versus local plans is unclear.
- However you look at it, Medicare has become a more complex and uncertain program.