CHAPTER 3

The Medicare Advantage program

R E C O M M E N D A T I O N S

3A The Congress should eliminate the stabilization fund for regional preferred provider organizations.

COMMISSIONER VOTES: YES 15 • NO 1 • NOT VOTING 0 • ABSENT 1

3B The Secretary should calculate clinical measures for the fee-for-service program that would permit CMS to compare the fee-for-service program to Medicare Advantage plans.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

3C The Congress should clarify that regional plans should submit bids that are standardized for the region's Medicare Advantage–eligible population.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

3D The Congress should remove the effect of payments for indirect medical education from the Medicare Advantage plan benchmarks.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

3E a) The Congress should set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of the fee-for-service costs.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

b) At the same time, the Congress should also redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to Medicare Advantage plans based on quality measures.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

3F The Congress should put into law the scheduled phase-out of the hold-harmless policy that offsets the impact of risk adjustment on aggregate payments through 2010.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

CHAPTER 3

The Medicare Advantage program

In this chapter

- Overview of changes to the managed care program under the MMA
- What are the new types of plans?
- Quality
- Enrollment
- Benefits
- The MA bidding process for 2006
- Financial neutrality under the 2006 bidding system

MedPAC supports giving Medicare beneficiaries a choice among health care delivery systems. Where private plans can improve the efficiency and quality of health care services for Medicare beneficiaries they should be encouraged to do so and beneficiaries should be given an opportunity to choose them. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) introduced a number of changes to the program of private plans in Medicare and created the Medicare Advantage (MA) program. New types of plans were introduced, plan quality requirements were altered, and payment policies were modified. Some of these changes raise issues concerning financial neutrality and the conditions of competition between choices. This chapter provides an overview of major changes and provides recommendations on a number of provisions related to the MA program.

MedPAC supports private plans in the Medicare program. In general, Medicare beneficiaries should be able to choose between the fee-for-service (FFS) Medicare program and the alternative delivery systems that private plans can provide, as long as the choices are efficient for the program. Private plans may have greater flexibility in developing innovative approaches to care, and these plans can more readily use tools such as care coordination and other health care management techniques to improve the efficiency and quality of health care services that Medicare beneficiaries receive.

Since 1982, Medicare beneficiaries in many areas of the country have been able to choose between whether to receive care under the traditional FFS program or through private plans—which, in return for a fixed monthly payment from the Medicare program, agree to provide a benefit package at least equivalent to that available in FFS. Often, these plans have supplemented Medicare benefit packages and have offered them for less than the price beneficiaries pay for supplemental Medigap policies. Private plans in Medicare have experienced varying degrees of enrollment over the years, peaking at 17 percent of the Medicare population in 1999 but declining to 12 percent by 2004 (MedPAC 2004a).

MedPAC also supports financial neutrality between payment rates for the FFS program and private plans. Additionally, MedPAC supports equitable payment rates among private plans. Financial neutrality means that the Medicare program should pay the same amount, regardless of which Medicare option a beneficiary chooses. If a beneficiary chooses a more expensive plan, that beneficiary can choose to pay additional premiums. In paying private plans more than FFS—or paying certain private plans more than other private plans—the payment system encourages inefficiency and contributes to increased overall spending for the Medicare program (MedPAC 2004b).

Financial neutrality is important because Medicare costs are high and will continue to increase rapidly for the foreseeable future, particularly with the impending eligibility of the baby boom generation. The Medicare program needs to offer private options that will help reduce, not increase, overall program spending. In raising MA plans' rates above FFS rates in order to attract plans to new areas of the country, Medicare does not create incentives for the efficient provision of high-quality care. Medicare should set payment rates to encourage plans to achieve high quality with lower resource use. It may be consistent with the Congress's goal of increased availability of MA plans to set MA rates higher than FFS rates in the short term to help plans build infrastructure; however, to continue to do so would be a disservice both to Medicare beneficiaries and—in these times of increasing budget deficits—the taxpayer. If MA plans exist in markets only because payment rates are higher than FFS rates, any reduction in those rates would likely lead to considerable disruption for beneficiaries; they would have to switch to another MA plan or return to the FFS program. This change could make Medicare beneficiaries' perceptions of the MA program unfavorable—as happened after plans withdrew from Medicare in the late 1990s—and could ultimately undermine the ability of efficient, high-quality MA plans to succeed under Medicare.

However, MedPAC is also aware that the Congress has raised payment rates for private plans and has introduced new types of private plans, such as regional preferred provider organizations (PPOs), to encourage expansion of the MA program to new areas and to try to reverse several years of declining enrollment. Lowering rates to achieve financial neutrality in the short run would likely reduce the participation of plans and beneficiaries in the MA program; doing so in the midst of the 2006 bidding process would cause significant disruption. Regional PPOs and new local MA plans are preparing to enter the MA program, but they might reconsider whether to enter certain markets—or whether to leave certain markets after a short period of time. Additionally, some provisions in the MMA, such as the more competitive system, may provide valuable information to inform our thinking about more appropriate payment rates.

Thus, MedPAC supports a policy of financial neutrality for the MA program, coupled with incentives for delivering high-quality care. We have found that organizations are more likely to be efficient when they face financial pressure. The Medicare program needs to exert consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, in order to maximize the value it receives for the dollars it is spending. MedPAC recognizes that the Congress may not be able to achieve this objective immediately. We designed the recommendations in this chapter to provide future, as well as immediate, steps toward this objective.

Overview of changes to the managed care program under the MMA

The MMA is the Congress's most recent attempt to increase private plans' participation in the Medicare program. The MMA changed several major elements of the program for private plans that participate in Medicare. These changes include:

- ***Types of plans.*** The MMA added two new types of plans: regional PPOs and special needs plans.
- ***Payment method.*** The MMA changed the method of payment from one in which Medicare pays plans based on an administered price to one in which plans will bid against an administered price.
- ***Drug benefit provision.*** All MA plans—except private fee-for-service (PFFS) and Medicare Savings Account (MSA) plans—will offer the minimum drug benefit that will be available to all beneficiaries under Part D.
- ***Enrollment period.*** Current policy allows beneficiaries to change plans on a monthly basis. Beginning in 2006, the enrollment process will change to an annual open enrollment period. However, dual eligibles (that is, beneficiaries who are eligible for both Medicare and Medicaid) will be allowed to change plans at any time.
- ***Name of program.*** The MMA renamed the program from Medicare+Choice (M+C) to Medicare Advantage (MA).

Table 3-1 details the full list of MMA changes in the MA program.

TABLE 3-1

Medicare Advantage changes as a result of the MMA

Program feature	Medicare+Choice	Medicare Advantage
Types of plans	HMOs, PPOs, PFFS, MSA, specialized plans	HMOs, regional and local PPOs, PFFS, MSA, special needs plans
Cost plans	Were to expire 12/31/04	Expire 12/31/07 unless fewer than two Medicare Advantage plans in an area
Quality	Quality assurance focus	Quality improvement focus
Enrollment	ESRD allowed only if beneficiary already enrolled in Medicare+Choice plan prior to onset of ESRD	ESRD allowed only if beneficiary already enrolled in Medicare Advantage plan prior to onset of ESRD or if beneficiary enrolled in special needs plan that accepts ESRD beneficiaries
Open enrollment period	Continuous monthly	Annual, with several exceptions
Medicare benefits package	All Part A and Part B services except hospice	All Part A and Part B services except hospice; certain types of plans must offer a Part D drug plan. Regional PPOs must offer a combined deductible and stoploss
Payment	Administered prices based on three-prong system	Bidding with administered prices as a benchmark in a two-prong system
Additional benefits	Difference between plan costs and price must be returned as additional benefits. If Part B premium reduction, 80% of difference available and 20% retained by Medicare	75% of difference between plan bid and benchmark must be returned as additional benefits/premium reductions; 25% of difference retained by Medicare
Payment areas	County	County, for local plans; regions, for regional plans
Basic risk adjustment	CMS–HCC method	CMS–HCC method

Note: HMO (health maintenance organization), MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003), PPO (preferred provider organization), PFFS (private fee-for-service), MSA (medical savings account), ESRD (end-stage renal disease), CMS–HCC (CMS–hierarchical condition category).

Source: Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

What are the new types of plans?

The MMA allowed two new types of plans under the MA program and changed several features of the existing plans.

Regional PPOs

The addition of regional PPOs was probably the most visible change to the types of plans allowed to participate in the program. PPOs in the private market generally contract with a set of providers to offer services at discounted fees. Providers accept the lower fees in return for anticipated higher patient volume, because PPO members generally have financial incentives—structured through differences in cost sharing—to seek care from preferred providers. Unlike a health maintenance organization (HMO), PPO members can receive care from providers outside the preferred PPO network, although they generally pay higher cost sharing for doing so. PPOs and point-of-service plans (POS)—which have a similar plan design—existed under the earlier M+C program. But until CMS established a PPO demonstration program in 2003, these types of plans were slow to emerge. However— perhaps in preparation for the emergence of regional PPOs in 2006 and the subsequent moratorium on local PPOs (discussed later in this chapter)—CMS received new applications from 70 local PPOs for 2005, 26 of which the agency approved. These were available to beneficiaries as of January 2005. These new PPO offerings are in addition to those from the existing demonstration PPOs. Regional PPOs differ from local PPOs in that they must serve the entire region that CMS has defined for this type of plan.

PPO regions

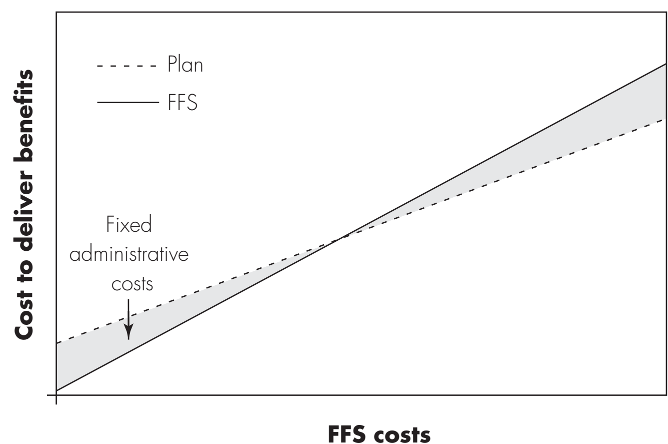
Some policymakers hope that requiring plans to serve larger regions will bring MA plans to more parts of the country and give beneficiaries more choices. Policymakers also expect that specific provisions in the MMA relating to payment, network adequacy, and cost sharing will encourage private plans to serve rural as well as urban areas in a region. The MMA specified a minimum of 10 regions and a maximum of 50 regions for regional PPOs and required that the Secretary construct the regions based on an analysis of current health insurance markets. (As we discuss later, the Secretary ultimately decided on 26 PPO regions.) During the course of Medicare's managed care program, the Congress has often taken steps to encourage private plans to broaden their service areas, hoping that these plans—with their often attractive benefit packages—would make themselves available to more beneficiaries. Most notable have been congressional increases in payment rates in areas that have below-average levels of FFS program spending. (We discuss the payment rates later in this chapter.) These areas often tend to be rural.

MedPAC and others have cited two primary reasons (other than Medicare payment rates) why MA plans are less likely to serve rural, sparsely populated areas (MedPAC 2001). First, unlike managed care products sold to employers (in which plans market to an employer to win the business of an entire group of employees), MA plans sell policies to individual Medicare beneficiaries. Marketing individual products is expensive, and the return on investment is lower in areas that contain few Medicare beneficiaries.

Second, plans face difficulty in building provider networks in less densely populated areas. In areas that have many competing hospitals and physicians, these providers are more willing to accept a plan's contracting terms. In rural areas, less competition among providers means less incentive to negotiate with plans over fees and other plan requirements. Additionally, health plans face certain fixed costs before they can enroll a single member. Thus, plans face problems in establishing programs in low-cost (generally rural) areas, and they have certain advantages in higher cost (generally urban) areas.

FIGURE 3-1

Comparison of private plan versus FFS costs, by market area, 2004



Note: FFS (fee-for-service).

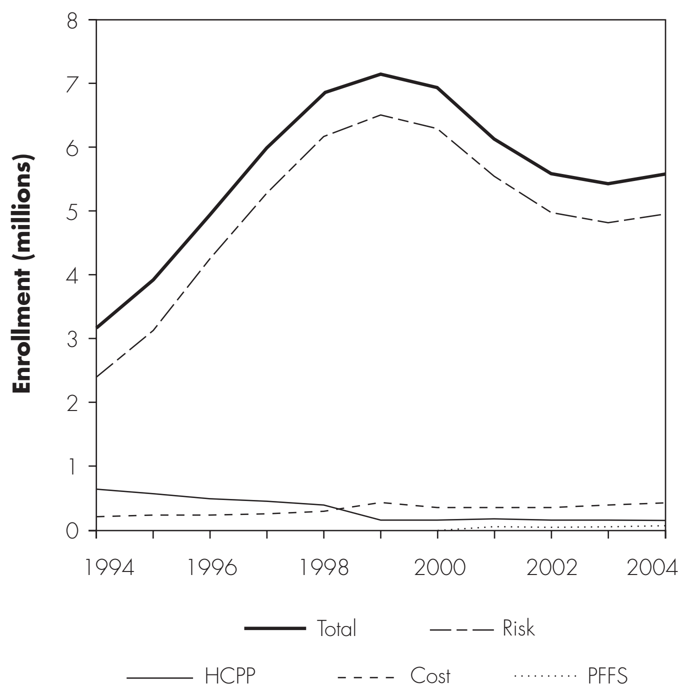
Source: MedPAC analysis of Adjusted Community Rate Proposal data.

MedPAC illustrates these problems in an analysis of private plan adjusted community rate (ACR) data. In areas that have low levels of FFS costs, plan costs exceed FFS costs. However, in areas that have high levels of FFS costs, plans are increasingly able to provide Medicare benefits at less than FFS costs (either by managing care more efficiently or negotiating reduced prices from providers)—even considering their initial fixed costs (Figure 3-1). This helps to explain why the majority of MA enrollment is in higher cost, urban areas.

One type of MA plan—the PFFS plan—specifically targets enrollees in rural areas where Medicare payment rates are high relative to spending under the traditional FFS program.[1] Because PFFS plans do not need to contract with providers to meet Medicare's access and participation requirements, they face lower fixed costs. These PFFS plans are considered to have met the access requirements by paying providers at least the fees that would apply under the traditional FFS program, thus enabling them to compete in lower cost rural counties. Although for several years only one company offered these types of plans, several more companies offered them in 2004 and 2005—and we expect more in 2006. As of March 2005, total enrollment in PFFS plans was 71,000, a small share of the 5.6 million total enrollment in private plans, but an increase of more than 150 percent from March 2004 (Figure 3-2).

FIGURE 3-2

Enrollment in Medicare private plans, by plan type



Note: HCPP (health care prepayment plan), PFFS (private fee-for-service).

Source: CMS.

The Congress hopes that regional PPOs will have much broader appeal to Medicare beneficiaries than existing plan types because PPOs have become the most popular health insurance option in the private sector, following a consumer backlash against HMOs in the late 1990s. If many of these plans enter the program to serve regions across the country, private plans will be more widely available to beneficiaries. The ultimate popularity of the regional PPO offering will not be evident for a number of years, but as of May 2005, plans had indicated an interest in becoming regional PPOs in 21 of the 26 PPO regions (Inside Washington Publishers 2005).

CMS analyzed a number of factors in determining how to establish regions to encourage regional PPOs' participation in the MA program (CMS 2004) (Figure 3-3, p. 64). These factors included the following:

- ***Population size.*** CMS concluded that an area needs at least 200,000 eligible beneficiaries for a plan to be able to form networks. CMS also concluded that the region should include no more than 3 million beneficiaries because of potential start-up costs.
- ***Sufficient number of existing competitors.*** CMS looked at whether existing competitors were already located in the area, expecting that the regional PPO plans would be developed by companies already offering health insurance coverage.
- ***Limited variation in payments within regions.*** CMS grouped states that had similar average plan payments.
- ***The preservation of geographic patient flows.*** CMS grouped states in which beneficiaries typically receive care across state borders.

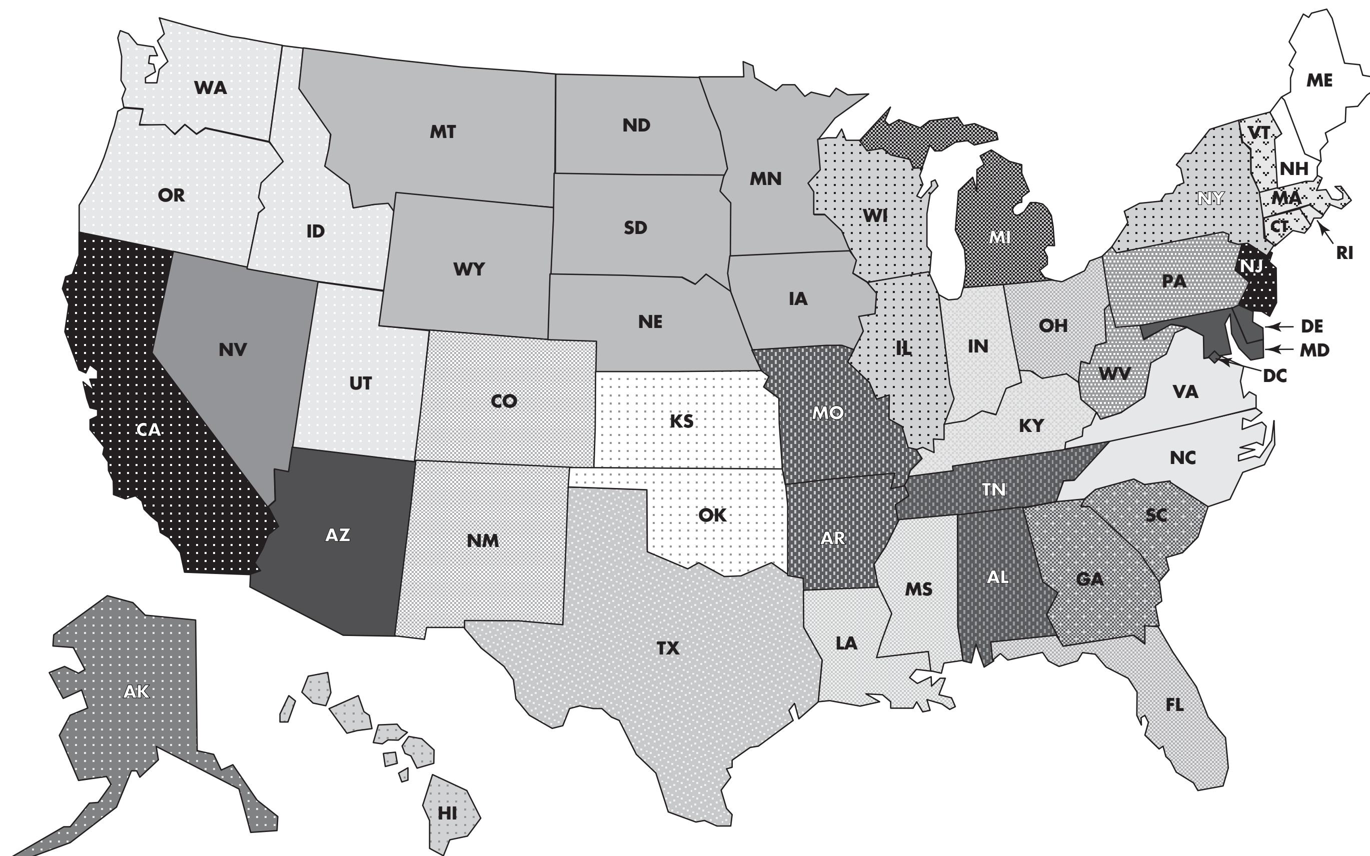
Based on this analysis of existing insurance markets, CMS chose 26 PPO regions.

Regional PPO features

Regional PPOs and local MA plans must cover the same Medicare Part A and B benefits as under the FFS program (with the exception of hospice care). All MA plans must follow local coverage decisions, but regional PPOs that span multiple areas with differing policies can select a set

FIGURE 3-3

Medicare Advantage regions



Source: CMS.

of local coverage policies from a single FFS contractor group and apply them uniformly across the region. Regional PPOs may also require different cost sharing for in-network and out-of-network providers. Aggregate in-network cost sharing in a regional PPO cannot exceed aggregate cost sharing under FFS Medicare. Neither regional PPOs nor local MA plans may allow providers to balance-bill Medicare beneficiaries, nor may they limit particular benefits to only in-network providers.[2]

Similar to local plans, regional PPOs generally must ensure access to a network of providers. Local plans must document this requirement with written agreements to furnish services. However, recognizing the difficulty of establishing provider networks in rural areas, CMS allows regional PPOs to have more flexibility and to propose alternative methods of establishing that they meet access requirements. CMS states in its final MA regulation that it "will allow MA regional plans to contract with CMS with less robust networks of contracted providers" than CMS requires of local coordinated care plans (CMS 2005a). These plans will meet CMS's access requirements provided that the plans reimburse providers with whom they do not contract at Medicare FFS rates and limit enrollee cost sharing liability to in-network levels. For example, a regional PPO may establish a network that meets the statutory network adequacy requirements throughout 85 percent of a region. In that part of the region, the plan may charge higher cost sharing for out-of-network services. But in the part of the region without a network, the plan cannot charge higher cost sharing for out-of-network services. In certain areas, CMS's flexibility toward PPOs regarding network adequacy requirements could be perceived as giving regional PPOs an advantage over local MA plans.

Regional PPOs that use a combination of in- and out-of-network services cannot require beneficiaries to get services preauthorized. However, plans can warn beneficiaries that they do not cover certain services and they can encourage beneficiaries to first call the plan to determine whether it covers the services in question. Plans can offer an incentive for beneficiaries to call by charging less cost sharing when beneficiaries notify them of their intent to use out-of-network services.

To the extent that they have deductibles, the MMA requires regional PPOs to provide a combined deductible for Part A and Part B services (thus combining the deductibles for hospital, physician, and post-acute care), and an overall cap on beneficiary cost-sharing liability. The deductible may be waived for preventive services, and the cap may differ for in-network and out-of-network cost sharing. Neither the MMA nor its subsequent regulations set parameters for these benefit design elements, although the actuarial value of the deductible, coinsurance, and copayments in an MA plan may not exceed the actuarial value of the deductible, coinsurance, and copayments that would apply, on average, to FFS enrollees. Additionally, CMS continues to have the authority to disallow the offering of an MA plan if CMS determines that the benefit design is likely to substantially discourage enrollment by certain MA-eligible individuals. Local MA plans do not have to offer a combined deductible, or the overall cap on beneficiary out-of-pocket liability.

Financial incentives to attract regional PPOs

The Congress added three types of financial incentives to encourage regional PPOs to participate in MA: risk sharing for 2006 and 2007, a regional stabilization fund, and essential hospital payments that may go to certain hospitals in a regional PPO plan's network. In addition, the MMA established a moratorium on local PPO plan entry in 2006 and 2007 (the act permits existing local PPOs to offer new products within the existing service area). This moratorium is intended to prompt private plans to consider participating as regional PPOs.

Risk sharing for 2006 and 2007

Risk sharing for regional PPOs is structured through "risk corridors"—plan-specific spending targets against which actual plan spending is compared. Risk corridors may function as a valuable protection for plans that serve large regions with variable conditions. If costs exceed the target, Medicare gives additional payments to the plans; if costs fall below the target, plans must return funds to Medicare following a set schedule (Figure 3-4, p. 66). For example, a regional PPO that Medicare paid $700 per member per month but that spent $735 on benefits net of administrative expenses would receive an additional $7 per member per month under this formula (but would lose an additional $28). By contrast, a regional PPO that Medicare paid the same amount per month but that had actual costs of $630 would remit $29 back to Medicare (but would retain $41 in additional profits).

The risk corridor provision does not extend to drug benefits that MA plans may cover under Part D; Part D already includes separate risk-sharing arrangements for these benefits through reinsurance and risk corridors. Risk sharing applies to Part A and Part B services, as well as any additional benefits that the MA plan provided through the rebate process (which we describe later in this chapter). However, risk sharing does not apply to administrative costs. The target with which CMS compares the costs is the plan's payment less the portion of administrative expenses assumed in the plan's bid.

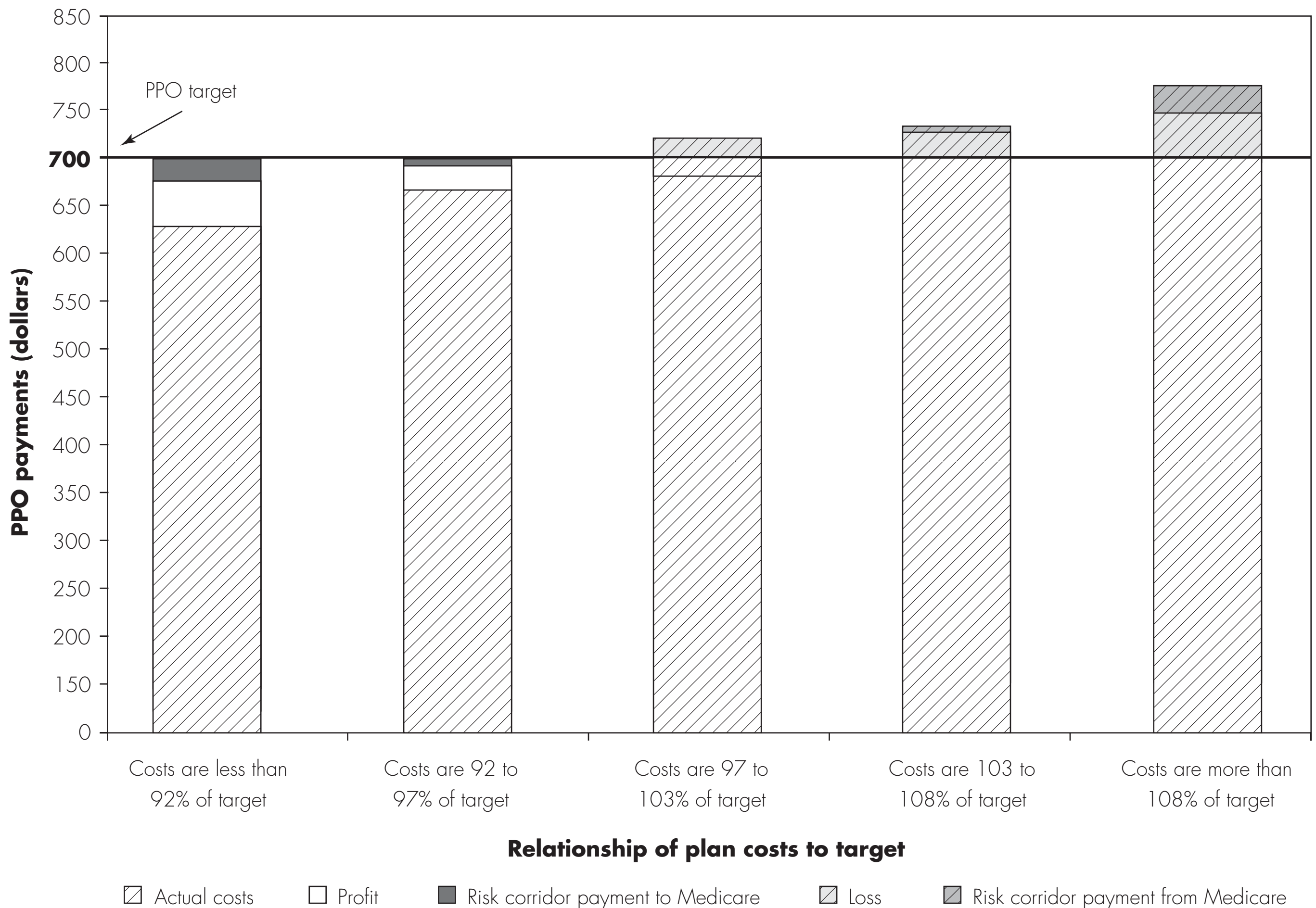
Regional stabilization fund

The MMA provided for a regional PPO stabilization fund. This fund would make additional payments to regional PPOs, thus encouraging them to not only enter but remain in markets. Beginning in 2007, $10 billion will be available for the fund, and the fund will remain in operation until December 2013. The $10 billion in initial funding will be supplemented by 50 percent of any government savings that accrue as a result of regional PPOs bidding below the benchmarks (we discuss the benchmarks and bidding process later in this chapter). If CMS uses the fund for two years in a row, it must report to the Congress on the market conditions that led to the fund's use. In response, the Congress could then change the regions or payment systems.

Payments from the fund may be available in the following circumstances:

- The regional PPO plan or plans that become the first national plan or plans to serve all regions of the country will receive a bonus amount equivalent to 3 percent of the benchmark amount for each regional plan the PPO offered.

FIGURE 3-4 **Risk corridors for regional PPOs under Medicare Advantage, 2006–2007**



Note: PPO (preferred provider organization). When costs are less than 92 percent of target, plan pays Medicare 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target and actual costs. When costs are between 92 and 97 percent of target, plan pays Medicare 50 percent of the difference between actual costs and 97 percent of the target. When costs are between 97 and 103 percent of target, there are no risk corridor payments. When costs are between 103 and 108 percent of target, Medicare pays plan 50 percent of the difference between actual costs and 103 percent of the target. When costs are more than 108 percent of target, Medicare pays plan 2.5 percent of the target amount plus 80 percent of the difference between actual costs and 108 percent of the target.

- If no national plans are offered, the Secretary may increase the benchmark for a regional PPO plan that becomes the first to serve a region. The Secretary will determine this extra amount. The Secretary also has the discretion to raise the benchmark in a region that did not have any regional PPOs the previous year.
- If a regional PPO intends to depart from a region—thus leaving the region with fewer than two regional PPO plans—and a national plan does not exist, the Secretary may increase the benchmark in order to retain plans.

Note that the national plan bonus is the least targeted of these circumstances because the bonus will be paid to the national plan(s) in all regions, even if regional PPOs already serve many regions. Additionally, the payments for regional PPOs that intend to depart a region may be administratively difficult to implement and may create incentives for regional PPOs to threaten to leave the program in order to receive additional payments.

RECOMMENDATION 3A

The Congress should eliminate the stabilization fund for regional preferred provider organizations.

RATIONALE 3A

MedPAC supports a level playing field, not only between MA plans and the FFS program but also among different types of MA plans. The PPO stabilization fund explicitly makes available additional funds to regional PPOs—funds that are not available to other MA plans. MedPAC understands that Congress intends the stabilization fund to encourage regional PPO plans' participation and that plans may be unsure of the risk they face by participating in the regional PPO program. The Commission also notes that the risk corridor system will shield regional PPOs from risk during the first two years of the program. As discussed earlier, regional PPOs will have more flexibility in assembling a provider network because of the looser network adequacy requirements. If, over time, specific problems emerge regarding regional PPO market entry or exit, the Congress could revisit the kinds of incentives that may be appropriate to attract plans to certain areas.

IMPLICATIONS 3A

Spending

- This recommendation has no spending implications over one year, as Medicare will not make payments from the stabilization fund until 2007. This recommendation would decrease federal spending by $1 billion to $5 billion over five years.

Beneficiaries and plans

- Although it is unclear what the PPO stabilization fund's precise impact would be on stimulating plan entry and preventing plan exits, this recommendation could potentially discourage regional PPOs from entering certain regions. Similarly, certain PPOs may exit regions in which they otherwise might have chosen to stay had they received payments from the stabilization fund. As a result, beneficiaries in certain areas may have fewer private-plan options from which to choose.

Essential hospital payments

Regional PPOs that have trouble contracting with hospitals may ask CMS to make additional payments to those hospitals in order to secure an adequate network. The MMA defines these hospitals as "essential hospitals." They are not critical access hospitals (CAHs), but rather are hospitals paid under the inpatient prospective payment system (IPPS) for FFS Medicare. The regional PPO must demonstrate that the hospital's inclusion in the network is necessary to meet the plan's access requirements and that the PPO has made a good-faith effort to contract with the hospital, paying it IPPS payment rates. To satisfy the access requirement, the regional PPO must also show that no competing hospitals in the area will contract with the PPO. Additionally, the hospital must demonstrate that IPPS rates are too low to cover the hospital's costs.

The MMA limits essential hospital payments to $25 million per year in the aggregate (adjusted for inflation). CMS makes essential hospital payments directly to eligible hospitals. The payment to the hospital constitutes the difference between the payment that the hospital would receive under the IPPS and the amount that the program would pay a CAH. CMS will make essential hospital payments on a first-come, first-served basis until the annual amount is spent. This program represents an additional source of funding that CMS makes available to regional PPOs and not to other MA plans—a situation that does not align with the Commission's position on financial neutrality. Additionally, some regional PPOs may view the essential hospital program as more of a deterrent than an aid, as it provides an incentive for hospitals to refuse to contract with regional PPOs in the hope of securing essential hospital payments.

Specialized plans

The MMA created another new category of MA plans called specialized MA plans for special needs individuals, or special needs plans (SNPs). SNPs are local or regional MA plans that enroll a disproportionate share (defined as a greater proportion of the target group of special needs individuals than that which occurs nationally in the Medicare population) of special needs individuals. In the MMA, the Congress suggests that eligible beneficiaries might include institutionalized patients, dual eligibles, and other individuals who have severe or disabling chronic conditions. Rather than defining these plans in advance, CMS has opted to allow the plans themselves to propose target populations; CMS will then evaluate the proposals on a case-by-case basis. The criteria for choosing specialized plans include the existence of clinical programs or special expertise for that plan's target population. CMS has approved 48 SNPs and is reviewing 18 applications for

services to be offered later in 2005. In addition, more than 100 SNPs have submitted applications to provide services in 2006 (CMS 2005b).

Specialized plans are not new to the Medicare program but have generally existed as CMS demonstration programs. These specialized plans include social HMOs, Evercare, plans for beneficiaries with end-stage renal disease (ESRD), and plans for dual eligible beneficiaries offered through both Medicare and Medicaid. The Program of All-Inclusive Care for the Elderly (PACE) was a demonstration program and is now a permanent program under Medicare and available under Medicaid at individual state discretion. All of these programs provide targeted services and care management to their enrollees.

Many observers of these earlier specialized demonstration plans questioned whether Medicare's payment method accurately accounted for the potentially higher costs of these specialized populations. Plans and beneficiary advocates expressed concern that even with risk adjustment, CMS still might not pay plans accurately for beneficiaries who have limitations in activities of daily living. CMS devised a special payment policy called a frailty adjuster for some of these demonstration plans and for PACE. When MedPAC reviewed the social HMO program, it suggested that the Secretary investigate the need for broader payment adjustments for all frail populations who are enrolled in private plans under Medicare (MedPAC 2003).

By statute, CMS will pay specialized MA plans the same way it pays all other MA plans: It will use the bidding process and the same risk-adjustment factors detailed in the subsequent sections of this chapter. The frailty adjuster will not apply to MA plans—although it will continue to apply to demonstration plans. The preamble to the final MA regulation indicates that in 2006, CMS plans to include more diagnoses in its risk-adjustment model. The broader model should better capture disease burden among the Medicare population (CMS 2005a). CMS also plans to refine its risk-adjustment model over time, perhaps including a frailty adjuster that the agency can apply across the entire MA population (not just by type of plan)—a policy that MedPAC supports.

Treatment of existing types of MA plans

Along with the addition of two new types of plans under MA, the MMA also made several changes to existing plans' participation in Medicare.

The Congress introduced MSAs combined with a high-deductible insurance product to the Medicare program in the Balanced Budget Act of 1997. The pilot MSA program was limited both in the number of enrollees permitted to participate (390,000) and in the length of time during which insurers could offer such products (the law permitted no new enrollments after January 1, 2003). As a result, no organization decided to offer an MSA plan in the Medicare market. The MMA then permanently removed these limits. However, even setting aside these constraints, MedPAC concluded that two market characteristics contributed to the absence of MSA offerings in the earlier program:

- little demand from the risk-averse Medicare beneficiary population because of the high deductible, and
- the difficulty of marketing a complex new product (MedPAC 2000).

However, it is possible that as more beneficiaries become accustomed to health savings–type accounts, high-deductible insurance products in the non-Medicare market, and high-deductible Medigap products, they may become interested in Medicare MSAs as well.

The MMA also introduced health savings accounts (HSAs) as a health insurance option outside the Medicare program. Similar to MSAs, these plans combine (a) an account into which an employer can deposit funds to be used to pay for health expenses and (b) a high-deductible plan that limits the holder's overall financial liability. Medicare beneficiaries may not make HSA contributions. However, people who participated in HSAs before they became eligible for Medicare may use funds deposited earlier to pay Medicare Part A, Part B, or MA supplemental premiums and to pay (tax free) the employee share of employer-related supplemental coverage. Beneficiaries may not use HSA funds to pay for Medigap premiums without incurring a tax penalty.

CMS reimburses cost plans for 100 percent of their costs instead of receiving a fixed monthly payment. Both the Congress and CMS have considered eliminating cost plans from Medicare many times. The plans will be eliminated starting in 2008, provided that their area contains at least two MA plans. Risk plans have raised concerns that cost plans can receive higher payments and charge their enrollees lower premiums than plans that accept risk for the full benefit package. These plans enroll

about 300,000 beneficiaries (another 100,000 are enrolled in cost plans that provide Part B services only). CMS has not permitted any new cost plans to join Medicare since 1997, although it has permitted service area expansions for existing plans.

Quality

In this section, we review the current situation regarding quality in MA plans, explore the ability of beneficiaries and others to make quality comparisons between the FFS program and MA plans, and review the requirements for quality improvement that the MMA and related regulations lay out. Finally, we look at the role that pay-for-performance might play in improving quality in MA plans.

What do we know about the quality of care in MA plans?

One of the ways in which CMS measures the quality of care for MA plans is through the Health Plan Employer Data and Information Set (HEDIS). Plans collect data on HEDIS measures by reviewing administrative claims and medical charts. Among MA plans, only HMOs report on all HEDIS measures (MSAs do not report any HEDIS measures, and PPOs only report those HEDIS measures that they can assess without reviewing medical charts). HEDIS measures for HMOs (which cover more than 90 percent of MA enrollees) indicate that the clinical effectiveness of care in Medicare plans is generally improving over time, although some measures continue to show low rates (NCQA 2004). While certain MA plans generally perform extremely well on the HEDIS measures, the data on overall plan scores vary considerably, suggesting that certain plans could work to improve their overall quality of care.

TABLE 3-2

Plans improve, but rates are still low on some measures

Measure	2000	2001	2002	2003
Advising smokers to quit	59.7%	60.8%	61.5%	63.3%
Beta-blocker treatment after heart attack	89.3	92.9	93.0	92.9
Breast cancer screening	73.9	75.3	74.5	74.0
Cholesterol management				
Control	52.9	58.4	62.3	66.7
Screening	70.6	75.5	77.7	81.0
Controlling high blood pressure	46.7	53.6	56.9	61.4
Comprehensive diabetes care				
Eye exams	62.8	66.0	68.4	64.9
HbA1c testing	82.5	85.7	85.0	87.9
Lipid control	50.9	57.5	62.6	67.7
Lipid profile	80.5	85.7	87.9	91.1
Monitoring diabetic nephropathy	45.0	51.9	57.3	53.6
Poor HbA1c control*	33.4	26.8	24.5	23.4
Antidepressant medication management**				
Acute phase	N/A	51.3	52.1	53.3
Continuation phase	N/A	36.8	37.7	39.2
Contacts	N/A	11.9	10.8	10.5
Follow-up after hospitalization for mental illness				
Less than 7 days	37.5	37.2	38.7	38.8
Less than 30 days	59.3	60.6	60.6	60.3

Note: HbA1c (hemoglobin A1c), N/A (not available). Rates refer to patients who received the clinically indicated treatment.
* Lower rates are better than higher ones for this measure.
** "Acute phase" refers to the percentage of patients who received effective treatment after a new episode. "Continuation" refers to the percentage of patients who remained on antidepressants continuously for six months after initial diagnosis. "Contacts" refers to the percentage of patients who received at least three follow-up office visits in a 12- week acute phase.

Source: National Committee for Quality Assurance 2004.

Data on these HEDIS measures show the rate at which members who are eligible for the clinical care being measured receive that care. For example, the measure for provision of a beta blocker after a heart attack tracks the number of beneficiaries with a heart attack who received a prescription for a beta blocker upon discharge from a hospital. Care on almost all of the 17 reported measures improved during the last three years (Table 3-2, p. 69). Only two measures noticeably declined, and the rest improved or stayed the same.[3] As part of HEDIS, MA plans also report Health Outcomes Survey (HOS) measures, which assess MA enrollees' physical functioning and mental well-being over time (Haffer and Bowen 2004).

As with other measure sets, MedPAC recognizes the importance of processes that improve and refine quality measures to ensure that measure sets continuously evolve. As performance on some measures reaches a high level, CMS needs to support a process that adds new dimensions. To avoid unnecessary burdens on plans and providers, this evolution should use processes that convene a variety of interested parties to agree on a standard set of measures. As these new measures emerge, CMS should also collect them in the FFS program (to the extent practical).

CMS can also compare quality between Medicare private plans and FFS by using patient-centered measures of quality. CMS collects information from beneficiaries on their perceptions of care while enrolled in MA plans and in the FFS program through the Consumer Assessment of Health Plans (CAHPS) survey. Levels of satisfaction with access, such as getting care when one needs it, are generally similar for MA and FFS beneficiaries, although the latter are less likely to report problems in accessing specialists (Table 3-3). FFS beneficiaries and beneficiaries enrolled in MA rate their plan and overall health care similarly. In general, the measures have proven stable over time, with the exception that beneficiaries in both MA plans and the FFS program are reporting declining overall levels of satisfaction. However, this CAHPS question is broad and not specific to any type of provider or service, asking both FFS and managed care participants to rank their 'plan' on a scale of 0 to 10, in which 0 is the "worst health plan possible" and 10 is the "best health plan possible."

Comparing quality between FFS and MA plans

Although HEDIS measures provide the ability to compare quality among MA plans, CMS does not routinely publish the HEDIS measures for the FFS program. Therefore, apart from the CAHPS survey, quality comparisons between MA plans and the FFS program are difficult nationally and locally. CMS does collect information at the state and national level that permits comparison of the FFS program to MA plans on the HEDIS measure, Access to Ambulatory Health Services (CMS 2005a). Further, CMS can derive some of the HEDIS measures—most notably those that PPOs report—from administrative data. CMS could begin to routinely calculate and publish HEDIS measures for the FFS program derived from administrative data. CMS could also explore existing approaches—and data sources such as those used by

TABLE 3-3

MA plans and the FFS program have similar patient experience scores

	MA plans			FFS program		
Measure	**2001**	**2002**	**2003**	**2001**	**2002**	**2003**
None or small problem getting care when needed	94%	93%	94%	97%	95%	95%
Usually or always got care quickly	87	81	83	87	81	84
Doctors usually or always communicate well	93	93	93	94	94	94
Rated health care overall 8–10	84	84	84	84	85	86
Rated plan 8–10	77	76	70	78	77	69
None or small problem seeing a specialist	N/A	92	92	N/A	95	95

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not available).

Source: 2001–2003 Consumer Assessment of Health Plans Survey (CAHPS) data for Medicare Advantage plans and the fee-for-service program from CMS.

quality improvement organizations (QIOs)—that draw samples of medical records in defined geographic areas in order to calculate additional HEDIS measures that require medical record abstraction.

RECOMMENDATION 3B

The Secretary should calculate clinical measures for the fee-for-service program that would permit CMS to compare the fee-for-service program to Medicare Advantage plans.

RATIONALE 3B

In order for beneficiaries to make informed choices between the FFS program and the array of MA plans, they need a consistent set of quality measures that they can use to compare their options. Further, CMS should be able to compare the two programs' performance.

IMPLICATIONS 3B

Spending

- This recommendation has no federal budget implications. CMS should find most measures relatively easy to implement by using analyses of existing claims data. Some measures might require additional resources—particularly if they require the creation of new, or the expansion of current, survey instruments.

Beneficiaries and providers

- Beneficiaries will have an additional set of comparisons on which to evaluate the FFS program and MA plans; this new data source will foster competition between the two programs.

CMS does not collect the measures that MA plans collect as part of the HOS for the FFS program. CMS administered a version of the HOS to 10 subsamples of the Medicare FFS population in 1998 (Pope et al. 2000), but this was on a pilot basis and the agency has no plans for further data collection in the FFS program. CMS can potentially use the HOS as a tool for comparison between MA plans and the FFS program. However, the HOS also has limited clinical information, relying on self-reported measures of health and functional status.

In its March 2005 report, MedPAC recommended that CMS develop measures of physicians' processes of care using claims data (enhanced by pharmacy and laboratory data) for a physician pay-for-performance program (MedPAC 2005). As CMS develops these clinical measure sets for FFS, the agency may learn that these sets allow better comparison between the quality of care for Medicare beneficiaries in private plans and for those in the FFS program.

What are the requirements for quality programs?

The MMA and related CMS regulations specified certain quality requirements and measures for the MA program. In general, the requirements that CMS imposed on MA plans are considerably less prescriptive than they were under the old M+C program. Under M+C, plans adhered to a defined list of requirements that its quality assurance plan should address and were required to participate in national or statewide quality assurance and performance improvement projects. CMS replaced these requirements with the following new ones:

- Each MA plan (other than a PFFS plan or an MSA plan) must have an ongoing quality improvement program.
- Each quality improvement program must include a chronic care improvement program.
- Each MA plan must provide for the collection, analysis, and reporting of data that permit CMS to measure health outcomes and other indices of quality (CMS 2005a).[4]

The specific type of quality improvement approach and the sets of measures that plans will collect will vary by type of plan (Table 3-4, p. 72). For example, all plans must maintain a health information system. But MSA and PFFS plans do not have to institute a quality (or chronic care) improvement program. CMS will allow some variation in measure reporting for HMOs and PPOs, at least in the early stages of the MA program. CMS expects to collect measures from HEDIS, CAHPS, and the HOS for both HMOs and PPOs. However, the HEDIS measures will vary: PPOs will not have to submit HEDIS measures that require medical record review. CMS indicates that it expects to move to the same measures over time, as PPOs build the capacity to report measures derived from medical records.

SNPs that target institutionalized beneficiaries will not report on HEDIS and HOS measures. Instead, these plans will report on measures similar to those on which long-term care facilities report in the Nursing Home Compare

TABLE 3-4

Selected quality requirements and measures vary by type of Medicare Advantage plan

Type of plan	Quality improvement program	HEDIS measures	Quality improvement projects	Health information system
Local plan: HMO	✓	All	✓	✓
Local plan: PPO	✓	Some	✓	✓
Specialized plan	✓	Depends on target enrollees	✓	✓
Regional PPO	✓	Some	✓	✓
PFFS	✗	Some	✗	✓
MSA	✗	✗	✗	✓

Note: HEDIS (Health Plan Employer Data and Information Set), MSA (medical savings account), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: CMS 2005a.

database. CMS expects to derive these measures from the Minimum Data Set (MDS) that the agency requires of nursing facilities.

Should MA plans have pay-for-performance standards?

In its March 2004 report, MedPAC concluded that Medicare should introduce pay-for-performance incentives to provide high-quality care in the MA program because MA meets all the Commission's criteria for successful implementation (MedPAC 2004c). CMS collects standardized, credible performance measures on all MA plans. Every year, plans collect data on specific clinical process measures and data that reflect members' satisfaction with the plan's service provision. Together, these data show a widely accepted, broad cross-section of plan quality. Most of the process measures in these data sets do not require risk adjustment, and CMS has developed risk adjusters for the satisfaction measures. Plans have developed various strategies to improve their scores on these measures by working with providers in their networks.

MedPAC has argued that by including all private plans in a pay-for-performance program, CMS would maintain a level playing field between plan types and simultaneously reward those plans that invest in improving quality. CMS would not require plans to report on all measures, but the plans would not receive pay-for-performance funds if they opted not to do so. Later in this chapter, we discuss how the mechanics of a pay-for-performance system might work within the structure of the current bidding system.

Enrollment

The MMA deals with several issues related to enrollment in MA plans, including:

- implementing an annual open enrollment process; and
- permitting beneficiaries who have ESRD to join specialized MA plans—should a specialized plan exist that covers those who have ESRD—while continuing to prohibit beneficiaries who have ESRD from enrolling in other MA plans.

Coordinated annual open enrollment period

The MA program moves private-plan enrollment to an annual process, starting in 2006. Previously, beneficiaries could enroll and disenroll on a month-to-month basis—a provision that could limit a plan's ability to provide enrollees with coordinated care. Now, beneficiaries who elect to enroll in MA plans will generally have only a single opportunity each year to switch plans or return to the FFS program. In 2006, beneficiaries will have a six-month window at the beginning of the year during which they may switch plans; in 2007 and thereafter, they will have a three-month window. If beneficiaries do not elect to change within this window, they will need to stay in their current plan until the end of the calendar year.

During the annual open enrollment period, beneficiaries choose whether to join an MA plan and whether to buy into Part D for drug coverage. (Later in this chapter, we

discuss the rules about which types of plans must offer Part D coverage.) As is the case with Part B, beneficiaries who do not enroll in Part D during open enrollment will pay a penalty. This penalty is based on the number of months they delay enrolling in Part D after they are eligible and whether they are enrolled in the FFS program or in a private plan. Beneficiaries will pay this penalty every remaining month in which they are enrolled in the Part D program.

CMS will need to dedicate resources to explain these new enrollment rules to beneficiaries who are making changes, particularly changes among MA plans. For example, beneficiaries who choose a private plan will need to understand that (a) in order to receive the prescription drug benefit, they will need to enroll in the MA plan that offers prescription drug coverage and (b) they cannot enroll in an MA plan that does not offer prescription drug coverage (unless they are enrolled in a PFFS plan). Beneficiaries will also likely experience confusion regarding the decreasing window of time in which they may switch among MA plans.

Medicare beneficiaries who have ESRD

The MMA generally continues to prohibit beneficiaries who have ESRD from enrolling in MA plans. However, CMS does permit beneficiaries who are enrolled in MA plans and later develop ESRD to remain in their plans. Beneficiaries who have ESRD are allowed to join specialized MA plans (which we discussed earlier in this chapter) if these plans choose to admit them.

CMS has improved its risk-adjustment system for beneficiaries who have ESRD: The agency designed a new risk-adjustment system specifically for ESRD beneficiaries who are receiving dialysis. This model should perform much better than the current demographic risk-adjustment system; therefore, payments to plans will more accurately reflect the costs of treating these beneficiaries. Despite CMS's general prohibition on enrollment of these beneficiaries in MA plans, evidence from a recent demonstration showed that quality of care for ESRD patients in M+C plans was good. Most participants' quality of care and outcomes equaled or exceeded those of ESRD patients enrolled in the FFS program (The Lewin Group 2002).

MedPAC has recommended that CMS allow ESRD beneficiaries to enroll in plans once the agency has implemented adequate risk adjustment. CMS should allow all beneficiaries to choose private plans, provided that payment is accurate. Further, many private plans offer care coordination and disease management services that may benefit these beneficiaries, as they often have multiple chronic conditions in addition to ESRD—such as diabetes, congestive heart failure, and hypertension.

Benefits

The MMA added voluntary outpatient prescription drug coverage for all Medicare beneficiaries, including those who are enrolled in MA plans. Medicare subsidizes drug coverage through the combination of a direct subsidy of the premium and reinsurance, and beneficiaries pay a portion of the premium that increases with the plan's bid. In this section, we discuss the implications of the Medicare program paying MA plans to provide prescription drug coverage.

Coverage of drugs under MA

Most types of local and regional MA plans must offer at least one benefit package, including coverage under Part D (although they may offer packages that do not cover Part D, as well). PFFS plans may offer Part D coverage, and MSA plans may not.

MA plans that offer drug coverage under Part D (MA–Prescription Drug [MA–PD] plans) must meet the same program requirements as prescription drug plans (PDPs). Similar to PDPs, MA–PDs participate in the Part D bidding process to set their premiums. They may use any savings they achieve from bidding on the furnishing of Part A and Part B services (which we detail later in this chapter) to lower beneficiaries' Part D premiums or to enhance the Part D benefit. In enhancing the benefit, MA plans might cover drugs that Part D does not, or MA plans might reduce the deductible, cost sharing, or initial coverage limit.

Some MA plans would like to help their enrollees by filling in the coverage gap—that is, the portion of drug spending that falls above the initial coverage limit and below the catastrophic cap of Part D's benefit (see Chapter 1). For an individual without drug coverage that supplements Part D, this coverage gap could amount to high out-of-pocket spending—up to $2,850 in 2006. Thus, a benefit that fills in the coverage gap would likely be attractive to Medicare beneficiaries. But under a feature of Part D that the Congress designed to direct more federal subsidies toward beneficiaries who do not have

supplemental coverage (called the true out-of-pocket provision), only certain types of spending on behalf of the enrollee counts toward the enrollee's catastrophic threshold. In particular, most types of supplemental coverage would not count. In other words, every dollar of supplemental coverage that an enrollee receives would raise the level of drug spending at which that individual would qualify for Part D's catastrophic protection and federal reinsurance subsidies.

CMS recently announced that it will conduct a demonstration allowing both PDPs and MA–PD plans to fill in the coverage gap and still receive the reinsurance payments (CMS 2005c). In one option, CMS would allow either type of plan to receive their estimated reinsurance payment through a capitated payment. In the other option, CMS would allow only MA–PD plans to take rebate funds from the Part A and Part B bidding process and apply them to an enhanced drug benefit, then count this supplemental coverage toward the out-of-pocket spending limit. These MA–PD plans then would presumably receive reinsurance payments following the usual schedule. CMS will provide additional information about this demonstration in the future; the agency intends the demonstration to be budget neutral.

The MA bidding process for 2006

Beginning in 2006, private plans will submit formal bids to participate in the MA program. The Medicare program will pay plans based on their bids rather than on administratively set rates, although CMS will compare the bids to administratively set benchmarks to determine how much of the payment will come from Medicare and how much will come from beneficiary premiums. The bids are due to CMS by the first Monday in June each year.

Components of a plan's bid

Every plan will submit a separate set of bids to cover beneficiaries in each of their service areas. Each bid will consist of up to three separate components:

- The bid for all Medicare Part A and Part B benefits (except hospice). This portion of the bid must assume that the plan would collect the standard Medicare cost sharing from its enrollees. This bid is standardized to a nationally average beneficiary (a CMS risk factor of 1.0) enrolled in the plan's service area.
- The bid for supplemental benefits (if any) that the plan covers. Supplemental benefits may include lower cost sharing on Medicare services, as well as benefits that FFS Medicare does not cover.
- The bid for the Medicare Part D drug benefit (if offered).

The first component, the Part A/B bid, is the only component CMS uses to determine Medicare's payments to the plan for the standard Medicare nondrug benefits. CMS compares each plan's Part A/B bid with a benchmark. (See text box for the methods CMS uses to set benchmarks.)

How does CMS determine payment?

CMS will base the Medicare payment for private plans on the relationship between their bids and the benchmarks. If the plan's bid falls above the benchmark, then the plan receives the benchmark and the enrollees will have to pay an additional premium that equals the difference between the bid and the benchmark. If the plan's bid falls below the benchmark, the MMA defines the difference as the plan's savings. The Medicare program retains 25 percent of the savings (if it is a regional plan, CMS places half of this 25 percent into the regional PPO stabilization fund), and the plan receives the other 75 percent of the savings as a rebate. The plan must then return the rebate to its enrollees in the form of supplemental benefits or lower premiums. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total package that may include supplemental benefits.

The easiest way to illustrate the effects of the bidding process on beneficiaries' choices is to assume that the plan returns the entire rebate in the form of a reduction in the Part B premium (Table 3-6). This example shows the effects of returning the rebate to beneficiaries. If the rebate exceeds the Part B premium, which is a possibility, the plan would have to provide some of the rebate in the form of supplemental coverage (including reduction of the Part D premium).

Payments to regional plans will differ from payments to local plans

For regional MA plans, CMS bases the regional benchmark on the number of eligible Medicare beneficiaries in each county. However, when a regional

How does CMS set benchmarks?

The benchmark is a bidding target. CMS sets the benchmarks administratively, but in the case of regional PPOs, plan bids influence the benchmarks. Under MMA, CMS sets the benchmarks for local plans at the county-level payment rates used to pay MA plans before 2006. Generally, the law directs CMS to update the benchmarks each year by the national growth rate in per capita Medicare spending.[5] If a local MA plan serves a multicounty area, the benchmark against which it bids consists of an average of the different benchmarks for the counties it serves, weighted by its projected enrollment from each county.

CMS determines the benchmarks for the MA regional PPOs by using a more complicated formula that incorporates the plan bids. A region's benchmark is a weighted average of the average county rate and the average plan bid. As directed by the MMA, CMS computes the average county rate as the individual county rates weighted by the number of Medicare beneficiaries who live in each county—not by the plan's projected enrollment, which CMS uses as the weighting for local plans. The average plan bid is each plan's bid weighted by each plan's projected number of enrollees. CMS then combines the average county rate and the average bid into an overall average. In calculating the overall average, the average bid is weighted by the number of enrollees in all private plans across the country, and the average county rate is weighted by the number of all Medicare beneficiaries who remain in FFS Medicare.

For example, suppose that 1 million Medicare beneficiaries live in the region, in one of two local MA payment areas (Table 3-5). Local area 1 contains 800,000 beneficiaries and has a local MA payment rate of \$900. Local area 2 has 200,000 beneficiaries and a rate of \$600. Thus, the average county MA rate is \$840 (0.8 x 900 + 0.2 x 600). Assume that the average plan's Part A/B bid was \$715 and that nationally, 20 percent of Medicare beneficiaries were enrolled in MA plans. The regional benchmark under these assumptions would be \$815 (0.8 x 840 + 0.2 x 715). ■

TABLE 3-5

Example of calculating a regional benchmark

	Number of Beneficiaries	Average rate or bid
Local MA payment area 1	800,000	\$900
Local MA payment area 2	200,000	600
Average MA rate	N/A	840
Average regional plan bid	N/A	715
Regional benchmark		**\$815**

Note: MA (Medicare Advantage), N/A (not applicable). This example assumes a national Medicare Advantage penetration of 20 percent of Medicare beneficiaries.

TABLE 3-6

Example of premium calculations under 2006 bidding process

Plan	Bid	Benchmark	Part B premium	Premium rebate	Total premium
FFS	N/A	\$1,000	\$100	\$0	\$100.00
Plan 1	\$950	1,000	100	37.50	62.50
Plan 2	900	1,000	100	75.00	25.00

Note: FFS (fee-for-service), N/A (not applicable).

PPO bids, it takes into account where it projects its enrollment will originate. Averaging over all members, the PPO will receive its bid plus any rebate. As a result, two regional plans that are bidding the same amount in the same region would get different Medicare payments in the same county if their enrollment patterns among all counties in the region differ. The reason is because their bid is based on their average cost over all beneficiaries they serve, yet the benchmark is not.

For local plans, CMS bases the benchmarks and plan bids on a plan's projected enrollment. This difference in treatment between local and regional plans could create a situation in which local plans are disadvantaged relative to regional plans in some counties (see text box for example).

Many policy and industry observers thought that the MMA included a geographic adjustment that would better align regional plans' bids to the benchmarks. However, the final regulation did not include an adjustment for this issue. Instead, it takes into account differences between projected and actual enrollment.

To ensure more equal competition among regional plans and between regional and local plans, the Commission makes the following recommendation:

RECOMMENDATION 3C

The Congress should clarify that regional plans should submit bids that are standardized for the region's Medicare Advantage–eligible population.

RATIONALE 3C

The MMA requires that CMS adjust plan payments for health risk and MA local payment rates. CMS standardizes the benchmarks for risk and local MA payment rates; therefore, CMS should require that plans standardize their bids for risk and local payment rates. In not doing the parallel adjustment, the payment system may cause regional plans to have a competitive advantage over local plans in certain areas.

IMPLICATIONS 3C

Spending

- This recommendation would likely decrease Medicare spending relative to current law by $200 million to $600 million over one year, and by $1 billion to $5 billion over 5 years.

Beneficiaries and plans

- This recommendation could lower payments to regional plans under some circumstances. Therefore, this recommendation may cause regional plans to reduce the generosity of benefits or reduce the extent of their participation in the MA program. However, some regional plans (namely those that have disproportionately high enrollment from high-rate areas) would benefit from the payment recommendation, and the recommendation could prevent some local plans from leaving certain markets.

Financial neutrality and private plans

The Commission has long supported giving Medicare beneficiaries a choice in health care delivery systems, provided that such choices do not increase Medicare program expenditures. Private plans have the flexibility to use care management techniques that FFS Medicare does not encourage, and they have greater incentive to innovate. Thus, for some beneficiaries in some parts of the country, private plans may provide the same Medicare benefits with fewer resources, more benefits with the same resources, or higher quality than the FFS Medicare program.[6] If beneficiaries are able to choose between Medicare FFS and an array of private plans—and if the Medicare program pays the same on behalf of the beneficiaries making the choice—then over time, beneficiaries will gravitate either to the FFS system or to the plan that provides the best value in terms of efficiency and quality. The Medicare program would not subsidize one choice more than another. The Medicare program should be financially neutral regarding whether the beneficiary chooses to remain in the FFS system or enroll in a plan. This neutrality provides beneficiaries with the incentive to select the system that they perceive has the highest value, while maintaining their ability to choose a more generous plan by paying additional premiums.

With plans competing for Medicare enrollment, individual providers would want to improve the quality and efficiency of their services so that these providers can stay in the plans' preferred networks. In addition, if a provider follows the best practices of one payer, the provider's behavior may translate into better practice for all payers with which the provider participates.

Previous system was not financially neutral

Through 2005, Medicare will pay plans based on administratively set rates that are county based and partially risk adjusted. The formula that governs the rates

Payments to local and regional MA plans may differ

In this simplified example, two payment areas exist—one low-rate and one high-rate—with local MA payment rates of $600 and $900 per month, respectively. We assume the local plan in each payment area bids $100 below its benchmark rate and gets paid the bid amount plus a $75 rebate.

A regional plan that serves both areas also bids $100 below its benchmark. In the example, 20 percent of the eligible population lives in the low-rate area and 80 percent lives in the high-rate area. The resulting benchmark is $815 (as computed in the text box on page 75). Therefore, the regional plan will get, on average, $715 (the benchmark minus $100) plus the $75 rebate—or $790.

The payments to a regional plan in each area will depend on how its enrollee population splits between the two areas relative to the benchmark split of 20/80. If the projected enrollment for the plan splits evenly between the low- and high-rate areas (50/50), the payments for members in the two areas will be $647 in the low-rate area and $933 in the high-rate area. The average will be $790.

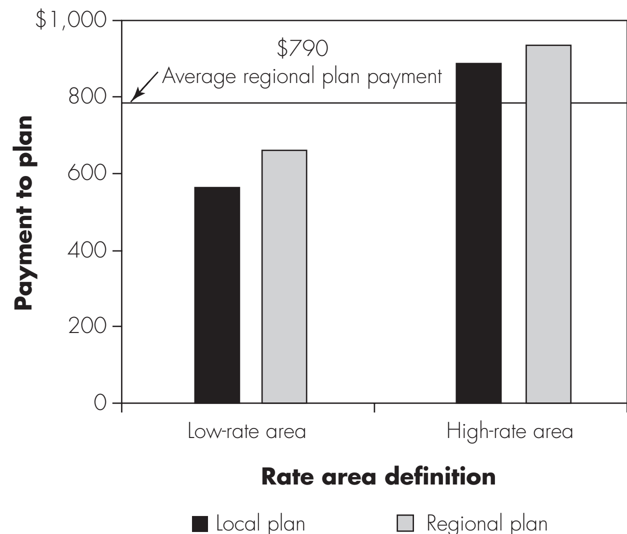
Figure 3-5 shows the result. The dark bars represent the payment rates for local plans, and the light bars represent the payment rates for the regional plan members in the two areas. Note that in both areas, the regional plan receives a higher rate, which would presumably give it a competitive advantage over the local plans in both areas.

Regional plans that have different mixes of projected enrollment will see different payments from one another. The plan in the example above, with the enrollment split 50/50, has an advantage over local plans in both areas. A plan that has a 10/90 split would be disadvantaged in both areas relative to local plans and would be disadvantaged more relative to the 50/50 regional plan shown in the figure.

A regional plan with a split of 20/80—identical to the underlying population mix—would have a slight advantage in the low-rate area and a slight disadvantage in the high-rate area. This asymmetry results from a different cause: The rebate is identical in both areas and thus constitutes a larger proportion of total plan payment in the low-rate area than in the high-rate area. ■

FIGURE 3-5

Example of payments to plans with different enrollment patterns



Note: In this example, 20 percent of Medicare beneficiaries in the region live in low-rate areas and 80 percent live in high-rate areas. The regional plan enrolls 50 percent of its members from low-rate areas and 50 percent from high-rate areas.

is only loosely based on county FFS costs.[7] Although the formula ensures that plan payments will not fall below FFS costs, rates in individual counties are as high as 85 percent above FFS cost, as measured by the adjusted average per capita cost (AAPCC).

Current plan payment rates average 107 percent of county FFS costs. The plans' payment rate advantage has come primarily from two sources. One is the result of two "floor rates" that the Congress created to raise the rates in low-rate counties. One floor rate, which mostly applied in rural areas and small cities, was often well above the comparable county FFS costs. Only 3 percent of plan enrollees live in these areas, but rates average 123 percent of the county FFS costs. Another 26 percent of plan enrollees live in large metropolitan areas where the

Congress created a higher floor rate. Payments in those areas averaged 116 percent of the county FFS costs.

The other main source of higher rates is Medicare's treatment of indirect medical education (IME) payment to hospitals. For the 40 percent of plan enrollees who live in counties where the MMA raised the rate to 100 percent of county FFS costs, the rates actually are higher than the comparable cost in FFS Medicare. The reason is that the measure the MMA used in that calculation includes spending for IME payments to hospitals, even though the Medicare program continues to make separate IME payments to hospitals on behalf of MA enrollees. In effect, the Medicare program is making IME payments on behalf of MA enrollees twice: once to the MA plans, and once to the teaching hospitals.

On the other hand, the AAPCC might underestimate the cost of Medicare services that beneficiaries receive because some beneficiaries receive services from Department of Veterans Affairs' (VA) facilities that Medicare would otherwise cover. The Congress instructed CMS to add the cost of these services when calculating county AAPCCs, but the agency has not been able to do so yet. We urge CMS to implement the VA adjustments as soon as possible. Note that the Congress had instructed that the calculation include Department of Defense (DoD) spending, but because of major changes to DoD supplemental coverage, we expect very few beneficiaries with DoD coverage to have lower use of Medicare benefits due to their use of DoD facilities.

In the future, all local benchmarks will increase at the same national growth rate (or by 2 percent, if the national growth rate is lower than 2 percent) using the result of earlier formulas as the base rate. The exception is that counties which fall below 100 percent of their AAPCC will see their rates rise to the 100 percent level.[8]

Financial neutrality under the 2006 bidding system

The 2006 bidding process will create a hybrid system that includes administratively set payment rates and competitive bidding. Although administratively set plan payment rates will no longer exist per se (except for MSA plans), Medicare will still have administratively set benchmarks, against which the plans will bid.

This process, as currently configured, will not result in Medicare making financially neutral payments relative to FFS cost. As we discussed earlier, the benchmarks are often well above the AAPCC. Therefore, plans bidding at or above the benchmark would often receive payments in excess of the local cost of FFS Medicare. Plans bidding below the benchmark will receive less than the benchmark, but the resulting payment might be higher or lower than the local cost of FFS Medicare. One way the system could be financially neutral is if the benchmarks were more reflective of the cost of FFS Medicare, and if Medicare used program savings from bids below the benchmarks to encourage quality-of-care improvement. However, Medicare could take other approaches to adjusting total payments so that payments to plans in the aggregate do not exceed FFS Medicare.

Adjusting the bidding system for consistency with the financial neutrality principle

The benchmarks currently average about 107 percent of FFS Medicare costs for plan enrollees. About two points of the seven-point difference are due to the treatment of IME payment to hospitals. In our March 2002 report, MedPAC supported Medicare's removal of graduate medical education costs from plan rates and direct payments to teaching hospitals that treat plan members. The Commission wanted to help ensure that plans have incentives to direct enrollees to use teaching hospitals when appropriate. With that goal in mind, we recommend removing the effect of IME payments from the benchmarks to bring the system closer to financial neutrality.

RECOMMENDATION 3D

The Congress should remove the effect of payments for indirect medical education from the Medicare Advantage plan benchmarks.

RATIONALE 3D

In removing the effect of these payments from the benchmarks while continuing to make payments directly to teaching hospitals on behalf of plan members, the Congress would bring the system closer to financial neutrality and would not change plan incentives to use teaching hospitals. The recommended action would also correct Medicare's double payment for these teaching costs.

IMPLICATIONS 3D

Spending

- This recommendation would decrease Medicare spending relative to current law by $200 million to $600 million over one year and would decrease spending by $1 billion to $5 billion over five years.

Beneficiaries and plans

- This recommendation would lower payments to plans in some areas. This result, in turn, may cause some plans to reduce their level of participation in the MA program—and thus reduce plan choice for some beneficiaries. Plan incentives to use teaching hospitals would not change.

Reaching financial neutrality under the current system

The Commission has previously recommended that Medicare set plan payment rates at 100 percent of local FFS costs. In 2006, a parallel recommendation might be to set the benchmarks against which plans will bid at 100 percent of local FFS Medicare costs, to ensure that the Medicare program does not pay MA plans more than the cost of covering the same beneficiaries under FFS Medicare. However, even this parallel recommendation would not result in financial neutrality because under the new bidding system, plans have the incentive to bid lower than the benchmark—with Medicare keeping part of the savings. Thus, the payment system would not be financially neutral because Medicare would pay (to plans that bid less than the benchmark) less than the county FFS rate. MedPAC has also recommended that payment policy provide stronger incentives for plans to improve the quality of care that they provide to Medicare beneficiaries (MedPAC 2004a). One solution would be to set benchmarks at 100 percent of FFS costs in each area and return any Medicare savings from bids below the benchmarks to the plans. Medicare would return the savings in the form of pay-for-performance payments based on quality measures.

However, financial neutrality is just one goal of payment policy. The Commission recognizes that the Congress may not achieve its wish of attracting plans to more areas of the country if it immediately begins reducing benchmarks in many areas. Also, the MA bidding process is just beginning, and MedPAC does not want to derail the system with sharp changes in expected payment rates. Moreover, the bidding process might produce instructive results. Perhaps CMS could adjust benchmarks in response to the level of bidding in such a way that benchmarks would be at 100 percent of FFS costs, on average. As long as the result appears stable, Medicare could maintain overall financial neutrality and fund performance payments with the savings relative to FFS costs. Under either scenario, if the bids are substantially lower than FFS costs, the Commission may suggest that some of the savings should fund a quality pool and the rest should return to the Treasury.

The following recommendation strives to achieve financial neutrality and improve quality through two steps:

- ***Step 1: Set the benchmarks to 100 percent of the costs of FFS Medicare, on average.*** One way the Congress can accomplish this part of the recommendation would be to set the benchmarks for each payment area equal to the costs of FFS Medicare in the area. However, it is possible to use other formulations or adjustments so that benchmarks increase in areas that have trouble attracting plans and decrease in areas where plans are able to bid below the benchmarks, while keeping the average benchmark at 100 percent of FFS cost.

- ***Step 2: Reward quality by redistributing savings from bids below the benchmarks back to the plans in the form of pay-for-performance payments.*** When a plan bids below the benchmark, the plan would receive its bid and retain 75 percent of the difference to rebate to its enrollees. Medicare would place the remaining 25 percent of the savings in a quality pool and redistribute it to plans as a reward for high or improving measures of quality performance. (The Commission also continues to support placing 1 to 2 percent of base MA payments into a quality pool, so that the savings contributions to the pool would be in addition to the initial 1 to 2 percent.)

RECOMMENDATION 3E

The Congress should set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of the fee-for-service costs.

At the same time, the Congress should also redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to Medicare Advantage plans based on quality measures.

RATIONALE 3E

On average, the Medicare program would pay the same amount for a beneficiary's enrollment in an MA plan as Medicare would expect to pay to cover the beneficiary in FFS Medicare. Plans would also have increased incentive to improve their quality scores in order to receive these quality incentive payments.

IMPLICATIONS 3E

Spending

- If fully implemented for 2006, this recommendation would decrease Medicare spending by more than $1.5 billion over one year and by more than $10 billion over five years, relative to current law. More gradual implementation would decrease savings.

Beneficiaries and plans:

- This recommendation would decrease the average payment to MA plans, but some plans may receive higher payments through pay-for-performance payments.
- It is likely that some plans would choose not to participate in some areas, thus leaving some beneficiaries with fewer choices.
- Plans would have greater incentives to improve quality, which could then lead to better quality of care for beneficiaries.

Concerns about hold-harmless modifications to payments under risk adjustment

Beginning in 2004, CMS has been transitioning from risk adjusting plan payments based on a demographic model to adjusting payments based on a health-risk model (see Chapter 2 for details on the models). For 2004, 2005, and 2006, CMS estimated that aggregate plan payments adjusted with the health risk model would be lower than payments adjusted with the demographic model. CMS is applying proportional increases to county payment rates so that in aggregate, total plan payments are held harmless for the effect of switching from the demographic model to the health-risk model. The net effect of this policy is that aggregate payments to MA plans are equal to what they would be if CMS adjusted 100 percent of payments using the demographic system, although payments to individual plans will still vary based on their specific risk scores.

The President's most recent budget proposal includes a phase-out of this hold-harmless policy from 2007 to 2010. The effect of the phase-out would be to increase risk-adjusted payments by progressively smaller proportions from 2007 through 2010, and to completely eliminate the policy in 2011. Despite the phase-out, this policy increases payments above levels assumed by the Administration. The President's proposed budget indicates that under the planned phase-out, federal spending from 2006 through 2010 would be $8.3 billion above the level that would occur if CMS did not increase MA payments above risk-adjusted levels.

Whether CMS continues this policy in full force or phases it out, any policy that increases risk-adjusted payments prevents risk adjustment from addressing risk-profile differences between beneficiaries in the MA and FFS programs. The ultimate effect is that payments for MA enrollees will be systematically higher than payments for those same beneficiaries if they enrolled in FFS Medicare.

MedPAC and its predecessor Commissions have strongly supported CMS's adoption of more accurate risk adjustment as a necessary step toward achieving the goal of financial neutrality. Increasing plan payments (as CMS has done) to offset the effect of more accurate risk adjustment is inconsistent with the Commission's view on payment equity. However, at this point, the Commission recognizes that payment reductions—resulting from removing the hold-harmless policy immediately—would be steep. In addition, some plans claim that they have not yet fully succeeded in collecting all the diagnostic information that feeds into the health-risk model, because some physicians are not accustomed to reporting it to plans. These plans believe that their payments under the new system do not reflect their enrollees' true health risk. Therefore, the Commission supports putting the Administration's phase-out of the hold-harmless policy contained in the 2006 budget proposal into law.

RECOMMENDATION 3F

The Congress should put into law the scheduled phase-out of the hold-harmless policy that offsets the impact of risk adjustment on aggregate payments through 2010.

RATIONALE 3F

MedPAC and its predecessor Commissions have strongly supported CMS's adoption of more accurate risk adjustment as an important step toward achieving payment equity between the Medicare FFS program and private plans in Medicare. Increasing plan payments to offset the

effect of more accurate risk adjustment is inconsistent with the Commission's views on payment equity. The President's budget indicates an intended phase-out of this policy from 2007 through 2010, and the Commission supports that schedule.

IMPLICATIONS 3F

Spending

- This recommendation would decrease Medicare spending by more than $10 billion over five years relative to current law.

Beneficiaries and plans

- Because the President's budget includes this hold-harmless policy, plans are likely to expect the resulting per member payment levels and should not change their offerings to beneficiaries. ■

Endnotes

1 The PFFS program allows private plans to offer Medicare benefits to enrollees without restricting them to a network of providers. PFFS plans reimburse providers using the same payment rates that apply in the traditional Medicare FFS program (MedPAC 2004a).

2 Balance billing refers to the practice of making patients pay for any difference between a provider's full charge and a health plan's (in this case, Medicare's) payment.

3 The eye exam and kidney screening measures had specification changes in 2003 that required more frequent screening for certain patients. These changes are likely responsible for the observed decreases in the measure rates.

4 The health information system requirements for the MA plans are very general: Plans must maintain health information systems that collect, analyze, and integrate data necessary to implement their quality improvement programs; ensure that the information they receive from providers is reliable and complete; and make all collected information available to CMS.

5 CMS must rebase the county benchmarks at least every three years. Rebasing will lift those benchmarks that are below the AAPCC to the county AAPCC.

6 As discussed earlier, CMS does not provide measures that permit comparison of private MA plans with the FFS Medicare system.

7 Medicare uses the adjusted average per capita cost (AAPCC) as its formal measure for setting rates (see Chapter 2 of this report for further discussion of this measure). The AAPCC rate is a risk-adjusted county-level measure and hence directly reflects local per capita spending in the FFS sector.

8 As noted earlier (endnote 5), CMS may not compare rates to the AAPCC every year.

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