Managed Medicare at the Crossroads

POLICY MATTERS

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The headlines are screaming about the abandonment of nearly half a million Medicare beneficiaries whose health plans have decided to leave the risk-contract marketplace. By the October 2, 1998, deadline, 53 health plans with risk contracts informed the Health Care Financing Administration (HCFA) of their intention not to renew their contracts for 1999, leaving many beneficiaries in 75 U.S. counties no recourse but to return to conventional fee-for-service Medicare. Although about 5.5 million beneficiaries remain in risk-contract HMOs, the atmosphere has changed significantly. The managed care component of the Medicare program had been growing rapidly, with more than 100,000 new members signing up each month. Why is it suddenly shrinking?

The answer is complex and, as is often the case in the world of policy and politics, different answers come from different points of view. Some health plan opponents insist that the plans have failed in their attempts to "skim the cream" by enrolling only the healthiest beneficiaries. Others see retrenchment as political theater and feel that the plans are simply "crying wolf." More than a few view a demise of managed care as a good thing. In this Policy Matters, I attempt to summarize the perspective of the plans themselves.

Current Forces

The health plans have been badly hit by several confluent sources of cost increases. Prescription drug costs are growing rapidly, partly as a result of demands induced by direct-to-consumer advertising. Technology, both in information and in medical treatment, is leapfrogging the ability of health plans to pay for it. New legislative mandates, such as those requiring minimum lengths of hospitalization for various procedures, are pushing costs up. Increasing litigious activity against physicians and health plans is adding to the cost of care, and a proposed federal statutory right to file suit for damages promises to drive this component up faster. Estimates of inflation plus the aggregate costs of these many factors range from 5% to 15% of current expenses.

At the same time, the health plans have a limited number of cost-containment strategies. Many have depended primarily on discounted contracts with provider networks to control costs, but this strategy is not as successful as it once was. The plans have found that the tolerance of providers to accept such contracts has a limit. More and more resistance is surfacing, in terms of both unionizing activities and statutory proposals to change the antitrust laws, which currently prevent cartels of independently practicing professionals from dominating markets. Physicians are also responding directly by dropping out of networks or refusing to join them.

Finally, the revenue available to the health plans is tightly constrained in the Medicare program. In the Balanced Budget Act of 1997, the U.S. Congress mandated new payment rules that effectively limit updates to 2% per year over the next 5 years. Added to this are user fees extracted from participating health plans to finance the costs of providing educational materials to Medicare beneficiaries about their new options under the Medicare Plus Choice program. This provision, also a part of the Balanced Budget Act, effectively reduces payment to health plans by an average of 0.2%. Additional costs are expected as the result of a lengthy and complex series of regulations issued late in June 1998, well after the deadline for health

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plans to submit their Medicare benefit and premium provisions had passed. With the new administrative compliance costs anticipated by most plans and the unwillingness of HCFA to renegotiate contracts for 1999, many plans believed that they had no option but to reconsider the financial viability of staying in the Medicare program.

Future Challenges

Health plans that stay in the Medicare program in 1999 will soon have to decide whether to stay beyond 1999. New contract rates and benefit structure submissions are due to HCFA by May 1, 1999, well before sufficient financial data will have accumulated on current-year performance under the new rules and payment structure to allow projections for the next year.

It is likely that many plans will decide to persevere by charging premiums (many currently offer "zero premium" programs) and by reducing add-on benefits that are not offered by conventional Medicare. Reductions could be made in such areas as routine physical examinations and visual, dental, and transportation services. Most important, however, would be a reduction in the prescription drug benefit. Long viewed by Medicare beneficiaries as one of the most appealing aspects of managed care, this advantage is shrinking as its dollar value is being limited by health plans in Massachusetts and elsewhere.

Just as health plans are scaling back their prescription drug benefit, there is some interest in the halls of Congress in adding this benefit to conventional fee-for-service Medicare. This would eliminate one of the comparative advantages of the health plans and would undoubtedly reduce the number of beneficiaries choosing to enroll (many confess that they switched to managed care specifically for this benefit). It would, of course, be very popular. Would it be affordable? Probably not. Estimates to cover this benefit range upward from $20 billion. Of note, the plans (and the U.S. treasury) may have an unusual ally in opposing this provision: the pharmaceutical manufacturers. The manufacturers are expected to oppose this benefit because they fear they may be forced to sign steeply discounted contracts (similar to the discounts currently mandated for the Medicaid program) with the federal government for medications used by Medicare beneficiaries.

Another proposal that the health plans view as a threat is competitive bidding. In the hope of driving prices lower, HCFA has designed demonstration projects to subject Medicare risk contracting to competitive bidding. Recent projects in Baltimore and Denver have foundered on local politics and lawsuits questioning HCFA's authority to establish such demonstrations. Congress solved the authority question, however, with a statutory mandate in the Balanced Budget Act. Seven demonstration projects are now planned for the next several years, with the first four to be completed before the end of the decade. A committee advising HCFA on this process has issued a list of cities in which these demonstrations might take place. These projects will pit all participating health plans against each other to drive rates down in a given geographic region. (Curiously, fee-for-service Medicare will not be required to compete.) If Medicare payment rates are forced down as the result of this turbo-charged competition, as anticipated, more health plans are likely to leave the Medicare program.

The irony is that the senior citizens and disabled persons who have selected health plans will be forced back into the expensive and fragmented fee-for-service program. This seems to be at cross-purposes with Congress's goal in setting up the Medicare Plus Choice program, which was intended to expand integrated and efficient medical care for persons older than 65 years. The outcome seems likely to be higher costs for all at a time when Medicare is on the ropes and reeling from projected future deficits.

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