

Recommendations on Medicare Modernization Act Premium Support: Preparing for a Future of Choice

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Recommendations on Medicare Modernization Act Premium Support: Preparing for a Future of Choice

A Policy Monograph of the
American College of Physicians

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Executive Summary

In December of 2003, Congress passed the Medicare Prescription Drug Improvement and Modernization Act (MMA), Public Law 108-173, creating the most significant changes in Medicare (and several other government programs) since its 1965 inception. These changes include new premium support measures that will revamp how Medicare finances its managed care plans. The premium support measures will try to foster competition among health plans, hopefully resulting in more efficiency driven by consumer demand for economy and quality.

The competition stems from a system where health plans submit bids to the Centers for Medicare and Medicaid Services (CMS) to help set the price for Medicare premiums. Those plans who bid under the average receive a percentage back (to be passed onto the beneficiaries), and those plans over the average must make up the difference in higher premiums that the beneficiaries must pay. This system begins in 2006 and will only include Medicare Advantage (MA) (formerly Medicare + Choice) plans through 2009. Starting in 2010, the MMA authorizes a limited six-year demonstration where Medicare fee-for-service (FFS) will compete directly with MA plans.

This last component of the MMA's premium support provisions presents a large concern because of the possible adverse consequences to Medicare FFS. The source of this concern involves the adverse selection fears that many private plans have about less healthy Medicare patients. Such fears may influence MA plans to enroll healthier Medicare patients while relegating the others to traditional Medicare FFS, whose risk will subsequently skyrocket. The resulting high costs for traditional Medicare FFS will in turn force higher FFS bids. MA plans, because of their presumably healthier population and lower risk, will submit lower bids. Such a discrepancy will result in increasingly higher premium costs to FFS beneficiaries as healthier patients leave traditional Medicare FFS in search of lower MA plan premiums, leaving a sicker population in FFS, potentially causing financial problems for FFS.

Several issues surround how CMS will implement this MMA premium support provision. Such issues include how plans will be risk-adjusted and what kind of efficiency can be expected in such adjustment. Also, in fostering competition, concerns remain about efficiency and quality in MA plans, given the ease of "cherry-picking" to avoid high-risk patients. Finally, though the MMA intends greater efficiency and quality through a choice-driven initiative, large doubts remain about how the Medicare population will adapt to the challenges such a system will bring. To address these questions, the American College of Physicians (ACP) recommends:

- 1. Medicare premium support plans must include risk adjustments that both are analyzed regularly to ensure accuracy and include health-status, geographic, and other relevant demographic issues that affect Medicare beneficiary health so that beneficiaries have chronic care options in both Fee-For-Service and Medicare Advantage.*
- 2. In attracting patients, those plans competing in a Medicare premium support system must base their marketing and recruitment efforts on providing quality initiatives that adequately address the needs of all Medicare population members, not just the most healthy Medicare beneficiaries.*
- 3. Efforts to implement a Medicare premium support system must include methods for making choices understandable for the Medicare population, including those with vision, hearing, language, cognitive, or other health-related or demographic-related issues.*

Background

In 2004, the MMA under Section 201 replaced the Medicare + Choice program with MA plans under Part C of Medicare. The MMA intended these MA plans to fill potentially two roles. MA plans could act as supplements to the MMA's Part D prescription drug plan (PDP) components (available in January 2006), providing just Part A and B benefits. Also, MA plans could as entities capable of administering all Medicare benefits, including Part D. To help structure MA plans on a national level, the MMA directed CMS to establish MA preferred provider organizations (PPOs) regions. In December of 2004, CMS settled on 26 regions for the MA PPO program and 34 regions for the PDPs, starting in 2006. In all except eight of the MA PPO regions, the PDP and MA plan are identical. In the remaining eight regions, the PDPs are "nested" within the MA PPO region. CMS will use these regions as a framework for the MMA's MA premium support program.

Beginning in 2006, MA organizations (other than MSA [Medical Saving Account] plans) will be required to submit bids to CMS for providing services to Medicare beneficiaries on either a local or a regional level. The Secretary of HHS cannot require any MA organization to contract with a particular hospital, physician, or other entity or individual. Bids will be compared to a benchmark amount that is the average of all plan bids (after each bid has been risk-adjusted for relevant Medicare population factors). Plans that submit bids below the benchmark will be paid their bids plus 75% of the difference between the benchmark and the bid, which must be returned to beneficiaries as additional benefits or reduced premiums. The government will keep the remaining 25% of the savings. Plans that bid above the benchmark amount will receive the benchmark amount as payment, with beneficiaries to pay the difference between the benchmark amount and the bid amount as a premium.

ACP policy opposes converting traditional Medicare to a defined contribution program, but favors demonstration projects to test a "premium support" defined benefit program. This type of program would involve the federal government making equal contributions to competing health plans that are required to provide benefits at least equal to traditional Medicare.

However, starting 2010, under Section 241 the MMA will require a six-year demonstration (comparative cost-adjustment program) in which fee-for-service (FFS) Medicare will compete directly against private plans for patients based on price. The study will attempt to see if competition between private plans and the FFS Medicare program enhances competition in Medicare, improving health care delivery for beneficiaries with greater price efficiencies (in terms of cost reduction). Some policymakers believe such competition will save money for Medicare in the long run, but others postulate it will increase premiums for beneficiaries who remain in traditional Medicare that may attract sicker patients.

The Secretary will select demonstration areas from qualifying metropolitan areas. The number of demonstration areas is limited to the lesser of six, or 25% of the total number of qualifying areas. The area needs at least 25% of eligible Medicare beneficiaries enrolled in a local coordinated care plan, and at least two coordinated MA local plans offered by different organizations in the demonstration's first year. However, in subsequent years, the number of MA plans can be as little as one. The secretary will determine the benchmark for plan bids by factoring the weighted contributions of the Medicare Advantage and FFS patients. Those beneficiaries in plans with bids under the benchmark will receive a reduction in premiums equal to 75% of the difference between the benchmark and their bid. Those beneficiaries in plans with bids over the benchmark will pay the difference between the benchmark and the bid

in their Part B premium (with the difference phased in and in no case greater than 5% per year). Low-income beneficiaries will not have their premiums affected, and the program cannot expand or extend without Congress's permission. The Congressional Budget Office estimates the comparative cost-adjustment provisions will save the Medicare program \$300 million from 2004-2013.

The MMA's premium support provisions represent a new Medicare philosophy that moves away from previous practices of standardization and social insurance towards a more individualized model reliant on the efficiencies of private sector healthcare. Some may argue that this ethos has great potential for leading Medicare to more effective health care, and greater accountability, as well as opportunity, for its various provider components. Others may take issue with how the previous guarantees of past Medicare have now been replaced by a hazy future where premiums could rise and fall with the mercurial fortunes of the market. In either case, the MMA's premium support provisions will certainly be a large change. To ensure that the resulting changes are for the better, it will be necessary to examine several areas including how the premium bids could be risk adjusted, how selection bias can end FFS, and how plans can help beneficiaries understand their benefit choices.

Areas of Importance in Medicare Program Premium Support

Risk Adjustment

ACP Recommendation: Medicare premium support plans must include risk adjustments that both are analyzed regularly to ensure accuracy and include health-status, geographic, and other relevant demographic issues that affect Medicare beneficiary health so that beneficiaries have chronic care options in both Fee-For-Service and Medicare Advantage.

With respect to health status, it is clear that the Medicare population is not a homogenous one. Furthermore, certain segments of the Medicare population have substantially different health statuses than their compatriots. The differences between beneficiaries' health statuses become more pronounced when one examines chronic disease. In fact, one out of five beneficiaries suffers with five or more chronic diseases, a demographic that consumes two thirds of all Medicare dollars.¹ Such consumption presents a dangerous picture to any insurance underwriter who must assimilate these members into the insurance pool. This crisis looks even worse for Medicare FFS beneficiaries most of whom, because of their age, "have one or more chronic conditions," according to the Medicare Payment Advisory Commission (MedPAC), adding in its June 2004 *Report to the Congress*, that:

As estimated from Medicare claims data, about 78 percent of the Medicare population had at least one chronic condition in 1999, and 63 percent had two or more. Self reported statistics put that number even higher, with over 70 percent reporting two or more conditions.²

Clearly, Medicare's chronically ill consume an inordinate share of Medicare resources. According to an April 20, 2004 press statement by Tommy G. Thompson, Secretary of the Department of Health and Human Services:

Chronic conditions are a leading cause of illness, disability, and death among Medicare beneficiaries and account for a disproportionate share of health care expenditures. For example, about 14 percent of Medicare beneficiaries have congestive heart failure but account for 43 percent of Medicare spending. About 18 percent of Medicare beneficiaries have diabetes, accounting for 32 percent of Medicare spending.³

To address this population, the MMA is attempting several experiments including the MMA's Section 721 Chronic Care Improvement Program (see "*Patient-Centered, Physician-Guided Care for the Chronically Ill: The American College of Physicians Prescription for Change*").⁴

However, until those changes, or other measures, have taken a positive and measurable effect, the less healthy of the Medicare population will be a threat to private plan profits. To compensate for this financial effect, the plan will have no choice (unless it wants to see its profits diminished) but to raise premiums. Such a reaction gets to the heart of the problem that poses a large obstacle for premium support. A plan with less healthy beneficiaries will cost more and so increase the plan's bid to Medicare. Hence that plan's premium cost will be over the average bid, and beneficiaries will pay the difference. Finally, and worst of all, the healthier beneficiaries will leave that plan in search of one with lower costs (because of its healthier population), abandoning the former plan to higher risks with higher premiums. One of the best ways the threat can be ameliorated, and that the MMA takes, is through risk adjustment.

Analysts use risk adjustment to help clarify the relationship between outcomes and variables that have a third factor in common to both. This third factor, called a *confounding variable*, can cause results that distort the true relationship between the actual variable and outcome of interest. By factoring out the confounding variable, one can get a better idea as to that true relationship. This factoring process forms the basis of risk adjustment. In the case of a Medicare population, the confounding variable related to both a Medicare population and its resulting premium costs is most often disease states, particularly the chronic disease problems mentioned earlier. Once these disease states have been factored into plan bidding, then all submissions to CMS will more accurately reflect a plan's efficiency.

Fortunately, the MMA has made explicit provisions to incorporate risk adjustments into premium support. Specifically, the MMA directs CMS to consider (for MA plan-bidding) risk adjustment for demographic factors such as age, disability status, gender, institutional status, and "such other factors as the Secretary [of HHS] determines to be appropriate."⁵ These factors tend to represent the most significant confounding variables with reference to the Medicare population, and are very appropriate targets for risk adjustment.

Furthermore, the MMA intends to incorporate risk adjustment with regards to intra-area payment rate variations for MA plan bids. Basically, CMS will now examine and take into account the different payment rates of areas within a region. That methodology will take into account different historical rates among various geographic areas. Hence, if a region has experienced historically higher rates because of a higher concentration of elderly (such as certain parts of Florida) or another similar factor, CMS will take these geographic considerations into account when adjusting premium bids. Furthermore, this adjustment applies to both MA local and the broader MA regional plan bids.

While these adjustments are a very important and well-reasoned component of MA plans, the MMA also made sure these adjustments would also be

available to FFS plan bids that are in the CCA demonstration program (where FFS competes directly with MA plans). According to the MMA, the adjustments to bids for these traditional Medicare FFS will include age, disability status, gender, and institutional status. Furthermore, the MMA will allow (for both MA and FFS plan bids) the consideration of “such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.”⁶

The addition of risk adjustment factors to both MA plan and FFS plan bids in a premium support demonstration represents well-thought methodology on the MMA’s behalf. In addition, there is a provision in the MMA stating that the Secretary of HHS will determine and announce new adjustment factors on an annual basis. Such a timely and regular dissemination of data represents what seems to be a diligent effort on the MMA’s behalf to ensure the risk-adjustment factors are as well-researched and accurate as possible. It is important that the risk adjusters be designed and implemented in such a fashion. This importance stems from the role these adjusters will have as the flood gates that prevent the mass exodus from FFS that many opponents of premium support fear.

An analysis performed by the Kaiser Family Foundation (KFF) in 2002 illustrates the importance of reliability in risk adjustment factors. If the model assumes 50% effectiveness (the adjustment accounts for 50% of the cost difference between a plan’s bid and the national average), the KFF analysis predicts enrollment in traditional Medicare FFS would gradually shrink down to 62% in 10 years. Moving that model effectiveness up or down by 25% shows that such reduction would reach levels of 76% and 47% respectively of the original FFS population. In conducting this analysis, the authors assume that there will be only one managed care plan competing against an FFS plan. Also, the authors used 1996 Medicare Expenditure Panel Survey (MEPS) Information. The assumption about the number of managed care plans should not be taken to heart, since the CCA requires two MA plans (which can collude easily, though not explicitly)⁷ only for the first year. 2002 MEPS data is available, but not in the format that the KFF authors’ assumptions employ. Please see the Table 1 for an illustration of risk-adjustment’s possible effects on FFS enrollment.

Table 1.

Simulated Impacts of a Premium Support Program, Payments from Government 25%, 50%, and 75% Risk-Adjusted

Year	25% Risk-Adjustment Effectiveness		50% Risk-Adjustment Effectiveness		75% Risk-Adjustment Effectiveness	
	FFS Premium	Percent in FFS	FFS Premium	Percent in FFS	FFS Premium	Percent in FFS
Year 1	\$548	83%	\$519	83%	\$494	84%
Year 2	\$571	81%	\$531	82%	\$496	83%
Year 3	\$605	78%	\$543	80%	\$499	82%
Year 4	\$643	75%	\$562	79%	\$503	82%
Year 5	\$694	72%	\$582	76%	\$507	81%
Year 6	\$762	68%	\$603	74%	\$510	80%
Year 7	\$845	63%	\$630	71%	\$514	79%
Year 8	\$943	58%	\$663	68%	\$520	78%
Year 9	\$1,065	53%	\$699	65%	\$524	77%
Year 10	\$1,219	47%	\$744	62%	\$528	76%
Year 15	\$2,590	21%	\$1,074	42%	\$562	69%
Year 20	\$5,360	7%	\$1,655	24%	\$613	60%

Source: Kaiser Family Foundation (based on 1996 MEPS data)*

As the above table illustrates, even the more accurate risk adjusters still could result in scenarios that drive significant numbers out of FFS leaving sicker patients with higher premiums that contribute to the downward spiral. Hence, it could be inevitable that premium-support sees the deterioration of FFS Medicare at some level. Because of this possibility, it is crucial that the risk adjusters that the CCA employs be as accurate as the current data allows.

Selection Bias

ACP Recommendation: In attracting patients, those plans competing in a Medicare premium support system must base their marketing and recruitment efforts on providing quality initiatives that adequately address the needs of all Medicare population members, not just the most healthy Medicare beneficiaries.

The diminishing FFS population that could very well result in Table 1 stems not only from risk factor efficiency and individual preferences, but also from selection bias that plans sometimes employ. The risk factors discussed can do much to ameliorate the aversion underwriters have for certain Medicare elements, but no adjustments will ever be able to sufficiently block out plan bias. This possibility exists even though the MMA gives the Secretary explicit direction to not approve a plan with a design that is “likely to substantially discourage enrollment by certain MA eligible individuals.”⁹ Despite this oversight authority, there are still methods that health plans may use to covertly “cherry-pick” among the Medicare population. Medicare managed care plans have pursued this strategy despite the eventuality that will occur when those members, originally selected for their better health statuses, begin to experience more adverse health outcomes. Such a short-sighted view will undoubtedly lead to inadequate care as patients’ health statuses decline while under lower-

quality plans designed for healthier beneficiaries. This quality gap will lead to even less healthy patients and higher premium costs as plans who “cherry-picked” try to catch up to the disease states of their patients, or worse, dump them into FFS plans with higher premiums. The ability of managed care plans to “cherry-pick” exists for several reasons.

First, HMOs have historically tended to enroll healthier populations,¹⁰ hence managed care companies have had an appreciable amount of time to perfect their enrollee selection techniques. For example, managed care companies can use subtle tactics such as: aggressively marketing services that might attract healthier individuals (such as health club memberships); down-playing their chronic care services; avoiding marketing to areas with patients that are known to have lower health statuses; or providing more barriers to those who need intensive care (increased administrative burdens, delayed referrals, etc.). Though some of these methods may not be so difficult to detect upon closer inspection by the Inspector General or another body of HHS, that type of oversight would be very taxing. Also, it would likely take a sea of litigation to ever really put a dent in private plan marketing efforts given their large magnitudes (a large part of the health plan cost, that FFS actually does not need) and established practices.

Adding to this concern, several real-world premium “death spirals” have actually taken place in recent history, due in large part to the selection bias discussed. For example, in 1994 the University of California health system incorporated a premium support system where a standard fee was paid to all health plans. As plans competed with each other, costs went down, and the university saved money. However, as more beneficiaries moved to the cheaper plans, the sicker patients in the university’s lone indemnity plan suffered premiums that sky-rocketed from \$750 in 1993 to nearly \$3,300 in 1996. By 2001, the indemnity plan had only a handful of beneficiaries with \$17,000 premiums, and new enrollment was barred.^{11 12} Harvard University health plans experienced a similar phenomenon in 1995 as they withdrew the subsidization of the lone PPO among their managed care plans, driving that PPO out of the market as soon as 1997.¹³

Though these relatively few examples already seem to dash the prospects for premium support in Medicare, there are several issues that need to be considered when grafting real world history onto the future CCA program. First, none of these break-downs exclusively concerns a retired population. That difference is significant, because younger populations more facile with today’s health options might be more likely to make changes swiftly. However, the Medicare demographic tends not to follow that lead. As a matter of fact, the Medicare population tends to cling to whatever systems of care that are available to them. This dedication to their medical care can be demonstrated through their price elasticity of demand. Price elasticity of demand refers to how much the demand for a product will change with given price changes. With retired populations, that change is actually very small relative to non-retired persons.¹⁴ This trend means that when the price of healthcare changes by large amounts, retired persons still want the product just as intensely. Hence, if a death-spiral should occur in the CCA program, its effects will manifest themselves slowly.

This slower pace will hopefully provide CMS with the time it needs to evaluate the efficiency of risk factors and evaluate plans carefully to as much as possible track for discriminatory practices. As discussed earlier, this type of tracking activity will be difficult, but it may be necessary. It is vital that MA plans and traditional Medicare FFS share the risk as evenly as possible so as to give FFS an equal standing with MA, one of the premises behind the competition that the

MMA envisions. Doing so will entail marketing to all Medicare beneficiaries equally, not just those with better health status. The death spiral that could result from such discrimination would not only threaten the beneficiaries in FFS and the FFS program, but possibly the MA plans as well.

This possibility stems from the opportunity MA plans will have to game the system. As MA plans consistently underbid their FFS competitors, CMS may come to believe that the high discrepancies in bid amounts may mean that MA plans are being overpaid. MA plans are supposed to pass the bid differences onto the beneficiary in the forms of lower premiums or increased benefits. However, CMS may decide that the consistent rise in beneficiary benefits for MA plans (resulting directly from FFS's demise) needs to have a quota (e.g., too many high tier drugs may create an expensive precedent). Hence, MA plans would see their payments lowered and begin to pull out of the market. This trend would closely mirror the experience of Medicare HMOs in the 1990s that were overpaid, wound up costing Medicare money, and so received lower payments which forced them out of the market. Hopefully, the experience will not repeat itself in the coming MMA implementation.

Beneficiary Education

ACP Recommendation: Efforts to implement a Medicare premium support system must include methods for making choices understandable for the Medicare population including those with vision, hearing, language, cognitive or other health-related or demographic-related issues.

Finally, in implementing a premium support system it is clear that the MMA intends greater efficiency and quality through an initiative driven by choice. Ideally, these choices will lead to more competition between health plans as beneficiaries make informed decisions. Such informed decisions will probably include some ability to use computers (as in the 2004-released Medicare Drug Discount Card), research different health plan options, and understand their healthcare needs along with how different health plans can address those needs. In addition to making choices on plans, Medicare seniors will now have to pay premiums that fluctuate on an annual basis. Furthermore, those premiums can now vary as a result of geography. Hence, seniors will have to be more cautious in their savings (perhaps through individual Health Savings Accounts) to avoid significant damage to their Social Security checks (where the funds will most likely be withdrawn). Unfortunately, these situations represent highly idealized models, and large doubts remain about how the Medicare population will adapt to the challenges such a system of choices and changes will bring.

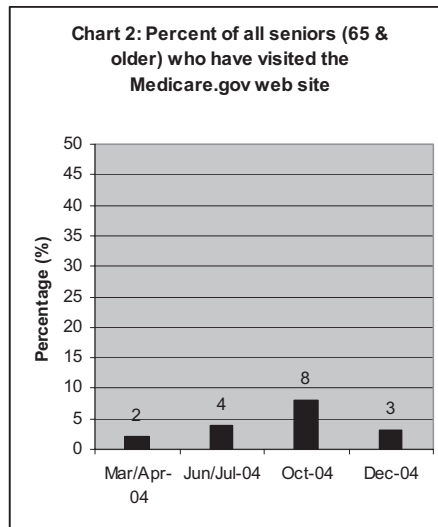
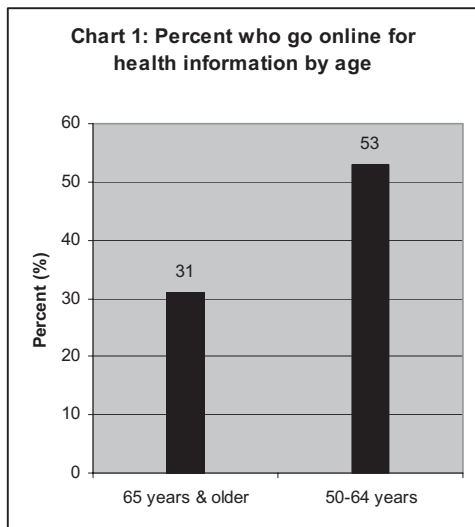
These doubts stem from the type of demographic the Medicare population represents. For example, most members of the Medicare population have little to no experience with managed care. The health insurance system that most current Medicare beneficiaries understand involves traditional indemnity. And even for those who are involved in Medicare HMO plans, the managed care selection, due to high market withdrawal in the 1990s, is mostly limited, so the choices are not overly complex. The choices raised by the new Medicare format will require very savvy beneficiaries.

Furthermore, experiments to try to educate Medicare beneficiaries have met with daunting results. For example, in a study designed to compare Medicare seniors' and younger non-Medicare respondents' capability in understanding health plan details, the seniors did overwhelmingly worse.¹⁵ The results showed Medicare senior beneficiaries making almost three times as many mistakes as the younger cohort. Also, the study was conducted in an area with

high managed care penetration, so this experiment represents what will probably be on the higher end of understanding choice. Another more recent study examined how a cohort of Medicare beneficiaries would perform when comparing health plan information.¹⁶ Once more, the results were daunting in that providing information on quality did not influence the beneficiaries to decide between FFS for managed care plans, suggesting that good information on quality has no effect on choice. And for those beneficiaries in the study who were able to exercise choices about Medicare managed care plans, most did not choose the less expensive plans even when they had higher quality ratings. Hence, not only could quality choice be invisible to future Medicare beneficiaries, but the resulting price could cause Medicare unnecessary cost.

The obstacles Medicare beneficiaries face when understanding choice in health plan decisions become more difficult when coupled with the increased risk of declining cognitive function that comes with advanced age. For the comparison study between Medicare seniors and younger beneficiaries mentioned above, more educated Medicare seniors made fewer mistakes; but that advantage only lasted till age 80. The higher frequency of cognitive barriers that increased aging brings will compel the MMA to make adjustments in order to make health plan choice a viable option.

The necessity to make the MMA premium support provisions more accessible becomes increasingly apparent when one examines the heavier reliance that the MMA is taking on web-based tools. This medium does not hold much promise for the current Medicare population. For example, a recent study performed by KFF shows only a third of Americans over 65 have ever been on-line, compared to over half of Americans 50-64 years old (see Chart 1). This lack of familiarity with the internet manifested itself with the recent Medicare Drug Card experience in 2004. Before the drug card program got off the ground, CMS made sure to consistently tout their *Medicare.gov* site as a key source of guidance for those seniors interested in useable information for their drug purchases. However, despite CMS's efforts, very few seniors took advantage of the site (see Chart 2).



Source: Kaiser Family Foundation *e-Health and the Elderly: How Seniors Use the Internet for Health Information*, conducted March 5 – April 18, 2004.

The digital divide separating Medicare beneficiaries from the intended benefits of the MMA must be crossed if those benefits are to be realized. Several methods are in use today to try and make that divide easier. For example, the National Institutes of Aging (NIA) employ technology that allows the user to change the font size to help those with vision impairments. Furthermore, the NIA offers an audio companion to assist the hearing impaired through their site as well. Finally, several geriatric societies have taken into account the cognitive difficulties that many seniors face in designing their web space. For example, the special challenges of scrolling have been found to be more confusing than simple clicking to move between paragraphs, hence these sites employ more clicking links than scrolling activity. In addition, web site designs for geriatric societies have in some cases attempted to make the site as shallow as possible so as not to drown out the user in deep web space that may be more difficult to navigate.

These methods represent just a few ways that web sites can adjust to the needs of seniors. Furthermore, it should be noted that most of these sites (in order to accommodate the more sophisticated price tools) use more complex software that requires faster download capability. However, most seniors today have only dial-up access, making this technology difficult to access. This difficulty just adds to the frustration, and makes it more likely that a Medicare senior will stop trying to access the site and give-up on the web tools altogether. Hence, another way Medicare and MA plans can make their web-based information more useable would be to either make their sites friendlier to dial-up internet connections, or at least consider the high-access needs of the Medicare beneficiaries that Medicare web sites are supposed to serve.

In addressing beneficiary education needs, the MMA, for its CCA program, authorizes \$100 million for beneficiary education in 2005, followed by \$200 million for 2006 and subsequent years. Furthermore, the MMA will begin to take greater advantage of State Health Insurance Programs (SHIPs) to hopefully provide not only outreach efforts, but also a forum for seniors to discuss and compare their plan experiences. Currently, seniors do not have as ready access to such forums as those non-elderly who still enjoy the benefits of annual or bi-annual benefit meetings at their jobs. These gatherings provide a method of plan discussion among fellow beneficiaries at enrollment time, something that would assist Medicare enrollees in making choices.

Conclusions

In examining the relevant issues surrounding the challenge of premium support in the MMA, it is clear that appropriate caution must be taken to ensure these changes take their desired effect with little or no adverse consequences. Such caution is important, because as previous analysis has shown, the potential for damage is wide ranging. If the premium support measures do not appropriately adjust for risk, discriminate against less healthy beneficiaries, or fail to adequately educate seniors, the damage can spread to several levels including:

- FFS beneficiaries (higher premiums)
- MA and FFS beneficiaries (confusion about plan choice)
- Physicians (unstable patient relationships from possibly annual plan-switching)
- Traditional Medicare FFS (less favorable risk, and plan “death spirals”)
- Medicare (inflated payments to MA plans based on population and not plan efficiency)
- MA plans (eventual cut-backs for unnecessary care leading to plan withdrawal)

To avoid these outcomes, it is important that CMS use the best data at its disposal (and research more when necessary) on accurate risk adjustments. It was noted that even with such estimates, there is the possibility that some FFS exit will occur. Still, the best way to avoid the mass exodus that contributes to “death spiral” effects is through superior risk adjustment. The MMA has taken the first steps toward this measure by specifically legislating for risk adjustment in its CCA program. Furthermore, the MMA attempts to supplement its risk adjustment efforts through provisions that bar plans with discriminating practices from participating in MA or CCA bidding. Actually implementing this provision will prove difficult as managed care plans have subtle tactics at their disposal for picking the best risk candidates. CMS will have to be diligent and thorough in its oversight to prevent the success of such tactics especially in private plan marketing. Also with respect to marketing, plans will need to make extra efforts in order to accommodate Medicare seniors who are not used to annually changing premiums, selecting among competing health plans, or using the web. The MMA has attempted to address these gaps through funding for beneficiary education, as well as increased coordination through the SHIPs. Hopefully, these measures will help initiate the Medicare population into the new era of choice through more senior-friendly web sites, simplified plan descriptions, and ready-access guidance sources. Without such adjustments, the competitive selection that MMA envisions for Medicare in the 21st century will fall flat and could very well lead to damaging consequences for the beneficiaries, the health plans, and Medicare itself.

Glossary

CCA

Comparative Cost Adjustment Program: Section 241 of the Medicare Modernization Act; 6 year demonstration competitive bidding program that puts Medicare fee-for-service in direct competition with Medicare Advantage plans for Medicare funding.

CMS

The Centers for Medicare and Medicaid Services: the component of the US Department of Health and Human Services responsible for administering Medicare and Medicaid.

Confounding Variable

A factor associated with both a variable and its outcome; results in a distortion in the relationship between the variable and its outcome.

FFS

Fee-for-service: refers to traditional Medicare indemnity coverage for beneficiary health expenses.

HHS

Health and Human Services: the principal United States government agency responsible for healthcare.

HMO

Health Maintenance Organization: organized health care systems that are responsible for both the financing (risk-bearing elements) and the delivery of a broad range of comprehensive health services to an enrolled population.

Medicare Part A

The Medicare component (funded by the Federal Hospital Insurance Trust Fund) covering inpatient hospital, home health, skilled nursing facility, psychiatric hospital, and hospice care services.

Medicare Part B

The Medicare component (funded by the Federal Supplementary Medical Insurance Trust Fund) covering physician visits, outpatient services, some mental health services, durable medical equipment, some preventive services, and home health visits not covered under Part A.

Medicare Part C

The Medicare component (formerly known as Medicare + Choice and now Medicare Advantage) that offers expanded benefits through private health plans such as health maintenance organizations and preferred provider organizations (beneficiary must first have Parts A and B).

Medicare Part D

The Medicare component (funded through the Federal Supplementary Medical Insurance Trust Fund) covering outpatient prescription drugs (not covered under Parts A and B).

MedPAC

Medicare Payment Advisory Commission: an independent committee responsible for advising Congress on Medicare payment issues.

MMA

The Medicare Modernization Act (The Medicare Prescription Drug Improvement and Modernization Act of 2003; Public Law 108-173).

MEPS

The Medical Expenditure Panel Survey: is a national survey on the financing and utilization of medical care conducted in the United States (performed by the Agency for Healthcare Research and Quality).

MA

Medicare Advantage (see Medicare Part C).

PPO

Preferred Provider Organization: organizations that employer health plans and health insurance carriers use for purchasing health care services for beneficiaries from a selected network of participating providers.

Price Elasticity of Demand

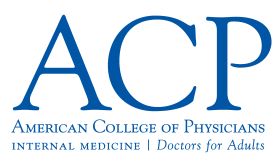
How much a consumer will want a product given a change in the product's price (Percent Change in Demand / Percent Change in Price).

SHIP

State Health Insurance Programs: a network of programs (in all 50 states, DC, Guam, Puerto Rico, and the Virgin Islands) providing information, counseling, and assistance to Medicare beneficiaries.

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