EXECUTIVE SUMMARY

PROJECT PURPOSE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made major changes in the Medicare Advantage (MA) program that are evident in 2006. In 2006, MA has expanded to include regional Preferred Provider Organization (PPO) plans in addition to such local plans as health maintenance organizations (HMOs) and local PPOs (historically referred to as coordinated care plans (CCPs)) and private fee-for-service plans (PFFS). MA has also been modified to include additional competitive features, such as the new competitive bidding system. Regional and local MA plans provide beneficiaries with access to a comprehensive set of benefits that includes the new and voluntary prescription drug benefit (Part D), which is being implemented in 2006. Beneficiaries wishing to receive the new Medicare prescription drug benefit must decide between enrolling in an MA plan or staying in traditional Medicare and joining a stand-alone prescription drug plan (PDP).

This project provides the Assistant Secretary for Planning and Evaluation (ASPE) with a baseline of timely, policy-relevant information that will help ASPE understand the MA products that are available in 2006, how they compare to past offerings when only local MA options were authorized, initial plan decisions and experiences under the new competitive bidding process, and how well available offers and enrollment meet Congress' overall objectives in enacting the MMA. The project seeks to help ASPE to identify emerging trends and determine whether further analysis or policy refinements may be desirable to address potential problems or opportunities

METHODS

We analyzed publicly available quarterly data from the Centers for Medicare and Medicaid Services (CMS) Geographic Service Area (GSA) Report and other sources in 2005 and 2006. Because CMS has not yet made these data available in 2006, we used the November 2005 release of the Medicare Plan Finder to develop a "pseudo-GSA" file that allowed for analysis of 2006 contracts[1]. We also conducted 14 telephone discussions with a total of 20 diverse firms to learn more about their decision-making process and strategies, and gathered information valuable in "getting beneath the numbers" to learn more about how firms perceive MA now and in the future. These discussions, held primarily during March and April 2006, were confidential so that firms would be more willing to speak freely.

[1] The "pseudo-GSA" file is an MPR created database based on the November 2005 release of the CMS Plan Finder data for 2006; the main differences between this and the GSA file are the that the CMS plan finder file used for the "pseudo GSA" does not include certain contract types (e.g. Health Care Prepayment Plan or HCPP, Program for All Inclusive Care for the Elderly or PACE, and demonstration contracts).

FINDINGS—DESCRIPTIVE ANALYSIS OF TRENDS

National Trends in MA Offerings, 2005-2006

- The total number of MA contracts increased substantially from March 2005 to 2006, leading to a substantial increase in the share of beneficiaries with at least one MA contract available to them in 2006.

- In most cases, firms expanding in 2006 did so before the start of the year. The most extensive number of new entries was between July and September 2005. Regional PPOs were an exception, as they were not authorized until 2006. Only a small number of contracts were withdrawn in 2006 once transitions are taken into account.

- Virtually all Medicare beneficiaries (including 93 percent of rural beneficiaries) had some form of MA choice in 2006. The dominant drivers of increased availability were the growing prevalence of PFFS contracts (reaching 78 percent of beneficiaries in 2006 versus 41 percent in March 2005) and newly available regional PPOs in 2006 (available to 86 percent of beneficiaries).

- Almost all MA contracts in 2006 include at least one plan offering prescription drug benefits (MA-PDs). Although drug coverage is optional under PFFS contracts, 62 percent of PFFS contracts have at least one plan with prescription drugs.

Variation in Choice Across the Nation

- HMOs and local PPOs are available to more beneficiaries nationwide in 2006 than in 2005, with local PPOs growing more rapidly than HMOs. However, HMO and local PPO availability continues to be uneven across geographical areas and much of the expansion in local PPOs is in areas already served by HMOs.

- The introduction of regional PPOs expanded choices but cannot be credited uniquely with driving the increase in MA overall availability in 2006, because PFFS contracts have also grown over this period. States with the most dramatic change in MA availability from 2005 to 2006 typically experienced growth in both types of contracts or, if only one, in PFFS contracts.

- Regions attracting regional PPO entrants appear to have a balance of urban and rural areas and counties with higher and lower payment rates. Entry was less likely in less populated regions with a heavy dominance of rural areas. In contrast, only 109 counties attracted no PFFS plans but many of these were highly populated and located in the Northeast and California. In many areas of the country, options may be offered but may not really be competitive or marketed heavily.

- PFFS is available in all but 109 counties in the United States but these exclude some highly populated counties especially in the Northeast and California. Virtually all beneficiaries in urban or rural floor counties have them available. Beneficiaries in urban and rural floor counties (i.e. counties whose payment rates are enhanced because Medicare has minimum payment levels for counties by type) make up 56 percent of beneficiaries with PFFS but only 3 percent of beneficiaries without it.

- Because regional PPOs and PFFS plans are so prevalent, enrollment data by county and product are essential to analyzing the effect that county-by-county variation in payment rates has had on the way firms are positioning themselves.

MA Contract Sponsors

- A small number of firms and affiliates play a disproportionate role in the MA program in 2006, as they have historically. Almost half (48 percent) of MA contracts are with seven MA firms that MPR has tracked as part of its M+C/MA Monitoring Project since 1999 or with affiliates of Blue Cross and Blue Shield (BCBS). These count for an even larger share of MA enrollment (65 percent in March 2005)[2].

- In the six-month period (March to September 2005) preceding the 2006 MA expansion, MA enrollment grew about five percent. HMOs account for only about half (53) percent of this enrollment growth, although they were 86 percent of MA enrollment at the start of the period. Humana accounted for about a third of the growth in non-HMO MA enrollment.

Enrollment Trends, 2005-2006

- MA enrollment grew from 5.1 million to 5.5 million between March and December 2005. The limited enrollment data for 2006 suggests such growth continued and even accelerated in 2006, reaching 6.8 million in April 2006—a Medicare market penetration rate of 15.5 percent.

- In March 2005, MA enrollment varied substantially across states, with 9 states having less than one percent of their population in MA and another 13 having under 5 percent penetration. In rural counties, penetration was only 2.4 percent on average. CMS has not yet made publicly available data sufficient to examine whether this pattern has changed in 2006. December 2005 shows some growth in enrollment but variability by state.

- While HMOs continue to dominate MA enrollment, their share of the market is declining as newer products are marketed. PFFS plans are the fastest growing segment of MA, with a total enrollment of over half a million members in 2006, twice that of local PPOs. About 1.3 percent of all beneficiaries are now in PFFS plans. Enrollment in regional PPOs, in contrast, remains very limited to date, with fewer than 55,000 enrolled nationwide.

- Three firms account for over two of five enrollees in MA—UnitedHealthcare/PacifiCare, Kaiser, and Humana. Since March 2005, Humana's

[2] MPR's M+C/MA tracking project includes, among other aspects of the work, tracking MA availability, enrollment, and penetration over time. Since 2004, Kaiser Family Foundation has funded the work. From 1999-2004, the work was funded by the Robert Wood Johnson Foundation as part of a broader project to examine the implications of M+C for beneficiaries.

enrollment has grown 61 percent, although the other two firms still have more enrollees.

- Enrollment data for December 2005 show that 88 percent of PFFS enrollment comes from urban or rural floor counties, with urban floor counties contributing over half (53 percent) of PFFS enrollment. This is very different from the distribution of general MA enrollment.

FINDINGS—INSIGHT FROM FIRM DISCUSSIONS

The Environment for MA and Firm Response

- Nationally, three strong forces encouraged firms to consider aggressively pursuing Medicare Advantage program involvement for 2006: (1) the entire Medicare program was in transition, particularly because of the introduction of Part D; (2) MMA introduced more favorable MA payment rates; and (3) the aging of the U.S. population has made senior products demographically attractive to firms.

- Given the breadth of the changes in the Medicare program in 2006, firms had to decide where to focus their resources. Most were also establishing PDPs, which required very large start-up costs. The attraction and demands of the PDP product, combined with the unstable history of the MA/M+C program, limited the resources firms had available for MA.

- In deciding how to position themselves in MA, firms balanced the pressure on their resources in different ways depending on what they perceived would best suit their long-term style and strategy in the marketplace. For example, they:

  - Built on their base
  - Targeted "low-hanging fruit"
  - Favored strategies consistent with their perceived market strength
  - Sought expansions appropriate within the full range of business, including both Medicare and other products
  - Tailored the level of business risk
  - Responded to market preferences
  - Began positioning themselves at least by 2005

- For some firms, the changes in 2006 were relevant mainly because of the threats they generated to their existing book of business rather than the opportunities. This appeared to be particularly true for the most traditional HMO-model firms.

Influence of Rates and Network Requirements on Firm Decisions

- Top leadership from each firm was involved in 2006 MA decisions, with the balance between corporate and local leadership differing across firms. Both MA payment rates and considerations relating to provider network formation were the major factors driving product- and market-specific decisions in 2006.

- Firms took into account how the expected revenues in each county affected the feasible structure and likely market viability of different products. While rates might be regarded favorably in 2006, firms also considered the risks associated with potential future reductions.

- While payment rates were important, a firm's ability to put together a viable provider network had a major influence in shaping 2006 offerings, with the need for on-the-ground resources to establish new networks a major limiting factor. The absence of network requirements was one of the major factors making PFFS products so attractive.

- Providers' requests that MA plans pay them more than Medicare pays them in the traditional Medicare program led to difficult negotiations, particularly with hospitals. MA viability could depend on being able to negotiate rates below Medicare for in-network services in a PPO; Medicare-based rates are typical in PFFS. Provider acceptance was an issue that extended beyond rural areas.

- Two factors helped firms address network issues, particularly for regional PPOs: (1) their expectation that CMS might allow them to use in-network payments for out-of-network providers if access problems in some counties might preclude the firm from offering a product; and (2) the expectation that CMS might approve a product even if its network was weaker than ideal in selected areas.

Product-Specific Considerations

- In 2006, firms were most likely to expand more loosely managed products that were easier and faster to implement.

- Firms did not invest heavily in establishing new HMOs because of the start-up demands, and because they often felt their existing placement of products generally spanned the geographical market for this type of product. Firms were also more likely to favor local PPO to HMO expansion in 2006, if they considered either.

- Interest in offering a regional PPO product was constrained by (1) the need to establish provider networks across broad areas of the country; (2) uncertainty about its viability and its financial mechanisms; and (3) less ability to tailor benefits and premiums to local market conditions compared with a local PPO.

- Firms explained the strong interest some had in PFFS as due to their ease of entry because: (1) they do not require provider networks or provider contracts and have no network adequacy requirements; (2) the business case for PFFS is more national in scope since firms do not need to create a local base to form or manage the network;

and (3) marketing is easier because these products are more like traditional indemnity insurance and can be sold through insurance brokers nationwide.

- Despite the advantages of PFFS, firms said they still had to put resources into provider education, particularly when market experience with such products was limited. While PFFS sponsors were optimistic, competitors said provider acceptance could be an issue, as is long-term economic viability.

BENEFITS, MARKETING, AND PRODUCT POSITIONING

- Firms often designed multiple benefit packages and/or a family of products to appeal to diverse subgroups of beneficiaries. They took into account what they expected their competitors to do; as might be expected, entry with very low-priced products drew their special attention and concern and firms were paying particular attention to Humana's aggressive approach.

- Drug coverage was often included in PFFS plan offerings, even though firms were not required to do so. Those firms not doing so typically offered an independent PDP to complement their PFFS plan.

- Traditional HMOs with in-house pharmacies and well-established formulary development processes found integrating Part D challenging for a variety of reasons discussed in the report.

- Beneficiary education and marketing was an important focus in 2006. The concentration of efforts over a brief period in 2005-2006 was a concern for all firms, consuming a large amount of resources. This included both efforts to educate existing enrollees about changes and efforts to reach new enrollees.

- Firms used a variety of channels to reach beneficiaries. Brokers and agents appear much more involved in selling MA in 2006 than they were perceived to be in prior years. Reasons include: their current role in Medigap and geographic scope; their established channels for reaching beneficiaries not accessible through other firm channels; and the fact that the way they are paid provides them an incentive to enroll beneficiaries.

Experience in 2006 and Plans for 2007

- Firms were appreciative of the pressures on CMS and the agency's efforts to collaborate. However, they also said it had been a very demanding year for them. They said that demands of the new drug benefit detracted from the energy both the firms and CMS had to devote to the MA sector. Part D issues affected both PDPs and MA, even if they were more acute for PDPs. Firms were especially concerned that it has been so difficult to reconcile their MA enrollment with CMS. This slowed revenue and generated fears that some current enrollees were being disenrolled. Firms hoped for more support than they have received from CMS in addressing this problem.

- Firms were hesitant to share their upcoming 2007 plans fully, noting concerns over what the 2007 payment rates may mean. The discussions suggest the following for 2007:
  - Substantial continued growth of PFFS unless firms are dissuaded by concerns over 2007 payment rates
  - Refinements in benefit structures and pricing for existing products
  - Modest, if any, growth in regional PPOs
  - Potential introduction of MSA products
  - No expansion in local PPOs because of the moratorium and limited, if any, expansion in HMOs for the general population
  - Continued development of SNPs and other specialized products

Firm Perspectives and Concerns for the Long Term

- Most firms were clear that program stability was important to them, as were predictable MA payment with stable increases. Firms provided mixed feedback on their commitment to the MA market. While they say they are committed to the market, they also typically indicated that they would need to make decisions should experience prove unfavorable over time.
- Aside from stability, firms also wanted to have some advance notice of changes. They said, for example, that Special Needs Plans (SNPs) interested them but that they might be reluctant to offer new plans in 2008 without timely action on reauthorization (which runs out after 2008). Firms wanted a partnership with CMS and had various additional suggestions for MA program improvement.

CONCLUSIONS

The growth in MA contracts in 2006 has made MA more available across the country, including in areas where such contracts were previously absent or limited. Beneficiaries also have more contracts to choose from in 2006. To the extent that the MMA sought to enhance the availability of more coordinated care options for a greater number of beneficiaries, the results are mixed. HMOs and local PPOs are available to more beneficiaries in 2006 than 2005, but geographical concentration persists and there has been less activity in this sector than others in MA. For the most part, the availability of regional PPOs and PFFS contracts is responsible most for the increase in MA availability nationwide, especially in rural areas. Because of the growth of PFFS contracts, regional PPOs cannot be credited, at least directly, as the sole or even predominant driver of expanded choice.

Although many firms participate in the MA market, a small number dominate. The decisions of these firms have a major influence on the MA marketplace. Regional PPOs, for example, would be far less available had Humana not decided to enter 14 of the 26 MA regions. Decisions by Humana and PacifiCare in 2006 also had a disproportionate influence on the PFFS market.

HMOs still account for most MA enrollment. However, while HMO enrollment continues to grow, other products—especially PFFS—are driving much of the current growth in MA enrollment. Preliminary indications are that PFFS enrollment will exceed PPO enrollment in 2006. In contrast, regional PPOs, although available, have not yet proven their viability in the market and current enrollment is very limited. PFFS enrollment is particularly strong in counties benefiting from urban or rural floor payments, which raise rates above what they would otherwise be in the traditional Medicare program.

Although we focused on MA, we heard from firms that they devoted more attention to developing free-standing drug plans than MA in 2006. Such plans are more popular than MA plans that integrate prescription drug coverage, at least in 2006. Yet the analysis also shows that firms are actively pursuing MA in 2006 and are likely to continue to do so in 2007. Much of this appears driven by the opportunities created by the MMA, which both increased MA payments and made it more likely beneficiaries would consider MA by making them have to consider a private plan option if they desired a drug benefit. The MMA positioned MA firms to compete well in this marketplace by paying rates that exceed traditional Medicare program costs and allowing firms to use these funds—to the extent they have savings in delivering the Part A/B benefit—to expand Part D benefits and/or offset the beneficiary premium for such plans, as well as to support other attractive benefits. Floor payments sought to provide a cushion for firms in markets where MA has historically had the most difficulty thriving.

What these trends mean for Medicare is unclear. While beneficiaries have more choice, it appears the main expansions have given them more choice of essentially fee-for-service options—either directly through PFFS or indirectly through regional PPOs that use the same techniques in parts of their service area. This trend may provide limited opportunity for government to capitalize on private plan's ability to offer health plans with more care management potential than the traditional Medicare program. In many cases, these products take advantage of Medicare's negotiated rates. They therefore may not improve Medicare's rates or utilization, and if they grow they could reduce the current market ability Medicare has to negotiate rates. In addition, to the extent MA enrollment grows disproportionately in floor counties, the outcome also could be expensive for Medicare because such payments are higher than what Medicare would otherwise pay in the traditional program.

It also is not clear that expanded choice will be stable over time. Regional PPOs have not yet proven themselves and may not prove to be viable in the marketplace. Local plans, particularly those with less management potential, may only be attractive because Medicare is paying above market rates to support them. Firms are likely to either exit or substantially reduce their benefits if payment levels erode. Lacking networks, PFFS plans are particularly easy to drop. To the extent firms in MA respond by raising premiums and reducing benefits, MA expansion could lead to an integrated MA/supplement package but may not make such coverage more affordable than the current combination of Medicare and Medigap.

In sum, the Medicare market has changed in 2006 but whether such changes are fundamental and, if so, how, remains to be seen.