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The Role and Future of Private Medicare Health Plans*

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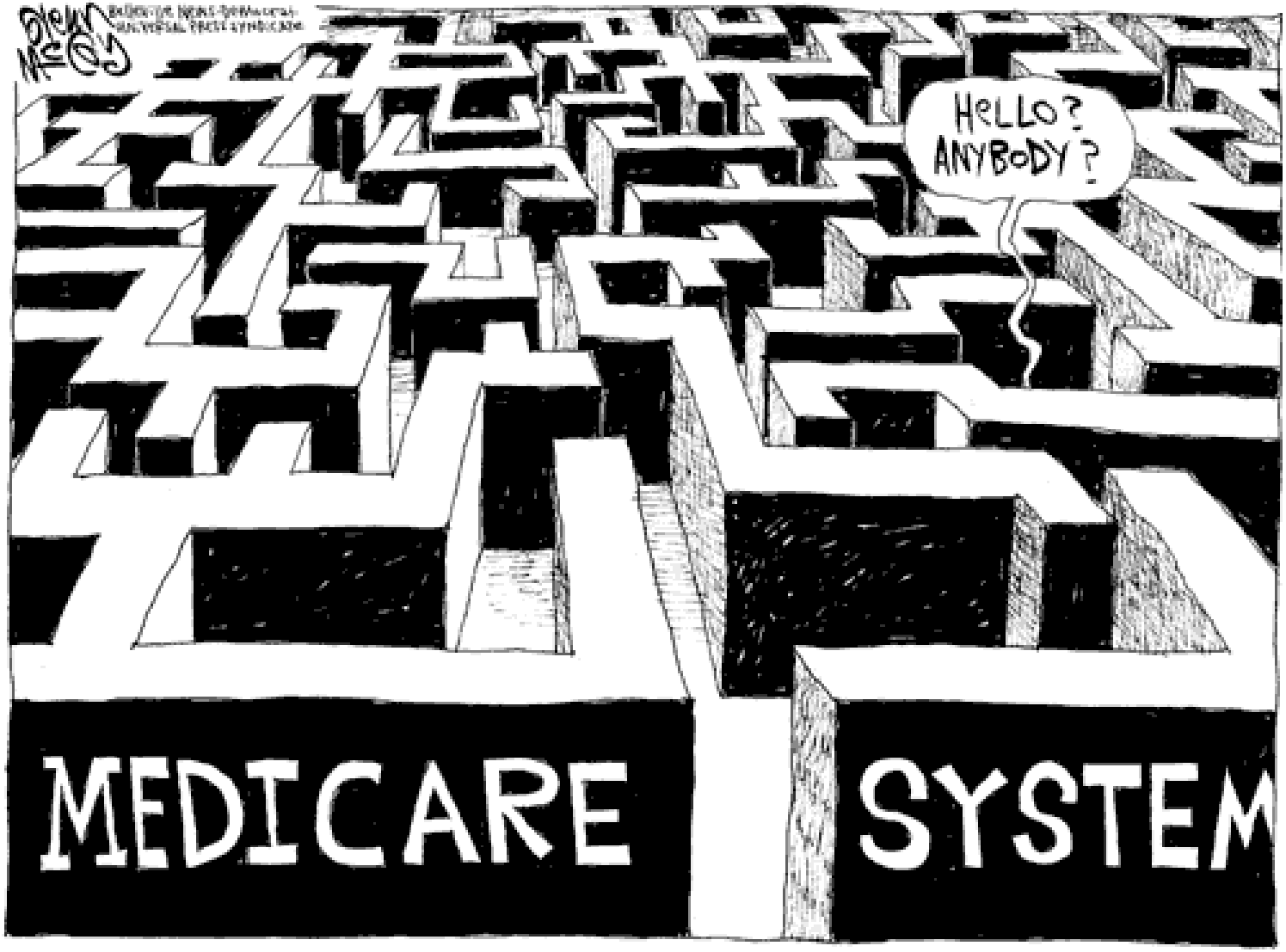

HELLO?
ANYBODY?
MEDICARE
SYSTEM

Recent Papers

- Frakt, Pizer, Feldman, "A Multiproduct Entry Model for Private Medicare Health Plans," *J. of Econ. & Manag. Strat.,* submitted Nov. 2009.
- Frakt, Pizer, Feldman, "Payment Rates and Medicare Private Fee for Service," *Health Care Financing Review*, 30(3), Spring 2009.
- Pizer SD, Frakt AB, and Feldman R, "Nothing for Something? …," *International Journal of Healthcare Finance and Economics*, 9(1) (March 2009):59-81.
- Frakt, Pizer, and Hendricks, "Controlling Prescription Drug Costs …," *J. of Health Politics, Policy and Law*, 33(6) (December 2008).

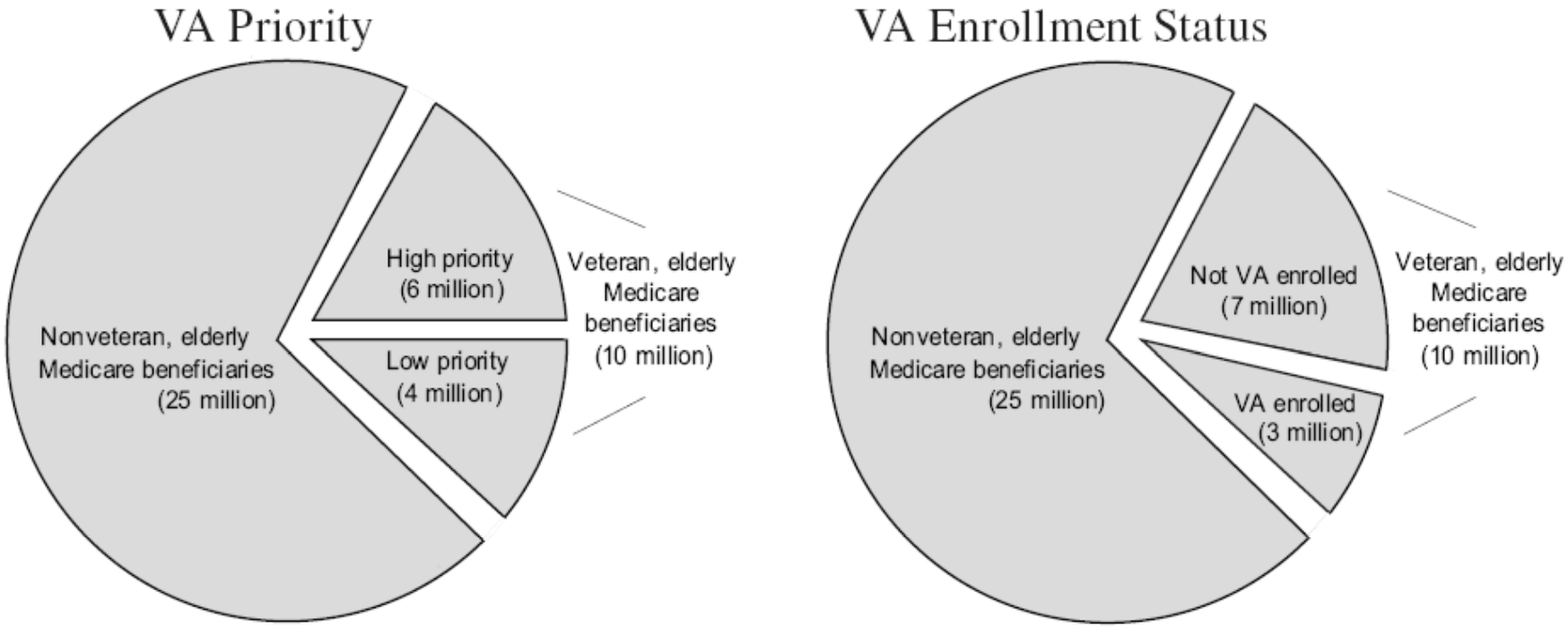
VA Context

- This is work from studies of the behavior of firms offering private Medicare plans.
- We (at the VA) care because:
  - Veterans enroll in such plans at the same rate as non-veterans (23% in comprehensive plans, 39% in drug-only plans).[1]
  - >50% of VA patients are Medicare beneficiaries. [1]
  - Dual use is common. [2]
- Medicare is the context in which elderly veterans make health care decisions.

[1] Shen Y, et al. (2003). Med Care Res Rev 60(2):253-267.

[2] Research findings from the VA Medicare data merge initiative (XVA 69-001). (2003). VIReC.

Elderly Medicare Beneficiaries by …



Frakt, Pizer, and Hendricks, "Controlling Prescription Drug Costs: Regulation and the Role of Interest Groups in Medicare and the Veterans Health Administration," *Journal of Health Politics, Policy and Law*, 33(6) (December 2008).

Roadmap

- Medicare private plans: enrollment & OOP cost
- Policy context
- Thinking about firms (descriptive results)

  [with very important data discussion]

- Multi-product entry model: background
- Multi-product entry model: results and import
- Multi-product entry model: methods details
- Conclusion

Private Medicare Plans: Enrollment

Plan Type	Num. (%) of Medicare Beneficiaries	Comments
Local coordinated care plans (CCPs)	7.2M (16%)	Mostly HMOs
Private fee for service (PFFS)	2.3M (5%)	Less generous
Prescription drug plans (PDPs)	17.5M (39%)	Drug only, donut hole

2009 figures. These are not mutually exclusive! PFFS + PDP is permitted.

- CCP + PFFS = MA (Medicare Advantage)
- Traditional FFS Medicare (34.8M (77%)) is the program's "public option."
- A few other small plan types account for < 1M enrollees (1.5%).

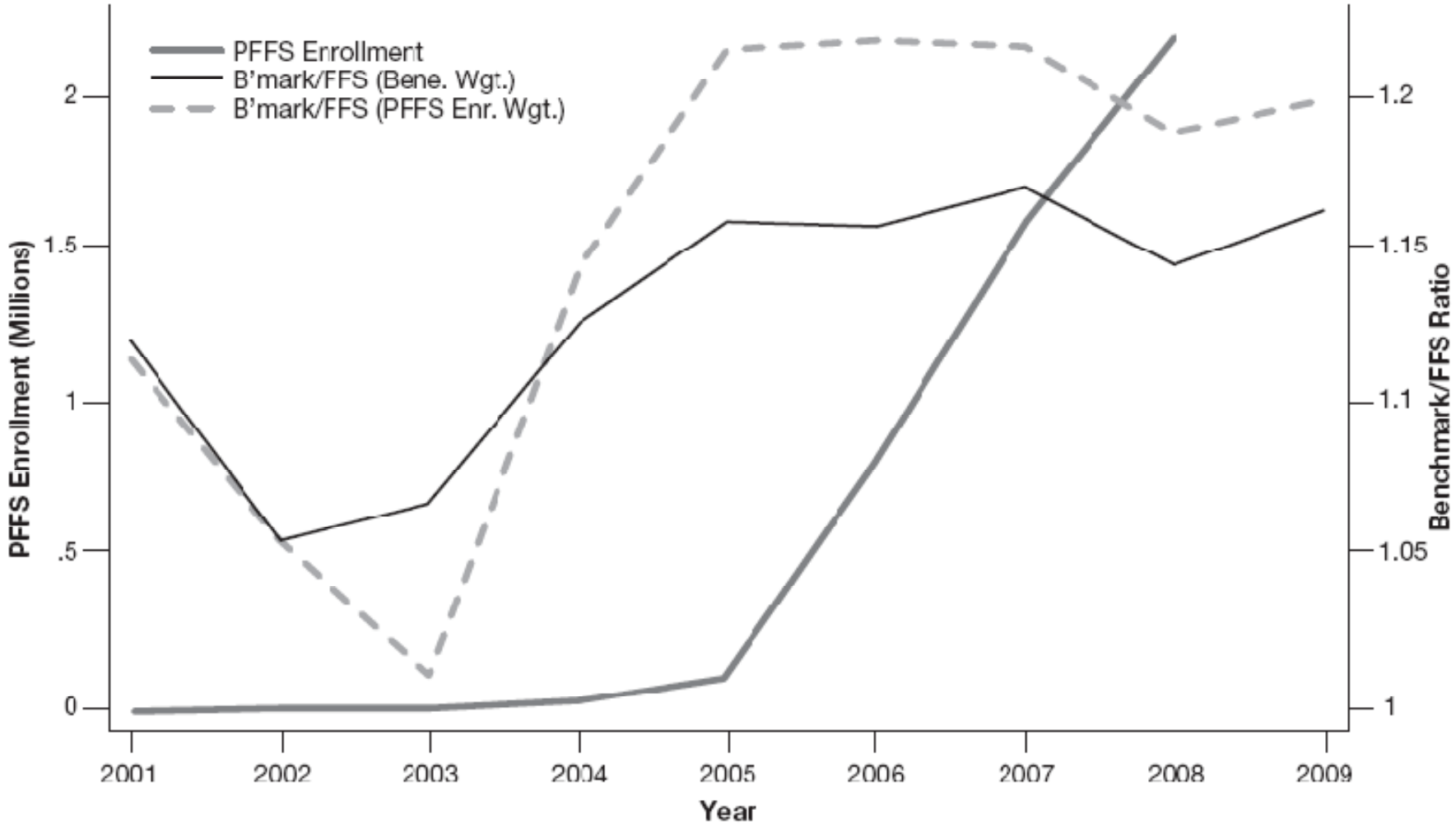
Private Medicare Plans: OOP Cost

Cost Sharing Type	Mean of Non-Zero (% $0)		
	CCP	PFFS	PDP
Non-drug premium	$68 (68%)	$56 (39%)	-
Primary care doc. visit copay	$11 (33%)	$21 (3%)	-
Drug premium	$25 (66%)	$30 (17%)	$35 (0%)
Drug deductible	$283 (90%)	$233 (66%)	$280 (58%)
Mean preferred drug copay	$33 (0%)	$35 (0%)	$37 (0%)

2009 figures. Enrollment weighted.

- In general, CCPs offer the best deal.

Policy Context



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Thinking About Firms: The Forrest

Num. Types Offered	Number of Firms	Percent of Firms
One plan type	151	75%
Two plan types	32	16%
All three plan types	16	8%
TOTALS	199	100%

2007-2009 data. Plan types need not be offered in the same year or county.

- Firms offering all three plan types represent 89% of PDP enrollment, 84% of PFFS enrollment, and half of CCP enrollment.

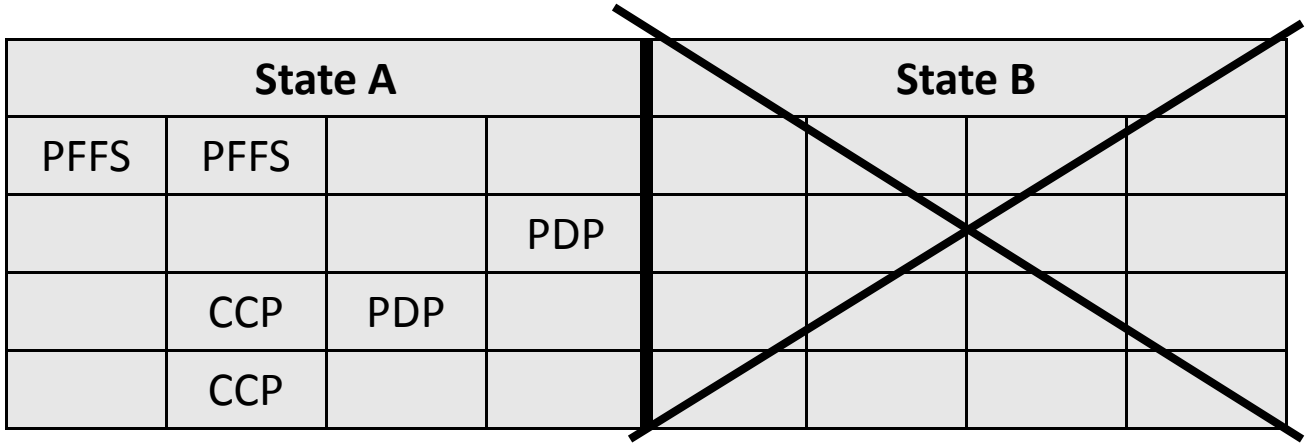
Important Data Discussion (I)

- ***Years?*** 2007-2009.
- ***What's in?*** Firms offering all three products, not necessarily at the same time or place.
- ***What about them?*** County-level entry of each product type by each firm in each year.
- ***What is entry?*** > 0.5% market penetration.

State A				State B			
PFFS	PFFS						
			PDP				
	CCP	PDP					
	CCP						

Important Data Discussion (II)

- ***Unit of Obs.?*** Year-County-Firm.
- ***Key variables?*** CCP entry, PFFS entry, PDP entry
- ***Risk set?*** All counties, less those in states where firm never had entry of any product.



In risk set. *Not in risk set.*

50% of counties at risk for entry.

Thinking About Firms: The Weeds

Firm	Pct. counties at risk for entry	Percent of counties in entry risk set entered with:							
		None	CCP only	PDP only	PFFS only	CCP & PDP only	CCP & PFFS only	PDP & PFFS only	All
Aetna	100	38	0	57	0	2	0	2	0
BCBS of FL	2	1	0	63	0	16	0	19	1
BCBS of MI	3	0	0	0	1	0	0	65	34
BCBS of SC	7	14	0	39	5	0	0	39	3
Bravo Health	56	64	0	35	0	1	0	0	0
Cigna	100	36	0	64	0	0	0	1	0
Health Care	100	13	0	40	2	1	0	43	2
Geisinger Health System	4	77	11	1	2	3	6	0	1
Health Net	100	57	0	38	1	1	0	4	1
Highmark	4	1	0	36	0	58	0	5	1
Humana	100	1	0	23	0	1	0	71	4
UnitedHealth Group	100	2	0	61	0	7	0	23	7
Universal American	100	3	0	56	0	0	0	41	1
Med. Cntr.	4	56	7	24	0	12	0	1	0
Wellcare Health Plans	100	11	0	68	0	2	0	18	1
Wellpoint	100	12	0	62	1	3	0	21	1

Joint entry

Thinking About Firms: The Trees

- Aggregate the prior table.
  - Take all year-county-firm combinations.
  - Toss state-firms with no business to get risk set.
  - How many have no products? That's the none entry below.

Firm	Pct. counties at risk for entry	Percent of counties in entry risk set entered with:							
		None	CCP only	PDP only	PFFS only	CCP & PDP Only	CCP & PFFS only	PDP & PFFS only	All
All firms in sample	61	22	0	51	0	2	0	23	2

Joint entry

Roadmap

- Medicare private plans: enrollment & OOP cost
- Policy context
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  [with very important data discussion]

- Multi-product entry model: background
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Objectives

- To estimate a model of multi-product entry across the three main types of private Medicare plans: CCPs, PFFS plans, PDPs.
- To discover the relation between the Medicare Advantage (MA) payment rate, the administratively-determined payment for CCP and PFFS plans, and entry decisions.

Health Care Reform

- Recall MA payments are 14% above FFS costs.
- House Leadership Bill (passed 11-7-09): Payments to MA plans will be reduced to 100% of FFS levels by 2013.
- Senate Leadership Bill (passed 12-23-09): Beginning in 2012 with 4-year phase-in, MA plans will submits bids with payment based on the average of plan bids in each market.

Prior Literature

- Cawley, Chernew and McLaughlin (JEMS, 2005) estimated the level of government payments necessary to induce various levels of participation by private Medicare plans in counties from 1993 to 2001.
- Other papers, mostly using earlier data, focus on firms' decisions to participate in Medicare.
- Frakt, Pizer, and Feldman (HCFA Review, 2009) estimated a model of PFFS participation by firm & county from 2001-2008.

Our Contribution

- With the exception of our recent paper, no prior study has examined private plan participation in Medicare during the period when PFFS plans have existed.
- Since 2006, a new type of plan – the prescription drug plan – has been offered but no study has examined PDP participation in Medicare.
- No study has looked at firms' joint decisions to enter local markets with different types of plans.

Firms' Joint-Entry Decisions (1)

- Inter-product competition.
  - MA payment rate is a key variable in our model.
  - Higher MA payment rate should lead to greater MA plan participation.
  - Effect of MA payment rate on PDP participation is complex:
    - MA plans may offer prescription drug coverage and at least one CCP plan must cover Rx.
    - Beneficiaries cannot hold both CCP and PDP.
    - We expect, therefore, that higher MA payment rate will 'crowd out' PDP plans.

Firms' Joint-Entry Decisions (2)

- Firms may share some costs across the three product types.
  - Advertising and marketing costs are an example.
  - PFFS and PDP plans can be jointly held.
  - We expect joint marketing of those plan types to be cost-saving.
- Shared costs would create economies of scope among products.
- We don't explicitly estimate the firm's multi-product cost function but we use an estimation method that is sensitive to economies of scope.

Recall Descriptive Results

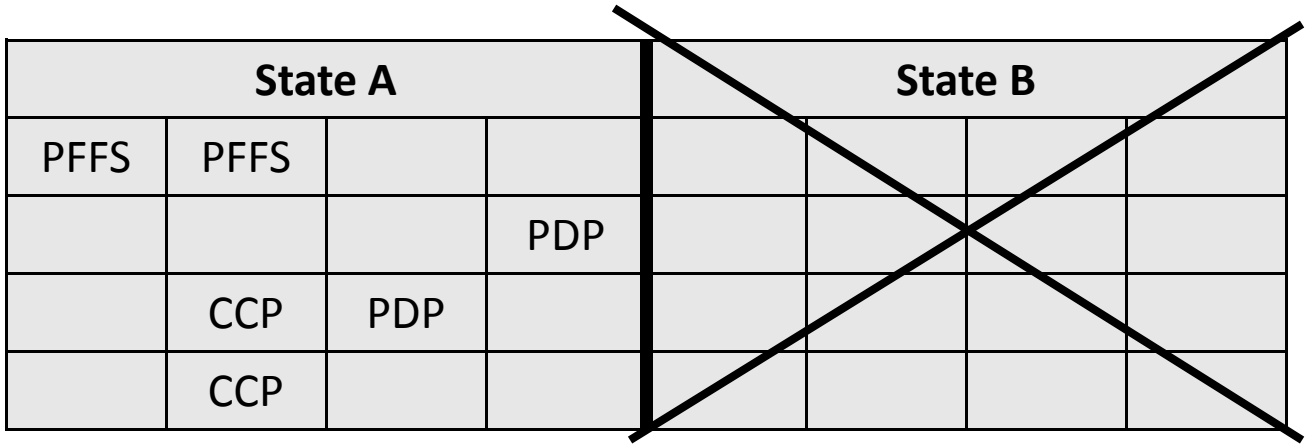
Firm	Pct. counties at risk for entry	Percent of counties in entry risk set entered with:							
		None	CCP only	PDP only	PFFS only	CCP & PDP Only	CCP & PFFS only	PDP & PFFS only	All
All firms in sample	61	22	0	51	0	2	0	23	2

Joint entry

- How will entry patterns change with MA payment rate?
- Controlling for cost and demand factors, is there strong correlation of entry between pairs of plan types?

Recall Data Details

- Same deal as before (year-county-firm, meaningful entry, drop state-firms with no activity).



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50% of counties at risk for entry.

Data Details (Variables)

Variable Description (Years)	Mean (SD)	[Min, Max]	Source
Entry			
CCP entry indicator (2007-2009)	0.04 (0.20)	[0.00, 1.00]	CMS
PDP entry indicator (2007-2009)	0.78 (0.42)	[0.00, 1.00]	CMS
PFFS entry indicator (2007-2009)	0.25 (0.44)	[0.00, 1.00]	CMS
Payment			
Benchmark payment rate (2007-2009)	769 (76)	[692, 1366]	CMS
Cost			
Average FFS cost (2007-2009)	659 (81)	[436, 1285]	CMS
Proportion of elderly 75+ years old (2000)	0.47 (0.05)	[0.21, 0.62]	CMS
General practitioners per capita (2006)	0.0003 (0.000)	[0.00, 0.00]	ARF
Hospital beds per capita (2005)	0.004 (0.005)	[0.00, 0.00]	ARF
Rural county (2003)	0.30 (0.46)	[0.00, 1.00]	ARF
Urban county (2003)	0.35 (0.48)	[0.00, 1.00]	ARF
Monthly drug Medigap premium (2005)	235.82 (34.00)	[180, 466]	-
Monthly non-drug Medigap prem. (2005)	136.33 (25.09)	[103, 263]	-
Aged/disabled risk score (2006)	0.96 (0.07)	[0.70, 1.35]	CMS
Demand			
Proportion elderly in poverty (1999)	0.12 (0.06)	[0.00, 0.48]	ARF
Per capita income in thousands (2005)	27.09 (7.01)	[0.00, 93.0]	ARF
Prop. 25+ pop. w/ HS diploma (2000)	0.77 (0.09)	[0.35, 0.97]	ARF
Prop. 25+ pop. w/ 4+ yrs col. (2000)	0.16 (0.08)	[0.05, 0.64]	ARF
Prop. workers manufacturing (2000)	0.16 (0.09)	[0.00, 0.49]	ARF
Prop. workers white collar (2000)	0.52 (0.08)	[0.31, 0.84]	ARF
Prop. workers construction (2000)	0.08 (0.02)	[0.02, 0.23]	ARF

Multivariate Probit Model

$$Y_i = \beta_{1i} Benchmark + \beta_{2i} Cost + \beta_{3i} Demand + \beta_{4i} (Year, Firm, and State FE) + \varepsilon_i$$

- Y_i = indicators for CCP, PFFS, PDP entry
- We estimate the model with multivariate probit, which allows the ε_i terms to be correlated across equations
- These correlations will capture economies of scope among products but also will pick up common unmeasured demand and cost variables

Key Results

Variable	CCP Entry	PFFS Entry	PDP Entry
Benchmark	0.27*** (0.00096)	0.41*** (0.065)	-0.18*** (-0.022)
FFS Cost	-0.063** (-0.00022)	-0.0078*** (-0.12)	0.068*** (0.0085)
rho	PDP-PFFS = 0.42, CCP-PDP = 0.30, CCP-PFFS = 0.10		

(Marginal effects) at the mean Benchmark = $769, mean FFS Cost = $659
*** = significant at .01, *** = significant at .001*

- Common unmeasured demand factors could explain PDP-PFFS residual correlation.
- Most likely unmeasured cost variable, network development, applies only to CCPs, explaining small CCP-PFFS residual correlation.

Simulation

Plan Type	Baseline Entry Probability	Simulated Entry Probability after Payment Cut	Absolute Change	Relative Change
CCP	14.0%	11.8%	-2.2	-15.7%
PDP	89.6%	90.6%	1.0	1.1%
PFFS	30.0%	25.5%	-4.5	-15.0%

Simulated changes in probability of entry in response to payment cut of one standard deviation in the 2009 benchmark-mean FFS cost difference ($58). All results beneficiary weighted.

Comments

- A simulated payment cut of $58 (one s.d. of the difference between the benchmark and FFS cost) would lead to 15% reduction in CCP and PFFS entry and modest increase in PDP entry.
- Congress is contemplating larger cuts.
- We did not calculate welfare effects from these changes, although our previous work (Pizer, Frakt, and Feldman, 2007 IJHFE) suggests that higher MA plan payments were an inefficient way to increase beneficiaries' consumer surplus.

Limitations

- Our results apply only to firms that offered all three plan types sometime between 2007 and 2009.
- During this period MA payment rates were well above FFS costs, so simulating the effect of MedPAC's recommendation (embodied in the House Leadership Bill) is outside the range of our data.
- We don't directly model economies of scope among plan types.

Follow-Up

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