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Updating Medicare Managed Care

The Medicare managed care program has been around for nearly 20 years; however, it has only been in the last 10 years that the program has seen significant growth in membership and visibility. At the inception of the program, the federal government could only contract with state-licensed managed care organizations (MCOs) to provide the full range of Medicare benefits for a fixed monthly amount. MCOs that could provide the full range of benefits for less than what the government paid were (and still are) required to provide additional benefits that equaled the cost of the savings. Any losses posted by the MCOs were fully borne by the MCO – hence the name "risk" managed care program. Throughout the early years of the Medicare managed care program, it was typical to see increases in the monthly payment rate of 5%-10% annually. This allowed MCOs to offer products with many benefits that were not covered by traditional Medicare. Enrolling in a Medicare MCO was (and still is) voluntary; however, a Medicare beneficiary who enrolled in an MCO gave up the freedom of choice to select his own health care provider – a right guaranteed by the Original Medicare program – in return for the cost savings and additional benefits of a Medicare MCO.

On August 28, 1997 President Bill Clinton signed into law the Balanced Budget Act (BBA). One of the key goals of this piece of legislation was to create choice in the Medicare program for Medicare beneficiaries – hence, the program became known as "Medicare+Choice" (M+CO). The BBA expanded the list of MCOs that the federal government could contract with beyond traditional HMOs, allowing for preferred provider organizations (PPO), medical savings accounts (MSA), provider sponsored organizations (PSO), private fee for service plans (PFFS), and religious fraternal benefit organizations (RFB) to also contract with the federal government to provide Medicare benefits to the growing number of beneficiaries across the country. The idea was that by expanding the types of entities that could provide Medicare benefits, more beneficiaries would ultimately have a "choice" in how they received their Medicare benefits. The BBA also capped the annual increase in the payments to MCOs to the greater of a 2% update, a blended rate of national and local rates, or a floor amount. Since the enactment of the BBA, the blended rate has only been triggered once, so for the most part, payment increases to MCOs have been at the legislatively mandated amount of 2%. Remember that prior to the BBA, annual payment increases to the MCOs were in the neighborhood of 5%-10% annually, so MCOs definitely view 2% increases as a reduction from previous levels. (Note that in 2001, the annual limit was raised just for 2001, from 2% to 3%.)

Where is Medicare managed care now? Medicare+Choice has not lived up to its name. Since the passage of the BBA in 1997, the number of contracted M+COs has dropped, from a high of 456 in December 1998 to 253 in December 2001. Total enrollment in M+COs has dropped from 6.7 million in December 1998 to slightly over 6 million in December 2001. The biggest impact of the BBA, however, has been in the pocketbooks of the Medicare beneficiary. With growth capped largely at 2% annually, MCOs began to pass costs on to the beneficiary. In 1997 when there were 236 $0 premium plans available nationwide, now there are less than 50. Additional benefits beyond what Original Medicare offered were common among MCOs in December 1998.

Prescription drug coverage was offered by 67% of MCOs, dental coverage by 37%, vision coverage by 83%, and hearing coverage by 72%. Now, fewer than 100 total plans offer any of these benefits. And prescription drug coverage (when offered) went from commonly being unlimited for both brand and generic coverage in December 1998 to tight limits (if any coverage at all) in December 2001. Drug formularies, unheard of in 1997, are now standard.

As stated above, the "choice" in Medicare+Choice did not materialize with the passage of the BBA. There has been the addition of one private fee for service plan and several PSOs and PPOs, but the expected growth in the numbers of these types of MCO options has not happened. Lastly, the intended growth of MCO options in rural areas has not materialized. Overall, beneficiaries have less choice in 2002 in their MCO options and less choice in their benefits covered by MCOs than they had in 1997.

What is the future of Medicare managed care? Initial legislation has passed on Capital Hill that will increase the annual amounts that MCOs receive monthly from the federal government for their Medicare programs. If such legislation becomes law in 2002, the possibilities of Medicare managed care as seen in 1997 may come to fruition, but with the current application process as it stands, growth will most likely not occur until 2003. In the meantime, MCOs will continue to make business decisions that allow them to withdraw from the Medicare program, increase premiums, or reduce benefits to the Medicare beneficiaries they have elected to serve.

About the Author

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