7/29/04

CHOICES FOR MEDICARE ADVANTAGE

The Medicare Modernization Act (MMA) expands the existing options available to Medicare beneficiaries to enroll in private health plans. Currently, about 4.7 million beneficiaries are enrolled in these plans, known as Medicare Advantage local plans. The key expansion is the MMA's new regional contracting option for health plans, called Medicare Advantage regional plans. The proposed regulation issued by the Centers for Medicare & Medicaid Services would propose to implement these and other changes to the Medicare Advantage program. The new regional plans, which will be available in 2006, are structured as preferred provider organizations (PPOs), which have a network of doctors and hospitals that contractually agree to provide health care services at a specified rate but also allow enrollees to go outside the network for care, usually for an additional charge. PPOs are now the most popular type of coverage in the private market in the U.S. In 2002, 52 percent of Americans covered under group health insurance programs were enrolled in PPOs. Also addressed in the proposed regulation is a new option created by the MMA that allows specialized plans for Medicare beneficiaries who have special needs, such as the institutionalized, those with Medicaid, and individuals with severe or disabling chronic conditions.

Increased funding designed to stabilize the Medicare Advantage program, in addition to special financial incentives for Medicare Advantage regional plans in the initial years after this plan option becomes available (discussed below), should serve to make more Medicare Advantage options available to more Medicare beneficiaries. Beneficiaries will receive materials each fall that outline the options available to them and direct them to sources for additional information, enabling them to make the choice best suited to their needs.

Benefits

Medicare Advantage plans must provide all Medicare-covered benefits. Most Medicare Advantage local plans currently provide limited, if any, coverage if their enrollees choose to go outside the network for non-emergency care. And they are not required to have a single deductible or catastrophic limit on enrollee out-of-pocket costs. Beneficiaries in Medicare Advantage regional plan beneficiaries will typically pay the least when they remain in network, and they may have to pay higher cost-sharing for covered services received outside the network, but they will have more generous coverage of care provided outside the network than that available in most local plans. In addition, unlike traditional fee-for-service Medicare with its separate deductibles for Parts A and B, regional Medicare Advantage plans are required to have a single, unified deductible (if they feature a deductible at all), though they may waive the deductible for preventive services and other services. Regional Medicare Advantage plans must also feature a catastrophic limit on out-of-pocket expenditures for in-network services, and a limit for all covered services.

Regions

Unlike local plans, which serve individual counties and groups of counties chosen by the plan sponsor, the new regional PPOs will bid to serve an entire region, which may be a state or multi-state area. The goal of these larger regional markets is to bring more plan options to rural areas by grouping them with the urban areas that have traditionally attracted managed care plans under the Medicare+Choice program. The Medicare Advantage regional plans may operate in more than one region, or even nationally. Following a market survey that will be completed later this year, as well as public comment, the Secretary will establish 10 to 50 Medicare Advantage regions, designed to maximize plan participation and beneficiary choices.

Financial Incentives for Regional PPOs

Risk Corridors

To encourage the offering of regional Medicare Advantage plans, MMA provided for risk sharing for Part A and B health benefits to be in effect for 2006 and 2007. Risk corridors will allow the government to share in any unexpected gains or losses that the plans incur and help plans in the early years of the regional plan program while they gain experience covering the Medicare population on a regional basis. With the risk corridors, a target amount of plan spending is set to equal the total payments to plans from the government and enrollee premiums, minus the plan's administrative costs assumed in its bid. Actual costs at the end of the year are then compared to this target amount. The risk corridors are symmetrical in that the government pays plans if costs are above the target and recoups its share of the savings when costs are below the target.

- The plan is fully at risk for the first 3 percent of costs above or below a target amount.
- The plan and the government share 50 percent of costs/savings that are 3 to 8 percent off the target.
- The government pays/keeps 80 percent of the costs/savings that are more than 8 percent off the target.

Plan Entry and Retention Fund

Starting in 2007, a plan entry and retention fund will be created consisting of $10 billion in appropriated funds plus additional monies from the bidding process (half of the government's portion of the savings based on the difference between the regional plans' bids and the regional bidding benchmarks). The fund is available through 2013 and can be used several ways:

- National Bonus. If a health plan enters the program nationally (by bidding to provide a Medicare Advantage regional plan in all regions), then its benchmark payment in each region is increased by 3 percent. This payment is available for one year only, and it is not available if a national plan was available the prior year.

- Regional Plan Entry Bonus. If no regional Medicare Advantage plans serve a given region in one year, then the Secretary may increase payments for plans in that region for the following year. The Secretary can choose how large the

increase is and how long it lasts.

- Regional Plan Retention Bonus. If plans signal that they are going to leave a region, the Secretary may increase the benchmark in that region in an effort to keep the remaining plans and attract new bidders. Two additional conditions must be met: the exits must result in fewer than two regional organizations being available, and the Medicare Advantage enrollment share in the region must be less than the national Medicare Advantage enrollment share. The Secretary can choose how high to raise the benchmark (within certain limits), and the increase can last for up to two years.

All of the above payments are subject to the overall budget constraints for the plan entry and retention fund. The Secretary and the CMS actuaries must certify that there is enough money in the fund to cover the payments, and they may limit enrollment in regional plans receiving the payments to make sure enough money is available. The Secretary must also periodically report to Congress about how the plan entry and retention fund has been used and the market conditions in regions that make its use necessary.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecomments