By Gretchen Jacobson

The **Emerging Role** of **Private Plans** in Medicare

Thirty percent of Medicare beneficiaries are now covered under private plans. How has this growth changed Medicare, and what are the implications for the future?

Private plans have been part of the Medicare program, and an alternative to traditional Medicare, since the program's inception. A hallmark of the Medicare program has always been that enrollment in private Medicare plans is voluntary. When people become eligible for Medicare, the default is enrollment in traditional Medicare.

Today, more than 15 million, or three in ten people on Medicare are enrolled in private plans, and the rest are in traditional Medicare (see Figure 1, page 79). Almost every person on Medicare (99 percent) has access to at least one private Medicare plan, and the average person on Medicare can choose from among eighteen private plans (Kaiser Family Foundation, 2014). The Medicare Advantage program that exists today—including its wide array of plans, the large number of beneficiaries enrolled in plans, the rules plans are required to follow, and the federal payments to plans—is the result of many years of policy development.

How Did the Current Medicare Advantage Program Develop?

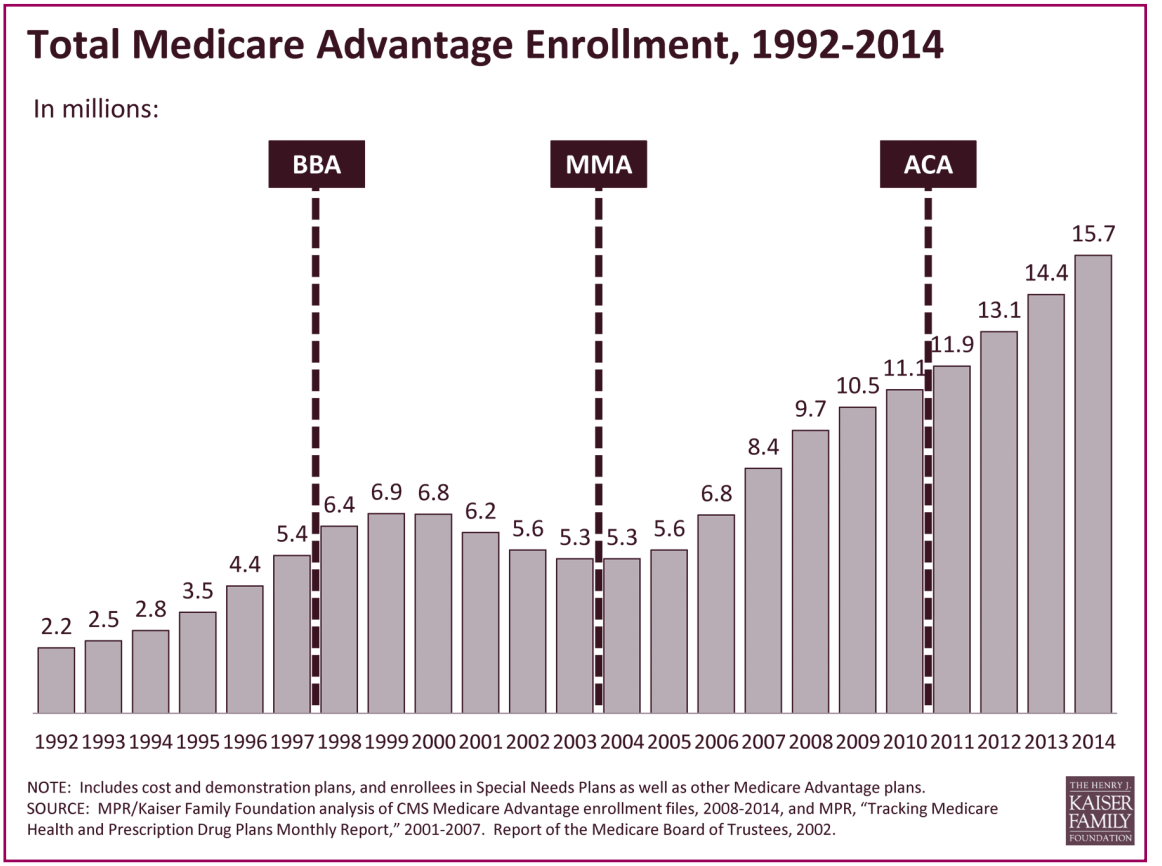
The role and prominence of private plans in the Medicare program have changed through the years in response to new policies, many of which were the product of a tension between providing sufficient choices to people on Medicare and budget constraints on payments to plans. The idea behind private plans in Medicare has been that private plans could coordinate care for beneficiaries with complex health needs, offer additional benefits not provided by traditional Medicare, and compete with each other for enrollment by way of lower prices, better benefits, and higher quality of care (McGuire, Newhouse, and Sinaiko, 2011). However, factions have continually disagreed about how much the federal government should pay Medicare private plans to meet these objectives (Coulam, Feldman, and Dowd, 2011). Thus, the story of private plans in Medicare reflects shifts in prevailing ideology about payment to plans and differing visions for Medicare's future.

Today, three in ten people on Medicare are enrolled in private plans, and the rest are in traditional Medicare.

The early years

Private plans were recognized in the statute that created the original Medicare program. These first private plans were what is now thought of as "staff-model" HMOs (such as

Figure 1.



Kaiser Permanente or Group Health Cooperative), in which doctors were employed by and received a salary from the healthcare system, and they received the same salary regardless of how many patients they saw or how many tests they performed. Including these plans in the Medicare program allowed people who received care from these healthcare systems prior to going on Medicare to continue to receive their healthcare from the same doctors and hospitals after they were on Medicare. These private plans were paid on a reasonable-cost basis, meaning Medicare would pay the plans what the program would otherwise have paid for the service, because the salary structure of these health systems made it difficult to define what specific services cost the healthcare organization (Zarabozo, 2000).

Then, in 1972, Congress amended the Social Security Act to define the term HMO and allow HMOs to contract with the Medicare program. Like Medicare managed care plans today, these plans had to provide all Medicare benefits and had to be available to all people on Medicare in any area in which they were offered (regardless of health status). Managed care plans received payments based on the average costs the Medicare program would have otherwise incurred for the plans' enrollees (known as the adjusted average per capita cost, or AAPCC). This payment structure allowed other types of HMOs (in addition to staff-model HMOs) to participate in the Medicare program and form networks of doctors and hospitals to treat the plans' enrollees. In turn, the plans took more financial risk because the federal payments were not tied to how much

healthcare a person actually used. This option was not popular with healthcare organizations, and very few chose to offer these plans to people on Medicare (Langwell and Hadley, 1989).

The 1980s: effects of the Tax Equity and Fiscal Responsibility Act

Ten years later, in 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which lowered payments to Medicare HMOs (to 95 percent of the AAPCC), based on the idea that HMOs were purportedly more efficient than traditional Medicare. Additionally, if HMOs' projected costs were lower than the federal payments, then the plan either had to use the difference between costs and payments to provide extra benefits to enrollees, or return the difference to the federal government. The differences between plan costs and federal payments (and extra benefits for plan enrollees) tended to be much larger in places where traditional Medicare spending was high, such as Miami, Los Angeles, and other urban areas. The differences between costs and payments (and the extra benefits) tended to be smaller in places where traditional Medicare spending was lower, such as Minnesota, Oregon, and other rural areas.

Following TEFRA, in the late 1980s and early 1990s, the number of HMOs contracting with Medicare declined, yet enrollment in plans continued to rise (Langwell and Hadley, 1989). One reason private plans continued to be attractive for people on Medicare is that many plans provided prescription drug coverage, which was a benefit not available in traditional Medicare. However, disenrollment from the plans was also high; about three in ten plan enrollees disenrolled from their plan and switched to traditional Medicare within two years of enrolling in a Medicare HMO (Langwell and Hadley, 1989).

Healthier people were also more likely to join Medicare HMOs than sicker people (Zarabozo, 2000). Medicare HMOs had a strong financial incentive to enroll only healthy people, and may have directed marketing efforts to healthy people on Medicare. As an extreme example, if a plan had enrollees who were so healthy that they used no healthcare, then the plan would receive payments from the federal government for the enrollees and would have very few expenses. In the absence of adjustments in payments for enrollees' health status and projected use of healthcare (i.e., providing higher payments for sicker enrollees), plans had no incentive to enroll sicker people. TEFRA required payments to be adjusted for some factors (namely, age, gender, institutional status, Medicaid status, and separate rates for elderly and disabled), but these factors explained little of the differences in Medicare spending (Congressional Budget Office [CBO], 1990).

The 1990s: the Balanced Budget Act passage and Medicare

In the 1990s, with the managed care revolution, Medicare HMO enrollment continued to grow rapidly. In areas in which Medicare HMOs were available, about 20 percent of people on Medicare were enrolled in a Medicare HMO (Buckley and D'Amaro, 1998). Additionally, the percentage of people on Medicare with access to an HMO grew from about 50 percent in 1993 to 74 percent in 1998 (Buckley and D'Amaro, 1998).

In 1997, Congress passed the Balanced Budget Act (BBA), which included some of the most significant changes to Medicare private plans. The Act created a Part C of the Medicare program (adding it to Parts A and B), and named it "Medicare + Choice." It also allowed a new alphabet of plans to contract with Medicare and provide Medicare benefits to beneficiaries, including provider sponsored organizations (PSO), preferred provider organizations (PPO), medical savings accounts (as a demonstration), private fee-for-service (PFFS) plans, and religious fraternal benefit organizations (RFB).

Like prior legislation, the BBA changed how the plans were paid. The BBA was enacted to reduce deficit spending and balance the federal

budget. For Medicare private plans in particular, the BBA also aimed to address the disparities in extra benefits offered by plans in areas with high versus low traditional Medicare spending, and encourage organizations to offer plans in areas with lower traditional Medicare spending—areas historically less likely to have managed care plans. The BBA set payments to plans so that they were a blend between national and local traditional Medicare spending. In the counties with the lowest traditional Medicare spending, it also established minimums that plans would be paid (known as *payment floors*). Additionally, it specified a minimum increase in federal payments to the plans each year (at least 2 percent), and plans in counties with lower payments received larger annual increases in payments. Lastly, the BBA attempted to address plans' disincentive to enroll sick people by requiring payments to the plans to be adjusted for the health status of plan enrollees, and providing higher payments for enrollees in poorer health.

Overall, plans asserted that their costs outstripped federal payments from the BBA, and the Medicare private plan program after the BBA was perceived to be spiraling downward. Between 1998 and 2000, many organizations stopped offering plans in areas that were no longer profitable, leaving many enrollees without an available plan. In response, Congress increased payments to plans twice—first with the BBA Refinement Act of 1999, and then with the Benefits Improvement and Protection Act (BIPA) of 2000. Nonetheless, total enrollment in plans continued to decline.

The 2000s: prescription drugs and additional plan refinements

Many of the plans that continued to be available provided prescription drug coverage as an extra benefit to enrollees. Given that private plans were only offered in select areas of the country, the lack of prescription drug coverage in traditional Medicare began to be viewed as problematic and inequitable. Thus, Congress began debating whether to add a prescription drug benefit to the Medicare program and, at the end of 2003, it passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which created the Part D prescription drug program.

The MMA also renamed the Medicare + Choice program to "Medicare Advantage," and increased federal payments to plans. The Act required plans to give back to the federal government a portion of the difference between the plan's estimated costs and the maximum federal payment (and continue to use the rest to provide extra benefits). The MMA also established regional PPOs as a new plan type. Regional PPOs are required to provide coverage for an entire state (or multi-state region), in an effort to provide beneficiaries in rural areas greater access to plans. And it further improved the system of adjusting the payments to plans to account for enrollees' health status, although concerns about the system persisted (Riley, 2012).

After the MMA, enrollment in Medicare Advantage plans grew rapidly, and virtually every person on Medicare had access to at least one plan. Plans provided many extra benefits, including eye care, dental care, and even gym memberships. However, it began to be noted that the federal government paid more for people on Medicare Advantage plans than it would cost to cover the same people in traditional Medicare (Medicare Payment Advisory Commission, 2009).

As a result, as part of the Affordable Care Act (ACA), payments to plans were reduced and tied to the costs of traditional Medicare. As a consequence, when traditional Medicare spending decreased, so did payments to plans. To continue to encourage organizations to provide plans in areas with lower traditional Medicare spending, the ACA continued to pay plans more than the average costs of traditional Medicare in these areas. It also paid plans less than the average cost of traditional Medicare in areas with the highest Medicare spending. The ACA also required plans to meet minimum medical loss ratios, such that medical expenses for the plans'

enrollees must comprise at least 85 percent of plans' expenses, and profits and administrative expenses can comprise no more than 15 percent of expenses. Finally, the ACA provided bonus payments to plans with high-quality ratings.

Plan Scandals and Schemes

Like other profitable businesses, Medicare HMOs have at times been involved in scandals, including unethical marketing and unsavory business practices. Consequently, marketing rules and operating regulations have become more specified, and federal oversight has increased.

The International Medical Center

One of the largest scandals that occurred in the nascent years of the program involved the International Medical Center (IMC). In 1987, Miguel Recarey, Jr., president of IMC, the largest Medicare HMO at the time, was indicted and charged with allegedly authorizing kickbacks in 1980 and 1982 to the president of the largest labor unions in Miami, to garner the contract to provide healthcare to union members (Pear, 1987). Recarey also was charged with obstructing justice and bribing a potential grand jury witness, as well as eavesdropping and illegal wiretapping of the conference room used by government auditors who were investigating IMC. Recarey fled the country before the FBI could take him into custody, and has been a fugitive from justice since then (GAO, 1994).

Marketing and enrollment

Marketing scandals with Medicare private plans also have occurred over the years. These marketing schemes have been compounded by the fact that a sizeable number of people on Medicare are cognitively impaired, frail and non–English speaking people who may be easier targets and require more protections. Some plans used questionable enrollment tactics in an effort to enroll the healthiest older people (known as "cherry-picking"). Some organizations would market their plans primarily in places where healthy enrollees are more likely to be present, such as exercise clubs or on the upper floors of buildings without elevators (Federal Register, 1999; Neuman et al., 1998). Other organizations would ask people about their health status prior to enrolling them in the plans, or would encourage people with high medical costs to disenroll from the plan. The financial allure of these schemes has been somewhat dampened by improving methods for adjusting federal payments for the health status of plan enrollees, and by tightening regulations.

Other schemes were broader in scope, and simply aimed to enroll more people. For example, one health plan allegedly told a group of Spanish-speaking elderly people on a bus to Atlantic City that the papers they were signing would get them information about the health plan (Moon, 2001). Instead, their signature had enrolled them in the plan. Other plans enrolled people with Alzheimer's Disease, who did not know what they were signing (Moon, 2001).

Over the years, the federal government has addressed these schemes by proscribing permissible financial incentives and requirements for plans and plans' sales agents. Additionally, organizations are now subject to sanctions (e.g., suspension of enrollment, suspension of payment) if they are found to engage in deceptive practices or practices that would reasonably be expected to discourage enrollment of certain individuals. Yet, oversight and prevention of fraud and abuse in Medicare Advantage continues to be a challenge as the program continues to grow (OIG, HHS, 2012).

Looking Ahead: Opportunities and Challenges

Today, fifty years since Medicare's inception, private plans have emerged as an important part of the Medicare program, and enrollment in Medicare private plans is projected to continue to increase (CBO, 2014). The growing role of private plans in the Medicare program presents both opportunities and challenges for Medicare

beneficiaries, organizations offering plans, and the federal government.

For many people on Medicare, including people in traditional Medicare, private plans seem to be an attractive option (Jacobson, Neuman, and Damico, 2015). Part of the allure may be plans' lower cost-sharing, which provides an opportunity for people on Medicare to reduce their out-of-pocket costs. Plans also may help coordinate the care of people with high medical needs and may provide higher quality of care to enrollees; however, the evidence appears to be inconclusive and varies from one plan to the next (Gold and Casillas, 2014).

For organizations offering Medicare private plans, the critical factor has always been the size of federal payments relative to costs. Organizations have responded to changes in payments by offering plans in areas where they can make a profit, resulting in more plans in areas with more beneficiaries and larger profits (McGuire et al., 2011). As a consequence, the number of plans available to people on Medicare ranges from more than forty plans in New York City to fewer than ten plans in many rural areas (Kaiser Family Foundation, 2014).

For the federal government, the largest challenge has been in setting fair payments to plans to provide Medicare-covered benefits, without "overpaying," given ongoing concerns about federal spending (Biles et al., 2012; Kronick and Welch, 2014). This challenge has become even more important as increasing numbers of people opt to receive Medicare coverage from private plans. As the role of private plans in the Medicare program continues to evolve, policy will need to continue to adjust in response to changes in the marketplace and to provide sufficient resources for the federal government to oversee plans and ensure the integrity of the program.

Some organizations would market their plans primarily in places where healthy enrollees are more likely to be present, such as exercise clubs or on the upper floors of buildings without elevators.

Private plans also present challenges for enrollees, including difficulty understanding plans' complex benefits and selecting a plan that meets their medical needs (Jacobson et al., 2014). There also is some concern that benefits may decline and cost-sharing may increase in response to ACA reductions in payments to plans (Ignagni, 2013). A relatively new concern has been that some plans change their provider networks at various times during the year, potentially disrupting some enrollees' care unless they change plans (Fairfield County v. UnitedHealthcare of New England Inc. et al., 2013).

Gretchen Jacobson, Ph.D., is associate director with the Henry J. Kaiser Family Foundation's Program on Medicare Policy in Washington, D.C. She can be contacted at jacobson@kff.org.

References

Biles, B., et al. 2012. "The Impact of Health Reform on the Medicare Advantage Program: Realigning Payment with Performance." The Commonwealth Fund. www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Oct/1637_Biles_impact_hlt_reform_Medicare_Advantage_rb.pdf. Retrieved March 31, 2015.

Buckley, J. E., and D'Amaro, R. 1998. *Health Benefits in 1998*. Arlington, VA: KPMG Peat Marwick.

Congressional Budget Office (CBO). 1990. "Managed Care and the Medicare Program: Background and Evidence." http://1.usa.gov/1H4YAYN. Retrieved March 19, 2015.

CBO. 2014. "Medicare Baseline." http://1.usa.gov/1MOa4D. Retrieved December 24, 2014.

Coulam, R. F., Feldman, R. D., and Dowd, B. E. 2011. "Competitive Pricing and the Challenge of Cost Control in Medicare." *Journal of Health Politics Policy and Law* 36(4): 649–89.

Fairfield County v. UnitedHealthcare of New England Inc. et al. Case 3:13-cv-01621-SRU (D. Conn., Nov. 6, 2013).

Federal Register. 1999. *Publication of the OIG's Compliance Program Guidance for Medicare + Choice Organizations Offering Coordinated Care Plans*. Office of Inspector General, Department of Health and Human Services. 64(219): 61893–910. http://1.usa.gov/1OaEYI3. Retrieved March 19, 2015.

General Accounting Office (GAO). 1994. "Fugitives: U.S. Efforts to Find Miguel Recarey." *Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives*. www.gao.gov/products/OSI-95-7. Retrieved March 19, 2015.

Gold, M., and Casillas, G. 2014. "What Do We Know About Health Care Access and Quality in Medicare Advantage versus the Traditional Medicare Program?" Kaiser Family Foundation. http://bit.ly/1uRepyN. Retrieved March 19, 2015.

Ignagni, K. 2013. Letter to Marilyn Tavenner, Administrator of the Centers for Medicare & Medicaid Services. November 19. http://www.ahipcoverage.com/wp-content/uploads/2013/11/doc00312720131119153110.pdf. Retrieved March 31, 2015.

Jacobson, G., Neuman P., and Damico, A. 2015. "At Least Half of All Medicare Advantage Enrollees Had Switched from Traditional Medicare, 2006–11." *Health Affairs* 34(1): 48–55. http://bit.ly/1BDpGSe. Retrieved March 19, 2015.

Jacobson, G., et al. 2014. "How Are Seniors Choosing and Changing Health Insurance Plans?" Kaiser Family Foundation. http://bit.ly/RCorTY. Retrieved March 19, 2015.

Kaiser Family Foundation. 2014. "Medicare Advantage Fact Sheet." http://bit.ly/1hvQQEQ. Retrieved March 19, 2015.

Kronick, R., and Welch, W. P. 2014. "Measuring Coding Intensity in the Medicare Advantage Program." *Medicare and Medicaid Research Review* 4(2): E1–19. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4109819/pdf/mmrr2014-004-02-a06.pdf. Retrieved March 31, 2015.

Langwell, K. M., and Hadley, J. P. 1989. "Evaluation of the Medicare Competition Demonstrations." *Health Care Financing Review* 11(2): 65–80. http://go.cms.gov/19Dz4Q3. Retrieved March 19, 2015.

McGuire, T. G., Newhouse, J. P., and Sinaiko, A. D. 2011. "An Economic History of Medicare Part C." *Milbank Quarterly* 89(2): 289–332. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/. Retrieved March 31, 2015.

Medicare Payment Advisory Commission (MedPAC). 2009. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC. http://medpac.gov/documents/reports/march-2009-report-to-congress-medicare-payment-policy.pdf. Retrieved March 31, 2015.

Moon, M. 2001. "Hearing on the Medicare + Choice: Lessons for Reform." Testimony before the Subcommittee on Health of the House Committee on Ways and Means. May 1. http://1.usa.gov/1CyxqdA. Retrieved March 19, 2015.

Neuman, P., et al. 1998. "Marketing HMOs to Medicare Beneficiaries: Do Medicare HMOs Target Healthy Seniors?" *Health Affairs* 17(4): 132–9. http://bit.ly/1DD9ZRX. Retrieved March 19, 2015.

Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). 2012. "Medicare Advantage Organizations' Identification of Potential Fraud and Abuse." OIE-03-10-00310. February 2012. http://1.usa.gov/1qtk0Mb. Retrieved March 19, 2015.

Pear, R. 1987. "Head of Health Plan Accused of Illegal Payments." *The New York Times*, April 23. http://nyti.ms/1Ewpmqg. Retrieved March 19, 2015.

Riley, G. F. 2012. "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service." *Medicare and Medicaid Research and Review* 2(4): E1–16. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006478/pdf/mmrr2012-002-04-a08.pdf. Retrieved March 31, 2015.

Zarabozo, C. 2000. "Milestones in Medicare Managed Care." *Health Care Financing Review* 22(1): 61–7. http://go.cms.gov/1FGDeCP. Retrieved March 19, 2015.