
Social and Economic Determinants of Medicare Managed Care Participation

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This edition of the *Health Care Financing Review* is dedicated to examining the social and economic determinants of Medicare managed care participation, to learn from past experiences and to anticipate future concerns. The seven theme articles examine and help to explain:

- How economic factors impact the decision by managed care plans to select their market areas.
- The role of social and economic factors in explaining the decision beneficiaries make in choosing among health plan choices.
- The variation in health services received by Medicare beneficiaries, due to local market forces, additional programs, and resources.

BACKGROUND

Medicare provides health benefits to nearly 41 million elderly and disabled Americans. The traditional fee-for-service (FFS) program, a pay-per-visit health plan where you choose doctor, hospital, or other health care supplier who accepts Medicare, covers approximately 37.5 million beneficiaries. Medicare managed care, a health plan where the plan coordinates use of health services by its enrolled members in order to contain health expenditures and/or improve quality covers approximately 4.6 million Medicare beneficiaries. From 1997 to 2003, beneficiaries

saw premiums increase, a reduction in benefits, high physician turnover rates and plan withdrawals which led to Medicare managed care program instability. Since 2000, 1.7 million beneficiaries have left the Medicare managed care program. From 1997 to 2003, the number of Medicare managed care plans decreased, from 346 plans in 1998 to 299 plans in 2004.

RECENT MEDICARE CHANGES

The 2003 Medicare Modernization Act (MMA) significantly changed the Medicare Program in an attempt to bring people with Medicare more choices in health care coverage and better health care benefits. The MMA strengthened the current Medicare Program by adding new coverage for prescriptions and preventive benefits and expanding the choice of health plans. Changes made to the way Medicare pays Medicare Advantage (MA) plans attempts to entice health plans to join the Medicare Program. Beneficiaries have the opportunity to get more benefits than they have now.

CHOOSING A HEALTH PLAN

While it is important to know why health plans decide to join the MA program it is equally important to understand how and why the beneficiary chooses among the various Medicare health plan choices. Traditional FFS Medicare, which offers beneficiaries identical premiums and benefits no matter where they live, contrasts

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with MA plans which offer different premiums and benefits in different areas, resulting in wide geographical variations in costs and access to services to plan enrollees. Beneficiaries who are used to the stable benefits available in the FFS program have difficulty understanding the MA program. Each MA plan offers different benefits packages and at varying premium costs. Beneficiaries have the responsibility for choosing among the plans available to them to find the plan that best suits their needs and preferences. The lack of standardization makes the comparison of health plans difficult and confusing for beneficiaries.

IMPACT OF VOLUNTARY AND INVOLUNTARY DISENROLLMENT ON VULNERABLE SUBGROUPS

Much can be learned about how well the Medicare managed care program works by looking at a variety of factors, such as disenrollment, the lock-in provision, financial status of the beneficiary, and plan payment incentives. Each of the following articles spotlights how one of these factors affects program participation by either the health plans or the beneficiaries. The article by Schoenman, Parente, Feldman, Shah, Evans, and Finch describes the impact of health plan withdrawal on vulnerable Medicare beneficiaries. The article by Parente, Evans, and Schoenman examines the changes in health care use and expenditures of beneficiaries when a health plan withdraws from Medicare. The authors found that the two major consequences of plan withdrawal were an overall reduction in beneficiary utilization of services and their increase in out-of-pocket costs. Additionally, traditionally vulnerable subgroups were more confused about their choices and were less able to understand the financial

implications of their decisions. These articles highlight that even in a robust Medicare managed care marketplace, involuntary disenrollees faced adverse consequences when a health plan decided to exit the market even when there were other available health plan choices.

Mobley, McCormack, Booske, Wang, Brown, West, Lynch, Squire, and Heller examined voluntary rather than involuntary disenrollment to learn the impact of differential disenrollment patterns. The authors found that the under age 65 disabled chose to leave their health plans at a proportionately higher rate than other beneficiaries and are more likely to cite problems with drug coverage and plan information than the over age 65 beneficiaries. Racial and ethnic minorities were more likely to cite access to care and services as the reasons for leaving. Knowing these differential patterns of disenrollment can be important indicators about the health plan's ability to manage entire patient populations versus the plan's desire to ensure favorable selection.

POTENTIAL CONSEQUENCES OF LOCK-IN PROVISION

One of the new features of the MA program is what is known as the "enrollment lock-in" provision. Beneficiaries will no longer be able to enroll and disenroll at will from Medicare health plans but rather will be locked-in to a plan for a set period of time. Laschober points out that the new lock-in rule adds a layer of complexity to the MA program and makes the comprehension of health plan choices more difficult, especially to the traditionally vulnerable sub-groups. The author also notes that in addition to the patterns of disenrollment being slightly higher for the vulnerable sub-groups, the timing of their disenrollment

differed from the general Medicare population. Laschober concluded that the lock-in provision may have a greater adverse impact on these subgroups.

FINANCIAL VULNERABILITY

The discussion so far has centered on traditionally vulnerable subgroups comprised of racial and ethnic minorities, the disabled, and the oldest beneficiaries. Two of the articles in this edition focus on financially vulnerable beneficiaries and their rationale for participating in the Medicare managed care program. The cost associated with each Medicare health plan plays an important role in their plan choice decisions. Robins, Heller, and Myers describe how financial well-being affected low-income beneficiaries access to services within their health plan. Beneficiaries were cognizant of the value and the quality of their health plan benefits and seemed to understand that to get more benefits than offered by traditional Medicare they needed to be in managed care plan. Satisfaction with the health plan product also appeared to be in part a function of overall plan affordability including premiums and co-payments.

Beneficiaries who are financial vulnerable are aware that the Medicare managed care program offered them supplemental insurance often at a lower cost than Medigap plans. A critical aspect of the MMA legislation is the opportunity for beneficiaries to obtain prescription drug coverage regardless of the health insurance delivery system they choose. One question is if the MA's expanded health insurance options will benefit the financially vulnerable. Atherly and Dowd estimate the effect of MA payments on low-income dually eligible beneficiaries and their decision to participate in traditional Medicare, with or without joining Medicaid. The

authors anticipate that a \$10 increase in monthly MA payments reduces the likelihood of dual program enrollment and FFS enrollment. The implications are that the MA program will become increasingly more attractive to low income beneficiaries and that the impact of adverse selection on the plans might be compensated for by the additional MA payments.

INCENTIVES FOR PLAN PARTICIPATION

The question of what is enough incentive to get a plan to join the Medicare managed care program is explored by Rachel Halpern. This author examines historical payment increases from 1999-2000 and 2000-2001 to determine if payment alone can predict plan program participation. While payment was an important factor, also significant were the number of beneficiaries enrolled in the plan and the financial viability of the plan. The importance of these findings is that increasing payment incentives to increase health plan competition may not be enough to maintain robust MA health plan choices.

CONCLUSION

The promise of the MMA is that it will be used to encourage efficiency and equity and to develop a more homogenous Medicare Program. These seven articles highlight the difficulties in attempting to create robust Medicare health plan markets across the United States to the benefit of the approximately 41 million Medicare beneficiaries. The Medicare Program relies on local marketplaces to deliver health care services to beneficiaries. The difficulty is that these local marketplaces are not the same. Inconsistencies in the Medicare Program, such as differential payment rates, uneven distribution of

beneficiaries and geographic variations in care, services, and providers together with a heterogeneous beneficiary population, makes for a less than efficient program. Incentives created to entice health plan participation might not be advantageous to beneficiaries due to increased program complexity and the need for individuals to understand the cost and benefits of individual choices. In order for the MMA to fully meet its promise these program variations must be taken into consideration.

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