The President's FY 1998 Budget:
Medicare Managed Care Reforms

PROPOSED CHANGES TO PAYMENT FOR MANAGED CARE PLANS

- **"GREATER OF" PAYMENT.** Starting in 1998, Medicare would pay managed care plans the greater of (l) a blended local/national rate; (2) a minimum payment amount; or (3) a minimum percent increase. Blended rates and minimum payment amounts would be updated based on projections of Medicare per capita growth.

- **IME/GME/DSH CARVE OUT.** Payments for IME, GME, and DSH would be carved out of the blended payment rates over a two-year period (50 percent in 1998; 100 percent thereafter) and provided directly to teaching and disproportionate share hospitals for managed care enrollees and to entities with recognized teaching programs.

- **ADJUSTMENT FOR FAVORABLE SELECTION.** Beginning in 2000, an adjustment would be made to payment rates to reduce Medicare's current overpayment, which results from managed care enrollees being, on average, healthier than beneficiaries who remain in fee-for-service. This adjustment would remain in place until a new health status adjusted payment methodology is implemented.

PROPOSED CHANGES WOULD REDUCED GEOGRAPHIC VARIATION IN RATES AND EXPAND CHOICE

- **BLENDED RATE METHODOLOGY AND MINIMUM PAYMENT AMOUNT-** The budget would dramatically reduce the current wide geographic variation in payment rates (monthly rates now range from $221 to $767). Managed care plans in relatively low payment counties would benefit from the blended rate. By 2002, 30 percent of their rate would be based on a higher national rate.

  The President's plan would create, for the first time, a national minimum payment amount which would significantly increase rates in isolated rural counties and could increase the number of managed care plans serving rural areas, especially with the entry of Provider Sponsored Organizations (PSOs) into the Medicare program. The blended payment rates, minimum payment and minimum increase would be implemented on a budget-neutral basis.

- **CHOICE PROVISIONS** - The budget proposes that beneficiaries receive comparative materials on all of their coverage options -- both managed care and Medigap. To help beneficiaries compare various plans, changes would be made to both the additional benefits offered by managed care plans and the standard Medigap packages. Medigap plans would be required to operate under the same rules followed by Medicare managed care plans. These Medigap reforms would: require annual open enrollment, prohibit

imposition of pre-existing condition exclusion periods and prohibit differential premiums based on age or health status.

$34 BILLION IN SAVINGS FROM MANAGED CARE ARE NOT EXCESSIVE

- **$18 BILLION IN SAVINGS RESULTS FROM SLOWING DOWN MEDICARE GROWTH.** Because rates would generally be updated based on projected Medicare growth, policies that would affect fee-for-service providers would also restrain the growth of managed care payments.

- **$6 BILLION IN SAVINGS RESULTS FROM REDUCING, EFFECTIVE IN 2000, THE CURRENT OVERPAYMENT TO PLANS DUE TO FAVORABLE SELECTION.** Research studies support basing payments on 90 percent of the AAPCC rather than 95 percent, to take into account that managed care enrollees are healthier than beneficiaries who remain in fee-for-service, a phenomenon referred to as favorable selection. In the last three years, the Medicare program has lost, at a minimum, $2.2 billion because of favorable selection into managed care plans, and over $1 billion in the last year alone.

- **$10 BILLION IN SAVINGS RESULTS FROM THE CARVE OUT OF IME/DME/DSH PAYMENTS.** This policy would guarantee that payments designed to compensate hospitals for conducting teaching programs and for caring for the neediest citizens are made directly to such hospitals for managed care enrollees. The carve out does not represent a reduction in payment for managed care enrollees.

  - Managed care plans can consider these funds available to such hospitals when they negotiate their rates.

  - A current law provision that requires non-contracting hospitals to accept the Medicare DRG amount as payment in-full would be modified to require non-contracting hospitals to accept the DRG amount, minus the IME/GME/DSH carve-out, as payment in-full.

THE BUDGET WOULD NOT FORCE MANAGED CARE PLANS TO CUT ADDITIONAL BENEFITS FOR ENROLLEES

- **THE BUDGET WOULD NOT DRAMATICALLY CHANGE RATES.** No county would receive a decrease in rates during the 5-year budget window, except in the year 2000. In 2000, almost 2/3 of counties (64 percent) would receive increases: the other counties would receive either no increase or a decrease no greater than 3.37 percent.

- **MARKET COMPETITION FORCES PLANS TO KEEP EXTRA BENEFITS.**

Since the beginning of the risk contracting program, market competition has been the driving force in determining the level at which plans establish their premium (if any) and additional benefits. In recent years, individual plans entering a market with a zero premium product, or plans choosing to reduce or eliminate their premium, have caused competing plans to follow suit rather than risk loss of market share. For example:

- San Francisco: In 1993, two of the three plans operating in San Francisco charged a premium. In 1994, six plans entered the market, two offering a $0 premium option. Today, all twelve plans operating in San Francisco offer a $0 premium option.

- Denver: In 1993, the four Medicare plans operating in Denver all charged a premium. In 1994, one plan dropped its premium to $0. Today, all seven plans operating in Denver offer a $0 premium option.

As payment reforms are implemented, the Administration expects market forces will continue to restrain premium increases.

- **COMPETITION WOULD INCREASE UNDER THE BUDGET**. The budget would increase competition in two ways:

  - **More Managed Care Choices** - Provider Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs) would be able to offer plans to Medicare beneficiaries and compete directly with HMOs.

  - **Medigap Reforms** - Medigap reforms would expand coverage options for beneficiaries. Today, beneficiaries who are dissatisfied with their managed care plan are locked-in because their Medigap choices are limited and generally do not include plans with drug coverage. With real freedom of choice, managed care plans will have to restrain premium increases in order to remain competitive with Medigap options, which still do not limit provider choice.

- **PLANS CAN REDUCE THEIR ADMINISTRATIVE COSTS AND PROFITS RATHER THAN REDUCE BENEFITS.** Part of Medicare's payment to plans is for the plan's administrative costs, including marketing costs and plan profits. In 1996, administrative costs ranged from less than 5 percent of total benefit costs to over 40 percent. Also in 1996, over 40 percent of plans showed administrative cost amounts in excess of 20 percent of benefit costs.