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## **Will Competition Return to Medicare?**

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## **Abstract**

One of the primary goals of the Medicare Modernization Act (MMA) of 2003 was to re-establish competition among private health plans in Medicare. At one level, that goal has been met. Thanks in part to more generous payment levels and more flexible regulations, numerous private plans now offer the new outpatient prescription drug benefit and most seniors can choose a comprehensive health plan (including preferred provider organizations, health maintenance organizations, and private fee-for-service plans) as an alternative to traditional Medicare. However, plans offering the drug benefit solely (rather than the full benefit package) are not sustainable without continued heavy subsidies, and defects in the design of the MMA inhibit effective competition between traditional Medicare and private plans. Although the drug benefit might prove to be a significant obstacle to future reforms, it is an important test of competition and consumer choice in Medicare.

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## **Introduction**

Private health plans have entered the Medicare market by the thousands with the advent of the outpatient prescription drug benefit. At last count, 1,413 prescription drug plans (PDPs) across the country are offering the new benefit as a stand-alone product in 2006.<sup>1</sup> In addition, there are 1,649 comprehensive health plans offering the full range of Medicare benefits (including drug coverage) in thousands of local areas. The average beneficiary has at least 40 drug plan options.<sup>2</sup>

Taken at face value, the large number of participating plans suggests that competition has returned to Medicare. Not only are there many suppliers in this market, but competition among those suppliers has driven down premiums for many of the plans.<sup>3</sup> The average monthly premium is \$32.20, about 13 percent below what had been expected, and most beneficiaries can enroll in plans with premiums under \$20.

However, it is too early for advocates of market approaches to declare victory in their ongoing debate with those who support greater government controls in health care. Enrollment in the new drug plans is anemic. During the first month of the open enrollment period, only 1 million beneficiaries made an explicit decision to sign up for one of the plans.<sup>4</sup> The large number of plan options has raised concerns that seniors would be paralyzed by too many choices and too much information.<sup>5</sup> Competition could be short-lived if consumers refuse to enter the market.

We have yet to see how the plans perform in practice, but the program has already been criticized for not reducing drug prices below what could be obtained at major retailers.<sup>6</sup> Over the long term, the new benefit will cost trillions of dollars even with a well-managed program. Rising budget deficits or perceived failures in the drug program could cause Congress to tighten regulatory controls or across-the-board cuts in Medicare's budget, which could drive out many private plans.

Competitive elements have been introduced into Medicare in the hope of lowering cost, raising efficiency, and maintaining or improving quality and consumer satisfaction. However, the competitive world envisioned by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 is at best a transition to effective Medicare competition. The system of stand-alone drug plans offering the benefit to seniors on a voluntary basis is not sustainable without the large subsidy and financial protections provided in the legislation. A competitive system that exempts traditional fee-for-service Medicare from direct competition places the private MA plans at a disadvantage that also has been resolved through subsidies that may not be sustained in the future. If we expect to reap budgetary savings from competitive reform, policymakers will have to restructure some of the key elements in Medicare's current design.

## **The Rise and Fall (and Rise Again) of Competition**

The idea that competition could yield substantial benefits to Medicare has been part of the policy debate for most of the program's forty year history. Although health maintenance organizations (HMOs) and group practice plans were first authorized as alternatives to traditional fee-for-service Medicare in 1972, few such plans entered the program.<sup>7</sup> The modern era of health plan competition in Medicare began with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

TEFRA established new payment rules for HMOs, which would receive 95 percent of the average cost of providing care under traditional Medicare. The health plan would be at full risk for costs above that rate, but could use any savings to increase benefits or reduce premiums paid by beneficiaries. The first risk HMOs began operation in 1985 with 87 plans. That number grew to 161 risk plans by 1987 before declining to 93 in 1991. Enrollment in such plans grew over that period, reaching 1.4 million beneficiaries by 1991.

Managed care came into its own in the mid-1990s. Mirroring growth in the private sector, Medicare HMO enrollment doubled between 1993 and 1996. By 1998, Medicare risk HMOs had 6.1 million enrollees, or over 15 percent of the Medicare population. Such plans became popular because they typically offered better benefits, particularly coverage for prescription drugs, than were available from traditional Medicare.

The rapid growth of managed care plans in both the public and private sectors sparked legislative attempts to broaden the scope of health plan competition in Medicare. After a failed attempt in 1995, Congress passed the Balanced Budget Act (BBA) of 1997.<sup>8</sup> The BBA established Medicare+Choice (M+C) as the component of Medicare offering private plan alternatives to the traditional program. New types of plans were authorized under M+C, including preferred provider organizations (PPOs) and private fee-for-service plans. Payment rates remained tied to the cost of care under traditional Medicare, but the structure of payments was changed to favor plans operating in rural and other areas that previously had no private health plan choice in Medicare. Plans accounting for most of M+C enrollment were limited to a 2 percent annual increase in federal payments, even though their expenses were rising more rapidly.<sup>9</sup>

Instead of encouraging health plan competition in Medicare, the BBA coupled with a backlash in the private sector against managed care had the opposite effect. Payments to M+C plans grew at a slower rate than had been expected as spending in traditional Medicare slowed.<sup>10</sup> HMOs saw their private markets contract as employers responded to employee demands for less restrictive health plans. As a result, many plans withdrew from M+C or reduced their service areas. Plans remaining in M+C cut back extra benefits and raised costs to enrollees.<sup>11</sup>

Legislation in 1999 and 2000 made further changes intending to enhance the M+C program, but that met with little success.<sup>12</sup> Consequently, the number of M+C contracts dropped from 412 in 1999 to 235 by 2003, and enrollment fell from 6.6 million beneficiaries to 5.1 million over that period.<sup>13</sup> Since M+C plans were concentrated in

large urban areas, mainly along the east and west coasts, many Medicare beneficiaries had no alternative to fee-for-service Medicare.<sup>14</sup>

The 2003 Medicare Modernization Act represents the boldest set of competitive reforms legislated to date. Unlike the BBA, which attempted to expand health plan choices while cutting their budgets, the MMA provides for billions of dollars in new funding for private plans.

Breaking with tradition, the new prescription drug benefit is available only through private plans. Beneficiaries in the traditional Medicare program who wish to receive the benefit must enroll in one of the many competing prescription drug plans in their local area. Moreover, the plans can vary many of the details of the benefit (such as deductibles, copayments, coverage in the infamous doughnut hole,<sup>15</sup> and drugs available on the plan's formulary) rather than adhering strictly to the standard benefit design specified in law. This is a major departure from the uniformity of traditional Medicare.

The MMA also revamped Medicare+Choice. Renamed Medicare Advantage (MA), the program includes private plans that operate in state-wide or multi-state regions as well as plans that operate in self-selected market areas determined on a county-by-county basis. Most MA plans offer a drug benefit, although many beneficiaries could also enroll in an MA plan without that benefit.

A variety of provisions were included to attract private plans into the drug program and MA. The administered pricing system of M+C that paid plans on the basis of costs in traditional Medicare was replaced by bidding systems for both the drug program and MA that reflect the plans' judgment about the conditions they face in their actual markets. In addition, the federal government is sharing in any large aggregate losses (or gains) that a drug plan might experience, with the greatest financial protection in 2006 and 2007.

Recognizing the difficulty of attracting comprehensive health plans into Medicare after the M+C experience, Congress boosted MA plan payments for 2004 and 2005. Plans were paid at least 100 percent of the cost in traditional Medicare, with higher payments in counties that had received special treatment under M+C. MA plans were also assured that annual payment increases would be the larger of 2 percent or the growth rate of Medicare spending nationally (in excess of 6 percent in 2004 and 2005).<sup>16</sup> Regional PPOs benefit from a risk-sharing arrangement similar to that offered to PDPs. The MMA also authorizes a stabilization fund that would provide additional payments as needed to encourage regional plans to maintain their offerings in 2007 and later.

The combination of a generously subsidized drug benefit, increased payments to comprehensive health plans, and other policies favoring private plans led to a rapid build-up of private Medicare plans. In 2005, 428 plans participated in the MA program, giving beneficiaries in 49 states access to a private plan alternative to traditional Medicare.<sup>17</sup> In 2006, there are more than 3,000 private plans offering drug coverage, more than half of which are MA plans. Even in the most remote parts of the country, Medicare

beneficiaries now have a choice of competing drug plans and most beneficiaries also may select a private plan instead of traditional Medicare for full health coverage.

### **Will the New Competition Work?**

Attracting private health plans to offer the drug benefit or to participate in MA is only one of the prerequisites for effective competition in Medicare. Other obstacles remain, including educating 42 million beneficiaries about an insurance decision they have never previously considered and maintaining private plan participation in future years.

Policymakers must also resolve contradictions inherent in the current structure of Medicare. The MMA provides substantial subsidies to plans and beneficiaries to jump-start the drug benefit and MA, but policymakers must wean the program off those subsidies if we expect to realize any efficiency gains from competition. Stand-alone drug plans exist only because of congressional action, but once created such an invention could block future evolution of Medicare competition. Competition among private plans could prove to be vibrant, but the potential benefits of competition do not extend to the traditional Medicare program, which accounts for most of the spending.

*Enrollment and adverse selection in the drug program.* A great deal of attention has been given to the challenges that health plan choice and the specific complications of the drug benefit pose for the Medicare population. The plethora of plan designs has contributed to a natural inclination on the part of many people to delay making a new and complex decision. If enrollment is low, the benefit could attract a high proportion of enrollees with high drug costs, who have a stronger incentive to wade through the details of plan options than those with lower costs.<sup>18</sup>

Adverse selection may be compounded by the unprecedented access to information about the drug plans provided by the Centers for Medicare and Medicaid Services (CMS). Consumers cannot make sound choices without information, but such information appears to have reinforced the mistaken belief that it is not worth signing up for the drug benefit unless there is a net financial gain in the first year.

Although program-wide adverse selection might be a problem at the outset, it is likely to recede quickly as the drug benefit meets its enrollment targets. Enrollment will pick up in the late spring as those who delayed their decision see the end of the enrollment period approaching<sup>19</sup> and can discuss the pros and cons of different options with friends who have several months of experience with the benefit. In addition, provisions designed to encourage beneficiary participation (particularly the 75 percent premium subsidy<sup>20</sup> coupled with widespread availability of low-premium drug plans<sup>21</sup>) will attract even seniors with relatively low drug expenses.<sup>22</sup>

The extent of adverse or favorable selection at the drug plan level is less certain and depends on the specific benefit designs offered by each plan sponsor. At least one drug sponsor designed its offerings to attract enrollees with lower than average drug costs. Humana offers low-premium plans to attract beneficiaries with less drug usage or

those who have retiree coverage now but wish to protect themselves against the possible future loss of that coverage.<sup>23</sup> The widely touted \$1.87 premium plan offered in six states in the upper Midwest is offered by Humana. Such plans typically have high cost-sharing requirements, however.

Many sponsors (including Humana) targeted the dual eligible population as a source of enrollees that could be attracted without incurring large marketing costs, despite the fact that this population has above-average drug spending. Since automatic assignment of dual eligibles is restricted to plans with premiums below the average in the region, that put pressure on the sponsors to keep premiums down.

Excluding high-cost drugs from the plan's formulary or placing high cost-sharing requirements on such drugs would discourage patients needing those drugs from enrolling in the drug plan. CMS is charged with ensuring that plans do not pursue such behavior. Based on its initial formulary review, CMS ordered all plans to cover every drug in six therapeutic categories to avoid interrupting ongoing treatments.<sup>24</sup> That step reduced the likelihood of adverse selection for plans that covered more of those drugs than other plans, but such a policy could also impede plan efforts to negotiate low prices from pharmaceutical manufacturers. Political pressure to increase the number of drugs covered by the private plans is likely to intensify if plan sponsors become more aggressive in the use of formulary and cost-sharing design to avoid enrolling high-cost beneficiaries.

*Bidding and cost containment in the drug benefit.* The MMA has shifted from a tradition of administered pricing to a bidding system for the drug benefit. Medicare drug plans are paid on the basis of their own assessment of costs and demand in their local market areas, rather than having their payment tied to an artificial benchmark.<sup>25</sup> The plans receive a risk-adjusted payment equal to about 75 percent of the national average bid. Enrollees pay the difference between the government's payment and the plan's bid.

This approach places the most important business decisions associated with the drug benefit squarely in the hands of the plan managers instead of Congress. Plans must decide what combination of cost-sharing arrangements, breadth of the formulary, availability of retail and mail order outlets, and premium is likely to attract enrollees. Plans negotiate prices with drug manufacturers based on their likely market share and ability to shift consumer demand to preferred drugs.

Consumer willingness to pay serves as the limiting factor on what drug plans may charge—a revolutionary idea in Medicare. Until the drug benefit was established, beneficiaries in traditional Medicare have largely been insulated from the direct costs of their health care choices by supplemental coverage (such as private Medigap insurance or retiree coverage that wraps around the Medicare benefit). That coverage typically pays most of the deductibles and coinsurance required by Medicare, blunting the financial incentive to reduce the use of covered services. The MMA largely eliminated such supplemental coverage for the drug benefit, which will make the cost-sharing requirements of the drug plans significantly more effective tools for cost containment.<sup>26</sup>

In addition, those remaining in traditional Medicare will also be able to influence the content of their drug benefit by which plan they enroll in. This is a major departure for a program characterized by nationally uniform benefits that heretofore could only change by an act of Congress.

To the discomfort of some policymakers, there is no direct federal control over drug prices or program costs under the current structure. Cost containment depends on the performance of the plans motivated by financial incentives common in virtually all markets outside of health care. Private insurers have obtained substantial savings through careful benefit management, and similar savings are hoped for in Medicare.

For example, the Government Accountability Office (GAO) found that pharmacy benefits managers (PBMs) in the Federal Employees Health Benefits Program obtained substantial discounts, ranging from 18 percent below the cash price for brand-name drugs purchased at retail pharmacies to 53 percent for generic drugs purchased through mail-order pharmacies.<sup>27</sup> PBMs also received manufacturer rebates of 3 to 9 percent, and saved 1 to 9 percent through interventions such as prior authorization and drug utilization review.

Cost containment efforts may be less successful under the Medicare drug benefit. Although Medicare drug plans bear financial risk for operating expenses above the levels assumed in their bids, the MMA substantially reduces that risk to encourage the entry of private plans into the new market.<sup>28</sup> The reduction in financial risk is a reduction in the financial incentive to manage costs.

In addition, the MMA made a permanent commitment of billions of dollars in federal subsidies to the Medicare drug program, lowering the average out-of-pocket cost of prescriptions to beneficiaries. That encourages greater drug utilization—which may be appropriate—but it also limits the effectiveness of cost containment techniques.

Medicare drug plans also are likely to proceed more cautiously than PBMs in pursuing cost control efforts given the high visibility of the program. The CMS action to mandate coverage of certain drugs even before the start of the program suggests that overly aggressive cost containment will not be tolerated.

It is too early to judge how well Medicare drug plans will perform. None of the drug plans had any previous experience with the Medicare program on which to base their price negotiations with manufacturers for the 2006 benefit year. The large number of plans also tended to splinter their market power. Consolidation is inevitable in this market, which should strengthen the hand of the remaining drug plans in future negotiations.

*Bidding and cost containment in Medicare Advantage.* Payments to MA plans are based on a bidding system that differs in important ways from drug plan bidding. Most notably,

the linkage between payments to MA plans and spending in the traditional Medicare program has not been eliminated.

The drug plan payment method relies exclusively on plan bids to set federal payments, with beneficiaries paying any remaining amount depending on the plan they select. All beneficiaries choosing to enroll in a Medicare drug plan pay a premium based on the bid of the plan they select, including beneficiaries who remain in the traditional Medicare program.

In contrast, MA plans bid against a benchmark that is set administratively and tied to payments made to such plans in 2005, which were at least 100 percent of traditional Medicare's cost in each county.<sup>29</sup> The government contribution is the benchmark amount. If the plan's bid is greater than the benchmark, enrollees pay the full difference.<sup>30</sup> If the bid is below the benchmark, the government retains 25 percent of the savings and the plan must increase benefits or reduce beneficiary premiums with the remaining savings. Only beneficiaries choosing an MA plan pay plan-specific premiums; those remaining in traditional Medicare continue to pay the standard Part B premium.

MA plans under this system have an incentive to bid below the benchmark, although beneficiary response might be dampened since enrollees would not realize the full benefit of signing up with a low-cost MA plan. However, the benchmark is tied to *at least* the full cost incurred by traditional Medicare in previous years, updated for inflation. That builds any excess costs generated by inefficiency in the traditional Medicare program into federal payments for MA plans.<sup>31</sup>

Such an arrangement increases the federal subsidy to beneficiaries selecting an MA plan over traditional Medicare, with the government recouping part of that extra subsidy from those who enroll in plans with costs below the benchmark. That makes MA more attractive to plans and beneficiaries, who might understandably be leery of the program after the problems of M+C.

What happens after MMA's payment policies re-establish comprehensive private health plans in Medicare? If there were no external benchmark, competition among MA plans could lead to aggressive bidding and lower premiums. With the benchmark, plan bids are likely to be less aggressive since the benchmark will serve as a price signal known to every competitor.

There are several ways that Congress could resolve this problem and encourage lower plan bids. Legislation could adjust the benchmark downward, for example. The Medicare Payment Advisory Commission (MedPAC) endorsed lowering the benchmark to 100 percent of the cost of traditional Medicare to make the choice of MA or traditional Medicare financially neutral.<sup>32</sup> However, such a policy also would lock program inefficiencies into the payment system, albeit at a lower level. Periodic downward revisions from that level might be justified, although there would be little information on which to base those adjustments.<sup>33</sup> Alternatively, the benchmark could be redefined to

include only the plan bids. That is precisely the concept Congress adopted for the drug benefit bidding system.

One could also try to work around the inappropriate incentives caused by the choice of benchmark. That might be the strategy CMS takes in any bid negotiations it undertakes with MA plans.<sup>34</sup> However, one-on-one negotiations are unlikely to correct the institutional bias toward bid clustering caused by the current benchmark.

*Competitive environment facing MA plans.* The MMA has created an unprecedented opportunity for the growth of private plans in Medicare. Although beneficiaries in traditional Medicare will have access to the drug benefit, MA plans offer considerable advantages to those who enroll.

Higher payment rates permit MA plans to offer lower costs and more generous benefits, including a more comprehensive drug benefit. Regional PPOs, which are available across the country, offer a more coherent insurance package with simplified cost sharing (replacing the complex series of deductibles and coinsurance of traditional Medicare) and greater financial protection (through a limit on out-of-pocket spending for covered services). For many beneficiaries, an MA plan is more comprehensive, less complicated, and lower cost than traditional Medicare with a Medigap policy and Medicare drug coverage through a PDP.

Even with those advantages, success for MA plans is not certain. Traditional Medicare remains the default plan presented to new Medicare beneficiaries, who must take an explicit action to enroll in an MA plan.<sup>35</sup> Research on consumer decision making has shown that people are likely to accept the default rather than taking even a simple action to select a superior option.<sup>36</sup> In addition, many beneficiaries seem willing to forego considerable savings for what they perceive as the ability to be treated by virtually any health care provider without having to worry about substantial extra out-of-pocket costs. That concern could be heightened by the requirement that MA enrollees remain locked into their plan for the calendar year.<sup>37</sup> However, the biggest challenge for MA plans may be the new drug benefit.

Enrollment growth is likely to be modest in 2006 for MA plans as the attention of most beneficiaries is absorbed by their decision regarding the drug benefit. Those who are in traditional Medicare are not likely to compound the difficulty of that decision this year by considering another set of MA plan options. Some plan sponsors have factored that view into their marketing strategy. Humana, for example, offers both PDP and MA plan options with the long-term goal of moving enrollees into their more lucrative managed care plans.<sup>38</sup>

The addition of a drug benefit available to all Medicare beneficiaries erodes an advantage that Medicare managed care plans have had in the past (at least when their payment rates were high enough to support such a benefit). Beneficiaries without retiree coverage or full Medicaid eligibility previously had no access to an affordable drug benefit other than managed care plans. Although MA plans are now able to offer a better

overall package of benefits that traditional Medicare, the plans must find a way to make that message appreciated. Some MA plans offer drug coverage in the doughnut hole, which addresses one of the concerns many seniors have about the standard drug benefit, but some PDPs also fill that coverage gap.

Two important objectives of the MMA were to create stand-alone drug plans for beneficiaries in traditional Medicare and to revive competition among comprehensive health plans in MA. Those objectives have been met through the use of large subsidies for both kinds of plans. Once granted, such subsidies have a way of becoming expected by both plans and beneficiaries even though Medicare's overall financing is not sustainable without politically difficult increases in taxes or cuts in other benefits.

The strategy of the MMA is to make MA plans so attractive that most beneficiaries will voluntarily switch out of traditional Medicare. If that were to transpire, there is no clear mechanism by which potential efficiency savings from competition among MA plans would be used to offset the Medicare's growing fiscal shortfall. However, such a switch in enrollment is made less likely if PDPs prove to be effective competitors who can deliver a reasonable drug benefit while limiting the growth of premiums and other costs paid by beneficiaries.

### **The Next Reform**

Private health plans had to weigh the attraction of higher payments and greater opportunity offered by the MMA to develop new markets against the risks of participating in Medicare. The plans might not be able to gain substantial market share given the dominance of traditional Medicare. A future Congress might cut budgets and tighten regulations in response to rising deficits or dissatisfaction with the performance of the plans.

Early skepticism on whether private plans would be willing to give Medicare another chance was off the mark.<sup>39</sup> Both PDP and MA plan sponsors recognized that the opportunities outweigh the risks, at least in the near term. The vast influx of plans in 2006 was caused by the opportunity to market the drug benefit to 42 million people, an opportunity that will not arise again. Many of those plans will fail to meet their business targets, and consolidation will reduce the number of options that beneficiaries must consider. Consequently, a small number of firms likely will emerge as the primary sponsors of PDPs and MA plans.<sup>40</sup>

Consolidation in the Medicare market could weaken competition if new firms face substantial barriers to entry. Established plan sponsors having a large share of a local Medicare market are likely to negotiate more favorable prices with providers, and such sponsors do not have the marketing costs that firms newly entering an area would have. Without a credible threat of new plan entrants and the potential to lose market share, established sponsors are likely to become less efficient and costs are likely to be higher than they could have been.

A similar argument can be made about the dominance of traditional Medicare. MMA reduced many of the entry barriers facing private health plans, but the legislation created new subsidies for those plans without truly leveling the playing field. What is needed is what Congress could not create with the MMA: full competition between a reformed fee-for-service Medicare program and private plans.

That idea—often referred to as premium support—would grant beneficiaries a risk-adjusted government contribution, which they could use to help pay the premium and other costs of the health plan they selected.<sup>41</sup> The subsidy would not depend on which plan a beneficiary chose, and those who enroll in more expensive plans would bear the additional cost themselves. Full competition would mean allowing all plans, including the traditional Medicare fee-for-service program, to change their benefit offerings or other provisions of their operation to meet consumer demand. Consumer information about the plan options and a variety of other changes in Medicare’s current structure would be necessary to assure that beneficiaries would make informed choices and competition would be fair.

The MMA includes two tests of premium support in Medicare. Most commentators have focused on the “comparative cost adjustment” program, a limited demonstration project scheduled to begin in 2010. This project has little chance of implementation. Similar demonstration projects have been attempted in the past, but political opposition prevented them from being placed into operation.<sup>42</sup>

The second test of premium support in Medicare has already begun. The consumer choice approach used for the drug benefit has key elements of premium support, including a fixed annual federal contribution toward the beneficiary’s choice of plans. If Congress is willing to learn, lessons from the drug benefit could help inform the next major Medicare reform.

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<sup>1</sup> The plan counts were reported by the Medicare Payment Advisory Commission; see Bureau of National Affairs, “Few PDPs Offering ‘Standard’ Rx Benefits; Most Offer Enhanced Coverage, MedPAC Says,” *BNA’s Health Policy Report*, November 21, 2005, p. 1488.

<sup>2</sup> Seniors typically have 40 to 50 PDP options plus perhaps a dozen or more additional MA plans offering a drug benefit; see Bureau of National Affairs, “Regional PPOs Available in Most States; 10 Firms to Offer Nationwide Coverage,” *BNA’s Health Policy Report*, October 3, 2005, p. 1257.

<sup>3</sup> U.S. Department of Health and Human Services, “Medicare Takes Major Step Toward 2006 Drug Benefit,” press release, September 23, 2005.

<sup>4</sup> Nearly 21 million Medicare beneficiaries (out of a total of 42 million) had enrolled in some drug benefit during the first month (November 15 – December 13) of the open enrollment period. However, only about 1 million of those people signed up for a stand-alone Medicare drug plan—about 5 percent of beneficiaries for whom the enrollment decision would require careful study of the costs of alternative plan options. About 6 million “dual eligibles,” people who were enrolled in both Medicare and Medicaid, were automatically enrolled in a Medicare drug plan. Another 9 million people remained covered by retiree drug benefits and 4.4 million people were enrolled in Medicare Advantage plans offering drug coverage; in both of those cases, beneficiaries could continue their benefits without taking an explicit action to enroll in a plan. See U.S. Department of Health and Human Services, “More Than 21 Million Medicare Beneficiaries to be Covered for Prescription Drugs as of January 1, 2006,” press release, December 14, 2005.

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<sup>5</sup> See, for example, Associated Press, “Seniors Express Medicare Confusion,” *Asbury Park Press*, November 28, 2005, and Susan Levine, “Seniors Find Medicare Plan Options Bewildering,” *Washington Post*, November 19, 2005, p. A01.

<sup>6</sup> Committee on Government Reform-Minority Staff, *New Medicare Drug Plans Fail to Provide Meaningful Drug Price Discounts*, U.S. House of Representatives, November 2005. Note that this report primarily compares prices offered by 10 Medicare drug plans at thousands of retail outlets with mail order sources, Canada, or the VA (which has a limited number of distribution sites). In addition, the report does not account for cost-saving methods that encourage the use of generics and lower-cost brand drugs.

<sup>7</sup> Much of the historical information reported here is from Carlos Zarabozo, “Milestones in Medicare Managed Care,” *Health Care Financing Review* 22(1); 61-67, Fall 2000.

<sup>8</sup> BBA provisions are explained in Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997*, CBO Memorandum, December 1997.

<sup>9</sup> Berenson argues that the 2 percent annual increases in payments to M+C plans were higher than such plans would have received under the pre-BBA methodology; see Robert A. Berenson, “Medicare+Choice: Doubling Or Disappearing?,” *Health Affairs* Web Exclusive, November 28, 2001, W65-W82. Although that may be true, Berenson also points out that health plans had difficulty managing costs in all lines of their business. Consequently, Medicare’s payment increases did not keep up with the costs actually borne by the plans.

<sup>10</sup> Medicare spending declined in 1999, due mainly to administrative actions against fraud and abuse. Subsequently, spending grew less rapidly than in the preceding several years. See Joseph R. Antos, “Medicare+Choice: Where Did the Scorekeepers Go Wrong?,” *Health Affairs* Web Exclusive, W83-W85, November 28, 2001.

<sup>11</sup> Marsha Gold, “Medicare+Choice: An Interim Report Card,” *Health Affairs*, July/August 2001; 20(4): 120-138.

<sup>12</sup> The Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 included increased payments to M+C plans.

<sup>13</sup> Marsha Gold, “Private Plans in Medicare: Another Look,” *Health Affairs*, September/October 2005; 24(5): 1302-1310.

<sup>14</sup> Marsha Gold, Lori Achman, Jessica Mittler, and Beth Stevens, *Monitoring Medicare+Choice: What Have We Learned?*, Mathematica Policy Research report, August 2004.

<sup>15</sup> The doughnut hole refers to a gap in coverage under the standard Medicare drug benefit after some initial coverage for prescription costs. In 2006, the standard benefit provides no reimbursement for drug spending between \$2,250 and \$5,100.

<sup>16</sup> Marsha Gold, “Private Plans in Medicare.”

<sup>17</sup> Centers for Medicare and Medicaid Services (CMS), “Medicare Beneficiaries to Have More Health Plan Choices and Greater Savings with Medicare Advantage Plans than Ever Before,” press release, June 30, 2005.

<sup>18</sup> Jonathan Blum, Jennifer Bowman, and Chiquita White, *The Impact of Enrollment in the Medicare Prescription Drug Benefit on Premiums*, Kaiser Family Foundation report, October 2005.

<sup>19</sup> One incentive that will influence some people is a late enrollment penalty that is permanently levied on beneficiaries who enroll in a Medicare drug benefit after they are first eligible (or who fail to maintain continuous enrollment in the benefit). The penalty is an additional premium equal to 2 percent of the average premium in their region for every month that the beneficiary fails to enroll in the benefit. Retirees with creditable coverage that is at least as good as Medicare’s are exempt from this penalty as long as they maintain such coverage.

<sup>20</sup> Sizeable premium subsidies have been shown to promote broad participation and stability in the Federal Employees Health Benefits Program. See Curtis S. Florence and Kenneth E. Thorpe, “How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?,” *Health Affairs* 22, no. 2 (March/April 2003): 211–218.

<sup>21</sup> All states but Alaska have at least one stand-alone drug plan with a monthly premium of less than \$20, and a number of states have plans with premiums below \$10 a month. About 70 percent of Medicare beneficiaries will have access to zero-premium Medicare Advantage plans offering drug benefits. See Bureau of National Affairs, “CMS Issues Drug Benefit Details as Plans’ Marketing to Seniors Begins,” *BNA’s Health Policy Report*, October 10, 2005, p. 1293.

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<sup>22</sup> The challenges of enrolling in the drug benefit are most acute for beneficiaries living in nursing homes and those living in the community but with serious impairments that prevent their making complex decisions. Since there is no default option for people who are not dual eligibles, some of those with such impairments will fail to enroll in the drug benefit even with heroic outreach and education efforts.

<sup>23</sup> Michael McCaughan, "Playing Offense in Part D: Three Aggressive Medicare Strategies Demand Pharma Attention," *The RPM Report*, December 2005, pp. 23–31.

<sup>24</sup> Centers for Medicare and Medicaid Services, "Clarification: Formulary Review," updated June 16, 2005.

<sup>25</sup> For a description of the new payment methods established by MMA, see Medicare Payment Advisory Commission (MedPAC), *Issues in a Modernized Medicare Program*, report to Congress, June 2005.

<sup>26</sup> The MMA prohibits new sales of Medigap drug coverage although they may continue to sell such coverage to people who already had such policies. The subsidized Medicare drug benefit is a better deal for such individuals, and that part of the Medigap market will disappear in the next few years. In addition, the MMA reduces the likelihood that retiree plans would wrap around the Medicare drug benefit. Any payments from such plans for cost-sharing in the drug benefit would not count toward the beneficiary's spending toward the catastrophic cap. Beneficiaries must spend \$5,100 in prescription costs before the Medicare benefit will pay 95 percent of subsequent costs.

<sup>27</sup> Government Accountability Office (GAO), *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, Report GAO-03-196, January 2003.

<sup>28</sup> The MMA limits financial exposure of the drug plans by paying a high proportion of the cost for enrollees who have exceptionally large drug needs. The federal government also shares in any large aggregate losses (or gains) that a plan might experience, with the greatest financial protection in 2006 and 2007.

<sup>29</sup> MedPAC, *Issues in a Modernized Medicare Program*.

<sup>30</sup> Both the bid and the benchmark are compared on a risk-adjusted basis.

<sup>31</sup> A similar point is made by Robert A. Berenson, "Medicare Disadvantaged And The Search For The Elusive 'Level Playing Field'," *Health Affairs* Web Exclusive, December 15, 2004, W4-572 – W4-585.

<sup>32</sup> MedPAC, *Issues in a Modernized Medicare Program*.

<sup>33</sup> However, Congress has a long history of arbitrary adjustments to Medicare payments.

<sup>34</sup> The MMA grants CMS authority to negotiate bids "similar to" the statutory authority given the Office of Personnel Management for the Federal Employees Health Benefits Program; see section 1854(a)(6)(B) of the Social Security Act. CMS indicated in regulation that the authority is limited by statutory formulas and other provisions of MMA; see U.S. Department of Health and Human Services, "42 CFR Parts 417 and 422: Medicare Program; Establishment of the Medicare Advantage Program; Final Rule," *Federal Register*, 70 no. 18, January 28, 2005, pp. 4587-4741. However, CMS is prepared to negotiate whether or not to accept a plan bid based on the bid's actuarial analysis and the reasonableness of plan costs.

<sup>35</sup> Instead of a single default option, one could randomly assign beneficiaries who do not make an affirmative choice of health plans with an opportunity to change their enrollment subsequently. Such a process was used to enroll dual eligibles in the Medicare drug benefit.

<sup>36</sup> For example, firms that automatically enroll new employees in their 401-K savings plans unless the person opts out have much higher participation in those plans than firms with the opposite decision rule. See James J. Choi, David Laibson, and Brigitte C. Madrian, *Plan Design and 401(k) Savings Outcomes*, NBER Working Paper W10486, May 2004.

<sup>37</sup> The barriers to enrolling in MA are discussed by Brian Biles, Geraldine Dallek, and Lauren Hersch Nicholas, "Medicare Advantage: Déjà vu All Over Again?," *Health Affairs* Web Exclusive, December 15, 2004, W4-586 – W4-597.

<sup>38</sup> Michael McCaughan, "Playing Offense in Part D."

<sup>39</sup> See Berenson, "Medicare Disadvantaged," and Biles et al., "Medicare Advantage."

<sup>40</sup> See Gold, "Private Plans in Medicare," and McCaughan, "Playing Offense in Part D."

<sup>41</sup> See Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What is the Next Step?," *Health Affairs*, 14 no. 4, Winter 1995, pp. 8-30, and Gail R. Wilensky and Joseph P. Newhouse, "Medicare: What's Right? What's Wrong? What's Next?," *Health Affairs*, 18 no. 1, January/February 1999, pp. 92-106.

<sup>42</sup> See Len M. Nichols and Robert D. Reischauer, "Who Really Wants Price Competition in Medicare Managed Care?," *Health Affairs*, 19 no. 5, September/October 2000, pp. 30-43, and Bryan Dowd, Robert

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Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs*, 19 no. 5, September/October 2000, pp. 9-29.