



The Medicare program is paying about \$10 billion more for the 20 percent of beneficiaries enrolled in MA plans than it would have paid if those beneficiaries had remained in FFS Medicare.¹

Time to Brace for a Change

The number of Medicare beneficiaries in private sector Medicare Advantage (MA) plans has almost doubled since 2003. Current enrollment is at 10.1 million members, which represents 23 percent of Medicare beneficiaries. The rate of enrollment growth has been extraordinary, and the level of new beneficiary enrollment, particularly among groups of the Medicare eligible that had historically been underrepresented in private Medicare plans, has gone a long way toward meeting the legislative and policy objective of providing increased coverage options to a wide range of Medicare beneficiaries.

Celebrations of the success of the expansion of Medicare Advantage have been tempered as concern about the cost of the Medicare program has risen, and as general economic conditions have deteriorated. In July of 2008, a series of Medicare Advantage reforms were enacted that were intended to limit rising costs and reform some aspects of MA program business practices. In recent months, demands for further reform have increased, as legislators, regulators, policy advocates and others recommend expansion of the scope of the reforms — particularly with respect to the costs associated with the Medicare Advantage program.

The future for Medicare Advantage plans is uncertain, but there can be no doubt that change is underway. Private sector plans that offer MA products have choices to make, strategies to develop and tactics that they must initiate now in order to succeed in the future.

This whitepaper provides an overview of the Medicare Advantage market and reviews the issues and implications associated with recent and planned reforms before suggesting a number of strategies for MA plans to consider as they prepare for the future.

Private Sector Medicare Plans

The traditional Medicare program for hospital coverage (Part A) and professional service coverage (Part B) is a fee-for-service (FFS) program operated on a national scale for Medicare beneficiaries by the federal government. Benefits administration, claims processing and other services are provided by various private sector organizations working under contract to Centers for Medicare & Medicaid Services (CMS).

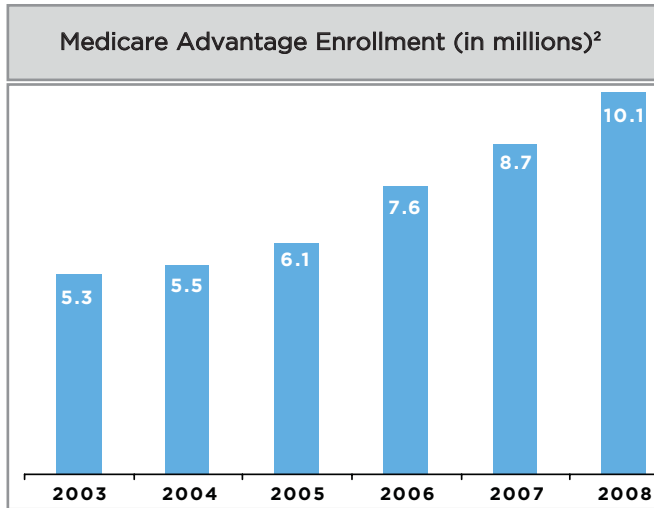
In the 1970s, Congress enacted the first legislation to expand the plan choices available to Medicare beneficiaries. Conceived as alternatives to the traditional Medicare coverage model, these plans have evolved from a small number of narrowly defined and tightly managed health maintenance organizations (HMOs) to include many organizational types and business models, various financing mechanisms, and broader geographic scope. Collectively, the private sector Medicare offerings are referred to as Part C plans.

The passage of the Medicare Modernization Act (MMA) in 2003 created the conditions for enormous growth in the private sector role in Medicare when it created the first ever Medicare prescription drug benefit (Part D) — and reserved it to the private sector to launch and maintain. Less spectacular, but very significant, were the MMA provisions enabling significant expansion of Part C offerings in the form of the newly named Medicare Advantage program.

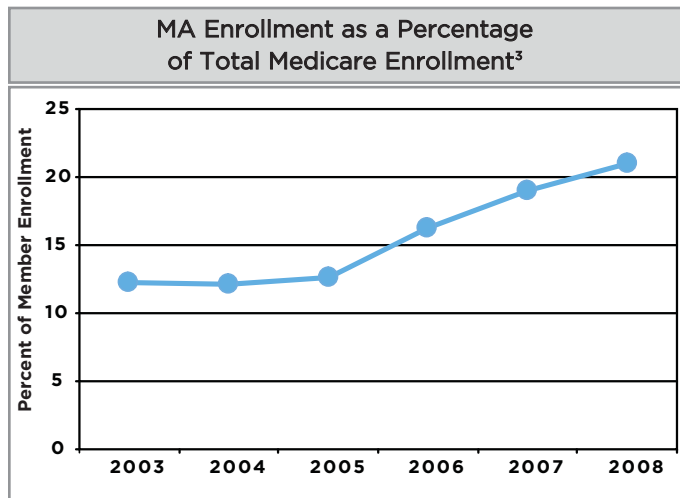
MMA Enables Expansion of Private Sector Plans

The passage of MMA in 2003 included several provisions to promote the expansion of Medicare Advantage offerings. Payment rates were increased significantly over previous levels in an effort to ensure that MA rates paid by CMS on behalf of beneficiaries kept pace with underlying economic trends for medical cost. In addition, several new types of plans were created. Special Needs Plans (SNPs), which have higher reimbursement rates and other features, were designed to enable the private sector plans to meet the particular requirements of the beneficiaries who qualify for Medicare based on a combination of physical disability, health status, economic status and age.

To promote expansion of Medicare Advantage to geographic areas that had not historically had access to private sector Medicare plans, MA plans were allowed to organize as “regional PPOs” where provider network management requirements were less stringent than those of a typical HMO. In many markets, MA plans were allowed to organize as private fee-for-service (PFFS) plans, which had virtually no network management, access or quality reporting requirements.



The creation of the Part D Prescription Drug Plans authorized by the MMA provided an indirect but profound stimulus to Medicare Advantage expansion as well. Part D plans, which required beneficiaries to enroll with a private sector plan, proved to be very popular with Medicare beneficiaries. MA plans that also offered Part D products (MA-PD plans) enjoyed a powerful co-branding and co-marketing opportunity as they capitalized on follow-on sales of MA coverage to satisfied Part D beneficiaries.



A Brief Timeline

1970s

Private sector Medicare HMOs introduced to beneficiaries.



1990s

Significant expansion of organizational types and business models for private sector Medicare plans, including PPOs, PSOs, PFFS and high-deductible plans linked to MSAs.



2003

The Medicare Modernization Act (MMA) creates the Part D prescription drug benefit for Medicare beneficiaries and includes increases in MA payments and the creation of regional PPOs and SNPs.



2008

The Medicare Improvements for Patients and Providers Act (MIPPA) reduces payment rates for MA plans and introduces new restrictions on MA business practices.



2009



Backlash and Reform

The cost of private sector Medicare plans has been a point of contention from their inception in the 1970s, and from this historical perspective the current debate about the excessive cost of the Medicare Advantage program should come as no surprise. However, a number of factors are causing the current scrutiny to gain momentum and increasing the likelihood of further reforms and reductions.

First, the number of beneficiaries now covered under MA plans is far greater than in any prior period. This expansion increases the impact and importance of the cost differential between MA plans and traditional Medicare coverage. In addition, MA plans have been profitable and attractive areas of expansion for the private sector. This profitability has tended to reinforce the perception that the higher cost of the program is resulting in excess profits for private sector plans. The continuing economic decline and in particular the pressure of federal deficits and spending cuts has resulted in increasing scrutiny on cost outliers as well. Finally, the new administration and new policy priorities are likely to bring a fresh perspective that seeks greater transparency and accountability from the private sector.

Critics point to a number of recent studies that claim that MA plans cost more, and that private sector MA plans realize “excess” profits. In March 2008, MedPAC projected that the average federal payment to MA plans per beneficiary was 13 percent higher than the average cost for a beneficiary in traditional Medicare. For the PFFS-type MA plans the differential is even higher at 17 percent.⁴ Another finding is that MA plans generally earned profits higher than they had estimated in their bids to CMS, and spent a lower percent of revenue on medical expenses than they had estimated.⁵

Combined, these factors have created an environment in which MA plans are increasingly likely to be subjected to reforms and regulation designed to expose and increase the benefits of the programs — and to decrease their costs.

Legislative and Regulatory Change on the Horizon

The Medicare Improvements for Patients and Providers Act (MIPPA) enacted in July 2008 was the first wave of these expected reforms. MIPAA provisions addressed and eliminated several sources of increased costs that had been features of earlier programs. In addition, reforms were passed to revise business practices in MA plans. These reforms addressed marketing practices for MA plans and extended network management and quality reporting requirements to PFFS plans.

Additional pressure on rates for MA plans is a virtual certainty as the administration and federal agencies seek ways to reduce costs, improve the efficacy of existing programs, and provide funds for healthcare reform and economic recovery efforts. PFFS-type MA plans are a likely first target for initial cost reforms because they have experienced the highest enrollment growth, and because their cost to CMS is much higher than that of the average MA plan. Moreover, with their relatively limited networks and care management requirements, PFFS-type MA plans are the ones that most resemble traditional Medicare plans — and thus regulators might reasonably expect them to operate on a similar cost basis.

Consumer opinion is beginning to align with the emerging regulatory perspective as well. AARP, a significant advocate for the Medicare eligible population, characterizes the MA cost differential as “unfair and fiscally irresponsible.” The AARP perspective is that higher payments to MA plans are made at the expense of the traditional Medicare program, “which is unfair to the majority of beneficiaries who participate in the traditional program.”⁶ Recent surveys of individual consumers suggest that many believe the cost differential is unfair and should be corrected.⁷

Cost reforms are unlikely to occur in isolation. Historically, each legislative package of reforms has included program and administrative changes along with financing changes. Marketing and sales practice reforms have been a frequent target, as they were most recently in the MIPAA legislation in 2008. Other likely targets will be quality and outcomes practices, provider oversight and reimbursement, grievance and appeal handling, customer service, and beneficiary satisfaction.

“We are spending a lot of money subsidizing the insurance companies around something called Medicare Advantage, a program that gives them subsidies to accept Medicare recipients but doesn't necessarily make people on Medicare healthier.”

— *President Barack Obama*

“The federal government should be financially neutral with regard to Medicare reimbursement.”

— *AARP*⁸

Finally, regulators and oversight agencies, including the Office of the Inspector General (OIG) and the Government Accountability Office (GAO), have repeatedly criticized CMS and the U.S. Department of Health and Human Services (HHS) for ineffective audit and enforcement of standards for MA plans.⁹ An increasing emphasis on private sector accountability and transparency is likely to bring an increase in the number and intensity of CMS compliance audits, corrective action plans and sanctions.

Some Direction for Plans

While it's not yet clear exactly what the reforms will target, prudent MA plans must prepare to operate at much lower levels of payment by addressing current cost structures, eliminating waste and maximizing operational efficiencies. At the same time, MA plans must optimize processes that will allow them to succeed in an environment that demands greater transparency and accountability, and in which there is a much higher level of regulatory oversight than has been true in the recent past.

Industry experience suggests that MA plans can realize significant operational and cost improvements when they focus first on attaining efficiencies in the enrollment and eligibility validation and reconciliation work processes. Enrollment and eligibility are the foundations of optimizing premium revenue and managing healthcare costs for any plan. The enrollment/eligibility process is always a complex one for health plans to manage because it requires information provided by group purchasers on behalf of plan members. MA enrollment and eligibility adds an additional layer of complexity because of the role that CMS plays in processing MA enrollment, updating eligibility and processing payments to MA plans. At a minimum, the MA plan with inefficiencies in enrollment and eligibility processing will experience higher costs and is likely losing revenue. At worst, the service failures and beneficiary impact of poor enrollment processing expose the MA plan to audits, fines and other sanctions.

Another critical performance area for MA plans is claims processing. In an environment of increasing cost pressure it is even more important for plans to ensure that benefits processing rules, fee schedules and payment rules are established, adhered to and maintained. Medicare payment rules vary from commercial claims payment rules and are updated more frequently. MA plans must take steps to ensure that these nuances are reflected in their systems, which in many cases have been optimized for commercial claims transaction processing.

Organizational readiness for audits and regulatory oversight should be another area of immediate assessment and planning. CMS activity in this area has been relatively light in recent years, and is likely to become more frequent and intense under future reforms. In an era of heightened accountability, MA plans must transition from reactive to proactive about regulatory inquiries — embedding performance measurement, adjustment, review and reporting as standard steps in business activities.

Finally, in an environment of transparency and accountability, customer service, support and issues resolution processes will become market differentiators and success factors. The MA plan that can operate efficiently and deliver proactive service levels that engage and support the needs of Medicare beneficiaries will have an advantage with regulators and with consumers.

A CBO study has estimated that limiting rates for PFFS-type MA plans to traditional Medicare program levels would reduce federal spending by about \$14 billion during 2009–2012 even if no action were taken to limit costs of other types of MA plans.¹⁰

A plan has to know who its members are, who is eligible for which types of benefits, how much revenue is due for a member, and whether or not the payment has been received.

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