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Will the Conferees' Medicare Insurance Provisions Really Work?

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The Washington Medicare reform debate has long been about whether Medicare benefits, including a stand-alone drug benefit, should be offered in the private sector or as part of the traditional government-run Medicare plan. When the House and Senate versions of Medicare reform were passed this summer, that disagreement was laid aside and we were headed full-speed toward a private-sector drug benefit and a series of new private Medicare plans.

If you listen to the Washington-based insurance industry trade associations, you generally hear at least a qualified enthusiasm for the private sector approach detailed in both the House and Senate bills. If you listen to the health plan executives that will actually make the decision to offer these plans, you hear another thing altogether.

The Stand-Alone Medicare Drug Plan

Many insurance executives are very concerned about the viability of offering a first-dollar stand-alone private drug benefit that they fear will be fraught with anti-selection as seniors calculate their own personal break-even point as they decide whether to purchase the new plans. The Senate version, for example, has a break-even point for seniors of about $1,100—having less in drug costs means paying more in premiums than they will get in benefits in any one year.

Some Republican leaders claim to know better. They are convinced that just about all seniors will buy the new drug benefit. They point to a Congressional Budget Office (CBO) study that estimates that

- The question policymakers and the press are not asking is, just which health plans are willing to commit to offering either the stand-alone drug plan or the Medicare PPO plan based on the details in either the Senate or House plan?
- Good policy and good business are synonymous. If the stand-alone drug plan is not financially tenable for the private sector, that means its costs aren't any more predictable for government—if it's a poor business bet, it's also a budget sinkhole for government.
- We need only look at the Federal Employees Health Benefits Program as an example of how the private insurance market and the federal government can succeed together as partners without all the complexity and political product development contained in the Medicare proposals. In 2003, the number of health plans participating grew to a total of 205 plans.

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93 percent of seniors will enroll in the new plan. The CBO cites the existing 99 percent take-up rate for Medicare Part B as evidence for that estimate where seniors receive the same 75 percent government premium subsidy they would receive for the new drug benefits.

What the CBO and the policymakers might be missing is that Part B Medicare is a comprehensive set of benefits it is *clear to seniors* that they cannot afford to do without.

The narrower drug coverage looks a lot like existing vision or dental benefit plans—as well as current private senior drug options—that have an entirely different take-up rate experience, often because consumers focus on their personal needs in relation to the first-dollar parts of the program.

Many seniors won't see the new drug plan as a "win." The CBO has also found that 32 percent of seniors have annual drug costs of less than $500 and 74 percent of seniors have drug costs of less than $2,000. That means that something approaching 60 percent of seniors have drug costs less than the annual "breakeven" under the Senate plan.

By focusing on a first-dollar drug benefit as part of their effort to have something for everybody, policymakers may have created the unintended consequence of focusing seniors' attention away from the more important catastrophic coverage the new benefit would provide and onto the less important first-dollar coverage. AARP, the big senior retiree group, is already reporting that their senior focus groups are doing a "back of the envelope" calculation, just as insurance executives feared they would, when the benefits are explained to them.

To make an insurance pool work, it is necessary to have a cross section of both the sick and the healthy. If the mix is off just a little bit, the program becomes unprofitable. While it is true that the Washington proposals limit how much an insurance company can lose on the new drug benefits, for-profit companies don't enter a market with the intention of having the government ensure that they lose only a small amount.

The anti-selection issue, compounded with insurer concerns about chronic government underpayment of health insurers and providers in the Medicare system, has everyone in the insurance industry wondering just who will show up for the new Medicare drug benefit.

The Medicare Private PPO Plan

Health insurance industry executives also worry about the regulatory complexity of the new Medicare preferred provider option (PPO) plans slated to begin in 2006. They worry about a number of issues:

- The requirements that a plan operate in at least one of 10 regions—essentially every nook and cranny in a region the size of one-tenth of the country. Most health plans operate in only one state, or two or three states, and rarely in every town and village in those areas.
- Being able to trust the government to adequately fund the new plans over the long run, pointing to the Medicare+Choice program and its current underfunding as the cause of that anxiety.
- Having too much of their business with the government. Most plans will likely not want more than 10 percent–15 percent of their business concentrated with the federal government, and Wall Street will likely punish those who exceed some such level of participation.
- Health plans have no reason to believe providers will give them contracts that pay the providers less than they get today from Medicare.
- Medicare has a 3 percent expense ratio—most private plans cannot expect to operate on less than 10 percent of revenue.
- Health plans see the ability to manage care as the one opportunity they have to better Medicare's overall performance. However, Congress has a history of responding to the drug, doctor, and hospital lobbies that will continually lobby for limits on a plan's ability to manage costs.
- The complexity of bidding and risk arrangements that can change over time as Congress sees the need to control costs. There would be an extraordinary commitment of capital to build the networks necessary to participate, and that investment would be subject to a "winners take all" re-bid process every few years.

Someone—congressional Republican policymakers or insurance industry executives—understands

the insurance market better than the other. Maybe Senator Ted Kennedy has this all figured out.

A key provision in the Senate version of the Medicare stand-alone drug plan may have an impact on everything. The Senate version triggers a "fallback" provision that requires Medicare to offer a drug plan if at least two private plans don't offer a benefit in a market. If at least two insurers don't offer a plan in a given market, Medicare steps in and the Democrats get their single-payer Medicare drug plan after all.

Those Republicans who claim to know more about how the insurance markets work than many of the jittery insurance executives had better be right—for their own good. They will be very surprised if the insurance companies don't show up and the result is the single-payer, government-run drug plan that they fear.

Better Payments for Existing Private Medicare Plans

The House provision in the Medicare bill that would increase existing Medicare+Choice (M+C) plan payments for health plans is also getting its share of attention.

Since the 1997 Balanced Budget Act, the maximum annual increase a health plan could get for its M+C business was 2 percent—at the same time health care costs were escalating in double digits for the private sector. As a result of this funding gap, it is not uncommon for some plans in certain markets to receive the equivalent of 85 percent of the Medicare fee-for-service per capita payment to fund their Medicare+Choice enrollee costs. This has led to a number of plan withdrawals from the M+C market and resulting beneficiary displacements in recent years.

Health plans have three business opportunities in the House and Senate bills:

- Better reimbursement for existing Medicare+Choice plans—as proposed in the House plan.
- The proposed Medicare stand-alone voluntary drug benefit contained in both bills that is scheduled to begin in 2006.
- The proposed private Medicare enhanced fee-for-service plan starting in 2006 in each of 10 national regions and—in the House version—to be put into direct competition with Medicare in 2010.

It has been no secret within the insurance industry that health plans are very leery about the feasibility of both the new voluntary stand-alone drug plan and the enhanced fee-for-service Medicare plan. But you wouldn't know it from some of the statements by industry representatives this month. A recent analysis published by the Bureau of National Affairs summed up the newfound "enthusiasm":

> Plan representatives interviewed in late July professed interest in—and even enthusiasm about—becoming involved with possible new programs offering provider networks, prescription drugs, and Part A and B benefits. All emphasized they would like to provide beneficiaries with more choices, particularly as Baby Boomers edge toward eligibility.[1]

Why the sudden optimism coming after months of skepticism in the industry about the anti-selection issues surrounding the new stand-alone drug benefit and the daunting task of going head-to-head with Medicare and its 3 percent expense ratio in each of 10 national regions?

In fact, there is no new optimism.

Two things: Look closely at what's being said by the industry representatives, and understand that this is more about getting those desperately needed Medicare+Choice increases than any great enthusiasm about proposals for a private stand-alone drug benefit or a new private Medicare plan.

There is still no list of health insurers who are willing to commit to offering the stand-alone drug benefit based upon either the existing Senate or House plan details. There are plenty of platitudes coming from the industry about the importance of consumer choice in Medicare and the huge emerging baby-boomer market—but no firm commitments to offer anything in response to the hundreds

1. Bureau of National Affairs *Health Care Policy Report*, Vol. 11, No. 31 (August 4, 2003), p. 1010.

of pages of details in both the House and Senate versions.

The industry desperately needs those increases to Medicare+Choice after six straight years of having the growth in their payments capped at 2 percent—and revitalized funding for M+C is seen as paving the way for the industry to move back into markets that were abandoned in recent years because of the financial problems.

The question the policymakers and the press are not asking is, just which health plans are willing to commit to offering either the stand-alone drug plan or the Medicare PPO plan based on the details in either the Senate or House plan? Sure, the insurers are entitled to a caveat for material changes in either proposed plan, but the House and Senate plans provide literally hundreds of pages of details on how the programs would work.

Can a health plan live with what's now on the table in either the Senate or House bill, or can't it? Good policy and good business are synonymous. If the stand-alone drug plan is not financially tenable for the private sector, that means its costs aren't any more predictable for government—if it's a poor business bet, it's also a budget sinkhole for government.

A Workable Model

What will work? We need only look at the Federal Employees Health Benefits Program (FEHBP) as an example of how the private insurance market and the federal government can succeed together as partners without all the complexity and political product development contained in the Medicare proposals. There is no major health plan—public or private—that can match the cost containment success of the FEHBP, and it is one that consumers, the federal government, and the private insurers are happy with.

Are insurers eager to participate in the FEHBP? Enthusiastically. In 2003, the number of health plans participating grew by 17 to a total of 205 plans.

What the insurance industry really thinks about these Medicare proposals is no small issue. If the health insurance industry gives the impression that it will offer the plans and then does not, its credibility among policymakers and consumers will be undermined and—with a fallback provision in place—we would be on our way to a single-payer senior drug plan. With no fallback provision, Republicans would see their senior drug plan collapse in 2006—an election year.

That would be trading a short-term gain (better M+C payments) for longer-term fallout—at a future time when it is inevitable the debate over continuing to rely upon the private insurance market, or alternatively moving to a single-payer government plan, can only become more critical.

This issue over whether the market will play is not just relevant to the senior health plan business—it will have an impact on every part of the industry if ultimately the private plans don't offer a stand-alone drug and private Medicare insurance product and industry credibility pays the price as a result.

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