SOCIETY OF ACTUARIES

Article from:

The Actuary

November 1997 – volume 31 - Issue 9

Doors open
Medicare options grow under balanced budget act

by Karl Madrecki and Carron Maxwell

This year, the U.S. Congress passed the most sweeping changes in the country's Medicare program in a generation, and industry experts continue to puzzle through the implications of the changes.

The Balanced Budget Act of 1997 (BBA) fundamentally revises the Medicare landscape and prepares the way for future changes that will have repercussions in every part of the health care industry. Provider systems, physicians and hospitals, health plans, and ancillary vendors are dramatically affected. The effects will cause a basic reorientation of roles that will last well into the next decade.

The act creates a new Part C under Title XVIII of the Social Security Act, providing for a new program known as Medicare+Choice. With almost 15% of Medicare beneficiaries already enrolled in HMOs, the act will accelerate the enrollment into managed care by expanding the variety and the number of private alternatives through the Medicare+Choice program:

- Coordinated care plans — HMOs, PPOs, and provider sponsored organizations (PSOs)
- Medical Savings Account plans — high-deductible health plans purchased in conjunction with establishing a medical savings account
- Private fee-for-service plans — fee-for-service plans that do not place providers at financial risk or restrict the selection of providers

At the same time, the act abolishes two managed care approaches allowed earlier by the Health Care Finance Administration (HCFA) that allowed contractors to assume only limited risk. Health care prepayment plans (HCPPs) have been eliminated with the discontinuance of existing contracts by Dec. 31, 1998, and no new cost contracts will be issued, phasing out this option altogether by Dec. 31, 2002.

The introduction of provider sponsored organizations potentially represents a fundamental change in the Medicare managed care marketplace. For the first time, HCFA will capitate integrated delivery systems that can deliver a full range of services to a Medicare population. Although key solvency and licensure issues remain open to regulation, it is clear that many health care providers that have not considered direct HCFA contracting will have to reevaluate this option. PSOs may have significant opportunities, particularly in lower-cost locations where HCFA's $367 "floor" payment in 1998 represents a significant increase over prior Medicare risk contractor payment rates.

Encouraging the move to managed Medicare

Changes in payments to coordinated care plans

The BBA's changes to the payment formula for coordinated care plans will fuel their expansion into new geographic areas. Beginning in 1998, coordinated care plans will begin a transition away from receiving 95% of the fee-for-service costs in the local county. These prior payment rates were referred to as the adjusted average per capita costs, or AAPCCs. The changes will likely slow the rate of increase in payments to HMOs in high-cost medical markets and increase payment to plans in rural areas.

HCFA released the 1998 payment rates in early September that implement the new formula. The rate for each county became the higher of the floor amount ($367 for 1998) or a 2% increase over the payment rate for the preceding year. For Guam, Puerto Rico, and the Virgin Islands, payment rate increases were limited to 50% if still below the $367 floor. All counties received the floor or 2% rate after a third rate — representing a blend between county and national rates net of the graduate medical education deduction — was eliminated by budget neutrality. The table below illustrates the number of counties that fall into each payment rate category:

Counties	$367 floor	2% increase	50% increase
U.S. and District of Columbia	1,099	2,047	NA
U.S. territories	3	0	99
Total	1,102	2,047	99

Rural markets and markets outside the U.S. mainland realized significant increases. Most urban markets where risk contractors are currently located saw increases of only 2% from last year's rates. In contrast, if the BBA had not been enacted, the AAPCCs would have increased about 6.5% overall.

Many organizations are moving quickly to qualify programs in markets such as Puerto Rico and the rural Midwest, where the payment rates have increased significantly. And there is no indication that current risk contractors are moving out of the highly paid markets. Markets that fare poorly are:

- Those with AAPCCs between the $367 floor and the country's average 1997 Medicare cost of $457
- Areas experiencing rapidly increasing costs and where payment rates increased the minimum of 2% rather than at the proposed blended rate that was eliminated by the BBA's budget neutrality provisions.

Reduced fee-for-service payments to providers

Managed care options also might become more desirable with the freezing of Medicare hospital payments for 1998. Much of the balanced budget act's $115 billion in savings comes from

slowing the rate of growth in fee-for-service reimbursements to hospitals and physicians. So, while coordinated care plan rates are guaranteed a minimum overall 2% increase, hospitals and physicians are seeing their fee-for-service unit payments fall or remain the same. In some markets, this may make the managed care option even more attractive than traditional Medicare to providers, and they may be encouraged to steer patients into managed care programs. Additionally, nonparticipating physicians and Part A providers must accept as payment in full the amount paid for charges allowed by Medicare. Previously, patients could be billed for amounts in excess of Medicare payments for outpatient hospital services, skilled nursing care, and home health services.

Uniform open enrollment

The act establishes (by 2003) a uniform open enrollment period for Medicare beneficiaries, changes enrollment and election procedures, and establishes increasingly stringent lock-in provisions. An annual, coordinated election period will begin in November 1999. Those familiar with the dramatic market changes brought on by the Federal Employees Health Benefits Program may have seen the future. The BBA's uniform open enrollment provision for Medicare beneficiaries will alter the Medicare market through new features, including a federal mailing, counseling for seniors, and uniform plan descriptions and report cards. Each fall "open season" can generate substantial new enrollment and, more significantly, increase movement among plans. Activities between 1999 and 2003 can be viewed as practice runs phasing in the annual exclusive enrollment periods.

To facilitate the uniform open enrollment, the BBA requires HCFA to compile comparative information on plans, including benefits, premiums, and quality performance measures. These comparisons are to be distributed to beneficiaries every fall or upon initial enrollment. Such comparisons are likely to be state or region specific. By 2003, the sales and marketing of Medicare managed care products will be largely driven by the value each company provides, as indicated by the comparisons and by the activities the organization engages in to retain enrollees.

Starting in 1998, organizations will be required to pay a fee related to their share of the costs HCFA incurs for enrollment, dissemination of health plan information, and health insurance counseling. After 2002, except in very limited circumstances, beneficiaries will no longer be able to choose health plan options during the year, only during the enrollment period.

Medical Savings Accounts (MSAs)

Under the BBA, HCFA must use a three-year period to conduct demonstration projects to learn how best to administer MSAs. Many fear these plans will siphon off good risks, worsening the pool for other Medicare options (such as the coordinated care plan options).

Private fee-for-service options

Under the balanced budget act, private fee-for-service plans are allowed as a Medicare+Choice option, provided they do not restrict selection of health care providers nor place the providers at financial risk. Providers with an agreement with a private fee-for-service plan can receive payment up to 115% of the Medicare payment rate.

Other issues

The balanced budget act addresses many other issues, including:

- The "Boomer Commission" (National Bipartisan Commission on the Future of Medicare) was established to recommend long-term changes by 1999 to offset the population effects of the Baby Boomers.
- A mandatory competitive pricing demonstration project will be started in several markets. The Competitive Pricing Advisory Committee, established by the BBA, must report its findings to Congress by 2003. This project, many believe, will signal HCFA's preferred payment method for the future.

- HCFA, as part of the U.S. Department of Health and Human Services, is required to further refine rates through a risk adjustment methodology developed and implemented no later than Jan. 1, 2000. The risk adjusters developed for the methodology will account for variations in health status not accounted for by age, sex, program (e.g., Medicaid), or institutional status (e.g., whether the person is in a nursing home).
- States are allowed to move to managed Medicaid without seeking a federal waiver first. The power of states to elect a managed Medicaid program without federal approval will have market implications for some of the organizations active in the Medicare managed care market. More states will seek managed care options to control costs, and more provider organizations and other contractors will apply because of the reduced uncertainty of the process.
- Providers receive greater protection under the balanced budget act than under previous Medicare risk contracts. Health plans must consult with participating physicians regarding the organization's medical policy, quality, and medical management procedures. Plans are prohibited

(continued on page 8)

NAFTA countries support SOA study on social security mortality

A research project led by the Society of Actuaries is seeking to determine the financial impact of the NAFTA countries' growing elderly populations on their social security systems. The project has received substantial cooperation from the three countries' social security administrations.

"Impact of Mortality Improvement on Social Security: Canada, Mexico, and the United States" will perform a detailed analysis of the historical and expected mortality improvement trend in each of the NAFTA countries and study the potential impact on the financial status of their social security systems. This initiative recognizes that the future of those countries' social security systems could be significantly affected by improvements in mortality over the next 50 years and by each country's ability to cope with the changes.

Results and possible implications of the study will be presented at the 150th annual meeting of the American Association for the Advancement of Science (AAAS), Feb. 12-17, 1998, in Philadelphia.

The project is divided into three phases. Phase 1, completed in September with the cooperation of a research firm and the three countries' social security administrations, reviewed the existing literature and analyzed the historical mortality improvement trend for each country.

Phase 2 was a one-day seminar on Thurs., Oct. 30, in which 90 invited participants heard presentations and then provided suggestions on approaches and assumptions to best project the three countries' social security mortality. The participants included actuaries, economists, demographers, and medical researchers. The seminar was held in Washington, D.C., immediately following the SOA's 1997 annual meeting.

In Phase 3, the assumptions and approaches chosen in Phase 2 will be used to analyze the impact of mortality improvement on the financial well-being of each country's social security program.

The three-phase project is being sponsored and funded jointly by the SOA, the SOA Foundation, and the Retirement Research Foundation. Other cosponsors are the social security administrations of Canada, Mexico, and the United States and the Pension Research Council.

More information is available from Judy Yore of the SOA Research Department (phone: 847/706-3573; fax: 847/706-3599; e-mail: *jyore@soa.org*).

Individual insurance after HIPAA (continued from page 5)

within the state). Also, the higher-level plan must have a benefit value at least 15% higher than the lower-level plan. These plans must also be substantially similar to others offered by that carrier.

The federal fallback currently applies in 10 states. Eight of these have formally adopted the federal fallback, and the other two — Missouri and Rhode Island — did not pass any conforming legislation during their recent legislative sessions. This means the federal government will be enforcing HIPAA provisions in those two states. For the 10 federal fallback states, both the NAIC and HCFA are working to develop guidelines for provisions of the federal fallback that are currently unclear.

That adds up to 49 states. The remaining state, Kentucky, has not had a regular legislative session since the passing of HIPAA and is excluded from the counts given.

Craig S. Kalman, an assistant editor of *The Actuary*, is health actuary, Missouri Department of Insurance. He can be reached by e-mail at *Craig_Kalman@compuserve.com*.

Doors open (continued from page 7)

from discriminating based on a provider's licensure or certification. And, plans are prohibited from requiring a provider to indemnify the organization against any liability resulting from the plan's denial of medically necessary care.

For health care providers and managed care plans, the Balanced Budget Act of 1997 represents a threat to traditional ways of conducting business and an unparalleled opportunity to enhance competitive positions through increased market penetration and product innovation. For beneficiaries, the changes introduce dramatically expanded alternatives for coverage.

Karl Madrecki is a consultant for Towers Perrin Integrated HealthSystems Consulting in Chicago. Carron Maxwell is the Chicago practice manager of Towers Perrin IHC. They can be reached through *The Actuary* or by e-mail at *madreck@towers.com* and *maxwelc@towers.com*