

Overview of Medicare for Managed Care Professionals

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OBJECTIVE:

To provide an overview of Medicare and current options under discussion for reforming the program with an emphasis on managed care.

DATA SOURCES:

Recent literature and the authors' experiences.

STUDY SELECTION:

Not applicable.

DATA EXTRACTION:

Not applicable.

DATA SYNTHESIS:

Authorized under amendments to the Social Security Act of 1965, the Medicare program has made two forays into the managed care world (through the Health Maintenance Organization Act of 1973 and the Tax Equity and Fiscal Responsibility Act in 1987). Medicare Part A provides

hospital insurance to the elderly and is funded by payroll taxes. Part B helps pay for physicians' services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and supplies not covered under Part A. The Medicare managed care program currently recognizes three types of contracts: Risk HMOs or competitive medical plans (CMPs), cost HMOs, and health care prepayment plans. Between 1994 and 1995, the number of managed care contracts issued by HCFA increased by 41%; some 9% of the Medicare population was enrolled in some type of managed care program. An attractive feature of Medicare managed care programs is coverage of prescription drugs. Data are conflicting on how satisfied Medicare beneficiaries are with the care they receive in managed care organizations. Some studies indicate that Medicare HMOs have recruited preferen-

tially the healthier members of the Medicare population and that the amounts being paid to those HMOs are actually too high as a result. Congress is presently considering various options for reforming Medicare, and many of these involve shifting more beneficiaries into managed care.

CONCLUSION:

Managed care organizations should play a key role in optimizing and sustaining the health care of the Medicare population.

KEY WORDS:

Medicare, Medicaid, Federal government, Elderly, Indigent patients, Managed care organizations, Risk health maintenance organizations, Cost health maintenance organizations, Health care prepayment plans, Benefit design, Prescription drug coverage, Legislation, Regulations.

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The health care industry in the United States is moving at an accelerated pace toward managed care. Because the current network of providers, patients, and payers is complex, interactions among patients, pharmacists, governmental regulators, employers, and insurers have also become more complicated.¹ Incorporating managed care principles into the health care system is a way to minimize the complexity, maintain or even improve the level of patient care, and control the cost of health care for everyone.

Because of their pivotal role in the delivery of health care, pharmacists must be aware of these changes and how they affect the profession of pharmacy. Medicare, which provides health benefit coverage to 36 million individuals

who are elderly, are disabled, or have end-stage renal disease (ESRD), is one aspect of the current health care system that is now incorporating the concepts of managed care.² This article provides a brief overview of Medicare and current options under discussion for reforming the program.

HISTORICAL DEVELOPMENT

Medicare began as a nationwide health insurance program for the aged and certain disabled persons authorized under amendments to the Social Security Act of 1965 (Medicare Title XVIII). It was developed as a federal program to provide financing of medical programs for the el-



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derly regardless of their ability to pay. Three pieces of health legislation (Kerr-Mills Act; Social Security Act of 1960, Medicare and Medicaid) were established during the 1960s to ensure that health care was a right—not just a privilege—in the United States for those individuals covered by these pieces of legislation.³

During the first 25 years following World War II, the federal government was highly successful in designing the nation's health care system. The number of health facilities and providers increased, new medical delivery systems were designed, and new financing mechanisms were established through Medicare and Medicaid. In the late 1960s, the government started to become alarmed when expenditures for Medicare and Medicaid exceeded the original projection of \$2 billion annually and continued to rise. This era marked the beginning of the rapid rise in health care costs and the increase in direct federal intervention into the health care system.³

The era of cost containment and federalization extended throughout the 1970s and early 1980s. Multiple pieces of legislation enacted during this time attempted to slow down the rising costs of medical care. The 1972 Social Security Amendments created professional standards review organizations (PSROs) responsible for cost containment and quality assurance, accomplished through a national network of utilization-review programs. PSROs achieved only limited success in containing the rising costs of health care and were eventually replaced by peer-review organizations (PROs) in 1983.³

The 1972 Social Security Amendments, under Section 1122, provided the mechanisms to control capital expenditures by mandating that a "certificate of need" (CON) or "determination of need" (DON) be established for any capital expenditure above \$150,000 and be reviewed by a designated state agency. If the state agency deemed that the new facility being constructed or the equipment being purchased created unnecessary duplication, the federal government could withhold payment for services rendered (i.e., Medicare payments).³

In the early 1970s, President Nixon sought a new health delivery system to be implemented by the federal government at a minimal cost. This impetus resulted in the Health Maintenance Organization (HMO) Act of 1973, which provided financial assistance for the development of HMOs and encouraged the use of HMOs by private employers with 25 or more employees. The new law started to change the belief that fee-for-service and private indemnity health insurance were the pre-eminent systems for delivery of health care in the United States. Public and private policy makers began to recognize the cost-effectiveness of HMOs, and new payment mechanisms were established to incorporate consumer choice of plans with incentives for preventive health care practices. Private employers encouraged and demanded cost-effectiveness as a shared responsibility for payers and providers.⁴

It was during the 1980s and under the Reagan Administration that defederalization occurred. The Omnibus Reconciliation Act of 1981 discontinued the capitation of educational funding for all health professions except for public health.³

Beginning October 1, 1983, the Medicare hospital reimbursement method changed from a retrospective fee-for-service payment method to a prospective pricing system (Medicare PPS) based on diagnosis-related groups (DRGs). Medicare PPS pays hospitals a preset diagnosis-specific amount dependent upon the expected length of stay and services provided to the patient.³

The Medicare PPS system was a turning point for managed care in the United States because of the following⁵:

1. It set prospective prices for certain services.
2. Services were bundled into payment groups.
3. Hospitals were at financial risk for cost control when delivering services.
4. Price setting was facilitated and hospitals were encouraged to conserve resources.

At this time, Medicare PROs were also added to the Medicare PPS program to control hospital admissions through a system of mandatory peer review and to monitor the quality of care rendered by hospitals to Medicare patients. Unlike the previous PSROs, PROs were given enforcement powers; they could deny hospital reimbursement for care determined unnecessary or inappropriate and sanction physicians as well as hospitals.⁶ The Medicare PPS and PRO programs changed the physician/hospital relationship by shifting some of the decision making to hospital administration and away from physicians. The erosion of absolute physician autonomy required that hospitals and physicians work together to provide patient services. In this regard, the magnitude of the Medicare PPS program stimulated changes in medical practice.⁵

During the 1980s and 1990s the competitive environment evoked several types of health care delivery systems, including HMOs, preferred provider organizations (PPOs), and third party administrators (TPAs).³ The government followed a path similar to private employers by allowing HMOs to participate in Medicare on a prospective payment basis. States instituted Medicaid reforms designed to save money by providing incentives toward administrative and operational cost-effectiveness. "Managed care" was becoming universally acknowledged as the basic principle of health care reform for achieving cost effectiveness while maintaining quality of care.⁴

MEDICARE TODAY

Enrollment, Cost Sharing, and Benefits

From a public policy perspective, two approaches to social welfare policy exist. First is the social insurance policy, which is reflective of Medicare, and, second, the welfare approach, which describes Medicaid.

These approaches differ with respect to beneficiaries, benefits, financing, and administration. Medicare employs the social insurance approach to financing health services for the elderly. Eligibility is independent of a means test, benefits are earned, the scope of benefits is narrow, financing is through special taxes, and the program is administered centrally with uniform rules. In other words, Medicare is available to all So-

cial Security beneficiaries, regardless of financial means.⁷

Most individuals who are 65 or older are entitled to Medicare Part A (described below) in the same manner that they are entitled to Social Security. Individuals who are not automatically entitled can pay a premium that reflects the actuarial value of the program to purchase Part A benefits. Those who qualify for disability payments under Social Security are also entitled to Part A benefits after a two-year waiting period. Some 32 million Medicare beneficiaries qualify based on age, and 4 million recipients qualify because of disability.²

The Medicare program consists of two parts. Part A provides hospital insurance to the elderly and is funded by payroll taxes. Coverage is provided for inpatient hospital care for up to 90 days per benefit period at no premium. Individuals can also draw upon an additional 60-day lifetime reserve before their inpatient benefits expire. The inpatient hospital deductible is \$716, and coinsurance payments are \$179 per day for days 61-90 and \$358 per day for lifetime reserve days. Part A also offers up to 100 days of skilled-nursing facility care, home health care, and hospice care. Skilled-nursing facility care has a coinsurance of \$89.50 per day for days 21-100.²

Medicare Part B helps pay for physicians' services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and supplies not covered by Medicare Part A. It is funded with general government revenue and by beneficiaries. Physician services can be received in the physician's office, a hospital, a skilled-nursing facility, the home, or at any other location. There is a \$100 annual deductible and 20% coinsurance for most services, with 50% coinsurance for outpatient treatment of mental illness.⁸

Medicare does not cover the majority of outpatient prescription drugs, although it does help to pay for the following items, depending on the specific carrier^{8,9}:

- ▲ **Antigens:** Prepared for the patient by the physician.
- ▲ **Blood or blood components:** If received as a hospital outpatient, or as part of another service.
- ▲ **Epoetin alfa:** When self-administered by dialysis patients or administered by caregivers.
- ▲ **Hemophilia clotting factors:** Blood clotting factors and items related to their administration for hemophilia patients unable to use them without medical or other supervision to control bleeding.
- ▲ **Hepatitis B vaccine:** Administered to beneficiaries considered to have a high or intermediate risk of disease contraction.
- ▲ **Immunosuppressive drugs:** Medically necessary to prevent or treat rejection of a Medicare-covered organ transplant.
- ▲ **Oral cancer drugs:** Certain self-administered chemotherapeutic oncolytic agents when used for medically accepted indications.

Financing

Benefits for Medicare Part A are paid from a trust fund using the Hospital Insurance payroll tax financed from active workers. The tax is currently 2.9% of wages, of which 1.45% is paid by employees and 1.45% by the employer. Individuals aged 65 or older and those qualifying for Part A benefits as a result of disability or ESRD may enroll in Part B by paying a

monthly premium, currently \$46.10 per month. The premium covers 25% of the cost of Part B benefits, with the remaining 75% paid out of general income tax revenues.²

Medicare Part B is forecasted to go bankrupt in the next seven years, if the present trend of spending and enrollment increases continue under the original plan design. Originally, the income tax subsidy was to cover only 50% of the cost of services. In 1994, Medicare spending was \$162 billion, and it is forecast to increase to more than \$350 billion by the year 2003. Currently, Medicare spending is growing at a compounded annual rate of 10% a year.¹⁰

The elderly are responsible for a substantial portion of their health care costs, despite funding from Medicare. In 1995, the average Medicare beneficiary paid \$3,053 in out-of-pocket health care expenses. In addition, Medicare does not cover certain benefits, including preventive services such as physicals, immunization, and outpatient prescription drugs, except for those named above. Medicare beneficiaries must cover these costs, even though these preventive services could potentially save *total* health care dollars. The elderly must therefore rely upon another third-party payer to cover these benefits or pay out-of-pocket expenses themselves.¹⁰

Administration and Provider Payment

The Medicare program is administered through private health care "intermediaries" for Part A and "carriers" for Part B. Private insurers typically contract with Medicare. They have responsibility for reviewing claims and making payments to providers for benefits under the Medicare plan with no risk for program spending. Medicare pays the administrative costs for these activities and is responsible for any insurance risk.²

The Medicare program is a fee-for-service (FFS) plan in which payments are made to any provider seen by a beneficiary (subject to coverage and other limitations). It is based on the dominant model of health benefit coverage that was in place at the time the program was enacted in 1965.²

Providers are paid by Medicare using a variety of arrangements. Payments for hospitals are made through the PPS. Medicare makes a fixed payment based on a patient's diagnosis and adjusts the payment to reflect geographic differences in input prices. The payments are also adjusted to reflect extra payments for certain types of facilities, such as teaching hospitals and hospitals serving a disproportionate number of low-income beneficiaries. Medicare makes payments for physician services under the Resource-Based Relative Value Scale (RBRVS), which fixes payments for each type of physician service (e.g., office visits, operations, diagnostic tests) and incorporates geographic adjustments.²

Payments to physicians are subject to Medicare Volume Performance Standards (MVPS). The MVPS is a budget control mechanism in which Medicare sets annual spending targets for physicians' services, monitors actual spending against those targets, and then makes adjustments in future physician payment rate increases to compensate for spending over (or under) the target.²

Table 1. Prescription Drug Benefits of MediGap Policies

Drug Benefit Description	MediGap Policy Type(s)
Basic coverage for 50% of the cost of prescription drugs, up to a maximum annual benefit of \$1,250 after the policyholder meets a \$250 per year deductible.	"H" and "I"
Extended coverage for 50% of the cost of prescription drugs, up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible.	"J"

MEDIGAP POLICIES

Medicare Supplement Policies

Medicare provides basic protection against the cost of health care, but it does not pay all medical expenses nor most long-term care expenses. Medicare beneficiaries can purchase Medicare supplement policies (Medigap) to reimburse the costs of products and services not covered by Medicare. Traditionally, Medicare supplemental policies have operated in a fee-for-service environment. Medicare supplement subscribers are not required to receive care from specific providers.

Although the federal government does not sell or service these insurance policies, it does instruct Medicare beneficiaries to shop carefully when purchasing a private insurance policy to supplement their Medicare benefits. During the first six months that Medicare beneficiaries are 65 or older and enrolled in Part B, they can enroll in Medigap. If they apply during this period, the Medigap insurer cannot refuse to issue the Medicare beneficiary a policy, place conditions on the policy, or discriminate in the price of the policy because of health status, claims experience, or current medical conditions. It is important to note that this open enrollment period is a one-time opportunity. After the six-month period ends, Medicare beneficiaries may have limited insurance policy options at the best price. Even when a Medicare beneficiary purchases a Medigap insurance policy during open enrollment, an insurer may still impose a waiting period of up to six months for coverage of a pre-existing medical condition.

Most states have adopted regulations that limit the sale of Medigap insurance to a maximum number of standard policies that may be marketed and sold in the state. The maximum number of standard policies is most commonly 10. One of the standard policies must be a basic policy offering a "core package" of benefits. The standardized plans are identified by the letters "A" through "J." Plan "A" provides the "core package" of benefits. The other plans have various additional benefits, but must include the "core package" of benefits. The "core package" benefit must be sold in all states.

Only three of the Medicare supplement (Medigap) policies have outpatient prescription drug benefits, designated as policies "H," "I," and "J." The outpatient prescription drug benefits for these policies are shown in Table 1.

In 1990, Congress established a three-year demonstration

project allowing health plans to market a Medigap product called Medicare Select. This project, offered in 15 selected pilot states, was enacted within the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The project provisions were designed to standardize and simplify Medicare supplement policies and to provide minimum coverage requirements. The Medicare Select demonstration project was to expire under "sunset" provisions on June 30, 1995. In July 1995, President Clinton signed a House-Senate compromise to extend the Medicare Select demonstration project to all 50 states for a period of three years, despite preliminary HCFA findings indicating that the program has increased Medicare costs in eight pilot states.¹¹ Currently, approximately 400,000 beneficiaries are enrolled in these demonstration projects.

Medicare Select is similar to traditional Medigap policies, the biggest difference being that the products are designed to use managed care providers and, technically, could be labeled as PPOs. Benefits are decreased if care is not administered by a managed care provider or in a managed care facility. Because of these restrictions, Medicare Select policies are generally less expensive than traditional Medicare supplement (Medigap) policies.

The extension and expansion of the Medicare Select project may eventually lead to increased enrollment of beneficiaries into Medicare risk plans, which generally provide enhanced benefits and reduced premiums in comparison to Medicare Select policies. This is based on the assumption that recipients who enroll in Medicare Select products will have an opportunity to experience managed care and become accustomed to managed health care environments.

MEDICARE MANAGED CARE

Overview

The Medicare managed care program was established in 1987 by the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA). It was created as a partnership between the Health Care Financing Administration (HCFA) and the managed care industry to provide affordable, accessible, and high-quality health care to Medicare beneficiaries.⁶

For a number of years Medicare has allowed beneficiaries the option of enrolling in HMOs and competitive medical plans (CMPs). CMPs are organizations in which physicians are not necessarily employees of the HMO. HCFA has three distinct types of managed care contracts⁶:

1. Risk Health Maintenance Organizations/Competitive Medical Plans (HMOs/CMPs);
2. Cost HMOs; and
3. Health Care Prepayment Plans (HCPPs).

Risk HMOs and CMPs assume all financial risk of caring for Medicare patients through their provider networks. Medicare pays risk HMOs and CMPs a per capita premium for an agreed-upon package of benefits. The reimbursement methodology is based on the Average Adjusted Per Capita Cost (AAPCC), which is the cost of providing Medicare services to the beneficiaries in a given geographic region, based

on retrospective fee-for-service (FFS) costs in the area. The HMOs and CMPs provide all Medicare-covered services, plus any additional benefits such as eyeglasses and prescription drugs. Members must receive all their medical care through the HMO or CMP network of providers except for emergency and out-of-area urgent care. These plans are appealing to Medicare beneficiaries who want comprehensive quality care with minimal out-of-pocket expenses and paperwork.⁶

Cost HMOs are paid a predetermined monthly amount per beneficiary based on the total estimated budget. Adjustments are made at the end of the year for any variation from the budget. Cost HMOs are structured similarly to point-of-service programs and do not lock Medicare enrollees into their networks. While the cost HMO will not pay for services when a member uses a provider outside the plan, Medicare will still pay its share for the covered service. Members are responsible for paying Medicare's coinsurance and deductibles as if they were receiving care under a traditional fee-for-service system.⁶

HCPPs are paid by Medicare in a manner comparable to cost HMOs, although HCPPs only partially cover Medicare benefits and do not provide any of the additional benefits covered by Risk HMOs. Some cover all Part B benefits, while others cover only a few of the benefits.⁶

The HCFA Office of Managed Care provides federal qualification to HMOs. As of 1995, 412 HMOs covering 29 million lives were qualified. A federally qualified HMO must meet certain standards set forth in the HMO Act of 1973, as amended, relating to the following⁶:

- ▲ Provision of basic and supplemental health services;
- ▲ A fiscally sound operation;
- ▲ Satisfactory administrative and managerial arrangements;
- ▲ Enrollment procedures;
- ▲ Consumer representation on the board of directors;
- ▲ Member grievance procedures;
- ▲ An ongoing quality assurance program;
- ▲ Health education services;
- ▲ Continuing education for health professionals; and
- ▲ Procedures for reporting statistics and other information.

Enrollment Trends

The number of Medicare managed care programs fluctuated greatly in their early years. After a period of decline between 1989 and 1992, the number of plans contracting with HCFA has increased steadily. From 1993 through 1994, the number of contracts increased by 21%, culminating in a record number of managed care plans (154) contracting with HCFA during 1995. HCFA data reveal a 41% increase in the number of managed care contracts issued in 1995 compared with 1994.⁶

As of January 1, 1995, total enrollment in all types of managed care contracts with HCFA (including risk, cost, HCPPs, and demonstration projects) totaled 3,114,566. The greatest growth has been in the risk programs, while enrollment in cost contracts, HCPPs, and demonstration projects has remained constant. Since the inception of the risk pro-

gram, enrollment increased by 13% from 1992 to 1993, a 19% increase between 1993 and 1994, and 27% from 1994 to 1995 (from 1,848,373 members to 2,339,562). Despite this growth, only 9% of the total Medicare population was enrolled in some type of managed care program.⁶

Regional enrollment in Medicare managed care varies substantially. More than 50% of Medicare beneficiaries reside in HCFA Region IX (California, Arizona, Nevada, and Hawaii). Substantial growth occurred in Region IV (Florida, Georgia, South Carolina, North Carolina, Tennessee, Kentucky, Mississippi, and Alabama), constituting 17% of the total enrollment. Texas, Louisiana, New Mexico, Oklahoma, and Arkansas (Region VI) make up 5% of the enrollment population.⁶

The five states with the highest percentage of Medicare beneficiaries enrolled in managed care are California, Arizona, Oregon, Nevada, and Florida. Substantial increases in penetration rates have occurred in these states over the past year.⁶

The top five Medicare Risk Plan contracts by enrollment as of January 1, 1995, include Pacificare of California (264,997); Humana Medical Plan of Miami, Florida (217,737); FHP of Fountain Valley, California (208,355); Kaiser Foundation HP, Los Angeles, California (142,586); and FHP of Phoenix, Arizona.⁶

MEDICARE RISK BENEFIT DESIGN COMPONENTS —

As previously discussed, enrollment in Medicare managed care plans by Medicare beneficiaries has increased substantially over the last several years. Much of this enrollment increase has occurred in Medicare risk HMOs (Medicare HMOs), which try to leverage their position by marketing the following features:

- ▲ Less paperwork and recordkeeping for the members.
- ▲ Lower out-of-pocket expenditures for members (deductibles/copayments).
- ▲ More comprehensive coverage for members.

Typically, Medicare HMOs offer much more comprehensive benefit packages than do traditional Medicare plans. The benefits commonly provided by Medicare HMO plans but not covered by Medicare (Part A and Part B) are as follows:

- ▲ Routine physical examinations.
- ▲ Routine visual examinations.
- ▲ Prescription eyeglasses.
- ▲ Nutritional counseling.
- ▲ Home infusion therapy.
- ▲ Extended coverage for hospital and inpatient care (after 150 days of stay).
- ▲ Prescription drug coverage.

Reimbursement from HCFA to Medicare HMOs is driven directly by the AAPCC, the anticipated dollar amount that would be expended for traditional Medicare benefits under fee-for-service (FFS) Medicare. The AAPCC is adjusted to reflect actuarial factors such as age, gender, Medicaid eligibility, and institutional status.² Rates are also set for those qualifying on the basis of disability. HCFA sets the AAPCC for each county in the United States.

Table 2. Definitions of Typical Benefits Offered by Medicare HMOs

Feature	Definition/Comments
Copayment	A "flat" dollar fee charged for prescription drug coverage, typically in the range of \$5-15 per prescription.
Coinsurance	A fee charged for prescription drugs based on a percentage of the total prescription costs (including professional fees), typically 20-50%.
Mandatory generic program	A program disallowing coverage of a single source (brand name) product if the product is a multisource (available as a generic) "A" rated product. Some plans provide coverage of multisource brand products if designated by the prescribing physician.
Benefit maximums	A designated ceiling, or dollar amount, of prescription drug purchases that a plan will cover for a plan member. This "ceiling" is usually based on a 12-month period (plan benefit year) and is prorated if the member joins a plan at any time other than the beginning of the plan benefit year.
Closed or restrictive formulary	A method of administering a drug formulary or drug list in which there is limited or no benefit to members for prescribed drug products not included in the formulary.
Quantity limits	Specific, established limits on prescription drug medication that may be in addition to existing "days supply" limits per dispensing. For example, quantity limits are sometimes established on the number of packages of oral inhaler products.
Prior authorization	The process of obtaining coverage approval for a specific service or medication.

PRESCRIPTION DRUG COVERAGE

In general, the elderly depend upon prescription drugs more than any other population group, yet traditional Medicare benefits exclude prescription drugs. Therefore, prescription drug coverage can be one of the most attractive features of Medicare HMO benefits to Medicare beneficiaries. However, only 66% of the Medicare HMOs have a funded prescription drug benefit program. The elderly (age 65+) comprise only 12.8% of the total U.S. population but account for a disproportionate share (37%) of domestic prescription drug spending.¹²

Approximately 46% of the elderly are estimated to have no insurance for prescription drugs. The majority of the elderly population who have insurance for prescription drugs have obtained this coverage through an employer-sponsored program. Prescription drug benefits provide an excellent marketing tool for capturing Medicare beneficiaries.

Medicare HMOs must also be cognizant of the high prescription-drug-use rates associated with the elderly. The per capita spending for prescription drugs by seniors was estimated to be nearly \$500 in 1991, while spending by the top 11% exceeded \$1,200 per person, or \$100 per month.² This top 11% accounted for almost one half of the spending for the en-

tire Medicare population. This uneven distribution of prescription drug costs among the elderly can be potentially catastrophic for HMOs offering pharmacy benefits as part of their Medicare risk product if they enroll a large percentage of high prescription drug users. HMOs typically base their decisions whether to provide prescription drug benefits for their Medicare HMO product on these factors:

- ▲ Local competitive market.
- ▲ Profit margin based on AAPCC and cost of administering the Medicare program.
- ▲ Ability to effectively manage prescription drug cost and use.
- ▲ Potential for "adverse selection" secondary to availability of the prescription drug benefit.

The scope and type of prescription drug benefit plans vary greatly among Medicare HMOs. For example, some plans offer a prescription drug benefit at no additional premium to enrollees, while others charge an additional premium for the benefit. HCFA allows Medicare HMOs to charge an additional premium for any benefit that is "richer" than the standard Part A and B Medicare benefit.

Table 2 provides features and definitions common in prescription drug benefit programs offered by Medicare HMOs.

Most Medicare beneficiaries are eligible to enroll in HMOs. In general, HMOs cannot underwrite this population. In other words, HMOs cannot formally screen applicants to determine if they are healthy or delay enrollment because of pre-existing conditions. The only enrollment criteria for Medicare HMOs are as follows⁸:

- ▲ Applicant must be enrolled in Medicare Part B.
- ▲ Applicant must reside in the HMO's service area.
- ▲ Applicant cannot be receiving care in a Medicare-certified hospice.
- ▲ Applicant cannot have permanent kidney failure.

EFFECTIVENESS OF MEDICARE MANAGED CARE

The federal government is looking toward managed care to assist in controlling Medicare health care costs while maintaining or improving the quality of care. Much controversy surrounds the effectiveness of managed care organizations in providing health care services to Medicare beneficiaries.

The effectiveness of Medicare managed care programs as they relate to quality of care is still subject to debate. Recent discussions in Congress have focused on the development and implementation of new quality-protecting requirements. Some members are proactively attempting to guard against quality of care issues that could develop if legislation is introduced that thrusts the Medicare population into managed care. Few methodologies can ascertain the quality of care administered by managed care organizations specifically for the elderly.

Based on the small percentage of Medicare members who disenroll from their HMOs, Medicare HMO members appear fairly pleased with the care they are receiving. A member survey of the enrollment and disenrollment patterns of Medicare HMO members conducted by the Group Health Association of

America (GHAA) found that an overwhelming majority—84%—of Medicare members stayed in the same plan in 1994.

Another recent report issued by the Inspector General of Health and Human Services found: “66% of disabled and end stage renal disease patients and 16% of all Medicare HMO enrollees would leave their plan if they could afford to.” But HMO industry officials cite other surveys, claiming that Medicare beneficiaries in HMOs were more satisfied than those in fee-for-service plans.¹³

The effectiveness of managed care Medicare programs, in terms of decreasing health care dollar expenditures, is also controversial. One could make the assumption that Medicare HMOs save the federal government 5% in expenditures for each Medicare beneficiary enrolled in a Medicare-risk HMO, based on the methodology on which these plans are reimbursed. Medicare-risk HMOs receive capitation payments from HCFA based on 95% of the AAPCC for the Medicare beneficiaries they enroll in their plan.

A study conducted by Mathematica Policy Research Inc. found that the government is actually paying more for the care provided by HMOs than the care provided in FFS environments. The five-year study (which ended in February 1993) concluded, “Costs [to the government] were 5.7% higher than they would have been under FFS. Even though payment rates are set at 5% less than HCFA’s projected FFS payments, the payments are about 1.1% too generous, because the HMOs are attracting beneficiaries who are healthier than the Medicare population [as a whole].”¹⁴ This study also concluded that Medicare HMOs appeared to be more efficient in delivering care to the elderly than FFS providers. HMOs appear to have the largest impact in reducing hospital days and average lengths of stay (ALOS) for the elderly. The Mathematica Policy Research study also concluded that Medicare HMO patients had similar health outcomes to FFS Medicare patients.

Critics of Medicare managed care contend that Medicare HMOs are attracting enrollees typically healthier than traditional Medicare beneficiaries. These opponents believe that Medicare HMOs’ marketing strategies are most effective in capturing the healthier members of the ambulatory Medicare population. They also suspect that the less healthy Medicare beneficiaries may be unwilling to join Medicare HMOs, particularly if they must change physicians. If this theory is valid, then any savings calculation methodology would require adjustments for these purported selection biases.

Studies also suggest that Medicare HMOs are saving the federal government money. One of these studies, published by the National Institute for Health Care Management in June 1995, investigated the relationship between HMO activity and Medicare spending levels. Data on expenditures for Medicare Part A and Part B and Medicare HMO market share in 3,073 counties from 1986 to 1990 assessed the importance of the relationship between market share and expenditures. “Results from this analysis of nationwide data on HMO market share and Medicare expenditures for FFS and HMO care between 1986 and 1990 indicate that 10 percentage point increases in

HMO market share are associated with decreases of 1.8% and 0.7% in Medicare expenditures for Part A and B FFS care, respectively, and 3.4% and 0.8% decreases in aggregate (HMO and FFS) expenditures for Part A and B care, respectively. These are conservative estimates of the effect of HMOs on expenditures, but may reflect effects of HMOs that occur outside of Medicare, as well as those that occur entirely within Medicare. These results indicate that HMOs affected the FFS sector and suggest that increasing HMO market share has also saved Medicare money on expenditures for HMO care.”¹⁵ Logical to assume is that managed care is influencing how health care is delivered to all patients, including those not enrolled in managed care. If this is true, then the current methodology for reimbursing Medicare HMOs could be adversely affected.

People have different opinions regarding the effectiveness and quality of care administered by managed care providers. Therefore, one should not be surprised at the variation in opinion on this topic as it relates to the Medicare HMOs. Even those who doubt or downplay the value of managed care are generally willing to concede that managed care does offer many of the necessary efficiencies and controls that will, in the long term, provide some of the solutions to health care delivery. The U.S. Congress realizes that managed care has been more effective at managing health care than the executive components of the federal government. The outcome of current discussions about Medicare reform in Congress will be a strong indication of the federal government’s perception of the effectiveness of managed health care. The following section discusses some of the options Congress has.

MEDICARE REFORM LEGISLATION

Congressional Republicans are motivated to shrink government, cut taxes, and balance the federal budget over the next seven years. To that end, they have approved a proposal that would erase federal deficits by the year 2002. Both Medicare and Medicaid reform proposals are important components of this balanced budget proposal.

The Republican proposal calls for \$270 billion in Medicare cuts over seven years, most of which would be created by reducing Medicare payments to hospitals and physicians. These cuts would provide a 20% reduction of Medicare’s projected budget in the year 2002. The plan would slow the expected annual rate of Medicare growth from 9.9% to 7.1% until 2002. The other prospective savings attributable to the Republican proposal include:

- ▲ Savings from increasing Medicare Part B premiums to cover 31.5% of Part B costs (1996 premiums are currently scheduled to cover 25% of Part B costs).
- ▲ Savings from imposing higher premiums on high-income beneficiaries.
- ▲ Savings from reducing fraud, providing regulatory relief, and limiting malpractice lawsuit awards.
- ▲ Savings from beneficiaries enrolling in managed care plans (e.g., HMOs, PPOs, and POS plans).

The Republicans have declared that, without reform, Medicare Part A faces insolvency in 2002. The President and Congressional Democrats claim that the Republican reform proposal would cut far more than is necessary to bring Medicare into short-term stability. The President also contends that the cuts would threaten the health care of enrollees, primarily because of the drastic reductions in payments to hospitals and physicians reimbursed on a fee-for-service basis. Clinton also maintains that cutting \$124 billion over seven years would provide stability for Medicare until the year 2006.

Medicare reform proposals are divided by political party lines. The Democrats and Republicans disagree about the extent of reform necessary to control Medicare spending. However, both sides agree that some reform is necessary to ensure the financial solvency of Medicare. The Republicans and Democrats will probably reach political compromises regarding Medicare reform legislation, and the resulting proposal will most likely be a scaled-down version of the current Republican plan. The compromises—or an ongoing debate if no compromise is reached—will form the basis for debate in the 1996 Presidential campaign.

The final reform plan will most likely provide some incentives for beneficiaries to receive care from managed care plans. Only 9% of Medicare's 36 million beneficiaries currently belong to managed care plans. To make managed care even more attractive to beneficiaries, the Republicans propose to allow managed care plans to offer point-of-service (POS) op-

tions. In a POS option plan, patients who wish to seek medical treatment outside the HMO can do so, as long as they are willing to pay a higher share of the bill.¹⁶ Many people believe that a POS option would increase enrollment in Medicare managed care plans. The Congressional Budget Office predicts that under the Republican proposal, the proportion of Medicare beneficiaries in managed care will grow 25% by 2002.¹⁶ This increase in managed care enrollment is forecast to save the federal government approximately \$5 billion. Although there is disagreement regarding Medicare reform, the majority of members of Congress agrees that managed health care plans offer some desperately needed efficiencies in the traditional fee-for-service Medicare arena.

CONCLUSION

Philosophically, managed care organizations should play a key role in optimizing and sustaining the health care of the Medicare population. Managed care pharmacy offers cost-effective therapeutic approaches, with an emphasis on disease prevention and coordination of care, which is vital to the success of a managed Medicare program that offers pharmacy benefits. As health care professionals it is important to understand the Medicare market—and the opportunities it provides—so that managed care principles can be integrated into the largest public health care program in the United States.¹⁷ ■

References

1. Fincham JE. Introduction. In: Fincham JE, Wertheimer AI, eds. *Pharmacy and the U.S. health care system*. New York: Pharmaceutical Products Press, 1991: 1-7.
2. *Reforming Medicare*. National Institute for Health Care Management, 1995 Feb.
3. Enj HJ. The U.S. health care system. In: Fincham JE, Wertheimer AI, eds. *Pharmacy and the U.S. health care system*. New York: Pharmaceutical Products Press, 1991: 8-29.
4. Ito SM, Blackburn S, ed. *A pharmacist's guide to principles and practices of managed care pharmacy*. Alexandria, VA: Foundation of Managed Care Pharmacy, 1995.
5. Curtiss FR. Managed health care. In: Fincham JE, Wertheimer AI, eds. *Pharmacy and the U.S. health care system*. New York: Pharmaceutical Products Press, 1991.
6. Medicare managed care program update. Baltimore, MD: Operations & Oversight Team, Office of Managed Care, Health Care Financing Administration, 1995.
7. Larson LN. Financing health care in the United States. In: Fincham JE, Wertheimer AI, eds. *Pharmacy and the U.S. health care system*. New York: Pharmaceutical Products Press, 1991: 108-36.
8. *Your Medicare handbook*. Publication No. HC-FA 10050. Baltimore, MD: Health Care Financing Administration, 1995(Jan).
9. DMERC Region D supplier manual. Baltimore, MD: Health Care Financing Administration, 1995(Jan).
10. Wilkerson B. Medicare market analysis. Indianapolis, IN: Eli Lilly and Company, 1995.
11. Anonymous. Clinton expected to sign into law Medicare Select extension compromise. *Managed Care Week* 1995(Jul 3).
12. Long S. Prescription drugs and the elderly: Issues and options. *Health Affairs* 1994(Spring).
13. McIlrath S. Medicare due for changes—but they won't come easy. *Am Med News* 1995(May 8).
14. Cerne F. Rehabbing Medicare: is managed care a cure—all or just a crutch?. *Hosp Health Networks* 1995(Apr 20).
15. Laurence B. Can managed care control costs: evidence from the Medicare experience. National Institute for Health Care Management. 1995(Jun).
16. Tritch T. How to beat the cuts in Medicare. *Money* 1995(Dec): 31.
17. Elder R, Sargent L. Untapped Medicare opportunities for managed care [editorial]. *J Managed Care Pharm* 1995; 1: 157.