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Changes in Health Care Financing & Organization (HCFO)

findings brief

Medicare Spending on HMOs and Stand-Alone Drug Plans: What is it Worth to Beneficiaries?

key findings

- Medicare beneficiaries value the expansion of stand-alone prescription drug plans more than they value the expansion of HMOs.
- The addition of subsidized stand-alone prescription drug plans generates nine times as much value per government dollar as the increase in payments to HMOs.

Overview

The Medicare Modernization Act of 2003 (MMA) created a prescription drug benefit for seniors and redesigned the Medicare managed care program to form Medicare Advantage. To ensure the success and viability of the new benefit, the MMA included two expansions. First, it established subsidized stand-alone prescription drug plans (PDPs) and second, it increased payments to HMOs. A key question for policymakers planning future Medicare budgets is whether one of these financial expansions of the Medicare program is more valuable than the other.

The HCFO program funded Steven D. Pizer, Ph.D., assistant professor at the Boston University School of Public Health and his research team, Austin B. Frakt, Ph.D., health economist at Boston University and Roger Feldman, Ph.D., Blue Cross Professor of Health Insurance at the University of Minnesota, to examine the costs and benefits of supporting private Medicare health insurance plans. Among their analyses, the researchers have evaluated MMA's success by measuring the welfare effects of these two expansions of the Medicare program—comparing the value of establishing PDPs with providing financial support to HMOs.[1]

Pizer and his team sought to answer the following questions:

1) Which had greater value to beneficiaries: spending on PDPs or increased spending on HMOs?

2) Given the scarcity of resources, how should Medicare payments be adjusted to maximize value for beneficiaries per dollar spent?

Background

With the passage of MMA, seniors gained access to prescription drugs through two vehicles. PDPs offer prescription drug coverage exclusively and beneficiaries in PDPs receive their medical care through the regular Medicare program. Early on, concerns were raised that the viability of PDPs was at risk due to adverse selection, but analyses by the researchers demonstrated that the subsidies accompanying PDPs sufficiently reduced that risk, thus ensuring stable plans.[2]

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The second vehicle for securing drug coverage was the newly titled Medicare Advantage program (formerly Medicare + Choice), which provides all medical services, including prescription drugs. Prior to MMA, HMO drug coverage, while available, was limited. Moreover, these plans had only scattered presence across the country and were mostly absent in rural areas. To reverse this trend, the MMA increased payment rates and made subsidies for drug coverage available to HMOs.

Potential Welfare Effects

The researchers posit that either mode of expansion should improve the welfare of Medicare beneficiaries. In formulating their analyses, the researchers identified the expected advantages and disadvantages of the two types of drug coverage.

Creating Prescription Drug Plans

In terms of its advantages, PDP expansion would likely benefit both rural and urban areas and create widespread competition. This market penetration should, according to economic theory, result in lower premiums for drug coverage. A disadvantage is that PDPs are not comprehensive in their coverage of medical services, so spending on PDPs cannot improve non-drug benefits.

Increasing Payments to HMOs

Increased payments to HMOs create the potential for a number of positive welfare effects. For example, higher rates should result in an improvement in benefits and a reduction in premiums. Higher payments could create greater HMO penetration in new markets and underserved areas. This in turn could increase competition with the attendant effect of even greater benefits and lower premiums. HMO expansion would likely have its greatest positive effect in urban areas, given the propensity for HMOs to enter markets with a large, established provider base. In terms of disadvantages, those in HMOs have more restricted choices among providers and services and HMOs incur higher costs to establish their networks.

Description of Analysis[3]

Pizer and colleagues structured their analyses to examine the effectiveness of the two expansions to increase benefits and reduce premiums by determining how well each improved the welfare of Medicare beneficiaries per dollar of additional federal spending.

They primarily used the Medicare Current Beneficiary Survey (MCBS) Cost and Use files from 1998-2003 to build models of insurance choice. Several groups were excluded from analysis because of unusual circumstances or because they did not make their own insurance choices.[4] Ultimately, the researchers analyzed information on approximately 12,700 beneficiaries matched with plan-level benefits and cost-sharing data.

The researchers simulated the welfare value of each of the two expansions. In this case, welfare for a particular beneficiary is the difference between what he or she would have been willing to pay for each insurance option and the actual premium. To calculate welfare from each expansion, the researchers used their model of insurance choice to simulate willingness to pay (i.e. demand) for the new drug benefit offered by a single PDP plan or for improved HMO options due to higher HMO payments. The researchers then compared the welfare gain of each expansion to its cost. They calculated the cost of the PDP expansion from the average subsidy per beneficiary who enrolls in this type of plan. The cost of the HMO expansion was based upon the estimated payment increase it would take to convince one drug HMO to enter a county that had at least one existing HMO in 2003 or to enter a market that gained new HMOs between 2003 an 2006.

Key Findings

Based on the models they constructed, Pizer and colleagues found that beneficiaries are more likely to select a PDP if they are better educated, in fair or poor health (heart problems, diabetes, Alzheimer's or emphysema), have insurance through a spouse, have high lagged drug spending or high incomes. The researchers suspect that these types of individuals have the resources to purchase less restrictive coverage on their own. The results demonstrate that Medicare beneficiaries, who have health problems but have financial means, tend to select a PDP instead of an HMO.

The researchers concluded that while the costs per enrollee were similar for beneficiaries in PDPs and HMOs, the value they received from each of the two expansions was vastly different. On balance, beneficiaries value the expansion of PDPs more than they value the expansion of HMOs. The researchers determined that the addition of subsidized stand-alone prescription drug plans produced nine times as much value for beneficiaries per government dollar as the increase in payments to HMOs.

Policy Implications

Insofar as the bulk of Medicare spending is financed through tax revenues, it is incumbent on policymakers to ensure that taxpayers and beneficiaries realize the greatest value from each dollar spent. More specifically, the Congressional Budget Office has cautioned policymakers to weigh the additional cost of Medicare Advantage against the benefits those plans provide.[5] Here Pizer and colleagues provide evidence of an imbalance between PDPs and HMOs in welfare produced per dollar spent.

"The bottom line," says Pizer, "is that the recent increase in payments to Medicare HMOs was not a good value for beneficiaries or taxpayers." He adds that this result should lead decision makers to consider reducing Medicare payments to HMOs while maintaining subsidies for drug coverage.

The researchers acknowledge that while the addition of a subsidized standard drug benefit to Medicare through PDPs was welfare-improving, it is not clear that other expansions would have the same result. Accordingly, as more information becomes available on the experiences of beneficiaries in various MMA plans, more analyses on the costs and benefits will be needed.

For more information, contact Steven D. Pizer, Ph.D., at pizer@bu.edu.

About the Author

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Endnotes

1 The analyses were also informed by the researchers' prior HCFO grant which examined the entry, enrollment, and risk selection in Medicare prescription drug plans. See: http://www.hcfo.net/grantees/grant.cfm?GrantNo=51151. See also, Frakt, A.B. and S.D. Pizer, "A First Look at the New Medicare Prescription Drug Plans," *Health Affairs* Web Exclusive, May 23, 2006, pp. W252-61; Pizer S.D., et al. "Defective Design: Regional Competition in Medicare," *Health Affairs* Web Exclusive W5-400, August 23, 2005, pp.399-411.

2 Pizer, S.D., A.B. Frakt and R. Feldman, "Predicting Risk Selection Following Major Changes in Medicare," *Health Economics*, April 2008, Vol. 17(4), pp.453-468.

3 Additional details of the analysis and complete findings can be found in Pizer, S.D., A.B. Frakt and R. Feldman, "Nothing for Something? Estimating Cost and Value for Beneficiaries from Recent Medicare Spending Increases on HMO Payments and Drug Benefits," *International Journal of Health Care Finance and Economics*, accessed at http://www.springerlink.com/content/106603/?Content+Status=Accepted, November 5, 2008.

4 Exclusions included: non-elderly Medicare beneficiaries, the institutionalized, Medicare-Medicaid dual enrollees, beneficiaries enrolled in employer-sponsored Medicare supplements, and enrollees in three waiver states (MA, MN, WI).

5 Statement of Peter R. Orszag, Congressional Budget Office, before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.