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November DTR Analysis: Medicare HMO enrollment varies dramatically

By: Tracey Walker

A review of Medicare HMO enrollment on a state-by-state basis shows that the availability and popularity of the programs varies dramatically, according to David St.Clair, chairman of the board and CEO of MEDecision.

While overall enrollment in the top 25 states declined slightly over the 2002 to 2003 period, some states experienced almost 30% growth in Medicare HMO enrollment, while others saw their enrollments reduced by about 20%, according to St.Clair.

"These variations probably say more about the continuing difficulty insurers are facing when trying to offer profitable plans with sufficient provider network depth and breadth than they do about the interest seniors have in these types of benefit plans," St.Clair says. "As has been well-publicized, the inability of the managed Medicare plans to maintain—or ever achieve—profitability in the face of rising costs and inadequate funding from Medicare drove many such plans to greatly restrict their markets to lower-cost areas or to get out of the business altogether."

The percentage decline in enrollment tended to be most significant in those states that originally saw the greatest increases in enrollment prior to 1999, ac-

ording to Cynthia Stamer, partner with Epstein Becker Green Wickliff & Hall's National Healthlaw practice. "In certain of these early growth states like Texas, for instance, declines leveled off in 2003 following withdrawals and cutbacks in service regions made by significant Medicare HMO carriers within the state during prior years," Stamer says.

It appears, however, that the Medicare HMO business may be positioned to rebound in the coming years, according to the experts.

"The key driver for a renewed expansion of the managed Medicare market is the government's increased willingness to use proactive means to improve the quality of healthcare and thereby reduce its overall cost," St.Clair says. "The recent flurry of activity around disease management pilots within the 'non-managed' Medicare population is just one example of CMS' eagerness to try strategies that extend beyond their traditional emphasis on simply driving down prices paid for services and procedures to control cost," St.Clair says. "Although some may see the disease management pilots as only a tentative step, this exploration signals a significant change that will ripple through the entire healthcare system. The evolution of the last and largest group from a pure indemnity form of coverage to a managed indemnity model has begun at last."

Joshua Habib, a principal at Towers

Perrin, shares a similar viewpoint. "Since the enactment of the MMA, interest in these plans has soared among employer groups seeking healthcare solutions for retirees," Habib says. "According to CMS data, eight states have 20% or more of their Medicare beneficiaries enrolled in Medicare Advantage plans, and there are many other metropolitan areas where seniors may choose among several strong Medicare Advantage plan options. We are optimistic that Medicare Advantage enrollment will increase over the next 12 to 18 months.

"With employers more excited about Medicare Advantage plans than they have been in years, managed care executives should recognize employer groups as a potential source of plan membership at a low acquisition cost," Habib adds. "To that end, most Medicare Advantage carriers are willing to provide group-specific plans containing richer benefits such as unlimited prescription drug coverage."

In addition to the MMA's Medicaid HMO reforms, Stamer says the legislation also includes certain subsidies for qualifying employers that offer retiree prescription drug coverage after the Medicare prescription drug coverage benefit takes effect. "Employers will be weighing all of their options when choosing retiree medical plan designs going forward. The carriers that can be responsive to the various choices made by particular employers are

most likely to benefit," she says.

Care management added to the mix

The introduction of care management to the basic Medicare coverage will have two significant effects, according to St.Clair. "First, it will help reinforce the development of the processes, evidence-based medicine standards and technologies needed to create a collaborative model for care management and, second, it will allow that model to become financially viable earlier than it would have otherwise," he says.

"The elder population is, generally speaking, sicker and more heavily infused with chronic conditions than the commercial populations for whom care management processes have been developed to date," St.Clair adds. "That additional

burden of illness will force care management organizations to respond with better technologies to predict coming episodes of illness for individual patients, better evidence-based care pathways to deal with patients with multiple conditions, and better information systems to share data and care plans with all elements of the care team—case managers, physicians, nurses, patients and other caregivers. These investments will be more easily justified by the tremendous volume of patients across which infrastructure costs—including the National Health Information Infrastructure project being driven by HHS—can be spread."

A third, and perhaps unintended, consequence of the shift to managed indemnity coverage for the basic Medicare population is that it will further lessen the perceived differences between basic and

HMO coverage, according to St.Clair. "Thus, we should expect that a larger and larger percentage of the elder population will be motivated by the financial advantages offered to shift into the real managed care plans. Perhaps it's telling that the state with the highest penetration for Medicare HMO members is California, which is also the most developed managed care market in the country for the commercial population," he says. "As care management is considered to be the norm in the West, there also appears to be less resistance to the prospect of switching into Medicare HMO plans. The California payers' emphasis on 'pay-for-performance' and on identifying and strengthening networks of high-quality providers seems to make seniors more willing to try fully managed models, hoping to take advantage of those payers investments."

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