

Medicare and Medicaid Managed Care: A Tale of Two Trajectories

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Two decades of efforts to promote managed care models in Medicare and Medicaid have resulted in vastly different experiences as measured by enrollment, plan participation, and ability to achieve the goals of public policy-makers. The Medicare Modernization Act of 2003 introduced a major transformation to engage and retain private health plans. It is useful for plan administrators to consider why the trajectories for the programs have been so divergent and to assess prospects for success in the Medicare Advantage initiative.

(Am J Manag Care. 2006;12:40-44)

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.¹ The MMA offers a prescription drug benefit and several private plan options to beneficiaries, including access to local and regional preferred provider organizations and regional freestanding drug plans. Payments are determined in part by competitive bidding rather than legislated formula, with incentives to plans to bid below established benchmarks. The MMA represents a major effort to remedy problems plaguing Medicare's health plan program for a number of years.

Instability of the Medicare managed care market contrasts sharply with the relative tranquility of managed Medicaid programs during the same time period. Both managed care initiatives were designed in the early 1980s to breathe new life into moribund public programs that were locked into fee-for-service-based purchasing strategies.¹ Since then Medicaid managed care enrollment has increased about 10-fold, to more than 27 million subscribers, while Medicare enrollment has only doubled, to about 5.0 million subscribers.² Understanding reasons for the divergent trajectories is useful for health plan administrators considering the new but unproven opportunities presented by the MMA.

CONTRASTING MEDICARE AND MEDICAID MANAGED CARE

Managed care enrollment was touted as a strategy to promote competition, enhance choices and benefits for beneficiaries, and improve care and cost management at

a time when expectations for managed care were rising.³ We highlight several dimensions (Table) on which the 2 government-sponsored initiatives can be contrasted to assess if the MMA has created a more hospitable and potentially successful environment for health plans.

Strategies and Objectives

Although the managed care programs of Medicare and Medicaid were launched almost simultaneously, the 2 strategies had different objectives. The Medicare program sought to enhance benefits and coordination of care. State-based Medicaid programs were constructed to control costs, but had additional objectives of improving access to care and enhancing quality. Because both programs were choking federal and state budgets, policy-makers hoped managed care could make costs more predictable and, in time, reduce growth.⁴

Benefit enhancement became a hallmark of Medicare managed care and contributed to a growing zest among policy-makers to expand availability of health maintenance organization (HMO) options to geographic areas initially spurned by plans. The Balanced Budget Act of 1997, and subsequently the MMA, explicitly promoted geographic expansion. State Medicaid agencies, however, turned to managed care to remedy an ailing program by obtaining access to adequate primary care, reducing use of unnecessarily costly care, and, ultimately, slowing expenditure growth.⁵

Benefit Structure and Enrollment

Medicare and Medicaid differ substantially on benefit package structure. Since its enactment in 1965, Medicare has been a catastrophic benefit program that has concentrated on full hospital coverage, with widely available supplements that provide varying degrees of outpatient coverage. While Medicare HMOs were originally viewed as alternatives to traditional Medicare, they came to be regarded as alternative sources for supple-

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Table. Comparison of Medicare and Medicaid Managed Care Programs According to Selected Features

Feature of Plan	Medicare	Medicaid
Strategic objectives	Enhance coordination of care; control costs; ensure cost predictability	Improve access to care; enhance quality; ensure cost predictability
Benefit structure and enrollment	Catastrophic benefit with beneficiary-sponsored supplements; voluntary enrollment in managed care plans; cost-sharing a standard feature	Comprehensive benefit structure with minimal beneficiary-sponsored benefits; mandatory enrollment in managed care plans; cost-sharing largely absent, except for rare exceptions
Healthcare needs of beneficiaries	Characterized by chronic illnesses	Predominantly disease prevention for newborns, but complicated by socioeconomic disadvantages that lead to episodic illnesses and newborn complications
Physician workforce challenges	Adequate access to specialists	Adequate access to primary care
Facility network composition	Managed population dispersed broadly across different neighborhoods and regions	Managed population mostly concentrated in inner city neighborhood
Administration and payment methods	Federally with CMS with strict regulatory oversight; payments based on fee-for-service costs by geographic regions	State-by-state administration through Medicaid agencies; payments reflect administrative pricing, but with negotiated variability
Plan participation in marketplace	Mostly business lines of existing nongovernment-sponsored commercial plans	Mixture of provider-sponsored, "pure play" publicly traded companies and commercial nongovernment-sponsored plans
Political context	Largest special interest group in the United States	Politically weak constituency

CMS indicates Centers for Medicare and Medicaid Services.

mental coverage, typically at a lower price for comparable or enhanced benefits. Health maintenance organization enrollment, where available, included many low-income beneficiaries willing to trade freedom of choice for economic gain.⁶

For individuals meeting eligibility standards, Medicaid is a far more comprehensive program, with access to rich benefits with minimal out-of-pocket expense. The challenge for state Medicaid programs has been to *finance* the benefit package; many now make choice restrictions a condition for receiving benefits. Whereas voluntary enrollment was an early feature of both Medicaid managed care and primary care case management, more recently mandatory enrollment has played a crucial role in the ability of Medicaid managed care programs to grow. This approach also ensured health plans could expect reasonable enrollment growth in specific regions, without major marketing efforts. In contrast to Medicaid enrollment in managed care plans, Medicare enrollment in health plans has been voluntary.⁷ But when zero premium plans flourished and

benefits included outpatient drug coverage, many beneficiaries found enrollment enticing.

Healthcare Needs and Physician Workforce

Among the most obvious differences between Medicare and Medicaid are the beneficiary populations and their healthcare needs. The predominantly senior population in Medicare is older and more likely to be beset by chronic illness; therefore medical care for Medicare beneficiaries is in general more costly per capita than for Medicaid beneficiaries. Because eligibility in Medicare is permanent for seniors, return on investment for managed care and chronic disease management should be more persuasive than in Medicaid.

The preponderance of Medicaid beneficiaries are low-income women and children. Age and sex demographics of this population reflect reasonably good health, with needs more similar to commercial managed care enrollees than Medicare beneficiaries. But the medical care needs of Medicaid beneficiaries are confounded by economic and social disadvantages, creating opportuni-

ties for managed care organizations to assist in overcoming barriers to access to quality care. The potential contribution of managed care in Medicaid is threatened by episodic eligibility that undermines a return on investment logic for prevention and disease management.⁸

As the healthcare needs of the Medicaid and Medicare beneficiaries diverge, so do the networks to serve these distinct populations. Whereas primary care represents the greatest need for most Medicaid beneficiaries, Medicare beneficiaries rely heavily on multiple specialists required to manage high-frequency chronic conditions. These divergent populations also influence facility networks. Medicaid populations are typically concentrated in inner city areas often served by safety net hospitals highly dependent on Medicaid revenues. The Medicare population is relatively more geographically dispersed than Medicaid beneficiaries—making it more difficult for Medicare plans to accumulate sufficient enrollment to leverage facility participation.

Administration and Payment Methods

The Medicare HMO program is centrally administered by the Centers for Medicare and Medicaid Services (CMS) and is particularly attentive to uniformity and compliance with legislative and regulatory requirements. Types of managed care plans permitted in Medicare are explicitly spelled out, management and marketing practices are highly prescribed, and methods of payment are carefully detailed. Until 1997, legislated payment methods to health plans in the Medicare program were based on fee-for-service costs, modeled on single counties, without risk adjustment. This methodology created enormous geographic variability and did not reward plan efficiency. The vagaries of these methods created some of Medicare HMOs' staunchest supporters—and biggest critics. Policy-makers either welcomed benefit enrichments in the high-payment, well-served counties, or rued the inequities for beneficiaries in low-payment, underserved areas.

Medicaid's managed care models have been more diverse than Medicare, reflecting the administrative malleability of Medicaid relative to Medicare and the practical realities that state-level agencies can make genuine program refinements in the face of local contingencies. Supporters of the states-as-laboratories position have highlighted varied payment approaches to managed care as indicative of state ingenuity and responsiveness to their distinct political and economic climates and varied medical marketplaces. Willingness to use multiple models, ranging from full risk with prepaid health plans to no-risk primary care case management models, reflects this adaptation. A number of states utilize multiple models to

achieve border-to-border managed care coverage across disparate geographic areas.

Plan Participation in the Marketplace

Multistate, multiproduct managed care firms have dominated Medicare HMOs. At one time, 50% of the Medicare HMO membership were enrolled in only 6 firms.⁹ The capacity of a few companies to offer Medicare products selectively and their mobility to enter markets where rates were lucrative represented important advantages. These plans could invest the customer acquisition resources needed in expensive, individual marketing efforts. But voluntary enrollment also raised questions about whether Medicare plans could attract members systematically healthier than the average beneficiary, and this criticism dogged Medicare plans for many years.¹⁰

Mandatory enrollment in Medicaid managed care programs has played an important role in attracting and maintaining plan participation. Identifying a large number of Medicaid beneficiaries who must choose or be assigned to HMOs offered health plans an important advantage in market entry. The confidence of a sizable enrollment facilitated network assembly for Medicaid health plans to enable them to meet specified access standards, while minimizing disruption in patient-provider relationships. This scenario contrasted with Medicare plans, whose members retained the opportunity to stay in traditional Medicare and continue with providers participating in both traditional and HMO programs.

Political Context

The experiences of Medicare and Medicaid with managed care can also be framed in a political context. Contrasting Medicaid with Medicare, Brown and Sparer noted that Medicare represents the far more "politicized and ossified" program.¹¹ As a national entitlement program, its administrators have less ability to deviate from uniformity. The size of Medicare and its significance to the federal budget also means that efforts to reform it on a large scale are alluring, but, inevitably, controversial.

Conversely, Medicaid has had both flexibility and political immunity to undertake reform. Insofar as Medicaid has become the single largest budget item for most states, the real Medicaid constituent is now the taxpayer.¹² While budget deficits engender much talk among federal policy-makers, constitutional mandates for balanced budgets compel action among state policy-makers, and Medicaid managed care has been a hardy perennial as a cost-control measure.

Managed care has grown within the Medicaid program because of a pervasive sense of financial constraint

and a beneficiary constituency unable to resist mandatory assignment. The more politically pliable Medicaid beneficiaries accepted managed care to obtain benefits. Abstract concerns about choice restriction were trumped by a guarantee of medical care. Mandatory enrollment also allayed the biased-selection concern that plagued Medicare.¹⁰ States were better able to predict savings by discounting premium rates to health plans from a cost base in which no biased selection could occur.

Although Medicare policy-makers were keen on the role of managed care in controlling costs of the program, they have also displayed ambivalence about its contributions. Superior benefits were seen as the most compelling reason to promote HMO enrollment, and this proved achievable—albeit on a highly uneven basis. Even savings that might have resulted from promoting enrollment in managed care were subject to debate because they ended up enriching beneficiaries and health plans, with little prospect for savings accruing to Medicare.¹³ Plans clustered in lucrative markets and shunned other areas. Where rates remained high, Medicare HMO programs have remained viable, but elsewhere, little has changed—until the MMA was passed.

IMPLICATIONS FOR MEDICARE
ADVANTAGE

Several implications for the new Medicare Advantage program can be drawn from the contrasts in public sector managed care experiences.

Administrative Flexibility and Customization

The new array of optional arrangements for Medicare beneficiaries allows for more customization than past models of care for the Medicare program.¹⁴ Creating practical, broad regions that are statewide, and beyond, creates challenges and opportunities for health plans. Several Medicaid agencies have succeeded in implementing managed care statewide, confirming that such markets can be feasibly established and made attractive to bidders.

Clarity of Program Goals and Tradeoffs

The MA plans are expected to expand options, offer enriched benefits, and be located in areas not previously served by Medicare managed care plans. They will be required to produce and document high-quality care. They are also supposed to control growth of costs as they mature and competition heats up. These goals will probably not be simultaneously attainable. Enriched benefits may not be sustainable if cost-containment

pressures brought on by competition materialize. Plans may achieve better outcomes, but at a higher cost, and a decision will have to be made to determine if this situation is desirable and supportable. Tradeoffs are inevitable, and both Congress and CMS, like state Medicaid agencies, will have to determine priorities.

Capacity to Encourage Beneficiary Participation

While Medicaid agencies can mandate enrollment by fiat, low-income Medicare beneficiaries have had an economic imperative to join plans that limit out-of-pocket costs. Markedly improved payments to plans have led to richer benefits and lower costs already. The prescription drug benefit integrated into health plans may be more attractively configured than freestanding plans, and could prove a powerful inducement to beneficiaries, ensuring plans of enrollment volume. Preferred provider organization products may possibly widen the appeal to beneficiaries in areas not served by HMOs, just as states have used primary care case management to implement rural managed care.

Rate-setting

A market once notorious for its instability, Medicaid has been portrayed by investment analysts in recent years as having markedly improved its financial predictability.¹⁵ Rather than being formulaic, Medicare rates under MMA need to reflect a willingness to make adjustments in the face of changing business conditions, including rising medical cost trends and a need for reasonable profit margins. The addition of bidding against benchmarks in Medicare provides greater reality testing than past payment approaches.

Securing Long-term Partners

Finding and devising solutions to problems that will arise with MMA implementation will depend on the climate for collaboration that emerges between CMS and contracting plans. The MMA plans will need to have sizable Medicare enrollments so that they will become proficient at managing care for their beneficiaries. Based on what has been observed in the evolution of Medicaid managed care, this endeavor will certainly require a growing tolerance by CMS for specialized health plans, and recognition of shared responsibilities for the well-being of Medicare beneficiaries. The potential for long-term relationships between CMS and health plans will receive an early test given huge current federal deficits that will soon provoke challenges to sustaining new payment methods. This challenge is similar to that weathered by many states during the recent recession, offering a further reason why Medicare has something to learn from its sister public program.

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