The Medicare Modernization Act

Medicare offers the greatest opportunity for and poses the greatest challenge to the commercial health insurance industry. The aging baby-boom generation is expected to increase enrollment from forty-three million in 2005 to fifty-three million in 2015 and then to seventy-eight million in 2030. With spending per beneficiary almost three times higher than for people with employment-based coverage, Medicare offers revenue gains on a scale that cannot be matched elsewhere in the economy. The history of private plans’ participation in Medicare has been volatile for many of the same reasons affecting Medicaid plans, with cycles of overpayment, plan entry, and enrollment expansion followed by underpayment, plan exit, and enrollment declines. MMA created a new upswing in the Medicare managed care cycle, legislating additional payments to drug-specific and full-service health plans. Depending on the sustainability of the federal payment levels and the industry’s response to the new environment, MMA could either accelerate the privatization of a quintessentially public program or generate a financial debacle for the industry that dwarfs the effects of the Balanced Budget Act (BBA) of 1997.

MMA authorized the creation of freestanding prescription drug plans (PDPs) for beneficiaries enrolled in FFS Medicare and expanded funding for the full-service Medicare Advantage with prescription drug (MA-PD) products. It also offered a partial subsidy for employment-based retiree health plans and mandated the transfer of dual eligibles from Medicaid to private PDPs. MMA’s implementation has been plagued with administrative difficulties, permitting wildly divergent predictions concerning enrollment patterns. During the first open enrollment period, up through 15 May 2006, thirty-eight million beneficiaries, representing 90 percent of those eligible, gained coverage in either a PDP, MA-PD plan, retiree program, or other governmental program (for example, military).

MMA has attracted numerous entrants into the Medicare prescription drug plan market, as pharmacy benefit managers (PBMs, such as Medco and Caremark) and retail pharmacy chains have rushed in. Bidding and price competition for enrollment has been fierce, resulting in a windfall for Medicare beneficiaries, whose premiums are lower than anticipated, but generating speculation about below-cost pricing and an eventual market shakeout. Specialized for-profit plans such as WellCare, HealthSpring, and Universal American have entered the capital markets; nonprofit Blue Cross and provider-sponsored plans have expanded their offerings; and full-service insurers have renewed their involvement in what seemed a moribund business sector. The commercial plans with traditionally large Medicare enrollment, including Humana and HealthNet, have offered new products in new geographic markets, while commercial plans such as United, WellPoint, and Aetna, which had dropped most of their Medicare enrollment after the BBA, now offer HMO products in selected areas and preferred provider organization (PPO) products on regional and national levels.

Exhibit 6 presents the distribution of enrollment and market shares in the com-
bined PDP and MA-PD Medicare market as of April 2006, highlighting the strong role played by the diversified full-service insurers such as United, Humana, and WellPoint but also the continued presence of nonprofit entities in some states and specialized PDP entities nationally. Total enrollment was almost twenty million (13.8 million PDP, 5.9 million MA-PD), excluding Medicare beneficiaries covered through retiree programs, those in federal employment and military programs, and those not electing any coverage for prescription drugs. Because of its acquisition of PacifiCare and marketing alliance with AARP, UnitedHealth Group is the dominant player, with almost five million enrollees and a 26 percent market share. Humana has focused on the MA-PD and PDP opportunity, with 3.2 million enrollees and a 17 percent market share; it now derives three-quarters of its earnings from Medicare and has been losing enrollment in the employment-based sector. WellPoint and the other investor-owned insurers, such as HealthNet and Coventry, account for 22 percent, nonprofit plans (principally Kaiser Permanente and several Blue Cross plans) account for 12 percent, and PBM and pharmacy chains account for 10 percent.

The consolidation of the Medicare sector is already beginning, evidenced most graphically in United's acquisition of PacifiCare. The short-term potential lies with local provider-sponsored plans, which in 2005 had a combined enrollment of 1.7 million. Limits to consolidation will come from nonprofit Blue plans, from Kaiser Permanente, and from selected regional HMOs. In the short term, growth in overall enrollment and entry by new plans will continue to generate competition on the basis of lower premiums and richer benefits. This price competition, more than direct mergers and acquisitions, may serve as the proximate cause for consolidation, by driving out PBMs and pharmacy chains that cannot shift enrollment from low-margin PDPs to high-margin MA-PD products.

The greatest future challenge to commercial participation in Medicare is the same as the greatest past challenge: the fluctuating commitment of the Centers for
Medicare and Medicaid Services (CMS). The contemporary land rush is driven by the Bush administration's dedication to expanding enrollment as part of a larger effort to reduce federal regulatory purview. However, the fat years of generous payments easily could be followed by lean years of payment cuts, as federal budget deficits compete for resources and insurers' robust profits attract attention. Optimists and pessimists with respect to the MMA business opportunity mainly are distinguished by the year in which they predict cutbacks, rather than by any difference in opinion as to whether cutbacks will occur.

**Concluding Comments**

The contemporary erosion of private employment-based coverage and expansion of public programs could have been expected to reduce the role of the commercial health insurance industry as an intermediary between the purchasers and providers of care. Instead of retrenching, however, the commercial sector is diversifying into Medicaid and Medicare and consolidating into firms that serve the full range of public and private purchasers. The interest among private insurers in serving public programs is reciprocated by the interest among public programs in outsourcing the management of their coverage benefits, provider networks, and enrollee expectations to private health plans. State and federal coverage sponsors increasingly lack the will to navigate the conflicting claims for resources between beneficiaries, taxpayers, and other stakeholders. They seek someone else to perform that inevitably thankless task.

Privatization is well under way in the Medicaid sector, where state budgetary pressures have generated a rapid conversion to managed care and, within managed care, to the multistate commercial insurers. While budgetary pressures will continue to tempt Medicaid programs to cut payment rates, states are reluctant to see the commercial carriers depart and relinquish enrollment back to sometimes-unstable provider-sponsored plans. Over time the sector could reach political and market equilibrium with continuous participation by commercial plans that earn a sustainable, if not exciting, profit margin and with state agencies that interpret their role as purchasers of health insurance rather than of health care itself.

The role of commercial health plans in the Medicare sector is far less developed than in Medicaid, and future trends are necessarily speculative. Medicare does not face severe budgetary pressures for another half-decade, at which point the baby-boom generation will become eligible for coverage. The contemporary efforts at outsourcing program management to the private sector stem from philosophical rather than financial sources. Advocates of private-sector involvement believe that the purchasing of health services, and the inherent trade-offs thereby required, are best performed through market contracting rather than governmental regulation.

The Bush administration has demonstrated its affinity for this vision by generously funding the Medicare Advantage program and, especially, by restricting coverage for prescription drugs to those beneficiaries who enroll in a private PDP or
MA-PD plan. This approach contrasts with the structure of Medicare prior to MMA, where private insurers competed at the margins but most beneficiaries remained with the publicly administered FFS program. Under MMA, there is no publicly administered drug coverage, no fall-back from the private plans. Beneficiaries can remain with the public program for their physician and hospital coverage, but both the industry and the CMS see the enrollment shift from limited PDP plans to comprehensive MA-PD plans as the means by which to greatly reduce the scale of the residual FFS program.

Although it appears safe to predict continued enrollment growth in the commercial health insurance industry, the earnings prospects for the sector are far from assured. The run-up in industry profits, now in an unprecedented sixth year, has raised the bar of earnings targets high and makes it easier to predict financial compression than expansion for the sector. Stock prices suffered a sharp pullback in the first half of 2006 under fears that the potential revenue and earnings from Medicare, while large on a per enrollee basis, were not sufficient on an aggregate basis to offset the erosion of enrollment and earnings in employment-based enrollment.

For the moment, however, most of the trend lines continue to point upward. Americans are moving from employment-based to public coverage, but public programs are eager to outsource to the private sector the difficult task of managing care. The industry's core strategy has been growth through diversification across purchasers, products, and markets. Health insurance increasingly is bought by public programs but sold by private firms that have grown to a scale and scope unimaginable in the once-fragmented world of health care finance.

This research was supported by the California Healthcare Foundation.

NOTES
1. An additional 8.2 million nonelderly people receive coverage through the military and related federal services.
5. M. Borch and A. Herman, Too Much Profit at the Not-for-Profit Blues (New York: Goldman Sachs Global Investment Research, 16 December 2005); and M. Borch, D. Miller, and A. Herman, Early Signs of a Slowdown in Managed Care (New York: Goldman Sachs, 24 April 2006).
6. The percentage earnings margin is much higher for self-insured than for insured business, but dollar reve-
muses per enrollee are much lower. The earnings margin for consumer-directed plans is estimated to be similar to that for comprehensive plans, but annual revenues per enrollee are lower because much of the cost of care is paid directly by enrollees because of the deductible provision. C. Boorady, L.A. Hubbard, and S.C. Morena, *United States Managed Care: The Medicare Industrial Complex* (New York: Citigroup Equity Research, 8 June 2006).


8. The "other nonprofit" category is dominated by Kaiser Permanente, Intermountain, Tufts, Harvard-Pilgrim, Group Health Puget Sound, HealthPartners, HIP, GHII, Medica, and Health Alliance.


15. M. Gold, "Can Managed Care and Competition Control Medicare Costs?" *Health Affairs* 22 (2003): w176-w188 (published online 2 April 2003; 10.1377/hlthaff.w3.175).


22. This 17 million enrollment figure excludes Medicare enrollment in nonprofit Blue Cross plans, Kaiser Permanente, and plans with fewer than 10,000 enrollees. J.R. Raskin, G.K. Nersesian, and S. James, *Medicare Managed Care: Markets and Share* (New York: Lehman Brothers, 26 October 2005).
WILL EMPLOYER COVERAGE ENDURE?

Insurers Adapt To An Eroding Workplace Market
James C. Robinson
Perspectives By Helen Darling, Marsha Gold & Robert Hurley

Understanding Employers' Mind-Set
Robert S. Galvin & Suzanne Delbanco

Employer Coverage — Past, Present & Future
Alain C. Enthoven & Victor R. Fuchs

The 'Graying' Of Group Health Insurance
Patricia Seliger Keenan, David M. Cutler & Michael Chernew

Massachusetts Reform: Lessons For Other States
Edmund F. Haislmaier & Nina Owcharenko

PLUS: RETIREE COVERAGE; COST SHARING & PREVENTION; TAX SUBSIDIES; ASSOCIATION PLANS; PORTABLE COVERAGE; PUBLIC PURCHASERS & MORE

HEALTH TRACKING
Coverage Among Immigrants • Age-Related Doctor Workloads
Hospital/MD Portals • Intellectual Property & Generic Drugs

NARRATIVE MATTERS
Bleeding-Edge Benefits • Life, Death & Who Pays?

DATABATCH
Incremental Coverage Expansions • Safety Net • Rural Underinsured

www.healthaffairs.org • Published by Project HOPE
This journal provided through your AcademyHealth membership