

## NHPF Forum Session

### Meeting Announcement

**NATIONAL  
HEALTH  
POLICY  
FORUM**

# Understanding Medicare Advantage Bidding and Payment: Effects on Plan Choice and Beneficiary Premiums

#### A TECHNICAL BRIEFING FEATURING:

**Marsha Gold, ScD**

*Senior Fellow*

Mathematica Policy Research, Inc.

**Rich Coyle**

*Actuary*

Centers for Medicare & Medicaid  
Services

**Jack Ebeler**

*President and Chief Executive*

*Officer*

Alliance of Community Health  
Plans

**Thursday,  
April 28, 2005**

11:45 am — *Lunch*

12:15–2:00 pm — *Discussion*

**Rayburn House Office  
Building**

Room 2322

Independence Avenue and  
South Capitol Street

#### **To register:**

Please send your contact information to [nhpfmeet@gwu.edu](mailto:nhpfmeet@gwu.edu) as soon as possible. *Due to limited space, priority will be given to congressional staff.*

#### **For additional information:**

See the report by Marsha Gold *et al.*, *Monitoring Medicare+Choice: What Have We Learned?* at [www.mathematica-mpr.com/publications/PDFs/monitor.pdf](http://www.mathematica-mpr.com/publications/PDFs/monitor.pdf).

THE GEORGE  
WASHINGTON  
UNIVERSITY  
WASHINGTON DC

# Understanding Medicare Advantage Bidding and Payment: Effects on Plan Choice and Beneficiary Premiums

The Medicare program first began offering beneficiaries the option of enrolling in private health plans in the mid-1980s. Since that time, Congress has tried numerous approaches to promote expanded choice for Medicare beneficiaries. Success has been mixed. Most recently, with the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and the establishment of the Medicare Advantage (MA) program, Congress and the Bush administration are attempting to foster private plan participation in Medicare.

MA replaces and expands the Medicare+Choice (M+C) program, which had been in operation since 1997. Under M+C program, the Centers for Medicare & Medicaid Services (CMS) paid organizations a fixed monthly amount for providing all Medicare-covered services to each beneficiary enrolled in their plans. Payment rates were set administratively for each county in the country on the basis of formulas prescribed in law. Adjusted Community Rate Proposals (ACRPs)—as submitted by the plans and negotiated by CMS—documented how the payments would be used by the plans.

Beginning in 2006, this payment system will be replaced with a bidding process designed to introduce more competition into the Medicare

## SESSION OVERVIEW

This technical briefing will provide details on the new Medicare Advantage (MA) bidding and payment calculation process, aimed at increasing plan choices for beneficiaries. Speakers will present an overview of Medicare's experience with private plans to date, discuss similarities and differences with the new payment methods enacted as part of the Medicare Modernization Act of 2003, and provide bidding and payment examples. In addition, speakers will discuss how these new payment methods are likely to affect plan and beneficiary participation in the MA program, as well as the premiums beneficiaries ultimately will have to pay.

### Forum Session Manager

**Nora Super**

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program. Payments will be based on the plan's estimate of what it costs to provide the Medicare benefit (including profit), rather than administratively set amounts. CMS will establish risk-adjusted benchmarks—similar to the payment rates under M+C—that will be compared to plan bids for the purpose of determining rebates and premiums. Plans that want to participate in the MA program are required to submit bids on the first Monday of June each year, beginning June 6, 2005, for the 2006 benefit year.

With that date just around the corner, MA plans, Medicare beneficiaries, and policymakers are trying to decipher the complex code of bidding and payment requirements established under the MMA. This technical briefing is designed to shed some light on these important issues.

## PROGRAM & SPEAKERS

**Marsha Gold, ScD**, will present trends in plan availability, diversity, and enrollment since Medicare began contracting with private plans. She will discuss factors that explain market variation and trends in benefit design, premiums, and out-of-pocket costs drawn largely from *Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage*, a report that she co-authored.<sup>1</sup> Finally, Dr. Gold will provide some insights for MA from the M+C experience. Dr. Gold is a senior fellow at Mathematica Policy Research. She is a nationally known expert on health care issues with an emphasis on managed care and the changing health care scene. Her current activities include the Monitoring Project, which has been tracking the use of private plans in Medicare since 1999.

**Rich Coyle** will provide an overview of the payment and bidding requirements established under the MMA. He will discuss the overall bidding and benchmarking concept—including the differences for local plans and regional plans—and will also review how rebates and premiums will be determined, and how CMS will evaluate bids and determine payments. Mr. Coyle has worked as an actuary in the CMS Office of the Actuary for the past six years. Since 2000, Mr. Coyle has focused on the MA and M+C programs and has had responsibility for (a) the actuarial review of the ACPR submissions, (b) analyzing the financial viability of managed care demonstration programs (including the preferred provider organization (PPO) program), and (c) implementing the MA actuarial provisions of the MMA, including the development of the bid submission form and review procedures.

**Jack Ebeler** will provide some examples of how the bid and benchmarking process will work from a health plan perspective. He will illustrate how payments may be different depending on the plan's location, risk profile, and whether or not it is a local or regional plan. Mr. Ebeler is president and chief executive officer of

the Alliance of Community Health Plans (ACHP). He was appointed to this position in 2001. Before joining ACHP, Mr. Ebeler was senior vice president and director of the Health Care Group at the Robert Wood Johnson Foundation, the nation's largest philanthropic organization devoted solely to health and health care. He has also served in the federal government and worked with a health policy consulting firm and a managed care organization.

## **KEY QUESTIONS**

- What have been the trends in plan availability, diversity, and enrollment under M+C? How do MA plans compare?
- What have been the trends in benefit design, premiums, and out-of-pocket costs?
- What factors explain market variation?
- Why have Medicare beneficiaries chosen to join or leave M+C plans?
- Why have plans chosen to participate or withdraw from the program?
- How does the calculation of MA payments differ from the calculation of M+C payments?
- How will the new bidding and payment calculation process differ for local MA plans versus regional MA plans?
- How will beneficiary rebates and premiums be determined?
- How will risk adjustment and the beneficiary's county of residence be taken into account in determining the payment amount?
- How will the MA drug benefits and/or premiums likely compare with those in prescription drug plans (PDPs)?
- What is the CMS timeline for implementation of MA?

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## **ENDNOTE**

1. Marsha Gold, Lori Achman, Jessica Mittler, and Beth Stevens, *Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage* (Washington, DC: Mathematica Policy Research, Inc., August 2004); available at [www.mathematica-mpr.com/publications/PDFs/monitor.pdf](http://www.mathematica-mpr.com/publications/PDFs/monitor.pdf).