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Report to Congressional Requesters

April 1999

MEDICARE MANAGED CARE PLANS

Many Factors
Contribute to Recent
Withdrawals; Plan
Interest Continues



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United States
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**Health, Education, and
Human Services Division**

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Congressional Requesters

In 1998, nearly 7 million Medicare beneficiaries (approximately 17 percent of all Medicare beneficiaries) were enrolled in health plans offered by managed care organizations (MCO).¹ Most were members of health maintenance organizations (HMO) that received a fixed (or capitated) monthly fee per enrollee regardless of the number and mix of services they provided.² These plans typically offered services not covered under the traditional fee-for-service (FFS) Medicare program—such as routine physical examinations and outpatient prescription drugs—and members generally paid less out of pocket than they would in FFS. Not all beneficiaries, however, had access to a managed care plan because HMOs were not available in all areas.

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice program to expand beneficiaries' managed care options, both by encouraging the wider availability of HMOs and by permitting other types of health plans to participate in Medicare. The BBA also contained provisions to slow the growth of Medicare spending. The Congressional Budget Office estimated that these provisions will result in net Medicare savings of \$116 billion between 1998 and 2002. Changes

¹A "plan" refers to a package of specific health benefits, out-of-pocket costs, and terms of coverage. An MCO refers to the entity that offers one or more such plans.

²Prior to 1999, these plans were known as risk HMOs or risk plans. Before the BBA was passed, only a few types of plans offered services to Medicare beneficiaries. In recent years, the vast majority of beneficiaries who opted for managed care enrolled in risk plans. Other types of Medicare plans included HMOs with cost contracts and health care prepayment plans. These plans differed substantially from risk plans both in how they operate and how Medicare reimburses them. Risk HMOs, along with new types of plans authorized by the BBA, are now known as Medicare+Choice plans. When we refer to a "plan" or a "managed care plan" in this report, we are referring only to plans that receive capitated payments, including both risk plans and Medicare+Choice plans; other types of plans with different payment mechanisms are excluded from our analysis.

to the method for calculating payments to managed care plans, along with slowed growth in Medicare FFS spending (upon which managed care payments are partially based), account for approximately \$22.5 billion of these projected savings. These changes followed a decade in which studies by GAO and others found that Medicare's previous payment methodology tended to overcompensate managed care plans.³ In addition, the BBA included provisions to make plans more accountable for the quality of care they provide. For example, the BBA required Medicare managed care plans to implement new and more comprehensive quality assurance programs.

Last fall, shortly before the start of the Medicare+Choice program, nearly 100 Medicare managed care plans announced that they would not renew their Medicare contracts or that they would reduce the geographic areas they served. Beneficiaries affected by these withdrawals either had to switch plans or return to FFS; a small percentage of these beneficiaries were left with no alternative but FFS.⁴ Because of your concern over these developments, you asked us to provide you with information about recent plan decisions (requesters are listed at the end of this letter). This report focuses on plans that receive capitated payments and provides information on the patterns of plan and beneficiary participation in managed care, factors associated with plans' decisions to enter or leave the Medicare+Choice program, and changes in plans' benefit packages and premiums. Appendix I presents details of our methodology.

RESULTS IN BRIEF

Although an unusually large number of managed care plans left the Medicare program recently, a number of new plans have demonstrated their interest in serving beneficiaries by applying to enter the program or expanding the areas in which they offer services. Last fall, shortly before Medicare+Choice was implemented, 45 plans announced they would not renew their Medicare contracts and 54 others announced they would reduce the geographic areas in which they provided services. About 407,000 enrollees (7 percent of the managed care population) had to choose a new managed care plan or switch to FFS. A small number of the affected enrollees had to switch to FFS because no

³Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

⁴Some beneficiaries affected by the withdrawals live in counties served by cost HMOs and could join this kind of plan rather than return to FFS. Medicare payments to these plans are based on the costs they incur and enrolled beneficiaries can receive covered Medicare benefits from providers regardless of their affiliation with the plan. For these reasons, cost HMOs are more similar to the FFS program than to risk HMOs, which receive a fixed monthly payment and whose enrolled Medicare beneficiaries must generally receive services through plan-affiliated providers.

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plans remained to provide services in their areas. At the same time, however, several new plans applied to enter the program. Thus far, the Health Care Financing Administration (HCFA), which administers Medicare, has approved 10 new plans for 1999 and is reviewing 30 additional plan applications. Some of the pending plan applications are for counties that previously had few or no managed care plans. If HCFA approves all of the pending plans and service area expansions, slightly more beneficiaries will have access to a managed care plan in 1999 than in 1998.

Plan withdrawals cannot be traced to a single cause; a variety of factors appear to be associated with plans' participation decisions. Payment level is one factor that influences where plans offer services, but withdrawals were not limited to counties with low payments. In fact, 91 percent of high-payment-rate counties experienced a plan withdrawal compared with 34 percent of low-payment counties. When a plan reduced its service area, however, we found that counties with low payment rates relative to payments in the rest of a plan's service area were more likely to experience a withdrawal than counties with higher payment rates. A review of other factors suggests that a portion of the withdrawals may have been the result of plans deciding that they were unable to compete effectively in certain areas. For example, plans were more likely to withdraw from counties in which they had begun operating since 1992, where they had attracted fewer enrollees, or where they faced larger competitors. Some plans have indicated that they withdrew from areas where they were unsuccessful in establishing sufficient provider networks. Plan representatives also cited the administrative burden associated with new Medicare+Choice program requirements as a significant factor in plans' decision-making. However, few national MCOs terminated all of their Medicare plans; instead, most continue to offer plans in other areas.

A broad comparison of plan benefit packages from 1997 and 1999 indicates modest reductions in the inclusion of certain benefits. Our analysis focused only on whether specific benefits were offered by plans in each of the 2 years, because information was not available to determine whether plans changed coverage levels for these benefits. In 1999, a slightly greater percentage of beneficiaries can join a plan that offers prescription drug coverage, while a slightly smaller percentage of beneficiaries have access to a plan offering dental care, hearing exams, and foot care. Beneficiaries living in the lowest-payment-rate areas experienced greater decreases in access than the average beneficiary. In addition, those living in the lowest payment areas experienced a decrease in access to plans offering prescription drug benefits, while beneficiaries in higher payment areas saw an increase in access to plans offering drug benefits. Decreases in the lowest-payment-rate areas occurred despite the fact that the average payment for plans in these counties rose by 23 percent between 1997 and 1999 compared with a 4-percent increase for all other counties.

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BACKGROUND

Medicare is the nation's health insurance program for those aged 65 and older and certain disabled individuals. All beneficiaries may receive health care through Medicare's traditional FFS arrangement. Alternatively, a beneficiary may enroll in a Medicare managed care plan if one is available in the county in which he or she lives. The vast majority of the nation's 39 million Medicare beneficiaries remain in the traditional FFS program, but enrollment in Medicare managed care plans has grown rapidly in recent years. Currently, about 17 percent of all Medicare beneficiaries are enrolled in a managed care plan.

Medicare Managed Care Before BBA

As of December 1, 1998, about 90 percent of Medicare's managed care enrollees were in risk plans. Such plans assumed the financial risk of providing care for a fixed monthly per-beneficiary fee paid by Medicare. Payment rates were determined for each county on the basis of the average adjusted per capita FFS spending in that county.⁵ Because these plans were assumed to be able to provide services more efficiently than the FFS sector, Medicare law set payment rates at 95 percent of the FFS amount in each county. These county rates were adjusted up or down on the basis of enrollees' demographic characteristics, such as age and gender. The adjustments, known as risk adjustments, were intended to account for differences in beneficiaries' expected health care costs. That is, payment rates for enrollees who were expected to require more medical care were supposed to be higher than the rates for healthier enrollees.

This payment methodology has been criticized for a number of weaknesses. Basing payments on per capita FFS spending resulted in significant variation in capitation rates across counties that did not necessarily reflect differences in costs faced by managed care plans.⁶ Rural areas, which generally had much lower payment rates than urban areas, often had few or no managed care plans. In addition, years of research indicated that Medicare's payment methodology and demographic risk adjusters resulted in excess payments to plans because they generally attracted healthier beneficiaries with below-average health care

⁵HCFA estimated how much would be spent in each county to serve the average FFS beneficiary. This amount could be higher or lower than actual per capita spending in each county if the demographic composition of the county's population differed from the national average.

⁶Medicare Managed Care: HMO Rates. Other Factors Create Uneven Availability of Benefits (GAO/T-HEHS-97-133, May 19, 1997).

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costs.⁷ Consequently, many managed care enrollees would have cost Medicare less if they had stayed in the FFS sector. In 1997 the Physician Payment Review Commission⁸ estimated that Medicare paid as much as \$2 billion annually in excess payments to managed care plans.

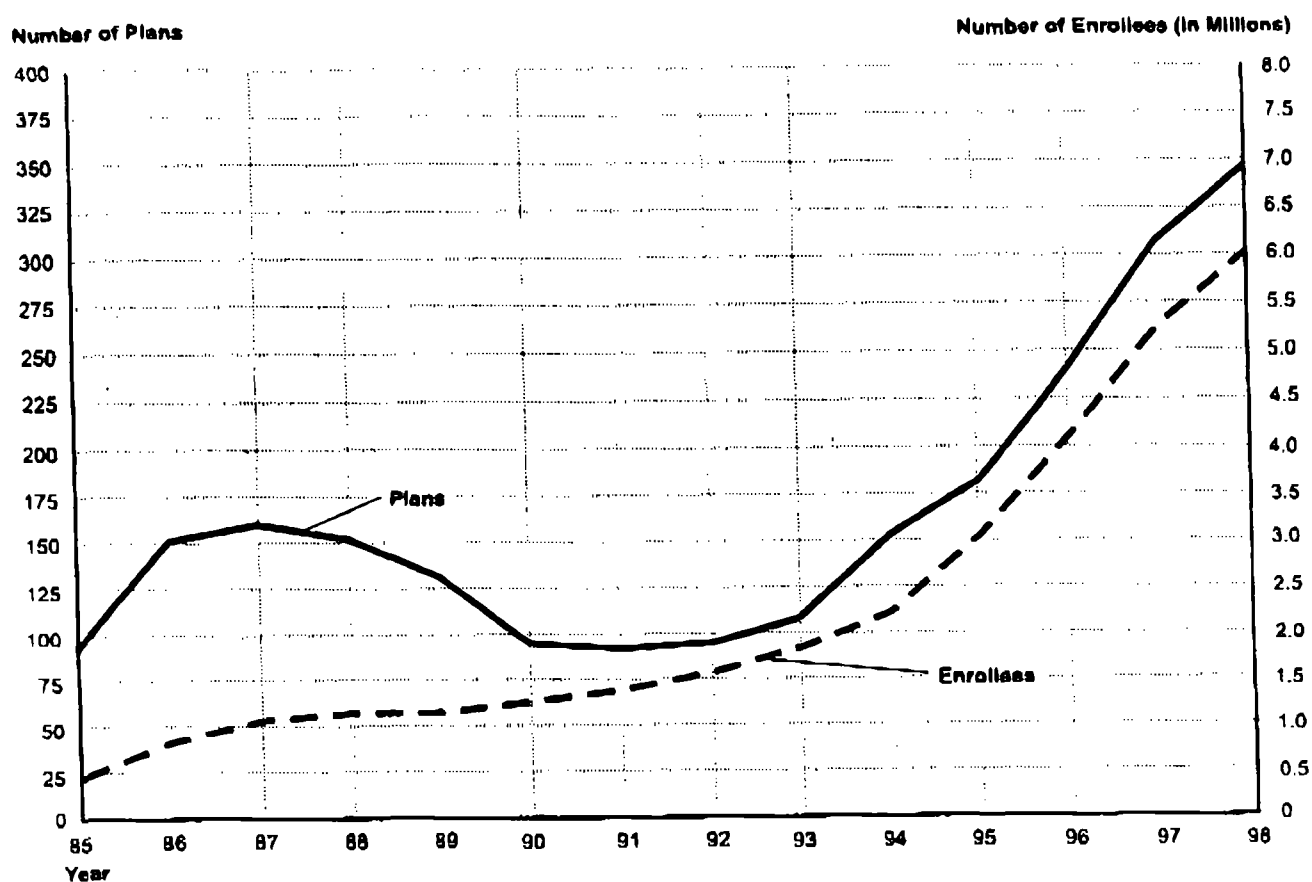
Historical Trends in Plan
Participation and Enrollment

In recent years, plan participation in Medicare has grown steadily (see fig. 1). Between 1987 and 1991, however, the number of plans dropped dramatically, from 165 to 93. The number of enrollees affected by these withdrawals was fairly small because many of the terminating plans had few or no enrollees. In fact, HMO enrollment has steadily increased each year, even during the years when the number of plans decreased. In the last 3 years, enrollment in Medicare plans has more than doubled, from about 3 million in 1995 to over 6 million in 1998.

⁷Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, Feb. 25, 1999).

⁸In October 1997, the Medicare Payment Advisory Commission replaced the Physician Payment Review Commission.

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Figure 1: Medicare Plans and Enrollment, 1985-98

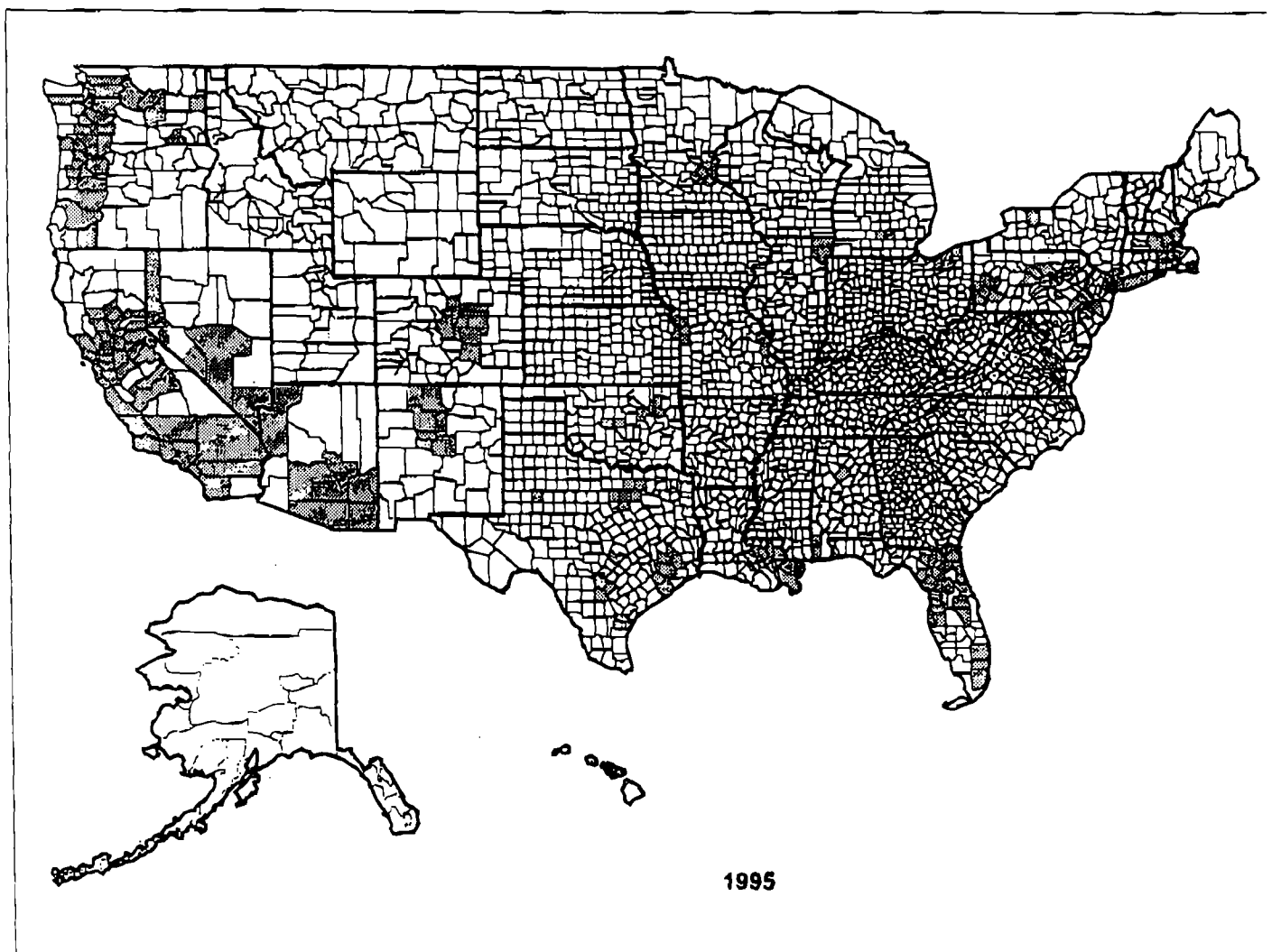
Note: Nonrisk plans are excluded from this analysis.

Sources: Medicare Managed Care Monthly Contract Reports for December 1985-98, www.hcfa.gov/80/stats/mmcc.txt (Dec. 9, 1998).

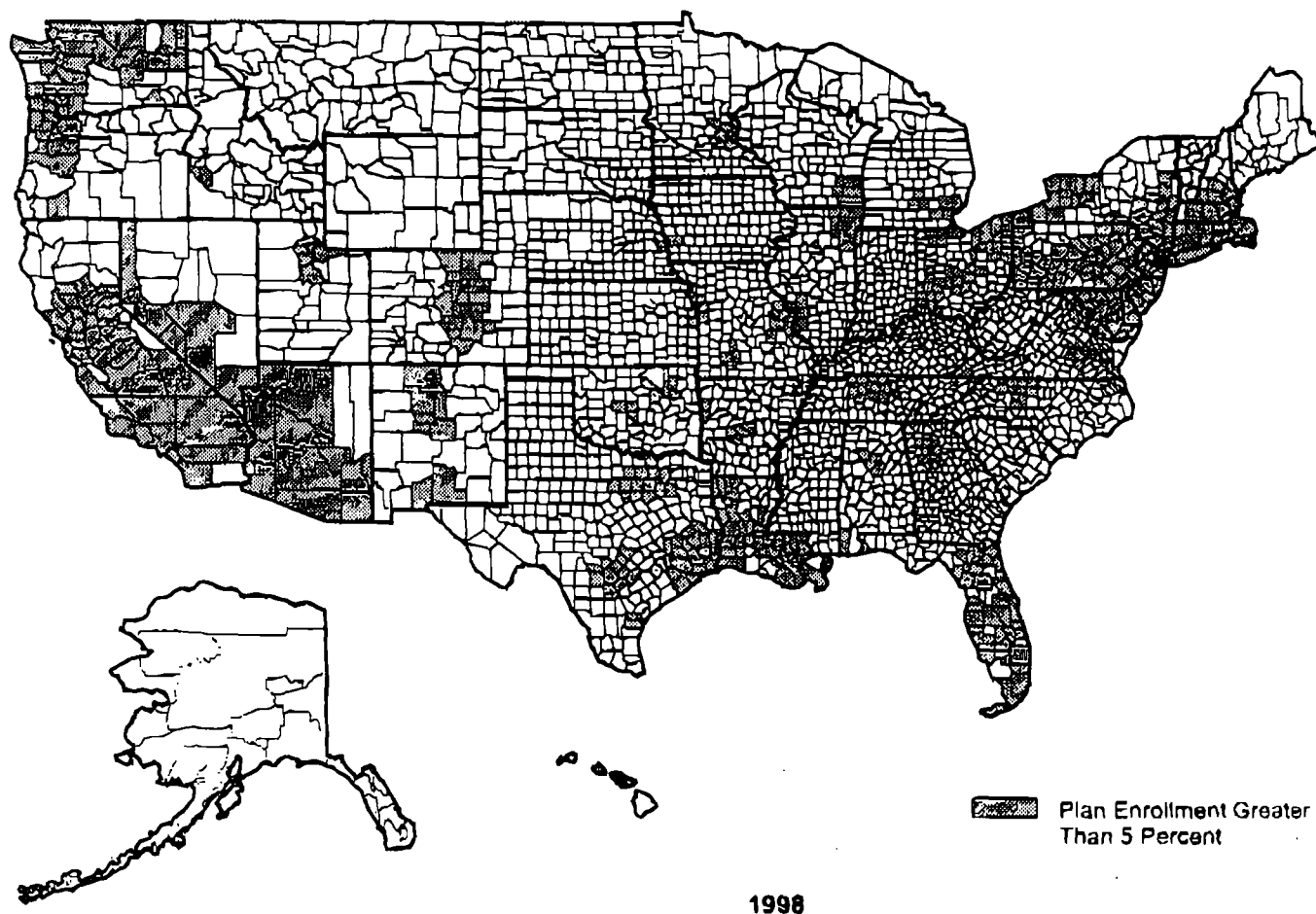
Managed care enrollment is not evenly distributed nationwide. A comparison of counties with Medicare managed care plan enrollment greater than 5 percent in 1995 and 1998 shows that enrollment has increased in many counties but remains concentrated in the West, Northeast, and Florida. (See fig. 2.)

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Figure 2: Counties With Medicare Plan Enrollment Greater Than 5 Percent of the Medicare Population, December 1995 and September 1998



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Note: Nonrisk plans are excluded from this analysis.

Sources: Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997), and Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Jan. 13, 1999).

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BBA Changes to Medicare Managed Care

The BBA substantially changed the method used to set the payment rates for Medicare managed care plans. As of January 1, 1998, plan payments for each county are based on the highest rate resulting from three alternative methodologies: a minimum payment amount, a minimum increase over the previous year's payment, or a blend of national and local FFS spending (see app. II for a description of the new payment methodology). The changes were intended to address criticisms of the original payment system by loosening the link between local FFS spending increases and managed care rate increases in each county. In addition, the establishment of a minimum payment rate was meant to encourage plans to offer services in rural areas, which have historically had low payment rates and few participating plans. The BBA also directed the Secretary of Health and Human Services to develop and implement a better risk-adjustment system based on beneficiaries' health status by January 1, 2000.

The BBA created the Medicare+Choice program, effective January 1, 1999, to broaden beneficiaries' health plan options. In addition to HMOs, two new types of managed care organizations were allowed to participate in Medicare: provider-sponsored organizations (PSO) and preferred provider organizations (PPO).⁹ The BBA also permits private indemnity plans to serve Medicare beneficiaries and allows beneficiaries to participate in medical savings accounts.¹⁰ Traditional FFS Medicare remains available to all beneficiaries.

Other BBA provisions changed the requirements for plans participating in Medicare+Choice. For example, plans are required to implement new and more comprehensive quality improvement programs. Compared with pre-BBA requirements, plans must also collect more information on such activities as appeals filed by enrollees and the number and type of the services provided by the plan; in addition, plans must report more information to HCFA and to beneficiaries. The BBA moved up the date for plans to submit their benefit package proposals from November 15 to May 1 of each year, allowing more lead

⁹A PSO is an entity established and operated by a group of providers who control the delivery of services and assume the financial risk involved in providing services. A PPO is a network of physicians and hospitals that contracts with an insurer to serve a group of enrollees.

¹⁰A private indemnity plan reimburses providers on an FFS basis without placing the provider at financial risk and will contract with any provider who will accept the plan's terms of payment. A Medicare+Choice medical savings account is a combination of a high-deductible insurance plan and a tax-exempt trust created solely for the purpose of paying the qualified medical expenses of the account holder.

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time to coordinate the beneficiary information campaign.¹¹ Additionally, the BBA eliminated the requirement that no more than 50 percent of a plan's enrollment may consist of Medicare and Medicaid beneficiaries. The elimination of this restriction means that Medicare plans can now serve areas without first building a commercial base.

Plans' Concerns About BBA Changes

While expressing support for many of the changes implemented under the Medicare+Choice program, officials from organizations representing managed care plans have also voiced a number of concerns about payment rates and the administrative burden created by some of the new requirements. They stated that the recent rate increases have not kept pace with plan costs or medical inflation. In both 1998 and 1999, many health plans received the minimum 2-percent payment increase. Managed care plans are also concerned about the impact that the new risk-adjustment methodology will have on payments. HCFA estimates that the new risk-adjustment methodology, which will be phased in over 5 years beginning in 2000, will reduce plan payments by \$11.2 billion over the period from 2000 to 2004. This reduction is in addition to CBO's estimates of \$22.5 billion in savings between 1998 and 2002 from the BBA's plan payment changes.

In addition, officials from organizations representing managed care plans believed that many of the new BBA requirements, as implemented by HCFA, are overly prescriptive, too costly, and being phased in too quickly. HCFA has responded to some of these concerns, for example, by giving plans more flexibility in meeting the new quality improvement requirements. Plans would also prefer a later submission date for their benefit package proposals so they can base their proposals on more current data. They believed that the May 1 date—8 months before the start of the contract year—is too early. Plans have to meet a similar deadline in order to participate in the Federal Employees Health Benefits Plan (FEHBP): they must submit similar benefit and rate information by May 31 each year to allow FEHBP to coordinate an information campaign for federal employees. To respond to plan concerns, HCFA officials recently changed Medicare's benefit proposal submission date to July 1, 1999, for the year 2000. Plans, however, continue to have concerns about these and other aspects of the new Medicare+Choice regulations and would like to see further revisions.

¹¹HCFA must approve these proposals, formally known as adjusted community rate proposals, which establish the minimum benefit package each plan must offer.

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**WITHDRAWALS REDUCE
ACCESS TO PLANS FOR SOME BENEFICIARIES,
BUT NEW PLAN ENTRIES MAY
INCREASE ACCESS FOR OTHERS**

In the fall of 1998, an unusually large number of plans decided to not renew their Medicare contracts for 1999 or to reduce the number of counties in which they offered services.¹² As a result of these decisions, about 7 percent of all Medicare managed care enrollees had to switch to another plan or return to FFS. A small group of the affected beneficiaries was left with no choice but to return to FFS. While some plans were deciding to leave, however, a number of plans were applying to enter the program or expand their existing service areas. If HCFA approves all of these applications, the number of beneficiaries with access to a managed care plan could increase in 1999 compared with 1998.

**Withdrawals Reduced or Eliminated
Managed Care Option for Some Plan Members**

As of December 1, 1998, there were 346 plans to serve Medicare beneficiaries in specific locations.¹³ Each plan represents a contract to serve a particular geographic area. Many managed care organizations, such as Aetna/U.S. Healthcare and Kaiser, operate numerous plans across the country. MCOs terminated 45 (or 13 percent) of these plans as of January 1, 1999. The vast majority of organizations involved in these terminations, however, continue to offer services to Medicare beneficiaries in other areas. For example, Aetna/U.S. Healthcare dropped its plans in Delaware and Maryland but continues to offer plans in California and Florida. An additional 54 plans (16 percent) reduced the number of counties in their service areas. Nonetheless, over 70 percent of the plans operating in December 1998 remain in Medicare with no reduction in their service areas.

These withdrawal decisions affected about 407,000 enrollees who could not continue receiving services in their chosen plan. Instead, they had to either choose a new managed care plan (if one was available in their county) or switch to FFS. About 61,000 of these enrollees, or 1 percent of the total Medicare managed care population, lived in counties in which no other Medicare+Choice

¹²We use the term "withdrawals" to refer to both instances when a plan withdrew from selected counties in its service area and when a plan terminated its entire contract (thus withdrawing from all counties in its service area).

¹³Throughout this report, we focus on capitated managed care plans that are not part of demonstration projects. Our analyses do not include HMOs with cost contracts or health care prepayment plans. The BBA eliminated certain health care prepayment plans as of December 31, 1998, and will eliminate HMOs with cost contracts as of December 31, 2002.

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plan was offered.¹⁴ Even if another managed care plan was available, about 450 beneficiaries affected by the withdrawals had end-stage renal disease (ESRD) and thus had to return to FFS.¹⁵ Medicare prohibits beneficiaries with ESRD from joining a managed care plan, although they may stay in a plan if they develop the disease while enrolled.¹⁶ For all affected beneficiaries, plan withdrawals can be highly disruptive and costly. Those who return to FFS typically face higher out-of-pocket costs than they incurred as managed care enrollees. Beneficiaries who choose another plan may have to switch health care providers and may have different benefit coverage.

Of the 957 counties that were covered by Medicare managed care plans as of September 1, 1998, 406 experienced at least one plan withdrawal; 94 of these counties were left with no Medicare plans. However, of all the instances of plans withdrawing from a county, about 37 percent were by plans withdrawing from a county with 100 or fewer managed care enrollees, including 43 instances in which a plan withdrew from a county with no enrollees. For example, Southeastern United Medigroup of Kentucky eliminated 11 counties from its service area, but had no enrollees in those counties. Consequently, while over 40 percent of counties with at least one plan experienced a plan withdrawal, only 7 percent of managed care enrollees were affected.

New Plan Applications May Mitigate Effects of Withdrawals

While some plans have chosen to curtail their participation in Medicare, new plans are entering the program and some existing plans are expanding the areas they serve. HCFA has approved applications from 10 new plans that were able to enroll beneficiaries as of January or February 1999. HCFA is also reviewing 30 additional new plan applications.¹⁷ In addition, 6 service area expansions had been approved and 14 other service area expansion applications were pending as

¹⁴Most of these beneficiaries had to return to FFS, although a small percentage lived in counties served by cost HMOs and could join this kind of plan.

¹⁵ESRD is the stage of kidney impairment that is considered irreversible and requires either regular dialysis treatments or a kidney transplant to maintain life. It is a relatively rare but expensive disease.

¹⁶An additional 43 beneficiaries with ESRD, who were enrolled in cost HMOs or plans participating in demonstration projects, will not be permitted to join another managed care plan.

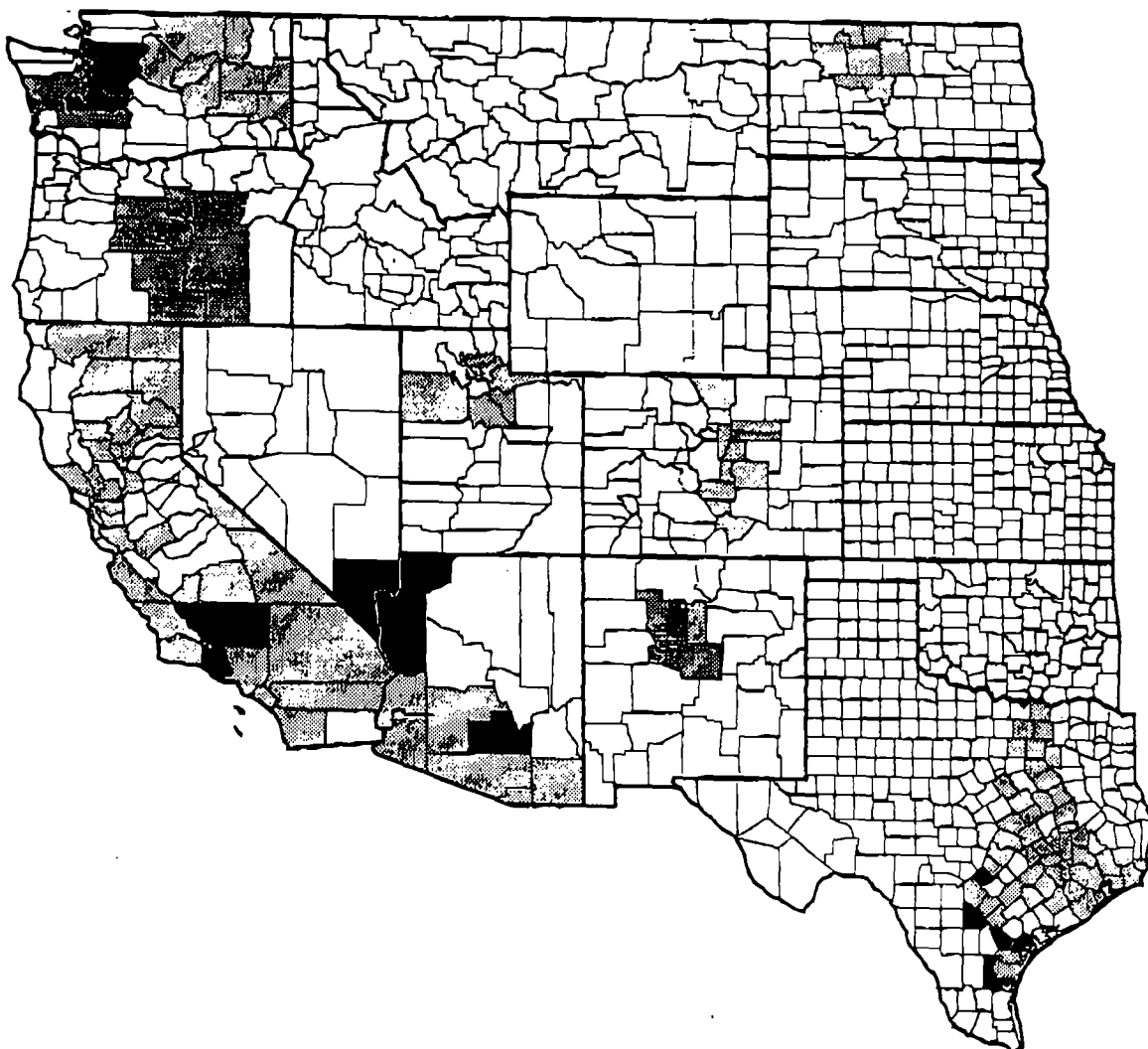
¹⁷The numbers of approved and pending plans and service area expansions are based on data provided by HCFA as of January 20, 1999. Some pending plans or service area expansions may have been approved and new applications may have been submitted since then.

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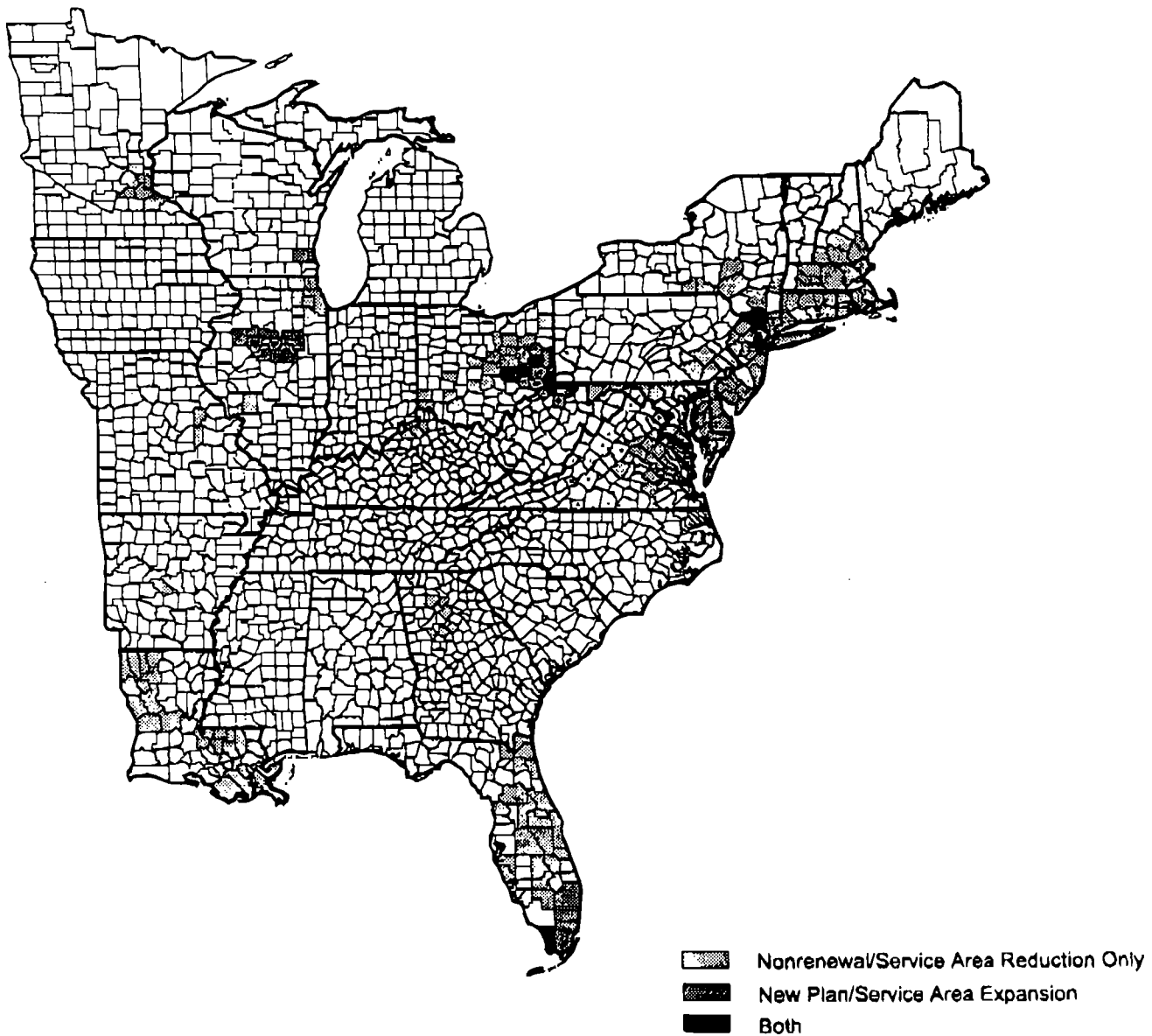
of January 1999. The number of recently approved and pending applications suggests that there is still considerable plan interest in participating in Medicare. Furthermore, total managed care enrollment has increased following the drop that occurred in January 1999 and is now slightly higher than it was when the withdrawals took effect.

The 10 new Medicare plans approved by HCFA as of January 20, 1999, offer services in Florida, Hawaii, Illinois, New Jersey, New Mexico, New York, Ohio, Oregon, Washington, West Virginia, and Wisconsin (fig. 3 shows the counties affected by the new plans and by plan withdrawals). Fourteen of the new or pending plans are applying to enter counties that previously had no Medicare managed care options. In 1998, for example, no plans were available in any of the counties in which the newly approved plans in Illinois and Oregon are offering services. One pending new plan has applied to offer services in 68 counties in Iowa, Minnesota, and South Dakota that did not have any plan as of September 1998. Figure 4 shows those counties that have pending new plan applications or pending service area expansions.

Figure 3: Counties With Plan Changes in January 1999



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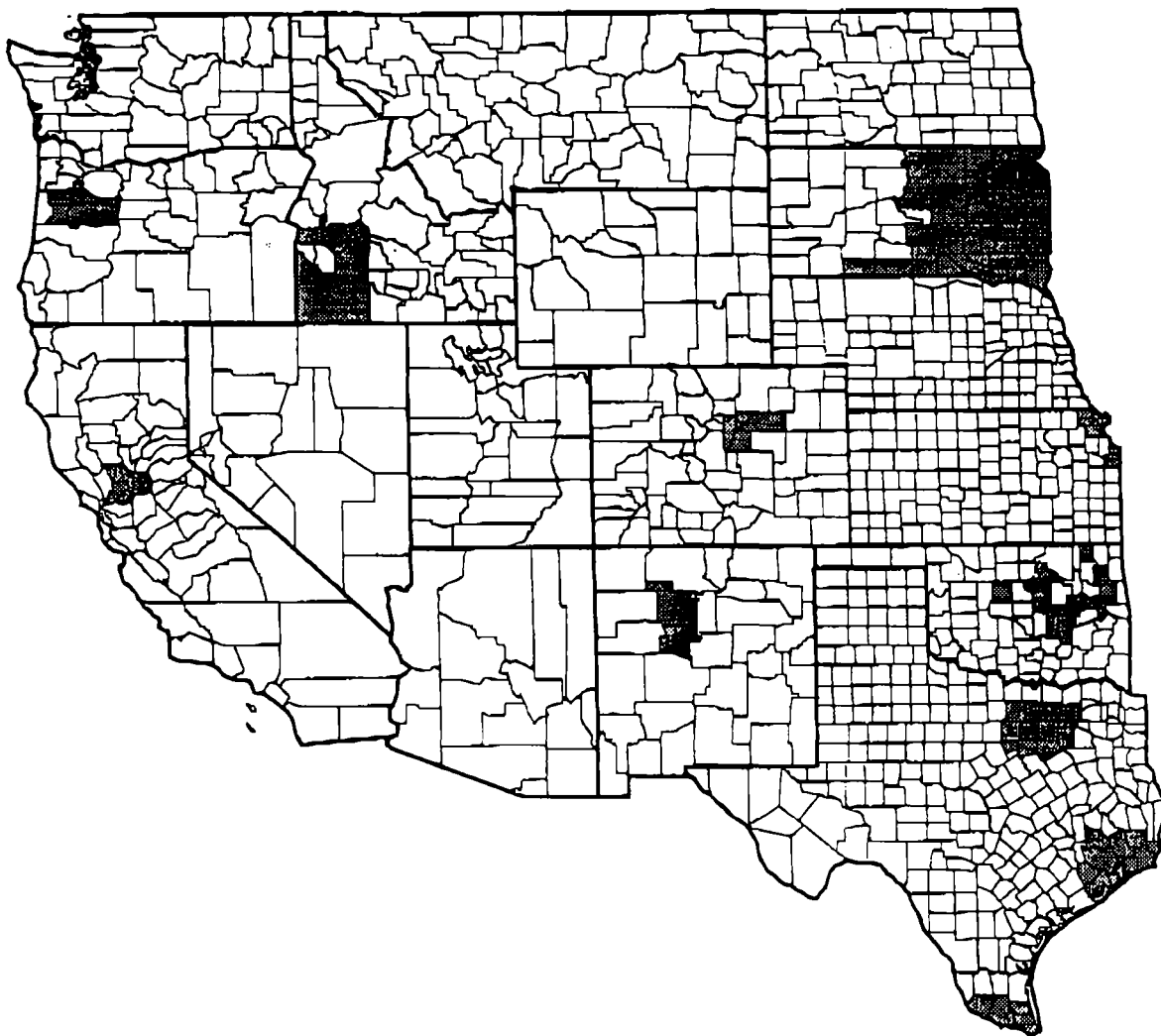


Note: Hawaii did not have any withdrawals but did have one new plan approved in January 1999. Alaska did not have any managed care plans in 1998 or 1999. Nonrisk plans are excluded from this analysis.

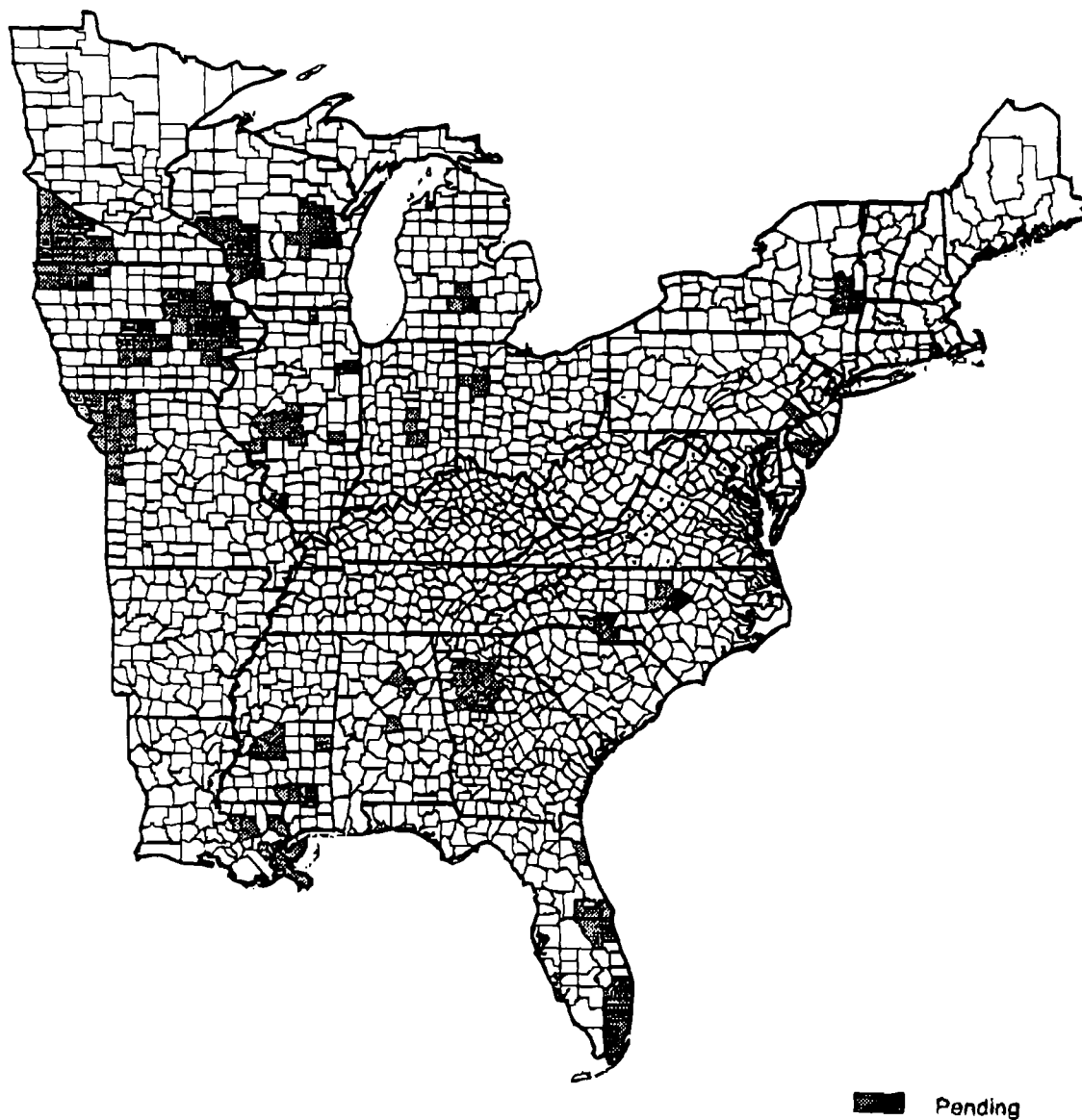
Sources: Files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

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Figure 4: Counties With Pending New Plan Applications or Pending Service Area Expansions



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Note: Hawaii and Alaska did not have any pending new plan applications or service area expansions. Nonrisk plans are excluded from this analysis.

Sources: Files of new plans and service area expansions from the Center for Health Plans and Providers at HCFA.

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Even with these newly approved plans, the number of counties with at least one Medicare managed care plan decreased from 957 in September 1998 to 883 in January 1999 (see table 1). However, if all pending new applications and expansions are approved, 1,045 counties will have at least one managed care plan, including 181 counties that had no such plans in 1998. These counties are identified in figure 5 along with those counties that no longer have a plan as a result of the withdrawals and service area reductions.

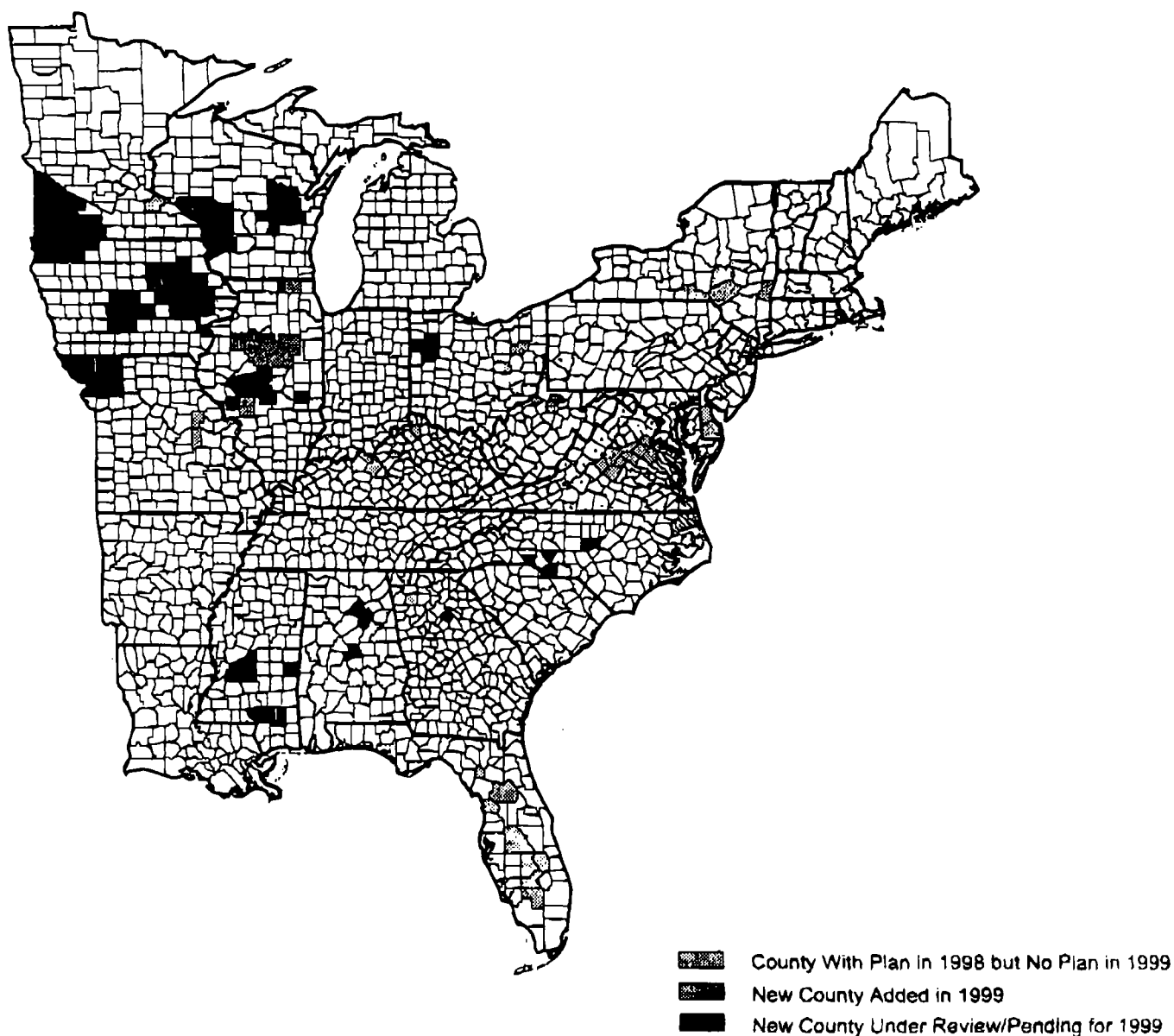
Table 1: Availability of Medicare Managed Care Plans, September 1998 and January 1999

	Counties with approved Medicare plans as of September 1998	Counties with approved Medicare plans as of January 1999	Counties with approved or pending Medicare plans as of January 1999
1 or more plans available	957	883	1,045
More than 1 plan available	574	490	527
1 plan available	383	393	518
No plans available	2,175	2,249	2,087

Notes: Nonrisk plans are excluded from this analysis. 1999 Medicare beneficiaries are based on September 1998 count of beneficiaries.

Sources: Medicare Managed Care Market Penetration State/County Data Files, September 1998, www.hcfa.gov/medicare/mpsctl.htm (Feb. 9, 1999); Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999); and files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

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Notes: Hawaii did not have any counties with a plan in 1998 that had none in 1999, but did have one county with a plan in 1999 that did not have a plan in 1998. Alaska did not have any managed care plans in 1998 or 1999. Nonrisk plans are excluded from this analysis.

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999); Medicare Managed Care Market Penetration State/County Data Files, September 1998, www.hcfa.gov/medicare/mpsctl.htm (Feb. 9, 1999); and files of contract

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nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

Although it is too early to estimate the impact of the recently approved and pending applications on managed care enrollment, it is possible to calculate the number of beneficiaries that have a plan available in their counties. In September 1998, 28.4 million beneficiaries lived in counties served by at least 1 managed care plan (see table 2). In January 1999, that number dropped by almost 800,000 beneficiaries because of plan withdrawals and service area reductions. However, if all pending new applications and service area expansions are approved, slightly more beneficiaries in 1999 will have the option to join a managed care plan than did in 1998. Nonetheless, fewer beneficiaries will have more than one plan to choose from even if all the new applications are approved.

Table 2: Beneficiary Access to a Managed Care Plan, September 1998 and January 1999

Beneficiaries in millions

	Beneficiaries in counties with approved Medicare plans as of September 1998	Beneficiaries in counties with approved Medicare plans as of January 1999	Beneficiaries in counties with approved or pending Medicare plans as of January 1999
1 or more plans available	28.4	27.6	28.5
1 plan available	4.0	4.3	4.7
More than 1 plan available	24.3	23.3	23.8
No plans available	10.6	11.3	10.4

Notes: Nonrisk plans are excluded from this analysis. In some cases, plans offer services to certain portions of a county rather than to the entire county. Because data on partial-county participation were not readily available, we count all beneficiaries in a county as having access to a plan if a plan was offered in that county. Consequently, these numbers overstate the number of beneficiaries who have access to a plan for each period. Totals may not add because of rounding.

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999); Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Jan. 13, 1999); Medicare Managed Care

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Market Penetration State/County Data Files, September 1998, www.hcfa.gov/medicare/mpsctl.htm (Feb. 9, 1999); and files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

Most of the new plan applications are from traditional HMOs. Thus far, HCFA has approved one PSO and no PPOs, medical savings accounts, or private FFS plans. However, it may be too early to assess how many of these new types of health plans will be interested in participating in the program. Medicare+Choice is still very new, and interim final regulations governing the program were just published in June 1998. Plans had little time to prepare and submit applications for 1999. The number and diversity of applications may increase in future years as plans become more familiar with the new program. However, officials from organizations representing managed care plans believe that the reduced growth in payments and increased administrative burden under Medicare+Choice may discourage future plan participation.

SEVERAL FACTORS, SUCH AS
PAYMENT, ENROLLMENT, AND
LEVEL OF COMPETITION, ARE
ASSOCIATED WITH PLAN PARTICIPATION

No one factor can explain why plans choose to participate in particular counties. Although plans obviously consider payment rates, many other factors also influence their business decisions. Our previous work showed that some areas, such as Boston, Massachusetts, had relatively high payment rates in 1993 but few managed care plans and enrollees.¹⁸ Other areas, such as a number of Oregon counties, had low payment rates but still had several managed care plans with high enrollment in 1995.

The pattern of recent plan withdrawals suggests that several factors, including payment rates, may have influenced plans' decisions. A plan was more likely to withdraw from a county where

- payment rates were low relative to other counties in the plan's service area,
- the plan had been operating since 1992,
- the plan had low enrollment, or
- the plan was in a weak competitive position compared with other plans in the county.

¹⁸Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

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An unusually high number of plans also withdrew from FEHBP in 1998, suggesting that general market conditions may have played some role in the Medicare plan withdrawals. In some respects, the current Medicare withdrawals are similar to those that occurred in the late 1980s. At that time, many plans left Medicare because they were unable to attract members and were unprofitable. Other factors, such as plans' inability to establish provider networks, also may have influenced the current withdrawals, but we were unable to quantify those effects.

Plans Withdrew From Both
High- and Low-Payment Counties

Both before and after the recent withdrawals, managed care plans were much more likely to offer services in high-payment-rate counties than in low-payment-rate counties. In 1999, for example, 91 percent of counties with monthly payment rates over \$694 are served by a managed care plan. By contrast, only 11 percent of counties with the minimum payment rate of approximately \$380 are served by a managed care plan. High-payment-rate counties, however, were disproportionately affected by the withdrawals (see table 3). Over 90 percent of the counties with the highest payment rates experienced a plan withdrawal, compared with 34 percent of counties with the lowest payment rate. It is possible that some plans withdrew from high-payment-rate counties because they anticipated that these counties will receive below-average payment increases in the coming years. In fact, for those counties with payments based on a blend of national and local FFS spending as specified in the BBA, this payment blending provision (expected to be implemented for the first time in 2000) will result in smaller payment increases for higher-payment-rate counties and larger payment increases for lower-payment-rate counties (see app. II for more information on the BBA's payment provisions). In addition, over the next 5 years, Medicare payments for graduate medical education (GME) will be eliminated from the blended rates.¹⁹ Because GME spending is concentrated in high-payment-rate counties, its removal will disproportionately slow payment rate growth in high-payment-rate counties.

¹⁹Medicare FFS payments include payments to teaching hospitals for Medicare's share of the costs of providing GME, such as resident and faculty salaries and overhead costs related to teaching activities. Prior to the BBA, managed care plan payments in certain counties included a share of Medicare GME spending. BBA provisions removed GME payments from managed care plan payments and provided for teaching hospitals to be reimbursed directly for these costs.

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Fax Transmittal Sheet

To: (Name and Address)

Devorah Adler

4/27/99

Telephone No.

Fax Telephone No.

Date

From: (Name and Address)

Susan Leigh Biggs

Telephone No.

202-512-7121

Fax Telephone No.

202-512-4778

Date

Subject:

HAC Report on Medicare Managed Care Plans

Additional Information

Please let me know if all pages are not legible. I am sending the report in two parts - ²⁵~~24~~ pages @ a time.

I will send the entire report through the mail. It will ~~not~~ include the appendices. The last page will be numbered "48."

Acknowledgement Requested

1. ☐ Yes ☒ No2. ~~25~~²⁶ pages, including this cover sheet, are being transmitted.3. If pages are not received, call Susan

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Table 3: Counties With Medicare Plans in September 1998 Affected by Withdrawals, by 1999 Payment Rates

	1999 payment rates ^a					Total
	\$379.84	379.85 to \$484.47	\$484.48 to \$589.10	\$589.11 to \$693.72	\$693.73 to \$798.35	
Counties with plans affected by withdrawals	50	185	131	30	10	406
Counties with plan(s) in September 1998	145	496	257	48	11	957
Percentage of all counties with plans(s) in September 1998 affected by plan withdrawals	34%	37%	51%	63%	91%	42%

Note: Nonrisk plans are excluded from this analysis.

^aPayment rate categories were determined by creating four equal rate categories (with a payment range of approximately \$105). The minimum payment rate was used as the fifth category.

Sources: Medicare Risk Monthly Payment Rates, 1999, www.hcfa.gov/stats/hmorates/aapcc.htm (Feb. 3, 1999); Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999); and files of contract nonrenewals and service area reductions from the Center for Health Plans and Providers at HCFA.

Although a smaller percentage of low-payment counties were affected by withdrawals compared with high-payment counties, enrollees living in the low-payment counties were more likely to be affected by the withdrawals. For example, 16 percent of enrollees who lived in counties with the lowest payment rates were affected by a plan withdrawal compared with 1 percent of enrollees in the highest-payment-rate counties (see table 4). These findings indicate that the plans that withdrew from high-payment counties had relatively few members.

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Table 4: Enrollees in Plans in September 1998 Affected by Plan Withdrawals, by 1999 Payment Rate

	1999 payment rates ^a					Total
	\$379.84	\$379.85 to \$484.47	\$484.48 to \$589.10	\$589.11 to \$693.72	\$693.73 to \$798.35	
Enrollees in plans affected by withdrawals, September 1998	19,400	174,900	158,000	51,300	3,100	406,500
Enrollees in plans, September 1998	119,100	1,445,700	2,783,000	1,208,400	331,600	5,887,900
Percent of enrollees in plans affected by withdrawals	16%	12%	6%	4%	1%	7%

Notes: Nonrisk plans are excluded from this analysis. Numbers are rounded to nearest hundred. Totals may not add because of rounding.

^aPayment rate categories were determined by creating four equal rate categories (with a payment range of approximately \$105). The minimum payment rate was used as the fifth category.

Sources: Medicare Risk Monthly Payment Rates, 1999, www.hcfa.gov/stats/hmorates/aapcc.htm (Feb. 3, 1999); Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999); Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Jan. 13, 1999); and files of contract nonrenewals and service area reductions from the Center for Health Plans and Providers at HCFA.

For plans that dropped selected counties from their service areas, payment rates appear to be one factor that influenced their decisions. In 1999, for example, PacifiCare of Arizona withdrew from four of the eight counties in its service area, withdrawing primarily from counties with the lowest payment rates. It continued to provide services in Pinal County, which had the highest payment of all the counties in its service area, but dropped Cochise County, where the payment rate was about 25 percent lower.²⁰ To assess the impact of relative county payment rates on plans' service area decisions, we compared the payment rate for each county in a plan's service area with the highest county

²⁰PacifiCare of Arizona withdrew from the following four counties (payment rates indicated in parentheses): Santa Cruz (\$380), Cochise (\$415), LaPaz (\$478), and Mohave (\$494). The plan remained in the following four counties: Pima (\$483), Gila (\$485), Maricopa (\$509), and Pinal (\$541).

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payment rate in that plan's service area.²¹ We repeated our calculation for every plan. The results (shown in table 5) suggest that counties with payment rates that were low relative to the maximum county payment rate in a given service area were disproportionately affected by service area reductions. For example, while plans reduced their service areas in 5 percent of counties with payments that were between 90 and 100 percent of a plan's maximum payment rate county, they reduced their service areas in 28 percent of counties that had payment rates between 50 and 60 percent of the plan's maximum payment rate county.

Table 5: Relationship of Payment Rates for Counties Dropped by a Plan to the Maximum Payment Rate in the Plan's Service Area (Includes Only Service Area Reductions)

	County payment as a percentage of the maximum county payment for a plan					Total
	50-60	>60-70	>70-80	>80-90	>90-100	
Counties experiencing a service area reduction	27	30	66	75	43	241
All plan/county combinations	95	147	417	800	937	2,396
Percentage of plan/county combinations experiencing a service area reduction	28%	20%	16%	9%	5%	10%

Notes: Nonrisk plans are excluded from this analysis. Only plans serving more than one county are included. A county may be included more than once in this table if it is included in more than one plan's service area.

Sources: Medicare Risk Monthly Payment Rates, 1999, www.hcfa.gov/stats/hmorates/aapcc.htm (Feb. 3, 1999); and Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999).

²¹For example, a Florida plan offered services in Broward, Dade, Martin, and Palm Beach counties with payment rates of \$677, \$778, \$515, and \$589, respectively; so the four counties are included in the table as 87 percent, 100 percent, 66 percent, and 76 percent of the plan's maximum payment county, which, in this example, is Dade County.

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Enrollment, Competition,
Level, and Other Factors
Also Influence Participation
Decisions

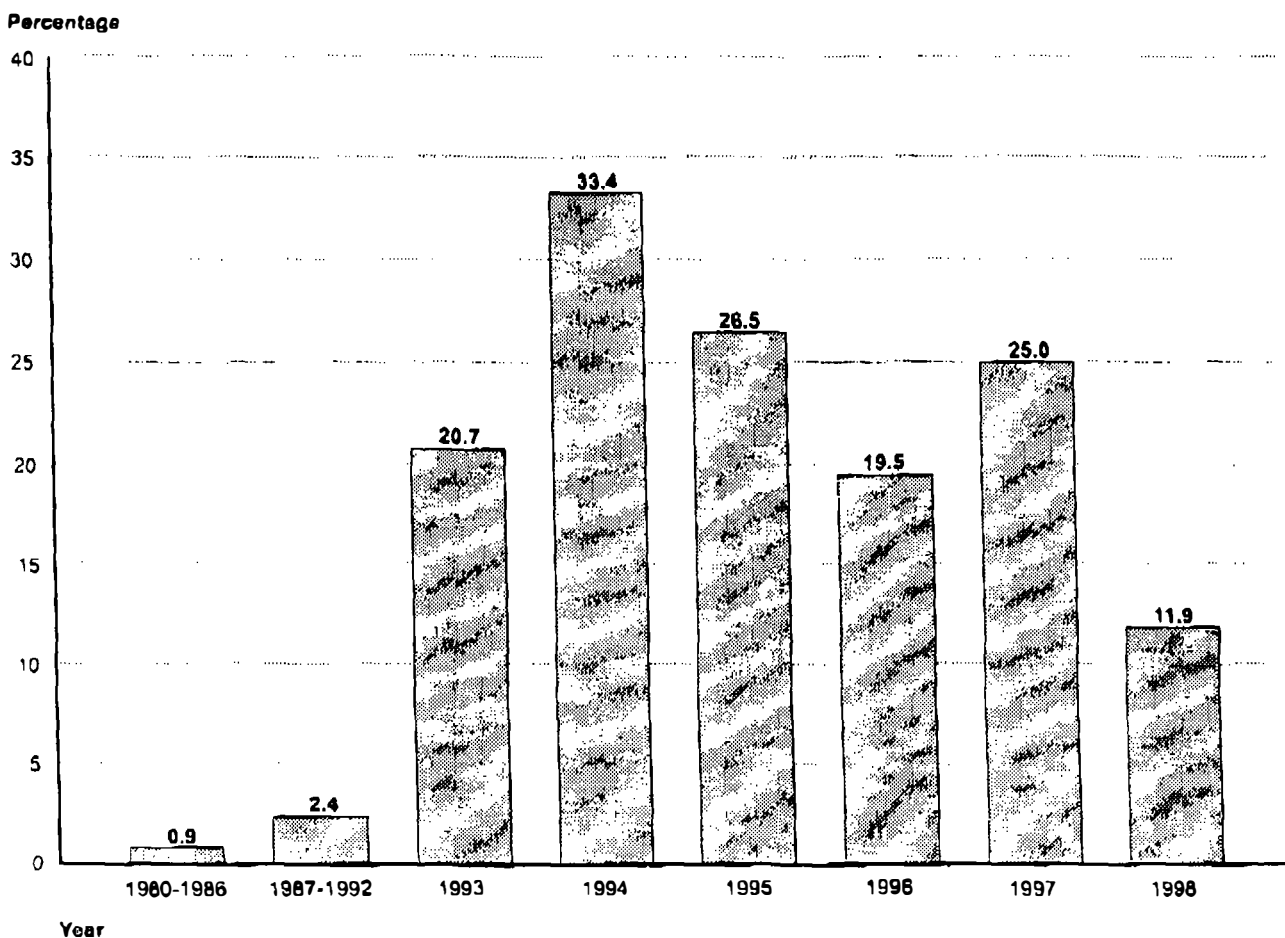
Several factors, in addition to payment rates, appear to be associated with a plan's decision to withdraw from a specific county: short length of time operating in the county, low enrollment, and a weak competitive position compared with other Medicare plans in a county. The Medicare managed care program expanded rapidly in recent years; many new plans entered the program, and existing plans expanded the areas they served. The recent withdrawals may represent a market correction—some plans with low Medicare enrollment and in counties dominated by large plans may have concluded that they could not compete effectively and so withdrew. A number of plans left the Medicare program between 1988 and 1991 for similar reasons. Moreover, the market conditions that led to the recent withdrawals may not be unique to the Medicare program. The experience of FEHBP, which also sustained an unusually high number of plan withdrawals this year, suggests that plans may be reacting to general market conditions as well as program-specific ones.

Plans were more likely to withdraw from counties in which they had less Medicare experience. We looked at all instances in which a Medicare plan provided services in a county as of February 1998 and determined how long the plan had participated in Medicare in that county. In less than 1 percent of the instances in which a plan entered a county for the first time between 1980 and 1986—that is, plans with more than 12 years of Medicare experience in a county—did the plan withdraw from that county in 1998 (see fig. 6). In contrast, plans were much more likely to withdraw from areas in which they had less than 7 years experience. For example, about one-third of the plans with 5 years of Medicare experience in a county withdrew from that county in 1998.²² The withdrawal pattern suggests a retrenchment from the rapid growth of Medicare managed care that began in 1994.

²²In 107 of the 320 instances in which a plan entered a county for the first time in 1994 (plans with 5 years of Medicare experience in a particular county), the plan withdrew from that county in 1998; in 6 of the 665 instances in which a plan entered a county for the first time between 1980 and 1986 (plans with more than 12 years of Medicare experience in a particular county), the plan withdrew from that county in 1998.

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Figure 6: Plan Withdrawals in 1998 as a Percentage of New Plan Entries Into a County, by Year



Notes: A county may be included more than once in this figure. If there are two or more plans in a county, each plan is represented by a separate date of entry into the county. This figure includes all plan/county combinations that were in Medicare as of February 1998. Nonrisk plans are excluded from this analysis.

While HMOs have been authorized to provide services to Medicare beneficiaries since 1972, the risk program that immediately preceded the BBA and implemented capitated payments was created by legislation in 1982. Plans began operating under risk contracts in 1985 but may have provided services to Medicare beneficiaries in earlier years under the previous Medicare HMO program.

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Sources: Files of contract nonrenewals, service area reductions, and historical geographic service areas of all Medicare HMOs (Feb. 1998) from the Center for Health Plans and Providers at HCFA. The historical geographic service area file is missing 29 plan/county combinations affected by the withdrawals.

Plans that had difficulty attracting or retaining enrollees in a county were also more likely to withdraw from that county (see table 6). In almost a third of the instances in which a plan had no enrollees in a county, the plan withdrew from that county. In contrast, in only 12 percent of the instances in which a plan had more than 1,000 enrollees in a county did the plan withdraw.

Table 6: Plan/County Combinations Affected by Withdrawals, by Enrollment Level

	Individual plan enrollment by county, September 1998					
	0 enrollees	1-100 enrollees	101-500 enrollees	501-1,000 enrollees	>1,000 enrollees	Total
Plan/county combinations affected by a withdrawal	43	180	180	87	108	598
Total plan/county combinations in 9/98	140	646	708	373	919	2,786
Percentage of plan/county combinations affected by a plan withdrawal	31%	28%	25%	23%	12%	21%

Note: Nonrisk plans are excluded from this analysis. A county may be included more than once in this table if it is included in more than one plan's service area.

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, www.hcfa.gov/stats/geos.htm (Jan. 26, 1999); Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Jan. 13, 1999); and files of contract nonrenewals and service area reductions from the Center for Health Plans and Providers at HCFA.

A plan was also more likely to withdraw from a county if it faced larger competitors. Specifically, a plan was more likely to withdraw from a county if its Medicare market share²³ in that county was small relative to the market share of the plan with the highest Medicare enrollment in the county. The bigger the

²³In this analysis, market share is measured as the number of Medicare enrollees in a plan divided by the total number of Medicare plan enrollees in the county.

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difference in market shares, the more likely the smaller plan was to withdraw from the county. Moreover, the smaller plan was more likely to withdraw if the rest of the market was dominated by a few firms rather than divided up among many firms.²⁴

Some plans may have withdrawn from counties where they found it difficult to build or maintain provider networks. For example, a Medicare HMO in a rural area of North Dakota withdrew from the program when its hospital provider discontinued its contract with the plan. A HCFA official also told us that the two plans that withdrew from Utah made their decisions early in 1998, before the publication of the interim final regulations implementing Medicare+Choice. According to the official, the plans withdrew because they could not contract with enough physicians to maintain adequate provider networks. Physicians wanted higher reimbursements than the plan was willing or able to pay.

Officials from organizations that represent managed care plans have also cited the administrative burden of the new Medicare+Choice requirements as a significant reason for plan withdrawal decisions. For the most part, however, this burden was not so great as to induce MCOs to leave the Medicare program entirely. Many national MCOs, such as Aetna/U.S. Healthcare or Kaiser, offer numerous plans across the country. Nearly all of the MCOs that terminated a Medicare plan in one area continued to operate Medicare plans in other areas. Nonetheless, it may be that the increased administrative requirements, coupled with the expected slow growth in payments and the uncertainties associated with a new risk-adjustment methodology, affected some plans' participation decisions.

Finally, an anomaly related to the transition from the previous Medicare managed care program to Medicare+Choice may have played a role in the unusually high number of withdrawals witnessed this year. Under the previous managed care program, if a plan withdrew from a county, it could not reenter that area for 5 years. The BBA included a similar provision for Medicare+Choice plans, but did not make it retroactive to include plans with contracts under the earlier program. Plans that withdrew before January 1, 1999, have by definition never been Medicare+Choice plans. Consequently, these plans do not face the exclusion period and can reenter any county without waiting 5 years. The effect of this provision may have been to concentrate some of the plan withdrawals in

²⁴For instance, if there were three firms in a county with 50-, 40-, and 10-percent shares of that county's Medicare enrollment, the plan with the 10-percent market share was much more likely to withdraw from that county than the other two plans. However, a plan with a 10-percent market share but facing five competitors (one plan with 50-percent and four plans with 10-percent market shares) would be slightly less likely to withdraw than the plan with 10-percent market share competing against two other plans.

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1998. Some plans may have viewed this year as a one-time opportunity to pull back from the program while they waited to see what future changes might bring.

**SMALL REDUCTIONS
SEEN IN AVAILABILITY
OF SOME BENEFITS**

Medicare managed care plans have typically offered more generous benefits—such as coverage for prescription drugs, dental care, and hearing exams—than those available in the FFS program.²⁵ Although the extent of extra benefits varies by plan, they are more commonly offered in high-payment counties. Since the BBA payment changes were implemented, overall beneficiary access to plans that offer certain additional benefits declined slightly. However, beneficiaries who live in low-payment-rate counties experienced greater decreases in access between 1997 and 1999 than the average beneficiary. While the current benefit changes are having a greater impact on beneficiaries in low-payment counties, the BBA constraints on plan payment increases may lead plans to offer less generous benefits in the future to all beneficiaries than they have in the past.

Because of limitations in the available data sources, we can only report on whether a plan offered a particular benefit. The scope of the actual benefit may vary significantly among plans and over time. For example, while two plans may offer coverage of prescription drugs, one plan may have a dollar cap on the benefit and offer coverage only for plan-approved drugs, while the second plan may cover drugs without any limitations. Our study did not distinguish between these two different benefit levels.

Plans in counties with lower payments have generally offered fewer additional benefits; as a result, fewer beneficiaries living in lower-payment counties have had the opportunity to join plans that offer these benefits compared with beneficiaries living in higher-payment counties. In 1997, for example, only 61 percent of beneficiaries living in counties with payments under \$330 (and with at least one plan) had access to a Medicare plan that offered prescription drug

²⁵ A plan must cover all benefits offered by traditional FFS Medicare but can choose to offer additional benefits. If a plan's projected profits from its Medicare contract are estimated to exceed its normal profits, the plan must provide additional benefits, reduce premiums or copayments, deposit the excess funds in a benefit stabilization fund for use in future years, or some combination of these three options.

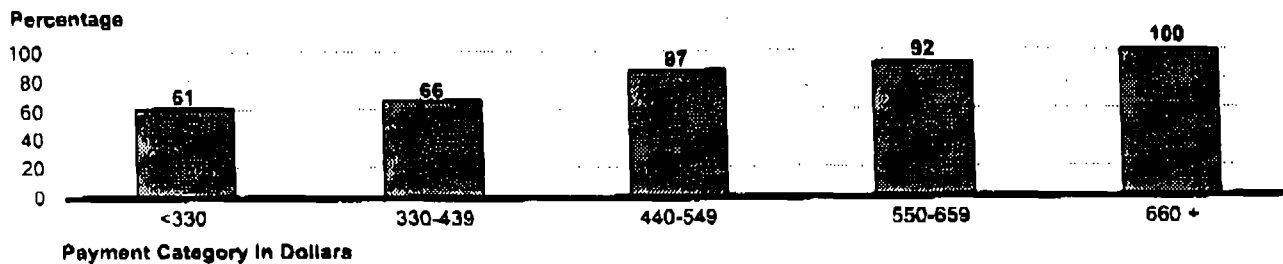
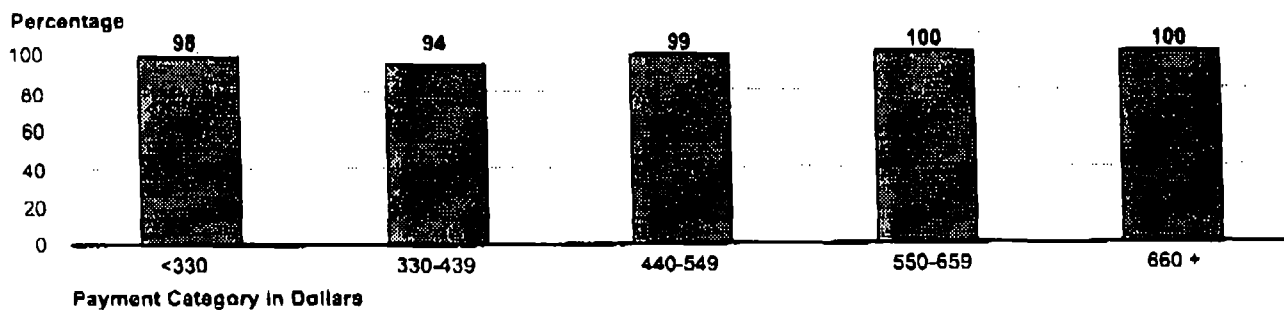
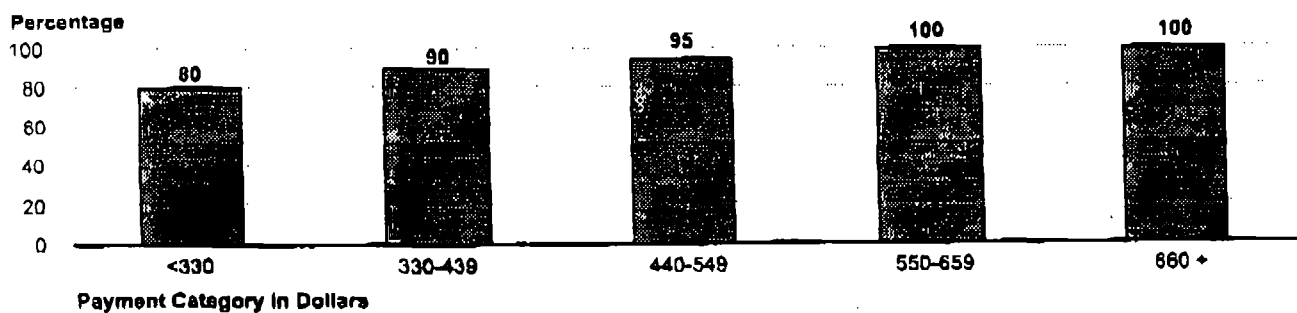
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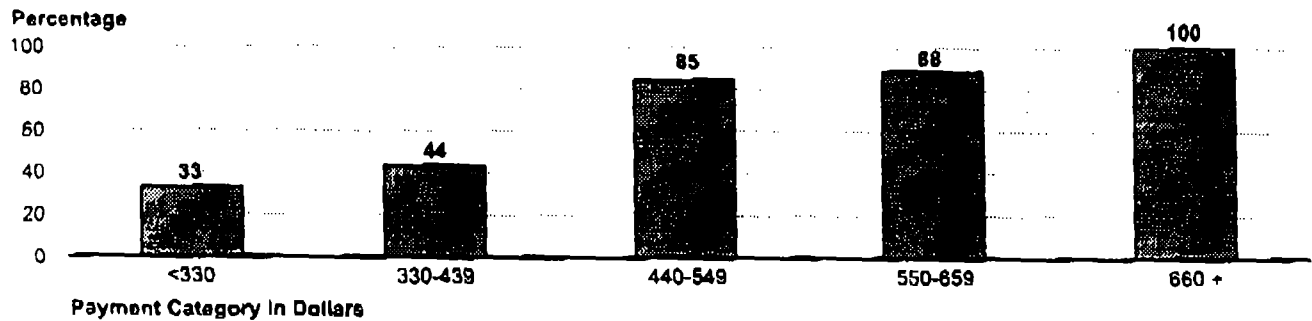
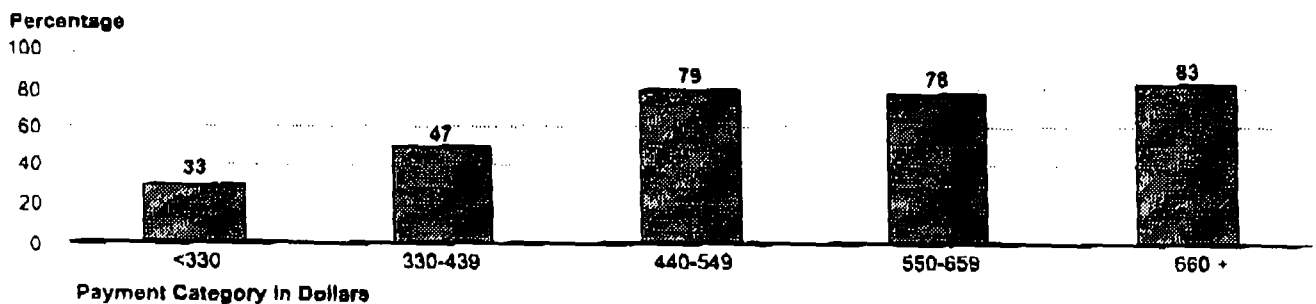
coverage, while 100 percent of beneficiaries living in counties with payments over \$658 had such access (see fig. 7).²⁶

²⁶Many FFS beneficiaries purchase supplemental insurance policies, which can cost up to \$270 per month, to obtain coverage for some of these additional benefits.

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Figure 7: Beneficiary Access to Plans Offering Selected Benefits in 1997, by County Payment Rate (Includes Only Counties With One or More Plans)

Prescription Drugs**Eye Exams****Hearing Exams**

Dental Care**Foot Care**

Notes: Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Nonrisk plans are excluded from this analysis. Payment categories are created by dividing the difference between the maximum and minimum payment rates into five equal segments.

Sources: Medicare Managed Care Geographic Service Area File, December 1997, www.hcfa.gov/stats/geos.htm (Feb. 23, 1999); adjusted community rate submissions for 1997; Medicare Monthly Managed Care Report, December 1997, www.hcfa.gov/stats/monthly.htm (Feb. 23, 1999); and Medicare Managed Care Market Penetration State/County Data File, December 1997, www.hcfa.gov/medicare/mpscpt1.htm (Feb. 23, 1999).

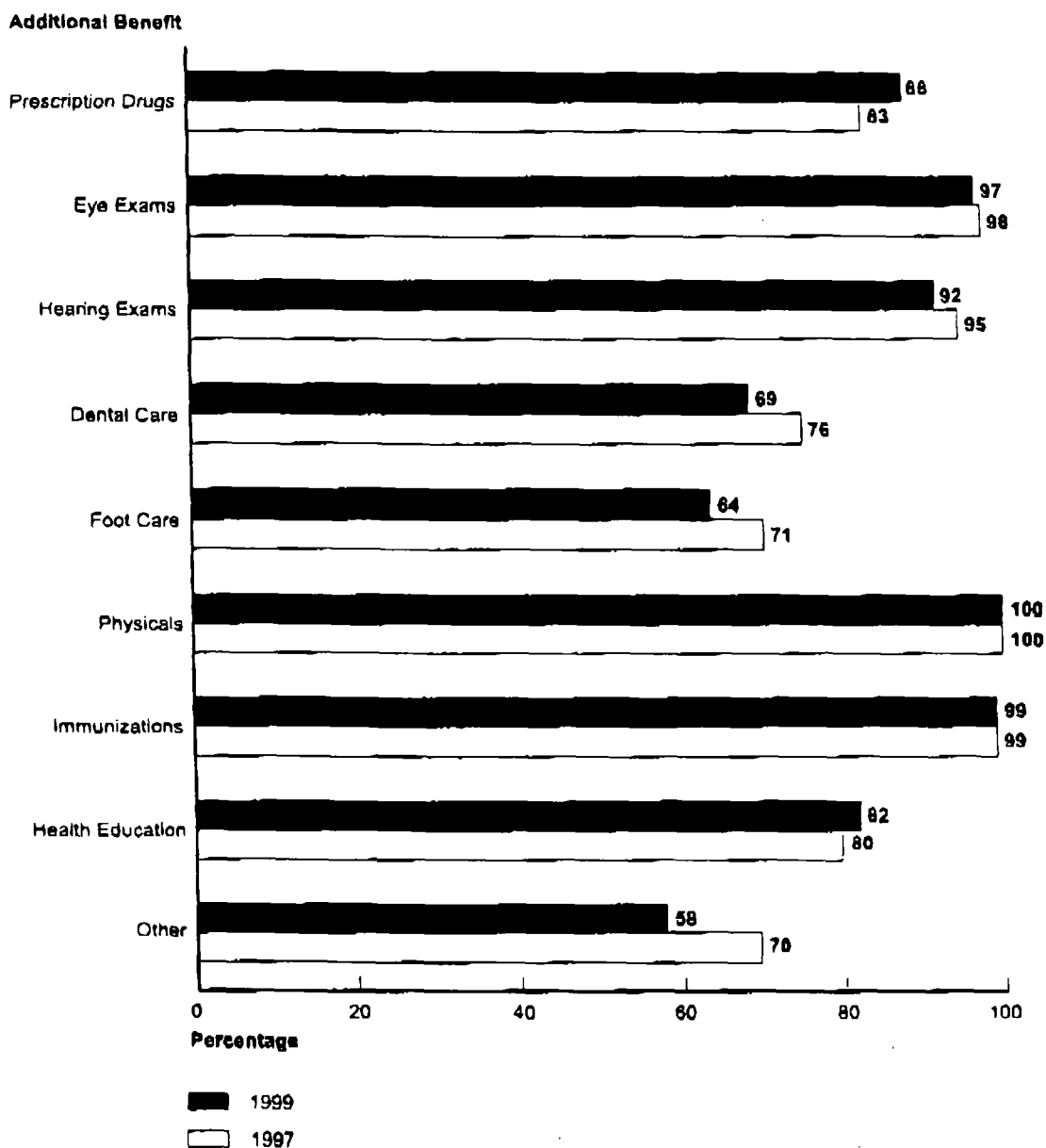
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**Benefit Changes Had Larger
Impact on Beneficiaries in Low-Payment Counties**

In comparing 1997 and 1999 plan benefit packages for beneficiaries living in counties with at least one managed care plan, we found that access to plans offering different additional benefits decreased slightly after the BBA payment changes (see fig. 8). For example, 71 percent of beneficiaries had access to foot care in 1997, but only 64 percent had access to such coverage in 1999. Access to physical examinations and immunizations did not change. The only benefit for which beneficiary access increased was prescription drug coverage—a benefit valued highly by beneficiaries who enroll in plans. Plans may be choosing to offer a different mix of benefits—substituting prescription drug coverage for other services. It is also possible that the drug benefit plans are offering is more limited; for example, it may have a lower maximum dollar amount that the plan will pay.

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Figure 8: Beneficiary Access to Plans Offering Selected Benefits, 1997 and 1999
(Includes Only Counties With One or More Plans)



Notes: Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Nonrisk plans are excluded from this analysis. For 10 plans where 1999 benefit information was unavailable, September 1998 benefit data were used.

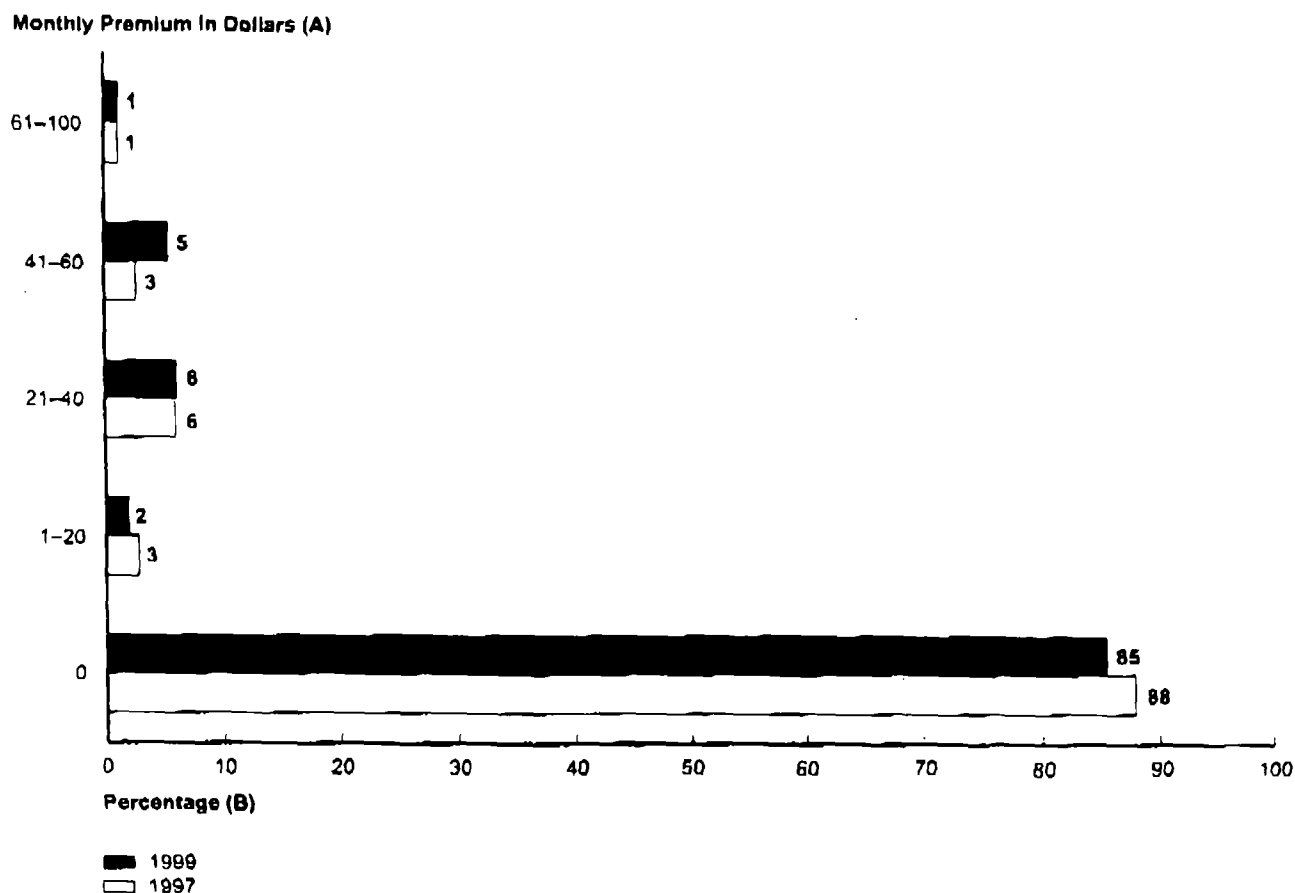
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Sources: Medicare Managed Care Geographic Service Area File, December 1997, www.hcfa.gov/stats/geos.htm (Feb. 23, 1999); adjusted community rate submissions for 1997; Medicare Monthly Managed Care Reports, December 1997 and January 1999, www.hcfa.gov/stats/monthly.htm (Feb. 23, 1999); Medicare Managed Care Market Penetration State/County Data Files, December 1997 and September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Feb. 23, 1999); and 1999 Medicare Compare database, www.medicare.gov/comparison/dbdownload/download.html (Feb. 23, 1999).

Most beneficiaries with access to a managed care plan can enroll without paying a separate monthly premium.²⁷ The percentage of beneficiaries living in counties where plans require enrollees to pay a monthly premium increased slightly from 12 percent in 1997 to 15 percent in 1999 (see fig. 9). In addition, the percentage of beneficiaries living in counties where the minimum plan premium was over \$40 increased slightly.

²⁷These premiums are in addition to the \$43.80 monthly Medicare part B premium that all beneficiaries must pay.

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Figure 9: Beneficiary Access to Plans by Premium Category, 1997 and 1999

Notes: (A) Premium in addition to Medicare part B premium. Premiums based on lowest premium available in a county. (B) 1999 Medicare beneficiaries based on September 1998 count of beneficiaries.

Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Nonrisk plans are excluded from this analysis. For 10 plans where 1999 premium information was unavailable, September 1998 premium data were used.

Sources: Medicare Managed Care Geographic Service Area File, December 1997, www.hcfa.gov/stats/geos.htm (Feb. 23, 1999); adjusted community rate submissions for 1997; Medicare Monthly Managed Care Reports, December 1997 and January 1999, www.hcfa.gov/stats/monthly.htm (Feb. 23, 1999); Medicare Managed Care Market Penetration State/County Data Files, December 1997 and September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Feb. 23, 1999); and 1999

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Medicare Compare database,

www.medicare.gov/comparison/dbdownload/download.html (Feb. 23, 1999).

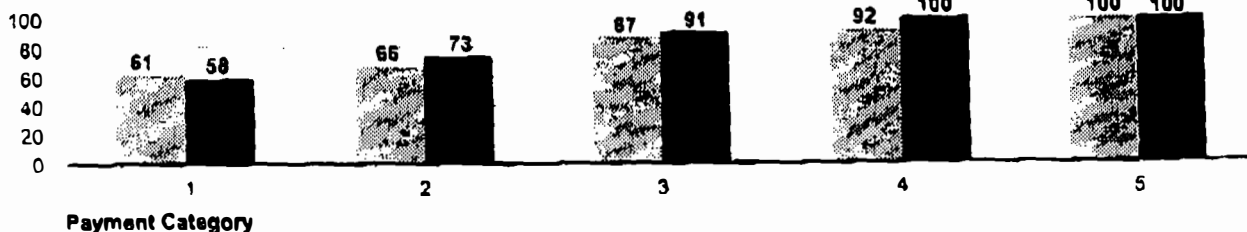
Although the changes in beneficiary access to plans offering additional benefits were relatively small, these benefit reductions were concentrated in low-payment-rate counties (see fig. 10). Access to plans offering additional benefits remained nearly constant for beneficiaries in high-payment-rate counties, although we do not know whether plans changed the scope of these benefits. For example, the percentage of beneficiaries in the lowest-payment-rate category with access to Medicare plans offering eye exams decreased from 98 percent in 1997 to 72 percent in 1999. In contrast, all beneficiaries living in the highest-payment-rate counties could obtain covered eye exams from a managed care plan in both years. Access to a plan offering prescription drug coverage, the only benefit for which overall beneficiary access increased between 1997 and 1999, decreased slightly for beneficiaries living in the lowest-payment-rate counties.

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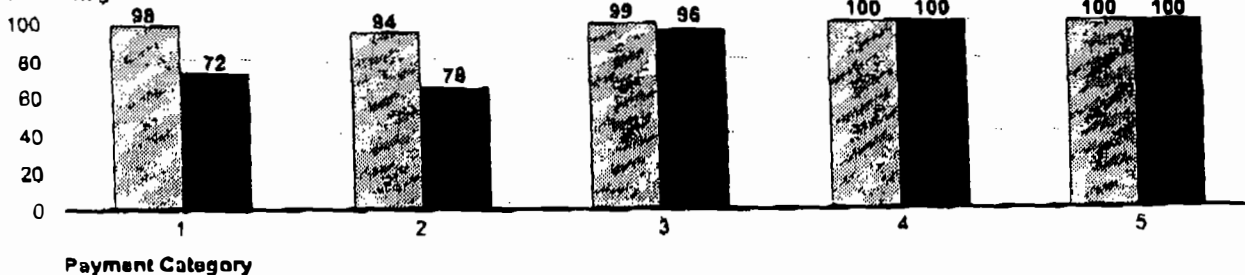
Figure 10: Beneficiary Access to Plans Offering Selected Benefits Across Different Payment Levels, 1997 and 1999 (Includes Only Counties With One or More Plans)

Prescription Drugs

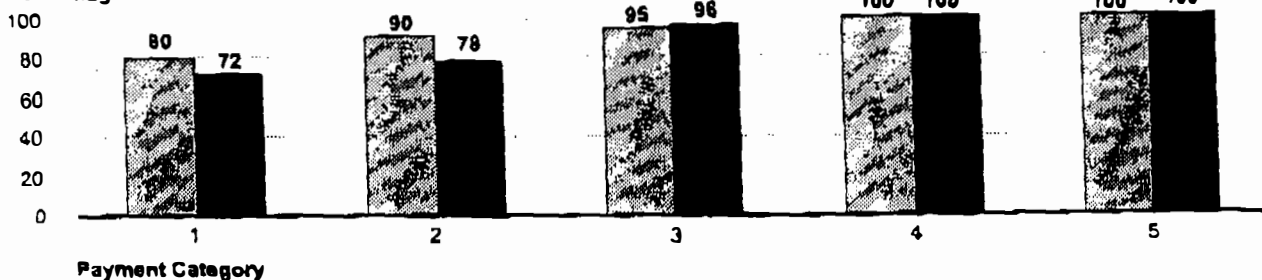
Percentage

**Eye Exams**

Percentage

**Hearing Exams**

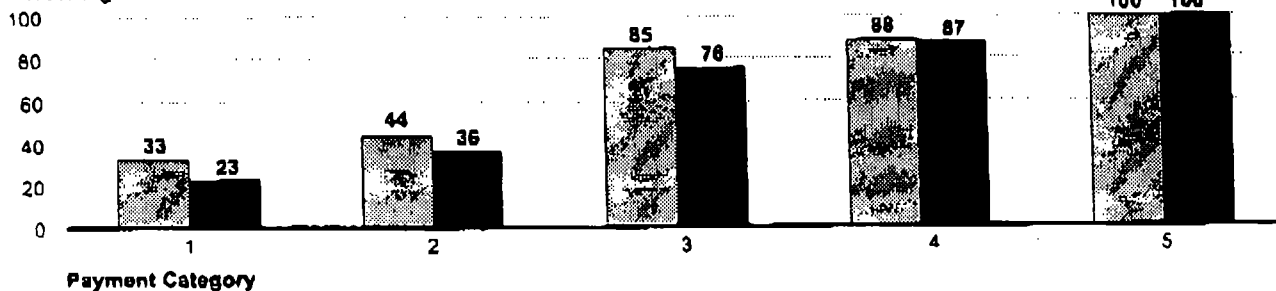
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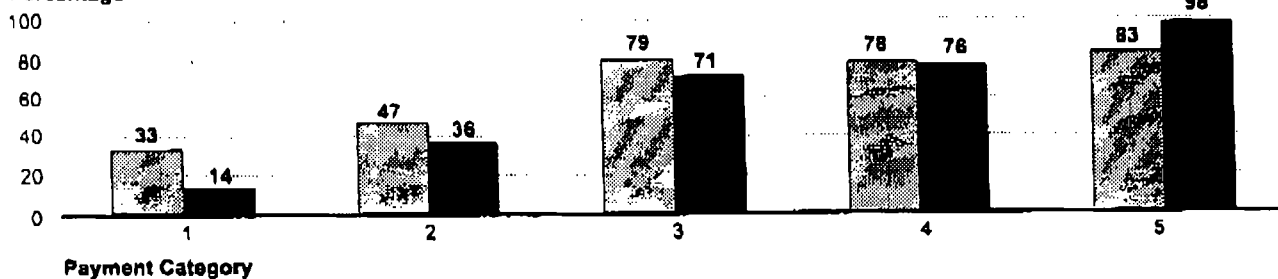
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Dental Care

Percentage

**Foot Care**

Percentage



1997

1999

Notes: Data include (1) only counties in which a plan was available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Nonrisk plans are excluded from this analysis. For 10 plans where 1999 benefit information was unavailable, September 1998 benefit data were used. Payment categories were created using 1997 payment rates; counties in each category were kept constant for the 2 years. (Category 1: < \$330; 2: \$330-\$439; 3: \$440-\$549; 4: \$550-\$659; 5: \$660+.) Categories were created by dividing the

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difference between the maximum payment rate and the minimum payment rate into five equal segments.

Sources: Medicare Managed Care Geographic Service Area File, December 1997, www.hcfa.gov/stats/geos.htm (Feb. 23, 1999); adjusted community rate submissions for 1997; Medicare Monthly Managed Care Reports, December 1997 and January 1999, www.hcfa.gov/stats/monthly.htm (Feb. 23, 1999); Medicare Managed Care Market Penetration State/County Data Files, December 1997 and September 1998, www.hcfa.gov/medicare/mpscpt1.htm (Feb. 23, 1999); and 1999 Medicare Compare database, www.medicare.gov/comparison/dbdownload/download.html (Feb. 23, 1999).

The decrease in access to plans offering additional benefits in the lowest-payment counties is interesting because these counties experienced an average payment increase of 23 percent between 1997 and 1999 compared with a 4-percent increase for all other counties.²⁸ It is unclear why coverage of additional benefits would decrease in the lowest-payment counties, given their relatively large payment increase in the past 2 years and higher-than-average payment increases expected in the future. Without data on the level of benefits being offered, the picture is incomplete. Plans in higher-payment-rate counties typically have more competitors than plans in lower-payment counties. Faced with more competition, plans in high-payment-rate counties may prefer to reduce benefit levels rather than eliminate benefit categories altogether. For example, a plan may lower the dollar limit on a prescription drug benefit or impose certain restrictions on the benefit. Plans facing less competition in lower-payment-rate counties may be more willing to eliminate benefits in the face of rising costs.

Plans Signal Desire to Revise 1999 Benefit Offerings

BBA constraints on plan payment increases may lead to more global reductions in future plan benefits. One indication of this potential effect is the effort by plans to revise their 1999 benefit packages. In 1998, plans were required to submit their proposed 1999 benefit packages to HCFA much earlier than in previous years and before HCFA had published the regulations implementing the new Medicare+Choice requirements. After HCFA published the new regulations in June 1998, some plans asked to revise their 1999 benefit packages. They argued that their initial submissions did not include the estimated costs of complying with the new regulations. In addition, plans noted that health care costs, especially prescription drug costs, had grown much faster than they had anticipated earlier.

²⁸ Average payment increases are weighted on the basis of the number of beneficiaries in each county.

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HCFA did not allow plans to revise their 1999 benefit packages because doing so might undermine the benefit submissions process. Plans normally establish benefit packages before they know what their competitors will offer. HCFA officials believe this uncertainty may motivate plans to offer more generous benefits. If plans were allowed to revise their benefit packages after they knew what other plans were offering, HCFA was concerned that plans whose original benefit packages were more generous than their competitors' might reduce enrollee benefits or raise premiums.²⁹ In addition, it would have been difficult for HCFA to review and approve benefit changes for all plans and still meet the statutory deadline for providing beneficiaries with comparative plan information. As a result of HCFA's decision, some plans may have withdrawn from the program because they could not afford to provide the benefit packages they initially proposed. Other plans remained in the program but may revise their benefit packages in the future.

CONCLUSIONS

The Medicare provisions of the BBA were intended to control the growth in Medicare expenditures and offer beneficiaries more health plan options. Toward those ends, the BBA slowed the rate of growth in FFS payments to certain health care providers, such as hospitals and physicians, and mandated new payment methodologies for other FFS providers, such as home health agencies. At the same time, the BBA addressed a number of known problems with the Medicare managed care program. It revised plan payments to address significant overpayment problems and to encourage managed care plans to offer services in areas with few plans. It also allowed new types of plans to participate in Medicare and imposed new requirements to ensure the quality of care provided by plans. When plans announced they would be withdrawing from Medicare or reducing the areas in which they offered services, however, some observers expressed concern about the future of Medicare managed care and debated whether certain provisions established by the BBA should be revised.

While future plan participation should be monitored, it is premature to conclude that Medicare+Choice must be radically revised to ensure the success of Medicare managed care. Enrollees affected by the withdrawals had to choose another plan or return to FFS, but only 1 percent of previously covered managed care enrollees were left without any Medicare+Choice plans. At the same time, HCFA has approved a small number of new plans and is reviewing 30 new plan applications, indicating continued plan interest in participating in Medicare.

²⁹Plans cannot reduce benefits or raise member premiums after HCFA approval of their benefit packages, although they have been allowed to add more services or reduce fees. According to HCFA officials, plans will continue to be allowed to make benefit package enhancements during each contract year until 2002. Beginning in that year, plans will be required to maintain their approved benefit packages for the entire contract year.

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Some of these new plans, if approved, would offer services in counties that previously had few or no managed care plans.

The current movement of plans in and out of Medicare may be primarily the normal reaction of plans to market competition and conditions. While the new payment rates and regulations were undoubtedly considered by plans in making their participation decisions, other factors associated with plan withdrawals—recent entry in the county, low enrollment, and higher levels of competition—suggest that a number of Medicare plans withdrew from markets in which they had difficulty competing. During the early years of the Medicare managed care program, a number of plans with low enrollment that were not operating profitably also withdrew from the program. The BBA transformed the Medicare risk program into Medicare+Choice with the goal of taking advantage of the efficiencies and choices that exist in the private managed care market. Medicare may not be able to harness these benefits without also experiencing some of the adjustments that occur in the health care market.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on our report, HCFA found our analysis of plan participation in the Medicare+Choice program to be sound and agreed with our findings and conclusions. HCFA emphasized that recent trends in the overall managed care market, such as low profit margins, increased competition, and plan consolidations, played a major role in plans' Medicare+Choice participation decisions. HCFA also noted that the withdrawal of many plans from FEHBP suggests the significance of overall market trends in plans' decision-making. In its comments, HCFA listed the Medicare+Choice program changes it has proposed to (1) protect beneficiaries affected by plan withdrawals and (2) promote program stability by alleviating plans' concerns regarding certain administrative requirements. (HCFA's comments appear in app. III.) HCFA also provided us with technical comments, which we incorporated in the report where appropriate.

We also provided a copy of the draft to representatives of the American Association of Health Plans (AAHP) and the Health Insurance Association of America (HIAA). Both groups expressed concern that our report understates the role of reductions in payment increases and the heavier administrative burden created by the Medicare+Choice regulations on the recent plan withdrawals. Similarly, they disagree with our conclusion that plans may be responding to current market conditions and competition. Instead, they believe that significant changes in program payments and regulations are needed to ensure future plan and beneficiary participation in Medicare+Choice. (AAHP's and HIAA's comments appear in apps. IV and V.) Both groups also provided technical comments, which we incorporated where appropriate.

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We recognize that the payment rates and administrative requirements of Medicare+Choice may have played a role in the decisions of some plans to withdraw from a county, particularly plans with low enrollment. However, we also believe that plan participation decisions are based on a number of factors. The relative importance of any single factor can be difficult to determine, in part because the significance of its role may vary among plans. We agree with AAHP and HIAA that plan participation in Medicare+Choice should be monitored, but we continue to believe that it is premature to conclude that the program needs to be radically revised.

We are sending copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services, and other interested parties. We will make copies available to others on request.

If you or your staffs have any questions about this report, please call me at (202) 512-7114 or James Cosgrove at (202) 512-7029. Other major contributors to this report include Kathryn Linehan, Susanne Seagrave, Patricia Spellman, and Michelle St. Pierre.



William J. Scanlon
Director, Health Financing and
Public Health Issues

B-282017

The Honorable Charles E. Grassley
Chairman

The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable William V. Roth, Jr.
Chairman

The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Tom Bliley
Chairman

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable William M. Thomas
Chairman

The Honorable Fortney H. (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

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Abbreviations

BBA	Balanced Budget Act of 1997
CBO	Congressional Budget Office
ESRD	end-stage renal disease
FEHBP	Federal Employees Health Benefits Plan
FFS	fee for service
GME	graduate medical education
GSAR	Medicare Managed Care Geographic Service Area Report
HCFA	Health Care Financing Administration
HMO	health maintenance organization
MCO	managed care organization
PPO	preferred provider organization
PSO	provider-sponsored organization

HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Deborah***FROM:***Peter*

**OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201**

PHONE: _____**PHONE: 202-690-6726****FAX : 202-690-6262****TOTAL PAGES:****ADDRESSEE'S FAX MACHINE NUMBER:****DATE:****REMARKS:**

United States General Accounting Office

**Draft Report to Congressional
Committees****March 1999**

**MEDICARE
MANAGED CARE**

**Many Factors
Contribute to Recent
Plan Withdrawals;
Plan Interest
Continues****Notice:****This draft is restricted to official use.**

This draft report is being provided to obtain advance review and comment from those with responsibility for the subjects it discusses. It has not been fully reviewed within GAO and is, therefore, subject to revision.

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DRAFT**B- 282017****March 31, 1999**

**The Honorable Charles E. Grassley
Chairman
Special Committee on Aging
United States Senate**

**The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
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The Honorable Fortney H. (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

In 1998, nearly 7 million beneficiaries (approximately 17 percent of all Medicare beneficiaries) were enrolled in health plans offered by managed care organizations (MCO).¹ Most are members of health maintenance organizations (HMO) that received a fixed monthly (or capitated) fee per enrollee regardless of the number and mix of services they provide. These plans typically offered services not covered under the traditional fee-for-service (FFS) program—such as routine physical examinations and outpatient prescription drugs—and members generally paid less out-of-pocket than they would in FFS.² Not all beneficiaries, however, had access to a managed care plan because HMOs were not available in all areas.

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice program to expand beneficiaries' managed care options, both by encouraging the wider availability of HMOs and by permitting other types of health plans to participate in Medicare. BBA also contained provisions to slow the growth of Medicare spending. The Congressional Budget Office (CBO) estimates that these provisions will result in net Medicare savings of \$116 billion between 1998 and 2002. Changes to the method for calculating payments to managed care plans, along with slowed growth in Medicare FFS spending (upon which managed care payments are partially based), account for approximately \$22.5 billion of these projected savings. These changes followed a decade in which studies by GAO and others found that Medicare's previous payment

¹ A "plan" refers to a package of specific health benefits, out-of-pocket costs, and terms of coverage. A MCO refers to the entity that offers one or more plans.

² Prior to 1999, these plans were known as risk HMOs or risk plans. Before the BBA was passed, only a few types of plans offered services to Medicare beneficiaries. In recent years, the vast majority of beneficiaries who opted for managed care enrolled in risk plans. Other types of Medicare plans included HMOs with cost contracts and health care prepayment plans (HCPP). These plans differed substantially from risk plans both in how they operate and how Medicare reimburses them. Risk HMOs, along with new types of plans authorized by the BBA, are now known as Medicare+Choice plans. When we refer to a "plan" or a "managed care plan" in this report, we are referring only to plans that receive capitated payments, including both risk plans and Medicare+Choice plans; other types of plans with different payment mechanisms are excluded from our analysis.

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methodology tended to overcompensate managed care plans.³ In addition, BBA included provisions to make plans more accountable for the quality of care they provide. For example, BBA required Medicare managed care plans to implement new and more comprehensive quality assurance programs.

Last fall, shortly before the start of the Medicare+Choice program, nearly 100 Medicare plans announced that they would not renew their Medicare contracts or that they would reduce the geographic areas they served. Beneficiaries affected by these withdrawals either had to switch plans or return to FFS; a small percentage of these beneficiaries were left with no alternative other than FFS.⁴ Because of your concern over these developments, you asked us to provide you with information about recent plan decisions. This report focuses on plans that receive capitated payments and provides information on the patterns of plan and beneficiary participation in managed care, factors associated with plans' decisions to enter or leave the Medicare+Choice program, and changes in plans' benefit packages and premiums. Appendix I presents details of our methodology.

RESULTS IN BRIEF

Although an unusually large number of managed care plans left the Medicare program recently, a number of new plans have demonstrated their interest in serving beneficiaries by applying to enter the program or expanding the areas in which they offer services. Last fall, shortly before Medicare+Choice was implemented, 45 plans announced they would not renew their Medicare contracts and 54 others announced they would reduce the geographic areas in which they provided services. About 440,000 enrollees (7 percent of the managed care population) had to choose a new managed care plan or switch to FFS. A small number of the affected enrollees had to switch to FFS because no plans remained to provide services in their areas. At the same time, however, several new plans applied to enter the program. Thus far, HCFA has approved 10 new

³ Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, April 25, 1997).

⁴ Some beneficiaries affected by the withdrawals live in counties served by cost HMOs and could join this kind of plan rather than return to FFS. Because Medicare payments to these plans are based on the costs they incur, cost HMOs are more similar to the FFS program than to risk HMOs that receive a fixed monthly payment.

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plans for 1999 and is reviewing 30 additional plan applications. Some of the pending plan applications are for counties that previously had few or no managed care plans. If HCFA approves all of the pending plans and service area expansions, slightly more beneficiaries will have access to a managed care plan in 1999 than in 1998.

Plan withdrawals cannot be traced to a single cause; a variety of factors appear to be associated with plans' participation decisions. Payment level is one factor that influences where plans offer services. Monthly Medicare plan payments per enrollee vary considerably among counties; high payment counties are more likely than low payment counties to have a managed care plan. The 1998 plan withdrawals, however, were more likely to occur in high payment rate counties. When a plan reduced its service area, however, we found that counties where payments were low relative to payments in the rest of a plan's service area were more likely to experience a withdrawal than counties with higher payment rates. In addition, plans were more likely to withdraw from counties that they had entered since 1992, where they had attracted fewer enrollees, or where they faced relatively high levels of competition. These findings suggest that a portion of the pullouts may have been the result of plans' deciding that they were too weak to effectively compete in certain areas. Some plans have stated that they withdrew from areas where they were unsuccessful in establishing sufficient provider networks. Plan representatives also cite the administrative burden associated with new program requirement as a significant factor in plans' decision-making. However, few national managed care organizations terminated all of their Medicare plans; instead they continue to offer plans in other areas.

A broad comparison of plan benefit packages from 1997 and 1999 indicates modest reductions in the inclusion of certain benefits. Our analysis focused only on whether specific benefits were offered by plans in each of the 2 years, because information was not available to determine whether plans changed coverage levels for these benefits. In 1999, a slightly greater percentage of beneficiaries could join a plan that offered prescription drug coverage, while a slightly smaller percentage of beneficiaries have access to a plan offering dental care, hearing exams, and foot care. Beneficiaries living in the lowest payment rate areas experienced greater decreases in access than the average beneficiary. In contrast to beneficiaries living in higher payment areas, those living in the lowest payment areas experienced a decrease in access to plans offering prescription drug benefits. Decreases in these areas occurred despite the fact that plans in these

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counties experienced an average payment increase of 23 percent between 1997 and 1999, compared to a 4-percent increase for all other counties.

BACKGROUND

Medicare is the nation's health insurance program for those aged 65 and older and certain disabled individuals. All beneficiaries can receive health care through Medicare's traditional FFS arrangement. Alternatively, a beneficiary can enroll in a Medicare managed care plan if one is available in the county in which he or she lives. The vast majority of the nation's 39 million beneficiaries remain in the traditional FFS program, but enrollment in Medicare managed care plans has grown rapidly in recent years. Currently, about 17 percent of all Medicare beneficiaries are enrolled in a managed care plan.

Medicare Managed Care Before BBA

As of December 1, 1998, about 90 percent of Medicare's managed care enrollees were in risk plans. These plans assumed the financial risk of providing care for a fixed monthly per-beneficiary fee paid by Medicare. Payment rates were determined for each county, based on the average adjusted per capita FFS spending in that county. Because these plans were assumed to be able to provide services more efficiently than the FFS sector, Medicare law set payment rates at 95 percent of the FFS amount in each county. These county rates were adjusted, up or down, based on enrollees' demographic characteristics, such as age and gender.⁴ The adjustments, known as risk adjustments, were intended to account for differences in beneficiaries' expected health care costs. That is, payment rates for enrollees who were expected to require more medical care were supposed to be higher than the rates for healthier enrollees.

This payment methodology has been criticized for a number of weaknesses. Basing payments on per capita FFS spending resulted in significant variation in capitation rates across counties

⁴ HCFA estimated how much would be spent in each county to serve the average FFS beneficiary. This average could be higher or lower than actual per capita spending in each county if the demographic composition of the county's population differed from the national average.

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that did not necessarily reflect differences in costs faced by managed care plans.⁶ Rural areas, which generally had much lower payment rates than urban areas, often had few or no managed care plans. In addition, years of research indicated that Medicare's payment methodology and demographic risk adjusters resulted in excess payments to plans because they generally attracted healthier beneficiaries with below average health care costs.⁷ Consequently, many managed care enrollees would have cost Medicare less if they had stayed in the FFS sector. In 1997 the Physician Payment Review Commission (PPRC)⁸ estimated that Medicare paid as much as \$2 billion annually in excess payments to managed care plans.

Historical Trends in Plan Participation and Enrollment

In recent years, plan participation in Medicare has grown steadily (see figure 1). Between 1987 and 1991, however, the number of plans dropped dramatically from 165 to 93. The number of enrollees affected by these withdrawals was fairly small, however, because many of the terminating plans had few or no enrollees. In fact, HMO enrollment has steadily increased each year, even during the years when the number of plans decreased. In the last 3 years, enrollment in Medicare plans has more than doubled from about 3 million in 1995 to over 6 million in 1998.

Figure 1: Medicare Plans and Enrollment, 1985 -1998

Figure note: Non-risk plans are excluded from this analysis.

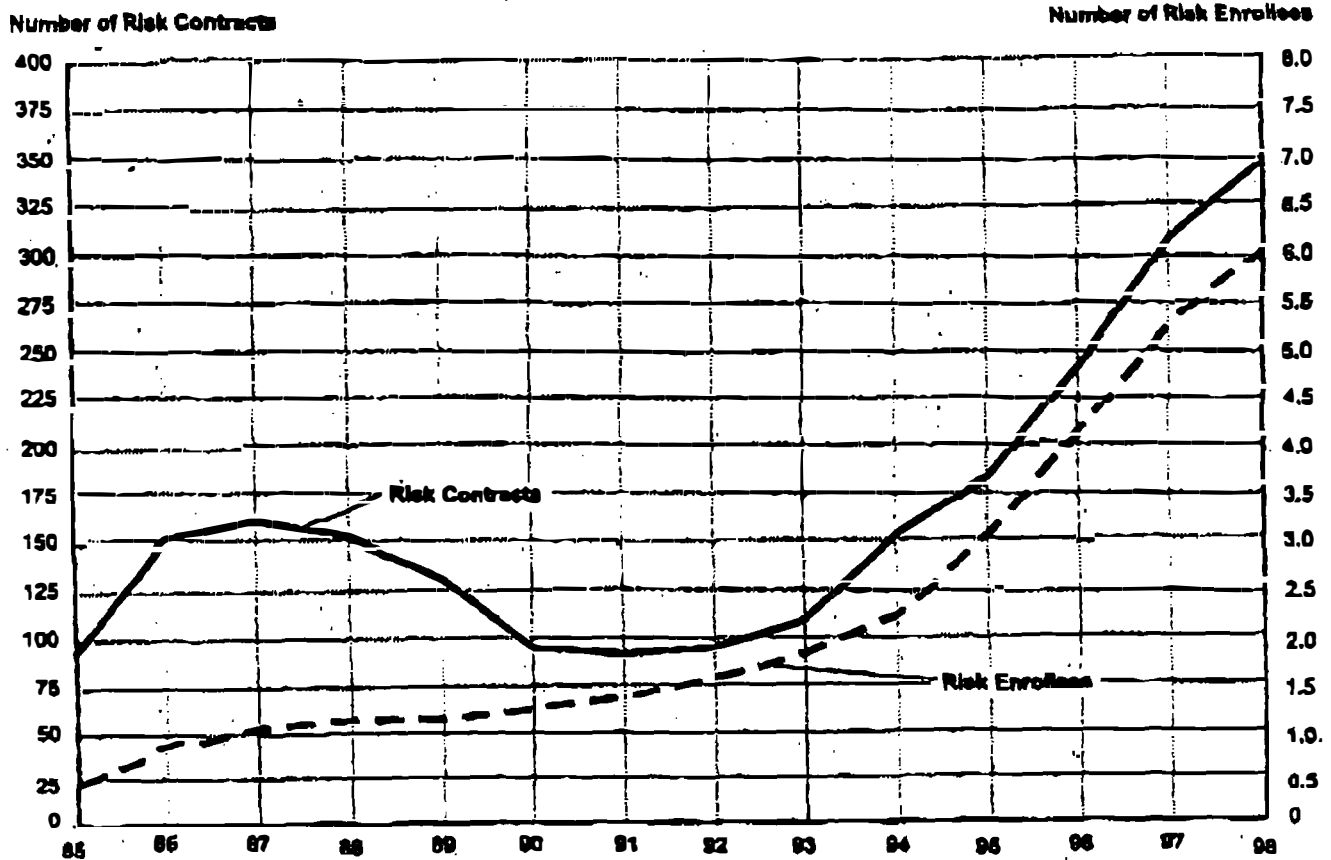
Sources: Medicare Managed Care Monthly Contract Reports, for December of each year, from HCFA's website.

Managed care enrollment is not evenly distributed nation wide. A comparison of counties with Medicare plan enrollment greater than 5 percent in 1995 and 1998 shows that enrollment has

⁶ Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits. (GAO/T-HEHS-97-133, May 19, 1997).

⁷ Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans. (GAO/T-HEHS-99-72, February 25, 1999).

⁸ In October 1997, the Medicare Payment Advisory Commission (MedPAC) replaced PPRC.

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increased in many counties, but remains concentrated in the West, Northeast, and Florida. (See figures 2 and 3.)

Figure 2: Counties with Medicare Plan Enrollment Greater Than 5 Percent of the Medicare Population, December 1995

Figure note: Non-risk plans are excluded from this analysis.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files.
HCFA Office of Managed Care.

Figure 3: Counties with Medicare Plan Enrollment Greater Than 5 Percent of the Medicare Population, September 1998

Figure note: Non-risk plans are excluded from this analysis.

Source: Medicare Managed Care Market Penetration File, September 1998, HCFA website.

BBA Changes to Medicare Managed Care

The BBA substantially changed the method used to set the payment rates for Medicare managed care plans. As of January 1, 1998, plan payments for each county are based on the highest rate resulting from three alternative methodologies: a minimum payment amount, a minimum increase over the previous year's payment, or a blend of national and local FFS spending (see appendix II for a description of the new payment methodology). The changes were intended to address criticisms of the original payment system by loosening the link between local FFS spending increases and managed care rate increases in each county. In addition, the establishment of a minimum payment rate was meant to encourage plans to offer services in rural areas, which have historically had low payment rates and few participating plans. The BBA also directed the Secretary of Health and Human Services to develop and implement a better risk adjustment system based on beneficiaries' health status by January 1, 2000.

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The BBA also created the Medicare+Choice program, effective January 1, 1999, to broaden beneficiaries' health plan options. In addition to HMOs, two new types of managed care organizations were allowed to participate in Medicare: provider-sponsored organizations (PSO) and preferred provider organizations (PPO).⁹ The BBA permits private indemnity plans to serve Medicare beneficiaries and allows beneficiaries to participate in medical savings accounts (MSA). Traditional fee-for-service (FFS) Medicare remains available to all beneficiaries.

Other BBA provisions added new requirements for plans participating in Medicare+Choice. For example, plans are required to implement new and more comprehensive quality improvement programs. Compared to pre-BBA requirements, plans must also collect more information on such activities as appeals filed by enrollees and the number and type of the services provided by the plan; in addition, plans must report more information to HCFA and to beneficiaries. The BBA moved up the date for plans to submit their benefit package proposals from November 15 to May 1 of each year, allowing more lead-time to coordinate the beneficiary information campaign.¹⁰

Plans' Concerns About BBA Changes

While expressing support for many of the changes implemented under the Medicare+Choice program, managed care plans have also voiced a number of concerns about payment rates and the administrative burden created by some of the new requirements. Plans state that the recent rate increases have not kept pace with their costs or medical inflation. In both 1998 and 1999, many health plans received the minimum 2 percent payment increase. Managed care plans are also concerned about the impact that the new risk adjustment methodology will have on payments in 2000.

⁹ A PSO is similar to an HMO except that it is established by a group of providers who control the delivery of services and assume the financial risk involved in providing services. A PPO is a network of physicians and hospitals that contracts with an insurer to serve a group of enrollees.

¹⁰ HCFA must approve these proposals, formally known as Adjusted Community Rate (ACR) proposals, which establish the minimum benefit package each plan must offer.

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In addition, plans believe that many of the new BBA requirements, as implemented by HCFA, are overly prescriptive, too costly, and are being phased-in too quickly. HCFA has responded to some of these concerns, for example, by giving plans more flexibility in meeting the new quality improvement requirements. Plans would also prefer a later submission date for their benefit package proposals, so they can base their proposals on more current data. They believe that the May 1 date—eight months before the start of the contract year—is too early. Plans have to meet a similar deadline in order to participate in the Federal Employees Health Benefit Plan (FEHBP); they must submit similar benefit and rate information by May 31 each year, to allow FEHBP to coordinate an information campaign for federal employees. To respond to plan concerns, HCFA officials recently changed Medicare's benefit proposal submission date to July 1, 1999 for the year 2000.

PLAN WITHDRAWALS REDUCE ACCESS FOR SOME BENEFICIARIES, BUT NEW PLAN ENTRY MAY INCREASE ACCESS FOR OTHERS

Last fall, an unusually large number of plans decided to not renew their Medicare contracts for 1999 or to reduce the number of counties in which they offered services.¹¹ As a result of these decisions, about 7 percent of all Medicare managed care enrollees had to switch to another plan or return to FFS. A small group of the affected beneficiaries was left with no choice but to return to FFS. While some plans were deciding to leave, however, a number of plans were applying to enter the program or expand their existing service areas. If HCFA approves all of these applications, the number of beneficiaries with access to a managed care plan could increase in 1999, compared to 1998.

¹¹ We use the term withdrawals to refer both to instances when a plan withdraw from selected counties in its service area and when a plan terminated its entire contract (thus withdrawing from all counties in its service area).

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Withdrawals Reduced Or Eliminated Managed Care Option For Some Plan Members

As of December 1, 1998, there were 346 plans to serve Medicare beneficiaries in a particular geographic area.¹⁴ Each plan represents a contract to serve a particular geographic area. Many managed care organizations, such as Aetna/U.S. Healthcare and Kaiser, operate numerous plans across the country. Managed care organizations terminated 45 (or 13 percent) of these plans as of January 1, 1999. The vast majority of organizations involved in these terminations, however, continue to offer services to Medicare beneficiaries in other areas. For example, Aetna/U.S. Healthcare dropped its plans in Delaware and Maryland, but continues to offer plans in California and Florida. An additional 54 plans (16 percent) reduced the number of counties in their service areas. Nonetheless, over 70 percent of the plans operating in December 1998 remain in Medicare with no reduction in their service areas.

These withdrawal decisions affected about 440,000 enrollees, who could not continue receiving services in their chosen plan. Instead, they either had to choose a new managed care plan (if one was available in their county) or switch to the FFS program. About 64,000 of these enrollees, or 1 percent of the total Medicare managed care population, lived in counties in which no other Medicare+Choice plan was offered.¹⁵ Even if another managed care plan was available, about 450 beneficiaries affected by the withdrawals had end stage renal disease (ESRD) and thus had to return to FFS.¹⁶ Medicare prohibits beneficiaries with ESRD from joining a managed care plan, although they may stay in a plan if they develop the disease while enrolled.¹⁷ For all affected beneficiaries, plan withdrawals can be highly disruptive and costly. Those who return to FFS typically face higher out-of-pocket costs than they incurred as managed care enrollees.

¹⁴ Throughout this report, we focus on capitated managed care plans that are not part of demonstration projects. Our analyses do not include HMOs with cost contracts or HCPPs. The BBA eliminated certain HCPPs as of December 31, 1998 and will eliminate HMOs with cost contracts as of December 31, 2002.

¹⁵ Most of these beneficiaries had to return to FFS, although a small percentage live in counties served by cost HMOs and could join this kind of plan.

¹⁶ ESRD is the stage of kidney impairment that is considered irreversible and requires either regular dialysis treatments or a kidney transplant to maintain life. It is a relatively rare, but expensive disease.

¹⁷ An additional 43 beneficiaries with ESRD, who were enrolled in cost HMOs or plans participating in demonstration projects, will not be able to join another managed care plan.

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Beneficiaries who choose another plan may have to switch health care providers and may have different benefit coverage.

Of the 957 counties that were covered by Medicare plans as of September 1, 1998, 406 experienced at least one plan withdrawal; 94 of these counties were "abandoned," that is, left with no Medicare plans. However, of all the instances of plans withdrawing from a county, about 88 percent were by plans withdrawing from a county with 100 managed care enrollees or fewer, including 47 instances of a plan withdrawing from a county with no enrollees. For example, Southeastern United Medigroup of Kentucky eliminated 11 counties from its service area, but had no enrollees in those counties. Consequently, while over 40 percent of counties with at least one plan experienced a plan withdrawal, only 7 percent of managed care enrollees were affected.

New Plan Applications May Mitigate Effects of Withdrawals

While some plans have chosen to curtail their participation in Medicare, new plans are entering the program and some existing plans are expanding the areas they serve. HCFA has approved applications from 10 new plans that were able to enroll beneficiaries as of January or February of 1999. HCFA is also reviewing 30 additional new plan applications.¹⁶ In addition, 6 service area expansions had been approved and 14 other service area expansion applications were pending as of January 1999. The number of recently approved and pending applications suggests that there is still considerable plan interest in participating in Medicare. Furthermore, total managed care enrollment has increased following the drop that occurred in January 1999, and is now slightly higher than it was when the withdrawals took effect.

The 10 new Medicare plans approved by HCFA as of January 21, 1999, offer services in Florida, Oregon, Washington, West Virginia, Hawaii, New York, New Jersey, Illinois, Ohio, Wisconsin, and New Mexico (figure 4 shows the counties affected by the new plans and by plan

¹⁶ The numbers of approved and pending plans and service area expansions are based on data provided by HCFA as of January 20, 1999. Some pending plans or service area expansions may have been approved and new applications may have been submitted since then.

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withdrawals). Fourteen of the new or pending plans are applying to enter counties that previously had no Medicare managed care options. In 1998, for example, no plans were available in any of the counties in which the newly approved plans in Illinois and Oregon are offering services. One pending new plan has applied to offer services in 68 counties in Iowa, Minnesota, and South Dakota that did not have any plan as of September 1998. Figure 5 shows those counties that have pending new plan applications or pending service area expansions.

Figure 4: Counties With Plan Changes in January 1999

Figure note: Hawaii did not have any withdrawals, but did have 1 new plan approved in January 1999. Alaska did not have any managed care plans in 1998 or 1999. Non-risk plans are excluded from this analysis.

Sources: Files of contract non-renewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

Figure 5: Counties With Pending New Plan Applications or Pending Service Area Expansions

Figure note: Hawaii and Alaska did not have any pending new plan applications or service area expansions. Non-risk plans are excluded from this analysis.

Sources: Files of new plans and service area expansions from the Center for Health Plans and Providers at HCFA.

Even with these newly approved plans, the number of counties with at least one Medicare managed care plan decreased from 957 in September 1998 to 883 in January 1999 (see table 1). However, if all pending new applications and expansions are approved, 1,045 counties will have at least one managed care plan, including 181 counties that had no plans in 1998. These counties are identified in figure 6, along with those counties that no longer have a plan as a result of the withdrawals and service area reductions.

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Table 1: Availability of Medicare Managed Care Plans, September 1998 and January 1999

	Counties With Approved Medicare Plans as of September 1998	Counties With Approved Medicare Plans as of January 1999	Counties with Approved or Pending Medicare Plans as of January 1999
No Plans Available	2,175	2,249	2,087
1 or More Plans Available	957	883	1,045
1 Plan Available	383	393	518
More than 1 Plan Available	574	490	527

Table note: Non-risk plans are excluded from this analysis. 1999 Medicare beneficiaries are based on September 1998 count of beneficiaries.

Sources: Medicare Managed Care Market Penetration State/County Data Files, September 1998, Medicare Managed Care Geographic Service Area Report, September 1998 and files of contract non-renewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

Figure 6: Counties That Were Abandoned By Medicare Plans or That Have a Newly Approved or Pending Plan in 1999 But Had No Plan in 1998

Figure note: Hawaii did not have any abandoned counties, but did have one county with a plan in 1999 that did not have a plan in 1998. Alaska did not have any managed care plans in 1998 or 1999. Non-risk plans are excluded from this analysis.

Sources: Medicare Managed Care Geographic Service Area File, September 1998, Medicare Managed Care Market Penetration State/County Data Files, September 1998, and files of contract non-renewals and service area reductions, new plans, and service area expansion from the Center for Health Plans and Providers at HCFA.

Although it is too early to estimate the impact of the recently approved and pending applications on managed care enrollment, it is possible to calculate the number of beneficiaries that have a plan available in their counties. In September 1998, 28.4 million beneficiaries lived in counties served by at least 1 managed care plan (see table 2). In January 1999, that number dropped by almost 800,000 beneficiaries because of plan withdrawals and service area reductions. However,

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if all pending new applications and service area expansions are approved, slightly more beneficiaries in 1999 will have the option to join a managed care plan than did in 1998.

Nonetheless, fewer beneficiaries will have more than one plan to choose from even if all the new applications are approved.

Table 2: Beneficiary Access to a Managed Care Plan (In Millions), September 1998 and January 1999

	Beneficiaries in Counties With Approved Medicare Plans as of September 1998	Beneficiaries in Counties With Approved Medicare Plans as of January 1999	Beneficiaries in Counties with Approved or Pending Medicare Plans as of January 1999
No Plans Available	10.6	11.3	10.4
1 or More Plans Available	28.4	27.6	28.5
1 Plan Available	4.0	4.3	4.7
More than 1 Plan Available	24.3	23.3	23.8

Table note: Non-risk plans are excluded from this analysis. In some cases, plans offer services to certain portions of a county, rather than to the entire county. Because data on partial county participation were not readily available, we count all beneficiaries in a county as having access to a plan if a plan was offered in that county. Consequently, these numbers overstate the number of beneficiaries who have access to a plan for each period. Totals may not add due to rounding.

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998, Medicare Managed Care Market Penetration State/County Data Files, September 1998, and files of contract non-renewals and service area reductions, new plans, and service area expansion from the Center for Health Plans and Providers at HCFA.

Most of the new plan applications are from traditional HMOs. Thus far, HCFA has approved one PSO and no PPOs, MSAs, or private FFS plans. However, it may be too early to assess how many of these new types of health plans will be interested in participating in the program.

Medicare+Choice is still very new and interim final regulations governing the program were just published in June 1998. Plans have had little time to prepare and submit applications for 1999. The number and diversity of applications may increase in future years as plans become more familiar with the new program.

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SEVERAL FACTORS, SUCH AS PAYMENT, ENROLLMENT, AND LEVEL OF COMPETITION ARE ASSOCIATED WITH PLAN PARTICIPATION

No one factor can explain why plans choose to participate in particular counties. Although plans obviously consider payment rates, many other factors also influence their business decisions. Previous GAO work showed that some areas, such as Boston, Massachusetts, had relatively high payment rates in 1998 but few managed care plans and enrollees.¹⁷ Other areas, such as a number of Oregon counties, had low payment rates but still had several managed care plans with high enrollment in 1995.

The pattern of recent plan withdrawals suggests that several factors, including payment rates, may have influenced plans' decisions. A plan was more likely to withdraw from counties where

- payment rates were low relative to other counties in the plan's service area;
- the plan had entered since 1992;
- the plan had low enrollment; or
- the plan faced more competition from other plans.

An unusually high number of plan withdrawals in the federal employees health program suggests that general market conditions may play some role in the Medicare plan withdrawals. In some respects the current withdrawals are similar to those that occurred in the late 1980s. At that time, many plans left Medicare because they were unable to attract members and were unprofitable. Other factors, such as plans' inability to establish provider networks, may have also influenced the current withdrawals, but we were unable to quantify those effects.

¹⁷ Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

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Plans Withdrew From Both High and Low Payment Counties

Both before and after the recent withdrawals, managed care plans were much more likely to offer services in high payment rate counties than in low rate counties. In 1999, for example, 91 percent of counties with monthly payment rates over \$694 are served by a managed care plan. By contrast, only 11 percent of counties with the minimum payment rate of approximately \$380 are served by a managed care plan. High payment rate counties, however, were disproportionately affected by the withdrawals (see table 3). Over 90 percent of the counties with the highest payment rates experienced a plan withdrawal, compared to 34 percent of counties with the lowest payment rate. It is possible that some plans withdrew from high payment rate counties because they anticipated that these counties would receive below average payment increases in the coming years. In fact, the payment blending provision of the BBA (expected to be implemented for the first time in 2000) will result in smaller payment increases for higher payment rate counties and larger payment increases for lower payment rate counties. In addition, over the next five years, Medicare payments for graduate medical education (GME) will be eliminated from the blended rates.¹⁸ Because GME spending is concentrated in high payment rate counties, its removal will disproportionately slow payment rate growth in high payment rate counties.

¹⁸ Medicare FFS payments include payments to teaching hospitals for Medicare's share of the costs of providing GME, such as resident and faculty salaries and overhead costs related to teaching activities. Prior to the BBA, managed care plan payments in certain counties included a share of Medicare GME spending. BBA provisions removed GME payments from managed care plan payments and provided for teaching hospitals to be reimbursed directly for these costs.

DRAFT**Table 3: Counties with Medicare Plans in September 1998 Affected by Withdrawals, by 1999 Payment Rates**

	1999 Payment Rates*					TOTAL
	\$379.84	\$379.85 to \$484.47	\$484.48 to \$588.10	\$589.11 to \$693.72	\$693.73 to \$798.35	
Counties With Plans Affected by Withdrawals	50	185	131	30	10	406
Counties with Plan(s) in September 1998	145	496	257	48	11	957
Percent of All Counties With Plan(s) in September 1998 Affected By Plan Withdrawals	.34	.37	.51	.63	.91	.42

*Payment rate categories were determined by creating four equal rate categories (with a payment range of approximately \$106). The minimum payment rate was used as the fifth category.

Table note: Non-risk plans are excluded from this analysis.

Sources: Medicare Risk Monthly Payment Rates, 1999, Medicare Managed Care Geographic Service Area Report, September 1998, from the HCFA website, and files of contract non-renewals and service area reductions from the Center for Health Plans and Providers at HCFA.

Although a smaller percentage of low payment counties were affected by withdrawals compared to high payment counties, enrollees living in the low rate counties were more likely to be affected by the withdrawals. For example, 16 percent of enrollees who lived in counties with the lowest payment rates were affected by a plan withdrawal, compared to 1 percent of enrollees in the highest payment rate counties (see table 4). These findings suggest that the plans that withdrew from high payment counties had relatively few members.

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Table 4: Enrollees in Plans in September 1998 Affected by Plan Withdrawals, by 1999 Payment Rate

	1999 Payment Rates ¹					TOTAL
	\$379.84	\$379.85 to \$484.47	\$484.48 to \$589.10	\$589.11 to \$693.72	\$693.73 to \$798.35	
Enrollees in Plans Affected By Withdrawals, September 1998	18,900	183,100	181,400	50,000	3,200	486,700
Enrollees in Plans, September 1998	119,100	1,445,700	2,783,000	1,208,400	331,600	5,887,900
Percent of Enrollees in Plans Affected By Withdrawals	16	13	7	4	1	7

¹ Payment rate categories were determined by creating four equal rate categories (with a payment range of approximately \$105). The minimum payment rate was used as the fifth category.

Table note: Non-risk plans are excluded from this analysis. Numbers are rounded to nearest hundred. Totals may not add due to rounding.

Sources: Medicare Risk Monthly Payments Rates, 1999, Medicare Managed Care Geographic Service Area Report, September 1998. Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998 from the HCFA website, and files of contract non-renewals and service area reductions from the Center for Health Plans and Providers at HCFA.

For plans that dropped selected counties from their service areas, payment rates appear to be one factor that influenced their decisions. In 1999, for example, PacifiCare of Arizona withdrew from 4 of the 8 counties in its service area, withdrawing primarily from counties with the highest payment rates; it continued to provide services in Pinal County, which had the highest payment of all the counties in its service area, but dropped Cochise County, where the payment rate was about 25 percent lower.¹⁸ To assess the impact of relative county payment rates on plans' service area decisions, we compared the payment rate for each county in a plan's service area with the highest county payment rate in that plan's service area.¹⁹ We repeated our calculation for every plan. The results (shown in table 5) suggest that counties with payment rates that were low relative to the maximum county payment rate in a given service area were disproportionately affected by service area reductions. For example, while plans reduced their

¹⁸ PacifiCare of Arizona withdrew from the following four counties (payment rates indicated in parentheses): Santa Cruz (\$380), Cochise (\$415), LaPaz (\$478), and Mohave (\$494). The plan remained in the following four counties: Pima (\$483), Gila (\$485), Maricopa (\$509), and Pinal (\$541).

¹⁹ For example, a Florida plan offered services in Broward, Dade, Martin, and Palm Beach counties with payment rates of \$677, \$778, \$515, and \$589 respectively, so the four counties are included in the table as 87 percent, 100 percent, 66 percent, and 76 percent of the plan's maximum payment county, which in this example, is Dade County.

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service areas in 5 percent of counties with payments that were between 90 and 100 percent of a plan's maximum payment rate county, they reduced their service areas in 28 percent of counties that had payment rates between 50 and 60 percent of the plan's maximum payment rate county.

Table 5: Relationship of Payment Rates for Counties Dropped by a Plan to the Maximum Payment Rate in the Plan's Service Area (Includes Only Service Area Reductions)

	County Payment as a Percentage of the Maximum County Payment For a Plan					Total
	50 - 60	>60 - 70	>70 - 80	>80 - 90	>90 - 100	
Counties Experiencing a Service Area Reduction	27	30	66	75	43	241
All Plan/County Combinations	95	147	417	800	937	2,396
Service Area Reduction Plan/County Combinations as a Percentage of Total	28	20	16	9	5	10

Table note: Non-risk plans are excluded from this analysis. Only plans serving more than one county are included. A county may be included more than once in this table. If a county is served by more than one plan, the county is represented by its unique payment percentage of each plan's maximum county payment.

Sources: Medicare Risk Monthly Payment Rates, 1988 and Medicare Managed Care Geographic Service Area Report, September 1988 from the HCFA web site.

**Enrollment, Competition
Level, And Other Factors
Also Influence Participation
Decisions**

Several factors, in addition to payment rates, appear to be associated with a plan's decision to withdraw from a specific county: short length of time operating in the county, low enrollment, and above average levels of competition. The Medicare managed care program expanded rapidly in recent years; many new plans entered the program and existing plans expanded the areas they served. The recent withdrawals may represent a market correction—weaker plans facing higher levels of competition and insufficient enrollment may have decided to withdraw from the program at this time. A number of plans left the Medicare program between 1988 and 1991 for similar reasons. Moreover, the market conditions that led to the recent withdrawals may not be unique to the Medicare program. The experience of the Federal Employees Health

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Benefit Program, which also sustained an unusually high number of plan withdrawals this year, suggests that plans may be reacting to general market conditions as well as program specific ones.

Plans were more likely to withdraw from counties in which they had less Medicare experience. We looked at all instances in which a Medicare plan provided services in a county as of February 1998, and determined how long the plan had participated in Medicare in that county. For example, in less than 1 percent of the instances in which a plan entered a county for the first time between 1980 and 1986—that is, plans with more than 12 years of Medicare experience in a county—did the plan withdraw from that county in 1998 (see figure 7). In contrast, plans were much more likely to withdraw from areas in which they had less than 7 years experience. About one-third of the plans with 5 years of Medicare experience in a county withdrew from that county in 1998; almost 27 percent of plans with 4 years experience in a county withdrew from that county in 1998. The withdrawal pattern suggests a retrenchment from the rapid growth of Medicare managed care that began in 1994.

Figure 7: Plan Withdrawals in 1998, As a Percentage of New Plan Entries into a County, by Year

Figure note: A county may be included more than once in this figure. If there are two or more plans in a county, each plan is represented by a separate date of entry into the county. This figure includes all plan-county combinations that were in Medicare as of February 1998. Non-risk plans are excluded from this analysis. While HMOs have been authorized to provide services to Medicare beneficiaries since 1972, the risk program that immediately preceded the SBA and implemented capitated payments was created by legislation in 1982. Plans began operating under risk contracts in 1985, but may have provided services to Medicare beneficiaries in earlier years under the previous Medicare HMO program.

Sources: Files of contract non-renewals, service area reductions, and historical geographic service areas of all Medicare HMOs (February 1998) from the Center for Health Plans and Providers, HCFA. The historical geographic service area file is missing 29 plan-county combinations affected by the withdrawals.

Plans that had difficulty attracting or retaining enrollees in a county were also more likely to withdraw from that county (see table 6). In about a third of the instances where a plan had no enrollees in a county, the plan withdrew from that county. In contrast, in only 12 percent of the instances where a plan had more than 1,000 enrollees in a county did the plan withdraw.

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Figure 7:

Percent of Plan Withdrawals in 1998 by Year of Plan Entry into County

1998 Withdrawals as a Percent
of All Plan-County Combinations
Entering in a Given Year

40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

1980 - 1987 - 1993 1994 1995 1996 1997 1998
1986 1992

Year Plan Entered County

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DRAFT**Table 6: Plan/County Combinations Affected by Withdrawals, By Enrollment Level**

	Individual Plan Enrollment by County, September 1998					TOTAL
	0 Enrollees	1-100 Enrollees	101-500 Enrollees	501-1000 Enrollees	>1,000 Enrollees	
Plan/County Combinations with Plans That Experienced a Plan Withdrawal	47	178	172	91	110	598
Plan/County Combinations with Plan(s) in 9/98	140	646	708	373	919	2786
Percent of Counties with Plans That Experienced a Plan Withdrawal	33	28	24	24	12	21

Table note: Non-risk plans are excluded from this analysis. A county may be included more than once in this table. If there are two or more plans in a county, each plan is represented by its unique level of enrollment in that county.

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998 from the HCFA website, and files of contract non-renewals and service area reductions from the Center for Health Plans and Providers at HCFA.

Plans were also more likely to withdraw from counties where they faced greater competition. For example, plan withdrawals occurred in 63 percent of counties where the number of competing plans was above the national average, but in only 28 percent of counties where the number of competing plans was below the national average. In addition, we calculated a measure of competition for each county that incorporates both the number of plans competing in a county and the distribution of their market shares.²¹ There were plan withdrawals in 59 percent of counties where the level of competition was above the national average, but in only 26 percent of the counties where the level of competition was below the national average.

Some plans may have withdrawn from counties where they found it difficult to build or maintain provider networks. For example, a Medicare HMO in a rural area of North Dakota withdrew from the program when its hospital provider discontinued its contract with the plan. A HCFA official also told us that the two plans that withdrew from Utah made their decisions early in 1998, prior to the publication of the interim final regulations implementing Medicare+Choice,

²¹ We used the Herfindahl index, a generally accepted measure of competition. This index will tend toward zero if there are more plans competing in the county or if the market share is more evenly distributed

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because they could not establish adequate provider networks. In at least one of the cases, physicians wanted higher payments than the plan was willing or able to pay.

Plans have also cited the administrative burden of the new Medicare+Choice requirements as a significant reason for their withdrawal decisions. For the most part, however, this burden was not so great as to induce managed care organizations to leave the Medicare program entirely. Many national managed care organizations, such as Aetna/U.S. Healthcare or Kaiser, offer numerous plans across the country. Nearly all of the managed care organizations that terminated its Medicare plan in one area continued to operate Medicare plans in other areas. Nonetheless, it may be that the increased administrative requirements, coupled with the expected slow growth in payments and the uncertainties associated with a new risk adjustment methodology, affected some plans' participation decisions.

Finally, an anomaly related to the transition from the previous Medicare managed care program to Medicare+Choice may be partly responsible for the unusually high number of withdrawals witnessed this year. Under the previous managed care program, if a plan withdrew from a county, it could not re-enter that area for 5 years. The BBA included a similar provision for Medicare+Choice plans, but did not make it retroactive to include plans with contracts under the earlier program. Plans that withdrew before January 1, 1999 have—by definition—never been Medicare+Choice plans. Consequently, these plans do not face the exclusion period and can re-enter any county without waiting 5 years. The effect of this provision may have been to concentrate plan withdrawals in 1998. Some plans may have viewed this year as a one-time opportunity to pull back from the program while they waited to see what future changes might bring.

SMALL REDUCTIONS SEEN IN AVAILABILITY OF SOME BENEFITS

Managed care plans have typically offered more generous benefits—such as coverage for prescription drugs, dental care, and hearing exams—than those available in the FFS program.

among the competing plans. It will tend toward 1 if there are fewer firms or if either one or a few firms

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Although the extent of extra benefits varies by plan, they are more commonly offered in high payment counties. Since the BBA payment changes were implemented, overall beneficiary access to plans that offer certain additional benefits declined slightly. However, beneficiaries who live in low payment rate counties experienced greater decreases in access between 1997 and 1999 than the average beneficiary. While the current benefit changes are having a larger impact on beneficiaries in low payment counties, the BBA constraints on plan payment increases may lead plans to offer less generous benefits in the future to all beneficiaries than they have in the past.

Due to limitations in the available data sources, we can only report on whether a plan offered a particular benefit. The scope of the actual benefit may vary significantly among plans and over time. For example, while two plans may offer coverage of prescription drugs, one plan may have a dollar cap on the benefit and offer coverage only for plan-approved drugs, while the second plan may cover drugs without any limitations. Our study did not distinguish between these two different benefit levels.

Plans in counties with lower payments have generally offered fewer additional benefits; as a result, fewer beneficiaries living in lower rate counties have had the opportunity to join plans that offer these benefits compared to beneficiaries living in higher payment counties. In 1997, for example, only 61 percent of beneficiaries living in counties with payments under \$330 (and with at least one plan) had access to a Medicare plan that offered prescription drug coverage, while 100 percent of beneficiaries living in counties with payments over \$658 had such access (see figure 8).²²

dominate market share. The index equals 1 if there is only 1 firm in the county.

²² Many FFS beneficiaries purchase supplemental insurance policies, which can cost up to \$270 per month, to obtain coverage for some of these additional benefits.

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Figure 8: Beneficiary Access to Plans Offering Selected Benefits in 1997, By County Payment Rate (Includes Only Counties With One or More Plans)

Figure note: Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Non-risk plans are excluded from this analysis. Payment categories are created by dividing the difference between the maximum and minimum payment rates into five equal segments.

Sources: Medicare Managed Care Geographic Service Area File, December 1997, ACR submissions for 1997, Medicare Monthly Managed Care Report, December 1997, Medicare Managed Care Market Penetration State/County File, December 1997.

Benefit Changes Had Larger Impact On Beneficiaries in Low Payment Counties

In comparing 1997 and 1999 plan benefit packages for beneficiaries living in counties with at least one managed care plan, we found that access to plans offering different additional benefits decreased slightly after the BBA payment changes (see figure 9). For example, 71 percent of beneficiaries had access to foot care in 1997, but only 64 percent had access to such coverage in 1999. Access to physical examinations and immunizations did not change. The only benefit for which beneficiary access increased was prescription drug coverage. While plans are concerned about the ability of plan payments to keep up with rapidly increasing drug costs, plans may offer drug coverage to make themselves more attractive to beneficiaries, who value this benefit. While continuing to offer a drug benefit, plans may be limiting this benefit, for example, by establishing a maximum dollar amount that the plan will pay.

Figure 9: Percentage of Beneficiaries With Access To Plans Offering Different Types of Benefits, 1997 and 1999

Figure note: Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Non-risk plans are excluded from this analysis. For 10 plans where 1999 benefit information was unavailable, September 1998 benefit data were used.

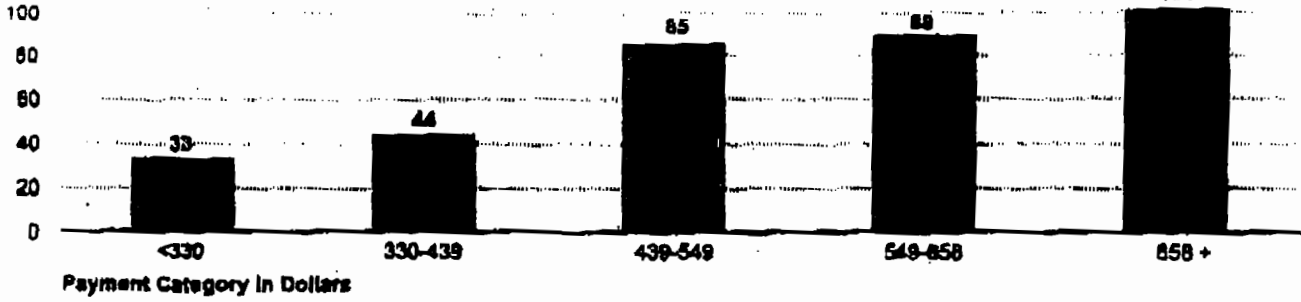
Sources: Medicare Managed Care Geographic Service Area File, December 1997, ACR submissions for 1997, Medicare Monthly Managed Care Report, December 1997 and January 1999, Medicare Managed Care Market Penetration State/County File, December 1997 and September 1998, and 1999 Medicare Compare database.

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Figure 8: Beneficiary Access to Plans Offering Selected Benefits in 1997, By County Payment Rate

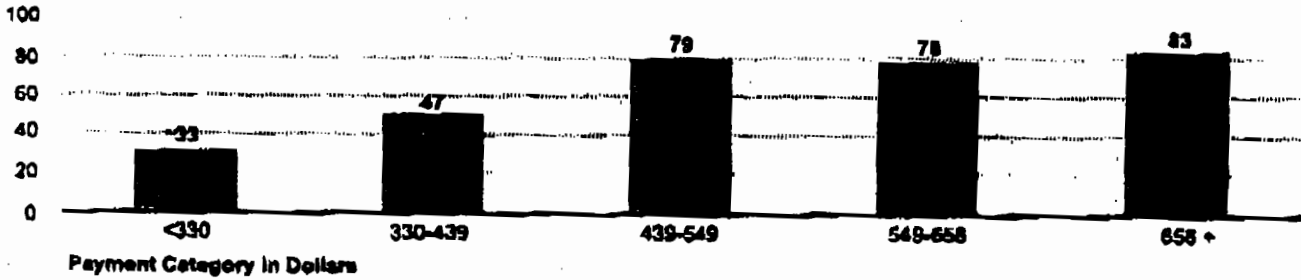
Dental Care

Percentage

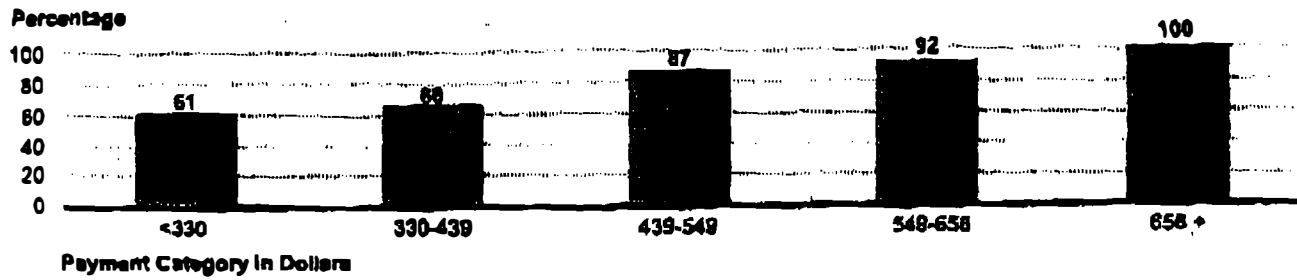
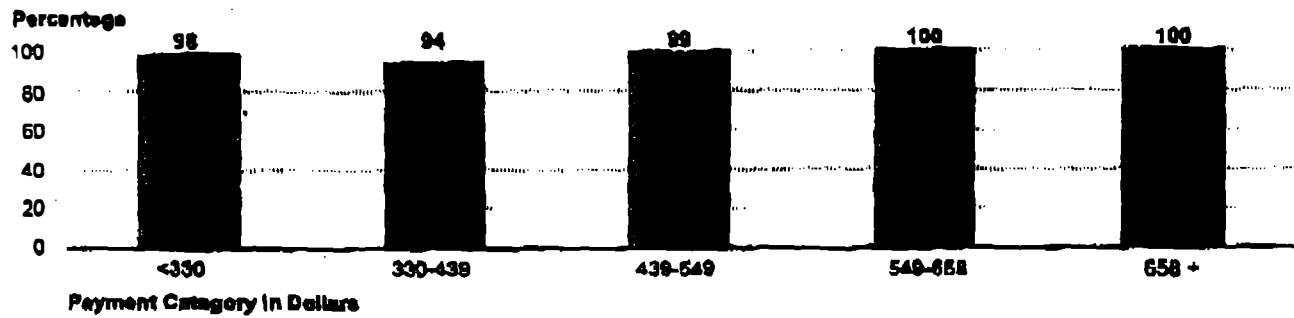
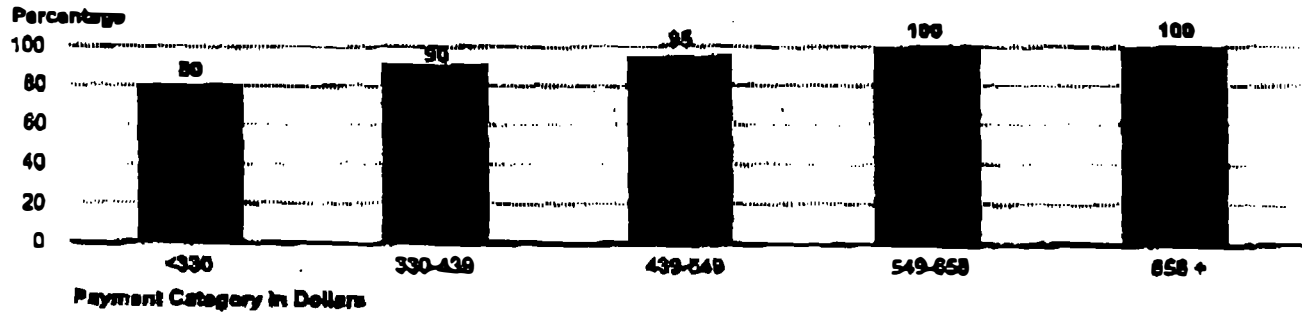


Foot Care

Percentage



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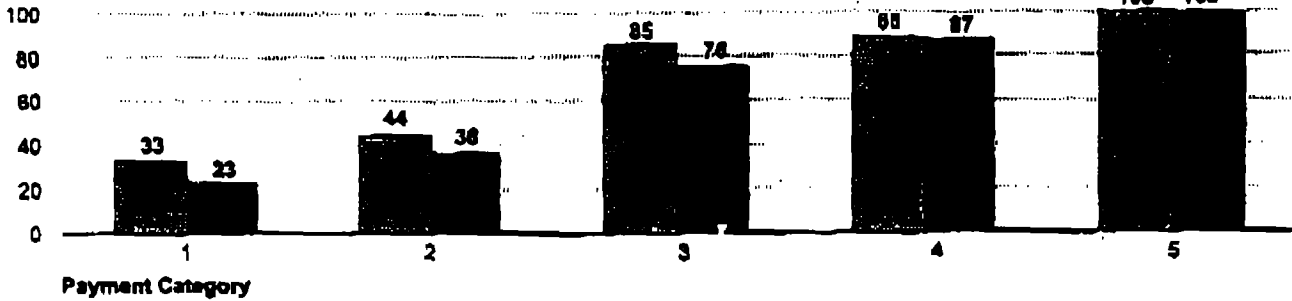
DRAFT**Prescription Drugs****Eye Exams****Hearing Exams****DRAFT**

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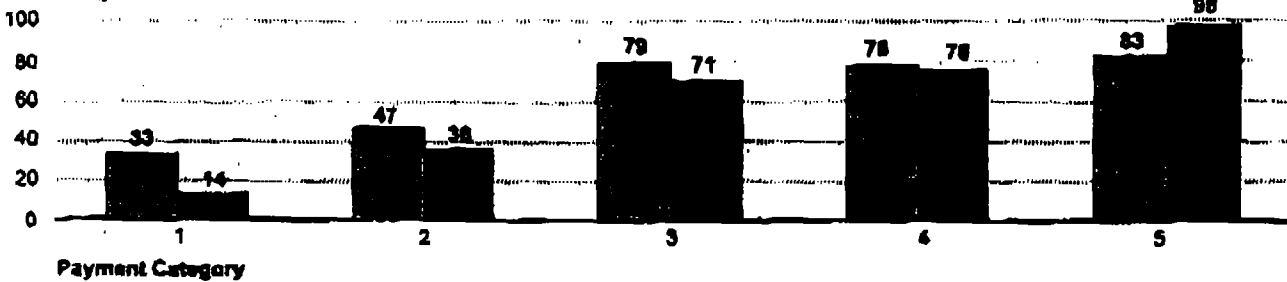
Figure 9: Percentage of Beneficiaries With Access To Plans Offering Different Types of Benefits

Dental Care

Percentage

**Foot Care**

Percentage



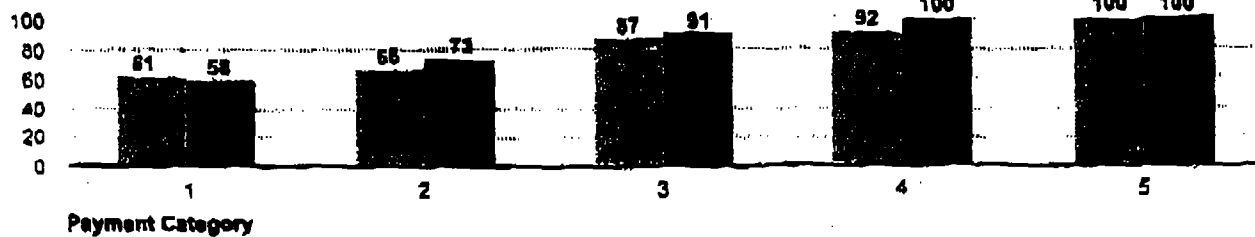
1997

1999

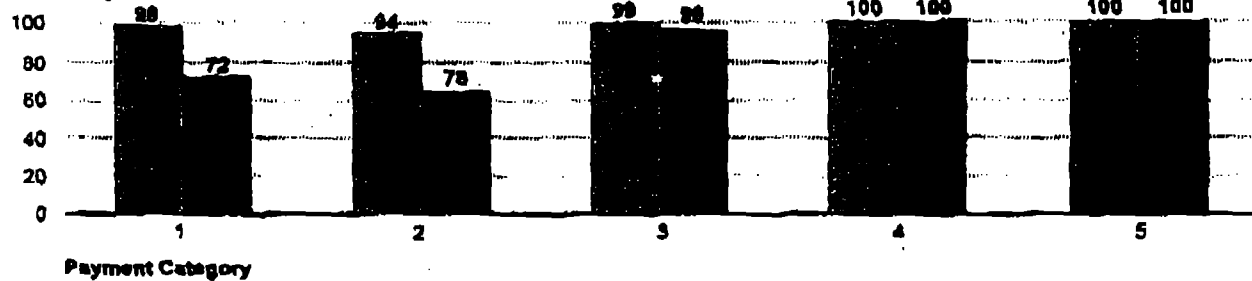
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DRAFT**Prescription Drugs**

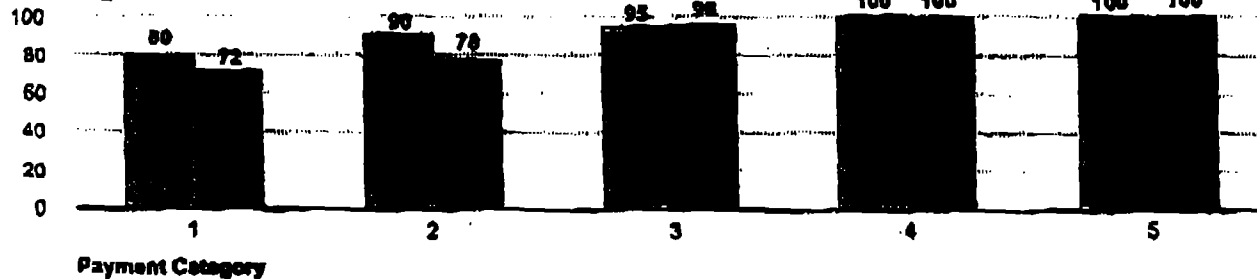
Percentage

**Eye Exams**

Percentage

**Hearing Exams**

Percentage

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Most beneficiaries with access to a managed care plan can enroll without paying a separate monthly premium.²⁵ The percentage of beneficiaries living in counties where plans require enrollees to pay a monthly premium increased slightly from 12 percent in 1997 to 15 percent in 1999 (see figure 10). In addition, the percentage of beneficiaries living in counties where the minimum plan premium was over \$40 increased slightly.

Figure 10: Medicare Managed Care Premiums, 1997 and 1999

- (1) Premium in addition to Medicare Part B premium. Premiums based on lowest premium available in a county.
- (2) 1999 Medicare beneficiaries based on September 1998 count of beneficiaries.

Figure note: Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Non-risk plans are excluded from this analysis. For 10 plans where 1999 premium information was unavailable, September 1998 premium data were used.

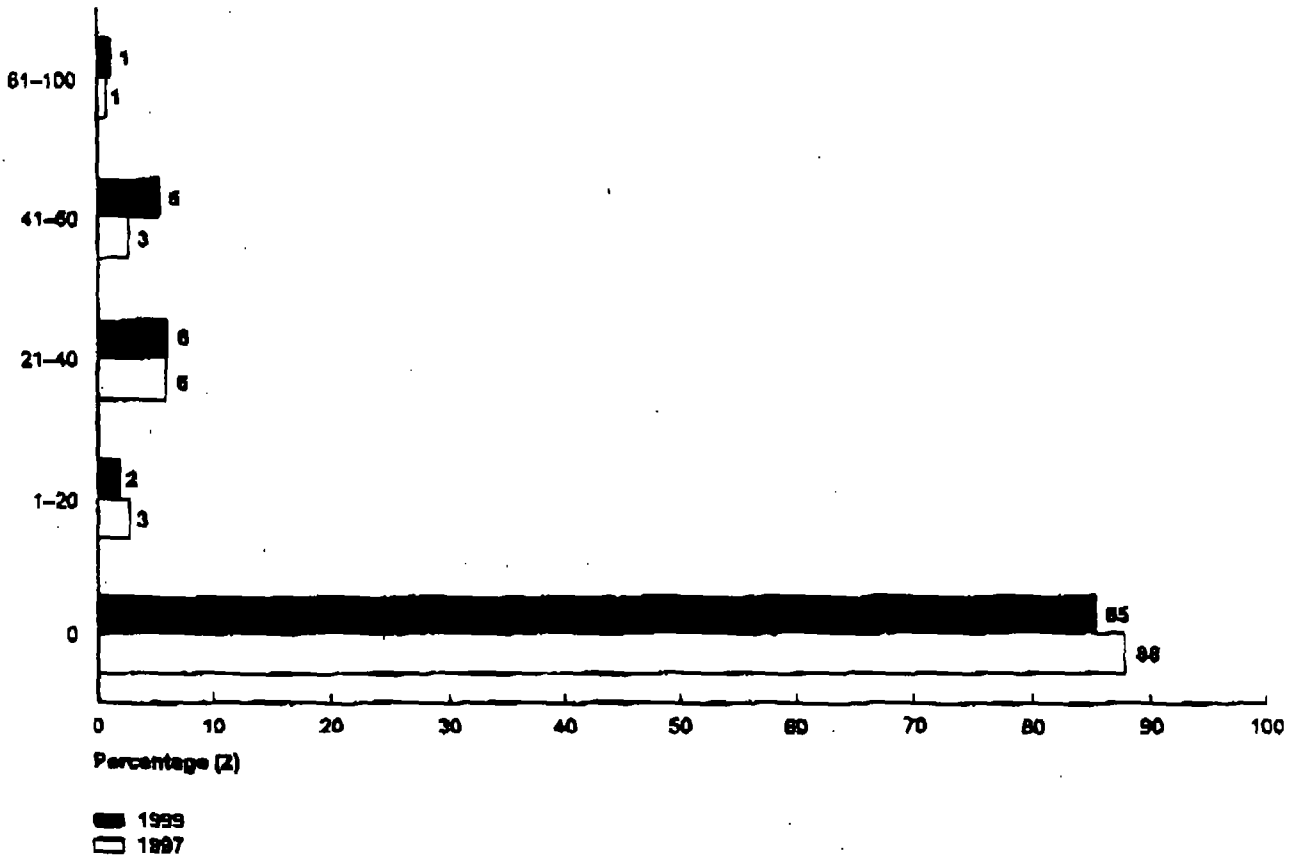
Sources: Medicare Managed Care Geographic Service Area File, December 1997, ACR submissions for 1997, Medicare Monthly Managed Care Report, December 1997 and January 1999, Medicare Managed Care Market Penetration State/County File, December 1997 and September 1998, 1999 Medicare Compare database.

Although the change in beneficiary access to plans offering additional benefits was relatively small, these benefit reductions were concentrated in low payment rate counties (see figure 11). Access to plans offering additional benefits remained nearly constant for beneficiaries in high payment rate counties. For example, the percentage of beneficiaries in the lowest payment rate category with access to Medicare plans offering eye exams decreased from 98 percent in 1997 to 72 percent in 1999. In contrast, all beneficiaries living in the highest payment rate counties could obtain covered eye exams from a managed care plan in both years. Access to a plan offering prescription drug coverage, the only benefit for which overall beneficiary access increased between 1997 and 1999, decreased slightly for beneficiaries living in the lowest payment rate counties.

²⁵ These premiums are in addition to the \$43.80 monthly Medicare Part B premium that all beneficiaries must pay.

DRAFTFigure 10: Medicare Managed Care Premiums

Monthly Premium in Dollars (1)

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Figure 11: Beneficiary Access to Plans Offering Selected Benefits Across Different Payment Levels, 1997-1999

Figure note: Data include (1) only counties in which a plan is available to Medicare beneficiaries and (2) information on flexible benefits when available in a county in 1997. Non-risk plans are excluded from this analysis. For 10 plans where 1999 benefit information was unavailable, September 1998 benefit data were used. Payment categories are created using 1997 payment rates; counties in each category are kept constant for the two years. (Category 1: < \$330; 2: \$330-\$439; 3: \$439-\$549; 4: \$549-\$658; 5: \$658+) Categories are created by dividing the difference between the maximum payment rate and the minimum payment rate into five equal segments.

Sources: Medicare Managed Care Geographic Service Area File, December 1997, ACR submissions for 1997, Medicare Monthly Managed Care Report, December 1997 and January 1999, Medicare Managed Care Market Penetration State/County File, December 1997 and September 1998, 1999 Medicare Compare database.

The decrease in access to plans offering additional benefits in the lowest payment counties is interesting because these counties experienced an average payment increase of 23 percent between 1997 and 1999, compared to a 4-percent increase for all other counties.²⁴ It is unclear why coverage of additional benefits would decrease in the lowest payment counties, given their relatively large payment increase in the past two years and higher than average payment increases expected in the future. Without data on the level of benefits being offered, the picture is incomplete. Plans in higher payment rate counties typically have more competitors than plans in lower payment counties. Faced with more competition, plans in high payment rate counties may prefer to reduce benefit levels rather than eliminate benefit categories. For example, a plan may lower the dollar limit on a prescription drug benefit or impose certain restrictions on the benefit. Plans facing less competition in lower rate counties may be more willing to eliminate benefits in the face of rising costs.

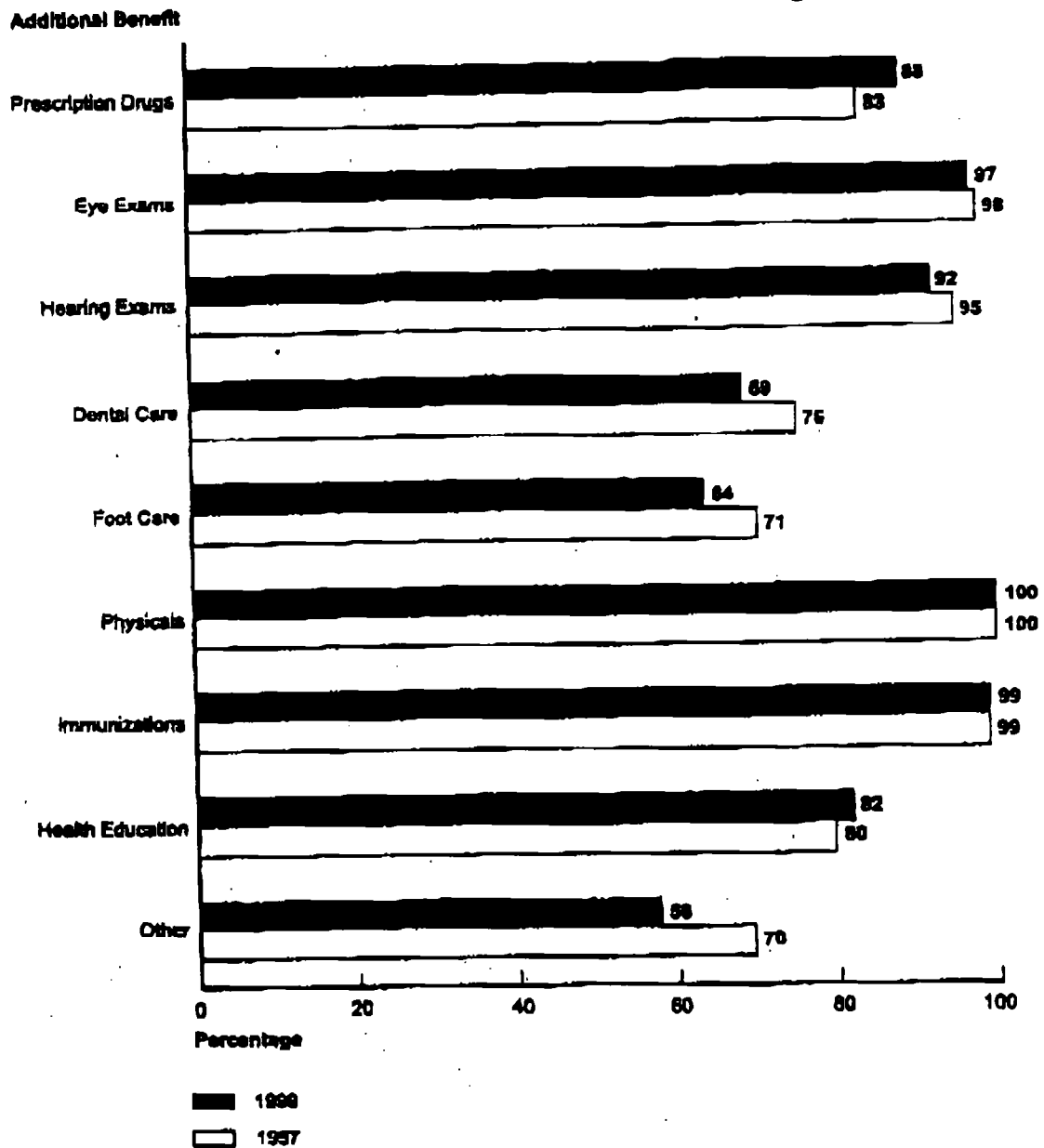
Plans Signal Desire To Revise 1999 Benefit Offerings

BBA constraints on plan payment increases may lead to more global reductions in future plan benefits. One indication of this potential effect is the effort by plans to revise their 1999 benefit packages. In 1998, plans were required to submit their proposed 1999 benefit packages to HCFA

²⁴ Average payment increases are weighted based on number of beneficiaries in each county.

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Figure 11: Beneficiary Access To Plans Offering Selected Benefits Across Different Payment Levels

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much earlier than in previous years and before HCFA had published the regulations implementing the new Medicare+Choice requirements. After HCFA published the new regulations in June 1998, some plans asked to revise their 1999 benefit packages. They argued that their initial submissions did not include the estimated costs of complying with the new regulations. In addition, plans noted that health care costs, especially prescription drug costs, had grown much faster than they had anticipated earlier.

HCFA did not allow plans to revise their 1999 benefit packages because there was not enough time to incorporate these changes and still meet the statutory deadline for providing beneficiaries with comparative plan information. Some plans may have withdrawn from the program because they could not afford to provide their initially proposed benefit packages. Other plans remained in the program, but may revise their benefit packages in the future.

CONCLUSIONS

The Medicare provisions of the BBA were intended to control the growth in Medicare expenditures and offer beneficiaries more health plan options. Toward those ends, the BBA slowed the rate of growth in FFS payments to certain health care providers, such as hospitals and physicians, and mandated new payment methodologies for other FFS providers, such as home health agencies. At the same time, the BBA addressed a number of known problems with the Medicare managed care program. It revised plan payments to address significant overpayment problems and to encourage managed care plans to offer services in areas with few plans. It also allowed new types of plans to participate in Medicare and imposed new requirements to ensure the quality of care provided by plans. When plans announced they would be withdrawing from Medicare or reducing the areas in which they offered services, however, some observers expressed concern about the future of Medicare managed care and debated whether certain provisions established by the BBA should be revised.

While future plan participation should be monitored, it is premature to conclude that Medicare+Choice must be radically revised to ensure the success of Medicare managed care. Enrollees affected by the withdrawals had to choose another plan or return to FFS; however, only 1 percent of previously covered managed care enrollees were left without any

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Medicare+Choice plans. At the same time, HCFA has approved a small number of new plans and is reviewing 30 new plan applications, indicating continued plan interest in participating in Medicare. Some of these new plans, if approved, would offer services in counties that previously had few or no managed care plans.

The current movement of plans in and out of Medicare may be primarily the normal reaction of plans to market competition and conditions. While the new payment rates and regulations were undoubtedly considered by plans, other factors associated with plan withdrawals—recent entry in the county, low enrollment, higher levels of competition—suggest that a number of Medicare plans withdrew from markets in which they had difficulty competing. During the early years of the Medicare managed care program, a number of plans with low enrollment that were not operating profitably also withdrew from the program. The BBA transformed the Medicare risk program into Medicare+Choice with the goal of taking advantage of the efficiencies and choices that exist in the private market. Medicare may not be able to harness these benefits without also experiencing some of the adjustments that occur in the health care market.

AGENCY COMMENTS AND OUR EVALUATION

To be obtained

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties, and we will make copies available to others on request.

If you or your staff have any questions, please call me at (202) 512-7114 or James Cosgrove at (202) 512-7029. Other major contributors to this report include Kathryn Linehan, Susanne Seagrave, Patricia Spellman, and Michelle St. Pierre.

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Sincerely yours,

William J. Scanlon

Director, Health Financing and Public Health Issues

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Appendix I

Scope, Methodology, and Data Sources

We reviewed pertinent laws, regulations, HCFA policies, and research by others, to obtain information on the Medicare+Choice program, including its new payment methodology and new requirements for plans. To obtain different perspectives on why plans withdrew or reduced their service areas, we interviewed officials at HCFA's Center for Health Plans and Providers and representatives from the American Association of Health Plans and the Health Insurance Association of America. We conducted our study from December 1998 to March 1999 in accordance with generally accepted government auditing standards; however, we did not independently verify data obtained from HCFA.

To identify counties with a risk plan in 1998, we used HCFA's September 1998 *Medicare Managed Care Geographic Service Area Report (GSAR)*. We excluded cost, demonstration, and health care prepayment plans from our analyses. In cases where the contract type was not identified with the plan name and contract number, this information was verified using the September 1998 *Medicare Managed Care Market Penetration for All Medicare Plans Contractors—Quarterly State/County/Plans Data Files*, September 1998 *Medicare Managed Care Contract and Segment Service Area File* or HCFA's Plan Information Control System (PICS). The GSAR provides a list of the service areas for all risk and cost managed care contracts.

To analyze the changes in plan participation in the Medicare+Choice program we used HCFA data on the 1999 Medicare+Choice plan contracts. HCFA provided us with a list of plans that withdrew from the program or reduced their service areas as of January 1, 1998 and the counties affected. They also provided a list of new Medicare+Choice plans and service area expansion applications approved and under review as of January 1999 and the counties affected. We noted some inconsistencies between the service areas listed on the GSAR and list of contract non-renewals and service area reductions. To improve the accuracy of the GSAR, counties were added if they appeared on the contract non-renewal/service area reduction file and were listed on PICS as part of a plan's contracted service area but excluded from the original GSAR.

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We excluded Guam, Puerto Rico, and the Virgin Islands from the county level analyses. In some of the analyses, the same counties are defined as separate entities if plans can contract with them separately. For example, Los Angeles County, California is divided into Los Angeles (1) and Los Angeles (2); they are counted separately because plans may contract with them separately. The independent cities of Virginia are also counted as separate counties because their payment rates differ from those of their counties and plans contract to serve these areas as if they were independent counties.

County-level payment rate information for 1990 to 1999 for Medicare risk plans and Medicare+Choice plans, including payment reductions resulting from the removal of graduate medical education (GME) spending, was obtained from the HCFA website. In addition, we obtained a February 1998 file containing historical county-level information on the year that plans first entered individual counties from HCFA's Office of Information Systems. There are 29 cases in which plans withdrew from a particular county in January 1999 that are not listed in the historical county-level information as ever having served that county. Some plans may have started serving these counties after February 1998, or the information might have been inadvertently omitted from the historical county-level information. As a result, the total number of plan-county combinations affected by the recent withdrawals contained in this file is incomplete.

We obtained information on the number of Medicare beneficiaries by county and Medicare managed care enrollees by county and plan from HCFA. The September 1998 *Medicare Managed Care Market Penetration for All Medicare Plan Contractors—Quarterly State/County Data File* showed the number of Medicare entitled beneficiaries by county. This file was used to determine the net effect of the plan withdrawals, new plans, and service area expansions on Medicare beneficiary access to 1999 Medicare+Choice plans and benefits. Similarly, 1997 beneficiaries by county were counted from the December 1997 *State/County Penetration File*. Medicare managed care plan enrollment for 1999 was obtained from the September 1998 *State/County/Plan Penetration Files*.

To obtain information on benefits offered by plans in 1999, we used the 1999 Medicare Compare database and the January 1999 *Medicare Managed Care Monthly Report*. Merging these two

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sources provided us with plan benefits at a county level. We compared the 1999 benefits to 1997 benefits to identify any changes. We chose 1997 because it was the year prior to the implementation of the BBA changes. To obtain information on benefits offered by plans in 1997, we used the December 1997 GSAR, the December 1997 *Medicare Managed Care Monthly Report*, and the 1997 Adjusted Community Rating (ACR) submissions. Merging these three sources gave us benefits provided by each plan at a county level. Where a plan provided flexible benefits to a county in 1997, those benefits were used in the analysis. Of the 307 risk plans that contracted with HCFA in December 1997, we did not have benefit information for 10 plans. These 10 plans were excluded from both the benefit and premium analysis. Of the 311 plans contracting with HCFA in January 1999, 5 plans were excluded from the benefit analysis and 8 plans were excluded from the premium analysis due to lack of benefit or premium information.

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Appendix II

BBA Changes to Plan Payment Methodology

The BBA changed how payments to Medicare managed care plans were calculated, in response to criticisms that the rates (1) overcompensated many plans for the beneficiaries they served, (2) varied greatly among counties, and (3) were too low in certain rural areas. The pre-BBA and post-BBA payment methodologies are described below.

Plan Payments Prior to the BBA

Before the BBA changed the rate-setting process in 1998, the monthly amount Medicare paid managed care plans for each plan enrollee was directly tied to local spending in the FFS program.

Although the actual rate-setting formula was complex, the methodology, in effect, was as follows. Each year, HCFA estimated how much it would spend in each county to serve the "average" FFS Medicare beneficiary.²⁵ Because managed care plans were assumed to be more efficient than FFS, Medicare set plan payments in each county at 95 percent of the FFS amount. Payments for individual beneficiaries were based on county of residence. Because some beneficiaries were expected to require more health care services than others, HCFA adjusted the payment for each beneficiary up or down from the county payment depending on the beneficiary's age, sex, eligibility for Medicaid, and residence in an institution.²⁶

In 1997, the average county payment was \$395 per month. This average increases to \$468 when weighted by the number of beneficiaries in each county. From county to county, however, the rates vary dramatically. For example, a plan that served an average beneficiary in Arthur County, Nebraska, would have received about \$221 per month. A plan that served a similar beneficiary in Richmond County (Staten Island), New York, would have received approximately \$767. The wide variation in capitation rates among counties reflected the underlying variation in

²⁵ HCFA made separate estimates for aged and disabled beneficiaries.

²⁶ Separate rates were set for beneficiaries with end-stage renal disease (kidney failure).

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Medicare per beneficiary FFS spending, which in turn was the result of local differences in the price and use of medical services.

New Rate Setting Process Under the BBA

The BBA loosened the link between the payment rate in each county and the average FFS spending in that county. This change was made to reduce the wide disparity in payment rates that existed under the previous system.

Payment rates in each county are now set at the highest of three possible payment rates: a minimum or "floor" rate, a minimum increase rate, and a "blended" rate. The BBA established a minimum payment—or floor—rate of \$367 in 1998. The floor rate will be increased each year to reflect overall growth in Medicare spending. The BBA also established a minimum rate increase of at least 2 percent each year in every county.

Finally, the BBA specified a blended rate for each county that reflects a combination of local and national average FFS spending. The blended rate is designed to reduce payment rate variation among counties. Blending will reduce payment increases in counties whose average FFS spending has been higher than the national average, and create larger payment increases in counties whose average FFS spending has been lower than the national average. Over time, the blended rate will rely more heavily on the national rate and less on the local rate.

In 1998 and 1999, plans received either the floor payment or a 2 percent increase over their payment from the previous year. Because of the BBA requirement to keep overall county payments budget neutral to what they would have been absent the legislation, no county received the blended rate in 1998 or 1999. For the year 2000, however, payment for 63 percent of counties will be based on the blended rate.

(101793)

MEMORANDUM

June 28, 1999

To: Chris Jennings

From: Jim Grossfeld, Director of Speechwriting
Office (202) 401-6113
Fax (202) 690-7318

Re: Draft New York Daily News Op-Ed

Attached is the draft of 500 word op-ed from Secretary Shalala for the New York *Daily News*. Melissa Skolfield was interested in any comments you might have.

Given the tight time frame we're faced with we would need to receive your suggestions or revisions no later than 9:00 AM Thursday.

Thank you in advance!

DRAFT NY DAILY NEWS OP-ED

It was 1965 and Americans were glued to their TV sets watching *Ben Casey*. At the time we thought we were seeing modern medicine at its best, but watch any rerun today and you can't help notice how outdated it is. We Americans understand that medicine has advanced light years since 1965, but in some ways our Medicare program has changed little since Lyndon Johnson first signed it into law 34 years ago. That's why President Clinton's plan to modernize and strengthen Medicare is so important.

For instance, back when Medicare was created no one imagined the role prescription drugs would come to play in modern medicine. That's why Medicare still only pays for medicines provided during a hospital stay. It made sense back in 1965, but thousands of new medicines have come on the scene since then that, when properly used, can help older men and women to avoid costly hospital stays entirely.

But while these prescription drugs can help older people lead healthier lives, many older people are unable to pay their price. It's a problem that will only grow worse as fewer are able to afford the high cost of "Medigap" drug benefit plans. What Medicare needs is a drug benefit older people can afford, but at a price America can afford -- and that's exactly what our plan provides.

We've proposed that Medicare beneficiaries have the option to pay an extra \$24 per month for prescription drug coverage. This monthly premium would increase to \$44

in the year 2008. Coverage would start with the first dollar of prescription costs, with no deductible and a 50 percent co-payment. Medicare, in turn, would pay half the first \$2000 in 2002 with the limit rising to half the first \$5,000 by 2008. Some 31 million Americans would benefit from this one Medicare modernization alone. But our plan to move Medicare forward doesn't end there.

As the Woodstock generation slowly makes its way to retirement age, the ranks of Medicare beneficiaries will actually double over these next 30 years. Unless we strengthen its finances, Medicare could easily be washed away by this human tidal wave.

To prevent this, our plan would build on our past success battling waste, fraud and abuse to make Medicare more efficient than ever. For example, Medicare would be given new clout to negotiate better prices with health care providers and stretch tax dollars further. Common sense reforms like these could reduce Medicare spending by as much as \$72 billion over 10 years. In addition, by setting aside 15 percent of the budget surplus to strengthening Medicare, we can guarantee its fiscal health through at least 2027.

The Medicare America needs today isn't a rerun from 1965, but a modern program ready to meet the challenges of the 21st Century. By updating benefits -- while simultaneously making it more competitive and efficient -- that's exactly the kind of Medicare our plan will create.

The Fairness Gap In 2001

Selected Major Markets*

	M+C Enrollment	Fairness Gap In 2001 (Dollars)	M+C/FFS In 2001 (Percent)
Baltimore City	15,470	1,093	88
Boston	13,230	735	92
Chicago	104,814	800	90
Cleveland	57,301	906	88
Dallas	42,124	758	90
Detroit	21,070	986	89
Houston	63,848	1,012	88
Los Angeles	308,812	930	89
Miami	128,303	1,202	89
New Orleans	13,026	997	89
New York City			
Bronx	24,937	813	92
Kings	43,387	784	92
New York	22,524	754	93
Queens	57,375	831	91
Richmond	16,959	966	91
Philadelphia	76,240	1,092	89
Pittsburgh	72,113	933	89
St. Louis City	13,017	791	90

* Major urban area in each county (ies). Enrollment represents aged enrollment as of 12/98.
Source: HCFA, Aged 2000.xls

The Fairness Gap In 2004

Selected Major Markets*

	M+C Enrollment	Fairness Gap In 2004 (Dollars)	M+C/FFS In 2004 (Percent)
Baltimore City	15,470	3,030	72
Boston	13,230	1,739	84
Chicago	104,814	1,625	83
Cleveland	57,301	2,171	77
Dallas	42,124	1,613	82
Detroit	21,070	2,528	77
Houston	63,848	2,533	75
Los Angeles	308,812	1,850	83
Miami	128,303	3,502	72
New Orleans	13,026	2,621	75
New York City			
Bronx	24,937	2,019	84
Kings	43,387	1,694	86
New York	22,524	1,553	87
Queens	57,375	1,591	86
Richmond	16,959	2,518	81
Philadelphia	76,240	3,157	74
Pittsburgh	72,113	2,416	76
St. Louis City	13,017	1,803	80

* Major urban area in each county (ies). Enrollment represents aged enrollment as of 12/98.
Source: HCFA. Aged 2000.xls

Medicare+Choice Timeline 2000

January 15, 2000

HCFA issues 45 day notice announcing any methodological changes for the CY 2002 M+C County Payment rates.



March 1, 2000

HCFA issues CY 2001 M+C County Payment rates.



July 1, 2000

(1) M+C plans notify HCFA of intent to not to renew M+C contract or to reduce service area(s). (2) M+C plans submit Adjusted Community Rate (ACR) Proposals outlining benefits and premiums for CY 2001.



Between September 15 and October 15, 2000

HCFA sends beneficiaries information on their Medicare coverage options for CY 2001.



October 15, 2000

M+C plans must notify members of any changes in benefits or program rules for CY 2001.



November 1-November 30, 2000

Annual Coordinated Election Period during which beneficiaries elect Medicare coverage option for CY 2001.



November 4, 2000

Election Day

NEW YORK

County	1999 Rate	2000 Rate After Budget Neutrality Adj.	Rate Category	Increase From 1999 to 2000	Risk Enrollment (12/98)
ALBANY.....	\$397.05	\$426.70	B	7.5%	3,452
ALLEGANY.....	\$387.41	\$422.64	B	9.1%	218
BRONX.....	\$757.66	\$772.91	M	2.0%	24,937
BROOME.....	\$379.84	\$415.83	B	9.5%	4,723
CATTARAUGUS.....	\$379.84	\$421.10	B	10.9%	893
CAYUGA.....	\$395.59	\$434.08	B	9.7%	20
CHAUTAUQUA.....	\$379.84	\$403.06	B	6.1%	2,382
CHEMUNG.....	\$379.84	\$410.09	B	8.0%	17
CHENANGO.....	\$379.84	\$401.61	F	5.7%	52
CLINTON.....	\$385.23	\$422.18	B	9.6%	13
COLUMBIA.....	\$382.24	\$424.72	B	11.1%	622
CORTLAND.....	\$379.84	\$410.32	B	8.0%	68
DELAWARE.....	\$390.08	\$427.10	B	9.5%	756
DUTCHESS.....	\$447.06	\$485.41	B	8.6%	5,005
ERIE.....	\$414.79	\$444.70	B	7.2%	34,008
ESSEX.....	\$379.84	\$406.73	B	7.1%	104
FRANKLIN.....	\$379.84	\$401.61	F	5.7%	96
FULTON.....	\$379.84	\$402.17	B	5.9%	361
GENESEE.....	\$401.59	\$435.80	B	8.5%	932
GREENE.....	\$392.37	\$429.94	B	9.6%	827
HAMILTON.....	\$434.19	\$463.55	B	6.8%	32
HERKIMER.....	\$379.84	\$401.61	F	5.7%	12
JEFFERSON.....	\$379.84	\$401.61	F	5.7%	26
KINGS.....	\$733.87	\$748.55	M	2.0%	43,387
LEWIS.....	\$379.84	\$401.61	F	5.7%	5
LIVINGSTON.....	\$403.04	\$429.12	B	6.5%	715
MADISON.....	\$379.84	\$410.00	B	7.9%	50
MONROE.....	\$428.60	\$449.04	B	4.8%	17,825
MONTGOMERY.....	\$379.84	\$415.97	B	9.5%	126
NASSAU.....	\$610.30	\$622.51	M	2.0%	45,108
NEW YORK.....	\$741.93	\$756.77	M	2.0%	22,524
NIAGARA.....	\$426.52	\$458.37	B	7.5%	6,194
ONEIDA.....	\$379.84	\$405.03	B	6.6%	36
ONONDAGA.....	\$382.11	\$417.97	B	9.4%	899
ONTARIO.....	\$379.84	\$405.78	B	6.8%	1,114
ORANGE.....	\$489.40	\$524.02	B	7.1%	4,580
ORLEANS.....	\$379.84	\$417.78	B	10.0%	969
OSWEGO.....	\$380.63	\$418.50	B	9.9%	153
OTSEGO.....	\$390.60	\$422.47	B	8.2%	657
PUTNAM.....	\$611.39	\$628.30	B	2.8%	1,702
QUEENS.....	\$685.46	\$699.17	M	2.0%	57,375
RENSSELAER.....	\$424.93	\$451.95	B	6.4%	2,971
RICHMOND.....	\$798.35	\$814.32	M	2.0%	16,959

NEW YORK

County	1999 Rate	2000 Rate After Budget Neutrality Adj.	Rate Category	Increase From 1999 to 2000	Risk Enrollment (12/98)
ROCKLAND.....	\$605.07	\$630.25	B	4.2%	6,672
ST LAWRENCE.....	\$379.84	\$401.61	F	5.7%	32
SARATOGA.....	\$389.80	\$426.15	B	9.3%	3,132
SCHENECTADY.....	\$379.84	\$414.50	B	9.1%	2,286
SCHOHARIE.....	\$379.84	\$408.51	B	7.5%	34
SCHUYLER.....	\$379.84	\$401.61	F	5.7%	8
SENECA.....	\$379.84	\$412.96	B	8.7%	111
STEUBEN.....	\$379.84	\$411.93	B	8.4%	55
SUFFOLK.....	\$568.77	\$592.30	B	4.1%	47,985
SULLIVAN.....	\$502.48	\$529.98	B	5.5%	711
TIOGA.....	\$379.84	\$403.34	B	6.2%	383
TOMPKINS.....	\$379.84	\$403.17	B	6.1%	17
ULSTER.....	\$444.27	\$476.85	B	7.3%	4,988
WARREN.....	\$379.84	\$403.43	B	6.2%	630
WASHINGTON.....	\$379.84	\$406.92	B	7.1%	497
WAYNE.....	\$379.84	\$415.82	B	9.5%	888
WESTCHESTER.....	\$584.38	\$608.47	B	4.1%	25,525
WYOMING.....	\$388.44	\$424.89	B	9.4%	633
YATES.....	\$379.84	\$401.61	F	5.7%	193
New York Average (weighted by risk enrollment)	\$601.23	\$621.46		3.4%	397,685

① Schedule

ACKS to June -

July prob is that HCFA
would have to push up their
printing schedule

CMB - movement to summer

② service area

plans were able to
market flexible benefits
before - want uniform
benefits around a service
area. We'll continue flex
for another year;
payment area & service
areas match.

1 yr extension in
flex payment but need
movement towards unified
del. of service areas.

③ user fees

rather than trust fund —
with all of the providers
rather than trust fund.

"everyone has potential
to go into me"

Reduces resistance
from HMO — small
enough for people to
forget

④ funding of blend

High flyer ches —

BBA minimum 2% update

bottom floor

middle - blends.

\$29.95 find \$ to pay blend

BBA carried medical ed
payments out of rates —
teaching hospitals building it
implicitly did —→
left med ed in base
take it out of base.

that would be
enough \$ —→
AND it's budget neutral..

④ risk adjustment
if there's anything industry
rates, it's this. They
are worried
supposed to implement
in 2000. —→ need to delay.

④ need 2 kinds of data
inpatient data. Risk adj
based on this

⑤

actuaries assumed
that risk adjustment
was part of the baseline

- ① it costs
- ② delay → never get it.

⑤ Medigap
~~guarantee. enrollments~~
~~for~~

② OMB likes this one
open enrollment
for disabled, ESRD &
aged for initial &
in the case of HMO
dropping