Medicare + Choice: Recent Experience and Issues for the Future

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Summary

The Medicare+Choice (M+C) program established by the Balanced Budget Act (BBA) of 1997 has failed to achieve its basic goals. The program was intended to make a wider variety of health plan alternatives available to beneficiaries in more areas, save Medicare money, and give beneficiaries greater access to low-cost supplemental benefits. Instead, with a few exceptions, options other than traditional HMOs did not materialize. As a result of plan withdrawals, fewer beneficiaries have access to HMOs, and the plans that remain have reduced the supplemental benefits they offer. Enrollment, which had been growing rapidly in the mid-1990s, has dropped nearly 10 percent in the last year.

The managed care industry has attributed these developments largely to new payment rules established by the BBA, as well as to what are seen as excessive administrative burdens and regulation. Congress has responded, most recently in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, by increasing payments, offering bonuses to organizations entering new areas, and relaxing some administrative requirements. It has done so in the face of evidence that M+C plans continue to attract healthier beneficiaries, so that Medicare's payments to M+C plans are already more than would have been spent if their enrollees had remained in original Medicare. Moreover, because BIPA provides only a one-time infusion of new funds, there is no guarantee that there will not be further plan withdrawals or service cutbacks. At the same time, beneficiaries in many areas still have no access to a coordinated care plan.

The problems of the M+C program may raise questions about the workability of any broader reform that relies on a private insurance model. Proponents of such a model contend that it can achieve savings for Medicare while at the same time providing improved coverage. But of course this is exactly what M+C was supposed to do. What went wrong? What would need to change to make M+C sustainable in its present form?

Recent History

The HMO risk contracting program that preceded M+C was in a period of explosive growth until the enactment of the BBA; the program has since been in a period of contraction. To attribute this contraction chiefly to the BBA is to suggest that, without it, managed care enrollment would have continued to grow indefinitely at the rates observed in the early to mid-1990s. An alternate view is that the program expansion was the product of exceptional circumstances and would have slowed over time even if the BBA had not been enacted.

During the period of fastest HMO growth, Medicare fee-for-service spending was rising much faster than private insurance spending. Payment rates for risk HMOs rose accordingly, making it more feasible for private plans to compete and offer generous supplemental benefits. HMO enrollment may have become more attractive because access to alternative forms of coverage, including Medigap and retiree benefits, was eroding. Plans were expanding into new areas, both for commercial and Medicare markets, and some national managed care firms were seeking to position themselves as the carriers of choice for the retiree benefit market.

All of these trends peaked around 1996 and might have moderated in any event. Expansion into new areas was slowing, enrollment growth in established markets was coming to a halt, and employers who had been enthusiastic about enrolling their retirees in risk HMOs found other ways of saving money. The cost of supplemental benefits—especially prescription drugs—was rising rapidly; plans would have had to curtail these benefits. And the younger beneficiaries who found HMOs attractive were (and will continue to be, until the boomers retire) the slowest-growing segment of the Medicare population.

The M+C program was meant to broaden options for beneficiaries and also address some longstanding problems with HMOs (now renamed coordinated care plans, or CCPs), including favorable risk selection and lack of access to plans in areas where Medicare fee-for-service spending was low, and instability. While HMO payment rates had been tied to average fee-for-service spending in the areas they served, rates in low-cost areas were raised to a new minimum level (the payment floor), while rates for high-cost areas were subject to sharp growth limits—partly to recapture the overpayments resulting from favorable selection and partly to compress the very large rate variation among different areas. The BBA also introduced new quality standards and enrollment rules and made numerous other changes that have increased administrative burdens on CCPs.

In the years following BBA, some existing plans began withdrawing from the program, although the program as a whole continued to expand. This was reversed in 2000, when nearly half of participating organizations (counted at the level of corporations) announced that they would leave the program or reduce their service areas for contract year 2001. Nearly 15 percent of enrollees were dropped by their current plan. While many had an alternate CCP option available, most appear to have returned to original Medicare. Beneficiaries who have remained enrolled in CCPs have seen cuts in benefits: the proportion of Medicare payments returned to enrollees in the form of free supplements

dropped from 25 percent in 2000 to 18 percent in 2001, while average premiums rose by an estimated 45 percent.

While plan withdrawals and service area reductions for 2001 have been largely attributed to BBA payment changes, the plans that ended or reduced their participation were not harder hit by BBA than other plans. Their Medicare payments, relative to 1997 levels, rose just as rapidly as those of plans that stayed in the program. These plans were already marginal: they started the year 2000 expecting to just scrape by, spending a higher proportion of their Medicare payments furnishing basic services and furnishing inferior supplemental benefits. Their business plans depended on continued enrollment growth; instead their average enrollment dropped between mid-1999 and mid-2000. Almost half of the enrollees dropped for 2001 were in two national chains, Aetna U.S. Healthcare and CIGNA. Both chains had expanded rapidly into new markets, had never met their business expectations, and essentially chose to consolidate, drawing back into the markets they were serving at the start of the decade.

The Benefits Improvement and Protection Act (BIPA) of 2000

BIPA included a variety of measures affecting the M+C program. Perhaps most immediately important are increases in M+C basic payment rates. One other change may have a longer-term impact. Beginning in 2003, M+C plans can offer enrollees a reduction in their part B premium; this represents at least a first step toward implementation of a more fully competitive model for Medicare.

Payment changes. The payment changes include a new payment floor for low-cost counties in larger metropolitan areas, an increase in the payment floor for other low-cost areas, and a much smaller increase for the higher-cost areas where most CCP enrollees are. While these are one-time increases, they affect the base from which future rate increases will be calculated. Thus they will have continuing effects, raising projected M+C spending by $11 billion over five years.

The BIPA rate increases may be thought of as having two goals: to attract plan participation in new areas, and to encourage existing plans to continue their participation and to increase supplemental benefits. They are much better targeted for the first goal than for the second. Counties with no plan, or with the Sterling private fee-for-service plan only, received much larger rate increases than counties served by CCPs. In rural areas, rates for unserved counties are now almost to those for counties with CCPs. In urban areas, rates for counties served by a CCP are still higher than those for unserved counties. However, as a percentage of local Medicare fee-for-service costs, rates in unserved counties are much higher. Whether the rate enhancements will lead to greater CCP

availability in uncertain. There remain formidable barriers to CCP expansion, to be discussed below.

Because current CCP enrollees are concentrated in areas with lower increases, the per enrollee increase averages about 3 percent. Many of the largest CCPs received much smaller increases—as little as 1 percent—while some smaller plans saw increases as high as 27 percent. CCPs were required to: return the new funds to enrollees in the form of enhanced benefits or reduced premiums; hold the funds in reserve to maintain benefits in future years; or use them to "stabilize or enhance beneficiary access to providers," presumably by paying them more. Overwhelmingly, CCPs took the last option. Overall, 71 percent of the new money went for increased spending on basic benefits, while 18 percent went toward enhanced benefits and 11 percent went into stabilization funds. A typical enrollee has received about $1 in additional benefits and has seen a premium reduction of about $2. That most of the new money went to providers reflects the fact that plans (both Medicare and commercial) are having to pay higher prices to maintain provider networks broad enough to attract enrollees. Scheduled M+C rate increases for 2002 will average less than 3 percent per enrollee. The result will almost certainly be further erosion in the supplements offered to enrollees and perhaps another wave of plan withdrawals.

Part B premium reduction. Before BIPA, a plan could share savings with beneficiaries only in the form of free or low-cost supplemental benefits. Enrollees still paid the entire part B premium ($50 a month in 2001). Beginning in 2003, a plan able to provide Medicare benefits for less than its Medicare payment may reduce or eliminate the premium (a portion of savings would revert to the Medicare program). The result is a competition scheme much like one of the two Breaux-Frist proposals (S. 358) in the current Congress and also resembling the one proposed by President Clinton in his last budget. The BIPA scheme and these two proposals fall somewhat short of the full price competition envisioned by the other Breaux-Frist proposal (S. 357), which would increase charges for beneficiaries remaining in original Medicare if other plans in their area were less costly. BIPA provides a carrot for beneficiaries choosing to join an M+C plan, but no stick for those who choose not to do so. In addition, it leaves in place a rating scheme under which a plan's ability to reduce the premium (or provide other supplements) may have less to do with efficiency than with where the plan happens to be located. Federal funds continue to be used implicitly, and haphazardly, to finance supplemental benefits for some lucky beneficiaries.

Setting Medicare+Choice Payment Rates

The BIPA payment changes represented a one-time infusion of cash into the Medicare+Choice program. Beginning with 2002, however, the rating system

now reverts to the one established under BBA. Rates in high-cost areas will continue to be squeezed down toward a national average; rates in the low-cost floor counties, now often much above fee-for-service costs in those counties, will rise with inflation. For a variety of reasons, all CCPs are receiving higher payments in 2001 than they would have under the pre-BBA rules. In 1997, plans were paid 95 percent of expected fee-for-service (FFS) cost in their area. In 2001, no plan receives less than 95 percent; the average payment for current enrollees is 103 percent of FFS. This will change very soon. Under current rules, the average payment will be 98 percent of FFS. Over a third of contractors, with 39 percent of enrollees, will receive less than 95 percent of FFS.

All of these estimates omit one key factor: risk selection, the continued tendency of plans to enroll healthier than average beneficiaries. When this is taken into account, current payments average 10 percent above FFS and will still be 5 percent above FFS in 2005. A plan by the Health Care Financing Administration (HCFA) to phase-in risk-adjusted payments, using information about enrollees' past hospitalizations, has been halted for the time being. Still, the effect of the coming payment changes strikes plans randomly, partly by setting local prices in ways that may not adequately reflect variations in the need for care. Some plans that are actually saving the Medicare program money today will see larger payment reductions in the coming years than some that are now significantly overpaid.

MedPAC has recommended a return to a "financially neutral" payment system, which would base payments on local FFS costs, with appropriate risk adjustment. This report compares the effects of this option with those of three alternatives: the scheduled rate reductions under current payment rules, a more rapid phase-in of risk adjustment with no other rule change, and a return to rates based on local FFS costs but without risk adjustment. All of these schemes would reduce rates, relative to 2001 levels, for most plans and most enrollees. Their distributional effects are very different. Under current rules, no plan will see a rate increase (in constant dollars) between now and 2005. All the other options will raise rates for some contractors and reduce them for others. Unless plans can rapidly improve their efficiency, some are likely to be driven out of the program under any of the options. Anywhere from 22 to 45 percent of current enrollees could be dropped by their CCPs or face sharp cuts in supplemental benefits.

Of course, if the program places no pressure on plans to improve efficiency, it will never save money. Schemes that would replace the current system--which distorts incentives--with true competitive pricing have faltered, largely because of difficulties in determining how to price original Medicare. But the current scheme of overpaying in low-cost areas has done nothing to improve

access. At the same time, if rates in high-cost areas are driven down faster than plans can respond with efficiency improvements, the program will simply sacrifice whatever more modest efficiencies might have been achieved, as well as any prospect of further improvement in the future. Pressure for improved efficiency could be imposed more gently through a return to area-based rates, with steady progress toward risk adjustment and perhaps a gradual phase-down of rates in the most overpaid counties. The choice may be between killing the system in the hope of rapid savings and growing it slowly.

Access to M+C plans

In 2001, 18 percent of beneficiaries have no access to an M+C plan and another 18 percent have access only to the Sterling private fee-for-service plan and no CCP. Raising M+C payment rates in low-cost areas has had little effect. Other studies have noted a variety of non-payment barriers to expansion in rural areas: difficulty in forming provider networks in isolated areas; low population density and income; and utilization levels at or below those in urban areas, leaving little room for efficiency gains. While these factors are important, they are less useful in explaining why there are over 6 million beneficiaries in metropolitan areas who have no CCP option. One problem may be that, while M+C payments in smaller urban areas are well above average FFS spending, FFS payments in these areas (and in rural areas) are below the actual costs of providing services for Medicare beneficiaries. This leaves no room for private plans to negotiate further discounts. In addition, while the cost of providing basic Medicare benefits varies by area, the cost of supplements may not vary proportionately; even efficient plans in low-cost areas may not be able to offer attractive benefits.

Access in areas served by a CCP. Of urban beneficiaries without a CCP option, 1 million are in unserved counties within metropolitan areas (MSAs) some part of which is served by a CCP. One solution would be to require a plan to serve the entire MSA, or at least to conform its Medicare service area to its commercial one. However, this might invite selective enrollment practices and could drive a plan out of the area altogether if it cannot get favorable terms from providers throughout the MSA. Another option would be multi-year contracts, which would at least prevent plans from arbitrarily expanding and contracting service areas.

Access in unserved areas. The Federal Employees Health Benefit Plan and other national employers do not achieve nationwide coverage just by negotiating with multiple local plans; they contract with national PPOs that reach every area. While such a plan could be envisioned for Medicare, it is not clear that any organization or consortium would be willing to assume the risk,

how it would be paid, or how (since loose network plans tend to achieve savings through provider discounts rather than management of care) it could operate at lower cost than original Medicare. An alternative is to promote establishment of more local plans. This is likely to require direct federal start-up money, with a high possibility of failure, as well as conflict of interest if one agency is charged with both fostering and regulating new plans.

Employer groups. BIPA allows waivers to encourage more employer groups to offer M+C plans to their retirees. Initially, M+C plans may be allowed to tailor supplemental benefit packages for specific employers. Consideration might also be given to allowing plans to broaden service areas for retiree groups without offering enrollment to other beneficiaries in the expanded area. Finally, there might be renewed exploration of schemes under which very large employers (such as federal and state governments) would form their own at-risk M+C plans specifically for their retirees.

Despite all these measures, there will remain large areas of the country in which no CCP will operate on a risk basis. There might be some price, far above FFS costs, that would induce plans to enter these areas, but it is hard to justify massive overpayment simply in the name of promoting choice. So far the only effect has been to encourage development of private fee-for-service plans that offer little prospect of real savings. For the foreseeable future, the program will have to live with a dual system: CCPs in some areas, others with original Medicare alone. This means that that M+C or other private plans cannot be the sole mechanism for providing prescription drugs or other benefit improvements. The goals of competitive restructuring and modernization of the Medicare benefit package must be seen as entirely separate.

Supplemental Benefits

Under Medicare+Choice, beneficiaries are offered a bargain: those willing to accept the restrictions of a more efficient private plan could share in the savings by receiving reduced cost-sharing and other additional benefits. This deal has always presented equity problems, related to pricing and geographic access. Moreover, the nature of the bargain—and the competitive advantage of M+C plans—would be profoundly affected if Medicare itself begins to provide the most valuable supplement, coverage of outpatient prescription drugs.

Equity. The equity problem stems from the fact that the cost of supplements does not vary directly with the cost of basic Medicare services. If two efficient plans, one in a high-cost and one in a low-cost area, can each cut spending for basic services by 15 percent, the one in the high-cost area can provide more generous supplements. This report reviews several proposed

solutions, each raising political or technical difficulties. One alternative that might be workable would be to award a *fixed* contribution toward supplements for a plan that achieved a certain *relative* degree of efficiency in furnishing basic services compared to a local benchmark. Thus, if a plan saved, say, 2 percent relative to local cost, it might receive a flat $120 (roughly 2 percent of national average spending) to use toward supplemental benefits.

Prescription drugs. Most proposals to add a Medicare prescription drug benefit assume that M+C plans would provide the coverage for their own enrollees, while other beneficiaries would receive it through some other mechanism. But it is by no means obvious that M+C plans should manage the benefit or be at risk for it. Relatively few HMOs manage their own drug benefits. Many contract with pharmaceutical benefit managers (PBMs); this makes sense especially for smaller plans, who cannot exert the market force of a large PBM. Nor is it clear that even plans that are highly efficient at managing medical costs can be equally successful in managing drug costs. While there are possible trade-offs in medical and drug costs, these are uncertain; placing plans at risk for the new benefit could eat up any existing potential for cost savings on basic services. Perhaps it could be left to the plans themselves to opt for accepting risk or merely serving as a cost-reimbursed pass-through for any new federal funds. But, in the latter case, why retain the middleman?

Wherever the drug benefit is managed, if Medicare offers affordable coverage outside M+C plans, would the competitive advantage of M+C be reduced? While beneficiaries say drug coverage is a major reason for considering M+C enrollment, in fact the presence or absence of a drug benefit does not appear to make much difference in penetration or market share. Beneficiaries are drawn to M+C plans for many reasons, and this will likely remain so.

INTRODUCTION

The Medicare+Choice program established by the Balanced Budget Act (BBA) of 1997 has failed to achieve its basic goals. The program was intended to make a wider variety of health plan alternatives available to beneficiaries in more areas. Medicare was expected to save money, while beneficiaries would have more choices and greater access to low-cost supplemental benefits.

None of these things happened. With a few exceptions, options other than traditional HMOs did not materialize. Beginning with contract year 1999, some organizations that had been participating in the existing Medicare risk contracting program began to terminate their contracts or reduce their service areas. Overall in 2001, only 63 percent of beneficiaries will have access to a coordinated care plan, compared to 74 percent in 1998. The plans that remain have reduced the supplemental benefits they offer or are charging higher premiums for those benefits. Enrollment growth, which had been at double-digit levels in each of the years since 1988, ended in 1999. Enrollment held stable at about 6.3 million enrollees through 2000, then dropped sharply to 5.6 million in January 2001. The drop was largely attributable to plan withdrawals for the 2001 contract year: over 900,000 M+C enrollees were dropped by their plans, and over a quarter of these had no other coordinated care plan available to them. Of those who had the option to switch to another coordinated care plan, about 60 percent apparently chose to return to original Medicare.

The managed care industry has attributed these developments largely to limits on growth in Medicare payment rates established by the BBA, as well as to what are seen as excessive administrative burdens and regulation. Congress has responded, in the Balanced Budget Refinement Act (BBRA) of 1999 and again in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, by increasing payments, offering bonuses to organizations entering new areas, and relaxing some administrative requirements.

The BIPA payment increases are substantial, raising payment rates for 2001 in some counties by as much as 27 percent over what would have been paid under existing law. Congress provided the new funds despite continuing evidence that Medicare's payments to M+C plans were already more than would have been spent if their enrollees had remained in original Medicare. The main goal has been to prevent continued erosion in access to the low-cost supplemental benefits that M+C plans have provided. The most recent round of payment increases was intended to maintain or expand these benefits, and to encourage organizations to enter (or return to) unserved areas. Instead, most organizations have used the funds to increase payments to providers. They

contend that this step was necessary to maintain their provider networks and prevent further reductions in service areas.

In the short term, the new funds may be sufficient to maintain the program in the areas it now serves. However, because BIPA provides only a one-time infusion of new funds, there is no guarantee that there will not be further plan withdrawals or service cutbacks if future payment growth fails to keep pace with plans' costs. At the same time, beneficiaries in many areas still have no access to a coordinated care plan. Unless plans can be induced to enter these areas, BIPA effectively pours extra money into maintaining a source of enhanced coverage for some beneficiaries while leaving others with no assistance.

Why should the federal government continue to put money into a program that has provided special benefits only to some beneficiaries, and that has managed to do so only through substantial overpayments? The apparent answer is that many policymakers still expect the M+C program to provide the base for a general restructuring of Medicare on some form of competitive model, such as the "premium support" system proposed by Senators Breaux and Frist in the 107th Congress and endorsed in general terms by the incoming administration.[1] (BIPA actually takes the first step toward such a system by allowing plans to offer enrollees a reduction in their part B premium, thus introducing direct price competition into the Medicare program for the first time.)

The spate of recent plan withdrawals has raised the specter that, by the time Congress has legislated a system-wide reform intended to encourage beneficiaries to shift to private health plans, there will be no such plans available. Even if the rules are very different from those in effect today, no one may want to play. In particular, some major insurers that made a substantial investment in the Medicare market in the 1990s, and that have since been slowly departing, might be hesitant to reenter the market no matter how it is restructured. To the extent that BIPA may temporarily forestall further withdrawals, it can be seen as life support for a system that has been characterized by the insurance industry as in a state of "Code Blue" (Fried and Ziegler). In effect, the M+C program is being sustained until its successor can be designed.

However, the problems of the M+C program necessarily raise questions about the feasibility of any broader reform that relies on a private insurance model. Proponents of such a model contend that it can achieve savings for

[1] As is discussed in chapter 2, there are actually two Breaux/Frist proposals embodying very different models.

Medicare while at the same time providing improved coverage, especially coverage of prescription drugs. But of course this is exactly what M+C was supposed to do. What went wrong? What would need to change to make M+C sustainable in its present form?

This report reviews the history of Medicare's dealings with private health plans, examines the M+C experience, and discusses key issues in the program and possible solutions. It generally does not address questions about the design of a premium support system or about the wisdom of undertaking such a system. However, it may show that the M+C program offers important lessons for any future program reform efforts.

A note on terminology

The Medicare statute uses a complex and internally contradictory set of terms for the entities that participate in Medicare+Choice, the programs they operate, and the benefits those programs offer.

A single insurance company or other entity may enter into multiple contracts with Medicare, each covering a defined geographic area. Each of these contracts is deemed to be with a distinct Medicare+Choice organization (M+CO) and is administered separately by HCFA.[2] Within its service area, an M+CO may offer one or more Medicare+Choice "plans." The statute initially defines plans in terms of delivery models. HMOs, PPOs, point-of-service (POS) plans, and plans operated by provider-sponsored organizations (PSOs) are collectively known as coordinated care plans (CCPs). Other forms of plans an organization may offer include private fee-for-service plans and MSA plans.[3]

Each plan may offer a choice of several different benefit packages. These are, bewilderingly, also called "plans." An organization that is operating an HMO within a given service area might offer one plan without drug benefits and another plan with drug benefits. Moreover, it may offer some benefits in one part of its service area and not another, or may vary supplemental premiums for the same benefits in different parts of the area. Each of these variants is a "plan."

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[2] This is a source of some duplicative administrative effort for both HCFA and organizations, particularly if an organization must deal with multiple HCFA regional offices.

[3]Under the statute, one MCO could offer several different plans—for example, both an HMO and a PPO—in a given service area, as is common in the commercial market. In practice, HCFA usually enters into a separate contract if an organization wishes to offer several different delivery models and sometimes allows both a strict HMO and a point-of-service plan under one contract.

All of this makes counting difficult. In 2000, for example, Aetna U.S. Healthcare held or managed 25 distinct Medicare+Choice contracts.[4] In nineteen of these, it offered only an HMO plan; in six it offered both an HMO and a POS plan. Most of these plans offered multiple benefit packages, and some varied benefits or premiums by market area. Under Aetna's Philadelphia area contract, there are 36 "plans," reflecting two different delivery models (HMO and POS), five geographic areas, and four different benefit packages (not all available in every area).

This report generally uses the following terms:

?? An **organization** is an entity, such as an insurance company or a non-profit organization, that offers health care plans. Aetna U.S. Healthcare or Kaiser Permanente are each considered as single organizations, although they may operate under different corporate identities in different states.

?? A **plan** is a program operated by an organization under a contract with Medicare and made available to beneficiaries in a given area. All of the different offerings by Aetna in the Philadelphia area are treated as constituting one plan. As in the statute, a plan that operates as an HMO, POS, or PPO, or that is operated by a provider-sponsored organization, is referred to as a **coordinated care plan** (CCP).

?? A **benefit package** is a defined set of supplemental benefits offered to beneficiaries, along with any associated premium.

As of April 2001, approximately 114 organizations offered plans under 181 Medicare+Choice contracts. One offered a PFFS plan. The remainder offered CCPs, including 109 offering an HMO or POS plan or both, three offering a PSO plan, and one offering both an HMO plan and a PPO option, the only one currently available under M+C.[5] These plans included 562 different benefit packages.

[4] This count includes the NYLCare plans in Texas; although Aetna has sold these plans, it continues to administer them under a contract with their new owners.
[5] The count of corporations is approximate; it represents the author's best effort to group together entities that were under common ownership or management as of October. Because mergers and acquisitions occur frequently, the count might have been different a month earlier or later.

Chapter 1: HISTORY

TEFRA and Its Aftermath

Almost from the beginning of the Medicare program, beneficiaries in some areas have had the option of obtaining their Medicare benefits through private organizations that contracted with HCFA to provide these benefits. Most of the early arrangements were designed to accommodate retirees who were in some form of employer- or union-sponsored arrangement—including prototype HMOs and union-sponsored clinics--that could not readily adapt to Medicare's fee-for-service reimbursement system. Payment was generally on a cost-reimbursement basis. There were some experiments with risk contracting, but there were sharp restrictions on the types of organizations that could participate. Moreover, the contracts operated on a heads-I-win, tails-you-lose basis. Organizations accepted an open-ended liability for losses, but had to share any profits with the government.[6]

By the early 1980s, the commercial HMO industry was booming. Alarmed by double-digit increases in the cost of employee health benefits, increasing numbers of employers were encouraging or mandating enrollment in HMOs and in newly emerging arrangements such as PPOs. The managed care industry was not only growing but changing its face. The Federal start-up funds that had encouraged growth of nonprofit HMOs in the 1970s were eliminated in 1981. From that point, managed care start-ups and expansions had to rely on private capital. Many nonprofits converted to for-profit status in order to access the equity markets, while existing indemnity insurers with deep pockets began their own managed care operations.

In 1982, Congress removed some of the key barriers to growth in the Medicare risk contracting program. The Tax Equity and Fiscal Responsibility Act (TEFRA) made several key changes:

?? Commercial insurers that were not federally qualified HMOs could participate as "competitive medical plans" (CMPs).[7]
?? Medicare's payment for each enrollee would be fixed at 95 percent of the adjusted average per capita cost (AAPCC), HCFA's estimate of what it

[6] Losses could be carried over to offset profits in succeeding years.
[7] The difference between an HMO and a CMP was not in how it operated under its Medicare contract, but in how it operated in the commercial market. Federally qualified HMOs had to operate solely as HMOs—ruling out major insurers that operated an HMO "line of business"--and generally had to use modified community rating, with very limited experience adjustments. CMPs faced neither of these constraints.

would have spent for a comparable enrollee remaining in the fee-for-service program.

- ?? Each plan was to submit an "adjusted community rate" (ACR), an estimate of what the plan would charge its commercial enrollees for a package comparable to basic Medicare benefits, adjusted for differences in the characteristics of commercial and Medicare enrollees. (Note that the ACR includes a profit margin equivalent to the margin realized for commercial enrollees.) If a plan's ACR was less than its projected Medicare payments, the difference would generally have to be used to provide supplemental benefits to enrollees, such as reduced cost-sharing or coverage of outpatient prescription drugs.

The changes were implemented in 1985, when HCFA certified that it had developed an acceptable method for computing the AAPCC, using geography, age, sex, and other factors to estimate the likely fee-for-service cost for each enrollee. The new TEFRA risk contracting program grew fairly rapidly; by early 1988, there were 133 risk contracts serving almost one million enrollees. Even at this early date, however, there were already emerging concerns about the program. This list, from a 1988 report, would require little revision today:

- ?? The factors used to compute the AAPCC did not adequately account for the risk represented by particular enrollees. There was evidence that plans enrollees were healthier than the average beneficiary in each AAPCC cell—that is, the plans experienced favorable selection. As a result, Medicare did not achieve its expected 5 percent savings, but actually paid more than under the fee-for-service program.

- ?? Enrollment was heavily concentrated in a few urban areas with high payment rates. Rural areas and low-payment urban areas did not attract HMO/CMP participation.

- ?? Participation by organizations was unstable. Between 1987 and 1988, for example, 22 percent of plans terminated their contracts or reduced their service areas; nearly 8 percent of enrollees were dropped from the program in a single month. This was partly due to large year-to-year fluctuations in payment rates for specific counties, as well as to a general shakeout in the HMO industry during this period. (Merlis)

In succeeding years, the program continued to grow. The proportion of beneficiaries with access to a risk plan grew from 49 percent in 1993 to 72 percent in 1997. Enrollment doubled to 2 million between 1988 and 1990, doubled again by 1996, and was over 5 million by early 1997 (HCFA 2000).

Enrollment growth brought with it some changes in the nature of the beneficiaries who were enrolled. Penetration—the proportion of beneficiaries enrolled in risk plans—grew much faster among the under-65 disabled and the younger elderly than among older beneficiaries in 1993 through 1997. This did not have much effect on the overall age breakdown of plan enrollments, because a larger share of beneficiaries were in the older groups by 1997. Despite the growth in the share of the disabled population joining plans, the small share remains perplexing, as the disabled are not covered under open enrollment rules for Medigap and often have no other source of supplemental coverage. This may reflect the fact that, while informational materials must at least mention that plans are open to all beneficiaries, marketing materials and even the names of plan often suggest that they are designed only for seniors.

Table 1. Percent of Beneficiaries Enrolled in HMOs by Age, 1993 and 1997

Age	1993 (cost and risk)	1997 (risk only)	Percent change
Under 65	2.2%	6.4%	192%
65-74	7.7%	16.1%	108%
75-84	8.1%	12.9%	59%
85 and over	6.2%	9.8%	59%
Total	7.0%	13.2%	90%

Source: 1993 data from HCFA 1996 and 1997 data from
http://www.hcfa.gov/surveys/mcbs/PubCNP97.htm.

Table 2. Distribution of HMO Enrollees by Age, 1993 and 1997

Age	1993	1997
Under 65	4%	6%
65-74	55%	56%
75-84	33%	30%
85 and over	9%	8%
Total	100%	100%

Source: 1993 data from HCFA 1996 and 1997 data from
http://www.hcfa.gov/surveys/mcbs/PubCNP97.htm.

More significant were changes in the income levels of enrollees. Enrollment grew faster among two groups: those with incomes between $5,000 and $10,000, and those with incomes above $25,000. Growth in the first group is understandable. Many beneficiaries at this income level are ineligible for full

Medicaid benefits,[8] do not receive retiree coverage, and cannot afford a Medigap plan. One recent study has shown that HMOs are the major form of supplemental coverage for modest-income beneficiaries who have no access to subsidized coverage (AAHP).

The increased enrollment in the higher-income group may reflect growth in the number of employers who provided incentives for retirees to join risk plans; this development is discussed further below. In any event, to the extent that the risk contracting program and now M+C have served to provide federal subsidies for supplemental coverage, it is worth noting that almost 30 percent of the beneficiaries receiving this assistance have incomes above $25,000.

Table 3. Percent of Beneficiaries Enrolled in HMOs by Income, 1993 and 1997

Annual income	1993 (cost and risk)	1997 (risk only)	Percent change
$5,000 or less	5.9%	10.3%	73.2%
$5,000-$10,000	5.1%	12.5%	144.4%
$10,000-$15,000	7.6%	13.4%	77.1%
$15,000-$25,000	8.7%	14.2%	64.0%
$25,000 and over	7.1%	13.8%	96.1%
Total	7.0%	13.2%	90.5%

Source: 1993 data from HCFA 1996 and 1997 data from http://www.hcfa.gov/surveys/mcbs/PubCNP97.htm.

Table 4. Distribution of HMO Enrollees by Income, 1993 and 1997

Annual income ($000s)	1993 (cost and risk)	1997 (risk only)	Percent change
$5,000 or less	6.4%	5.5%	-13.8%
$5,000-$10,000	19.0%	23.9%	25.9%
$10,000-$15,000	20.8%	17.3%	-16.8%
$15,000-$25,000	29.2%	23.8%	-18.7%
$25,000 and over	24.5%	29.5%	20.1%
Total	100.0%	100.0%	0.0%

Source: 1993 data from HCFA 1996 and 1997 data from http://www.hcfa.gov/surveys/mcbs/PubCNP97.htm.

Many analysts had anticipated that growth in enrollment would reduce favorable selection. In effect, once the HMOs had reached maximum

[8] Those above SSI levels may not have access to Medicaid drug coverage; those above poverty are not assisted with required Medicare cost-sharing.

penetration among the healthiest beneficiaries, further enrollment growth would include those with greater health care needs. However, the General Accounting Office (2000) has estimated that, in 1998, Medicare paid risk HMOs 13.2 percent more than would have been paid for the same beneficiaries under the fee-for-service (FFS) program, because the plans enrolled healthier than average beneficiaries.[9] This estimate was based on prior FFS utilization by new enrollees, with adjustments to reflect a "regression to the mean" for longer-term enrollees—the likelihood that their costs would over time more nearly resemble those of peers who remained in the FFS sector. Previous estimates by GAO, the Physician Payment Review Commission (1996), and others have varied in methodology but have also found evidence of favorable selection throughout the history of the risk contracting program.

While every available method for measuring risk is subject to considerable error, there seems little doubt that Medicare has been paying more for M+C enrollees than for comparable FFS beneficiaries. The industry contends that, even if this is so, the disparity may reflect inadequacies in the FFS program. Utilization by FFS beneficiaries may be depressed by the deterrent effects of cost-sharing, or beneficiaries may experience barriers to access resulting from artificially low FFS payment rates for some services.

Program Growth before 1997

The Medicare risk contracting program was in a period of explosive growth until the enactment of the BBA. The successor Medicare+Choice program has since been in a period of contraction. To attribute this contraction chiefly to the BBA is to suggest that, if Congress had not intervened, managed care enrollment would have continued to grow indefinitely at the rates observed in the early to mid-1990s. That is, rapid growth was somehow natural or inevitable, and the BBA interrupted it. An alternative view is that the program expansion was itself the product of exceptional circumstances and would have slowed over time even if the BBA had not been enacted. What were these circumstances?

First, per capita Medicare fee-for-service spending was rising rapidly—much faster than private insurance spending. Payment rates for risk HMOs rose accordingly. In effect, the fat in the rates was growing, making it more feasible for HMOs to compete and offer generous supplemental benefits. This might have been especially true because some of the growth in fee-for-service spending

[9] GAO found an additional 8 percent overpayment because of forecast errors and BBA payment provisions.

was fueled by an explosion in home health and nursing home expenses, which HMO enrollees were less likely to incur.

Table 5. Annual Per Enrollee Medicare and Private Health Insurance Spending Growth, 1991-98

	Medicare	Private insurance
1991-93	8.6%	7.8%
1993-97	7.5%	3.5%
1997-98	1.2%	7.2%

Source: HCFA (2000).

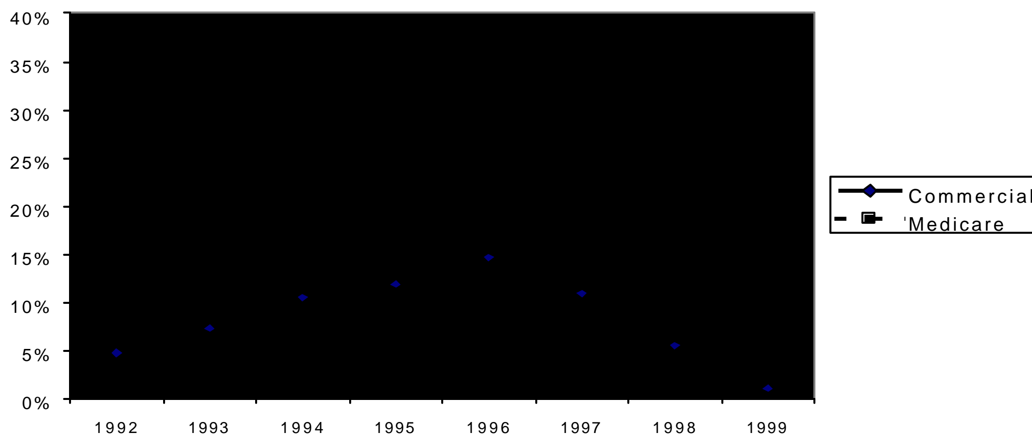
Second, HMO enrollment may have become more attractive because access to alternative forms of coverage, including Medigap and retiree benefits, was eroding. Medigap premiums rose sharply in this period. In 1996, the peak year of risk HMO enrollment growth, the largest Medigap plan, offered through AARP by Prudential, raised its rates 27 percent; the increase for 1997 was another 13 percent. In addition to the overall rate increases, there was a widespread shift to attained age rating (Alexcih et al.). Meanwhile, access to retiree coverage was dropping precipitously, partly in response to changes in the FASB accounting rules that required firms to book benefits promised to future retirees as a current liability. (This issue is discussed later in this section.) The number of large firms offering any form of retiree health benefits dropped from 66 percent in 1988 to 40 percent in 1995 and 37 percent in 2000 (Kaiser-HRET).

Third, beneficiary access to the HMO option grew dramatically, as more organizations chose to enter the Medicare market or to expand into previously unserved areas. These business decisions by insurers were not necessarily driven solely by a belief that the individual Medicare market was an inherently attractive one. Some insurers were seeking to achieve broader geographic coverage for their commercial lines, by expanding operations or acquiring existing HMOs. Entering the Medicare market in these new areas at the same time might have seemed like a reasonable way of helping to meet the fixed costs of the start-up or acquisition. In addition, some national managed care firms may have been seeking to position themselves as the carriers of choice for the retiree benefit market. Employers in the early 1990s showed increasing interest in offering risk HMOs to their Medicare-eligible retirees. An insurer wanting to serve the employer market through a risk contract in a given area had to make itself available to nongroup Medicare beneficiaries as well.

All of these trends peaked around 1996 and might have moderated even without congressional intervention. As figure 1 shows, growth in Medicare HMO enrollment followed the same pattern as growth in commercial HMO

enrollment in the 1990s: accelerating growth reaching its peak in 1996 and a sharp decline in growth in the following year—before enactment of the BBA. The factors contributing to the slowdown in the commercial market have been described elsewhere. Employers began to shift to other forms of managed care, such as PPOs. In addition, after several years of almost flat premium growth, employers began to see HMO premium increases after 1996. These were partly attributable to rising costs, especially for prescription drugs, and partly to the "underwriting cycle": expanding HMOs that had offered artificially low prices to attract new business raised their rates to profitable levels.

Figure 1. Annual Growth in HMO Enrollment, 1992-1999



Source: InterStudy.

The extent to which similar factors were at work in the Medicare market is unclear. Obviously beneficiaries weren't shifting from HMOs to PPOs, as this option did not exist. But this shift in the commercial market was partly driven by growing consumer resistance to highly restrictive managed care, and there might similarly have been some natural limit on the proportion of Medicare beneficiaries willing to enroll in these arrangements. The generosity of supplemental benefits offered by Medicare plans would likely have eroded, or their premiums would have gone up, even without the BBA payment constraints, because the cost of the benefits—again, especially drugs--was rising faster than the cost of the basic Medicare package. Moreover, there are indications that the underwriting cycle was at work in the Medicare market as well as the commercial one: organizations were offering artificially low rates to consumers and would eventually have raised them. (The example of Aetna-US Healthcare will be considered below.)

There are several indications that the Medicare market was approaching saturation. Penetration—the proportion of beneficiaries enrolled in risk HMOs--tripled from 1993 to 1998, from 5.1 to 15.1 percent of beneficiaries. However, this growth was largely driven by expansion of plans into new areas. In 1993, the handful of markets in which 15 percent or more of beneficiaries were in HMOs accounted for nearly three-quarters of total enrollment. By 1998, these markets accounted for only 35 percent of total enrollment; two-thirds of enrollment growth over the five years was in markets that had previously had little or no participation.

Table 6. Change in Risk HMO Penetration and Share of Risk Enrollees by MSA/CMSA, 1993-98, by 1993 Penetration Level

Penetration, December 1993	Number of MSAs	Share of HMO enrollees		Share of total enrollment growth	Penetration, December 1998
		1993	1998		
Under 1%	247	1%	28%	40%	10%
1-4.9%	27	10%	21%	26%	22%
5-9.9%	14	9%	10%	11%	22%
10-14.9%	6	7%	6%	6%	34%
15-19.9%	6	10%	6%	3%	29%
20% and over	16	63%	29%	13%	42%
All MSAs	316	100%	100%	100%	19%

Source: December 1993 and 1998 HCFA market penetration data.

As table 7 shows, new enrollment in all of the markets was slowing after 1995.[10] In the mature markets it may have been asymptotically approaching zero.

[10] Peak year different from InterStudy because this is December to December, while InterStudy above is July to July. Also, InterStudy includes non-MSA enrollment growth and may omit some Medicare risk HMOs.

Table 7. Risk Enrollment Growth by MSA/CMSA, 1993-98, by 1993 Penetration Level

Penetration, December 1993	Number of MSAs	Enrollment growth				
		1994	1995	1996	1997	1998
Under 1%	247	249%	321%	137%	74%	26%
1-4.9%	27	66%	89%	46%	28%	13%
5-9.9%	14	47%	39%	31%	22%	12%
10-14.9%	6	28%	32%	26%	15%	12%
15-19.9%	6	15%	18%	14%	7%	3%
20% and over	16	12%	11%	7%	6%	3%
All MSAs	316	24%	36%	31%	25%	12%

Source: December 1993 and 1998 HCFA market penetration data.

Although plan expansions into new areas continued until 1998, the rate of growth was already dropping after 1996, as table 8 shows. It is likely that organizations were identifying fewer unserved areas that it might be profitable to enter.

Table 8. Change in Percent of Beneficiaries with Access to an HMO or CMP, 1993-1998

	Percent of beneficiaries with access to at least one managed care plan	Percent change
1993	49%	
1994	57%	16%
1995	61%	7%
1996	68%	11%
1997	72%	6%
1998	74%	3%

Source: HCFA 2000 and Medicare Compare data.

If the two trends—slowing expansion and slowing penetration growth—had continued, it is not inconceivable that the proportion of beneficiaries with access to an HMO would eventually have peaked at about 75 percent, and participation in markets with an HMO available at 35 to 40 percent. This would still have meant that 25 to 30 percent of beneficiaries would have been in HMOs, nearly twice the actual peak of about 16 percent reached in 1999. In March 1997, before the BBA, the Congressional Budget Office projected that risk plan penetration would reach 30 percent by 2005 (CBO).

Even this estimate is probably high, however. Rising costs, especially for drugs, would likely have led to curtailment of supplemental benefits or higher beneficiary premiums even in the absence of the BBA. In addition, while enrollment was growing most rapidly among younger beneficiaries, this has been (and will be, until baby boomers enter the program) the slowest-growing segment of the Medicare population. Plans' continued failure to attract many older beneficiaries would have further dampened enrollment growth.

None of this is to say that the BBA had no impact, but only that the Medicare market was probably already headed into a period of consolidation and stagnant growth. The effect of the BBA may have been to accelerate these trends.

The BBA and its aftermath

Despite the rapid growth in the TEFRA risk contracting program, the problems that were apparent at the outset—biased selection, geographic concentration, and instability—remained, as did concerns about quality and beneficiary information. Moreover, while new types of managed care plans had emerged in the commercial market, Medicare beneficiaries still had the option only of joining highly restrictive HMO plans.

In 1997, as part of the Balanced Budget Act, Congress folded the TEFRA risk contracting program into a new Medicare+Choice program. The new program aimed to broaden the types of health plan choices available to beneficiaries, allowing contracts with new types of plans, including PPOs, provider-sponsored organizations, MSA plans, and private fee-for-service plans. At the same time, it made major changes in the treatment of HMOs/CMPs, now part of a class known as "coordinated care plans." These changes were intended to address many of the long-standing concerns about the risk contracting program.

To encourage plan availability in more areas, geographic variation in payment rates was reduced and some other barriers to participation were removed.[11] At the same time, overall growth in Medicare payment rates was to be held for several years at levels below the rate of growth in Medicare FFS spending—in part to recapture some of the estimated overpayment resulting from favorable selection. HCFA was directed to develop a risk adjustment

[11] For example, plans no longer needed to meet minimum enrollment requirements or have a mix of Medicare and private sector enrollees.

system, under which payments would better reflect expected costs for the beneficiaries joining M+C plans.

All of these changes were accompanied by a new beneficiary education program, intended to make more beneficiaries aware of their health plan options and financed through assessments on plans; phase-in of an annual open enrollment period during which beneficiaries could change plans; and stronger quality standards for plans and other beneficiary protections.

The details of the new payment scheme are important for understanding the remainder of this report. The following are the most important features:

- Each year, the basic payment rate for each county—before enrollee-specific demographic or risk adjusters--was to be set at the largest of a **floor** rate (beginning in $367 in 1998), a **minimum increase** of 2 percent over the same county's rate in the preceding, or a **blended** rate made up of an area-specific amount and a national amount. The area-specific amount was based on 1997 payment rates and was thus initially equal to 95 percent of the AAPCC. The national amount was the beneficiary-weighted average of all the area-specific amounts, adjusted for each county using an index of input prices. (Both amounts were also adjusted to remove Medicare spending for graduate medical education in hospitals.) The blended rate for 1998 was to be 90 percent area-specific and 10 percent national; the national share would gradually rise, reaching 50 percent for 2003 and later years.

- An annual growth percentage was to be established, based on expected growth in per capita spending for beneficiaries remaining in the fee-for-service program ("original Medicare"). For 1998, this percentage would be used to update the 1997 are-specific figures used to compute blended rates. For 1999 and later years, it would also be used to update the floor rate. For each of the years 1998 through 2002, the growth percentage was to include a fixed reduction from the actual projection of FFS spending (0.8 percentage points for 1998 and 0.5 percentage points for the next four years).[12]

- HCFA was directed to adjust payment rates to assure that the total amount spent was no more than would have been spent if every plan had received the area-specific amount. This "budget

[12] The BBRA of 1999 changes the percentage reduction for 2002 to –0.3 percentage points.

neutrality" adjustment could not affect the floor rate or the minimum 2 percent increase. It was to be taken entirely in counties that were to receive the blended rate, and could not reduce any of these counties' rates to less than 2 percent more than their rate for the preceding year. This has proved mathematically impossible in most years. Only in 2000 did any counties receive a blended rate; in all other years, every county received either the floor or the minimum increase. One important consequence is that the rate reductions to remove medical education spending never occurred, because these reductions applied only to the blended rates.

?? An adjustment reflecting health risk was to be added to the demographic adjusters used in computing rates for specific enrollees. In 1999, HCFA announced that it would begin using "principal inpatient diagnostic cost groups" (PIP-DCGs), which would adjust rates for each enrollee based on diagnoses associated with any inpatient hospital admissions for that enrollee in the prior year. For 2000, the rate for each enrollee would be a mix of 10 percent of a rate computed using the PIP-DCG adjuster and 90 percent of the rate computed under the old demographic method. By 2003, 80 percent of the rate would be based on the PIP-DCG. For later years a new system based on outpatient diagnoses as well as inpatient would be used. HCFA estimated that risk adjustment would reduce payments to plans by over 5 percent by 2003.[13] In the BIPA of 2000, Congress has frozen the phase-in at 10 percent PIP-DCG, 90 percent demographic, through 2003 and has specified a phase-in schedule for the new system to be used beginning in 2004.

Congress's expectation was that the BBA would accelerate the existing trend of rapid growth in managed care enrollment. Instead, as the BBA began to take effect in 1998, organizations began leaving the program or reducing their service areas. The first wave of withdrawals, for contract year 1999, had a limited effect on beneficiaries. Many involved plans that had recently entered markets where there were existing Medicare plans, had failed to capture an adequate market share, and departed—leaving their enrollees with the same choices that had existed before. Seven out of eight affected enrollees had another CCP available, and the HHS Office of the Inspector General (2000) estimated that two-thirds of affected enrollees joined another CCP. While a smaller number of

[13] This is smaller than the overpayment estimated by GAO, in part because the PIP-DCG method still overestimates cost for the lowest-cost enrollees and underestimates costs for the highest-cost enrollees.

enrollees was affected the following year, they were less likely to have another option; an estimated 55 percent joined another CCP.

Table 9. M+C Enrollees Affected by Contract Terminations, 1999-2001

Withdrawals effective for year beginning:	Enrollees affected by withdrawals or service area reductions	Enrollees left with no CCP option	Percent with no CCP option
January 1999	407,000	50,000	12%
January 2000	327,000	79,000	24%
January 2001	910,000	159,000 – 252,000[a]	17% - 28%[a]

[a]The higher figure includes beneficiaries who nominally have access to a plan but who may not be able to enroll in it because of capacity limits.
Source: HHS Office of the Inspector General (2000) and HCFA (2000a and 2000b).

At the same time, new organizations were continuing to join the program and existing ones were still expanding into new areas. Overall enrollment continued to grow in 1999 but stabilized at about 6.3 million and remained at about this level through most of 2000. The proportion of beneficiaries who had access to a CCP dropped gradually, from 74 percent in 1998 to 72 percent in 1999 and 69 percent in 2000.

Changes for 2001

Withdrawals

In the year 2000, effective for the 2001 contract year, 58 organizations—almost half of those participating--terminated some or all of their M+C contracts or continued contracts but reduced their service areas. Overall, 910,379 beneficiaries in 464 counties—about 15 percent of all enrollees--lost enrollment in their current organization.[14] Most of these had the option of enrolling in a different CCP for 2001, although they might receive less generous benefits, pay a higher premium, and/or have to change medical care providers. In its initial announcement HCFA estimated that 158,805 beneficiaries, or 17 percent of those affected, would not have access to any CCP in their county in 2001 (HCFA 2000a). This figure is somewhat misleading, however, because organizations are allowed to establish HCFA-approved capacity limits, beyond which they are not required to accept new enrollees. When these limits are considered, another

[14] These figures differ from those in HCFA's original announcement because two organizations rescinded withdrawals from specific counties before the end of 2000.

93,110 enrollees who lived in a county where a CCP was nominally available did not actually have the opportunity to join it.

The number of discontinued enrollees who shifted to another plan is not yet available, but it appears that there were fewer such shifts than in prior years. The total drop in CCP enrollment from June 2000 to January 2001 was 590,000. This included nearly all the enrollees in a county left with no other plan. (Some beneficiaries in these counties were and are enrolled in plans not officially serving their county.) Of discontinued enrollees who had another option available, as many as 60 percent may have returned to original Medicare. This might be because of capacity limits, because any remaining CCP options were unattractive, or because the beneficiaries were simply disenchanted with the M+C program.

Table 10. Change in CCP Enrollment, December 2000-March 2001, by Renewal Status of CCPs in County

CCP renewal status in county	CCP enrollees (thousands)			Change, June 2000 - March 2001
	June 2000	December 2000	March 2001	
All CCPs remained	1,713	1,741	1,718	+5
Some CCP remained	4,302	4,278	3,875	-427
No CCP remained	179	147	17	-162
Total	6,195	6,166	5,610	-585

Note: Includes only beneficiaries in counties within a CCP service area in 2000.
Source: HCFA market penetration data.

Seventeen organizations terminated all of their Medicare business; these accounted for 15 percent of affected enrollees. Of the remainder, 16 organizations terminated some M+C contracts but continued others, while 25 continued all their contracts but reduced service areas in one or more of them. As table 11 shows, a few organizations accounted for a large share of the affected enrollees. Aetna and CIGNA accounted for almost half, and ten organizations for three-quarters. Of these, only two, CareFirst in the Baltimore area and Blue Cross/Blue Shield of Northeast Pennsylvania, gave up all their Medicare business.

Table 11. Organizations with Largest Number of Enrollees Affected by Contract Terminations and Service Area Reductions for 2001

Organization	Affected enrollees	Percent of organization's enrollees	Percent of all affected enrollees	Service area reduction	Contract termination
Aetna U.S. Healthcare	334,273	53.15%	37.31%	52,755	281,518
CIGNA	100,931	68.99%	11.27%	9,168	91,763
Humana	65,075	12.80%	7.26%	53,999	11,076
United Healthcare	48,141	11.91%	5.37%	19,139	29,002
CareFirst	31,045	100.00%	3.47%	0	31,045
Blue Cross/Blue Shield of Northeast Pennsylvania	30,324	100.00%	3.38%	0	30,324
Anthem	25,724	28.30%	2.87%		25,724
Health Net	18,912	7.29%	2.11%	15,913	2,999
Penn State Geisinger Health Plan	16,748	34.37%	1.87%	16,748	0
PacifiCare	14,346	1.43%	1.60%	9,237	5,109
All other (48 organizations)	210,375	10.77%	23.48%	86,588	123,787
Total	895,894	17.54%	100.00%	263,547	632,347

Note: The counts of affected beneficiaries are smaller than those reported in HCFA 2000a, because June 2000 enrollment data are used and enrollees under terminated plans who lived outside a plan's service area are not included.
Source: June 2000 market penetration data.

Benefit changes

From the beneficiary perspective, the major advantage of M+C enrollment is access to low-cost supplemental coverage. Many plans that did not reduce their participation in M+C for 2001 have markedly curtailed these benefits or increased the premiums charged to enrollees for basic coverage. Original benefit offerings for 2001 were modified after March 1, 2001, in response to the payment increases provided by BIPA. As will be discussed in chapter 2, however, CCPs used most of the BIPA increases to increase payments to providers; benefit enhancements were generally small. This section compares benefits in 2000 to post-BIPA benefit packages for 2001.

Premiums. In 1997, 67 percent of plans were "zero-premium"--charged nothing for their basic package; 21 percent had a premium below $40 and 11 percent a premium of $40 or more (House Ways and Means 1998). In 2000, among beneficiaries in a county with any CCP, 77 percent had access to at least one zero-premium plan. For 2001, this figure has dropped to 63 percent. As there has also been a drop in overall access to any CCP, the proportion of beneficiaries with access to a zero-premium plan has dropped from 52 percent to 40 percent. For beneficiaries in counties with no zero-premium plan, prices for the least costly available plan have risen considerably. About 19 percent would have to pay $30 or more for any plan in 2001, compared to 10 percent in 2000.

Table 12. Percent of Beneficiaries by Lowest Monthly Premium in County, 2000 and 2001

Lowest premium in county	2000	2001
No plan in county	32%	37%
Zero	52%	40%
Under $15	1%	1%
$15-30	4%	4%
$30-45	3%	9%
$45-60	5%	5%
$60-75	1%	2%
Over $75	1%	3%
Total	100%	100%

Source: Contractor ACR submissions and HCFA market penetration data.

Because HCFA does not collect information on how many CCP enrollees accept their CCP's least costly package and how many purchase high-option packages for an additional premium, there is no way of knowing exactly how much more CCP enrollees are actually paying in 2001 as opposed to 2000. However, CCPs do estimate in advance, as part of their ACR submission, the proportion of their enrollees who will choose different packages. Assuming these advance estimates were correct, and applying the proportions to total enrollment under each contract, the change in expenses would be as shown in table 13.[15] The average CCP enrollee was paying $19.92 for coverage in July

[15] The estimates of distribution of enrollees among packages for 2001 are likely to be more accurate than those for 2000, as they were actually submitted in early 2001, while the 2000 projections date from mid-1999.

2000; 55 percent of enrollees were paying nothing. In 2001, 37 percent of enrollees are in zero-premium plans; the average enrollee is paying $28.90.[16]

Table 13. CCP Enrollees by Plan Premium, 2000 and 2001

Monthly premium	Percent of enrollees	
	2000	2001
Zero	55%	37%
Under $15	2%	3%
$15-30	11%	14%
$30-45	13%	18%
$45-60	9%	12%
$60-75	3%	5%
Over $75	6%	10%
Total	100%	100%
Average premium	$ 19.92	$ 28.90

Source: Contractor ACR submissions and HCFA market penetration data.

Benefits. Beneficiaries' ability to obtain a zero-premium plan has, perhaps, been overemphasized. It may be better to pay $25 a month for a plan with generous benefits than nothing for a plan with stingy ones. For the vast majority of enrollees, post-BIPA premiums are still well below what they would have had to pay for even the least generous Medigap coverage. However, the value of benefits has also been dropping. In 2000, the average CCP enrollee received $143 per month worth of additional benefits, including $97 in Medicare cost-sharing reductions and $46 in other benefits. For 2001, the average enrollee is receiving $125 in additional benefits, including $85 in Medicare cost-sharing reductions and $40 in other benefits. The proportion of Medicare payments returned to enrollees in the form of free supplements (that is, total supplements less any required premium) has dropped from 24.5 percent to 18.2 percent.

[16] Some CCPs offer, not only several different packages, but also optional supplements within a package that may be purchased for an additional premium. The estimates here assume that enrollees in a given package did not purchase optional supplements.

Table 14. Use of Medicare Payments to CCPs, 2000 and 2001

Use of funds	2000	2001
Medicare benefits -- service costs	64%	72%
Medicare benefits -- administration	11%	9%
Free supplements for enrollees:		
Reduction in Medicare cost-sharing	18%	13%
Other free supplements	7%	5%

Note: 2001 sums to less than 100 percent because a portion of payments was used to establish benefit stabilization funds.
Source: Contractor ACR submissions and HCFA market penetration data.

Most prominently, the availability and scope of outpatient prescription drug coverage has been eroding. Most beneficiaries who are in counties where any CCP is available still have access to prescription drug benefits, although not always in the least costly package offered by any CCP. In counties with a CCP, the proportion of beneficiaries with access to some drug coverage dropped only slightly between 2000 and 2001, from 94 percent to 92 percent. (Again, the 2001 estimates are for benefit offerings after BIPA). However, the likelihood that beneficiaries could obtain this coverage only by selecting a high-option package increased. Table 15 shows the lowest available premium for drug coverage in 2000 and 2001. In 2000, 46 percent of beneficiaries were in counties where they could obtain drug coverage at no cost; this represented 87 percent of beneficiaries in counties with any zero-premium plan. In 2001, only 27 percent of beneficiaries have access to free drug coverage. This represents 68 percent of those with access to any zero premium plan.

Table 15. Percent of Beneficiaries by Lowest Monthly Premium For Drug Coverage in County, 2000 and 2001

Lowest premium in county for any drug coverage	Percent of beneficiaries	
	2000	2001
No plan in county	32%	37%
No plan offering drug benefit	4%	5%
Zero	46%	27%
Under $15	1%	1%
$15-30	3%	5%
$30-45	3%	10%
$45-60	6%	2%
$60-75	2%	3%
Over $75	2%	10%
Total	100%	100%

Source: Contractor ACR submissions and HCFA market penetration data.

Accounting for CCP withdrawals

While the industry has offered a number of explanations for plan withdrawals and benefit cuts, including burdensome administrative requirements and program instability, it has placed the greatest emphasis on the impact of the BBA reimbursement changes. The basic contention is that, under the new payment formulas, reimbursement has been growing more slowly than costs since 1997, making Medicare participation unsustainable for a growing number of plans.

Effect of BBA changes. The key aim of the BBA was to induce new kinds of plans to enter the program and to offer choices to beneficiaries in areas previously unserved under the TEFRA risk contracting program. The changes made by the BBA were generally disadvantageous to the organizations already participating in Medicare. In particular, the new payment rules were designed to shift funds from areas already served by plans to areas not served, as well as to squeeze out some of the estimated overpayment resulting from inadequate risk adjustment. At the same time, existing plans were subjected to a panoply of new administrative requirements and an assessment to fund beneficiary education.

That all of these changes might make it more difficult for plans to go on expanding or even continue in place was evident early on. By late 1998, the industry was already suggesting that the BBA payment changes were unsustainable and would drive plans from the program (HIAA). What was not foreseen was that the changes made by the BBA in fee-for-service payment rules would so dramatically slow spending in original Medicare. Per capita fee-for-service spending actually dropped in 1998 and 1999. As a result, annual M+C rate updates were lower than expected, and payments for a much larger share of CCP enrollees than had been anticipated were increased each year by the minimum 2 percent.

In the aggregate, the CCPs still received cumulative per enrollee increases larger than the growth in per capita fee-for-service spending in 1998 through 2000. Based on the geographic distribution of enrollees as of July 2000, base payment rates for aged beneficiaries averaged about 8.5 percent above 1997 levels, while per capita fee-for-service payments had grown an estimated 4.6 percent.[17] Actual increases for CCP enrollees were slightly lower, because of the initial phase of risk adjustment, and even the gross figure was below the rate of inflation for medical care services (about 3.4 percent a year in the CPI-U for 1997-2000). The original increases in base payment rates for 2001, again using July 2000 enrollees, would have left the CCPs well behind the fee-for-service sector. Their average base rate would have gone up only 2 percent, while per capita FFS spending for aged beneficiaries (before BIPA changes in FFS) was originally projected to increase by 6 percent.

Still, at least through 2000, plans in the aggregate were able to hold growth in spending for basic Medicare services to less than the rate of increase in their payment rates. As table 16 shows, CCPs' ACR submissions for contract year 2000 projected that they would on average spend 75.5 percent of their Medicare payments furnishing basic Medicare services, down from 80 percent four years earlier. (The ACR figure includes administration and an allowance for a surplus comparable to that realized for commercial members.)

Those that continued their contracts for 2001 projected (before BIPA) that Medicare service costs would rise sharply—increasing by almost 12 percent—while Medicare payments would rise by less than 3 percent.[18] As a result they expected the share of payments spent on Medicare services to rise to 81.5 percent. This would still have been less than the average CCP was spending in 1995. (Why plans projected such large increases in service costs will be

[17] As updated in 2002 rate calculations and omitting the BBA percentage reductions in M+C updates.
[18] These are averages weighted by projected enrollment and corrected for the change in the mix of CCPs submitting rate proposals for 2000 and 2001.

considered in the next chapter.) In the aggregate, then, while the BBA changes did squeeze reimbursement for CCPs, those that remained in the program for 2001 were still doing about as well as the typical CCP was before the enactment of the BBA.

Table 16. Projected Share of Medicare Payment to CCPs Spent on Basic Medicare Services, 1992-1996 and 2000-2001

Contract year	Projected share of Medicare payment spent on basic Medicare services
1992	87.5%
1993	88.4%
1994	86.2%
1995	84.3%
1996	80.0%
2000	75.5%
2001 (pre-BIPA)	81.5%

Source: CBO (1997) and ACR submissions for 2000 and 2001, weighted by estimated enrollment in June 2000 and March 2001.

Does this mean that the BBA payment constraints played no role in plan withdrawals or service area reductions? GAO and HCFA have both pointed out that, while all organizations have been affected by the reimbursement changes, some left the program and some stayed (GAO 2000a, including HCFA comments). They suggest that some business considerations other than payment levels must be affecting participation decisions at the individual corporate level, and that merely increasing reimbursement might not affect these decisions. While this is true, it is not the case that all plans were equally affected by the BBA.

Some plans operated exclusively in areas that received the minimum 2 percent rate increase in all four years 1998-2001, for a cumulative increase of 8.24 percent. Other plans operated in areas whose rates were dramatically increased by the payment floor. Considering only base payment rates, without risk adjustment, the enrollee-weighted average increase was 10.5 percent. As table 17 indicates, however, there were entire organizations that received the minimum increase for every single enrollee, and others that received much higher average increases. One organization's average base rates for 2001 (before BIPA) were 47 percent above the 1997 AAPCC for its enrollees.[19]

[19] The phased rate reductions to remove GME expenditures also had differential effects in 2000 only, to the extent they affected the blended rates.

Table 17. Enrollee-Weighted Average Increase in Base Rates between 1997 and 2001 (before BIPA), by Number of Organizations

Base rate increase, 1997-2001 (pre-BIPA)	Organizations
Minimum (8.24%)	13
8.25%-9.9%	53
10%-12.4%	26
12.5%-14.9%	19
15%-19.9%	20
Over 20%	13

Source: Changes in base payment rates for aged beneficiaries applied to enrollment data for June 2000.

If one were to assume that all plans were doing equally well under their 1997 payments and were equally able to improve their efficiency in succeeding years, one would expect that these considerable differences in the effects of the BBA rating rules would go at least some of the way toward explaining participation decisions. Organizations that terminated their participation in Medicare altogether would tend to be those that had received the smallest rate increases. Organizations that retained some enrollees and dropped others would have dropped those for whom they received the smallest increases.

This was not true. Organizations that left the Medicare program entirely would have had only slightly lower cumulative increases for 2001 than those that continued all their enrollees. Organizations that retained some enrollees and dropped others had higher four-year rate increases for the enrollees they dropped than for the enrollees they retained. These are weighted averages; some organizations in each category did much better or much worse. Still, it does not seem that area differences in the effects of BBA explain participation decisions.

Table 18. Enrollee-Weighted Average Increase in Base Rates between 1997 and 2001 (before BIPA), by Participation Decisions for 2001

Participation decision for 2001	Base rate increase, 1997-2001 (pre-BIPA)
Organization dropped Medicare completely	10.3%
Organization dropped some enrollees:	
Retained enrollees	10.3%
Dropped enrollees	10.5%
Organization retained all enrollees	10.8%

Source: Changes in base payment rates for aged beneficiaries applied to enrollment data for June 2000.

Even when plans kept some counties and dropped others within an MSA, this was not usually because some counties had higher cumulative rate increases than others. Out of 35 cases in which a plan reduced its service area within an MSA for 2001, the four-year rate increases for the dropped enrollees were equal to or greater than those for retained enrollees in 20 cases. In some cases the dropped enrollees represented a minor or peripheral part of the plan's business in the area. In other cases plans dropped a substantial share of their enrollees even when payment levels were as high as for the enrollees they retained. (Details by organization and MSA are in appendix A.)

CCP efficiency. What all of these figures suggest is that the likelihood that plans would continue their Medicare contracts or continue serving a particular population may have less to do with payment rates than with a set of factors that might loosely be called plan "efficiency." This term must be understood to embrace not only ability to manage enrollees' care, but also ability to negotiate discounts with providers in the area, a sufficient market share to cover fixed costs, and other business factors—as well as risk selection not accounted for in the payment system.

Were the plans that decided to end or curtail their Medicare participation for 2001 operating less "efficiently" than other plans in 2000? CCPs' annual ACR submissions do include information on past financial performance. However, CCPs that terminated their contracts for 2001 of course did not submit an ACR proposal; the most recently available information for these CCPs is the 2000 ACR submitted in mid-1999. Past financial performance reported in these submissions

would have been for contract year 1998, the first post-BBA year, and would not tell much about how these CCPs were doing two years later.

What can be gathered from the 2000 ACR submissions is how CCPs *expected* to do in 2000. The submissions show that the plans that decided, in mid-2000, to end their participation for 2001 were already—in mid-1999—projecting that their financial performance for contract year 2000 would be poorer than that of other CCPs. Table 19 compares ACR submissions for contract year 2000 according to the contractor's renewal decision for 2001. (Note that the table is at the level of contracts rather than entire organizations. If an organization renewed one contract and terminated another for 2001, expected results for the two contracts in 2000 would be averaged into the "renewed" and "terminated" columns respectively.)

Table 19. Projected 2000 Financial Performance by Contract Renewal Decision for 2001

	All contracts		Renewed, full service area		Renewed, reduced service area		Terminated	
	Dollars per enrollee month	Percent of Medicare payment	Dollars per enrollee month	Percent of Medicare payment	Dollars per enrollee month	Percent of Medicare payment	Dollars per enrollee month	Percent of Medicare payment
Projected Medicare payment	**$ 495**	**100.0%**	**$ 509**	**100.0%**	**$ 482**	**100.0%**	**$ 466**	**100.0%**
Costs for basic Medicare benefits:								
Services	$ 318	64.3%	$ 324	63.6%	$ 312	64.7%	$ 310	66.7%
Administration	$ 45	9.2%	$ 44	8.6%	$ 46	9.5%	$ 52	11.1%
Surplus	$ 10	2.1%	$ 14	2.7%	$ 6	1.3%	$ 3	0.6%
Subtotal, basic benefit cost	**$ 374**	**75.5%**	**$ 382**	**74.9%**	**$ 364**	**75.5%**	**$ 365**	**78.4%**
Free supplements								
Reduction in Medicare cost-sharing	$ 87	17.5%	$ 88	17.2%	$ 87	18.1%	$ 79	17.0%
Other free supplements	$ 35	7.1%	$ 40	7.9%	$ 31	6.4%	$ 22	4.7%
Subtotal, free supplements	$ 122	24.5%	$ 128	25.1%	$ 118	24.5%	$ 101	21.6%
Supplements paid with premium								
Reduction in Medicare cost-sharing	$ 11		$ 10		$ 10		$ 14	
Other paid supplements	$ 11		$ 9		$ 10		$ 17	
Total supplement value	**$ 143**		**$ 147**		**$ 139**		**$ 132**	
Premium	**$ 21**		**$ 19**		**$ 21**		**$ 31**	

Note: Columns may not sum due to rounding.
Source: 2000 ACR submissions, weighted by estimated June 2000 enrollment.

As noted earlier, CCPs on average projected spending about 76% of Medicare revenue furnishing basic Medicare benefits. Those that terminated their contracts for 2001 projected higher spending in 2000 on both services and administrative costs. Even though they allowed for virtually no surplus on basic Medicare services, they expected to be able to return a much smaller percentage of their Medicare payments to enrollees in the form of supplemental benefits. (Many projected a negative surplus—that is, they went into the year expecting to subsidize Medicare enrollees from other operations or from capital.)

The table separates "free supplements"—those financed by the excess of Medicare payments over costs for Medicare services—from additional supplements that are financed through a monthly premium paid by enrollees. In dollar terms, CCPs that terminated their contracts could offer only $101 per month in free supplements, compared to $128 under contracts that were renewed for their entire service areas. When supplements financed through premiums are added in, terminated contractors were offering a total of $132 in supplements at a charge of $31 a month. Fully renewed contractors offered $147 in supplements for a charge of $19. On all these measures—basic service costs and supplements—contractors that reduced their service areas fall midway between full renewals and terminations.

That the terminating contractors were offering less to enrollees in dollar terms does not necessarily mean that their benefit packages were inferior. The terminating contractors expected both lower Medicare payments and lower Medicare service costs—either because they operated in low-cost areas or because they had younger or healthier enrollees. If the cost for supplemental benefits varied in direct proportion to the cost for basic Medicare benefits, they might have been able to provide equally generous supplements for a smaller dollar amount. This is illustrated in table 20. Terminating contractors projected that costs for their total benefit package would be 36 percent above costs for Medicare services alone. This ratio was only a little below that for all contractors. In theory, then, their benefits should have been only a little less generous than those of other contractors.

Table 20. Projected Cost for Medicare Benefits and Total Benefits, 2000, by Contract Renewal Decision for 2001

Contract renewal status for 2001	Medicare services	Total services	Ratio of total to Medicare
Renewed, entire service area	$ 382	$ 529	1.39
Renewed, service area reduction	$ 364	$ 503	1.38
Terminated	$ 365	$ 497	1.36
All contracts	$ 374	$ 517	1.38

Source: 2000 ACR submissions, weighted by estimated June 2000 enrollment.

Unfortunately, the cost of supplements does *not* necessarily vary in proportion to the cost of basic Medicare services. (This critical problem in the design of the Medicare+Choice program is discussed further in chapter 5.) Table 21 values CCPs' total benefit packages for 2000, using estimates of actuarial value developed by the Actuarial Research Corporation for HHS. These estimates score benefits on a scale of zero to 1.0, with the highest possible value assigned to a package that offers every benefit typically offered by any CCPs (prescription drugs, dental, and so on) with no required cost-sharing. On this scale, the basic Medicare benefit package has a value of 0.5975. The average contractor offered a package in 2000 with an estimated value of 0.767, or 28 percent above that of the basic Medicare program. The estimated value of the package offered by terminating contractors was only 22 percent above the Medicare-only value. (Note that all of the estimated values assigned by the Actuarial Research Corporation are lower than those implied by CCPs' ACR submissions.)

Table 21. Estimated Relative Value of Total Benefit Package for 2000, by Contract Renewal Decision for 2001

	Medicare services	Total services	Ratio of total to Medicare
Renewed, entire service area	0.598	0.774	1.30
Renewed, service area reduction	0.598	0.767	1.28
Terminated	0.598	0.730	1.22
All contracts	0.598	0.767	1.28

Source: Estimated benefit values developed by Actuarial Research Corporation, weighted by estimated enrollment in June 2000.

Enrollment shortfalls. The terminating plans started the year expecting to realize almost no surplus on Medicare services. Plans' advance projections of financial performance depend in part on assumptions about how many enrollees they will have. While some CCP costs vary directly with the number and

characteristics of enrollees (e.g., inpatient hospital costs), others—especially administrative costs—are more nearly fixed: the plan will incur the costs whether it has 100 enrollees or 100,000.[20] A plan that fails to meet its enrollment targets over the course of the year will have higher per capita costs than were assumed in its financial planning.

In 2000, CCPs in the aggregate failed to reach their enrollment targets. Table 22 compares the average enrollment assumed in plans' ACR submissions to their actual enrollment as of June 2000. While all plans fell short of their projected enrollment at midyear, the shortfall was much larger for the terminating plans (possibly because their benefits were so weak). This almost certainly meant much higher per capita costs per member than projected.

Table 22. Enrollment Shortfall in 2000 by 2001 Contractor Renewal Decision

	Projected average monthly enrollment for 2000 (thousands)	Actual enrollment at June 2000 (thousands)	Shortfall
Renewed, all areas	3,643	3,516	-3.5%
Renewed, service area reduction	2,113	2,050	-3.0%
Terminated	779	636	-18.4%
Total	6,534	6,201	-5.1%

Source: ACR submissions for 2000 and June 2000 market penetration data

Plans that terminated their contracts or reduced their service areas for 2001 didn't just fail to meet their enrollment targets. They were in fact steadily losing enrollees in the areas that they dropped. Table 23 shows the changes in enrollment between the time plans made their projections for 2000 (in mid-1999) and the time they made their participation decisions for 2001 (in mid-2000).

Plans that terminated their contracts or reduced their service areas for 2001 had suffered an 8.5 percent loss in enrollment the preceding year in the areas they dropped. In areas where plans continued their contracts, enrollment grew by 8.5 percent. Drops in enrollment affect not only a plan's ability to meet fixed costs, but also the cash flow that can make a difference in a plan's ability to continue as a going concern. Even a struggling plan that is steadily gaining enrollment can pay last month's bills (for population x) out of next month's premium check (for larger population x+y). A plan that is shrinking will instead

[20] Service costs will actually be inversely related to enrollment if a CCP with a larger market share can command larger discounts from providers.

face mounting losses. These in turn mean that the plan cannot finance the enhanced benefits that might restore enrollment growth.

Table 23. Change in Plan Enrollment, 1999-2000, in Counties Continued and Dropped by Plans for 2001

Plan/county renewal status	Enrollees, June 1999 (thousands)	Enrollees, June 2000 (thousands)	Percent change
Plan renewed in county	4,789	5,197	8.5%
Plan dropped in county			
Service area reduction	274	255	-6.9%
Contract termination	695	632	-9.1%
All dropped counties	970	887	-8.5%

Source: HCFA market penetration data for June 2000 and 2001; limited to enrollees within plan service areas.

The picture is different, but still instructive, at the level of organizations rather than plan/county pairings. Organizations that continued all their Medicare business for 2001 had seen a 15 percent enrollment increase between 1999 and 2000, while organizations that dropped all their Medicare business had seen 6 percent growth. In the organizations that retained some areas but dropped others, enrollment in the retained areas had risen almost 7 percent, while enrollment in the dropped areas had fallen by 11 percent.

Table 24. Change in Organization Enrollment, 1999-2000, by Organization's Participation Decision for 2001

	Enrollees, June 1999 (thousands)	Enrollees, June 2000 (thousands)	Percent change
Organization dropped Medicare completely	144	152	5.9%
Organization dropped some areas			
Retained areas	3,674	3,919	6.7%
Dropped areas	826	735	-11.0%
Organization retained all areas	1,114	1,278	14.7%
Total	5,758	6,084	5.7%

Source: HCFA market penetration data; limited to enrollees within plan service areas.

As with everything else, this pattern was inconsistent within organizations. Appendix A gives figures for the ten organizations dropping the largest number of enrollees. Most of the organizations dropped areas with

shrinking enrollment; but CIGNA left areas where enrollment was flat and retained ones where enrollment was dropping.

Changes in corporate strategy. In sum, withdrawals for 2001 reflected not just payment constraints but a variety of other factors. It is not possible to examine what went into individual organizations' business decisions about specific markets. However, some of the largest withdrawals and service area reductions appear to reflect general shifts in corporate strategy. Aetna U.S. Healthcare and CIGNA, which together accounted for almost half the enrollees affected by withdrawals, had both expanded their Medicare operations into many new areas during the mid-1990s, either directly or through acquisition of plans with existing Medicare contracts.

For 2001, CIGNA simply dropped every Medicare contract dating from this period of expansion—11 new contracts it had entered into between 1994 and 1998. (See appendix A for a breakdown by contract.) It retained, with reduced service areas, its own Arizona contract—begun as a pre-TEFRA cost contract in 1978—and that of the acquired Lovelace plan, which dated from 1981.[21] Average base payment rates in the terminated contracts were 14 percent above those in the retained areas; rates for terminated enrollees were 10 percent above 1997 levels, compared to 11 percent for the retained enrollees. Several of the terminated contracts had larger enrollments than Lovelace, and overall enrollment under the terminated contracts was stable, while enrollment was shrinking in the retained areas.

All of this suggests that CIGNA had once expected Medicare to be an important part of its business and had simply reversed course. It may have retained the oldest contracts because it is easier to drop enrollees after two or three years than after twenty; in addition, that both contracts started as cost contracts suggests that they may have involved long-standing arrangements with retiree groups. The remaining contracts may simply not have been worth the administrative hassle; Medicare accounted for only 7 percent of CIGNA's risk enrollment as of mid-2000.[22]

The pattern at Aetna is less clear-cut, but similar (see appendix A). It terminated all but one of the new Medicare contracts it entered into in the 1990s, continued its own older operation and those of U.S. Healthcare, and dropped Medicare contracts in all recent acquisitions except the HMO of New Jersey, whose large Medicare business dated from 1983. These changes were part of a

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[21] Lovelace has since reentered some of the dropped counties.
[22] Based on CIGNA financial statement at http://www.cigna.com/general/investor/VUVBSN6K.xls

general consolidation that also included cutbacks in its commercial operations in a number of areas, particularly those acquired in its ill-starred purchase of Prudential's health care business in 1999.

Some picture of what has happening at Aetna can be gathered from its financial statements, summarized in table 25.

Table 25. Aetna U.S. Healthcare HMO Performance, 1997-2000

	1997	1998	1999	Annual percent change, 1997-1999	2000	Percent change, 12/99-12/00
Premium per member per month						
Commercial	$ 132.57	$ 134.68	$ 138.58	2.2%	$ 150.14	8.3%
Medicare	$ 459.69	$ 474.67	$ 491.21	3.4%	$ 535.44	9.0%
Medical cost per member per month						
Commercial	$ 111.69	$ 110.61	$ 115.77	1.8%	$ 129.58	11.9%
Medicare	$ 429.31	$ 441.63	$ 453.30	2.8%	$ 519.25	14.5%
Medical loss ratio						
Commercial	84.2	82.1	83.5	-0.4%	86.3	3.4%
Medicare	93.4	93.0	92.3	-0.6%	97.0	5.1%
Hospital bed days per 1,000						
Commercial	235	222	217	-3.9%	225	3.7%
Medicare	1,435	1,386	1,453	0.6%	1,559	7.3%
HMO SG&A as percent of revenue	12.1	11.4	12	-0.4%	11.6	-3.3%

Source: Aetna U.S. Healthcare quarterly earnings statements, http://www.aetna.com/investor/qearn.htm

Aetna was apparently already losing money on its Medicare business in 1997. Even if its SG&A (selling, general, and administrative) percentage for Medicare enrollees was in the same range as for commercial members[23],

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[23] This is unlikely. Marketing, enrollment, billing, and compliance costs are clearly higher for non-group Medicare beneficiaries than for commercial members. On the other hand, because

combined medical and administrative costs were over 104% of premiums. Over the next two years its Medicare premiums rose more slowly than the national minimum increase of 4.04 percent. This could reflect either faster growth in lower-rate areas or a shift in enrollment composition toward younger members. In addition, because the premium figure includes enrollee-paid premiums, growth would have been depressed if these premiums did not increase at the same rate as Medicare. During 1998 and 1999, Medicare medical and administrative costs grew less rapidly than revenue, but the company still appears to have been losing money. Both revenues and expenses jump in 2000.[24] However, expenses rose much faster than revenues, leading to a Medicare loss ratio of almost 97 percent. (This reflects costs for supplemental as well as basic services.)

In sum, the picture is of a company whose Medicare business was already performing poorly before the enactment of the BBA in 1997 and that nevertheless continued its expansions and acquisitions in the ensuing years. Its newer Medicare contracts lost enrollment between 1999 and 2000, and its overall cost performance deteriorated. At this point it concluded that the newer operations were not going to become profitable in the foreseeable future, and it pulled back to its original base.

What does it mean that these national insurers made an initial commitment to Medicare and have since reversed course? One common assertion is that the government is an "unreliable business partner." Organizations entered into Medicare contracts with one set of expectations, made business plans, and then had these plans disrupted by unexpected changes in Medicare payments and regulatory requirements. That government policies change is certainly true, and will remain so unless Congress were to forever renounce any further tinkering with Medicare.

However, business is also an unreliable business partner. While Medicare has never terminated a contract without cause, Sears, Roebuck dropped 30 of its 180 HMOs for 2001 and is modifying cost-sharing to encourage enrollees to shift from HMOs to PPOs. Andersen Consulting has terminated 125 HMOs and a point-of service plan and has replaced them with a national PPO and a Blue Cross/Blue Shield network (Freudenheim 2000). More to the point, some industry analysts contend that the major chains expanded their Medicare

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revenues are so much higher for Medicare enrollees, SG&A as a percentage of revenue might conceivably be lower.

[24] This apparently reflects in part the March 2000 sale of NYLCare Texas, whose 129,000 Medicare members must have had lower average premiums and expenses than the retained membership. In addition, 2000 is the first year in which the higher-cost acquired Prudential enrollees affect averages for the entire year. Results were about the same with or without Prudential.

business in the first place to serve employer groups and then found that employers themselves had lost interest in the risk HMO option for retirees. Nor is it extraordinary for health insurers themselves to enter markets and then withdraw from them; the abandon with which carriers wander into and out of the small group market is legendary.

Overall, what has happened in Medicare+Choice can possibly be best described as a shake-out. Organizations everywhere were subjected to new financial and other pressures—some of these, like skyrocketing drug costs, unrelated to any Medicare policy change. Most companies have adjusted and have continued their participation. Some, especially those that failed to grow their business or entered marginal markets with unrealistic expectations, are gone. As was suggested earlier, it is likely that the Medicare market would have entered a period of consolidation even without the BBA. The BIPA changes for 2001 may stabilize the M+C program for a limited time. There remains the question of what should be done to promote sustainable growth of the program over the long term.

Chapter 2: THE BENEFITS IMPROVEMENT AND PROTECTION ACT

Congress responded to the plan withdrawals and benefit reductions by enacting the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act in December 2000. While BIPA includes a variety of measures intended to stabilize the M+C program, two will be focused on here. The first is the rate increases. The second is the provision allowing a reduction in the part B premium for M+C enrollees, which represents at least a first step toward implementation of a more fully competitive model for Medicare.

Rate increases

Effective March 1, 2001, BIPA raises the floor payment rate from $415.01 to $475, and establishes a new floor of $525 for counties in an MSA with a population of 250,000 or more.[25] It raises the minimum rate increase from 2 percent to 3 percent for 2001 only. As these changes affect the base from which future rate increases will be calculated, they will have continuing effects, raising projected M+C spending by $11 billion over five years. In the case of existing CCPs, BIPA requires that the new funds be returned to enrollees in the form of enhanced benefits or reduced premiums or cost-sharing. Alternatively they may be held in reserve to maintain benefits in future years, or may be used to "stabilize or enhance beneficiary access to providers," presumably by paying them more.

The BIPA rate increases may be thought of as having two goals: to attract plan participation in new areas, and to encourage existing plans to continue their participation and to increase supplemental benefits. As table 26 shows, they are much better targeted for the first goal than for the second. Counties with no plan, or with the Sterling private fee-for-service plan only, received much larger rate increases than counties served by CCPs. The largest immediate winner, however, appears to have been the Sterling plan. Although it has only a few thousand enrollees to date, the BIPA increases put it in a position to substantially enhance its benefits and increase its market share. (In fact, like the CCPs, Sterling used virtually all of the increase to raise provider payment rates.)

[25] HCFA has interpreted this floor as applying to smaller primary MSAs within a consolidated MSA (CMSA) whose population is above the threshold.

Table 26. Beneficiary-Weighted BIPA Increase over Original 2001 Base Rates, by Area Access to an M+C Plan

M+C access in March 2001	Counties	Beneficiaries (thousands)	Base rate		Increase	
			Pre-BIPA	Post-BIPA	Percent	Dollars per month
CCP only	346	17,479	$ 579	$ 596	3%	$ 16
CCP and Sterling	308	8,138	$ 525	$ 552	5%	$ 27
Any CCP	654	25,617	$ 562	$ 582	4%	$ 20
Sterling PFFS only	1245	7,121	$ 452	$ 496	10%	$ 44
No plan	1123	7,686	$ 453	$ 492	9%	$ 39
Total	3676	40,423	$ 522	$ 550	5%	$ 28

Source: Base rates for aged beneficiaries weighted by March 2001 beneficiary population, HCFA market penetration data.

Effect on unserved areas

The BIPA changes markedly reduce the disparity in rates between counties that have a CCP and counties that do not. Tables 27 and 28 look at post-BIPA base rates for different areas in two different ways. Table 28 compares rates to the national average rate for an aged beneficiary, while table 29 compares rates to estimated per capita fee-for-service spending in the same areas.

In nonmetropolitan areas, there is now almost no difference in the rates for areas with access to a CCP and/or Sterling and the rates for areas with no M+C plan. In metropolitan areas, however, rates for areas with a CCP remain considerably higher than those for areas served only by Sterling and areas with no plan.

Table 27. Area Post-BIPA Rates as a Percent of National Average, by Area Access to an M+C Plan and Metropolitan Status

County location and M+C access	Beneficiaries (thousands)	BIPA rate	As percent of national average
Nonmetropolitan			
CCP only	473	$ 499	90%
CCP and Sterling	965	$ 500	91%
Any CCP	1,438	$ 500	91%
Sterling PFFS only	4,230	$ 486	88%
No plan	3,556	$ 486	88%
Total	9,224	$ 488	88%
Metropolitan			
CCP only	17,006	$ 598	108%
CCP and Sterling	7,173	$ 558	101%
Any CCP	24,179	$ 587	106%
Sterling PFFS only	2,891	$ 510	93%
No plan	3,532	$ 514	93%
Total	30,602	$ 571	103%
Total			
CCP only	17,479	$ 596	108%
CCP and Sterling	8,138	$ 552	100%
Any CCP	34,133	$ 582	105%
Sterling PFFS only	7,121	$ 496	90%
No plan	7,088	$ 500	91%
Total	39,825	$ 552	100%

Source: Base rates for aged beneficiaries weighted by March 2001 beneficiary population, HCFA market penetration data.

The picture is somewhat different when rates are compared to estimated per capita fee-for service (FFS) spending in the same areas. Note that the comparison here is to "full" FFS cost in each county, rather than to the area-specific amounts. Full FFS is 100% (not 95%) of the 1997 AAPCC, updated by the

full estimated growth in national per capita FFS spending without the percentage reductions for 1998-2001, minus the full medical education adjustment.

Table 28. Area Post-BIPA Rates as a Percent of Area Fee-for-Service Cost, by Area Access to an M+C Plan and Metropolitan Status

County location and M+C access	Base rate as percent of full fee-for-service cost		Percent change
	Before BIPA	After BIPA	
Nonmetropolitan			
CCP only	104%	110%	5.8%
CCP and Sterling	102%	108%	5.1%
Any CCP	103%	109%	5.4%
Sterling PFFS only	105%	114%	8.2%
No plan	104%	112%	7.4%
Total	105%	112%	7.4%
Metropolitan			
CCP only	100%	103%	2.8%
CCP and Sterling	101%	106%	5.1%
Any CCP	100%	104%	3.4%
Sterling PFFS only	103%	115%	11.7%
No plan	102%	111%	9.0%
Total	101%	105%	4.6%
Total			
CCP only	100%	103%	2.8%
CCP and Sterling	101%	106%	5.1%
Any CCP	100%	104%	3.5%
Sterling PFFS only	104%	114%	9.7%
No plan	103%	112%	8.2%
Total	101%	107%	5.2%

Source: Base rates for aged beneficiaries weighted by March 2001 beneficiary population, HCFA market penetration data.

After BIPA, all types of nonmetropolitan areas now have base rates substantially exceeding the cost of providing FFS Medicare. The disparity is slightly larger for unserved areas and those served only by Sterling than for areas served by CCPs. In metropolitan areas, unserved counties now have average base rates considerably above FFS. Counties with a CCP have rates slightly above FFS. (It should be noted that all of the FFS estimates continue to be based on 1997 figures, which are in turn based on data from 1995 or earlier. It is quite

likely that FFS service costs in different areas have been growing faster or slower than the national average.)

If reimbursement levels alone drove plans' decisions to enter new areas, one might expect that the enhancement of rates in unserved areas would be a sufficient inducement to produce a significant expansion in access to CCPs. A larger effect might be expected in unserved urban areas, which have benefited more from the BIPA changes than rural ones. However, many of the largest of these areas are unserved in 2001 precisely because a major plan just withdrew from them. It seems unlikely that these decisions, often made as part of a larger consolidation strategy, will be lightly reversed. At the same time, there remain formidable barriers to CCP expansion in rural areas. The problem of geographic access in both rural and urban areas will be discussed further in chapter 4.

Effect for current enrollees

Because current CCP enrollees are concentrated in areas with lower increases, the per enrollee increase averages 3.2 percent, or about $15.81 for a "typical" enrollee—that is, one with a risk/demographic index of 1.0.[26] (The actual dollar amount going to plans will vary according to the demographic and risk adjusters for specific enrollees; the percentage increase will not.) The rate of increase varies considerably by CCP. As table 29 shows, many of the corporations with the largest enrollment received smaller increases. The top 10 organizations account for 68 percent of enrollees, but might get as little as 50 percent of the new dollars for current CCP enrollees (again depending on the characteristics of their enrollees). On the other hand, some smaller plans will see increases as high as 27 percent—or almost $110 a month for a "typical" enrollee.

The differences in treatment of current enrollees operate at the level of entire states, as table 30 shows. Again, this table assumes that plans in these states received the average dollar increase for a "typical" enrollee in each county they served. California has 26 percent of the current enrollees, but received 14 percent of the new dollars. Florida has 12 percent of enrollees, but receives less than 7 percent of the dollars. On the other hand, Oregon, with 2.4 percent of enrollees, received almost 12 percent of the funds. The state of Washington, with 2.6 percent of enrollees, received almost 8 percent of the new dollars.

[26] This estimate assumes that enrollees in 2000 who are able to continue with their current plan in 2001 do so. It does not include any estimate of how many enrollees dropped by one CCP will shift to another.

Table 29. BIPA Base Rate Increases for Ten Largest Organizations

Organization	Enrollees, March 2001 (thousands)	BIPA increase in base rates
PacifiCare	1,040	3.0%
Kaiser	752	2.9%
Humana	423	1.6%
United Healthcare	374	2.9%
Aetna U.S. Healthcare	285	1.0%
Health Net	269	1.6%
Highmark	159	1.6%
Independence BC	154	1.0%
BCBS Florida	132	1.1%
HIP	106	1.0%
All other	1,932	4.9%
Total	5,625	3.2%

Source: Base rates for aged beneficiaries weighted by March 2001 enrollment, HCFA market penetration data.

Table 30. Estimated Share of New BIPA Funds by State

State	Average percent increase	Percent of enrollees, March 2001	Percent of BIPA dollars
California	1.5%	19.7%	10.6%
Oregon	17.4%	1.8%	9.1%
New York	5.2%	5.5%	9.0%
Washington	9.9%	2.0%	6.0%
Florida	1.5%	9.0%	5.0%
Pennsylvania	1.6%	6.8%	3.9%
Ohio	3.4%	3.4%	3.7%
North Carolina	16.7%	0.6%	2.9%
Colorado	5.0%	1.7%	2.7%
New Mexico	21.1%	0.4%	2.2%
All other states	2.8%	24.6%	22.4%
U.S. Total	3.2%	100.0%	100.0%

Source: Base rates for aged beneficiaries weighted by March 2001 beneficiary population, HCFA market penetration data.

All of these effects are, in any event, short-term. For 2002, most areas served by CCPs will receive the minimum 2 percent increase in their base rates. As will be discussed in chapter 3, continuing constraints on rate increases in the areas where most CCP enrollees live are likely eventually to jeopardize access in many of these areas.

What CCPs have done with the money

When Congress was considering the payment increases ultimately included in BIPA, the Clinton administration initially opposed any increase and then suggested that existing plans be required to use all payment increases to fund additional benefits for their enrollees. Under the conference agreement, plans could do any of four things with the added payments: reduce premiums or cost-sharing, enhance benefits, deposit the increase in a "stabilization fund" meant to preserve benefits in future years,[27] or "stabilize or enhance beneficiary access to providers"—that is, maintain or expand their provider networks by increasing payments for services.

Overwhelmingly, CCPs have used the money for the last of these objectives. Table 31 shows the change in Medicare payment for an average CCP enrollee in March 2001 and what the typical plan did with the increase. Before BIPA, the average plan expected to spend $419, or about 82 percent of its Medicare payment, furnishing basic Medicare payments. The remaining amount went toward reductions in Medicare cost-sharing and other added benefits. The average enrollee paid a $31 premium, which covered further reductions in Medicare cost-sharing and other benefits.[28] In total, enrollees received $125 in free and paid supplements at a cost of $31.

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[27] Plans have always had the option of setting aside part of the difference between the ACR and the Medicare payment rate in a benefit stabilization fund, to be drawn upon if future Medicare payment increases were insufficient to maintain the current level of supplemental benefits. Before BIPA, no plan had exercised this option for contract year 2000 or 2001.

[28] The premium and benefit values shown are for "mandatory supplements," those that any enrollee must accept. Some plans offer additional optional supplements that may be purchased for a higher premium.

Table 31. Change in Average Monthly Medicare Payment and Use of Funds, 2001 ACR Submissions before and after BIPA

	Before BIPA		After BIPA		Change per member month
	Dollars	Percent of Medicare payment	Dollars	Percent of Medicare payment	
Projected Medicare payment	**$ 513.38**	**100.0%**	**$ 530.21**	**100.0%**	**$ 16.83**
Costs for basic Medicare benefits:					
Services	$ 358.86	69.9%	$ 380.98	71.9%	$ 22.12
Administration	$ 42.12	8.2%	$ 42.13	7.9%	$ 0.02
Surplus	$ 17.67	3.4%	$ 7.38	1.4%	$ (10.29)
Subtotal, basic benefit cost	**$ 418.65**	**81.5%**	**$ 430.49**	**81.2%**	**$ 11.84**
Stabilization fund	-------		**$ 1.92**	**0.4%**	**$ 1.92**
Free supplements					
Reduction in Medicare cost-sharing	$ 68.35	13.3%	$ 70.11	13.2%	$ 1.77
Other free supplements	$ 26.38	5.1%	$ 27.24	5.1%	$ 0.86
Subtotal, free supplements	**$ 94.73**	**18.5%**	**$ 97.35**	**18.4%**	**$ 2.63**
Supplements paid with premium					
Reduction in Medicare cost-sharing	$ 17.08		$ 15.40		$ (1.68)
Other paid supplements	$ 13.60		$ 13.81		$ 0.21
Subtotal, paid supplements	**$ 30.68**		**$ 29.21**		**$ (1.47)**
Total supplements					
Reduction in Medicare cost-sharing	$ 85.43		$ 85.51		$ 0.08
Other free and paid supplements	$ 39.98		$ 41.05		$ 1.07
Subtotal, all supplements	**$ 125.41**		**$ 126.56**		**$ 1.15**
Premium	**$ 30.68**		**$ 28.76**		**$ (1.92)**

Note: Assumes actual enrollee distribution among different available benefit packages is proportionate to distribution projected by plans in their post-BIPA ACR submissions; only enrollees within approved service areas are counted. Only 2001 packages available both before and after BIPA (that is, packages with common identifier codes in the ACR submissions) are included. Columns may not sum due to rounding.
Source: ACR submissions and March 2001 market penetration data.

BIPA increased payments by $17 per member month. Plans increased payments for services by even more, $22 a month. Only $12 of this increase was actually funded through the BIPA payment; the rest came from a reduction in

plans' projected surpluses.[29] Total supplemental benefits, including reductions in Medicare cost-sharing and other benefits, were increased by about $1. In addition, a slightly larger proportion of these benefits was "free"—financed by the difference between Medicare payments and costs for basic Medicare services. As a result, average premiums were reduced by about $2. Finally, the average plan deposited the remainder of the BIPA increase into a stabilization fund. Overall, 71 percent of the new money went for increased spending on basic benefits, while 18 percent went toward enhanced benefits and premium reductions and another 11 percent went into stabilization funds.

Table 32 shows how the new funds were used by plans receiving different levels of rate increases under BIPA. A "plan" here is a specific benefit package offered by a contractor. As before, when one contractor offers multiple plans, estimated enrollment is based on the contractor's projection of the distribution of enrollees among plans. Note also that this table is based on pre- and post-BIPA ACR submissions for 2001. Plans can show a payment increase of less than 1 percent if their pre-BIPA estimate of average Medicare payments was overstated.

Plans receiving the largest payment increases devoted only a slightly larger share of the funds to benefit improvements than plans receiving the smallest increases. However, since the monthly dollar amount of their payment was much larger, the value of the benefit changes was considerably greater. Enrollees in plans that received increases of 10 percent or more got $3.40 a month in additional benefits and a $9.32 premium reduction. Enrollees in plans with an increase below 1 percent got 64 cents in additional benefits and a 9 cent premium reduction.

[29] Plans generally reduced their surplus projections for both basic and supplemental benefits. The change for supplemental benefits has been netted out of the post-BIPA surplus for basic benefits, so that the rows for supplemental benefits will show the gross change in the value of these benefits to enrollees.

Table 32. Use of BIPA Funds by Average Payment Increase over Pre-BIPA Level

	Under 1%	1%- 2.99%	3%- 4.99%	5%- 9.99%	10% and above	Total
Number of plans	145	182	63	58	93	543
Estimated enrollment, March 2001	1,683	2,134	641	463	639	5,560
Projected Medicare payment increase	$ 5.41	$ 8.29	$ 17.85	$ 31.43	$ 63.84	$ 16.83
Percent of increase used for:						
Increased spending, basic benefits	56%	78%	86%	64%	68%	70%
Stabilization fund	30%	5%	0%	15%	12%	11%
Increased benefits/reduced premiums	13%	17%	14%	21%	20%	18%

Note: Assumes actual enrollee distribution among different available benefit packages is proportionate to distribution projected by plans in their post-BIPA ACR submissions; only enrollees within approved service areas are counted. Only 2001 packages available both before and after BIPA (that is, packages with common identifier codes in the ACR submissions) are included. Columns may not sum due to rounding.
Source: ACR submissions and March 2001 market penetration data.

This report will not attempt to assess why CCPs have had to increase their payments to providers or whether this trend is likely to continue. In some areas, there appears to have been a shift from a buyers' to a sellers' market; that is, while several years ago a few health plans with large market share could command discounts from a fragmented provider community, the plans must now negotiate with multi-hospital systems or better-organized physician groups (Freudenheim 2001). For example, PacifiCare's recent decline in earnings has been partly attributed to large rate increases granted to the Tenet hospital chain (Brick). In addition, plans face consumer pressure to maximize provider choice. Aetna U.S. Healthcare has had to modify its physician contracting and utilization review practices in order to assure an adequate physician network (Aetna). In some cases, plans may simply have squeezed all they can from providers. One recent study found that a third of hospitals had canceled one or more managed care agreements, usually citing poor financial results (Deloitte & Touche).

These trends affect health plans' commercial operations as well as their Medicare contracts. Commercial plans either accept declining profit margins or raise their charges to employers, who may in turn seek to pass them on to employees. The same is true under Medicare: in effect, both the program and

beneficiaries have paid for the increase in CCP costs for providing basic Medicare benefits. These costs rose about $55 per member month between 2000 and 2001. Medicare payments rose by $31, while beneficiaries received $27 a month less in free supplements. (These two figures sum to more than $55 chiefly because $2 of the Medicare payment increase went into stabilization funds.)

Table 33. Change in CCPs' Medicare Cost, Medicare Payment, and Free Supplements, 2000-2001

	2000	2001	Change
Average cost for Medicare services	$ 375.13	$ 430.49	$ 55.36
Average Medicare payment	$ 499.42	$ 530.21	$ 30.79
Average free supplements	$ 124.30	$ 97.35	$ (26.95)

Source: ACR submissions for 2000 and 2001 (post-BIPA). Contracts terminated for 2001 are excluded from the 2000 data.

Assuming no change in the geographic distribution and other characteristics of current CCP enrollees, average Medicare payments for 2002 will increase by 2.9 percent, or about $15.55 per member month. Full ACR submissions for 2002 are not due until September of this year, but it seems almost inconceivable that plans will hold increases in their basic Medicare service costs to this level. The result will almost certainly be further erosion in the supplements offered to enrollees.

The Part B premium waiver and alternate competitive structures

Before BIPA, any difference between a plan's ACR for basic Medicare benefits and its Medicare payments had to be returned to beneficiaries in the form of supplemental benefits or reduced Medicare cost-sharing. However, all CCP enrollees continued to pay the full part B premium, $50 a month in 2001. Under BIPA, beginning with contract year 2003, a plan may use some or all of the difference between its ACR and its Medicare payment rate to reduce enrollees' part B premium. A plan would exercise this option by agreeing to a fixed reduction in its Medicare payments. Twenty percent of this reduction would be retained by the government, while the rest would be used to reduce premiums. Thus, if a plan were in a position to accept a reduction of $62.50 in its monthly Medicare payments, its enrollees would pay no part B premium, while the government would realize net savings of $12.50 a month.

This provision strongly resembles similar rules under the Medicare proposal included in President Clinton's 2001 budget plan and under one of the two Breaux/Frist plans (S. 358, labeled Breaux-Frist II here) introduced in the

107th Congress. None of these plans goes as far toward introducing price competition into Medicare as would the other Breaux/Frist proposal introduced this year (S. 357, or Breaux-Frist I), which is largely modeled on the restructuring proposal offered by the co-chairmen of the National Bipartisan Commission on the Future of Medicare, Sen. Breaux and Rep. Thomas, in 1999.

Table 35 compares the BIPA rules to those under the BBA and under three alternatives.

Plan price. Under BBA, a plan quotes a price for the basic Medicare benefits (the ACR) and then in effect quotes a second price for a broader package of benefits it intends to offer enrollees.[30] This second price, in effect a bid amount for a plan-designed benefit package, must at least equal the plan's expected average Medicare payment for the basic benefits. It may be greater, in which case enrollees will have to pay a supplemental premium (see below). BIPA leaves this system intact, as do the two Breaux-Frist plans (with complications, not considered here, related to the inclusion of a high-option plan that includes drugs). The Clinton proposal had a significant difference: the plan would bid solely on the basic Medicare benefit package, rather than on a plan-designed package that included supplements.

[30] For the purpose of simplicity, the following discussion ignores the option of establishing a benefit stabilization fund.

Table 34. Prices, Benefits, and Beneficiary Costs under Medicare + Choice and Alternative Plans

	BBA	Breaux-Frist I (S. 357)	Breaux-Frist II (S. 358)	Clinton 2001 budget proposal	BIPA
Plan price	Local bid price for plan-designed package.	Local bid price for plan-designed package, adjusted for risk.	Local bid price for plan-designed package, adjusted for risk.	Local bid price for basic Medicare benefits only (limited reduction in cost-sharing permitted), adjusted for risk.	Local bid price for plan-designed package.
Benchmark	Local Medicare payment rate (base AAPCC modified by floor, minimum increase, and blend rules), partially adjusted for risk.	National weighted average of bid prices for basic Medicare benefits, including "bid" for original Medicare, adjusted for risk and local input prices.	Greater of local BBA rate or AAPCC, adjusted for risk.	Greater of local BBA rate or 96 percent of AAPCC, adjusted for risk.	Local BBA rate, with changes in floor and minimum increase, partially adjusted for risk
Cost/benefit for beneficiary choosing private plan	If plan price equals benchmark, beneficiary pays part B premium and gets any additional	If plan price less than benchmark, beneficiary pays reduced part B premium (0 if plan less than 85 percent of	If plan price less than benchmark, beneficiary may pay reduced part B premium and/or receive additional	If plan price less than benchmark, beneficiary pays reduced part B premium. Beneficiary pays separately for any	If plan price less than benchmark, beneficiary may pay reduced part B premium and/or receive additional

	BBA	Breaux-Frist I (S. 357)	Breaux-Frist II (S. 358)	Clinton 2001 budget proposal	BIPA
	benefits in plan-designed package. If plan price exceeds benchmark, beneficiary pays excess.	benchmark) and gets any additional benefits in plan-designed package. If plan price exceeds benchmark, beneficiary pays excess.	benefits at plan option. If plan price exceeds benchmark, beneficiary pays excess.	additional benefits. If plan price exceeds benchmark, beneficiary pays excess.	benefits at plan option. If plan price exceeds benchmark, beneficiary pays excess.
Cost for beneficiary remaining in original Medicare	Part B premium.	If local Medicare FFS cost is less than adjusted national benchmark, beneficiary pays reduced premium. If local FFS cost exceeds benchmark and alternate plans are available, beneficiary pays difference.	Part B premium.	Part B premium.	Part B premium.

Benchmark. Medicare payment amounts are related to a locally determined benchmark. Under BBA, this benchmark was based on local per capita FFS spending differences in 1997, with all the various adjustments and updates described earlier. BIPA extends this principle, with some modifications in the updates. The Clinton plan and Breaux/Frist II instead would pay the larger of the rate determined under BBA rules or a rate based on area-specific costs (96 percent of those costs under Clinton and 100 percent under Breaux/Frist). The Clinton plan contemplated that the BBA rates would continue evolving until all counties' rates were set at the floor rate or the blend amount. At this point the BBA rates would no longer be calculated; the benchmark for each area would be permanently fixed, with a uniform annual update, at 96 percent of the largest of the floor, the blend, or the area-specific amount. This appears to be the intent of Breaux/Frist II as well, locking at 100 percent rather than 96 percent.[31] Thus low-cost areas would permanently have a benchmark higher than the FFS cost in the area, while high-cost areas would be benchmarked at 96 or 100 percent of FFS.

Breaux/Frist I works very differently. A national benchmark would be set, based on the enrollee-weighted average of the portion of each plan's bid attributable to the basic Medicare benefits. This national average would include a "bid" by original Medicare for beneficiaries remaining in the fee-for-service sector. A local benchmark would then be established by adjusting this national figure for local input prices. This system would have two important potential consequences. First, as enrollment in plans other than original Medicare grew, then—assuming the other plans' bids were lower than that of original Medicare—the national benchmark would gradually fall below the cost of original Medicare. Second, because the local benchmark varies solely by input prices and does not use a national/local blend to reflect other variations in historic local costs, the system would place very rapid price pressure on plans (and original Medicare) in high-cost areas.

Costs and benefits for beneficiaries: private plans. Under the BBA, the Medicare payment is equal to the benchmark. If the plan's price for its plan-designed benefit package is exactly equal to this amount (it can never be less), the enrollee receives any additional benefits in the package at no cost; that is, the plan is a zero-premium plan. If the price exceeds the Medicare payment, the

[31]The bill actually provides that, when all areas' BBA-based benchmark is either the floor or the blend, the entire system abruptly shifts to a benchmark based solely on the area-specific amount. That is, low-cost areas that had been receiving higher amounts under the BBA rules would revert to pre-BBA payment levels. This appears to be a drafting error.

beneficiary pays the difference. All beneficiaries continue to pay the full part B premium.

Under BIPA and all three reform plans, payment to a plan whose bid is below the benchmark may be less than the benchmark amount, and some of the difference may be shared with plan enrollees in the form of a reduced part B premium. However, there is a critical difference between the Clinton proposal and the others. Because, under the Clinton proposal, the plan bids only on the basic Medicare benefits, a plan that bids below the benchmark *must* receive a lower payment and enrollees *must* receive a reduction in their part B premium. Under the other three proposals, a plan that can furnish the basic Medicare benefits for less than the benchmark essentially decides on its own how the savings will be shared with beneficiaries—whether in benefits or premium reductions.[32]

The difference has two key implications. First, under BIPA and the Breaux/Frist proposals, a highly efficient plan could reduce the enrollee's part B premium to zero and also offer extra benefits. Under the Clinton plan, the most the enrollee could receive was the zero premium. Any additional benefits had to be priced separately and paid for by enrollees.[33] The proposal thus limited the potential degree of competition between plans and original Medicare.

Second, while the Clinton proposal mandates a premium reduction, BIPA and Breaux/Frist II leave the decision to the plans and also provide that the government gets a cut of the savings if the plan opts for premium reduction, while the government takes no share if the plan instead chooses to offer enhanced benefits. So, for example, if a plan's ACR were $40 a month below its expected Medicare payments, it could offer either a $32 premium reduction ($30 under Breaux/Frist II) or benefits with an expected value of $40. If all beneficiaries cared equally about benefits and money, plans would always be expected to opt for benefits. However, all beneficiaries don't care equally, and the plans' ability to decide which kind of price signal to send is likely to affect risk selection. Assuming that sicker beneficiaries are more risk-averse, while healthier ones might care more about the premium savings, the effect of BIPA may be to exacerbate favorable selection.

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[32] Because the original Breaux/Frist proposal required no empirical basis for a plan's bid on the basic benefits, a plan could have set its price at the benchmark and simply kept all the savings as profit. The assumption was that market competition would have prevented this "shadow pricing."

[33] If a plan could fudge its ACR, submitting a bid higher than its true cost for the basic benefits, it could use the excess to discount the price for the supplements.

Costs for beneficiaries remaining in original Medicare. Except for the Breaux/Frist I, all the plans hold beneficiaries harmless if they choose to remain in original Medicare; they simply continue to pay the full part B premium and receive no supplemental benefits. Under Breaux/Frist I, if the price for original Medicare (the "HCFA-sponsored plan") is above the local benchmark, the beneficiary would have to pay more than under the current system.[34] (This would not be true if no competing plan was available.)

Proponents of earlier versions of Breaux-Frist I have argued that real competition requires sticks as well as carrots. That is, it is insufficient to offer extra benefits to beneficiaries choosing more efficient plans; beneficiaries remaining in original Medicare need to bear at least some of the cost of that decision. (Nichols) Whatever the merits of this argument, that the sponsors themselves have offered a less draconian alternative suggests a recognition that sticks will not be part of an enacted competition proposal in the near future. However, it is difficult to get even the carrots right without working out the terms under which local M+C plans compete with a national Medicare program.

In sum, the BIPA provisions represent a transitional policy that leaves open some of the basic structural problems in the M+C program.

?? M+C continues to use an administrative pricing mechanism that distorts competition and, as will be seen in the next section, may well force additional plans out of the program in the near future.

?? Over a third of beneficiaries have no access to a coordinated care plan. Financial incentives for plans to enter unserved areas have had little effect.

?? Federal funds are being used implicitly, and haphazardly, to finance supplemental benefits for some lucky beneficiaries. Proposals for a Medicare drug benefit and other program enhancements--explicit in place of implicit federal financing—will complicate this situation and may also affect the competitive position of CCPs.

The next sections will consider each of these problems in turn.

[34] The bill gives no indication that original Medicare itself (the HCFA-sponsored plan) would have been locally priced. Apparently it would have had a single national rate, as the Blue Cross plan and other national plans under FEHBP do. As is the case under FEHBP, original Medicare would then have been more expensive than its competitors in low-cost areas and less expensive in high-cost areas.

Chapter 3: SETTING MEDICARE+CHOICE PAYMENT RATES

The BIPA payment changes represented a one-time infusion of cash into the Medicare+Choice program. The increased rates for 2001 affect the baseline from which future rate increases will be calculated, and will thus raise spending for many years. Beginning with 2002, however, the rating system now reverts to the one established under BBA. The base rate for each county will be the greater of: one of the two floor amounts, a blended rate equal to half of the area-specific amount and an adjusted national amount, or a rate set at a minimum of 2 percent above the prior year's rate. (A fuller explanation of the system is in chapter 1.)

This system was designed to move all rates closer to national average FFS costs, to encourage plans to enter previously unserved low-cost areas and gradually pressure plans in high-cost areas to improve their efficiency. Increases in the low-cost areas would be offset by rate reductions in higher-cost ones. In practice this has not occurred, for several reasons:

?? BBA changes in fee-for-service payments reduced FFS spending so sharply that M+C rates rose faster than the FFS average even in counties receiving the minimum 2 percent increase. In addition, the floor amount was initially raised too rapidly, because HCFA underestimated the effects of BBA on FFS spending.

?? The BBA provided that the blended rates could be implemented only if they did not increase aggregate payments to more than would have been paid if area-specific rates were used. The BBA cuts in fee-for-service spending depressed growth in the area-specific rates. As a result, except in 2000, the budget-neutrality rule foreclosed the use of the blend for the roughly two-thirds of counties that would have been paid on this basis. These counties instead received the minimum 2 percent increase or the floor amount.

?? BIPA increased the floor amount, established a new, higher floor for larger metropolitan areas, and raised the minimum increase to 3 percent for 2001 only.

The result of all this is that, in 2001, the post-BIPA rate in every single county is at least as high as it would have been under the old 95-percent-of-FFS system. Table 35 compares current base rates to "full" FFS. Again, full FFS is

100% (not 95%) of the 1997 AAPCC, updated by the full estimated growth in national per capita FFS spending without the percentage reductions for 1998-2001, minus the full graduate medical education (GME) adjustment. There is no county in which M+C rates are less than 95 percent of this amount. Over three-quarters of beneficiaries, and 62 of percent M+C enrollees, are in counties where rates are over 100 percent of FFS. Nearly a third of beneficiaries, but only 14 percent of M+C enrollees, are in counties where the base rate is 10 percent or more above FFS.

Table 35. Beneficiaries and M+C Enrollees by Ratio of 2001 Post-BIPA M+C Base Rate to Fee-for-Service Average

M+C rate as a percent of full FFS average	Beneficiaries	M+C enrollees
95%-99%	24%	38%
100%-104%	28%	34%
105%-109%	14%	15%
110%-119%	14%	7%
120% and above	20%	7%
Total	100%	100%
Average ratio	109.5%	103.4%

Source: March 2001 market penetration data.

MedPAC (2001) has recently expressed concern about the number of beneficiaries for whom the floor rates have pushed payment amounts substantially above FFS. As they note, relatively few M+C plans are actually receiving these very high rates, so the budgetary impact has so far been fairly small. Still, they believe the current system distorts the market by giving private plans an advantage over original Medicare in the highly overpaid areas. MedPAC recommends (with some qualifications) that rates in all areas be set at the FFS average, so that the system will treat beneficiaries equally whether they choose M+C or original Medicare. The equity concerns raised are important ones, and MedPAC's recommendations will be discussed further below.

However, perhaps a more immediate concern for the program is that the system—which never, as intended, compensated for overpayments in some counties by underpaying in others—is about to do so. In the high-cost areas where many CCP enrollees now reside, rate increases over the next several years are likely to lag far behind growth in Medicare FFS costs. The result may be significant erosion in the current program.

Future payments under current rules

Partly because of payment increases under the BBRA and BIPA, fee-for-service spending has been and will be growing much faster than in the years immediately following the BBA. This means that it will eventually be possible to implement the blend without violating the budget-neutrality rule. Because of the extraordinary increases granted to some areas under the new floors, use of the blend appears unlikely in 2003. However, given HCFA's current projections of growth in the fee-for-service sector for 2003 and 2004, and assuming per capita growth in later years of 5.5 percent per year—the annual per capita increase estimated by CBO (2001) for 2002-2011--nearly all areas should be receiving the floor or the blend by 2008.[35] The transition will be largely complete even sooner, as early as 2005. At that point, 80 percent of counties will be paid using the floor, 16 percent will receive the blended amount, and only 4 percent will receive the minimum increase.

Table 36. Hypothetical Progress toward Full Blend, 2002-2008

	2003	2004	2005	2006	2007	2008
Counties paid using:						
Floor	2668	2766	2614	2629	2633	2638
Blend	0	167	517	563	584	597
Minimum	581	316	118	57	32	14

Source: 2002 rate calculation for aged beneficiaries, with updates of 3.4 percent for 2003, 5.3 percent for 2004, and 5.5 percent for later years.

As table 37 shows, nearly half of all current beneficiaries are in counties where 2005 M+C base payment rates will be below the full estimated cost of the fee-for-service (FFS) program; 29 percent are in counties where the rates will be less than 95 percent of FFS—the savings target used in setting rates before 1998. M+C enrollees are heavily concentrated in counties with a low rate/FFS ratio.[36] Two-thirds are in counties where payment will be less than 100 percent of FFS in 2005, and 46 percent in counties where rates will be less than 95 percent of FFS.

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[35] This estimate uses the area-specific population, demographic, and medical education factors used in the 2002 rate calculations. The calculations thus assume that beneficiary distribution and characteristics and area GME variation will go unchanged.

[36] Again, "full" FFS is 100% (not 95%) of the 1997 AAPCC, updated by the full estimated growth in FFS spending without the percentage reductions imposed for 1998-2001, minus the full medical education adjustment.

Table 37. Beneficiaries and M+C Enrollees by Projected 2005 Base Payment Rate as a Percent of Area Fee-for-Service Cost

M+C payment rate as percent of full FFS	Beneficiaries	M+C enrollees
85%-95%	30%	46%
95%-99%	15%	22%
100%-109%	21%	18%
110%-119%	14%	7%
120%-149%	18%	7%
150% and above	2%	0%
Total	100%	100%
Average ratio	106%	98%

Source: March 2001 market penetration data and 2002 rate calculation for aged beneficiaries, with updates of 3.4 percent for 2003, 5.3 percent for 2004, and 5.5 percent for later years.

Table 38, which is at the level of CCP contracts, shows how dramatic a shift from the current situation this represents. After BIPA, no contract has average 2001 payments below 95 percent of FFS in 2001; 71 percent of contracts, representing 69 percent of enrollees, have average payments greater than 100 percent of FFS. By 2005, with no change in the current distribution of enrollees, over a third of contracts, representing 39 percent of enrollees, will have average payments below 95 percent of FFS. Only 28 percent of enrollees will be in contracts with average base payments greater than FFS.

Table 38. M+C Contracts and Enrollees, by Base Payment Rate as a Percent of Area Fee-for-service Cost, 2001 and Projected 2005

Rate as a percent of fee-for-service cost	2001		Projected 2005	
	Percent of contracts	Share of enrollees	Percent of contracts	Share of enrollees
85%-95%	0%	0%	35%	39%
95%-99%	29%	32%	23%	33%
100%-109%	47%	57%	18%	17%
110%-119%	9%	5%	9%	5%
120% and above	15%	7%	15%	6%
Total	100%	100%	100%	100%

Source: March 2001 market penetration data and 2002 rate calculation for aged beneficiaries, with updates of 3.4 percent for 2003, 5.3 percent for 2004, and 5.5 percent for later years.

One key element is missing from these comparisons: risk selection. Most CCPs still have healthier-than-average enrollee populations, and this has never been adequately accounted for in payment rates. As noted earlier, GAO (2000) estimated that in 1998, as a result of favorable selection, plans were paid 13.2 percent more than their enrollees would have cost under original Medicare. The interim risk assessment system adopted by HCFA, the PIP-DCGs, gives a somewhat lower estimate. The CCPs themselves, in their post-BIPA ACR submissions, projected that their enrollees would have an average risk factor of 0.928 on the PIP-DCG scale[37]—meaning that they would be 7 percent less costly than demographically comparable beneficiaries remaining in FFS.

Because Congress has frozen the phase-in of risk adjustment at the current blend, under which only 10 percent of the payment rate is adjusted for risk, the actual rate reduction for the current year was only seven-tenths of 1 percent. Once risk is taken into account, current average payments to CCPs are not 3 percent above FFS, but more than 10 percent above FFS. If the freeze on phase-in of risk adjustment is still in effect in 2005, average payments in that year would be 105 percent of FFS, rather than 98 percent.

That plans have been and may continue to be overpaid, on average, is obviously an important issue; this will be considered in the next section. For the moment, however, let it be supposed that overpayment is not a policy concern and that the prime objective is to maintain at least current levels of plan and beneficiary participation in the M+C program. How likely is it that the payment changes that will occur between now and 2005 under current policy will lead plans to leave the program or to curtail benefits so dramatically that they will cease to be attractive to beneficiaries?

Table 39 compares contractors' expected costs for providing basic Medicare services to their Medicare payments in 2001 and 2005. The cost is confined here to service and administration costs; that is, it is the ACR minus any projected surplus. The figures for 2005 assume that contractors will be able to hold the growth in their service costs to the projected growth in per capita FFS spending. Given CCPs' recent experience, this assumption may be optimistic.

[37] Based on estimated enrollment by benefit package in March 2001, and averaging in the many instances in which plans projected a pro forma risk factor of 1.0.

Table 39. M+C Contracts and Enrollees, by Cost of Providing Basic Medicare Benefits as a Percent of Medicare M+C Payment, 2001 and Projected 2005

	2001		Projected 2005	
Medicare service cost as a percent of Medicare payment	Contracts	Percent of enrollees	Contracts	Percent of enrollees
Under 70%	13	11%	5	6%
70%-79%	57	39%	34	14%
80%-89%	70	38%	79	55%
90%-99%	25	8%	37	18%
100% and above	11	4%	21	7%
Total	176	100%	176	100%

Source: Post-BIPA 2001 ACR submissions and 2005 rate calculations as above.

Currently, 70 contractors, with half of all enrollees, are spending less than 80 percent of their Medicare payments providing basic Medicare services; another 70, with 38 percent of all enrollees, are spending 80 to 90 percent of their payments for basic services. The handful shown as spending more than 100 percent are either subsidizing their Medicare operation from other operations or spending capital, presumably in the hope that their performance will improve in the future. By 2005, only 20 percent of enrollees will still be in contracts where Medicare service costs are less than 80 percent of payments. The rest are likely to see substantial reductions in supplemental benefits. How many contracts would actually be terminated is impossible to guess. However, if one can assume that contractors whose costs exceed payments will not continue indefinitely, and that even contracts where costs are above 90 percent of payments are not very viable, it seems possible that as many as 58 current contracts, with a quarter of all enrollees, could be terminated by 2005.

All of these effects could, of course, occur much sooner. As was noted earlier, the 2002 payment rates already announced would give current contractors an average per-enrollee increase of just 2.9 percent. Until final ACR submissions are received in September, there is no way of knowing how many CCPs will reduce benefits or terminate their contracts, how many will accept a reduced operating margin, and how many will find ways of improving their efficiency sufficiently to maintain current benefits and premiums.

Alternative rate-setting options

MedPAC's recommendation for reforming M+C payments is as follows:

> The Medicare program should be financially neutral as to whether beneficiaries enroll in Medicare+Choice plans or in the traditional Medicare program. Therefore, Congress should make Medicare payments for beneficiaries in the two sectors of a local market substantially equal, after accounting for risk.

This recommendation implies setting rates equal to area FFS costs—with some possible grouping of counties into larger defined market areas to improve reliability—and full implementation of some form of risk adjustment. This might use the PIP-DCG system, the proposed modified system that would consider outpatient as well as inpatient diagnoses, or some entirely different method.

This section will review how current payments to M+C plans would change under four different rating options:

1. The rates projected for 2005 under the current rules, shown in constant 2001 dollars.
2. Rates set equal to 2001 area FFS spending, with no risk adjustment beyond the limited adjustment now in use.
3. Rates held at the 2001 level, but with full risk adjustment using the PIP-DCG scores.
4. Rates set equal to 2001 area FFS spending, with full risk adjustment using the PIP-DCG scores.

The last of these is essentially the MedPAC recommendation, except that MedPAC expresses reservations about all available risk measurement systems and merely "posits" that a more reliable system can be developed.

Table 40 shows how average monthly payments for current M+C enrollees would change under the four systems. All of the systems would reduce current payments. A shift to area FFS, with no change in risk adjustment, has the smallest effect. Adding risk adjustment, either under current payment rules or under a system based on area FFS, leads to much larger rate reductions. Again assuming that what plans must spend providing basic Medicare services remains constant, the average share of payment devoted to these services would rise from

the current 80 percent to anywhere from 82 to 87 percent. This could mean (unless plans improved their efficiency or reduced their surplus) that average dollars available for supplemental benefits could drop from the current $97 a month to as little as $52 under a system resembling that recommended by MedPAC.

Table 40. Change in Average M+C Payment and Medicare Service Cost as a Percent of Payment under Four Rate-Setting Options

	Average payment	Change from current average	Current Medicare service cost as a percent of payment
2001 average payment	$ 530		80%
Payment under:			
2005 rules (in constant 2001 dollars)	$ 502	-5.4%	84%
Area FFS, no change in risk adjustment	$ 517	-2.4%	82%
2001 rules, full risk adjustment	$ 496	-6.4%	85%
Area FFS, full risk adjustment	$ 485	-8.6%	87%

Source: Post-BIPA 2001 ACR submissions and 2005 rate calculations as above.

Free supplements worth over $600 a year are still a pretty good deal. If all plans were affected equally, the shift to a system that was “financially neutral” with respect to beneficiaries’ enrollment decisions would still offer a substantial inducement to enroll. Of course it would produce no savings for the federal government, but at least it would not increase total spending as the current M+C system does.

However, all plans would not be affected equally. A shift to a financially neutral system—area FFS and full risk adjustment—would probably drive current contractors out of the program even more rapidly than the payment changes scheduled to occur under current rules. Tables 41 and 42 show the range of payment reductions under the four systems, first by the number of M+C contracts affected and then by the proportion of current enrollees in these contracts.

Table 41. M+C Contractors, by Change in Average M+C Payment under Four Rate-Setting Options

Change in average M+C payment	2005 rules (in constant 2001 dollars)	Area FFS, no change in risk adjustment	2001 rules, full risk adjustment	Area FFS, full risk adjustment
Greater than -30%	0	2	0	10
-21% -- -30%	0	10	9	32
-11% -- -20%	20	28	68	54
-6% -- -10%	58	25	24	31
Zero -- -5%	98	59	38	25
Greater than zero	0	52	37	24
Total	176	176	176	176

Source: Post-BIPA 2001 ACR submissions and 2005 rate calculations as above.

Table 42. M+C Enrollees, by Change in Contractor's Average M+C Payment under Four Rate-Setting Options

Change in average M+C payment	2005 rules (in constant 2001 dollars)	Area FFS, no change in risk adjustment	2001 rules, full risk adjustment	Area FFS, full risk adjustment
Greater than -30%	0%	0%	0%	2%
-21% -- -30%	0%	3%	1%	8%
-11% -- -20%	6%	8%	39%	35%
-6% -- -10%	52%	9%	15%	14%
Zero -- -5%	42%	38%	16%	18%
Greater than zero	0%	42%	30%	22%
Total	100%	100%	100%	100%

Source: Post-BIPA 2001 ACR submissions and 2005 rate calculations as above.

Under the current rules for 2005, most contractors would see rate reductions in the range of zero to 10 percent. No contractor would receive an overall increase. The floor rates increase zero in constant dollars, while the minimum increase of 2 percent a year is negative in constant dollars. A few contractors operate in counties where the blend raises rates, but all of them also operate in some minimum increase counties, so their average increase is negative.[38]

[38] Use of blended rates would increase payments in only 127 of the 517 counties that would receive the blend in 2005.

A simple shift to area FFS, without risk adjustment, would mean fairly small rate increases or decreases for most contractors and most enrollees. Still, 40 contractors, with 11 percent of enrollees, would see payment reductions of greater than 10 percent. Using current 2001 rules but adding full risk adjustment would cause rates for 37 percent of enrollees to drop by more than 10 percent, while it would increase rates for contractors serving almost a third of enrollees.

Finally, under the system using area FFS and full risk adjustment, rates would drop by more than 10 percent for 96 contracts, representing 45 percent of current enrollees. At the same time, rates would increase for 24 contracts with about one-fifth of the enrolled population. It should be noted that the enrollees under these contracts are the only ones for whom the available measures (whatever their inadequacies) allow the conclusion that Medicare is actually saving money in 2001.

How would all of these changes affect contractors' ability to stay in business and offer attractive supplements? Tables 43 and 44 show changes in the proportion of Medicare payments that would be used to fund basic Medicare services, again by the number of CCP contracts affected and then by the proportion of current enrollees in these contracts. As before, these tables assume that plans hold their Medicare service costs constant in real dollars.

Table 43. M+C Contracts, by Medicare Service Cost as a Percent of Average M+C Payment under Four Rate-Setting Options

Medicare service cost as a percent of Medicare payment	Current payments	2005 rules (in constant 2001 dollars)	Area FFS, no change in risk adjustment	2001 rules, full risk adjustment	Area FFS, full risk adjustment
Under 70%	14	6	14	7	7
70%-79%	60	35	47	39	31
80%-89%	69	80	48	45	38
90%-99%	23	35	30	52	34
100% and above	10	20	37	33	66
Total	176	176	176	176	176

Source: Post-BIPA 2001 ACR submissions and 2005 rate calculations as above.

Table 44. M+C Enrollees, by Medicare Service Cost as a Percent of Contractor's Average M+C Payment under Four Rate-Setting Options

Medicare service cost as a percent of Medicare payment	Current payments	2005 rules (in constant 2001 dollars)	Area FFS, no change in risk adjustment	2001 rules, full risk adjustment	Area FFS, full risk adjustment
Under 70%	12%	8%	12%	7%	6%
70%-79%	42%	17%	40%	33%	35%
80%-89%	35%	52%	25%	23%	14%
90%-99%	9%	16%	12%	27%	24%
100% and above	3%	7%	10%	11%	21%
Total	100%	100%	100%	100%	100%

Source: Post-BIPA 2001 ACR submissions and 2005 rate calculations as above.

The effect of the 2005 rules was discussed earlier. Fewer plans can provide Medicare services at 80 percent or less of payments; many wind up with a cost/payment ratio greater than 90 percent, the level suggested earlier as a possible threshold for viability.

The effect of shifting to rates based on area FFS, without additional risk adjustment, is interesting. About the same number of plans might be driven out of the program as under the 2005 rates. For those that remain, however, the distribution of cost/payment ratios does not change very much, suggesting that these plans might be able to offer roughly the same level of supplements as before.

Paying under 2001 rules, while adding full risk adjustment, markedly increases the number of plans with cost/payment ratios above 90 percent. At the same time, it leaves about 40 percent of enrollees in plans with a cost/payment ratio below 80 percent. Finally, combining rates based on area FFS with full risk adjustment would drive 100 plans, with nearly half of all enrollees, above the 90 percent cost/payment level. The proportion of enrollees in plans with very low cost/payment ratios would be about the same as under risk adjustment alone—41 percent, compared to 54 percent under current rules.

What does all this tell us about the current payment system and about which alternatives might be preferable? Under the current system, 152 out of 176 contractors are apparently being overpaid, in terms of area FFS costs, relative enrollee risk, or both. As many as 65 contractors, with one-fifth of all enrollees, are currently providing basic Medicare services at a cost greater than 100 percent of what they would be paid under a system based on area FFS and risk

adjustment. This means that *all* of their supplemental benefits and any profit they are realizing is being financed by the overpayment.[39] Some of these plans are very small or recent start-ups and cannot be expected to operate very efficiently. Others are large and well-established; arguably the overpayment under the current system has left them with no incentive to improve their efficiency.

At the same time, 24 contractors, again with about one-fifth of all enrollees, are being paid less than they would receive under a system based on area FFS and risk. These contractors (and only these contractors) are actually saving money for the Medicare program and furnishing valuable supplements to enrollees. The remaining contractors, serving about 60 percent of all enrollees, are being overpaid to some extent but are also furnishing the basic Medicare benefits at a cost below FFS. In effect, supplemental benefits for enrollees in these mid-range plans are being financed partly by overpayment and partly by efficiency.

It must be emphasized that all of the estimates in this section rest on some heroic assumptions: that plans are correctly estimating and reporting their costs for basic benefits; that the PIP-DCG measures are valid and are also correctly estimated by plans; that 1997 county-level FFS spending was correctly estimated; and that FFS spending in every county has risen uniformly at the same rate as the national average. (The last of these seems especially unlikely, although it is the key assumption of the current rate-setting system.) While the numbers are shaky, they point to what might have been obvious in any event: that some plans really are much more efficient than Medicare, others may thrive only because of inadequacies in the rate-setting system, and many more are somewhere in between.

There is no way of knowing whether plans in any of these categories are operating as efficiently as they could. The BBA system places pressure on plans with high-risk enrollees or operating in high-cost areas, whether or not they are operating efficiently, and rewards plans in low-cost areas with low-risk enrollees. The current rate-setting method is a blunt instrument, for two reasons.

First, of course, because risk adjustment has never been implemented. Whatever the technical and political barriers to putting an acceptable system in place, there are still plans actively recruiting healthy beneficiaries and being rewarded for doing so. (The author encountered, in June 2001, a plan web page

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[39] In theory a plan could be paid less than an area/risk rate and spend more than that rate; there happens to be no such case in 2001.

that highlighted discount gym memberships for seniors. Perhaps this primordial selection technique can be characterized as health promotion.)

Second, because—as MedPAC points out—we still lack even the most minimal understanding of why FFS spending varies so much in different areas. The methodology adopted for the blended rates assumes that any spending differences among areas that are not attributable to differences in input cost must reflect differences in "efficiency"—variation in provider practice patterns or in other factors that are not clearly related to quality and access.[40] While it has been shown that there is inexplicable variation in the use of specific high-cost procedures or services, no one has ever really established how much of the *aggregate* spending difference among areas reflects practice patterns, as opposed to unmeasured socioeconomic, epidemiological, and other factors that may affect the need for care. Even if efficiency differences did explain all variation, it is not clear that plans can squeeze all the inefficiencies out of current service provision in the very short time frame being allowed without compromising quality. After all, if plans could identify and correct every inefficient practice, so could the fee-for-service program.

As analysts have been pointing out for some years, the problem here stems from the use of administered prices. In the absence of a clearer understanding of the sources of cost variation and the extent to which this variation could be reduced by efficient plans, arbitrary targets are set that may be too high or too low. The commonly offered alternative is to let competition set the "right" price for each area. Plans would bid a rate for the Medicare benefit package (whether or not expanded to include drugs or other supplements). Medicare's payment in a given area, and hence the share to be paid by beneficiaries, would be based on some average or percentile of these bids.

Attempts by HCFA to test such a system through competitive pricing demonstrations in selected localities have been blocked repeatedly, partly because of resistance by health plans.[41] Plans might be more interested in this

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[40] There may also be questions about the input price measure itself. Of the 30 metropolitan areas with area-specific rates more than 15 percent above an input price-adjusted national rate, 11 had per capita incomes ranking in the bottom fifth for all metropolitan areas, and 14 were in the bottom two-fifths. Because the price adjuster relies heavily on area wages, an area may be classed as high-cost because it is low-income. Compare, for example, the West Palm Beach and Texarkana areas, whose per capita income differed by 100 percent in 1994. West Palm Beach has an area-specific rate of $613, 25 percent above the national average before input price adjustment; Texarkana has an area-specific rate of $534, 8 percent above the national average. After the price adjustment, both come out over 20 percent above their imputed national rate, largely because the wage index for West Palm Beach is 25 percent higher than that for Texarkana.

[41] For a set of conflicting post-mortems on the competitive pricing demonstrations, see *Health Affairs*, Sep/Oct 2000.

approach as the BBA blend continues to arbitrarily squeeze their rates. However, one of their principal objections was that original Medicare was not brought into the proposed demonstrations. The problem of how original Medicare should "bid," and how this bid should affect what beneficiaries who wish to remain in it must pay, remains the most difficult issue in the design of a competitive system. If Medicare is priced locally, private plans in high-cost areas can "shadow price"—bid above their real cost but below the Medicare figure—while plans may continue to refuse to enter low-cost areas. If Medicare is priced nationally, even with local input adjustments, the reverse occurs: Medicare effectively underbids in high-cost areas, and plans have difficulty competing.

The major competition proposal on the table, Breaux/Frist I (S. 357), does not really resolve this issue. As was discussed earlier, this plan relies on comparison of plan bids to local benchmarks set on essentially the same principles as the national component of the BBA blend. Plans would still in effect be competing against arbitrary administratively set targets, rather than operating in a true market. Perhaps the underlying problem is that, even if it makes sense in theory to let original Medicare enter the competition like any other health plan, it is too big a gorilla to be allowed to act like a real business. A private health plan is free to price itself strategically—perhaps low-balling in some areas to retain market share and making up its losses in other areas where it faces limited competition.[42] As it is inconceivable that original Medicare could be allowed the same latitude, it enters the competition on the leash of administered prices. This is likely to be true in some way no matter how a competition proposal is designed. The question of what is a "fair" price will therefore remain a political one for the foreseeable future.

The current rate-setting approach is almost certainly not the answer. It seeks to expand geographic access to private plans—with, as will be discussed in the next section, little success—by overpaying in low-cost areas. Arguably, some areas might have historically low costs because beneficiaries have inadequate access to medical care. But it is hard to see how the arrival of private health plans would fix this. The whole premise of M+C is that there is fat in Medicare spending and that more efficient private plans can reduce the excess. The BBA rating system actually creates fat where there was none so that plans will have something to cut. It then seeks to finance this by rapid compression of payments in higher-cost areas; but this balancing will not work if plans are driven out of

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[42]Under current law, the ACR process is supposed to prevent this by requiring an empirical basis for plan prices. BIPA seeks to strengthen this requirement by requiring the HCFA actuary to review plan ACR submissions. However, because plans offer many products to many purchasers, it may never be possible to establish the "true" cost of any one product. Even to attempt to do so is fundamentally incompatible with a market approach, as Breaux/Frist I acknowledges by dispensing with the ACR altogether.

those areas. If rates are driven down faster than plans can respond with efficiency improvements, the program will simply sacrifice whatever more modest efficiencies might have been achieved, as well as any prospect of further improvement in the future.

This problem was implicitly recognized in the Clinton proposal and in Breaux-Frist II (S. 358), which would leave the BBA payments in place for low-cost areas and take a fixed 4 percent saving (or no saving under Breaux-Frist) against area-specific costs in high-cost areas. Four percent is not very much--it will not preserve Medicare—while no saving is no saving. Another option is simply to return to payments based entirely on area-specific costs, as MedPAC recommends. If this is done with the very gradual phase-in of risk adjustment contemplated under current law, the results in the near term would resemble those shown above under the label, "Area FFS, no change in risk adjustment." This would sustain some level of supplemental benefits for most current enrollees, at the price of driving out of the program the plans in lower-cost areas that serve 10 to 20 percent of current enrollees. The latter effect could be alleviated through some less abrupt shift from floor rates to area-specific ones—yet another blend, that would gradually lower rates in the counties where the floor rates overpay most egregiously. (A valuable side effect would be to discourage indemnity insurers from seeing the PFFS option as a potential bonanza in those counties.)

In sum, it may be possible to increase pressure on plans more gently and gradually than the BBA system does. It must be recognized that most plans still have only a few years' experience in dealing with the Medicare population, and are just beginning to learn how to deal with needs quite different from those presented by the employer groups they were originally structured to serve. The choice may be between killing the system in the hope of rapid savings and growing it slowly.

At the same time, it is clear that use of area-specific costs cannot be a permanently satisfactory way of establishing the right price for health plans. If, as suggested here, it may never be possible to escape administered prices altogether, better methodologies can certainly be developed. This will require ongoing research into the sources of cost variation and identification of those factors that might be addressed through greater efficiency and those that are more intractable.

Chapter 4: ACCESS TO M+C PLANS

A key aim of the BBA, as the conference report indicates, was to make alternatives to original Medicare available in more areas:

> In addition to ensuring more health care delivery options for Medicare beneficiaries, the conference agreement also ensures that these options will be available to beneficiaries nationwide, not just to those in select geographic areas. By blending local and national payment rates and by instituting a minimum payment amount, the agreement significantly narrows the range in capitated payments to Medicare risk plans…It is the intent of the Conferees that these payment reforms will provide incentives for health care organizations to broaden and multiply their service areas beyond their current areas of concentration to reach all Medicare beneficiaries, including those in rural America. (U.S. House 1997)

In essence, the strategy was to pay more than FFS costs in low-cost areas, in order to encourage plans to enter these areas. The BBRA of 1999 added a further enticement in the form of payment bonuses for plans entering counties that had no plan: 5 percent in the first year after entry and 3 percent in the second.

The payment increases did not achieve their goal. In 2001, 36 percent of counties, with 18 percent of all beneficiaries, have no M+C plan available. Another 43 percent of counties, again with 18 percent of all beneficiaries, have only the Sterling Life Insurance private fee-for-service plan and no CCP. While there has been considerable attention to the lack of access to CCPs in rural areas, there are many unserved counties in MSAs, as table 45 shows. Beneficiaries in smaller MSAs are only a little more likely to have access to a CCP than those in rural counties adjacent to an MSA. As table 46 shows, more than two-fifths of beneficiaries without CCP access are in MSAs.

Table 45. Percent of Counties and of Beneficiaries in Counties with Access to a CCP, by County Type, 2001

	Counties	Percent with CCP	Beneficiaries (thousands)	Percent with access to CCP
Central counties of MSAs of 1 million population or more	180	87%	16,370	96%
Fringe counties of MSAs of 1 million population or more	132	60%	1,453	69%
Counties in MSAs of 250,000 to 1 million population	319	53%	9,079	70%
Counties in MSAs of fewer than 250,000 population	206	21%	3,391	26%
Total in MSAs	837	54%	30,292	79%
Non-MSA county, adjacent to MSA	1,001	15%	5,334	24%
Non-MSA county, not adjacent to MSA	1,308	4%	4,229	7%
Total	3,146	21%	39,856	64%

Source: March 2001 market penetration data, Medicare Compare, and county classification based on Rural-Urban Continuum codes developed by the Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture. Codes were unavailable for a small number of counties in the HCFA data.

Table 46. Beneficiaries without Access to a CCP, by County Type, 2001

	Beneficiaries without access to a CCP (thousands)	Percent of all beneficiaries without access
Central counties of MSAs of 1 million population or more	607	4%
Fringe counties of MSAs of 1 million population or more	454	3%
Counties in MSAs of 250,000 to 1 million population	2,700	19%
Counties in MSAs of fewer than 250,000 population	2,493	17%
Total in MSAs	6,254	44%
Non-MSA county, adjacent to MSA	4,052	28%
Non-MSA county, not adjacent to MSA	3,942	28%
Total	14,248	100%

Source: March 2001 market penetration data, Medicare Compare, and county classification based on Rural-Urban Continuum codes.

It was shown earlier that post-BIPA rates, relative to local fee-for-service costs, were higher in counties without access to a CCP that in counties with a CCP (see table 28). This was true, overall, in both metropolitan and nonmetropolitan areas. However, as table 47 shows, the difference between CCP and non-CCP counties varies by county classification.

Table 47. Post-BIPA M+C Payment Rates as a Percent of Area Fee-for-Service Cost, by CCP Access and County Type

County classification	M+C rates as a percent of FFS		Ratio, no CCP to has CCP	Percent of beneficiaries with CCP access
	No CCP	Has CCP		
Metropolitan				
Central counties of MSAs of 1 million population or more	111%	102%	1.09	96%
Fringe counties of MSAs of 1 million population or more	107%	106%	1.01	69%
Counties in MSAs of 250,000 to 1 million population	116%	107%	1.08	70%
Counties in MSAs of fewer than 250,000 population	111%	108%	1.02	26%
Nonmetropolitan				
Urban population of 20,000 or more, adjacent to an MSA	113%	107%	1.05	34%
Urban population of 20,000 or more, not adjacent to an MSA	116%	112%	1.03	12%
Urban population of 2,500 to 19,999, adjacent to an MSA	112%	106%	1.06	20%
Urban population of 2,500 to 19,999, not adjacent to an MSA	114%	117%	0.97	5%
Completely rural or fewer than 2,500 urban population, adjacent to an MSA	112%	111%	1.01	12%
Completely rural or fewer than 2,500 urban population, not adjacent to an MSA	114%	117%	0.97	4%

Source: March 2001 market penetration data, Medicare Compare, post-BIPA rates, and county classification based on Rural-Urban Continuum codes.

The overpayment of non-CCP counties is generally largest for the types of counties where beneficiaries are already most likely to have access to a CCP. While the rising tide of BIPA may have raised all ships, it may not have targeted the new funds well enough to overcome whatever other differences may exist between served and unserved counties.

As for the entry bonus, it has had virtually no effect on participation by CCPs. Instead, the major beneficiary was the Sterling plan, which qualified for the bonus in 74 percent of the 1,662 counties it entered in 2000. (Its entry into these counties has the effect of foreclosing a bonus for any CCP that might consider entering the same counties. Proposals in the last Congress would have allowed a bonus when a CCP entered an area with only other plan already present.)

Barriers to M+C Access

Merely raising rates above FFS has done little expand access while, as the previous chapter suggested, allowing some inefficient plans to prosper entirely as a result of the overpayment. Clearly there are barriers to expansion other than Medicare payment levels. MedPAC's recent report, *Medicare in Rural America* (2001a), identifies a number of these barriers in rural areas, including difficulty in forming provider networks in isolated areas; low population density and income; absence of large employers (who might offer a CCP to retirees); and utilization levels at or below those in urban areas, leaving little room for efficiency gains.

All of these factors are undoubtedly at work, and this report will not repeat MedPAC's thorough analysis of them. Instead, it will draw attention to two other problems that may also have prevented CCP expansion in small metropolitan and rural areas.

First, while M+C payment rates are above FFS levels in unserved areas, FFS payment rates themselves are not equally adequate in all areas. For example, Medicare payments for inpatient hospital services are above the cost of delivering services for hospitals in large urban areas (defined as those with a population greater than 1 million, or 970,000 in New England). In smaller urban areas, they are below the cost of delivering service, and in rural areas far below cost. Table 48 suggests that what private insurers have to pay is inversely related to what Medicare is paying. The greater hospitals' losses on Medicare, the more they may need to cross-subsidize these losses through higher charges to other payers. A CCP seeking to enter an area where hospitals had negative margins would not only be unable to secure discounts from Medicare rates, but might have to offer more than Medicare pays.

Table 48. Ratio Payment to Cost by Hospital Location and Source of Payment, 1999

	Medicare	Private payers
All hospitals	101.1	112.3
Urban	99.7	113.0
Large urban	101.2	108.1
Other urban	97.8	120.5
Rural	90.4	134.2

Source: MedPAC 2001. Large urban areas have a population greater than 1 million (970,000 in New England).

Market-level research would be needed to verify that plans in smaller urban and rural areas may be facing this kind of price pressure from providers. Data from 2001 ACR submissions do show that plans in large urban areas devote a smaller share of their M+C payments to hospital inpatient costs. Without utilization data, however, this comparison is merely suggestive. In any event, it seems clear that, if original Medicare is commanding steeper discounts from providers in some areas than in others, CCPs will have greater difficulty competing in those areas.

A second barrier to competition by CCPs outside large urban areas is limited ability to offer attractive supplemental benefits. MedPAC has observed that benefits appear to be poorer in rural areas. The Actuarial Research Corporation estimates of relative actuarial values of total plan benefit packages confirm this. Again, these estimates score plans on a scale of zero to 1, with the value of benefits under original Medicare equal to 0.5975. The supplemental benefit values shown in table 51 are the total benefit value estimated by Actuarial Research minus the value of original Medicare. Supplemental benefit values for plans in large urban areas are about 60 percent higher than those for plans in smaller urban and rural areas.

Table 49. Average Value of Plan Supplements, M+C Payment, and Share of Payment Available for Supplements, by CCP Location, 2000

CCP location	Average supplemental benefit package value	Average M+C payment	Share of M+C payment available for supplements
Large urban	0.191	$ 514	26%
Other urban and rural	0.120	$ 442	23%
Ratio, large urban/other urban and rural	1.60	1.16	1.12

Source: ACR submissions for 2000 and benefit value estimates by Actuarial Research Corporation. Large urban areas have a population greater than 1 million (970,000 in New England).

This is only partly because large urban plans are more "efficient"; they do spend a slightly smaller portion of their M+C payments furnishing basic Medicare benefits and so have a slightly larger share left over for supplements. At least as important, however, is that the M+C payments are larger in the first place. The difference in the dollar value of the M+C payment explains 31 percent of the difference in benefits, while the efficiency difference explains 24 percent of the benefit difference. (The remaining difference is due to uninvestigated factors.)

The apparent explanation is that the cost of furnishing a given package of supplemental benefits in different areas does not necessarily vary in proportion to the cost of furnishing basic Medicare services. This problem has important implications for the design of any competition system under Medicare; it will be discussed further in chapter 5.

In thinking about how CCPs might be induced to enter unserved areas, it is useful to distinguish between areas that are near a currently participating CCP—rural counties adjacent to an MSA or unserved counties within an MSA with a CCP—and areas that are not. An existing CCP might be encouraged to enter nearby areas through rate increases (BIPA might already have this effect over time) or through a requirement that CCPs serve an entire MSA or other defined market area. Areas where there is no CCP at all present a much more difficult problem.

The BBA was enacted at a time when a few large managed care companies were striving for something resembling nationwide coverage and were prepared to accept initial losses in new areas with the expectation that their operations would eventually become profitable. No company is pursuing this strategy now.

While some regional HMOs might still expand into nearby areas, it can no longer be expected that a new outpost of a national chain will magically sprout in an unserved MSA. In fact, some of the largest unserved MSAs in 2001 are ones that a major chain has just abandoned. It seems improbable, even with the BIPA rate increases, that these companies will reverse their decisions in the near future.

This section will consider two strategies for stabilizing existing access to M+C coverage: defined minimum service areas and multi-year contracts. It then explores two approaches for expanding access, contracts with national or regional plans and initiatives to encourage development of new local organizations. It reviews options for expanding access for employer groups. Finally it will consider the implications for M+C if the system permanently makes choices available in some areas and not in others.

Improving access in areas with a nearby CCP

Defined service areas

Plans are allowed to define their Medicare service areas and to add or drop counties in those areas from year to year. Usually at least one CCP is available throughout a metropolitan area or none is available in any part of the area.[43] For 2001, there are 36 MSAs in which some counties have access and others do not. There are 89 unserved counties in such areas, with just under 1 million Medicare beneficiaries. Some of these counties may never have been served, while others were affected by the recent rounds of service area reductions. Of 239 counties dropped in service area reductions for 2001, 54 were in primary MSAs where the contractor maintained a presence.

Table 50. CCP Access for Counties within PMSAs, 2001

Coverage in MSA	MSAs	Total counties	County has CCP	No CCP
All counties served[a]	128	294	294	0
Some counties served	36	247	158	89
No counties served	153	306	0	306
Total	317	847	452	395

[a]All counties are served if there is some CCP in every county, whether or not any one CCP covers the entire MSA.
Source: Medicare Compare.

[43] The tables in this section treat PMSAs within a CMSA separately, because it is unlikely that a CCP could be required to cover an entire CMSA.

Table 51. CCP Access for Beneficiaries within PMSAs, 2001

	Beneficiaries (thousands)		
Coverage in MSA	Total eligibles	County has CCP	No CCP
All counties served[a]	16,328	16,328	0
Some counties served	8,849	7,851	998
No counties served	5,424	0	5,424
Total	30,602	24,179	6,423

[a]All counties are served if there is some CCP in every county, whether or not any one CCP covers the entire MSA.
Source: Medicare Compare.

Medicare risk contractors were initially expected to have Medicare service areas identical to those established for the commercial market. (Commercial service areas do not necessarily conform to MSAs.) The current rule allowing selection of individual counties dates from 1987, at a time when individual county rates fluctuated dramatically from year to year. The BBA considerably reduced year-to-year fluctuation in individual county rates, but left in place wide rate variations among counties in a given market that reflected variations in the base FFS experience.

BIPA reduced these variations: as table 52 shows, the proportion of MSAs in which all counties are paid at the same rate has gone from 49 percent in the original 2001 calculation to 73 percent. This is chiefly because all the counties in an MSA are being paid under one or the other of the two new floors. Variation may diminish further as more counties are paid blended rates, because the input-price factors used to adjust the national portion will often be the same throughout an MSA.

Table 52. Variation in County Base Rates within MSAs, 2001, before and after BIPA Changes

Rate variation within MSA	Original 2001 rates		BIPA rates	
	MSAs	Percent	MSAs	Percent
None	156	49%	231	73%
0-5%	50	16%	34	11%
5-10%	39	12%	23	7%
10-20%	50	16%	16	5%
Over 20%	22	7%	13	4%
Total	317	100%	317	100%

Source: Rate notices for 2001.

Given these changes, it is reasonable to ask whether plans should now be expected to cover entire MSAs, some other defined area[44], or at least those parts of an MSA in which they offer coverage to commercial clients. The last of these might be preferable, as it would let the market draw the boundaries and would not require plans to expand into areas where they have no provider network—although it would require them to assure that the providers serving their commercial enrollees were prepared to accept Medicare enrollees as well.

Defined market areas would not only potentially extend access to more beneficiaries, but would also improve stability. M+C enrollees would no longer have to be concerned that they would lose enrollment because of year-to-year service area changes. However, this option also has serious disadvantages. Some plans might drop entire MSAs if they were required to serve areas they believed to be unprofitable or in which they had particular difficulty maintaining provider networks. New entry into MSAs by existing plans, or start-ups of new plans, might be discouraged if the plans had to cover all parts of the area immediately. Finally, plans would have incentives to discourage enrollment in the areas they did not wish to serve, either through selective marketing efforts or by forming provider networks that, while meeting minimum Medicare access standards, were unattractive or inconvenient for beneficiaries. Some of these problems might be addressed by reducing or eliminating rate variation in those areas where large variations still exist. [45] However, as the averaging involved

[44] One way of defining an area might be all those contiguous counties for which identical price adjusters are used in computing the national component of payment rates.
[45] MedPAC (2001a) suggests that rates should be computed for some larger market area than a county, to improve sample size and reliability; this is not the same as saying that a plan's market area must be coterminous with a rate-setting area.

would probably reduce payments in the areas plans are currently serving, it might increase the likelihood that some plans would abandon entire markets.

Whether it is practical for Medicare to specify service areas might depend on its buying power in a particular market. A large employer may press a health plan to expand its service area so that most or all employees have access; whether the plan will respond depends on how important the employer's business is. Similarly, Medicare may be in a better position to define service areas in markets where M+C penetration is above some threshold and some plans are heavily reliant on its business.

Multi-year contracts

Plans could be encouraged or required to enter into multi-year contracts. These might include a commitment by the plan to maintain a defined set of benefits in a defined service area for the duration of the contract, presumably in return for some commitment from Medicare about future payment levels. This would entail risks for both sides. Plans may have difficulty projecting costs very far into the future—perhaps especially for prescription drugs, but also for the basic benefits. Medicare's projections are equally uncertain: if it agreed to a multi-year rate just before a slowdown in fee-for-service spending, it would pay more than under the current year-by-year system. Still, it ought to be possible for Medicare and contractors to agree to more stable arrangements.

One major barrier is the risk adjustment system, which is based on prior-year utilization and which could lead to large payment fluctuations, especially in plans with small populations. MedPAC (2000a) has suggested that payments might be stabilized if risk adjustment were based on multiple years of experience, although it notes that this raises data collection and other technical problems. Another solution might to be replace risk adjustment, entirely or in part, with a stop-loss or other reinsurance arrangement, under which plans would be compensated for especially high-cost cases without a change in the agreed basic payment levels.

A second barrier is that, while plans might be willing to commit to a multi-year contract, they cannot necessarily agree that their providers will make a similar commitment. There is no ready solution for this; multi-year contracts may be more feasible for staff or group-model plans or (if they should ever appear in large numbers) for PSOs.

Gaining access in unserved areas

National or regional plans

The BBA conference report offers the Federal Employees Health Benefits Program (FEHBP) as one model for Medicare+Choice. Unlike M+C, FEHBP is able to offer a choice of health plans in every part of the country. FEHBP does not achieve nationwide coverage by negotiating area-specific contracts. Federal employees may be somewhat more geographically concentrated than Medicare beneficiaries, and most may have access to one or more HMOs. However, there are postal workers and other kinds of federal workers, as well as annuitants, everywhere. FEHBP reaches this population through national PPO contracts, including the Blue Cross/Blue Shield contract and several with employee organizations that may in turn contract with a health insurer to offer a nationwide plan. Although all of these plans have a PPO feature, not all of them actually undertake to structure a nationwide provider network. Participants who happen to live in an area where the plan has network providers pay lower cost-sharing if they use these providers. Participants in areas without access to the network pay higher out-of-network cost-sharing for all services.

If the aim is to provide some alternative to original Medicare everywhere, some form of national or large regional arrangement is probably necessary. The Sterling Life Insurance private fee-for-service plan is not a promising model. Sterling appears to have exploited a market niche by disproportionately entering counties where Medicare's payment rates are far in excess of expected fee-for-service costs and by developing a benefit package that is likely to discourage enrollment by high-risk beneficiaries.[46] As it is not clear that any PFFS could successfully compete with original Medicare without adopting similar strategies, this is unlikely to form the basis for a universal plan.

Would a PPO, such as those contracting with FEHBP, be more workable? The only PPO now contracting under M+C is operated by Independence Blue Cross in the Philadelphia area. It offers substantially reduced cost-sharing for in-network services and a benefit for generic drugs for a monthly premium of $114. For out-of-network services, there is a $250 deductible and 20 percent

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[46] It excludes prescription drugs and initially charged 50% coinsurance for home health care, which original Medicare covers in full. (This has been reduced, post-BIPA, to 35 percent.) Discouraging enrollment by likely home health users is an excellent selection tool. The 12% of beneficiaries who received any Medicare-paid home health care in 1996 had average Medicare costs six times those of beneficiaries who did not receive home health care. (Author's analysis of 1996 Medical Expenditure Panel Survey.)

coinsurance. (The coinsurance applies to inpatient care; the out-of-network benefit is thus considerably inferior to original Medicare.)

In Philadelphia, it competes with six other M+C organizations, including Independence Blue Cross's own HMO (Keystone), offering twelve different plans—including three zero premium plans that include prescription drugs. Presumably the PPO hopes to attract beneficiaries who are reluctant to enter more restrictive plans. The high premium suggests that it anticipates (or has experienced) adverse selection. In addition, the plan has established a capacity limit, suggesting that not all providers in the Blue Cross network are prepared to participate or, again, that there is concern about selection.

Table 53. Independence Blue Cross PPO and Its Competitors

Organization	Premium	Includes drugs
Independence Blue Cross PPO	$114	X
Aetna U.S. Healthcare, Inc.	40	X
Aetna U.S. Healthcare, Inc.	0	
Qualmed Plans for Health, Inc.	0	X
Keystone Health Plan East, Inc. (Point of service add-on)	0 25	(with supplemental Rx premium)
Health Partners of Philadelphia	0	X
Americhoice Of Pennsylvania, Inc.	0	X
Sterling Life Insurance Company	65	

Source: Medicare Compare

If this might be taken as a model for what could be offered in other areas, a PPO could offer a modest package of supplements at a price that may be at least competitive with Medigap policies. Why haven't similar plans appeared elsewhere? There was an initial barrier to PPO entry, because HCFA was imposing quality improvement system requirements identical to those for HMOs. BBRA removed this impediment, but there is only one additional PPO application pending as of January 2001. Possibly the organizations in a position to offer a PPO are concerned about adverse selection, or they may already offer a Medicare Select plan and see no reason to accept full Medicare risk for a similar product.

Suppose HCFA were to solicit a contract for a national PPO arrangement, or one covering an entire region, and were to allow a package more comparable to that in private market PPOs. Would anyone respond? It is not clear that any organization other than the Blues could structure a meaningful national plan. (Of the chain insurers, Aetna probably comes closest to achieving national PPO

coverage.[47]) Conceivably some other consortium of plans could come together for this purpose. Whether the potential participant were the national Blues association or some other entity, it would be made up of organizations that have already forgone the opportunity to undertake a risk contract in the unserved areas. It is hard to see why these organizations would now wish to accept risk under a national umbrella. Even under FEHBP, the reserve and rating arrangements are such that the Blue Cross plan is really not operating at risk over the long run. OPM essentially self-insures, and the Blues function as an administrative services organization with some incentives for performance.

If a similar arrangement were adopted under Medicare—perhaps a partial-risk national PPO contract--would it offer a meaningful alternative to original Medicare itself? To attract beneficiaries it would have to be able to assure that they would have access to in-network benefits. This means that, in isolated areas, it would probably have to offer providers at least full Medicare fees or allow enrollees in these areas to pay in-network cost-sharing for out-of-network services. Again, this might well be feasible under a rate-setting system that overpays for enrollees in low-cost areas. But one would then have to ask why Medicare should pay a private organization more than the cost of original Medicare so that the organization can pay providers what Medicare would have spent anyway and offer reduced cost-sharing. (Of course this question can be asked about the entire M+C payment system; see chapter 5.)

The alternative is to pay the organization some form of nationally set rate; for example, its payment in all areas might be equal to the input price-adjusted national component. It would then be overpaid in low-cost areas and underpaid in high-cost areas (just as the FEHBP national plans are). Its ability to operate would depend on its achieving the right geographic balance of enrollees: it would need to garner a big enough market share in low-cost areas to cross-subsidize the enrollees in high-cost areas. Unless it varied its benefits, however, it is not clear that this balance is attainable. The Independence Blue Cross PPO suggests the limits of what can be offered in high-cost areas; this may not be sufficient to make many beneficiaries in low-cost areas shift from Medigap to an unfamiliar arrangement. Moreover, in at least some low-cost areas, the plan could be undercut by CCPs that did not bear the burden of cross-subsidizing and could offer more attractive benefits or premiums. It is possible that the plan would suffer adverse selection, relative to CCPs, everywhere, as the FEHBP plans now do.

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[47] The Aetna PPO offered through the FEHBP Alliance plan in 1998 reached 43 states and Puerto Rico. The geographic scope of the network may since have been reduced.

Perhaps the fundamental problem is that a PPO may not be able to obtain bigger price discounts than original Medicare, even in areas where it has a large market share, and has few alternative ways of achieving savings. A POS arrangement might offer somewhat greater opportunities for utilization control. But it not clear that POS plans can operate efficiently under Medicare. To some extent, POS plans realize savings not through actual coordination of care but by creating bureaucratic impediments to excess utilization (for example, by limiting self-referrals)—in effect, raising the opportunity costs of obtaining medical care. This may not work well for a population that has the leisure to make obtaining medical care a full-time occupation.

Building local plans

The BBA eliminated the requirement that plans seeking a Medicare contract have commercial contracts as well and have a minimum number of enrollees. Instead it allows contracts with new entities that plan to serve Medicare beneficiaries only. In addition, it sought to promote development of one kind of plan—provider-sponsored organizations—by offering temporary preemption of state licensure requirements for PSOs meeting solvency requirements established by the Secretary. In January 2001 there was only one active PSO contract and one application pending. Some plans other than PSOs might also be developed for Medicare only. In southern Florida, for example, the America's Health Choice Medical Plan was developed locally in 2000 to serve counties that had just lost all their M+C plans. It is not known whether there similar initiatives elsewhere.

Whatever the model, a start-up organization—or an existing organization entering a new area--needs capital. A new health plan can expect to lose money for several years, until its enrollment is sufficient to cover the fixed costs of operations. Entry bonuses and overpayments through floor rates are no substitute for initial capitalization, because they provide funds in direct proportion to enrollment, rather than the inverse proportion that is actually required.

In the 1970s, when the federal government wished to promote development of HMOs, it provided start-up capital. Under the HMO Act, planning and development grants brought new organizations to the point of beginning operations; then low-interest loans were available to carry the organizations through the years until they reached the break-even point. This program ended with the Reagan Administration, largely because there were then enough private investors interested in HMOs that the industry could grow without further federal support. However, it seems highly unlikely that private

capital is going to be available to begin Medicare-only health plans in areas with a limited potential enrollment base and other barriers to success.

Would it make sense for the federal government once again to provide some form of start-up funding? Possibly—with the understanding that there is likely to be a high failure rate. The Office of HMOs that administered the old grant and loan program tried to forestall this through an extensive feasibility study and planning process, but this was costly and burdensome in itself and nevertheless failed to prevent some spectacular collapses. There is also a question of whether funds should be made available for geographic expansion of existing plans or for adding a Medicare component to a plan already serving commercial enrollees. If such funds were available, why would any organization ever contemplate an expansion using its own resources?

Another way that has been suggested for promoting new plans is to offer some form of partial risk or reinsurance arrangement (MedPAC 2001b). While these options have been proposed as a general solution to the risk adjustment problem, they could also be a way of fostering new organizations whose initial enrollment is too small to sustain a full-risk contract. One problem with partial capitation is that it is difficult to see how an organization would fund the supplemental benefits needed to attract enrollees. If, for example, payment were based on an equal blend of the BBA rate and the plan's actual cost for furnishing basic Medicare services, even a successful plan could offer only half as much in supplemental benefits as an equally efficient full-risk plan.

Finally, new entrants could be encouraged through some relief from Medicare administrative requirements. The burdens and complexity of compliance with Medicare rules and instructions have been a frequent source of complaints from plans. This report does not address this broad complaint—not because administrative burdens are not a factor in nonparticipation, but because a detailed assessment of specific requirements would take many volumes, while a general assertion that HCFA regulates too much is more or less unanswerable. It is worth asking, however, whether the same standards can be applied to an established organization with hundreds of thousands of enrollees and a new one with just hundreds. To take a single example: should a new plan that enrolls 500 enrollees in its first year collect HEDIS performance data or conduct quality assessment and performance improvement projects? To say that it shouldn't is to suggest that quality is unimportant in smaller plans; to say that it should is to increase the barriers to formation of new plans. (Again, these barriers might be reduced if new plans were given at least some assistance with the costs of developing information systems and other needed resources.)

This question raises a larger one about the role of HCFA in dealing with Medicare+Choice plans—or of any successor agency, if this is contemplated, dealing with whatever kinds of private plans are imagined. There is and has always been an inherent tension between the objective of promoting the development and geographic expansion of health plans and the objective of assuring adequate quality and access and maintaining other beneficiary protections. This is not simply a matter of whether one agency's institutional culture tilts too far toward one objective or the other. It is a question of whether it is more important to have some form of M+C plan everywhere, or to promote efficient and high-quality plans only in those markets that can sustain them. This question is considered further below.

Promoting enrollment through employer groups

A substantial--though not precisely known--share of current M+C enrollment consists of retirees enrolled under arrangements between their former employers or union plans and M+C plans. About 28 percent of new M+C enrollees in 1998 "aged in" to M+C enrollment; that is, they joined an M+C plan immediately on first qualifying for Medicare (GAO 2000). It is likely that a considerable number of these remained in the organization that had served them when they were active workers. Kaiser Permanente informally estimates that about a quarter of its current Medicare population is enrolled through employer groups. This is probably exceptional; Kaiser has Medicare enrollees who were in the plan throughout their working lives. Still, among employers who offered any form of coverage to retirees over age 65 in 1997, 39 percent offered enrollment under a Medicare risk contract—up from just 7 percent in 1993. In the West, where HMOs are longer established, 61 percent of large employers offered a risk contract option (Mercer/Foster Higgins). Other employer and union groups are enrolled through the remaining cost contracts, which were originally developed precisely in order to serve these groups.

Employers' mounting interest in the HMO option stemmed in part from a change in accounting standards (Financial Accounting Standards Board rule 106), which required them to treat future obligations for retiree health benefits as a current liability and which thus made them more sensitive to growth in costs for these benefits. The risk HMO option was attractive as an alternative to conventional retiree plans because these plans usually "wrap around" Medicare, paying required cost-sharing for participants; their cost growth thus mirrors growth in FFS spending. HMOs could reduce that wraparound cost and could also offer supplements that were financed through their Medicare savings, effectively replacing existing employer spending for these benefits.

Recent employer surveys suggest that growth in the number of employers offering an M+C option stopped after the mid-1990s; among large employers, the figure is still around 38 percent. Some observers believe that employer interest waned because employers found other ways of reducing their benefit obligation—such as curtailing the promises of future benefits made to currently active workers. Moreover, the post-BBA benefit cuts and premium increases implemented by many M+C plans may have made them a steadily less attractive alternative to conventional coverage. In addition, employers have had some technical problems in coordinating with the Medicare program, for example because the M+C open enrollment period does not coincide with the employer's (Fox).

These issues aside, there are two key barriers to further employer involvement with M+C plans.

First, the plans may not be available to many of an employers' retirees. This is obviously the case for national employers, but is also a problem at the local level for employers who would like to offer retirees the same HMO options they had as active workers. The plans' Medicare service areas may not be coextensive with their commercial service areas; this is all the more true given recent Medicare service area reductions.

Second, employers generally prefer to offer uniform benefits to all retirees, and often want these benefits to conform to those for active workers. However, they are constrained in their negotiations with plans by current HCFA policy on this subject. An employer who gives retirees the option of joining an M+C plan may negotiate a supplemental benefit package and premiums different from those that the plan offers to non-group Medicare beneficiaries. However, the benefits offered through the employer group must include all of the benefits provided in the basic or least costly package that the M+C plan offers to non-group beneficiaries. That is, the employer can only buy more, never less. This is true even if the employer wishes to offer a package that is in total actuarially more valuable than the plan's basic package; the plan cannot reduce some benefits and increase others. Again, this rule is especially burdensome for national employers, who must deal with multiple HMOs and hence multiple minimum benefits. However, because M+C plans may now vary their benefits for different counties within their service area, the rule is a problem even at the local level.

BIPA gives HCFA an open-ended authority to "waive or modify requirements that hinder the design of, the offering of, or the enrollment in" M+C plans through arrangements with employer or union groups. Before

considering what kinds of waivers might be appropriate, it is worth asking why Medicare should wish to promote these arrangements.

Increasing or at least maintaining current levels of employer involvement with M+C would have a number of advantages. It might provide plans with a more stable enrollment base. Employers might discourage plans from terminating their M+C plans or changing their service areas from year to year if the effect was to drop some retirees. If employers could achieve savings, they might be more likely to maintain current levels of retiree health benefits.

While the potential benefits to plans, employers, and retirees are manifest, the benefits to the federal government are less apparent. If the experience in the group market mirrors that for non-group beneficiaries joining M+C plans, the plans might experience favorable selection. Medicare would overpay for these beneficiaries, essentially replacing current employer spending with Medicare spending.[48] GAO (2000) contends that favorable selection is as prevalent among beneficiaries who join an M+C plan immediately on becoming eligible for Medicare as among those who shift after having been in original Medicare. While there is no information on the characteristics of beneficiaries enrolled in M+C plans through retiree groups, those who age in might be especially low risk, since by definition they were healthy enough to continue employment until full retirement age.[49] On the other hand, if retirees stay in the plans longer, there might be greater regression to the mean.

In any event, risk adjustment should eventually address much of this problem (if it doesn't drive plans out of business). On balance, promoting employer involvement could not only contribute to the short-term stability of the M+C program but also produce savings for Medicare over the long term. If it became more routine for active workers to age into M+C enrollment upon retirement, plans might have greater incentives to provide preventive services to fifty year-olds that would produce savings when they were seventy. All of this assumes, of course, that employers themselves will stay with one plan over time. This has certainly not been the case in recent years. Whether employer/plan relations will stabilize over time is impossible to know.

What might be done, under the waiver authority, to encourage M+C contracts for retirees?

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[48] The growth in enrollment among higher-income beneficiaries, shown in table 4, suggests that this was already occurring to some extent before the BBA.

[49] This would not necessarily be the case when an employer also offered the same HMO to pre-Medicare retirees.

Benefits. HCFA's position in imposing the minimum benefit rule has been that retirees are, after all, still Medicare beneficiaries and should have access to at least the same benefits nongroup beneficiaries are entitled to receive through an M+C. However, nothing prevents a retiree who wishes to join a plan under its standard M+C contract from doing so; he or she would merely sacrifice whatever premium contribution the employer would otherwise have made or whatever alternative benefits the employer had negotiated. It is not clear why this is any concern of the government's, so long as every beneficiary in the plan's service area retains the option of enrolling directly under the standard nongroup contract.

A second question about benefits is whether an employer should be able to negotiate a more valuable package at no greater cost, or the same package at lower cost, than the premium charged by the plan to nongroup beneficiaries. In theory, through the ACR process, a plan's supplemental benefits are supposed to equal its savings on basic Medicare services. If the plan can offer more benefits to an employer group, it must somehow have been giving nongroup beneficiaries less than they were supposed to be getting. This view ignores the fact that there are administrative savings to the plan from offering enrollment through groups. Moreover, the characteristics of the members of an employer group may be different from those of the nongroup enrollees, meaning that the cost of providing the basic Medicare benefits is different. If the ACR process is to be continued, it might at least be reasonable to allow computation of a separate ACR for group enrollees.

Service area. Should a plan be allowed to serve retiree groups in counties in which it does not serve nongroup beneficiaries, assuming that usual Medicare standards for adequacy of the provider network are met?[50] There are arguments for and against this policy. Certainly it would encourage more group contracts; employers who offer HMO enrollment both to active employees and retirees are likely to want common service areas. In addition, a plan that expanded its service area to meet employers' needs might eventually offer nongroup enrollment in the same area. By the same token, however, service areas for nongroup enrollees might erode even more rapidly if a plan could drop these enrollees in a given county without dropping retirees. Some plans that reduced their service areas for 2001 reported at least some countervailing pressure from major employer groups.

Might a plan offer retiree coverage in entire regions in which it did not serve nongroup Medicare beneficiaries? This could facilitate contracting with

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[50] Plans that close off new Medicare enrollment in an area because of capacity limits are already allowed to continue enrollment of retirees who age in directly from employer coverage.

national employers; one could imagine, for example, that an Aetna or CIGNA might have stayed in some of the regions they dropped, or entered new ones, if they could have served major purchasers without running full-scale M+C plans everywhere. However, HCFA and the plans would have to go through the entire contracting and monitoring process for plans that might be serving relatively few enrollees. (This might be less burdensome if the employers required accreditation and more progress was made toward deeming.)

Employer-specific plans

Finally, further consideration might be given to the possibility of allowing large self-insured groups to develop their own Medicare plans.

In the late 1980s, the Reagan administration began exploring the possibility of "Medicare insured group" arrangements, under which an employer or union group would be capitated by Medicare and would assume risk for basic Medicare benefits. Some employers thought that, with their existing managed care arrangements, they could provide the basic Medicare benefits more efficiently and use the savings to help finance the supplemental benefits offered to retirees. HCFA planned a demonstration under which capitation rates would be based on the actual Medicare FFS experience of the particular group, rather than the usual 95 percent of AAPCC. Congress intervened, concerned that employers would somehow receive a windfall and that retirees would be forced into managed care. It authorized a demonstration, but with restrictions on the use of experience rating, a requirement that enrollee participation be voluntary, and other conditions.[51] Although talks continued with a number of groups, no MIG demonstration was ever implemented.

It is by no means clear that, in the present environment, many employers would be eager to assume the Medicare risk for their retirees. As was suggested earlier, employers may find it easier to curtail their commitments to retirees rather than find ways of managing the costs. Likely exceptions may include state and local governments: 71 percent of government units with 200 or more employees offered retiree benefits in 2000, compared to 37 percent of private firms, and government commitments to their employees are likely to continue (Kaiser-HRET). In addition, there is the federal government itself. Medicare is already participating in the TRICARE demonstration for beneficiaries who are also eligible for military retirement benefits. A cooperative arrangement with FEHBP could similarly lead to more rational financing for annuitants in plans participating in both M+C and FEHBP.

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[51] Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203), section 4015.

How would a revived MIG option work? One of the barriers to the earlier efforts, the issue of rating, may now have been rendered moot by the adoption of risk adjustment for M+C payments. The other key issue was voluntary enrollment. The rules established by Congress for the MIG demonstrations required that employers continue to offer some alternative form of supplemental coverage for retirees who did not wish to be in the experiment, that benefits under the MIG be actuarially equivalent to those under the alternative, and that the value of these benefits be maintained for the life of the demonstration. Again, it is not clear why this is any of the government's business. Active workers take the health insurance options offered by their employer or are free to hunt for coverage on their own. There is no clear reason to have a different rule for retirees, so long as those eligible for Medicare remain free to forgo their employer's contribution to benefits and obtain supplemental coverage on their own, through Medigap or an alternative M+C plan.

Living with a dual system

At least in the immediate future, it is likely that there will continue to be large areas of the country in which no coordinated care plan will operate on a risk basis. Most of these are areas with relatively low FFS costs. The BBA adopted a strategy, reinforced by BIPA, of paying more than FFS in these areas in order to attract plans. Possibly there is some price, even higher than the BIPA rates, that could bring alternative plans into every single area of the country. But it is obviously paradoxical to pay more and more to establish competition if the point of the competition is to save money. If there are places where no one can really compete effectively with original Medicare, why not accept this and leave original Medicare (with some form of drug coverage and other enhancements) as the only option in some areas while promoting competition in those areas where it promises real efficiency gains?

The current policy has been driven by two considerations other than cost savings. The first is that choice is good in and of itself. There is little evidence that beneficiaries themselves find the FFS system unsatisfactory and would rather be in private plans. Those who have been accustomed to getting care through highly organized systems for many years may prefer to remain in them in retirement, and this may be steadily more true as current workers age into Medicare. But most beneficiaries who have even considered joining an M+C plan have been driven chiefly by cost and benefit considerations.[52] If they could

[52] In a recent survey, factors cited by beneficiaries as "extremely important" in choosing a health plan were, in descending order, (1) ability to get health care when sick, (2) choice of personal doctor, (3) prescription drug coverage, (4) keeping premiums down, (5) low out-of-pocket costs,

obtain comparable coverage at the same cost through a Medigap plan, or through original Medicare itself, they would probably prefer it.

This does not mean that beneficiaries would not actually be better off in more organized delivery systems. They might well be, and--if outcomes can be improved through better coordination--it may be worth spending money to create such systems even if they do not yield measurable savings in the near term. If the systems can be built, it may also be worth enticing or nudging beneficiaries into them with carrots or sticks. But this objective should not be confused with one of meeting the preferences of the current generation of beneficiaries, or even with the goal of letting the market prevail. It is instead a top-down strategy of pushing beneficiaries into something thought to be good for them.

The second explanation for current policy is that the M+C program has functioned to some extent as a way of covertly slipping federal funding for supplemental benefits to beneficiaries lucky enough to live in an area where an M+C plan operates. While this is a cumbersome and—given access disparities—inequitable way of funding these benefits, it has so far been easier than adding them to original Medicare. The next section reviews how supplements are being allocated today and how things might change if basic Medicare benefits themselves were expanded.

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and (6) ability to self-refer to specialist (Gold and Justh). The factors not related to cost or benefits would all presumably dispose a beneficiary *not* to prefer an HMO.

Chapter 5: SUPPLEMENTAL BENEFITS

The provision of supplemental benefits is the foundation of the Medicare+Choice program. Under both Medicare+Choice and the predecessor TEFRA risk contracting program, Medicare has offered beneficiaries a bargain: those willing to accept the restrictions of a more efficient private plan could share in the savings by receiving reduced cost-sharing and other additional benefits. This deal has always presented equity problems, once again related to pricing and geographic access. Moreover, the nature of the bargain—and the competitive advantage of M+C plans—would be profoundly affected if Medicare itself begins to provide one of the most valuable supplements, coverage of outpatient prescription drugs.

Equity

Under TEFRA, beneficiaries in high-cost areas were more likely to have a risk plan available, while those in low-cost areas—where Medicare was already operating "efficiently"—had no access to the low-cost supplements. Moreover, because the part B premium is uniform, beneficiaries in low-cost areas paid a higher share of the cost for their own basic benefits than those in high-cost areas. Medicare+Choice has to some extent reversed this situation. Now Medicare offers extra funds, and potentially (beginning in 2003) a reduction in part B premiums, to residents of low-cost areas—*if* a health plan chooses to do business in their area. Meanwhile, the bargain is growing less attractive for beneficiaries in "inefficient" areas: under the current rate-setting system, the government over the next few years will gradually take a larger share of any plan savings, squeezing out the surplus that funded the supplements.

It is hard to say how a truly equitable system would work. Ideally, perhaps, beneficiaries everywhere would have a choice among a variety of plans and would be more or less uniformly rewarded when they chose a more efficient delivery system. So, for example, a beneficiary choosing between original Medicare and an HMO would see roughly the same price or benefit differences no matter where he or she lived. A key problem, under both the current system and some reform proposals, is that, while the cost of furnishing the basic Medicare benefits varies, the cost of some possible supplements is constant. The cost of others may vary geographically, but not necessarily in proportion to the cost of Medicare services.

Table 54. Likely Geographic Variation in Cost of Possible M+C Supplemental Benefits

	Varies in proportion to local Medicare spending	Varies, but not necessarily in proportion to local Medicare spending	Constant
Medicare cost-sharing			
Part B premium			X
Inpatient deductible and coinsurance			X
Part B deductible			X
Coinsurance, part B services	X		
Non-Medicare supplements			
Prescription drugs		X	
Physicals, other preventive services	X (?)		
Dental care		X (?)	
Vision and hearing			X (?)

Of current Medicare cost-sharing amounts, only the value of the 20 percent coinsurance for physician and other part B services varies according to local prices and utilization patterns. Among possible non-Medicare supplements, the cost of preventive services and dental care probably varies geographically; variation is probably smaller for vision and hearing services.

Most critically, the cost of a prescription drug benefit may not vary in proportion to costs for basic Medicare benefits. In 1996, among beneficiaries who had prescription drug coverage, those in rural areas received slightly more prescriptions per person than those in urban areas (23 versus 21) and paid slightly less for each prescription ($34 versus $37). Overall drug spending for the rural beneficiaries was $793, compared to $762 for urban ones.[53] Medicare basic benefit spending for rural beneficiaries, as measured by full area FFS for 2001, is 20 percent lower than for urban beneficiaries. Obviously there will be variation in drug benefit costs in specific market areas, as a result of different health risks and prescribing patterns. Still, drugs are a nationally priced commodity, and there is no particular reason to suppose that a plan operating in an area with low hospital and physician prices will also face lower drug prices.

Thus, even if it were possible in every area for an efficient plan to save x percent relative to an appropriately adjusted local benchmark, the dollar value of these savings would still vary from place to place, and the value of the benefits a

[53] HCFA, Office of Strategic Planning, unpublished analysis of data from the 1996 Medicare Current Beneficiary Survey.

plan could supply would also vary. This means both that some beneficiaries get more goodies than others and also that efficient plans are more attractive, relative to original Medicare, in some places than others.

It could at least be argued that this is not necessarily inequitable. If fee-for-service beneficiaries in high-cost areas are actually getting something for the additional expenditures made on their behalf—in the form of better quality, access, or satisfaction—then they are giving up more by entering private plans and should be rewarded proportionately. This argument, however, contradicts the bedrock assumption of M+C: that fee-for-service beneficiaries aren't getting anything of value for the additional spending. The following discussion will instead assume that the equity problem is a real concern that needs to be addressed.

One partial solution would to make beneficiaries in different areas pay different amounts for original Medicare. The Breaux/Frist I plan (see chapter 2) effectively varied the part B premium by area, and the principle could apply to cost-sharing as well—for example, the inpatient deductible could vary with the hospital wage index. This might mean that, even if a plan in a high-cost area could save more in absolute dollars, the relative value of the benefits it could return would not be greater than in a low-cost area. Suppose a plan could save $75 in a high-cost area and another could save $25 in a low-cost area. If the part B premium varied in the same proportion, the two plans would be equally positioned to write it off. Even if this approach were thought to be fair, it is politically impossible, as was recognized in Breaux/Frist II. Moreover, it still leaves some plans better positioned than others to furnish drugs and other non-Medicare supplemental services.

A second approach—embodied in the Clinton proposal—more or less inverts this problem by separating supplements into two classes: Medicare premiums and cost-sharing on the one hand, and drugs and other non-Medicare services on the other. A plan that could furnish the basic Medicare services more efficiently could share its savings only by reducing beneficiary costs for those services. It could not also provide non-Medicare supplements; these would have to be offered separately and paid for by the beneficiaries. Plans would still be able to offer more or less generous write-offs of Medicare cost-sharing depending on where they were. In addition, the proposal theoretically limits the efficiency incentives for plans, since a plan that has saved enough to write off all Medicare cost-sharing has nothing to further to offer beneficiaries if it saves any more.

A third possible solution might be to pass around funding for supplemental benefits in ways that are not tied to the absolute dollar value of any savings achieved by private plans. The BBA does this to some extent

through the floor payment rates. However, because the difference between the floor payment and the local cost of furnishing basic benefits still varies from place to place, plans in some floor counties can still offer richer benefits than others. A more equitable system might award a *fixed* contribution toward supplements for a plan that achieved a certain *relative* degree of efficiency compared to a local benchmark. Thus, if a plan saved, say, 2 percent relative to local cost, it might receive a flat $120 (roughly 2 percent of national average spending) to use toward supplemental benefits.

Both the second and third solutions continue to rely on ACR submissions, the plans' own estimates of how much they will spend (including a profit margin proportionate to their commercial profits) to furnish basic Medicare services. The system assumes that a plan's profit margin on its commercial enrollees is the right margin for its Medicare enrollees. (FEHBP's dealings with HMOs work in essentially the same way.) This approach might seem to be market-based, because what Medicare allows for basic benefits is tied to what private purchasers in the same area are prepared to pay for comparable coverage.

In most markets, however, purchasers get volume discounts related to size. A large employer can pay less for health insurance than a smaller one, not just because large groups incur smaller administrative cost, but also because larger groups can bargain for a reduced plan profit margin. FEHBP at least accounts for this by basing its rates on those paid by each plan's two largest commercial groups. Medicare instead uses the plan's average revenue from all purchasers, and thus never gets a volume discount. The alternative, as in Breaux/Frist I, is to dispense with the ACR, simply let plans bid a price, and assume that the market will hold these prices down. As was suggested earlier, however, so long as one player in the market—original Medicare—is not allowed to set its own bid prices, the system invites shadow pricing and other distortions.

Prescription Drugs

Proposals to add some form of outpatient prescription drug benefit to Medicare have important implications for the Medicare+Choice program. The issues presented obviously depend on the basic design of the benefit. Some plans would provide the benefit to all beneficiaries; others would make it voluntary, with a supplemental premium and some income-based subsidies. Some plans would have the government provide the benefit, directly or through administrative arrangements with pharmaceutical benefit managers (PBMs). Others would provide it through risk contracts with private insurers (or at-risk PBMs) or would simply provide subsidies to help beneficiaries purchase drug coverage directly from private carriers.

This report cannot consider all these different permutations. For the following discussion, it will be sufficient to assume that some kind of federally subsidized benefit will be available to beneficiaries who are not enrolled in M+C plans. (Even competition proposals such as the Breaux/Frist plans, which assume that M+C plans will have a major role in furnishing a drug benefit, have to create an alternative system of carriers for beneficiaries who do not have access to, or choose not to join, an M+C plan.) This will raise two key questions:

?? What role should M+C plans play in providing this benefit for their own enrollees?

?? How will the competitive position of M+C plans be affected if affordable drug coverage, potentially a major inducement for enrollment, becomes available to beneficiaries through other means?

Locus of a drug benefit

Most proposals assume that Medicare would simply add the expected cost of the drug benefit to plan payments and the plan would assume the risk of providing this benefit as it does for all other Medicare-covered services. If the benefit were a voluntary one for original Medicare beneficiaries, it would also be voluntary for M+C enrollees, forming part of a high-option package that enrollees could purchase with some federal assistance. As under the current program, the plan could offer more generous benefits, financed through savings in the provision either of the core Medicare services or of the drug benefit itself.

Whatever the scheme, it is simply taken for granted that M+C plans should manage the drug benefit and should be at risk for it. This is not as obvious as it may seem. Many, perhaps most, managed care plans do not administer their own drug benefits. Larger employers may purchase medical coverage from one carrier and contract separately with a PBM for the drug benefit. About 34 percent of workers with drug coverage are in these “carve-out” arrangements, although they are less common when the basic insurer is an HMO than when it is a PPO (Kaiser-HRET 2000). When the benefit is included in an HMO’s package, whether commercial or Medicare, the HMO will itself often subcontract with a PBM to administer it. There are HMOs that do manage their own drug benefits, including some major M+C plans, but this is by no means universal.

Smaller plans in particular may find it more advantageous to contract with a major PBM because the PBM enjoys economies of scale in managing the benefit and may, because of its market share, be able to command larger discounts from both manufacturers and retail pharmacies. (The extent to which manufacturer rebates are actually shared with the end purchaser is subject to negotiation between plans or employers and PBMs.) PBMs generally do not accept full risk, although they may be given incentives to control costs. The HMO is thus left with the risk for a benefit it does not directly manage. If a Medicare drug benefit worked in the same way, the government would give health plans a lump sum for drugs, they would pay a PBM on a cost basis, and they would experience a profit or loss that was essentially beyond their control. Why not eliminate the middleman? M+C plans that were in a position to manage and accept the risk for their own drug benefit might be paid to do so. Others might be reimbursed on a cost basis. Or if, as under some schemes, large PBMs would themselves be paid by Medicare on a risk basis for fee-for-service beneficiaries, M+C plans might be allowed to participate in these arrangements.

The major argument for placing M+C plans at risk for a drug benefit is that drugs can substitute for or reduce the need for other costly services, such as surgical procedures or inpatient admissions. While savings from the use of prescription drugs have been shown in specific instances--for example, reduced inpatient admissions for patients taking asthma drugs--there is no way of knowing whether increased drug spending in the aggregate is, as the pharmaceutical industry contends, offset by savings in other health care sectors. (HCFA has recently announced a demonstration, to be conducted in cooperation with the United Mine Workers, to test whether adding a drug benefit produces savings in basic Medicare costs.) Probably there are some instances in which drug therapy is more cost-effective than any alternative and others in which the reverse is true. If so, it makes sense to hold one entity at risk for the whole spectrum of services, so that it will have an incentive to choose the most cost-effective treatment for each specific condition.

That health plans themselves are ambivalent on this point is suggested by a 1999 survey of plans' payment methodologies for intermediate entities, such as IPAs and PHOs, that serve Medicare beneficiaries on a risk basis (Mathematica). In "global risk" contracts, those in which the intermediary accepts risk for a broad spectrum of health services, including inpatient care, 53 percent included outpatient prescription drugs in the package. When contracts were less than global—covering professional and selected ancillary services—27 percent included prescription drugs. Clearly many plans have not concluded that the interplay of drugs and other services is clear enough to warrant bundling them together. Some may even operate or contract with separate programs intended

to contain drug spending without any consideration of potential offsets in medical care.

Assuming that it does make sense to place M+C plans at risk for any basic Medicare drug benefit, should they also be able to offer broader coverage, funded through savings in delivery of the basic benefit or, more probably, savings on other services? While it seems obvious that they should, this will merely heighten the current geographic inequity in the funding of supplements. Suppose that furnishing a given drug can reduce inpatient utilization by 10 days per thousand members. The dollar savings will be greatest for a plan in a high-cost area, and this plan will in turn be able to expand drug coverage further. Again, this reflects the problem of funding a constant-value supplement from savings on basic benefits whose value varies.

Effect on plan competition

In a recent survey, 49 percent of beneficiaries said drug coverage would be "extremely important" if they were choosing a health plan (Gold and Justh). If Medicare provides an adequate drug benefit at affordable cost outside M+C, what effect might this have on plans?

Tables 57 and 58 show estimated penetration and market share for benefit packages offered by plans with different levels of drug benefits. (One CCP can offer several packages with different drug benefit values.)

Gross drug benefit value is the plan's projected spending for the benefit in its ACR submission minus the projected value of enrollee copayments or other required cost-sharing. *Net* drug benefit value is the portion of the gross value that is free to the enrollee; that is, no portion of the plan's premium, if any, is used to finance this benefit.[54] Note that while table 57 shows 1,218 packages with some drug benefit, table 58 shows only 452 packages with any net value. Most packages are funded entirely through enrollee premiums, rather than through plans' savings on basic Medicare benefits.

Penetration is the estimated number of enrollees receiving the package in March 2001 divided by the total number of Medicare beneficiaries in the county. *Market share* is the estimated number of enrollees receiving the package divided by the total number of enrollees in Medicare CCPs in the county. This is computed only when a package is competing with some other package in the

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[54] In ACR lingo, gross is additional benefits and mandatory supplements; net is just additional benefits.

county, with or without a dug benefit and whether offered by the same CCP or another CCP.

Table 55. Penetration and Market Share of M+C Benefit Packages by Gross Value of Drug Benefit (before Premium), March 2001

Gross benefit value	Packages	Penetration	Packages with competition	Market share
No benefit	674	5%	603	29%
$1-$24	295	5%	272	28%
$25-$49	649	5%	626	29%
$50-$74	174	6%	174	21%
$75 and above	28	1%	28	6%
Any drug benefit	1,218	5%	1,172	26%

Source: Post-BIPA 2001 ACR submissions and March 2001 penetration data.

Table 56. Penetration and Market Share of M+C Benefit Packages by Net Value of Drug Benefit (after Premium), March 2001

	Packages	Penetration	Packages with competition	Market share
No benefit or no net value	1,440	4%	1,346	25%
$1-$24	125	6%	114	28%
$25-$49	241	6%	229	27%
$50 and above	14	3%	14	8%
Any drug benefit	452	6%	429	26%

Source: Post-BIPA 2001 ACR submissions and March 2001 penetration data.

Presence or absence of a drug benefit with any gross value has no apparent effect on penetration or market share. Among plans that have a drug benefit, penetration drops when the benefit's gross value exceeds $75; market share begins dropping at $50. This may be because plans with very generous gross benefits are likely to have higher premiums, and beneficiaries are only willing to pay a certain amount.

Presence or absence of a drug benefit with a real net value does make a very small difference in penetration—suggesting that beneficiaries might be cannier shoppers than they are given credit for. The effect on market share is minimal. As in the case of gross values, penetration and market share drop for the plans with the greatest net value.

Clearly beneficiaries are considering factors other than drug benefits in choosing plans—including other supplements, the nature of the plan's delivery system, brand familiarity, and so on. This does not mean that there are no beneficiaries for whom drug benefits are the critical factor in deciding whether or not to join a CCP, or which CCP to select. It seems intuitively likely that the availability of drug coverage has been an incentive for M+C enrollment.

At the same time, it is almost certain that this incentive would erode in the future even if no Medicare drug benefit were enacted, because the cost of drug coverage is rising so much faster than plans' Medicare payments for basic benefits. While plans could hold the gross value of their drug benefits constant by raising premiums, the net values are likely to diminish sharply. It is conceivable that plans would do better over the long run if drugs were essentially taken out of the equation and they could compete on the basis of reductions in cost-sharing and premiums, benefits that are more closely connected to their efficiency in delivering basic services.

CONCLUSION

Despite the failure of M+C to meet expectations, many people still regard some system of competing health plans as the most promising way of controlling the growth of Medicare spending over the long term. After the tinkering in recent years, the basic scheme of M+C and of proposed alternatives such as premium support is still the one embodied in TEFRA: beneficiaries will be encouraged to enroll voluntarily in more efficient delivery systems. Part of the resulting savings will be returned to the enrollees in the form of enhanced benefits or reduced premiums, while the remainder will accrue to the government.

The two key problems with this framework have been apparent for twenty years and have never been resolved:

1. While the FFS program may be inefficient everywhere, there is apparently more fat in some places than in others.

If payments are based on local experience, beneficiaries in high-cost areas will be offered rich benefits with a government subsidy, while those in low-cost areas may be offered nothing. If, on the other hand, payments are more nearly equalized (as, for example, in the blend envisioned by the BBA), beneficiaries in high-cost areas will see reduced supplemental benefits and have less incentive to enroll. Those in low-cost areas will be rewarded with enhanced benefits, but at an increased cost to the federal government.

2. The highest-cost beneficiaries have been the most reluctant to enter restrictive delivery systems.

This has resulted in payment distortions that can be partially addressed through risk adjustment. However, if plans continue to attract lower-cost beneficiaries, the result will merely be reduced payments, a corresponding reduction in benefits, and declining enrollment. Meanwhile, the beneficiaries for whom the greatest savings might be achieved remain in the fee-for-service system. Biased selection might be overcome if the price of remaining in original Medicare (either in increased premiums or valuable benefits forgone) were made unacceptably high, but this would threaten access unless high-quality alternatives can be made available everywhere, and in any event appears to be politically impossible.

These problems have been compounded in recent years by policy instability; a lack of clarity about the role of government in overseeing the

scheme; and fast-paced evolution in the health care market with which government policy cannot always keep up.

The basic conflicts in the M+C program may merely be accentuated if new federal dollars are made available to subsidize prescription drug coverage and other enhancements in the basic Medicare benefits. If drug coverage is subsidized equally in original Medicare and in M+C plans, there will be even less incentive for beneficiaries to participate in these plans. Alternatively, more generous benefits might be available to M+C plan enrollees, financed in theory through the plans' greater efficiency. However, unless all beneficiaries can be given access to such plans, this could merely exacerbate the system's current geographic and other inequities. Moreover, because prescription drug costs are rising much faster than expenditures for other services, they cannot be financed through savings on basic Medicare benefits unless plans can improve their efficiency as rapidly as drug costs grow.

Does this mean that market-based reforms in Medicare are merely a pipe dream, representing—as one recent critique put it (Cooper and Vladeck)—a triumph of unproved theory over political reality and objective experience? If so, the loss would be more than financial. The original theorists of the competitive model hoped that it would achieve, not only cost savings, but also improved coordination of care, greater emphasis on prevention and disease management, and continued pressure for quality improvement. These goals are obviously important, but the system changes needed to effect them require long-term investment that may not necessarily produce immediate payoffs.

Workable Medicare reform is inseparable from fundamental structural changes in health care delivery, and promoting these changes may not be compatible with a desire for dramatic savings in a five- or ten-year budget window. Nor can it be expected that a restructuring of Medicare would instantly be accompanied by the appearance of new privately financed ventures designed to take advantage of the new structure. The white knights who were supposed to build a national system of competitive plans have spent their capital, and the system is not there. Even if Medicare is redesigned, growing the systems to accommodate the new structure will take time. The program will need to build on the base of organizations that are already participating—which means keeping them participating, while at the same time applying moderate incentives for steady improvement in efficiency and quality.

This paper has suggested a few concerns that will need to be addressed as the program works to achieve these goals:

- ?? More needs to be learned about the sources of geographic spending variations and the extent to which these variations can be reduced by efficient plans. This is necessary both to rationalize the payment system and to reduce the current inequities in support for enriched benefits. Until sound reimbursement methods can be developed, the program can afford to exert only limited pressure for savings without destroying its current contractor base or compromising access and quality. The most practical option at this point appears to be a return to a system based on area costs, with continued progress toward risk adjustment and a gradual phase-down of the floor rates.

- ?? Developing alternative plans in areas with limited competition is likely to require direct public investment. In addition, the program should continue to explore new partnerships with employers, perhaps especially in the public sector. Even so, it must be assumed that original Medicare will be the only option for a substantial number of beneficiaries for years to come. This means that promoting competition and modernizing Medicare benefits must be seen as separate goals.

- ?? If a prescription drug benefit is added to Medicare, it cannot be assumed that coordinated care plans have some magic solution to the problem of rising drug costs—or can somehow make up these costs through savings on basic Medicare services. Until plans are better equipped to harness any "pharmacoeconomic" benefits of drug therapy, their role in, and risk for, providing these benefits will need to be carefully defined.

Most of all, what is probably needed is patience. M+C will grow as new beneficiaries already accustomed to managed care age into the program, and as plans slowly learn how to manage chronic illness, multi-system complaints, and the other special problems presented by an aged and disabled population. For the time being, Medicare policy should promote stability and gradual evolution of the M+C sector, so that efficient systems will be ready to meet the challenge of the exploding beneficiary population in years to come.

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Appendix A: Supplemental Tables on CCP Withdrawals

Table 57. Enrollee-Weighted Average Percent Difference Between 2001 Base Rate (Before BIPA) and 1997 AAPCC, by Retained and Dropped Enrollees within an MSA/CMSA, 2001

Organization	Metropolitan statistical area (MSA) or consolidated MSA (CMSA)	Retained enrollees	Rate increase, 1997-2001 (pre-BIPA)	Dropped enrollees	Rate increase, 1997-2001 (pre-BIPA)
Aetna	Allentown-Bethlehem-Easton, PA	10,910	8.4%	185	8.8%
Aetna	New York, NY	36,125	9.0%	1,730	9.1%
Allina	Minneapolis-St Paul, MN-WI	14,343	16.0%	14,159	14.8%
AvMed	Orlando, FL	626	8.2%	54	8.2%
AvMed	Tampa-St Petersburg-Clearwater, FL	2,309	8.9%	767	8.3%
Blue Cross Blue Shield Georgia	Atlanta, GA	21,115	8.4%	305	9.7%
Community Health of Ohio	Columbus, OH	1,427	16.5%	155	14.1%
Coventry	St Louis, MO-IL	36,548	9.1%	1,864	11.3%
Fallon Community Health Plan	Boston-Worcester-Lawrence, MA-NH-ME-CT	35,407	8.2%	895	9.2%
Harvard	Boston-Worcester-Lawrence, MA-NH-ME-CT	45,482	8.6%	10,105	9.4%
Health Net	Hartford, CT	1,926	11.2%	2,665	15.8%
Health Net	Philadelphia, PA-NJ	7,818	8.2%	701	8.4%
Highmark/Capital Blue Cross	Harrisburg-Lebanon-Carlisle, PA	6,585	9.2%	938	16.0%
Humana	Beaumont-Port Arthur, TX	2,086	8.2%	1,080	8.2%
Humana	Chicago, IL	78,288	9.0%	6,001	11.5%
Humana	Galveston-Texas City, TX	584	8.2%	2,512	8.2%
Humana	Houston, TX	8,238	8.3%	16,480	8.2%
Humana	Jacksonville, FL	6,130	8.2%	3,868	10.4%
Humana	Kansas City, MO-KS	21,869	8.9%	1,788	11.9%
Humana	Tampa-St Petersburg-Clearwater, FL	68,946	8.7%	9,282	8.3%
Mercy Health Plans	St Louis, MO-IL	1,949	9.8%	363	15.7%

Organization	Metropolitan statistical area (MSA) or consolidated MSA (CMSA)	Retained enrollees	Rate increase, 1997-2001 (pre-BIPA)	Dropped enrollees	Rate increase, 1997-2001 (pre-BIPA)
Ochsner Health Plan	New Orleans, LA	22,746	8.2%	369	8.2%
Oxford	Middlesex-Somerset-Hunterdon, NJ	866	8.7%	243	14.1%
PacifiCare	Dallas, TX	20,519	8.3%	1,330	10.6%
PacifiCare	Fort Worth-Arlington, TX	37,830	9.4%	357	11.6%
Promedica	Toledo, OH	16,683	8.5%	1,049	11.6%
SummaCare Health Plan	Cleveland-Lorain-Elyria, OH	873	9.0%	601	8.2%
Trinity	Detroit, MI	1,138	8.2%	90	8.2%
United Healthcare	Atlanta, GA	1,773	8.6%	2,698	8.4%
United Healthcare	Baltimore, MD	1,537	8.3%	12,725	8.3%
United Healthcare	Boston-Worcester-Lawrence, MA-NH-ME-CT	3,008	8.4%	9,974	13.2%
United Healthcare	Providence-Fall River-Warwick, RI-MA	20,347	10.7%	1,692	11.1%
United Healthcare	St Louis, MO-IL	57,808	9.0%	581	15.3%
United Healthcare	Tucson, AZ	347	9.6%	11,716	9.6%
United Healthcare	Washington, DC-MD-VA-WV	602	9.9%	1,863	8.8%

Source: June 2000 market penetration data.

Table 58. Change in Enrollment, 1999-2000, in Areas Retained and Dropped for 2001, Continuing Organizations with Largest Number of Dropped Enrollees

Organization	Percent change in enrollment	
	Retained areas	Dropped areas
Aetna	-1%	-12%
CIGNA	-13%	0%
Humana	17%	-5%
United Healthcare	3%	-22%
Anthem	31%	-12%
Penn State Geisinger Health Plan	13%	1%
Health Net	28%	-12%
PacifiCare	-1%	-41%
Harvard	-6%	-38%
Coventry	15%	-20%

Source: June 1999 and June 2000 market penetration data.

Table 59. CIGNA Terminations and Service Area Reductions for 2001

	Retained enrollees	Dropped enrollees	Earliest Medicare contract
Cigna Healthcare Mid-Atlantic	-	8,195	1998
Cigna Healthcare of Arizona	33,179	4,083	1978
Cigna Healthcare of California	-	15,398	1994
Cigna Healthcare of Connecticut	-	10,280	1997
Cigna Healthcare of Delaware	-	3,546	1998
Cigna Healthcare of Florida	-	14,932	1995
Cigna Healthcare of Georgia	-	9,655	1998
Cigna Healthcare of New York	-	6,911	1996
Cigna Healthcare of New Jersey	-	3,902	1997
Cigna Healthcare of Texas	-	2,484	1997
Cigna Healthcare of Virginia	-	13,625	1996
Healthsource Tennessee	-	2,835	1997
Lovelace Health Plan (New Mexico)	12,190	5,085	1981
Total	45,369	100,931	

Source: June 2000 market penetration data.

Table 60. Aetna U.S. Healthcare Terminations and Service Area Reductions for 2001

	Medicare enrollees, July 2000	Retained	Service area reduction	Terminated contract
Aetna				
Arizona (1997)	10,885	10,885	-	-
California (1981)	46,476	46,476	-	-
Connecticut (1987)	14,308	-	-	14,308
Florida (1997)	6,575	-	-	6,575
Georgia (1996)	6,813	-	-	6,813
Illinois/Indiana (1997)	6,878	-	-	6,878
Kentucky (1997)	3,751	-	-	3,751
Louisiana (1997)	5,092	-	-	5,092
Ohio (1997)	33,087	-	-	33,087
Washington (1998)	10,578	-	-	10,578
US Healthcare				
New York (1986)	70,883	36,125	34,758	-
Pennsylvania (Philadelphia area, 1977)	100,750	83,409	17,341	-
Pennsylvania (Pittsburgh area, 1987)	29,028	28,372	656	-
Other acquisitions				
HMO of New Jersey	89,365	89,365	-	
NYLCare	130,085	-	-	130,085
Prudential	50,188	-	-	50,188
Bay Pacific	14,163	-	-	14,163
Total	628,905	294,632	52,755	281,518

Source: June 2000 market penetration data.

Appendix B: Sources of Data

The following are the HCFA data sources used for this report.

Medicare Compare

The Medicare Compare data are used for the interactive plan comparison feature on HCFA's beneficiary-oriented web site, medicare.gov. The file includes information on M+C contractors, service areas, and benefit packages; for this report it was used only to establish service areas. The data are updated more or less continuously. Service areas for 2000 are based on the August 3, 2000, update; service areas for 2001 are based on the April 6, 2001, update.

Market penetration files

Quarterly county/plan penetration files give the number of Medicare beneficiaries in each county and the number of M+C enrollees in the county in each plan (including enrollees in plans that do not include the county in its service area). For confidentiality reasons, the files suppress data on counties with very small numbers of beneficiaries. Files before December 2000 gave current month enrollee counts and prior month beneficiary counts. Thus the June 2000 data used in this report reflect June M+C enrollees but May beneficiary counts. As no table in this report uses the two numbers together, this discrepancy is unimportant.

Rate calculation files

These annual files give the county-level factors used in computing M+C rates and the national update factor, including revisions in estimated updates for prior years. Area-specific FFS cost estimates for 2001 in this report use the revised updates for 1998-2001 provided in the rate calculation for 2002, rather than the updates used in calculating pre-BIPA and post-BIPA 2001 rates.

Adjusted community rate (ACR) files

Each year contractors submit ACR proposals for the coming contract year; for 2001, contractors submitted a second set of proposals to reflect changes made in response to BIPA. A proposal is submitted for each benefit package a contractor plans to offer. It includes the counties where the package will be available and projections of enrollment under the package, the average Medicare payment rate (the APR), costs for furnishing basic Medicare benefits (the ACR), costs of proposed supplements, and coinsurance, copayment, and/or premium amounts

to be paid by enrollees. The ACR includes total medical and administrative costs, plus (sometimes minus) surplus, before any beneficiary cost-sharing. In determining a contractor's obligation to furnish free supplements—that is, the difference between the APR and the ACR—HCFA reduces the ACR by the estimated national average amount of cost-sharing for Medicare services ($100.66 in 2001). All estimates in this report take the reduction against the medical services component of the ACR, rather than the total.

Many of the analyses in this report allocate actual enrollees under a contract to the different available benefit packages. If a contractor's submission for 2000 projected 1,000 enrollees under package A and 500 enrollees under package B, and if actual June 2000 enrollment in a county where both packages were available was 3,000, the analysis assumes 2,000 enrollees in package A and 1,000 in package B. A very few contractors erroneously used their total projected enrollment as the projected enrollment for each package; in this case, it was assumed that enrollees were equally distributed among the various packages.