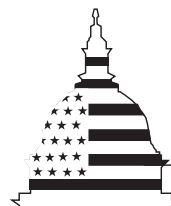


April 1999

# MEDICARE MANAGED CARE PLANS

## Many Factors Contribute to Recent Withdrawals; Plan Interest Continues



G A O

Accountability \* Integrity \* Reliability

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

B-282017

April 27, 1999

Congressional Requesters

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

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice program to expand beneficiaries' managed care options, both by encouraging the wider availability of HMOs and by permitting other types of health plans to participate in Medicare. The BBA also contained provisions to slow the growth of Medicare spending. The Congressional Budget Office estimated that these provisions will result in net Medicare savings of \$116 billion between 1998 and 2002. Changes to the method for calculating payments to managed care plans, along with slowed growth in Medicare FFS spending (upon which managed care payments are partially based), account for approximately \$22.5 billion of these projected savings. These changes followed a decade in which studies by GAO and others found that Medicare's previous payment methodology tended to overcompensate managed care plans.<sup>3</sup> In addition, the BBA included provisions to make plans more accountable for the quality of care they

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

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

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

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provide. For example, the BBA required Medicare managed care plans to implement new and more comprehensive quality assurance programs.

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

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## Results in Brief

Although an unusually large number of managed care plans left the Medicare program recently, a number of new plans have demonstrated their interest in serving beneficiaries by applying to enter the program or expanding the areas in which they offer services. Last fall, shortly before Medicare+Choice was implemented, 45 plans announced they would not renew their Medicare contracts and 54 others announced they would reduce the geographic areas in which they provided services. About 407,000 enrollees (7 percent of the managed care population) had to choose a new managed care plan or switch to FFS. A small number of the affected enrollees had to switch to FFS because no plans remained to provide services in their areas. At the same time, however, several new plans applied to enter the program. Thus far, the Health Care Financing Administration (HCFA), which administers Medicare, has approved 10 new plans for 1999 and is reviewing 30 additional plan applications. Some of the pending plan applications are for counties that previously had few or no managed care plans. If HCFA approves all of the pending plans and service area expansions, slightly more beneficiaries will have access to a managed care plan in 1999 than in 1998.

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



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

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

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## Background

Medicare is the nation's health insurance program for those aged 65 and older and certain disabled individuals. All beneficiaries may receive health care through Medicare's traditional FFS arrangement. Alternatively, a

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beneficiary may enroll in a Medicare managed care plan if one is available in the county in which he or she lives. The vast majority of the nation's 39 million Medicare beneficiaries remain in the traditional FFS program, but enrollment in Medicare managed care plans has grown rapidly in recent years. Currently, about 17 percent of all Medicare beneficiaries are enrolled in a managed care plan.

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## Medicare Managed Care Before BBA

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

This payment methodology has been criticized for a number of weaknesses. Basing payments on per capita FFS spending resulted in significant variation in capitation rates across counties that did not necessarily reflect differences in costs faced by managed care plans.<sup>6</sup> Rural areas, which generally had much lower payment rates than urban areas, often had few or no managed care plans. In addition, years of research indicated that Medicare's payment methodology and demographic risk adjusters resulted in excess payments to plans because they generally attracted healthier beneficiaries with below-average health care costs.<sup>7</sup> Consequently, many managed care enrollees would have cost Medicare less if they had stayed in the FFS sector. In 1997 the Physician

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

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

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

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Payment Review Commission<sup>8</sup> estimated that Medicare paid as much as \$2 billion annually in excess payments to managed care plans.

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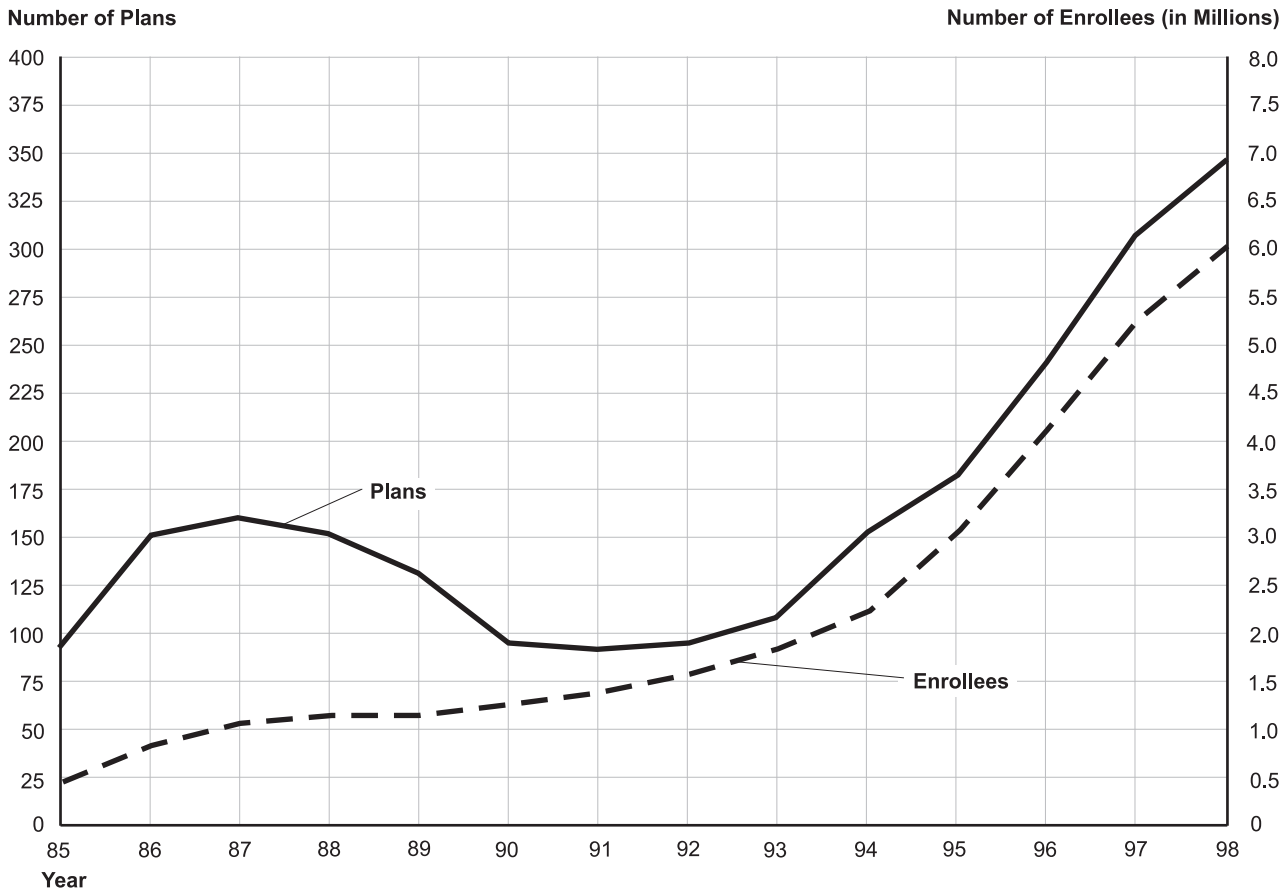
## Historical Trends in Plan Participation and Enrollment

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

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<sup>8</sup>In October 1997, the Medicare Payment Advisory Commission replaced the Physician Payment Review Commission.

**Figure 1: Medicare Plans and Enrollment, 1985-98**

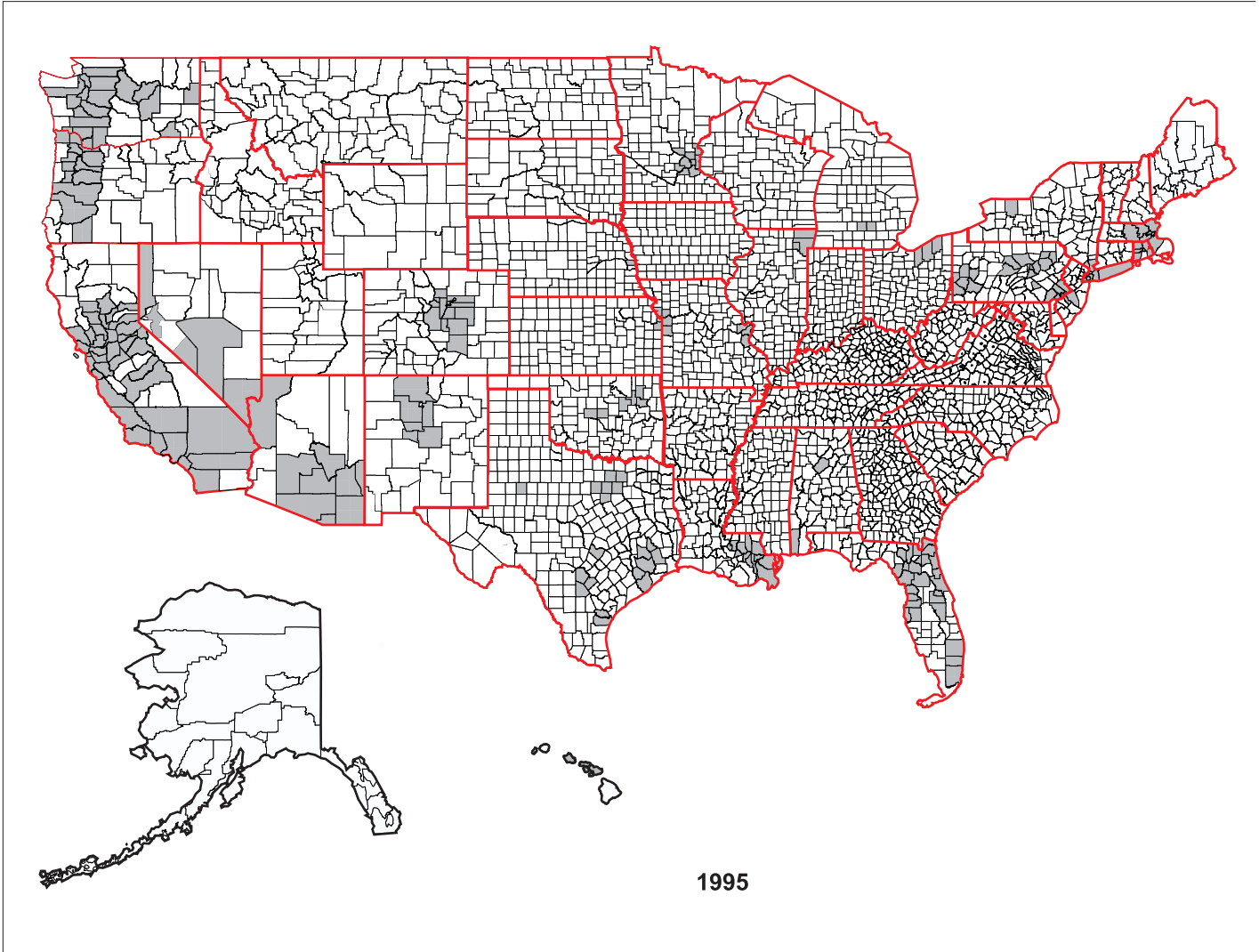


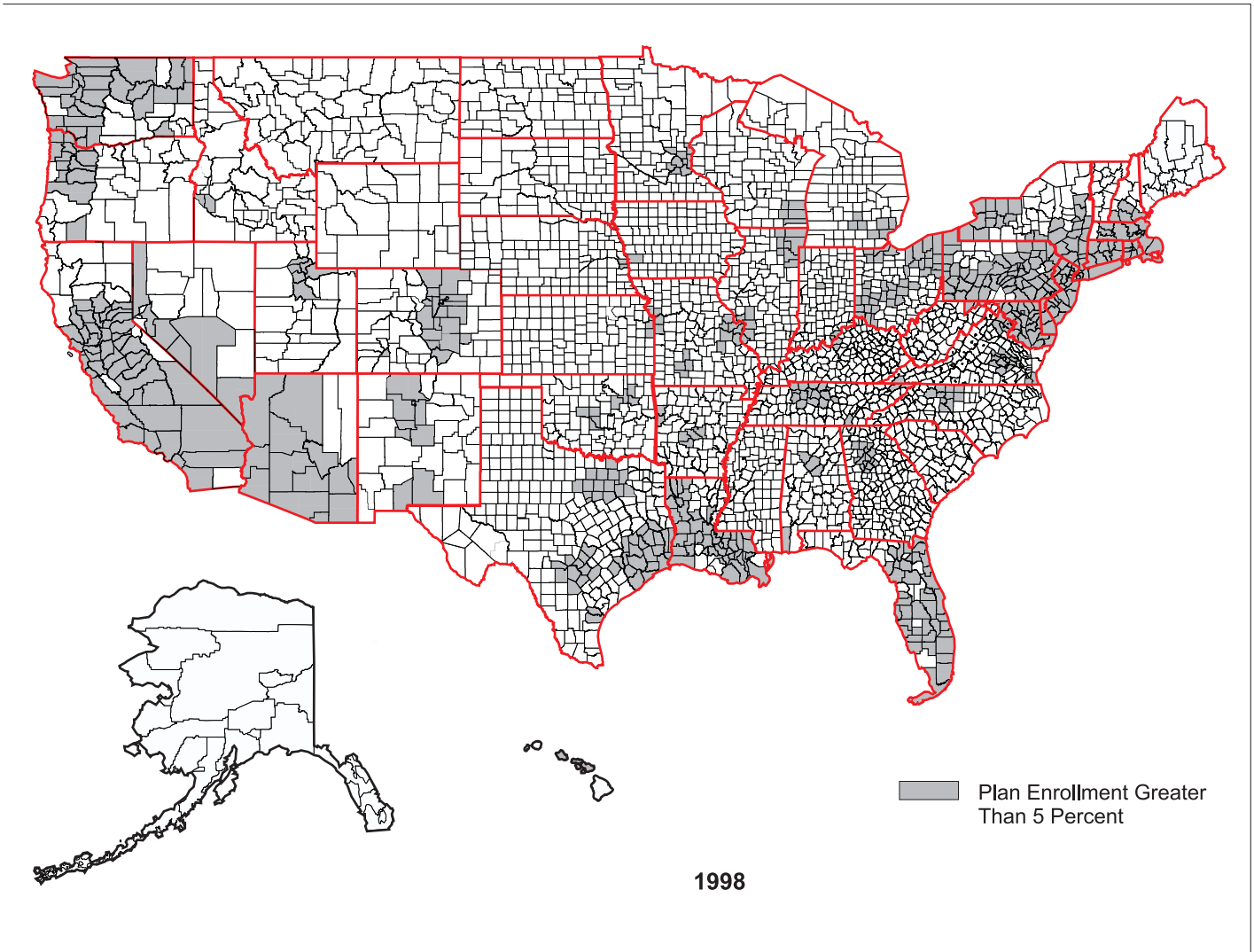
Note: Nonrisk plans are excluded from this analysis.

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

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

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





Note: Nonrisk plans are excluded from this analysis.

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

## BBA Changes to Medicare Managed Care

The BBA substantially changed the method used to set the payment rates for Medicare managed care plans. As of January 1, 1998, plan payments for

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

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

Other BBA provisions changed the requirements for plans participating in Medicare+Choice. For example, plans are required to implement new and more comprehensive quality improvement programs. Compared with pre-BBA requirements, plans must also collect more information on such activities as appeals filed by enrollees and the number and type of the services provided by the plan; in addition, plans must report more information to HCFA and to beneficiaries. The BBA moved up the date for plans to submit their benefit package proposals from November 15 to May 1 of each year, allowing more lead time to coordinate the beneficiary information campaign.<sup>11</sup> Additionally, the BBA eliminated the requirement that no more than 50 percent of a plan's enrollment may consist of

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

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

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

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Medicare and Medicaid beneficiaries. The elimination of this restriction means that Medicare plans can now serve areas without first building a commercial base.

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**Plans' Concerns About  
BBA Changes**

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

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



## Withdrawals Reduce Access to Plans for Some Beneficiaries, but New Plan Entries May Increase Access for Others

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

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

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

These withdrawal decisions affected about 407,000 enrollees who could not continue receiving services in their chosen plan. Instead, they had to either choose a new managed care plan (if one was available in their county) or switch to FFS. About 61,000 of these enrollees, or 1 percent of the total Medicare managed care population, lived in counties in which no other Medicare+Choice plan was offered.<sup>14</sup> Even if another managed care plan was available, about 450 beneficiaries affected by the withdrawals

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

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

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

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

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

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## New Plan Applications May Mitigate Effects of Withdrawals

While some plans have chosen to curtail their participation in Medicare, new plans are entering the program and some existing plans are expanding the areas they serve. HCFA has approved applications from 10 new plans that were able to enroll beneficiaries as of January or February 1999. HCFA is also reviewing 30 additional new plan applications.<sup>17</sup> In addition, 6 service area expansions had been approved and 14 other service area expansion applications were pending as of January 1999. The number of recently approved and pending applications suggests that there is still considerable plan interest in participating in Medicare. Furthermore, total managed care enrollment has increased following the drop that occurred in January 1999 and is now slightly higher than it was when the withdrawals took effect.

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

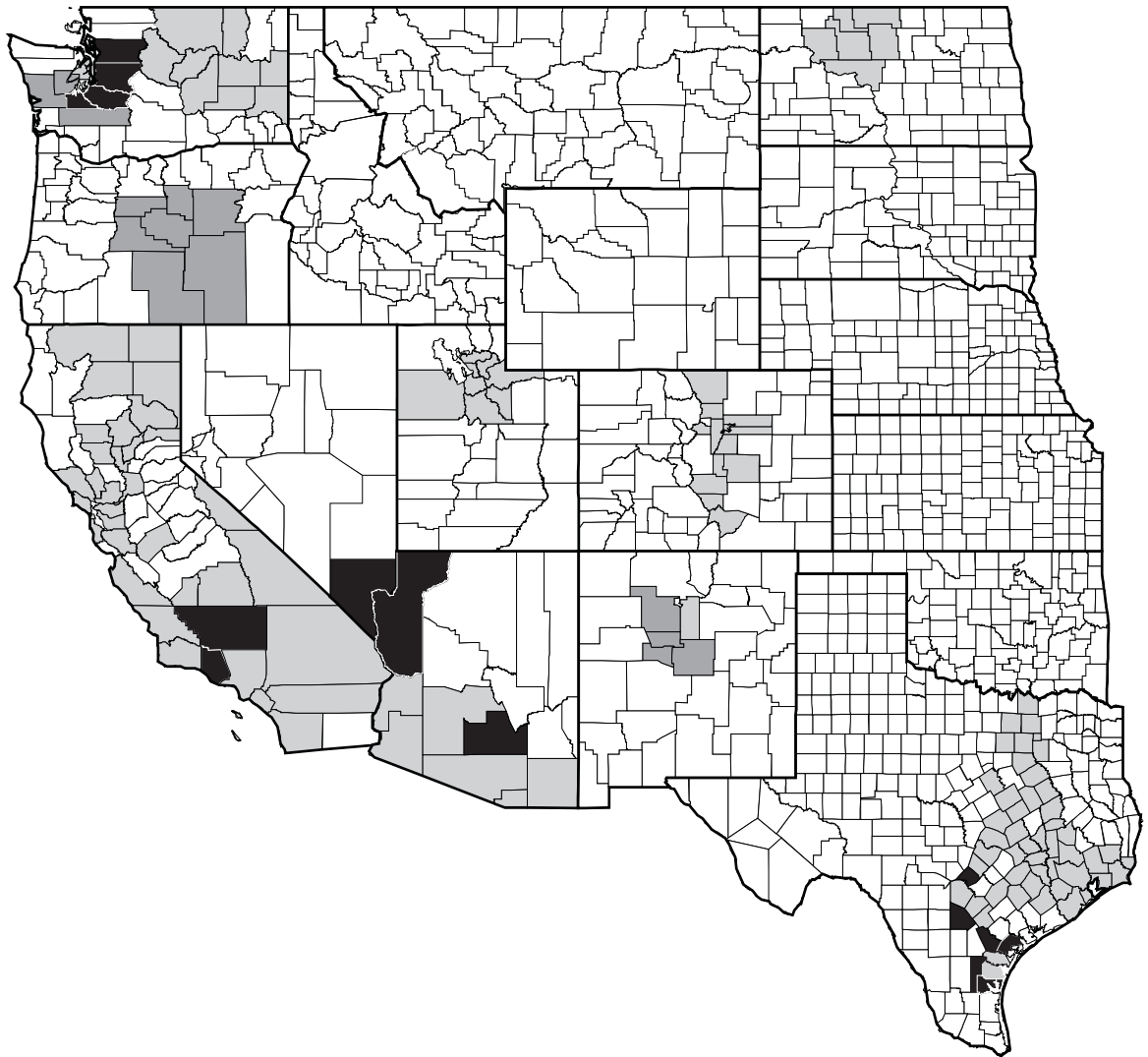
<sup>16</sup>An additional 43 beneficiaries with ESRD, who were enrolled in cost HMOs or plans participating in demonstration projects, will not be permitted to join another managed care plan.

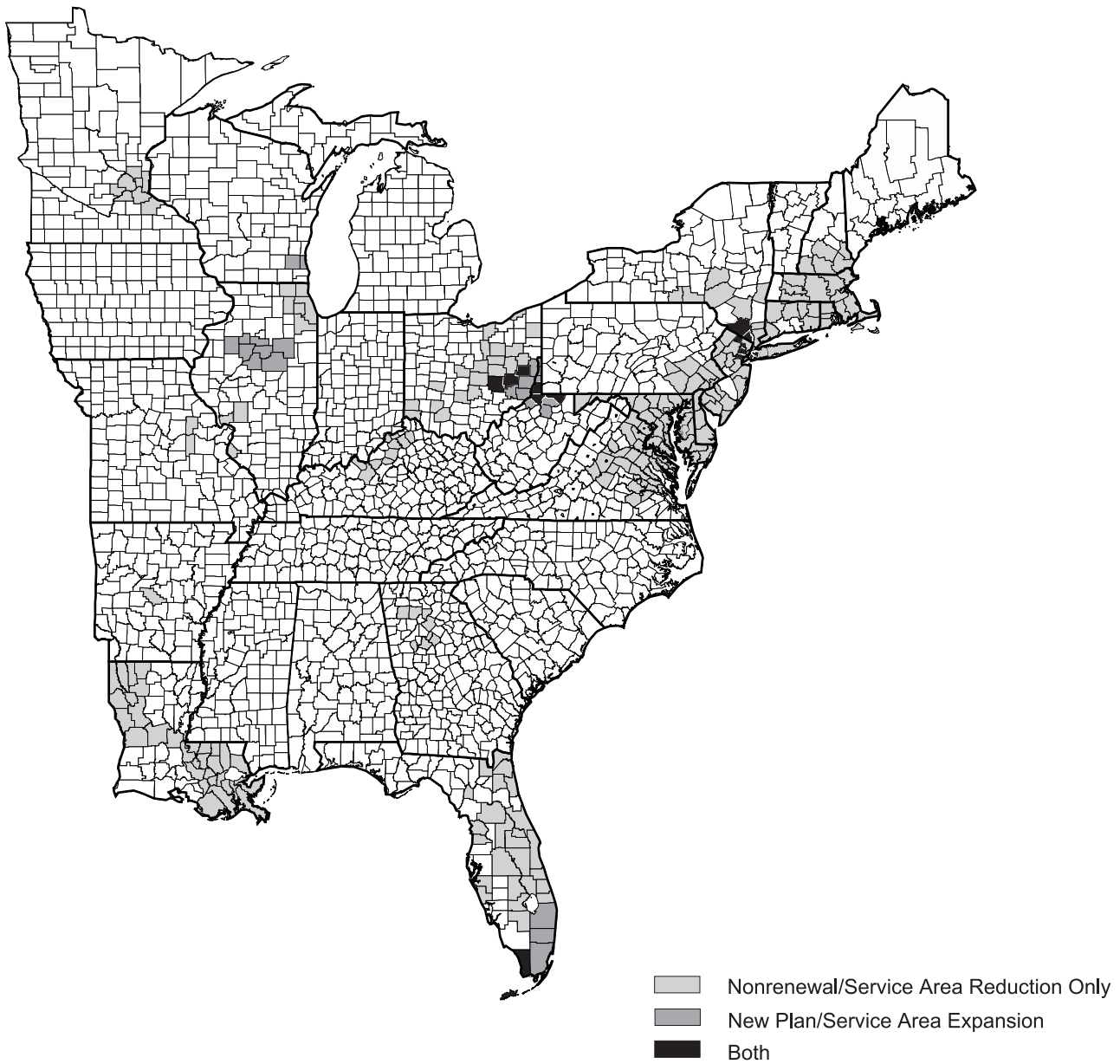
<sup>17</sup>The numbers of approved and pending plans and service area expansions are based on data provided by HCFA as of January 20, 1999. Some pending plans or service area expansions may have been approved and new applications may have been submitted since then.

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

Figure 3: Counties With Plan Changes in January 1999





(Figure notes on next page)

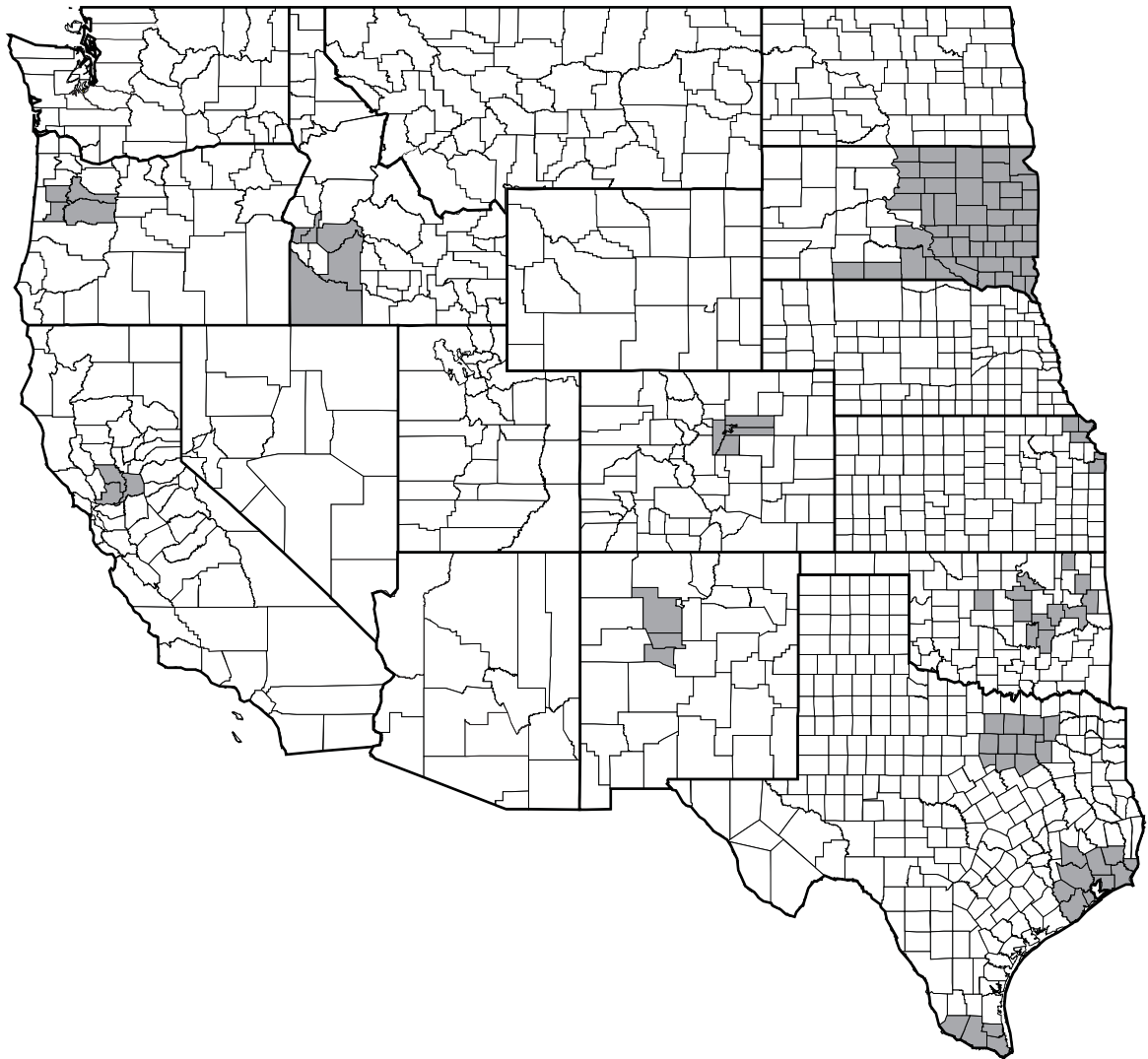
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Note: Hawaii did not have any withdrawals but did have one new plan approved in January 1999. Alaska did not have any managed care plans in 1998 or 1999. Nonrisk plans are excluded from this analysis.

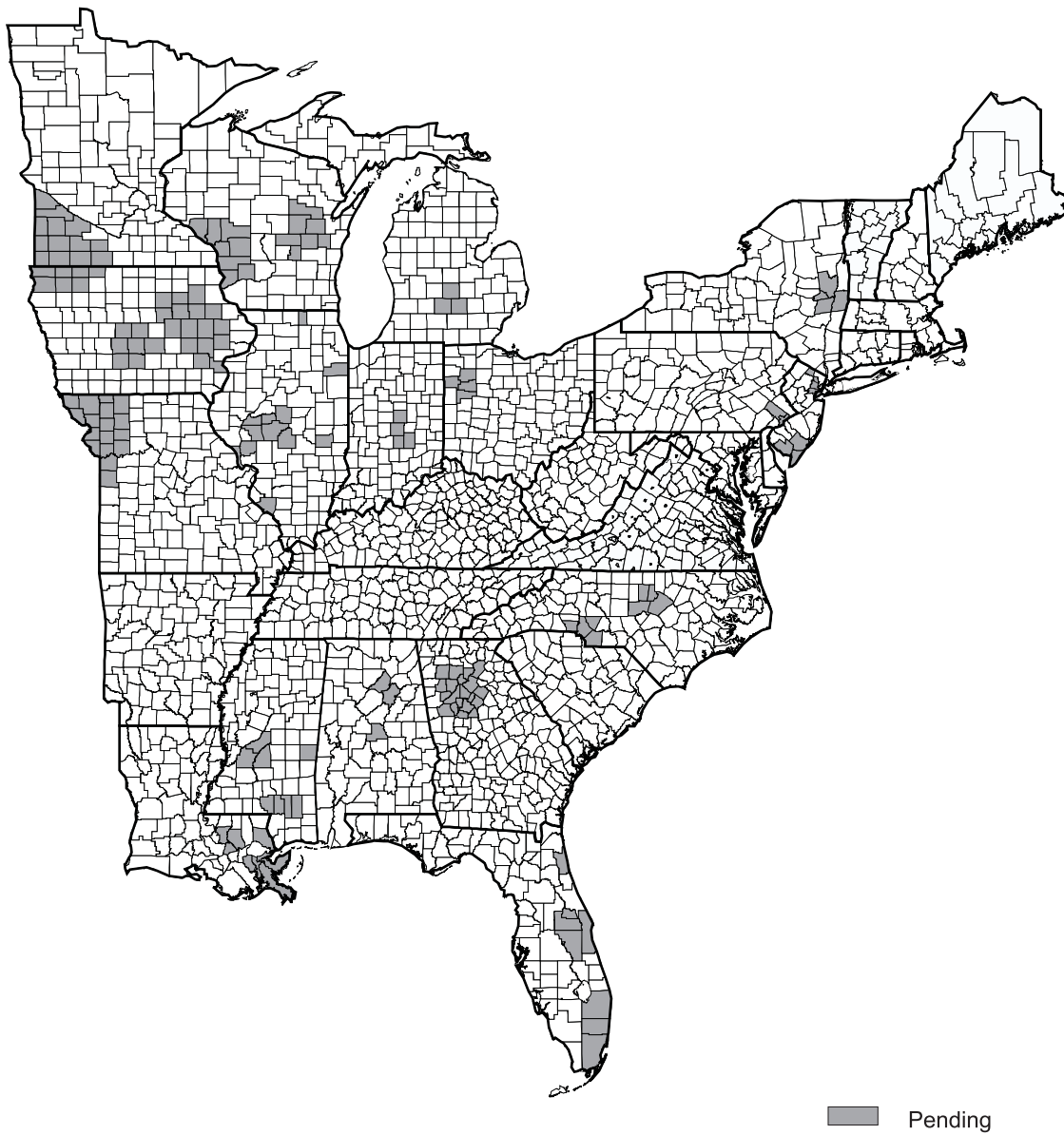
Sources: Files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.



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







(Figure notes on next page)

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

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

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

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

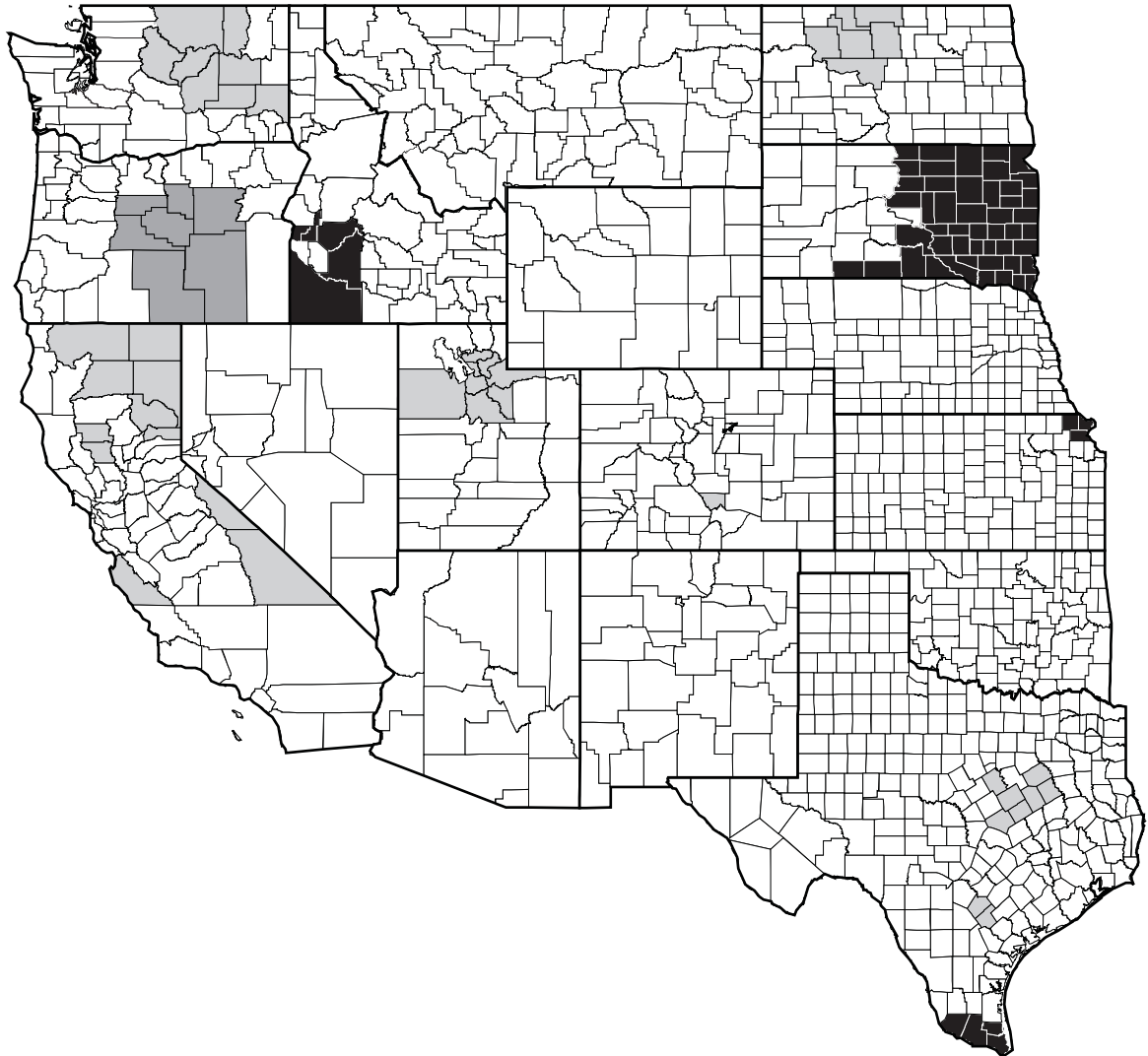
	Counties with approved Medicare plans as of September 1998	Counties with approved Medicare plans as of January 1999	Counties with approved or pending Medicare plans as of January 1999
1 or more plans available	957	883	1,045
More than 1 plan available	574	490	527
1 plan available	383	393	518
No plans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

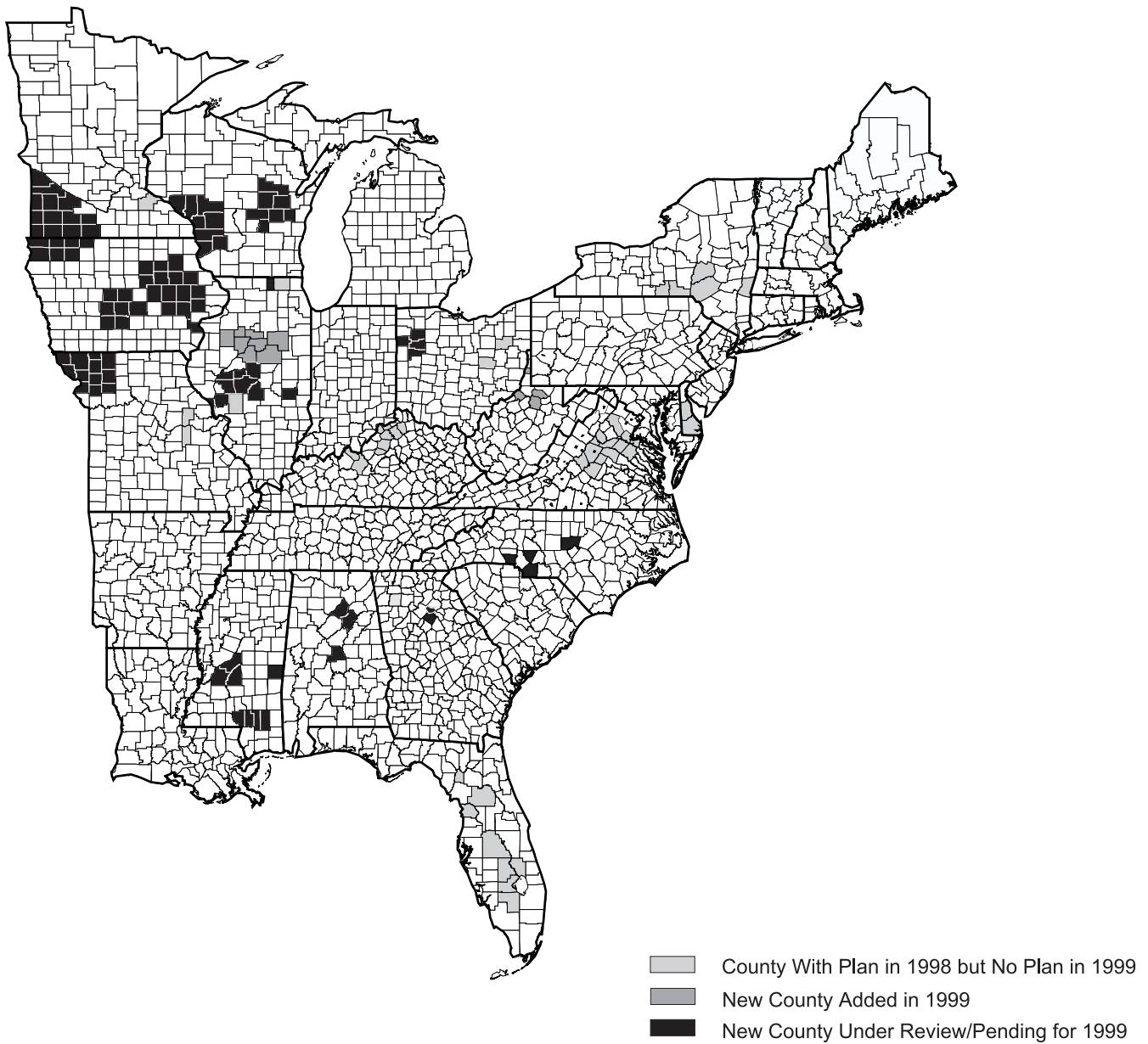
Notes: Nonrisk plans are excluded from this analysis. 1999 Medicare beneficiaries are based on September 1998 count of beneficiaries.

Sources: Medicare Managed Care Market Penetration State/County Data Files, September 1998, [www.hcfa.gov/medicare/mpsct1.htm](http://www.hcfa.gov/medicare/mpsct1.htm) (Feb. 9, 1999); Medicare Managed Care Geographic Service Area Report, September 1998, [www.hcfa.gov/stats/geos.htm](http://www.hcfa.gov/stats/geos.htm) (Jan. 26, 1999); and files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.



**Figure 5: Counties That Had a Medicare Plan in 1998 but None in 1999, or That Had No Plan in 1998 but Have a Newly Approved or Pending Plan in 1999**





(Figure notes on next page)

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

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, [www.hcfa.gov/stats/geos.htm](http://www.hcfa.gov/stats/geos.htm) (Jan. 26, 1999); Medicare Managed Care Market Penetration State/County Data Files, September 1998, [www.hcfa.gov/medicare/mpsct1.htm](http://www.hcfa.gov/medicare/mpsct1.htm) (Feb. 9, 1999); and files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

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

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

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

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

Sources: Medicare Managed Care Geographic Service Area Report, September 1998, [www.hcfa.gov/stats/geos.htm](http://www.hcfa.gov/stats/geos.htm) (Jan. 26, 1999); Medicare Managed Care Market Penetration State/County/Plan Data Files, September 1998, [www.hcfa.gov/medicare/mpsct1.htm](http://www.hcfa.gov/medicare/mpsct1.htm) (Jan. 13, 1999); Medicare Managed Care Market Penetration State/County Data Files, September 1998, [www.hcfa.gov/medicare/mpsct1.htm](http://www.hcfa.gov/medicare/mpsct1.htm) (Feb. 9, 1999); and files of contract nonrenewals and service area reductions, new plans, and service area expansions from the Center for Health Plans and Providers at HCFA.

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

Medicare+Choice is still very new, and interim final regulations governing the program were just published in June 1998. Plans had little time to prepare and submit applications for 1999. The number and diversity of applications may increase in future years as plans become more familiar with the new program. However, officials from organizations representing managed care plans believe that the reduced growth in payments and increased administrative burden under Medicare+Choice may discourage future plan participation.

## Several Factors, Such as Payment, Enrollment, and Level of Competition, Are Associated With Plan Participation

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

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

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

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

## Plans Withdrew From Both High- and Low-Payment Counties

Both before and after the recent withdrawals, managed care plans were much more likely to offer services in high-payment-rate counties than in low-payment-rate counties. In 1999, for example, 91 percent of counties with monthly payment rates over \$694 are served by a managed care plan. By contrast, only 11 percent of counties with the minimum payment rate of approximately \$380 are served by a managed care plan. High-payment-rate counties, however, were disproportionately affected by the withdrawals (see table 3). Over 90 percent of the counties with the highest payment rates experienced a plan withdrawal, compared with 34 percent of counties with the lowest payment rate. It is possible that some plans withdrew from high-payment-rate counties because they

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



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anticipated that these counties will receive below-average payment increases in the coming years. In fact, for those counties with payments based on a blend of national and local FFS spending as specified in the BBA, this payment blending provision (expected to be implemented for the first time in 2000) will result in smaller payment increases for higher-payment-rate counties and larger payment increases for lower-payment-rate counties (see app. II for more information on the BBA's payment provisions). In addition, over the next 5 years, Medicare payments for graduate medical education (GME) will be eliminated from the blended rates.<sup>19</sup> Because GME spending is concentrated in high-payment-rate counties, its removal will disproportionately slow payment rate growth in high-payment-rate counties.

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

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

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

Note: Nonrisk plans are excluded from this analysis.

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

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

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

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

	1999 payment rates <sup>a</sup>					Total
	\$379.84 to \$379.85	\$484.47 to \$484.48	\$589.10 to \$589.11	\$693.72 to \$693.73	\$798.35 to \$798.36	
Enrollees in plans affected by withdrawals, September 1998	19,400	174,900	158,000	51,300	3,100	406,500
Enrollees in plans, September 1998	119,100	1,445,700	2,783,000	1,208,400	331,600	5,887,900
Percentage of enrollees in plans affected by withdrawals	16%	12%	6%	4%	1%	7%

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

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

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

For plans that dropped selected counties from their service areas, payment rates appear to be one factor that influenced their decisions. In 1999, for example, PacifiCare of Arizona withdrew from four of the eight counties in its service area, withdrawing primarily from counties with the lowest payment rates. It continued to provide services in Pinal County, which had the highest payment of all the counties in its service area, but dropped Cochise County, where the payment rate was about 25 percent lower.<sup>20</sup> To assess the impact of relative county payment rates on plans' service area decisions, we compared the payment rate for each county in a plan's service area with the highest county payment rate in that plan's service area.<sup>21</sup> We repeated our calculation for every plan. The results (shown in table 5) suggest that counties with payment rates that were low relative to the maximum county payment rate in a given service area were

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

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

disproportionately affected by service area reductions. For example, while plans reduced their service areas in 5 percent of counties with payments that were between 90 and 100 percent of a plan’s maximum-payment-rate county, they reduced their service areas in 28 percent of counties that had payment rates between 50 and 60 percent of the plan’s maximum-payment-rate county.

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

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

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

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

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

Several factors, in addition to payment rates, appear to be associated with a plan’s decision to withdraw from a specific county: short length of time operating in the county, low enrollment, and a weak competitive position compared with other Medicare plans in a county. The Medicare managed care program expanded rapidly in recent years; many new plans entered the program, and existing plans expanded the areas they served. The recent withdrawals may represent a market correction—some plans with low Medicare enrollment and in counties dominated by large plans may

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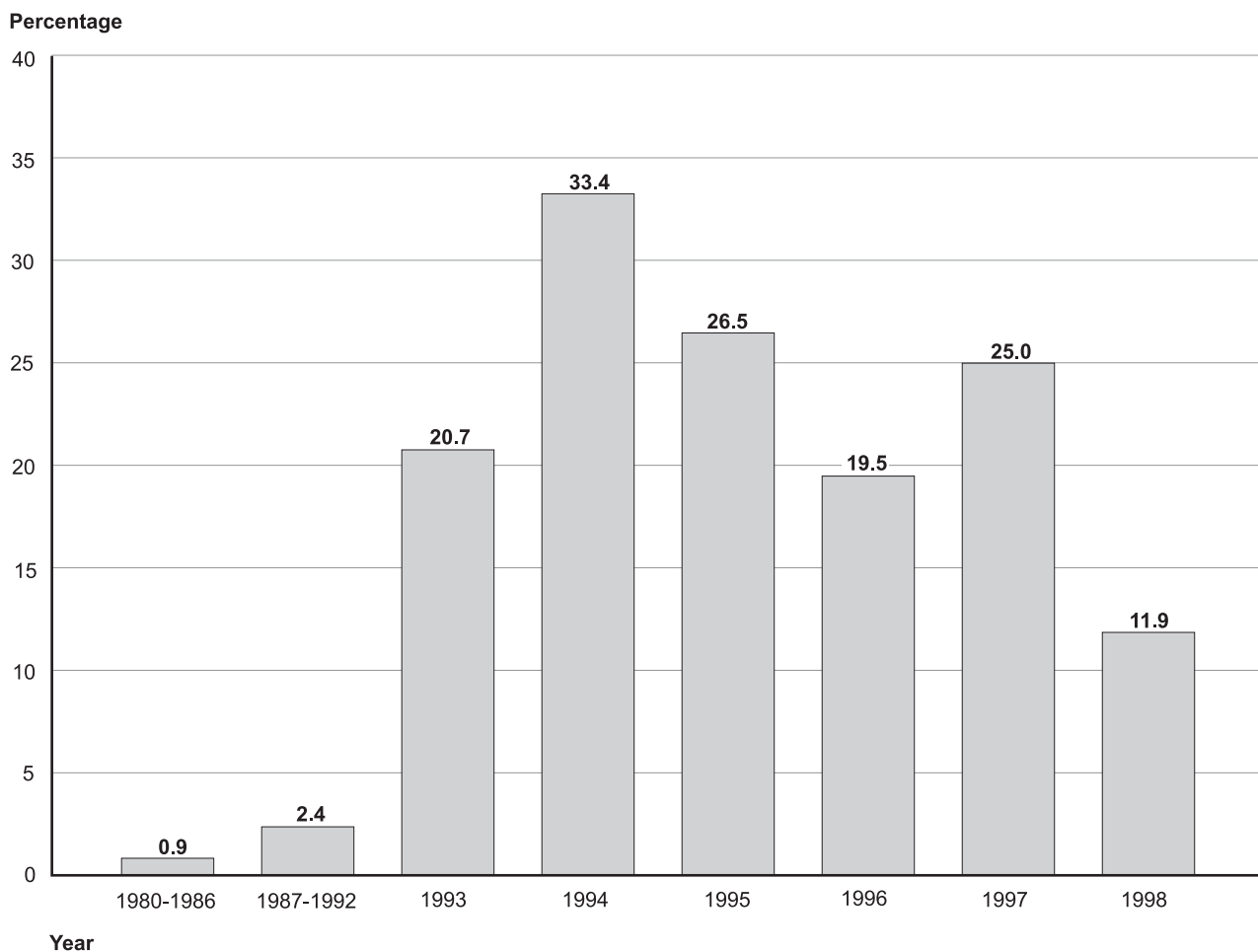
have concluded that they could not compete effectively and so withdrew. A number of plans left the Medicare program between 1988 and 1991 for similar reasons. Moreover, the market conditions that led to the recent withdrawals may not be unique to the Medicare program. The experience of FEHBP, which also sustained an unusually high number of plan withdrawals this year, suggests that plans may be reacting to general market conditions as well as program-specific ones.

Plans were more likely to withdraw from counties in which they had less Medicare experience. We looked at all instances in which a Medicare plan provided services in a county as of February 1998 and determined how long the plan had participated in Medicare in that county. In less than 1 percent of the instances in which a plan entered a county for the first time between 1980 and 1986—that is, plans with more than 12 years of Medicare experience in a county—did the plan withdraw from that county in 1998 (see fig. 6). In contrast, plans were much more likely to withdraw from areas in which they had less than 7 years experience. For example, about one-third of the plans with 5 years of Medicare experience in a county withdrew from that county in 1998.<sup>22</sup> The withdrawal pattern suggests a retrenchment from the rapid growth of Medicare managed care that began in 1994.

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

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



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

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

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

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

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

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

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

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

A plan was also more likely to withdraw from a county if it faced larger competitors. Specifically, a plan was more likely to withdraw from a county if its Medicare market share<sup>23</sup> in that county was small relative to the market share of the plan with the highest Medicare enrollment in the county. The bigger the difference in market shares, the more likely the smaller plan was to withdraw from the county. Moreover, the smaller plan

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

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was more likely to withdraw if the rest of the market was dominated by a few firms rather than divided up among many firms.<sup>24</sup>

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

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

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

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



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from the program while they waited to see what future changes might bring.

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## Small Reductions Seen in Availability of Some Benefits

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

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

Plans in counties with lower payments have generally offered fewer additional benefits; as a result, fewer beneficiaries living in lower-payment counties have had the opportunity to join plans that offer these benefits compared with beneficiaries living in higher-payment counties. In 1997, for example, only 61 percent of beneficiaries living in counties with payments under \$330 (and with at least one plan) had access to a Medicare plan that offered prescription drug coverage, while 100 percent of beneficiaries living in counties with payments over \$658 had such access (see fig. 7).<sup>26</sup>

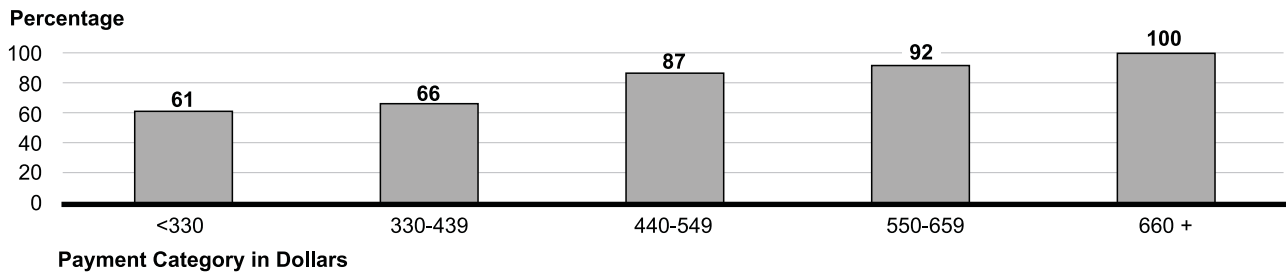
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<sup>25</sup>A plan must cover all benefits offered by traditional FFS Medicare but can choose to offer additional benefits. If a plan's projected profits from its Medicare contract are estimated to exceed its normal profits, the plan must provide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

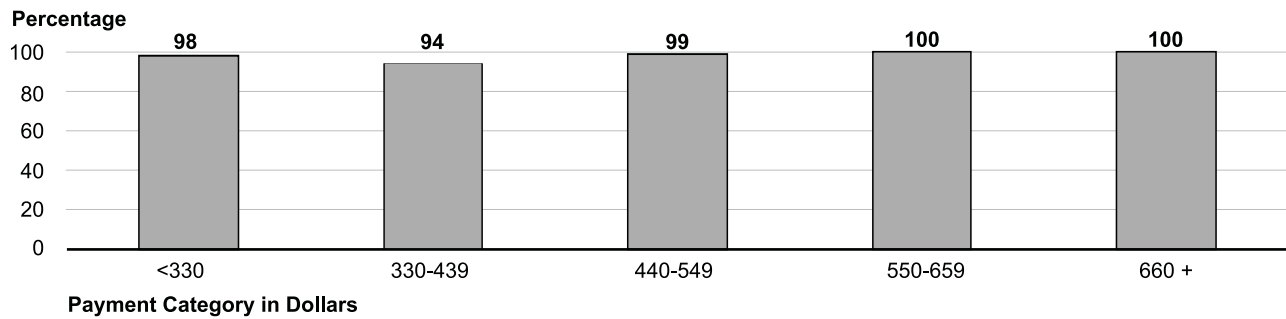
<sup>26</sup>Many FFS beneficiaries purchase supplemental insurance policies, which can cost up to \$270 per month, to obtain coverage for some of these additional benefits.

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

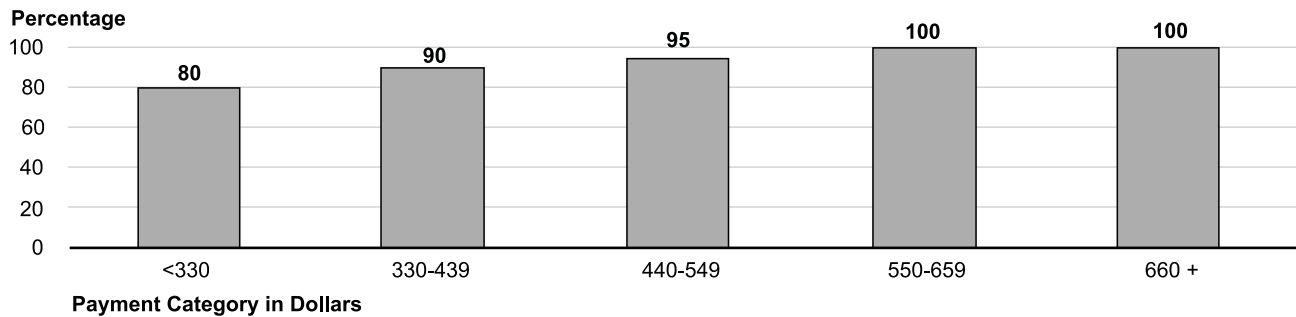
**Prescription Drugs**



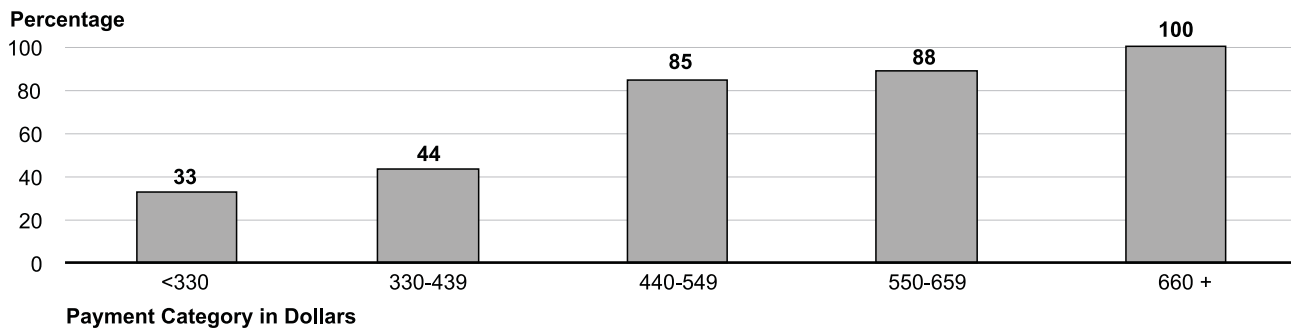
**Eye Exams**



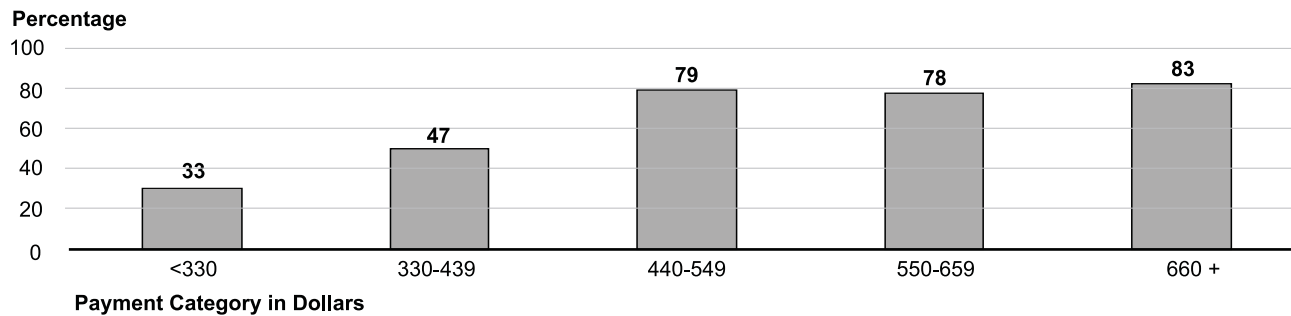
**Hearing Exams**



**Dental Care**



**Foot Care**



(Figure notes on next page)

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

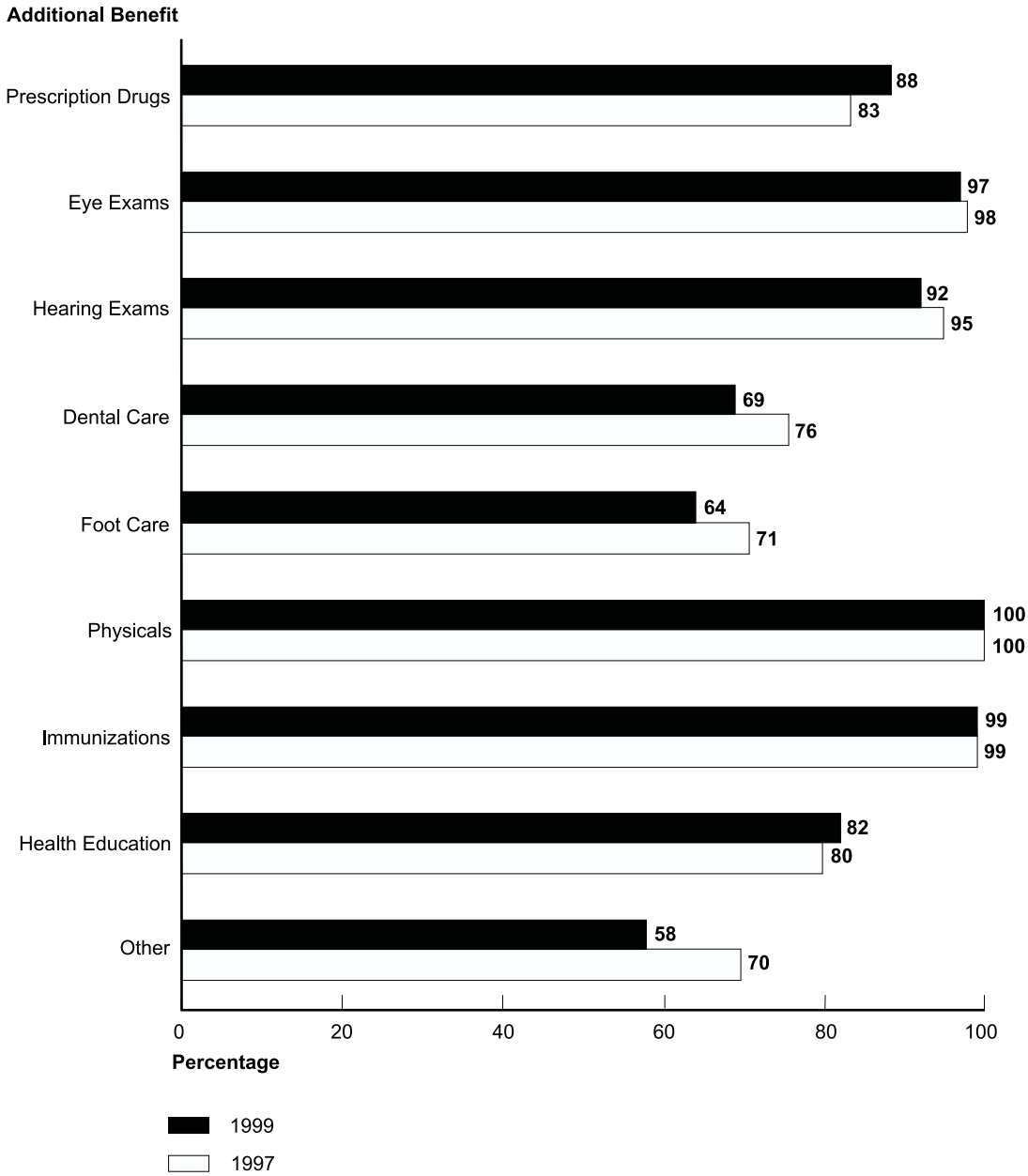
Sources: Medicare Managed Care Geographic Service Area Report, December 1997, [www.hcfa.gov/stats/geos.htm](http://www.hcfa.gov/stats/geos.htm) (Feb. 23, 1999); adjusted community rate submissions for 1997; Medicare Monthly Managed Care Report, December 1997, [www.hcfa.gov/stats/monthly.htm](http://www.hcfa.gov/stats/monthly.htm)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

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

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

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



(Figure notes on next page)

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

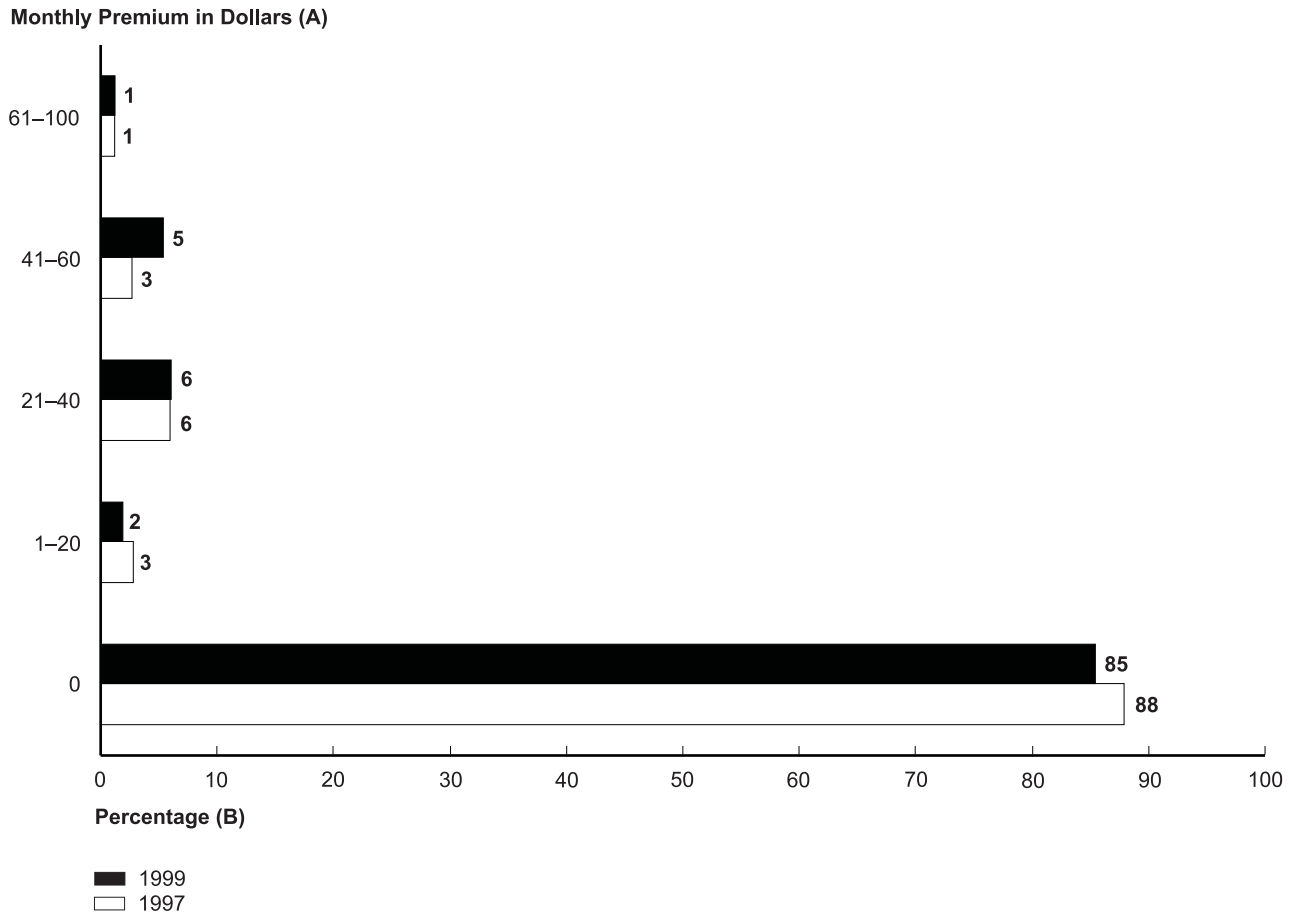
Sources: Medicare Managed Care Geographic Service Area Report, December 1997, [www.hcfa.gov/stats/geos.htm](http://www.hcfa.gov/stats/geos.htm) (Feb. 23, 1999); adjusted community rate submissions for 1997; Medicare Monthly Managed Care Reports, December 1997 and January 1999, [www.hcfa.gov/stats/monthly.htm](http://www.hcfa.gov/stats/monthly.htm)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

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

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

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



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

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

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

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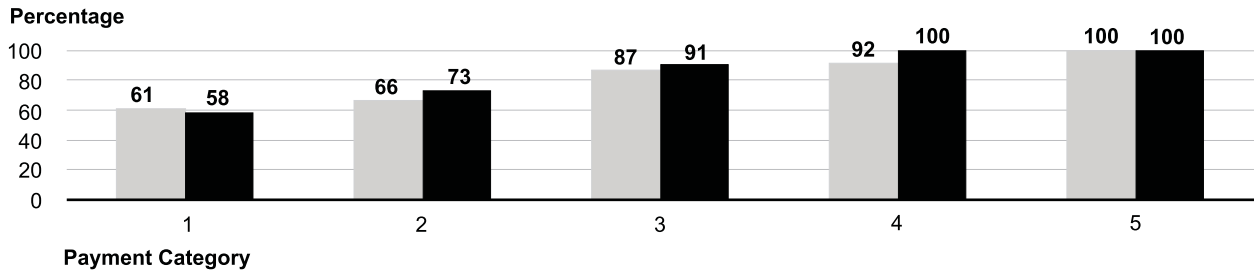
Although the changes in beneficiary access to plans offering additional benefits were relatively small, these benefit reductions were concentrated in low-payment-rate counties (see fig. 10). Access to plans offering additional benefits remained nearly constant for beneficiaries in high-payment-rate counties,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



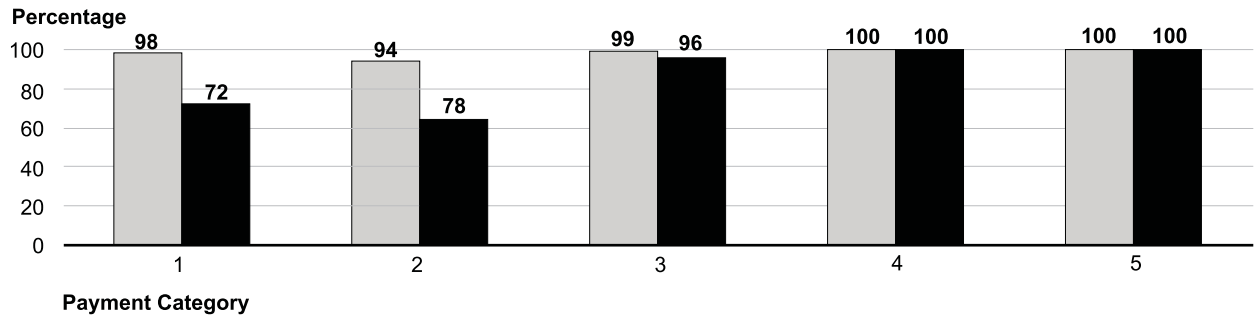


**Figure 10: Beneficiary Access to Plans Offering Selected Benefits Across Different Payment Levels, 1997 and 1999**  
(Includes Only Counties With One or More Plans)

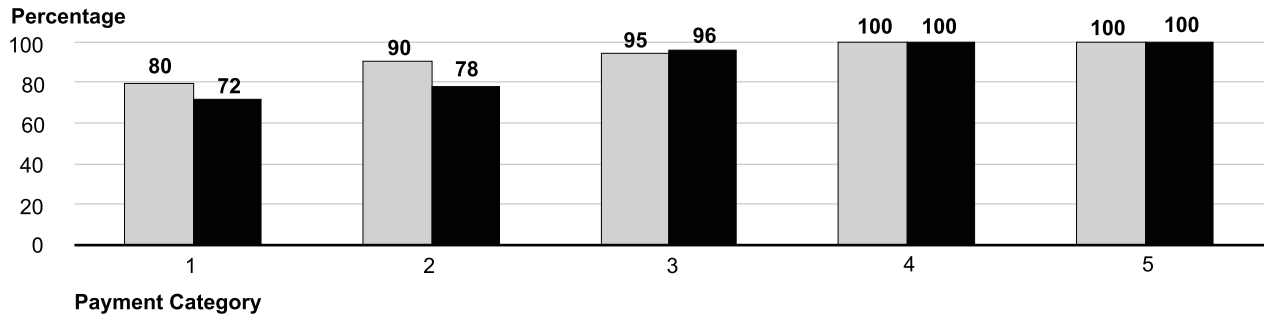
**Prescription Drugs**



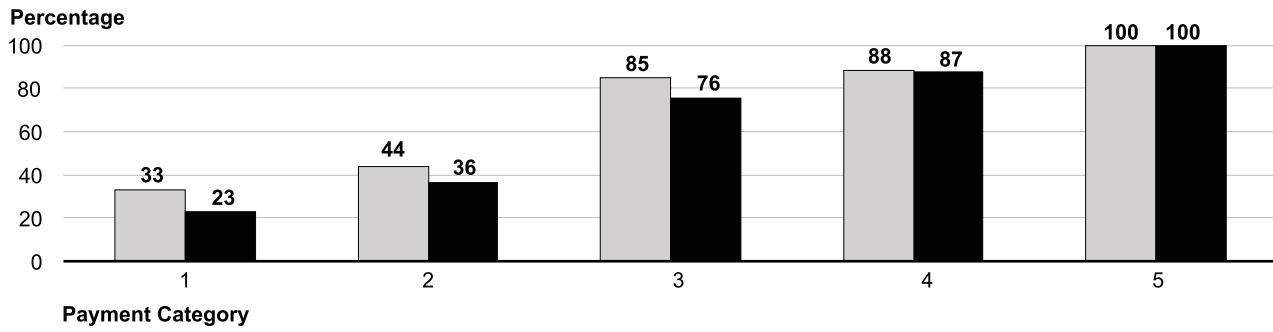
**Eye Exams**



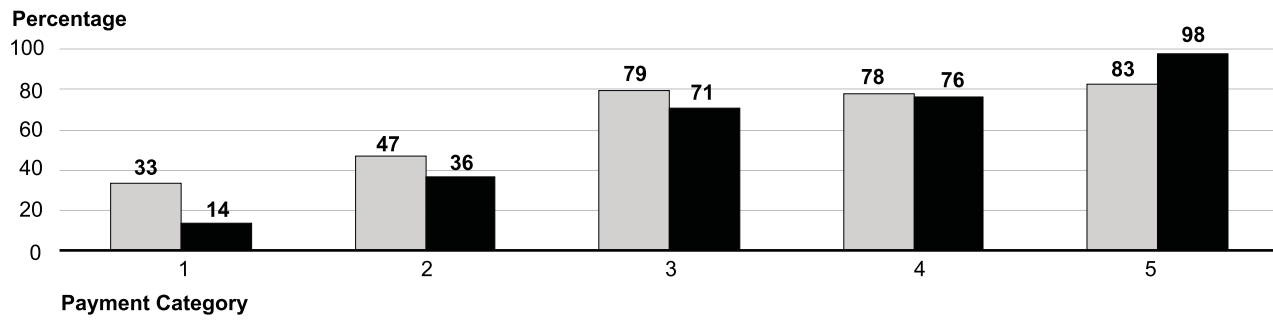
**Hearing Exams**



### Dental Care



### Foot Care



1997  
1999

(Figure notes on next page)

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

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

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

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## Plans Signal Desire to Revise 1999 Benefit Offerings

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

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

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new regulations. In addition, plans noted that health care costs, especially prescription drug costs, had grown much faster than they had anticipated earlier.

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

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## Conclusions

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

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

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While future plan participation should be monitored, it is premature to conclude that Medicare+Choice must be radically revised to ensure the success of Medicare managed care. Enrollees affected by the withdrawals had to choose another plan or return to FFS, but only 1 percent of previously covered managed care enrollees were left without any Medicare+Choice plans. At the same time, HCFA has approved a small number of new plans and is reviewing 30 new plan applications, indicating continued plan interest in participating in Medicare. Some of these new plans, if approved, would offer services in counties that previously had few or no managed care plans.

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

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## Agency Comments and Our Evaluation

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

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

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

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

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



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

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List of Requesters

The Honorable Charles E. Grassley  
Chairman

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

The Honorable William V. Roth, Jr.  
Chairman

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

The Honorable Tom Bliley  
Chairman

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

The Honorable William M. Thomas  
Chairman

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



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## Abbreviations

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

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# Scope, Methodology, and Data Sources

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

To identify counties with a risk plan in 1998, we used HCFA's September 1998 Medicare Managed Care Geographic Service Area Report (GSAR). We excluded cost, demonstration, and health care prepayment plans from our analyses. In cases in which the contract type was not identified with the plan name and contract number, this information was verified using the September 1998 Medicare Managed Care Market Penetration for All Medicare Plan Contractors—Quarterly State/County/Plan Data Files, September 1998 Medicare Managed Care Contract and Segment Service Area File, or HCFA's Plan Information Control System. The GSAR provides a list of the service areas for all risk and cost managed care contracts. The count of enrollees by plan by county in a plan's service area as of September 1998 was obtained from the State/County/Plan Penetration Files. To determine the effects of competitive market forces on plans' decisions to withdraw from particular counties, we used this enrollee information to construct market shares for each plan in each county. We then used a linear probability regression model to analyze the market share information.

To analyze the changes in plan participation in the Medicare+Choice program, we used HCFA data on the 1999 Medicare+Choice plan contracts. HCFA provided us with a list of plans that withdrew from the program or reduced their service areas as of January 1, 1998, and the counties and number of enrollees affected. We used this source to determine enrollees affected by withdrawing plans, because data from the State/County/Plan Penetration Files would have overstated the number of enrollees affected by service area reductions in those cases where a plan withdrew from only part of a county. HCFA also provided a list of new Medicare+Choice plans and service area expansion applications approved and under review as of January 1999 and the counties affected. We noted some inconsistencies between the service areas listed on the GSAR and the list of contract nonrenewals and service area reductions. To improve the accuracy of the

GSAR, counties were added if they appeared on the contract nonrenewal/service area reduction file and were listed on the Plan Information Control System as part of a plan's contracted service area but excluded from the original GSAR.

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

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

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

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

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# BBA Changes to Plan Payment Methodology

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

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## Plan Payments Before the BBA

Before the BBA changed the rate-setting process in 1998, the monthly amount Medicare paid managed care plans for each plan enrollee was directly tied to local spending in the FFS program. Although the actual rate-setting formula was complex, the methodology, in effect, was as follows. Each year, HCFA estimated how much it would spend in each county to serve the “average” FFS Medicare beneficiary.<sup>30</sup> Because managed care plans were assumed to be more efficient than FFS, Medicare set plan payments in each county at 95 percent of the FFS amount. Payments for individual beneficiaries were based on county of residence. Because some beneficiaries were expected to require more health care services than others, HCFA adjusted the payment for each beneficiary up or down from the county payment depending on the beneficiary’s age, sex, and eligibility for Medicaid and whether the beneficiary was a resident in an institution.<sup>31</sup>

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

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## New Rate-Setting Process Under the BBA

The BBA loosened the link between the payment rate in each county and the average FFS spending in that county. This change was made to reduce the wide disparity in payment rates that existed under the previous system. Payment rates in each county are now set at the highest of three possible payment rates: a minimum or “floor” rate, a minimum increase rate, and a “blended” rate. The BBA established a floor rate of \$367 in

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<sup>30</sup>HCFA made separate estimates for aged and disabled beneficiaries.

<sup>31</sup>Separate rates were set for beneficiaries with end-stage renal disease (kidney failure).

1998. The floor rate will be increased each year to reflect overall growth in Medicare spending. The BBA also established a minimum rate increase of at least 2 percent each year in every county.

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

In 1998 and 1999, plans received either the floor rate or a 2-percent increase over their payment from the previous year. Because of a BBA requirement to keep overall county payments budget neutral to what they would have been without the legislation, no county received the blended rate in 1998 or 1999. For the year 2000, however, payment for 63 percent of counties will be based on the blended rate.



# Comments From the Health Care Financing Administration

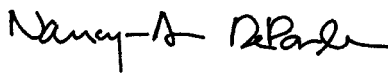


DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

APR 7 1999

FROM: Nancy-Ann Min DeParle  
Administrator, HCFA 

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare Managed Care: Many Factors Contribute to Recent Plan Withdrawals; Plan Interest Continues"

TO: William J. Scanlon, Director  
Health Financing and Systems Issues, GAO

We appreciate the opportunity to review your draft report to Congress on decisions by managed care plans to withdraw from Medicare. We agree with the report's major findings and with the conclusion that it is premature to say the Medicare+Choice (M+C) program requires radical revision at this time. We found the discussion of the parallels between the managed care organizations' 1998 decisions to withdraw from both M+C and the Federal Employee Health Benefits Program to be very useful.

We are committed to providing Medicare beneficiaries with the choices envisioned by the Congress in this important, new program. The Health Care Financing Administration will continue to work to refine M+C by enhancing existing beneficiary protections and promoting stability in the program. Furthermore, we will continue to develop the national information campaign created as part of the M+C program. The National Medicare Education Program (NMEP) includes the *Medicare & You* handbook, 1-800-MEDICARE, and a new beneficiary web site. The NMEP effort was of great help to beneficiaries during the plan withdrawals last year, and we will ensure that it provides accurate and unbiased information to beneficiaries regarding their choices and protections in the years to come.

Enclosure

**Comments of the Health Care Financing Administration  
on the General Accounting Office (GAO) Draft Report:  
“Medicare Managed Care: Many Factors Contribute to Recent Plan Withdrawals;  
Plan Interest Continues”**

**GENERAL COMMENTS**

The General Accounting Office's (GAO's) report provides a strong, comprehensive examination of the causes and effects of recent terminations and service area reductions in the Medicare+Choice (M+C) program. The findings are consistent with HCFA's internal analyses. We agree that a variety of factors were at play in determining whether organizations would decide to continue contracting with Medicare.

The GAO's analysis of the parallels between the Medicare plan withdrawals/service area reductions and the behavior of plans in private sector was very insightful. Although not fully discussed in the report, perhaps the most significant factor affecting the decisions of managed care contractors to withdraw from the M+C program was the condition of the overall managed care market. Until recently, the health maintenance organization (HMO) industry grew rapidly, and plans maintained low premium rates. However, a recent report by the Kaiser Foundation indicates that profit margins are down considerably for managed care companies --for both their commercial products and their Medicare business. The tighter, more competitive market (combined with increases in the cost of providing care) has forced these companies to reevaluate their participation in all types of markets, not just Medicare. It has also lead plans to increase premiums. Market conditions have also fostered consolidation within the industry; there have been several significant mergers of managed care companies over the last two years. In fact, some plan withdrawals from the Medicare program were the result of mergers. Additionally, consolidations within this segment of the provider community have reduced the purchasing leverage of some plans and reduced operating margins.

The close parallels between the significant number of managed care plan withdrawals from the Federal Employees Health Benefits Program (FEHBP) and the plan withdrawals from the Medicare program may also point to overall market conditions as a factor in a plan's decision to leave Medicare. Twenty percent of FEHBP managed care programs left the program at the end of 1998, and the Office of Personnel Management has advised us that very few enrollees were affected. Similarly, in Medicare, many of the plans that terminated their contracts had very few enrollees and were operating in very competitive areas.

The impact of Medicare non-renewals in the late 1980s and early 1990s may be greater than suggested in the report. In 1988, 8.2% of risk plan enrollees were affected by non-renewals among 22% of participating plans (excluding service area reductions but including conversion from risk HMO to cost HMO status); in 1989, even though 27 of the non-renewing plans had no enrollment, 6.6% of beneficiaries were affected by non-renewals. At that time, the trend in Medicare was similar to the trend in the private sector: according to a Solomon Smith Barney

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**Appendix III  
Comments From the Health Care Financing  
Administration**

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analysis of InterStudy data, 149 HMOs went out of business between 1986 and 1993. InterStudy data show that the number of HMOs in the US declined in the period 1987-1990 from 662 (1987), to 643 (1988), to 590 (1989), to 556 (1990).

The report demonstrates the need for some steps HCFA has already taken that: (1) mitigate the effect of plan withdrawals on beneficiaries; and (2) reduce the administrative requirements for participation in the M+C program. The Department of Health and Human Services (HHS), through its FY2000 legislative proposals and administrative actions, is making refinements to the M+C program. This includes a recommendation that there be a later reporting date for the annual submission of benefit information by renewing plans.

**Protecting Beneficiaries**

Plan withdrawals affected over 50,000 enrollees who lived in counties where no other M+C plan was offered; as a result, these people returned to fee-for-service Medicare. The report notes that these individuals "typically face higher out-of-pocket costs than they incurred as managed care enrollees." Similarly, beneficiaries who may have an M+C option, but chose to return to fee-for-service Medicare, often face higher costs. The report also notes that the Medicare statute precludes M+C enrollees with end-stage-renal-disease (ESRD) from enrolling in another M+C plan, even if one serves their county of residence.

To address these concerns, HHS' FY2000 budget proposed additional protections for beneficiaries enrolled in non-renewing plans when beneficiaries either choose to return to fee-for-service Medicare or have no other option. If passed by Congress, the proposals would:

- Provide flexibility to beneficiaries to choose from **all** Medigap options offered to newly-eligible Medicare beneficiaries. Currently, for individuals affected by non-renewals, access to Medigap coverage is limited to Medigap plans "A", "B", "C" and "F", none of which include coverage of prescription drugs. This proposal also includes guaranteed access to Medigap plans for 3 months before, as well as 2 months after, the date of a plan's termination.
- Protect beneficiaries with ESRD enrolled in managed care plans by allowing them to choose to enroll in another M+C plan and create a special open enrollment period for ESRD beneficiaries affected by plan terminations or service area reductions for the 1999 contract year.
- Allow a one-time, additional 90-day Medigap open enrollment period for individuals who were enrolled in a plan and who had no M+C option after the plan terminated its contract or reduced its service area effective January 1, 1999.
- Promote beneficiary protection by increasing the civil monetary penalties for Medigap issuers who violate the open enrollment requirements.

**Promoting Stability**

In addition to protecting beneficiaries, HCFA is also working to promote stability in M+C by taking concrete steps to alleviate plan concerns regarding administrative requirements. Several of changes were made in a final rule published in the *Federal Register* during February 1999. This rule addressed the issues that generated the most concern during the comment period on the June 1998 M+C interim final rule. (All other comments will be addressed in a second, more comprehensive final rule expected to be published later this year.) The February rule (described in the attachment with greater detail) increased plan flexibility where appropriate by:

- Increasing plan flexibility in coordinating patient care.
- Clarifying the requirement for initial care assessments in a way that reduces potential plan responsibilities.
- Simplifying requirements for plan notification of beneficiaries when specialists are involuntarily terminated by a plan.
- Narrowing the application of provider participation rules.

In September 1998, we also released the interim final version of our quality standards. The standards were changed significantly from their original form as a result of extensive public comments on the earlier draft in order to bring them more in line with similar requirements imposed by large, private health care purchasers. These changes were designed to reduce the reporting requirements placed on plans, while ensuring appropriate beneficiary protection.

HCFA has taken several other steps to improve the administration of the M+C program. For example, HCFA recently announced that we would consult with Congress on delaying the date by which plans must submit their benefit packages, known as adjusted community rate (ACR) proposals, from May 1 to July 1. We have received several letters from key Members of the House and Senate supporting this recommendation. Furthermore, HCFA announced that the risk adjustment payment methodology for plans that was required by statute would be phased-in over five years. We believe that both of these steps will increase market stability.

We will continue to explore other policies that will promote program stability. We are very pleased that the number of plans available to Medicare beneficiaries has been growing. As of April 1, 1999, HCFA has signed 12 new M+C contracts, and 24 plan applications are pending. At the same time, HCFA has approved 11 service area expansions, while 16 such applications are currently under review. This growth is an indication that the program is moving in the right direction.

# Comments From the Health Insurance Association of America



Health Insurance Association of America

Charles N. Kahn III  
President

April 8, 1999

William J. Scanlon  
Director  
Health Financing and Public Health Issues  
U.S. General Accounting Office  
Washington, D.C. 20548

Dear Mr. Scanlon:

Thank you for affording the Health Insurance Association of America (HIAA) the opportunity to comment on your March 1999 draft report "Medicare Managed Care: Many Factors Contribute to Recent Plan Withdrawals; Plan Interest Continues (GAO/HEHS-99-91). We also very much appreciated the opportunity to provide input when the study was being conducted.

The report provides a useful documentation of the Medicare risk plan withdrawals that occurred in 1998. It also successfully identifies many of the factors that likely influenced plan sponsors' decisions to withdraw from the Medicare program in 1998. We believe, however, that the report is seriously deficient in that it fails to alert Congress that, on its present course, the future of the Medicare +Choice program is in jeopardy.

The report concludes that the recent risk plan withdrawals do not necessarily signal fundamental problems with the Medicare+Choice program. Instead, the 1998 experience may have been a normal cyclical adjustment to market conditions, paralleling an earlier period—the late 1980s—when a number of Medicare risk plans with low enrollment left the program.

We believe that this conclusion underestimates the impact of reductions in Medicare+Choice plan payments and increased administrative burdens on Medicare+Choice organizations that are contained in the Balanced Budget Act of 1997 and associated regulations. In fact, the report's treatment of both of these topics misses the mark.

First, the report gives short shrift to the importance of administrative burdens in plan sponsors' decision-making. The report states that "Plan representatives also cite the administrative burden associated with new program requirements as a significant factor in plans' decision-making. However, few national managed care organizations terminated all of their Medicare plans; instead they continue to offer plans in other areas." (p. 4) (emphasis added.) Similar statements are made in the body of the report. (p. 22) The fact that Medicare+Choice

Now on p. 3.  
Now on p. 34.

555 13th Street, NW Suite 600 East Washington, DC 20004-1109 202-824-1858 Fax 202-824-1859

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**Appendix IV  
Comments From the Health Insurance  
Association of America**

William J. Scanlon  
April 8, 1999  
Page Two

plan sponsors chose to remain in some markets while exiting others proves nothing about the importance of administrative burdens. Further, the withdrawal patterns described in the report suggest that administrative costs may, indeed, have played an important role. For example, the report documents a pattern of withdrawals from low enrollment areas despite relatively high payments in those areas. It is difficult for M+C organizations to cover the high fixed administrative costs of program participation when plan enrollment is low. The report notes as well a pattern of withdrawals from low paying counties that were part of a larger service area. In these counties, the payments may not have been sufficient to cover both medical and administrative costs per enrollee, regardless of plan enrollment. As HIAA and others have commented to the Health Care Financing Administration (HCFA) and to Congress, the Medicare+Choice requirements add significantly to plan sponsors' burden and costs of regulatory compliance for what was, under the previous risk program, an already a heavily-regulated line of business. This factor should not be underplayed. (HIAA's comments on the HCFA's June 1998 Medicare+Choice regulations are attached for your information.)

Second, with respect to plan payments, the report notes that "It is possible that some plans withdrew from high payment rate counties because they anticipated that these counties would receive below average payment increases in the coming years." (p. 16) This is a good observation, as far as it goes. However, there is no further discussion here or elsewhere in the report of the serious implications of constrained payments in the higher payment rate counties - where the majority of risk plan enrollees are located.

There is no dispute that, in many counties, payments to Medicare risk plans have exceeded the plans' projected costs of providing core Medicare services. The Adjusted Community Rate (ACR) process demonstrates this. Rather than returning excess payments to the government, plans have chosen—with HCFA's sanction—to provide additional services. In large part, it is these additional benefits that have attracted beneficiaries to Medicare risk plans. If Medicare+Choice organizations are forced by insufficient payment updates to reduce the additional benefits they have offered, it is likely to be difficult, if not impossible, to achieve enrollment growth (and perhaps even to maintain current enrollment levels). Medicare+Choice organizations must determine each year, for each of their current service areas, whether the combination of plan costs, payments, and competitive market conditions support a viable product for that Medicare+Choice organization.

It should be no surprise, then, that last year some Medicare+Choice organizations chose not to renew contracts for plans with low enrollment, in light of increased administrative costs and perceived poor prospects for enrollment growth. The important point that the report misses is that this is just the beginning of a very significant squeeze on plan rates, as the geographic blend, the removal of graduate medical education payments, and risk adjustment take effect. Under current HCFA projections, for the foreseeable future payments for beneficiaries in Medicare+Choice plans, on average, will increase less year-by-year than payments for beneficiaries in Original Medicare. HIAA actuaries estimate that by 2003, per capita payments for Medicare+Choice on average will be down to 83% of the original Medicare payment (\$616 vs. \$742). The payment disparity will be much greater in very high cost counties where

Now on pp. 26-27.

**Appendix IV  
Comments From the Health Insurance  
Association of America**

William J. Scanlon  
April 8, 1999  
Page Three

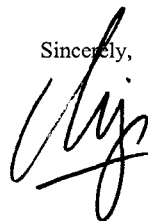
Medicare+Choice payments on average will be only 74% of original Medicare payments (\$768 vs. \$1032). Charts illustrating these HIAA estimates are attached.

Each year, additional Medicare+Choice plans are likely to move from marginally viable to not viable from a plan sponsor's perspective. In this respect, we believe the current situation is fundamentally different from the Medicare risk plan experience in the late 1980s. There is no doubt that competitive conditions weighed importantly in withdrawal decisions. However, all things considered, we do not believe last years' withdrawals represent simply a periodic "market adjustment" with few lasting consequences. Congress should be alerted in this report to the significant risk that, going forward, beneficiaries may not enroll in Medicare+Choice plans to the extent projected by HCFA, that Medicare+Choice organizations may decide to nonrenew more contracts, and that the anticipated savings from Medicare+Choice program, therefore, may not materialize.

Regarding the issue of "selection bias" noted above, the background section of the report (pp. 5-6) references the "conclusion" of the research literature that Medicare risk plans have been seriously overpaid because of a high level of selection bias in enrollment, favorable to the plans. The report does not mention that other researchers have noted methodological problems with many biased selection studies. Nor does the report acknowledge mitigating factors that may result in Medicare+Choice plan enrollees having higher—or at least average—health risks. Such factors include: (a) any selection bias that may have occurred when beneficiaries entered risk plans "wears away" over time as enrollees age and develop health problems; (b) many risk plans have maintained year-around open enrollment; and (c) the out-of-pocket costs of original fee-for-service Medicare have risen significantly. Furthermore, private plans' superior management of health care delivery, or their more successful efforts to reduce waste, fraud and overpayments as compared with original fee-for-service Medicare, could just as well explain the fact that plan sponsors in many counties projected their costs at less than 95% of the county average cost of beneficiaries. The so-called "overpayments" to plans have been sanctioned and were appropriate payments to plans for the (frequently augmented) services they have offered.

We thank you again for inviting our comments. We are providing a number of more technical comments on the report under separate cover. If you have questions, please contact Marianne Miller, HIAA's Director of Federal Regulatory Affairs and Policy Development, at 202-824-1693 or [mmiller@hiao.org](mailto:mmiller@hiao.org). I would be pleased to discuss our comments with you at greater length.

Sincerely,



Attachments

Now on pp. 4-5.

# Comments From the American Association of Health Plans



American Association of  
**HEALTH PLANS**

April 20, 1999

William J. Scanlon  
Director, Health Systems Issues  
U.S. General Accounting Office  
NGB/Health Finance  
441 G Street, NW  
Washington, DC 20548

Dear Bill:

Thank you for the opportunity to comment on the General Accounting Office's (GAO's) draft report "Medicare Managed Care: Many Factors Contribute to Recent Plan Withdrawals: Plan Interest Continues." Health plans have a longstanding commitment to serving Medicare beneficiaries and some plans withdrew reluctantly only after working very hard to avoid leaving the program. The GAO report offers several useful insights on factors that contributed to recent health plan withdrawals from the Medicare+Choice program. As indicated in our comments below, we disagree, however, with the GAO's analysis and conclusions in important areas.

#### *General Comments*

AAHP disagrees with the fundamental premise on which this report's conclusions are based, that a *combination of factors* contributed to plans leaving the Medicare+Choice program in 1998. In fact, there is no doubt that the unanticipated consequences of implementation of the Balanced Budget Act of 1997 (BBA) are the principal reason plans withdrew from the program. These consequences include a significant payment differential between the Medicare+Choice and fee-for-service programs, HCFA's statements in 1998 that their new risk adjustment approach would significantly cut Medicare+Choice payments, and the overly burdensome administrative requirements found in HCFA's Medicare+Choice regulations. In light of these changes, we believe that GAO's conclusion that plan movement in and out of Medicare may be primarily "the normal reaction of plans to market competition and conditions" is incorrect and understates the difficulty plans face in participating in the Medicare+Choice program.

We believe that the recent health plan withdrawals from the Medicare+Choice program are the consequence of the problems identified in our comments below and were exacerbated by HCFA's approach to implementing many of the BBA requirements. Mid-course corrections in the Medicare+Choice program are critical to avoid further disadvantaging beneficiaries and undermining achievement of the BBA's goal of increased choice.

It is important to note that the withdrawals may have been aggravated, in part, by uncertainty surrounding HCFA's new risk adjustment methodology and its anticipated impact on Medicare+Choice payment rates. While the recent plan withdrawals took place before HCFA

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announced the details of its risk adjustment approach, HCFA indicated on numerous occasions in 1998 that the risk adjuster would not be budget neutral and would, in fact, involve a substantial reduction to health plan payments. In January 1999, HCFA projected that, when fully implemented, its proposed risk adjuster will cut payments, on average, by an additional 7.6 percent. HCFA estimates that its new risk adjustment methodology will cut aggregate payments to Medicare+Choice organizations by an additional \$11.2 billion over the five-year phase-in period. Health plans did not anticipate this level of savings from the risk adjuster when the BBA was enacted. In fact, the Congressional Budget Office did not score the risk adjustment provision in the BBA as reducing capitation payments to plans, and has expressly stated that it assumed risk adjustment would be implemented on a spending-neutral basis. HCFA's proposed risk adjustment methodology threatens not only the goals that Congress sought to achieve through the BBA but also the very viability of the Medicare+Choice program.

*Additional Comments*

In its introduction, the report emphasizes the hardship on beneficiaries affected by HMO withdrawals. In light of this emphasis, AAHP urges GAO to: (1) articulate more fully the reasons beneficiaries choose to join health plans; and (2) report on the high level of Medicare beneficiary satisfaction with health plans. We also recommend that the GAO point out that the additional benefits and low out-of-pocket costs that beneficiaries value could be threatened by restrictions on payment growth and significantly increased administrative costs.

- **Disruptive Effects of Withdrawals.** The GAO notes that plan withdrawals are disruptive and costly for beneficiaries.

AAHP comment: The potential for disrupting beneficiaries is a major reason that health plans are reluctant to reduce their participation and the reason that AAHP and its members engaged in intensive efforts to seek HCFA action that would mitigate the potential for withdrawals. We urge the GAO to recognize this in its report.

- **Comparison to Withdrawals in the Late 1980s.** The GAO compares the recent withdrawals from Medicare+Choice to those that occurred in the late 1980s, noting that "at that time many plans left Medicare because they were unable to attract members and were unprofitable."

AAHP comment: We disagree that there are similarities between recent withdrawals from the Medicare+Choice program to withdrawals in the late 1980s. Unlike the late 1980s, enrollment growth in the late 1990s had been strong. In addition, the implementation of the Medicare+Choice program in 1998 and 1999 has created a far different and more difficult regulatory climate than that which existed in the late 1980s.

- **Discussion of "market correction."** The GAO likens the recent withdrawals to a "market correction" whereby "weaker plans" may have decided to withdraw at this time due to "higher levels of competition and insufficient enrollment."

AAHP comment: We recommend that GAO take into account the alternative explanation that lower margins combined with payment uncertainty and increased administrative burden make it riskier for health plans to remain in marginal portions of their service areas while at the same time trying to maintain existing benefit levels for beneficiaries.

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- **Comparison to FEHBP.** The report compares health plans withdrawing from the Medicare market to those withdrawing from the Federal Employees Health Benefit (FEHB) program. The GAO states that “an unusually high number of plan withdrawals in the federal employees health program suggests that general market conditions may play some role in the Medicare plan withdrawals.”

AAHP comment: The comparison with FEHBP is not accurate. Approximately two percent of beneficiaries were affected by health plan decisions to no longer participate in FEHBP, substantially less than the approximately seven percent of Medicare beneficiaries affected by health plan withdrawals.

- **Characterization of Withdrawal Activity as “a one-time opportunity.”** The GAO describes the decision by some plans to withdraw from the Medicare+Choice program as “a one-time opportunity to pull back from the program while they waited to see what future changes might bring.”

AAHP comment: We believe that this is an erroneous interpretation of the situation plans faced in 1998. The difficulty and expense of reestablishing provider networks and other operational factors make leaving the program for a short term and then reentering a generally unattractive business strategy. Likewise, the need to reestablish relationships with beneficiaries makes moving in and out of the program an undesirable strategy for health plans. Long term assessments of the viability of Medicare participation are a much more significant part of health plan decisionmaking.

- **Inability to Establish Provider Networks.** The GAO notes that some plans have withdrawn from areas where they were unable to establish sufficient provider networks.

AAHP comment: The GAO report does not identify the factors that produced this result, or identify plans’ withdrawal decisions as the result of providers’ decisions to not participate in Medicare+Choice. Difficulty in maintaining provider networks was directly related to constrained Medicare+Choice payment rates, and in some cases, may have had an impact on plan decisions to withdraw from certain markets. AAHP suggests recognizing that some providers, as well as health plans, decided not to continue participation in the Medicare+Choice program. Many plans continue to express concern that the growing disparity between payment to Medicare+Choice plans and reimbursement under fee-for-service will make it difficult to maintain their provider networks in certain markets.

- **Participation of National Organizations.** The GAO states that few national organizations terminated all of their Medicare plans and that these organizations continued to offer plans in “other areas.”

AAHP comment: This statement appears to imply that the continued participation of national organizations is an indication that the factors listed by GAO – payment levels, difficulty in establishing sufficient provider networks, and administrative burden – may not be as significant as health plans have indicated. AAHP disagrees with this interpretation. While national organizations did not leave the Medicare+Choice market entirely, they did in some cases reduce their service areas or terminate participation in particular markets. This is a logical and significant response by such large organizations to inadequate payment levels and the extensive new administrative requirements under the BBA. We recommend that the GAO reflect this perspective in the report.

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- **HCFA's Quality Improvement System for Managed Care (QISM) Requirements.** GAO states that HCFA has responded to health plan concerns regarding some of the new BBA requirements. The GAO cites QISM as an example where HCFA has made modifications to give plans greater flexibility in meeting new quality improvement requirements.

AAHP comment: While HCFA did make some modifications to its Quality Improvement System for Managed Care (QISM) requirements, AAHP continues to have serious concerns regarding implementation of QISM. GAO may wish to note that QISM lacks clear coordination with existing public and private sector accreditation and reporting standards. Health plans currently meet voluntary private accreditation standards, such as those developed by the National Committee for Quality Assurance, in order to satisfy requirements of private sector purchasers and some states. Rather than coordinate with these existing standards, QISM appears to establish a new system of requirements. This adds to administrative cost without a commensurate addition to value.

Again, thank you for the opportunity to provide comment on the GAO's draft report. AAHP and its member plans are firmly committed to the successful implementation of the Medicare+Choice program. We appreciate the opportunity to share with you some of the significant concerns with implementation of the program to date. If you have questions concerning our comments, please call me at (202) 778-8464.

Sincerely,



Richard I. Smith  
Vice President  
Public Policy and Research

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