No. 758

ISSUE BRIEF

NATIONAL HEALTH POLICY FORUM

Medicare+Choice: Where to from Here?

Friday, September 8, 2000
Washington, DC

A discussion featuring

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

David H. Lemire
Vice President, Senior Business Segment
CIGNA HealthCare

Michelle P. Holzer
Program Officer
Senior Health Insurance Program
Maryland Department of Aging

The George Washington University
WASHINGTON DC

Medicare+Choice

As the Medicare+Choice (M+C) program enters its third year, most observers and participants agree that recent trends for the program are discouraging. Intended by Congress to expand choice of health plans for Medicare beneficiaries, the number of M+C contracts declined in 2000, and beneficiary enrollment figures have been flat. And, while a few new players have recently entered the program, by most accounts the program has failed to meet the expectations envisioned by the policymakers who created it as part of the Balanced Budget Act of 1997 (BBA).

In June and July, several of the largest commercial health maintenance organizations (HMOs) announced plans to withdraw next year from the Medicare program in numerous markets. Aetna U.S. Health Care will cancel coverage for more than 355,000 beneficiaries in 14 states; CIGNA HealthCare will exit most of its Medicare HMO markets, affecting about 104,000 beneficiaries in 11 states; Humana will stop offering its Medicare HMO in 45 counties in 6 states, disenrolling about 84,000 people; and several other large and small plans have announced they will discontinue certain Medicare contracts. In total, 65 HMOs chose not to renew their M+C contracts and 53 reduced their service areas, affecting more than 934,000 Medicare beneficiaries—nearly triple the number of beneficiaries who were affected last year.[1]

These plan withdrawals have prompted many policymakers to worry about the future of the Medicare+Choice program. This Forum session will examine the most recent data regarding M+C plan participation, benefit coverage, and enrollment as well as the factors that have contributed to plans' decisions to participate in or withdraw from certain markets. Findings from the most recent General Accounting Office (GAO) studies on plan withdrawals and the costs of Medicare managed care relative to fee-for-service (scheduled to be released in mid- and late August) will be presented. In addition, the session will explore what has been happening to M+C enrollees in terms of costs, benefits, and continuity of care. This issue brief will also examine the reasons why alternative plan options —such as preferred provider organizations and provider-sponsored organizations—have failed to take hold. Finally, recent legislative proposals that might affect the future of Medicare+Choice will be discussed.

PLAN PARTICIPATION TRENDS

Prior to enactment of the BBA, plan participation in the Medicare-risk program (the precursor to M+C) had been trending upward. Between 1990 and 1998, the number of Medicare risk contracts had grown from 96 to 346. In 1999, the number of M+C contracts declined to 309 and in 2000 dropped to 263. This recent plan termination behavior is similar to that experienced in the late 1980s, but many more enrollees have been affected over the past three years because enrollment was much smaller in the 1980s than today. Before 1998, enrollment and plan participation in the Medicare risk program had been sizable and growing strongly. In 2000, 69 percent of beneficiaries had risk plans available to them as health plan options, a decline from 74 percent in 1998.[2]

Many factors have been cited as reasons for the recent withdrawals. Industry officials point to inadequate funding, overregulation, and difficulty establishing provider networks as the primary factors. Other analysts have attributed plan decisions to additional factors, such as low plan enrollment, strong competition, and general market conditions.[3] A study by Mathematica Policy researchers Randall Brown and Marsha Gold, published in *Health Affairs* in 1999, identified eight characteristics that influence the growth of Medicare managed care: (*a*) payment level, (*b*)

ISSUE BRIEF/No. 758

Analyst/Writer:
Nora Super Jones

National Health Policy Forum
2021 K Street, NW, Suite 800
Washington, DC 20052
202/872-1390
202/862-9837 (fax)
nhpf@gwu.edu (e-mail)
www.nhpf.org (Web site)

Judith Miller Jones, Director
Karen Matherlee, Co-Director
Judith D. Moore, Co-Director
Michele Black, Publications Director

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historical presence of managed care, (*c*) practice patterns and care expectations, (*d*) supplemental coverage, (*e*) extent and form of provider organization, (*f*) Medicaid managed care, (*g*) state regulatory patterns, and (*h*) geographic location.[4] (See Table 1 for an analysis of how these characteristics promote or impede the growth of Medicare managed care.)

This issue brief will focus on five factors that have reportedly contributed to plans' decisions to withdraw from certain markets. They include (*a*) payment levels, (*b*) uncertainty, (*c*) geographic location, (*d*) regulatory complexity, and (*e*) market responsiveness.

Payment Levels

In 1997, in response to widespread criticism associated with the previous adjusted average per capita cost (AAPCC) payment system, Congress substantially restructured the system for setting the rates that Medicare pays health plans. The AAPCC methodology tracked variation in fee-for-service spending at the county level. Under the old system, some areas received high payments that enabled health plans to offer extra benefits at little or no added cost to Medicare enrollees. But in low-payment areas, enrollees have had to pay substantial out-of-pocket costs for benefits beyond the

Table 1
Factors That Promote or Impede the Growth of Medicare Managed Care

Factor	Effect on Medicare Managed care
Capitation level	Higher payment rates mean more potential for plans to earn profits, charge low premiums, and provide enhanced benefits[a]
Historic managed care patterns (non-Medicare)	Higher managed care penetration historically means greater likelihood of managed care choices, greater beneficiary familiarity with choices, and higher proportion of area physicians affiliated with managed care plans[a]
Practice patterns and beneficiaries' care expectations	More resource-intensive practice style and speciality orientation reduce ability to offer generous benefit package and restrict network[b]
Beneficiary characteristics and pattern of supplemental coverage	Greater growth potential in price-sensitive markets where beneficiaries lack employer coverage and incomes are limited[a] Lower growth potential where Medicaid or employer-subsidized coverage for retirees is extensive unless these payers encourage enrollment[b]
Extent and form of provider organization	Managed care easier to develop with more organization and integration[a] Smoother relationships with provider risk sharing[a]
Concurrent goals and trends in other lines of business (commercial, Medicaid)	Efforts to expand managed care to other lines of business will encourage organization and increase attractiveness of Medicare managed care[a]
State regulatory context	More extensive regulation generally impedes managed care growth[b]
Geographic location of market	Close proximity to other markets where Medicare managed care is successful encourages growth[a]

[a] Factor promotes Medicare managed care growth.

[b] Factor impedes Medicare managed care growth.

Source: Randall S. Brown and Marsha R. Gold, Mathematica Policy Research, Inc., "MarketWatch: What Drives Medicare Managed Care Growth," Health Affairs, *18, no. 6 (November/December 1999), 144. Reprinted with permission.*

Medicare entitlement, even though all beneficiaries pay the same Part B premium, regardless of where they live. The new system was intended to address inequities across counties and to weaken the link between local fee-for-service costs and payment updates to plans. Under the new payment system, a rate for a particular county is the greater of three possible rates: a new minimum or floor payment, a minimum 2 percent increase over the previous year's rate, or a blend of the county rate and an input-price-adjusted national rate subject to a budget-neutrality test.[5] As a result of BBA-mandated budget neutrality and minimum payment constraints, however, no counties received a blended payment rate in 1998 or 1999. In 2000, the budget neutrality factor resulted in slight increases in blended county payments, but again in 2001 no plans will receive blended payments.

According to the American Association of Health Plans (AAHP) and the Health Insurance Association of America (HIAA), the BBA changes resulted in inadequate funding of the M+C program relative to costs. While Medicare fee-for-service spending is estimated to increase by 5.6 percent next year, payments for most M+C plans will increase by only 2 percent, according to AAHP.[6] For many plans, M+C rate increases have not kept pace with medical inflation. Unable to realize sufficient margins, a large number of these plans have decided they must pull out of some markets. Indeed, many plans have sustained sizable losses, according to industry surveys. In recent testimony before Congress, George Renaudin, senior vice president of administration for Ochsner Health Plan, said the ratio of medical costs to total reimbursements is 111 percent for his plan's M+C members. "No health plan can survive while paying 11 percent more in health care benefits than it receives in payments," remarked Renaudin.[7]

But the Health Care Financing Administration (HCFA) asserts that the Medicare program pays more than enough for the basic benefit package. GAO's ongoing work also shows that payments to plans for their Medicare enrollees continues to exceed the expected fee-for-service costs of these individuals. Plans have had more difficulty funding extra benefits—especially prescription drug benefits—than they did previously, but M+C plans were able to offer these extra benefits only "because of excessive payments made to them before the BBA," according to according Robert Berenson, director of HCFA's Center for Health Plans and Providers.[8]

HCFA maintains, moreover, that insufficient reimbursement does not adequately explain plan decisions to pull out of the program. In 1999, counties with the largest increases experienced the most disruption. Plan withdrawals in 1999 affected 11.1 percent of enrollees in counties where rates were rising by 10 percent, but affected only 2.3 percent of enrollees where rates were rising by just 2 percent.[9] A 1999 GAO study found that 91 percent of high-payment-rate counties experienced a plan withdrawal, compared with 34 percent of low-payment counties.[10] But a higher proportion of enrollees living in low payment rate counties were affected, compared to enrollees in high payment rate counties, according to GAO.

According to HCFA, the average M+C growth rate was 5 percent in 2000, and in some areas it grew as much as 18 percent, but these high growth rates were typically in areas with few enrollees. An AAHP analysis of HCFA data found that 40 percent of enrollees live in areas that received a 2 percent update and more than 57 percent of enrollees live in areas that received updates of 3.5 percent or less. HCFA's most recent data show that enrollees in lower payment areas are more likely to be affected by nonrenewals in 2001 than beneficiaries in higher payment areas.[11]

Uncertainty

In its March 2000 report to Congress, the Medicare Payment Advisory Commission (MedPAC) identified uncertainty as another concern that may be discouraging participating M+C plans. The advent of risk-adjusted payments for M+C plans has heightened anxiety about the predictability of future revenue streams. Because health status—not just demographic factors—is considered in payment, plans have more uncertainty in predicting future revenues. Several health plans have cited concern about risk adjustment as a key factor in their decisions to retreat from Medicare.

Under the BBA, HCFA is required to implement, beginning January 1, 2000, a method to base plan payments on beneficiaries' health status. On average, this method will reduce payment to M+C plans somewhat for most beneficiaries but increase plan payments significantly for the minority of beneficiaries who were hospitalized in the prior year for specific conditions (such as congestive heart failure). HCFA's proposed method has been met by considerable criticism because it initially relies on hospital inpatient data alone. HMOs state that they will be unfairly penalized for effectively managing the health of their members, particularly in terms of reducing hospitalization. HCFA estimates that its new risk adjustment methodology will result in a reduction of payments to health plans by nearly $6 billion over five years, with the largest decreases

occurring in the later years, when encounter data from multiple sites of care will be used in the calculations.

In the face of program instability, HCFA proposed to phase in the new interim risk adjustment system slowly, basing only 10 percent of plan payments on the risk adjusters in 2000, and gradually increasing the percentage until all payments were risk adjusted in 2004. The Balanced Budget Refinement Act of 1999 (BBRA) pushed the transition back even further, and several pending Medicare reform proposals would make additional changes to the risk adjustment rules. HCFA announced on June 19, 2000, that it would adjust the phase-in schedule once again and that it planned to announce the new schedule in January 2001. That schedule, said HCFA, would be based upon agency research on the collection of encounter data and a report by MedPAC on the new risk adjustment procedure as required by BBRA (and scheduled to be released in December 2000).

All of the proposed legislative and regulatory changes only exacerbate the uncertainty surrounding the M+C program and its future payments, further discouraging participation in the program. As stated in MedPAC's March 2000 report:

> It is difficult for managed care organizations to construct business plans if each year the rules for phasing in risk adjustment change, the amount of [graduate medical education] carveouts differs, or the administrative requirements change. For a plan, it is difficult not only to predict its own performance, but also to understand its competitors.[12]

Furthermore, recent congressional activity regarding the possibility of adding a prescription drug benefit to the basic Medicare benefit package puts into question M+C marketing strategies for the future. Most of the proposals would build on the current M+C model to distribute the benefit; these proposals are discussed in more detail later in this paper.

Geographic Location

Providing more choices for Medicare beneficiaries who live in rural and lower-payment counties was a key objective of the creators of the Medicare+Choice program. This result has not materialized. M+C plan participation remains highly concentrated in urban areas in the West, Northeast, and Florida. Five states—California, Florida, New York, Pennsylvania, and Texas—account for about 57 percent of the total M+C enrolled population, according to the most recent HCFA data.

The vast majority of rural beneficiaries have never had access to a managed care plan. The minimum payment floor was established as an incentive for plans to enter rural counties, but despite payment rate increases, participation in rural areas has declined overall recently. Only 10 percent of beneficiaries in counties at the floor rate will have access to an M+C plan in 2001, while 97 percent of beneficiaries with rates above $550 will have M+C plans available as an option (Table 2).

In its March 2000 report, MedPAC said that "bringing more choice to underserved areas remains an intractable problem." Plans often experience tremendous difficulty in developing or maintaining provider networks in rural areas because the limited number of providers are reluctant to contract with plans. Plans at full risk may simply not make sense in some rural areas, according to panelists who testified before MedPAC on rural Medicare policy issues. In addition, MedPAC's analysis of lower-payment areas suggests "plans may have trouble providing even the basic benefit and making a profit."[13]

Regulatory Complexity

A persistent complaint of M+C plans concerns the costs and burdens of complying with extensive M+C regulation. The requirements include complicated enrollment and disenrollment regulations, quality improvement initiatives, and encounter data reporting. A report by Bruce M. Fried and Janice Ziegler, sponsored by the HIAA, documents just how complex and detailed the rules governing the M+C program are.[14] The M+C interim final regulation, published on June 26, 1998, for example, is over 90 pages long, as printed in the *Federal Register*. In addition, between 1995 and June 2000, HCFA had issued over 120 operational policy letters (OPLs) detailing program requirements—many of which were related to the implementation of BBA changes. According to Fried and Ziegler, each new OPL requires review, interpretation, and implementation where changes are necessary.

In response to concerns regarding regulatory burden, HCFA has begun a number of initiatives designed to further streamline administrative procedures. For example, HCFA has simplified the requirements for provider contracts and has revised marketing guidelines. The agency also plans to issue a single manual for M+C operations this year and then update that manual quarterly to replace the need for most OPLs. HCFA's June 29 final rule governing the operations of health plans participating in the M+C program represents the agency's attempt to respond to plan concerns. According to a HCFA press release,[15] the new regulations improve earlier regulations by doing the following:

Table 2
Availability of Plans with Selected Benefits, 1999-2000

	Total eligible beneficiaries (in millions)	Any Plan			Zero-premium plan		Plan with Rx coverage		Zero-premium plan with Rx	
		1999	2000	2001*	1999	2000	1999	2000	1999	2000
National	39	71%	69%	63%	61%	53%	65%	64%	54%	45%
County rate/month										
$401.61 (floor)	4	14	15	10	5	3	12	12	3	2
$401.62-$449.99	12	50	47	29	29	18	39	40	18	14
$450-$550	14	86	81	66	78	67	81	76	70	52
> $550	10	97	97	97	97	94	96	96	95	91
Rural areas	9	23	21	14	14	9	19	16	8	6
Urban areas	30	86	83	78	75	66	80	79	68	57

*2001 figures, also based on MedPAC analysis, are preliminary and do not include access to private fee-for-service plans.

Source: MedPAC analysis of Medicare Compare data from HCFA website, August 1999 and January 2000 from Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, *120.*

- Increasing flexibility in establishing a provider network, which will allow more health care providers to serve plan enrollees.
- Improving freedom of choice by allowing plans to offer beneficiaries a point-of-service option that broadens access to health care services from both in-network and out-of-network providers.
- Allowing organizations that left M+C to return in two years, instead of five.
- Implementing the bonus payment program called for in the BBRA to encourage M+C plans to begin serving beneficiaries in areas that currently do not have M+C options.

Market Responsiveness

According to GAO, "the current movement of plans in and out of Medicare may primarily be the normal reaction of plans to market competition and conditions."[16] In fact, some analysts have said this behavior should come as no surprise. In testimony before Congress, Marilyn Moon, senior fellow at the Urban Institute, said,

> In a market system, withdrawals should be expected: indeed, they are a natural part of the process by which uncompetitive plans that cannot attract enough enrollees leave particular markets. . . . In fact, if no plans ever left, that would likely be a sign that competition was not working well.[17]

Clearly, plans have responded differently to market conditions and have seemed to make explicit business decisions about whether or not they want to continue working with the Medicare program for the long term. For instance, both Aetna and CIGNA dropped the majority of their Medicare enrollees, whereas Pacificare dropped 2 percent and Kaiser dropped 0.2 percent of current Medicare enrollees. Many plans have opted to change their benefit packages rather than withdraw from the program.

Fried and Ziegler's analysis takes exception to the notion that plans have simply responded to "market forces." These forces, they contend, were a direct result of changes in payment rates. Increased administrative and other costs relative to payment rates have forced M+C plans to decrease supplemental benefits or impose higher premiums, which in turn has discouraged enrollment. Lower enrollment levels result in smaller margins and, in some markets, actual losses, according to Fried and Ziegler.[18]

Others have pointed to the condition of the overall managed care market as a significant factor affecting the decisions of HMOs to withdraw from the M+C program. InterStudy's 1999 *HMO Forecasting Report* painted a bleak picture for HMOs:

> HMOs are struggling to find equilibrium in a competitive environment created by providers, consumers, and employers. Providers are asking to be paid more. Consumers are demanding more choice and access in selecting and using medical care. And finally, employers are saying that the cost of health care is too high.[19]

But others believe the HMO withdrawals signal the precarious nature of relying on the private market to deliver publicly funded benefits. Esther Canja, president of AARP, told Congress last year that

> when private businesses are given the authority to manage a beneficiary's care in exchange for the opportunity to earn a profit, several things can happen. On the positive side, the innovations in administrative efficiency and improved health care delivery may benefit the patient through lower costs, additional benefits, and better coordinated care. On the other hand, patients can be exposed to the vagaries of the market place. They may force instability in their benefits and premium charges, and worse yet, beneficiaries may not know from one year to the next whether their plan will remain a Medicare option.[20]

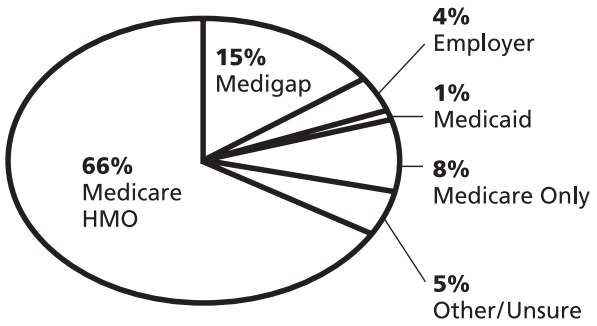
ENROLLMENT AND BENEFIT TRENDS

Medicare HMO enrollment increased steadily each year between 1985 and 1995. Between 1995 and 1999, however, it more than doubled, growing from about 3 million to 6.3 million. After peaking in December 1999, enrollment has remained flat in 2000 and even declined somewhat this year. As of July 1, 2000, 6.24 million beneficiaries were enrolled in coordinated care plans. In 2000, 69 percent of Medicare beneficiaries have access to one or more M+C plans, down from 71 percent in 1999. Beneficiaries living in nine states have no access to a M+C plan in 2000.

As stated earlier, plan withdrawals have affected a significant number of beneficiaries over the past three years. In January 1999, 407,000 beneficiaries were involuntarily disenrolled from their HMOs; an additional 327,000 had to find new coverage arrangements in 2000. Approximately 934,000 Medicare beneficiaries will be affected by plans' decisions to leave the M+C program in 2001. About 775,000 of the affected beneficiaries will be able to enroll in another Medicare HMO, if the HMO is accepting enrollees. HCFA estimates that about 17 percent or 159,000 of the remaining beneficiaries will be left with no M+C HMO options, although some may choose to enroll in a private fee-for-service plan (discussed below) if one is available in their community.

Concern about the effects of these withdrawals on beneficiaries has increased each year as the exodus of plans receives more publicity. A Kaiser Family Foundation-sponsored "Survey of Experiences with Medicare HMOs" found that two-thirds (66 percent) of Medicare beneficiaries who were involuntarily disenrolled from their HMO enrolled in another HMO that served their area.[21] (See Figure 1.) Fifteen percent of beneficiaries purchased Medigap coverage, 4 percent were covered by their or their spouse's employer-sponsored plan, and 1 percent received assistance from Medicaid. The remaining beneficiaries either went back to fee-for-service Medicare or their current arrangement is unknown. Information from two draft studies conducted by the Health and Human Services Department's Office of the Inspector General found that 17 percent of disenrolled beneficiaries chose fee-for-service Medicare over another HMO, even when there was a choice for contract year 1999, and 15 percent chose fee-for-service over another HMO for contract year 2000.

Figure 1
Distribution of Disenrolled Beneficiaries, by New Coverage Arrangement



Based on a nationally representative sample of 1,830 beneficiaries involuntarily terminated from a Medicare HMO as of January 1, 1999.

Note: Total percentages may not sum to 100 percent due to rounding.

Source: Barents Group analysis of the Kaiser Family Foundation–sponsored "Survey of Experiences with Medicare HMOs."

Benefit Changes

The Kaiser Family Foundation survey also found that, overall, many of the beneficiaries who were involuntarily disenrolled from their Medicare HMO experienced a decline in supplemental benefits, an increase in their premiums for these benefits, and some disruption in medical care arrangements. Thirty-five percent of survey respondents reported having fewer supplemental benefits under their new coverage arrangements, compared with some 20 percent who

reported a gain in benefits. Twenty-two percent of respondents reported having a different primary care provider and 17 percent reported having to change specialists after their HMOs withdrew from the market.

HCFA points out that changes in access to M+C and changes in the coverage and premiums for the year 2000 vary significantly by state and between urban and rural areas. In some areas, there were few changes in benefits or premiums, while in other areas, there were significant changes.[22] On average, plans continuing in the M+C program have reduced benefit packages and increased premiums. According to MedPAC, in 2000, 53 percent of beneficiaries have access to "zero" premium plans, which means beneficiaries pay no additional premium beyond the Medicare Part B premium. This represents a decline from 61 percent of beneficiaries in 1999. (See Table 2.) On average, individuals who were enrolled in a plan in 1999 that is still available in 2000 faced a premium increase of $11 per month for the basic benefit package. The percentage of M+C plans offering outpatient prescription drug coverage declined slightly from 65 percent in 1999 to 64 percent in 2000, according to MedPAC.

A recent study by Amanda Cassidy and Marsha Gold of Mathematica Policy Research found that, while large monthly premiums are still relatively rare, the premiums charged can be quite substantial.[23] According to the study, monthly premiums of $50 or more are required in 23 percent of the basic plans in 2000, nearly three times as many as in 1999 (8 percent). According to AAHP, this trend is likely to continue in 2001. But while premiums are increasing, a majority of plans continue to offer supplemental benefits, including drug coverage and preventive dental benefits. Plans seem to be holding the line on the annual dollar limit of pharmacy benefits, but more are likely to use copayments and/or formularies to steer enrollees to less expensive drugs, according to the Mathematica study. HCFA has found that the dollar limits for drug coverage have increased significantly. For example, in the last two years, the proportion of plans that limit drug coverage to $500 or less has increased by 50 percent. In 2000, about 75 percent of plans have annual dollar limits of $1,000 or less.[24]

These reductions in benefit packages decrease the attractiveness of Medicare managed care and therefore contribute to enrollment challenges for the remaining plans. Plans may have more trouble attracting beneficiaries to managed care without inducements such as drug coverage and zero premiums. On the other hand, remaining plans may be flooded with enrollees who have lost their coverage, creating concerns about the plans' capacity to absorb these new enrollees. Some plans have asked HCFA to allow them to cap their enrollment so that they can more accurately predict costs and manage enrollees' medical care. For example, in Maryland, only one plan, Kaiser Permanente of the Mid-Atlantic States, will remain in 2001, while the other three plans have pulled out, affecting 55,000 Medicare beneficiaries. Kaiser recently announced a freeze on enrollment and is awaiting HCFA approval for a plan to cap enrollment for 2001.[25] Currently, Kaiser's Medicare HMO covers about 27,000 beneficiaries in the Washington-Baltimore area. It recently decided to limit plan members' choice of doctors to only those working at Kaiser facilities. Kaiser also announced plans to sharply increase premiums in the region (for example, from $19 to $79 in the Baltimore area).[26]

Consumer Confidence

Beneficiary advocates have reported growing anxiety among beneficiaries about the reliability of the M+C program. Many beneficiaries have been confused by press reports surrounding plan withdrawals and, often unaware that only certain counties are affected, assume their benefits have been canceled throughout entire regions. The withdrawals have heightened awareness that plans can leave the market and may reduce the willingness of some Medicare beneficiaries to enroll in plans in the next few years.

As stated earlier, about 15 percent of those who could have chosen another managed care plan instead chose to return to the original fee-for-service Medicare program. They may have done so because a switch to a new plan would have required them to change doctors or because they had lost confidence in a Medicare HMO as an option. According to the Kaiser Family Foundation survey, about one-half of respondents who had not joined another HMO said they were not likely to join another Medicare HMO in the near future.

Employers—who once championed moving their retirees into M+C plans—have begun to have serious concerns about the disruptions caused by plan withdrawals. Complaints from retirees have created public relations headaches that most employers seek to avoid. Moreover, some of the nation's largest employers have seen their monthly M+C premiums double for a retiree health package with unlimited drug coverage; however, they are still considerably lower than Medigap premiums. In addition, the unpredictability of premium rates makes it difficult to determine retiree health liabilities as required by the Financial Accounting Standards Board. Nonetheless, Medicare HMOs are still the best

deal in terms of value for employers covering retirees, according to Joe Martingale, who oversees the Medicare+Choice initiative on behalf of 60 large employers for Towers Perrin.[27]

Wall Street has also turned a cold shoulder toward M+C. At a recent gathering of Wall Street analysts sponsored by the Center for Studying Health System Change, not a single analyst on the panel recommended that managed care plans participate in the program. In fact, they said they had been advising companies that M+C was a losing proposition. Companies pulling out of M+C were rewarded with higher stock prices as investors responded favorably to the withdrawals.[28]

NEW PLAYERS IN M+C (OR LACK THEREOF)

When Congress created the M+C program, it was intended to give beneficiaries the opportunity to choose between the existing Medicare fee-for-service program and a wide range of alternative plans, including managed care options, such as HMOs, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs), as well as private fee-for-service plans and medical savings account (MSA) plans. To date, this objective has not been achieved. No MSA plans have applied to participate in the program. As indicated earlier, many HMOs have decided to withdraw from the program in several areas of the country and other new plan options have rarely been utilized.

Since July 1998, HCFA has approved 58 applications for M+C plans to begin service or expand a service area.[29] HCFA recently approved its first private fee-for-service option and is currently reviewing five new M+C applications, including two preferred provider-type organizations. Five current M+C plans submitted service area expansions. An AAHP analysis of HCFA data found that the number of M+C contracts and service area expansions approved by HCFA has fallen substantially.[30] In the first six months of 2000, HCFA approved only eight new M+C contracts and eight service area expansions. In 1999, HCFA approved 26 new contracts and 26 service area expansions, compared with 55 new contracts and 46 service area expansions in 1998 and 53 new contracts and 38 service area expansions in 1997.

Preferred Provider Organizations

As far back as 1995, in the first round of Medicare reform activity under a new Republican leadership, greater choice of plans and a desire to shift risk from the government to health plans were put forward as key objectives. Lawmakers promised that PPOs with broad networks, no requirements to see a primary care "gatekeeper" for specialist referral, and out-of-network treatment options would be available to Medicare beneficiaries. As a result, PPOs were duly included among organizations eligible to contract with HCFA under what became Medicare+Choice—provided, that is, that they could demonstrate their ability to bear full financial risk and meet requirements for consumer protection, quality assurance, and solvency.

Bearing risk, in the form of accepting a capitated payment per member per month to provide any and all care that might prove needed, was the first threshhold. In 1995, the American Association of Preferred Provider Organizations could not identify among its members any PPO bearing full financial risk. Some managed health care organizations offered a capitated HMO product alongside a PPO, but PPO reimbursement continued to follow the pattern of discounted fee-for-service.

Medicare+Choice was preceded by a HCFA-sponsored demonstration project known as "Medicare Choices," which debuted in 1996 and was designed to test variations on the standard reimbursement model. While several PPOs were included initially, only one is operating as a M+C contractor today. Personal Choice 65, a PPO offered by Independence Blue Cross and Blue Shield (Pennsylvania), has approximately 14,000 enrollees. These beneficiaries pay an additional premium (as compared with a more tightly managed HMO option) for geographic flexibility and freedom from gatekeeping. Both options offer a limited prescription drug benefit.

In general, PPOs, which are characterized by looser networks and fewer care management tools, have found compliance with M+C requirements more challenging than tightly organized and managed plans. An Independence executive observed that Personal Choice 65 had to make numerous adjustments to qualify under M+C. In addition to reimbursement challenges, the PPO has found it difficult to comply with M+C requirements because the regulations are based on an HMO model. Thus, PPOs do not really fit into standard designs for membership materials or the Medicare Compare Web site.

The Blue Cross and Blue Shield Association raised similar concerns with respect to performance measurement and quality improvement, pointing out that PPOs were not designed to manage clinical performance, as originally called for in the BBA and echoed in some

versions of patient protection legislation. A provision in the BBRA exempted PPOs from compliance with some quality improvement requirements under M+C and called upon MedPAC to study what quality measurements would be appropriate for various types of Medicare plans.

Under President Clinton's Medicare reform proposal, Medicare would contract with private-sector PPOs to offer this alternative to beneficiaries. How this new option would relate to the current fee-for-service program is not fully clear. According to analysis of the proposal by Marilyn Moon, this option would likely be viable only in areas where Medicare payment levels are high relative to other payers.[31] The proposal also raises several questions, such as how would out-of-network providers be paid and what constraints would be placed on them? What incentives are available to encourage beneficiaries to select preferred providers, given that co-payments for most are already covered by Medigap policies and Medicare limits the amount physicians can charge when beneficiaries seek care outside the network?

Provider-Sponsored Organizations

Provider-based organizations lobbied intensively from 1994 up until passage of the BBA to obtain the right to contract directly with the Medicare program. Motivated in part by an attempt to regain market power and eliminate the insurance "middlemen," hospital and physician groups made inclusion of a PSO option under Medicare a chief objective, one that was championed by several leaders in Congress. Debate surrounding these proposals centered on what standards should be applied to PSOs and how the federal government and states would share responsibility for regulating them.[32]

Despite all the initial enthusiasm, the PSO concept has failed to take off. Several PSOs have participated in the Medicare Choices demonstration, but a number of difficulties have been noted, especially control of utilization under capitation. The BBA established a waiver process to encourage the development of PSOs, but to date, there is only one PSO operating under a waiver, and that plan is withdrawing from the program this year. In a letter to HCFA Administrator Nancy-Ann DeParle, the American Hospital Association (AHA) said that

> offering a Medicare+Choice plan may simply not be doable, especially for start-up organizations. Program requirements have expanded significantly, . . . [while] plan payments are undergoing major methodological changes that may not yield rates sufficient to comply with HCFA's requirements and permit plans to offer a benefit package that would attract Medicare beneficiaries.[33]

Moreover, AHA points out that the large number of well-established M+C plans scaling back or withdrawing from the program has sent up yellow caution flags to potential plan applicants. In addition, the overall effect of the BBA has left many hospitals with little or no operating margin to use for venture capital, according to the AHA. Financial pressure from both public and private payers has forced many hospitals to refocus on their core business of health care delivery. In terms of risk assumption, many hospitals have done a reversal with regard to their acceptance of capitation. In 1998, the number of hospitals receiving any capitated revenue declined for the first time, while hospitals that did accept capitation saw the average percentage of revenue paid on a capitated basis drop to 8.0 percent, down from 10.7 percent in 1994.[34]

Private Fee-For-Service

A private fee-for-service option has emerged recently as the most promising new option under M+C. Under this arrangement, Medicare, as it does with HMOs, will pay the private plan a premium to cover traditional Medicare benefits and any supplemental benefits. But unlike HMOs, plans can charge additional premiums and copayments for the basic benefit package.

In July 2000, Sterling Life Insurance Co. began offering Medicare's first private fee-for-service product to 8.2 million beneficiaries in 17 states. The company plans to market Sterling Option 1 as a less expensive alternative to Medigap and a more reliable alternative to Medicare HMOs. In fact, the option has been seen by some as a way to get around Medigap standardization rules. Plan representatives have said they expect that the volatility experienced by Medicare HMOs will help boost the success of the private fee-for-service plan.[35] Sterling will charge a $55 per month premium wherever the plans are offered; the plan will not cover prescription drugs. The company's newly approved private fee-for-service plan will operate initially in 1,221 counties; beneficiaries in 940 of those counties currently have no M+C options available to them.

BBRA AND PENDING LEGISLATION

The BBRA, enacted on November 29, 1999, made several modifications to the M+C program that were designed to moderate the effect of many BBA provisions. In addition, several proposals now pending in Congress would make significant changes to the current M+C program, in terms of both how and how much plans are paid and what benefits are covered.

The BBRA made numerous changes in M+C payment, contracting, and enrollment rules. The law changed requirements regarding the definition of service areas and the timing of premium submissions. It also further backloaded the phase-in of risk adjustment. The BBRA also established a new entry bonus for M+C payment areas in which a M+C plan has not been offered since 1997 (or from which, as of October 13, 1999, all organizations have filed a notice of withdrawal). In total, it is estimated that the BBRA will restore an additional $4.8 billion for M+C plans over the 2000 to 2004 period. Of this amount, $3.2 billion is the result of the indirect pass-through effect of higher payments to fee-for-service providers; $1.6 billion is a direct result of measures addressing M+C payment policy.

The predominant preoccupation of most federal lawmakers today regarding Medicare policy is the desire to provide outpatient prescription drug benefits to Medicare beneficiaries. Proposals to provide such benefits relate directly to the future of the M+C program, because many plans have used drug benefits as a way to attract beneficiaries and have recently scaled back on coverage as a result of payment reductions and increasing drug costs. Most of these proposals call for simultaneous reform of M+C payment policy. More recently, interest in stabilizing the M+C program has increased, and several bills have been introduced that would directly address issues related to the current payment and regulatory environment.[36]

The Clinton administration and Senate Democrats generally want to expand the Medicare benefit package to include prescription drugs (S. 2342). Under the House-passed, GOP prescription drug plan (H.R. 4680), the benefit would be provided through private plans that would receive federal financial and administrative support. Each of these proposals would create a new Medicare Part D that would be voluntary for beneficiaries. Under H.R. 4680, M+C plans would not be required to offer Part D coverage, but those plans that did would have to meet, as a minimum, standard coverage requirements. M+C plans could receive reinsurance subsidies if they provided actuarially equivalent or better drug coverage. Under S. 2342, M+C plans providing equal or better prescription drug coverage than the standard would be eligible for full subsidies.

Clinton's Medicare reform plan would set plan payment rates through market competition rather than a statutory formula. Plans would be required to submit two bids on two packages, one with and one without a prescription drug benefit. M+C plans would be explicitly paid for providing a standard drug benefit under the president's plan. Plans could offer additional benefits, but they would have to be priced and sold as separate packages that the enrollees could accept or reject.

H.R. 4680 contains numerous M+C payment reforms. These include increasing payment updates, allowing blended rates in 2002, providing a ten-year phase-in of risk adjustment based on data from all settings, and permitting higher payment rates through negotiations.

The "Medicare Prescription Drug and Modernization Act of 2000," (S. 2807) introduced by Sens. John Breaux (D-La.) and Bill Frist (R-Tenn.), would establish a new Competitive Medicare Agency as an independent executive branch agency. The new agency would administer the M+C program and the new Medicare Prescription Plus program. In 2003, it would establish a new competitive system under M+C under which plans would bid for the costs of delivering care and compete based on benefits, price, and quality. A proposal offered by Sen. William Roth (R-Del.) would also initiate a competitive bidding approach and allow M+C plans to bid on either the traditional or the expanded option plan.[37] Both proposals contain short-term payment improvements for M+C plans.

THE FORUM SESSION

The focus of this Forum session will be recent plan withdrawals and their implications for the future of the M+C program. In addition, this session will explore the impact of these withdrawals on Medicare beneficiaries in terms of costs, benefits, continuity of care, and general confidence in the program. It will also look at various policy options, including the addition of prescription drug coverage to the basic Medicare benefit package.

Key Questions

- What are the chief factors associated with plans' participation decisions?
- How have benefits provided by M+C plans changed over the past few years? How do these trends compare with commercial plan benefit packages?
- How have beneficiaries responded to these plan withdrawals?
- In 1999, both HCFA and GAO stated that they expected to see continued program growth, despite decisions of certain plans to withdraw. This expectation has not materialized. Should we expect continued declines or growth in participation in the future?

- Medicare managed care, although originally expected to save money, continues to add to program cost. Why is that and what does it mean for proposals that rely on managed care to achieve program savings in the future?
- Should alternatives to full risk assumption be explored? What about alternatives to HCFA's proposed risk-adjustment methodology?
- How might Medicare prescription drug coverage affect the future of M+C?
- Would a mandatory competitive bidding approach encourage more plan participation or less?

Speakers

William J. Scanlon, Ph.D., director of health financing and public health for GAO, will present the findings of GAO's most recent report on Medicare+ Choice plan withdrawals (scheduled to be released August 31). He will discuss the characteristics of the plans that leave the program and what distinguishes them from those that stay as well as what distinguishes the geographic areas where plans stay from the areas they leave. Before joining GAO in 1993, Scanlon was co-director of the Center for Health Policy Studies and an associate professor of family medicine at Georgetown University; earlier, he was a principal research associate in health policy at the Urban Institute.

David H. Lemire, vice president, Senior Business Segment, for CIGNA HealthCare, will discuss why his company decided to withdraw from most of the markets in which it participated as an M+C plan. He will also discuss how the group retiree health market plays into CIGNA's business decisions. Lemire has more than 25 years of experience in the employee benefits field, including sales, marketing, underwriting, new product development, and communications. His assignment at CIGNA was to create a national business providing M+C products to retirees and their dependents. Since CIGNA's announced 2001 withdrawal from all but two M+C markets, Lemire has been focused on providing high-quality health care to CIGNA's members while winding down the business.

Michelle P. Holzer, program officer for the Maryland Department of Aging's senior health insurance program (SHIP), will discuss the impact of plan withdrawals on beneficiaries. In Maryland, 55,000 beneficiaries will be affected by plan pullouts and only one plan out of four will continue to participate in the program in 2001. SHIP is a volunteer-based model program featuring claims assistance, counseling, public education, and legal advocacy for older persons. There are 19 SHIP projects in Maryland, serving the entire state. Holzer has worked for over 18 years in the field of health and human services planning and coordination.

ENDNOTES

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8. Robert A. Berenson, M.D., statement before the House Ways and Means Subcommittee on Health, July 25, 2000, 3.

9. Robert Berenson, M.D., statement before the House Commerce Subcommittee on Health and the Environment, August 4, 1999.

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11. Health Care Financing Administration, "Protecting Medicare Beneficiaries."

12. Medicare Payment Advisory Commission, *Medicare Payment Policy*, 122.

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32. For more information about congressional debate on PSOs, see Karl Polzer, "The Medicare Risk Contract Game: What Rules Should PSOs Play By?" National Health Policy Forum, Issue Brief No. 702, June 17, 1997.

33. Rick Pollack, letter to Nancy-Ann Deparle, HCFA Administrator, September 24, 1998.

34. Ellen Pryga, director, policy development, American Hospital Association, interview with author, July 26, 2000. Data are from Health Forum Annual Survey for 1994-1998 of U.S. registered community hospitals.

35. "Sterling Life Gets HCFA Approval to Start First U.S. Medicare FFS Plan," *News and Strategies for Managed Medicare & Medicaid*, May 15, 2000, 1, 6.

36. See S. 2937, S. 2905, S. 2807, H.R. 5039, H.R. 4968, H.R. 4951, H.R. 4937, H.R. 4236, H.R. 3284, and H.R. 2419.

37. To date, efforts to test Medicare competitive pricing as a demonstration project have failed to get off the ground. See Nora Super Jones, "Medicare Competitive Pricing: Lessons Being Learned in Phoenix and Kansas City," National Health Policy Forum, Issue Brief No. 750, November 8, 1999, for an analysis of the most recent demonstration. The BBRA delays implementation of the demonstration until 2002, or six months after the Competitive Pricing Advisory Commission reports to Congress on several overriding concerns.