

Improving the
Medicare+Choice Program:
Recommendations of the
Medicare Payment Advisory
Commission

APRIL 3, 2001

Statement of
Murray N. Ross, Ph.D.,
Executive Director

Before the
Committee on Finance
U.S. Senate

Chairman Grassley, Senator Baucus, members of the committee. I am Murray Ross, executive director of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss the Medicare+Choice (M+C) program. My testimony draws on the recommendations and analysis in MedPAC's March 2001 report to the Congress.

Prior to enactment of the Balanced Budget Act of 1997 (BBA), Medicare's payments to managed care plans were linked to fee-for-service (FFS) spending in individual counties. Wide variation in FFS spending among counties meant that managed care payment rates also varied widely. Because of this and because of market conditions, beneficiaries in some—mostly urban—areas had access to plans offering much greater benefits than those available to beneficiaries in other—mostly rural—areas. To address this inequity, the Congress changed the payment mechanism when it created the Medicare+Choice program. It put a floor under payments to plans, provided for blending of local and national payment rates, and limited increases in payments to higher-paid areas. In the Benefits Improvement and Protection Act of 2000 (BIPA), the Congress raised the floor further.

Reducing the variation in M+C payment rates across the country, however, has introduced a different problem by creating the potential for Medicare's payments to plans

in particular market areas to diverge significantly from FFS spending in those markets. In counties where payment rates have been increased above FFS costs, the Medicare program may pay Medicare+Choice plans more to provide the basic benefit package than it would have otherwise, thus increasing program spending. In other counties, payments to Medicare+Choice plans may fall below FFS costs as updates are limited. Over time, plans paid less than FFS costs will face difficulty in contracting with providers if their payment rates are not competitive with those of the traditional program.

No matter how much payments to plans are manipulated, achieving geographic parity in payments to M+C plans and maintaining local parity between Medicare+Choice and traditional Medicare cannot be accomplished simultaneously as long as there is significant underlying variation in fee-for-service spending across market areas.

MedPAC believes that Medicare's payment policies should not steer beneficiaries to either Medicare+Choice plans or the traditional Medicare program. Therefore, the Commission recommends that the Congress make payments for beneficiaries in the two sectors of a local market substantially equal, taking into account differences in risk.

The Commission also recommends that the Secretary study variation in spending under the traditional Medicare program to determine how much reflects differences in input prices and health risk and how much reflects differences in provider practice patterns, the

availability of providers and services, and beneficiary preferences. The Secretary should report to the Congress and make recommendations on whether and how the differences in use of services and preferences should be accounted for in Medicare fee-for-service payments and Medicare+Choice payment rates.

When the Congress put a floor under M+C payment rates, it sought to bring new choices and additional benefits to rural areas. However, low payment rates are not the only reason that managed care plans generally did not enter rural areas. Managed care plans seeking to participate in rural areas face two challenges. First, a lack of so-called intermediate entities (such as physician group practices) in many rural areas makes forming networks more costly and limits plans' ability to delegate risk to control costs. Second, the limited number of hospitals, physicians, and other providers in many rural areas reduces plans' ability to negotiate discounted prices for services because providers lack competition. As a result, even with the floor under Medicare+Choice payments, few managed care plans have entered rural areas.

In contrast to managed care plans, private fee-for-service plans need not establish networks of providers. In addition, the floor under M+C payment rates mean that such plans need not negotiate discounted prices to be profitable. A private fee-for-service plan whose enrollees' use of services was similar to their use in traditional Medicare could have the same costs for medical care as under the traditional program but be paid more.

This possibility has led one plan to enter over 1,600 counties (three-quarters of them floor counties) in 25 states, and another application is pending.

The entry of private fee-for-service plans into floor counties—or other counties where M+C payment rates substantially exceed local FFS costs—raises an important policy issue. On the one hand, such plans represent an alternative to traditional Medicare that the Medicare+Choice program was intended to provide. On the other hand, the lack of care management means that additional benefits provided by such plans come not from efficiency in the provision of medical care, but from higher-than-needed payments.

Further, the fact that payments in some floor counties substantially exceed FFS costs does not ensure that Medicare beneficiaries will have access to additional benefits. Some of the excess payment may generate higher profits for insurers and some of the excess payment may lead to higher payments to providers from those insurers. As a result, MedPAC recommends that the Secretary study how beneficiaries, providers, and insurers each benefit from the additional Medicare+Choice payments in floor counties.

How then can policymakers meet the goals laid out in the BBA of providing more choices of plan options and helping to control the growth of Medicare spending? MedPAC's recommendation to make payment rates for Medicare+Choice substantially equal to local FFS costs would help achieve the latter goal, but would not by itself encourage more plans to participate in rural areas. Additional steps will be needed.

One possibility to explore is risk sharing. Under current law, the financial risk for the costs of health care is assumed fully either by Medicare for beneficiaries in the traditional fee-for-service program and or by plans for Medicare+Choice enrollees. Allowing risk sharing could encourage greater participation by entities unwilling to bear risk for services beyond their control. Although the potential to reduce costs (and thus provide enhanced benefits) in a given area might not be as great under a shared-risk arrangement as under full risk, it might make alternatives to traditional Medicare available in more areas.

Another possibility would be to explore alternatives to county-based payments so that payment areas could better match local market boundaries and volatility in payment rates over time could be reduced. Basing Medicare+Choice payments on local FFS spending and risk factors would increase the importance of having reliable and stable data with which to calculate them. MedPAC recommends the Secretary explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.

Background

In enacting the Medicare+Choice program in the Balanced Budget Act of 1997, the Congress sought to control the growth in Medicare spending, to provide Medicare beneficiaries with more choice of plan options, and to address a perceived inequity in beneficiaries' access to private plans and the more generous benefits they offered.

The BBA expanded the types of private plans that could participate in Medicare; in addition to health maintenance organizations (HMOs), the law permitted preferred provider organizations (PPOs), provider-sponsored organizations, point-of-service plans, private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account.

The BBA also introduced a new payment mechanism intended to reduce variability in payment rates across markets. Prior to the BBA, payments to risk plans in a given county were set at 95 percent of the average fee-for-service costs of Medicare beneficiaries in that county, adjusted for demographic characteristics. The BBA set payments at the maximum of a floor rate, a minimum update applied to the previous year's rate and, subject to a so-called budget neutrality factor, a blend of local and national rates. The BBA also directed the Health Care Financing Administration to replace the existing risk adjustment method with one accounted for the health status of M+C enrollees.

Progress towards the Congress's goals has been halting. Although the fraction of Medicare beneficiaries enrolled in Medicare+Choice plans remained roughly constant between 1998 and 1999, this marked a sharp change from the rapid increase in managed care penetration that took place in the mid-1990s. Further, until the recent entry of a private FFS plan, no new types of plans sought to participate and a substantial number of plans withdrew from the program or reduced their service areas. In January 1999, there were 45 contract terminations and 54 service area reductions. In July 1999, another 41 terminations and 58 service area reductions were announced effective for 2000.

The cumulative effect of these changes is that beneficiaries' access to HMO plans, particularly those offering zero-premium coverage, has declined. The percentage of Medicare beneficiaries having access to a M+C HMO plan fell from 71 percent in 1999 to 69 percent in 2000 and again to 63 percent at the beginning of this year. The percentage of beneficiaries having access to zero-premium plans has been even more pronounced, falling from 61 percent in 1999 to 39 percent in 2001.

The Congress has acted twice in an attempt to maintain participation and stimulate entry by plans. The Balanced Budget Refinement Act of 1999 (BBRA) slowed the phase in of risk adjustment (which would have reduced payments to most plans), provided for bonus payments to plans entering areas without a Medicare+Choice plan, and exempted PPOs from certain quality assurance requirements. The Benefits Improvement and Protection

Act of 2000 raised the floor under payments in 2001 from \$415 to \$475 per month and introduced a separate floor of \$525 for counties that are part of Metropolitan Statistical Areas containing more than 250,000 people. The law also provided for a minimum update of 3 percent to 2001 payment rates. In addition, the increases in payment rates to fee-for-service providers enacted in the BBRA and the BIPA feed through to higher updates to M+C payment rates.

It is too early to determine the ultimate impact of these legislative changes. But if the higher floors enacted in the BIPA lead to increased enrollment in floor counties, then updates in high-payment counties will be constrained to the minimum update. This means that plans in high-payment counties will face continuing pressures to reduce additional benefits or increase cost-sharing and premiums for their enrollees.

Differences in fee-for-service spending

Fee-for-service spending varies widely across the country, with spending in the highest cost counties about triple spending in the lowest cost counties. Some of the variation is attributable to differences among counties in wage rates and in the health risks of their residents, factors that Medicare explicitly takes into account in its prospective payment systems. Some of the variation is attributable to differences in the practice patterns of providers, the availability of providers and services, and the preferences of beneficiaries.

These differences generally went unnoticed in the fee-for-service program. But they became much more visible as Medicare's risk contracting program grew because payments to managed care plans were linked to local fee-for-service spending. Areas with high fee-for-service spending received managed care payments that allowed private insurers to provide generous additional benefits if they could provide Medicare's basic benefits at lower costs. Areas with low FFS spending generally did not attract plans. Although differences in fee-for-service spending were not seen as inequitable, variation in the availability of extra benefits was.

When it enacted the Medicare+Choice program, Congress attempted to address this inequity by severing the link between M+C payment rates and local fee-for-service spending. It put a floor under payment rates and provided for blending of local and

national payment rates to bring them closer together. These higher payments were to be financed by limiting updates in payment rates to high-cost counties.

The practical impact of the divergence between M+C payments and local FFS spending was small during the first years of the M+C program because few beneficiaries living in floor counties were enrolled in M+C plans and because slow growth in Medicare FFS spending did not allow blended payments to be made. The increase in floor rates enacted in the BIPA, however, has substantially changed the distribution of payments because about half of Medicare beneficiaries live in the newly expanded set of floor counties. If the higher floors are even moderately successful in attracting new plans and enrollees, then counties with payment rates above the floor are likely to receive the minimum update (rather than a blended rate) for years to come.

The higher floor will compress payment rates. But setting Medicare+Choice payment rates substantially above fee-for-service costs in the floor counties also creates opportunities for insurers to receive much higher payments from Medicare than the program would otherwise spend. If the higher payments do not lead to additional benefits, then Medicare will be spending more than necessary to provide the basic benefit package.

MedPAC is concerned about wide divergences within health care markets between Medicare+Choice payment rates and Medicare spending for beneficiaries in the traditional program because we believe Medicare should be financially neutral as to whether beneficiaries choose the traditional program or a Medicare+Choice plan. This view implies striving to make Medicare+Choice payment rates substantially equal to local per capita fee-for-service costs, adjusted for differences in risk. Failure to do so will encourage financing care in the sector that is most costly to Medicare. Where payments to Medicare+Choice plans exceed FFS costs, beneficiaries are likely to seek out private plans because they will be able to offer additional benefits. Where payments are below FFS costs, plans will be reluctant to enter markets or will have to charge (or increase) premiums to their enrollees.

The underlying geographic differences in spending under traditional Medicare mean that resolving the dilemma of achieving both national equity and local efficiency cannot be done through M+C payment policy alone. Medicare+Choice payment policy is not an effective or appropriate means to address underlying variation in FFS spending.

MedPAC recommends that the Secretary study this variation to determine how much is caused by differences in input prices and health risk and how much is caused by differences in providers' practice patterns, the availability of providers and services, and the preferences of beneficiaries. The Commission also recommends that the Secretary report to the Congress on whether and how differences in use and preferences should be

incorporated into Medicare FFS payments and M+C payment rates. We recognize that payment policies intended to limit variation in local practice patterns under the FFS program would be difficult to formulate and even more difficult to implement.

In the absence of any change in law, higher M+C payments in floor counties raise the potential for plans and providers to earn above-normal profits. The Secretary should monitor the extent to which payments in those areas result in higher insurer profits, higher provider payments, and extra benefits for enrollees. The focus should be on areas with large divergence between M+C payment rates and FFS spending and on areas with few plans available (because the absence of competition reduces the likelihood that higher payments will yield additional benefits).

Medicare+Choice and rural areas

Even with the introduction of floor payments, Medicare+Choice HMOs have been reluctant to enter rural areas. In 2001, only 14 percent of Medicare beneficiaries living in rural areas have access to an M+C HMO, compared with almost 80 percent of those living in urban areas. The difference between rural and urban areas in the availability of additional benefits is even more striking: 8 percent of beneficiaries living in rural areas have access to a plan offering prescription drug coverage compared with two-thirds of those living in urban areas.

The reluctance of managed care plans to enter rural areas reflects a number of factors, including the difficulty plans face in establishing provider networks that meet regulatory guidelines and the lack of incentives monopoly providers have to negotiate with them. Further, returning to a system that links Medicare+Choice payment rates to local FFS spending would, in the absence of other changes, mean that payment rates were subject to large swings, as was the case under the risk contracting program.

The availability of intermediate entities, such as independent practice associations and large group practices, can make the formation of networks easier for managed care plans and allow them to pass on risk in the form of capitated payments. Because these intermediate entities are not as commonly available in rural areas as in urban areas, plans seeking to form networks might have to do so provider by provider—a costly method. Also, capitated payment arrangements may not be feasible; HMOs in rural areas commonly reimburse physicians on a FFS basis, which limits their ability to generate efficiency gains.

In urban areas with large numbers of providers, managed care plans often can negotiate discounts. In rural areas, hospitals and physicians with few competitors have little incentive to accept payment rates below fee-for-service Medicare. Further, even if plans could deliver significantly higher patient volume in exchange for lower payments, many

rural physicians would not be in a position to accept them; they already work longer hours and see more patients than their urban counterparts.

That rural areas are not conducive to managed care is not unique to Medicare. Proximity to urban areas correlates with managed care penetration in the commercial insurance market and in Medicaid. HMOs are not available in all counties in the Federal Employees Health Benefits Plan and eight predominantly rural states have no HMO available in any county.

Although managed care plans may be unwilling to enter rural areas, the Medicare+Choice program allows other types of plans to participate. The program has recently seen the entry of a private fee-for-service plan in 25 states (predominantly in floor counties) whose operations are not dependent on establishing networks of providers. Approval of another plan is pending. Under current law Medicare will pay artificially high rates to these plans for the same unmanaged care that the traditional program delivers.

In the absence of a floor under Medicare's payments to health plans, what steps could be taken to encourage participation? MedPAC is examining alternatives to full risk capitation, but makes no recommendations on specific solutions at this time. The Commission does, however, recommend that payment areas be expanded to reduce the volatility in local payment rates that could occur if the floor were removed.

The Medicare+Choice program asks plans to absorb all of the financial risks for beneficiaries' health care. Two alternatives to full-risk capitation are primary care case management (PCCM), which is widely used by the Medicaid program, and split capitation, under which the program could delegate risk for some services while retaining risk for other services.

Under PCCM, primary care providers are paid a small amount per member per month in addition to payments for patient encounters. Over 60 percent of rural counties participating in Medicaid managed care used PCCM in 1997. PCCM is popular among Medicaid beneficiaries, but would be unlikely to generate the extra benefits that Medicare beneficiaries desire.

Under split capitation, entities would bear risk only for the services under their control. For example, a multi-specialty group practice could take full risk for physicians' services and no risk for hospital inpatient services. Much of the efficiency gain that comes from managed care, however, stems from limiting referrals and reducing inpatient admissions. Physicians who were not at risk for those services would have little incentive to reduce them if they did not benefit in some way.

Finally, one step the program could take involves enlarging payment areas to reduce volatility in payment rates and make payment areas correspond more closely to the

markets in which beneficiaries receive care. In counties with relatively few Medicare beneficiaries, the presence or absence of a few large claims can lead to swings in average fee-for-service spending at the county level. Under the risk contracting program, swings in FFS spending caused volatility in payment rates to managed care plans; such swings also would be an issue under MedPAC's recommendation to make M+C payment rates comparable to fee-for-service costs. MedPAC recommends that the Secretary explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.