

CHAPTER 5

**Medicare+Choice: trends since
the Balanced Budget Act**

Medicare+Choice: trends since the Balanced Budget Act

The Congress had two explicit goals when it created the Medicare+Choice program as part of the Balanced Budget Act: (1) To provide beneficiaries with more choice of plan options, similar to that available in the private sector and the Federal Employees Health Benefits Program, and (2) to help control the growth in Medicare spending (U.S. Congress 1997). Balanced Budget Act proponents had other implicit goals. Some members of the Congress wanted to see the Medicare+Choice plans provide beneficiaries with benefit packages richer than the traditional Medicare fee-for-service package, particularly with respect to outpatient prescription drugs. Other policymakers wanted to see continual, rapid enrollment increases in Medicare+Choice plans to help set the stage for possible future changes in the structure of Medicare.

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- Addressing barriers to program goals through the Balanced Budget Refinement Act
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Since the passage of the Balanced Budget Act (BBA), progress toward these goals has been halting. The availability of plan options has not increased; most beneficiaries in rural areas still cannot enroll in Medicare+Choice (M+C) plans; benefit packages have become less generous; and enrollment growth in M+C plans has slowed. However, the rate of increase in program payments per beneficiary has decreased.

In the Balanced Budget Refinement Act of 1999, the Congress enacted new measures to help the M+C program realize its goals. In this chapter we analyze the M+C program's progress and discuss how these changes may affect future progress.

Barely moving toward congressional goals

The BBA introduced many changes to Medicare and created the Medicare+Choice program. In this section we discuss the program since the BBA and how the BBA's changes relate to the Congress's goals.

Controlling Medicare spending

The BBA has been successful in controlling the growth in Medicare spending; per capita spending actually has decreased since its enactment. The majority of savings has come from provider payment reductions in the traditional Medicare fee-for-service (FFS) program, but some BBA provisions also restricted the payment rate growth for M+C plans. Among these provisions were a reduction in the national update of 0.8 percent in 1998, a further reduction of 0.5 percent in 1999, an assessment for education charges borne by HCFA to inform beneficiaries about the M+C program (about 0.3 percent of payments), and a gradual removal of payments for graduate medical education, which previously had been considered part of the base payment amounts (see text box for a description of M+C payment rate methodology). Although no provision sought to increase the overall payment rates for M+C plans, the floor provision did increase payment

TABLE 5-1

Medicare+Choice contract terminations and service area reductions

	January 1999	January 2000
Terminations	45	41
Service area reductions	54	58
Enrollees who could not stay in their plans	407,000	327,000
Enrollees in counties where all plans withdrew	50,000	79,000

Source: HCFA announcements, December 8, 1998, and July 15, 1999.

rates for some counties, and the blend provision redistributed payments, generally from higher- to lower-payment areas.

Providing more plan options for beneficiaries

The M+C program can increase plan options for beneficiaries in two ways. It can extend operations of Medicare HMOs to new areas of the country and increase the number of active plans in existing markets. It also can introduce new types of plans to the program. Neither has occurred.

Withdrawals of existing Medicare+Choice plans

A substantial number of health plans have withdrawn from the M+C program over the past two years. In January 1999, there were 45 terminated contracts and 54 service area reductions (Table 5-1). Of 310 M+C contracts in existence in July 1999, 41 were terminated effective January 2000. Another 58 contractors reduced their service areas by withdrawing from at least one county. These changes meant that in 1999 about 405,000 beneficiaries could not stay in the M+C plans in which they were enrolled in July 1998. At the beginning of 2000, about 327,000 M+C enrollees were in the same circumstance. The plan withdrawals for 2000 were not evenly distributed; 4.5 percent of enrollees in counties getting the floor payment rates lost their plan, compared with 2.4 percent of enrollees living in counties with M+C payment rates above \$550 per month.

Counties in which all available plans withdraw are a particular concern in view of the Congress's goal to provide more choice to beneficiaries. All available plans

withdrew from 105 counties for 2000, leaving more than 79,000 M+C enrollees with no M+C alternative. These beneficiaries had to move into the traditional FFS Medicare program, unless they moved to a county with M+C plans. For 1999, HCFA announced that all plans withdrew from 72 counties, affecting about 50,000 enrollees.

When BBA was enacted in 1997, plans were still joining the program and 74 percent of beneficiaries had access to at least one M+C plan in 1998 (Table 5-2). Access dropped to 71 percent of beneficiaries in 1999 and to 69 percent in 2000. Approximately one million fewer beneficiaries have access to an M+C plan in 2000 than had access in 1999, and two million fewer than had access in 1998.

Lack of new products

The BBA expanded plan options to allow four new types of plans: provider sponsored organizations (PSOs), preferred provider organizations (PPOs), private fee-for-service plans, and plans attached to medical savings accounts (MSAs). Almost

TABLE 5-2

Beneficiaries with risk plans available, 1997-2000

	1997	1998	1999	2000
Total	67%	74%	71%	69%

Note: Puerto Rico is excluded from the analysis.

Source: MedPAC computations based on HCFA public data.

Medicare+Choice payment rates

Before the BBA, county payment rates (per beneficiary, per month) were based on the fee-for-service costs of Medicare beneficiaries in that county. The BBA established a new payment methodology, under which the county M+C rate is the maximum of:

- a floor rate
- a minimum update applied to the previous year's rate
- a blended rate.

The **floor rate** was set to \$367 for 1998 and is increased by an update factor equal to the projected growth in Medicare expenditures per capita each year thereafter. For 1999 and 2000 the update factor was decreased slightly each year to calculate the floor payment. As a result, the floor payment for 1999 was \$380; for 2000, \$402.

The **minimum update** is 2 percent.

The **blended rate** combines a national rate and the local rate. It is intended to reduce the variation in payments across the country by lowering the highest rates and increasing the lowest rates. Blended rates are phased in over six years. In 1998, the blend is 10 percent national and 90 percent local; by 2003, the blend becomes 50 percent national, 50 percent local and continues at that mix thereafter.

The actual computation of blended rates is complicated by several factors and the application of those rates is limited by a budget neutrality provision, which essentially limits total spending (resulting from the sum of the floor, minimum, and blend rates) to

what it would have been if county payments were based strictly on local rates. That provision resulted, for example, in no blended rates being applied in 1998 or 1999.

Other factors that complicate the blend calculation are:

- the graduate medical education (GME) adjustment. Local rates are decreased by a percentage of 1997 GME spending, beginning with 20 percent in 1998 and increasing 20 percentage points a year to 100 percent of GME spending by 2002.
- the update factor. Local rates for each year are calculated by multiplying the previous year's local rate by the update factor mentioned above. The BBA decreased the update factor by 0.008 in 1998 and by 0.005 from 1999 to 2002. The BBRA changed the reduction to 0.003 for 2002.
- input-price adjustment. National rates will be input-price adjusted for blending.

The national rate is the average of the local rates, weighted by the number of Medicare beneficiaries in each county. According to the phase-in schedule, that national rate is input-price adjusted and blended with the local rates to come up with the blended rate per county. If the budget neutrality provision permits, that rate becomes the blended rate per county that is then compared with the floor rate and minimum update to determine the actual county M+C payment rate. ■

no progress has been made toward the availability of these new types of M+C plans. The BBA set up a waiver process to encourage the development of PSO plans, but potential PSO plans said the process did not eliminate enough of the regulatory burden faced by HMOs. Instead, PSOs in the M+C program operate under HMO licences. At this time, there is only one PSO operating under a waiver. In addition, several PSOs that had been operating under the Medicare Choices demonstration project have withdrawn from the project.

The BBA also allows PPOs to become M+C plans. However, PPOs have complained that they are not structured to meet the quality requirements developed by the Health Care Financing Administration (HCFA) under the authority of the BBA. Although other factors also may be in play, no PPOs have become M+C plans.

The BBA introduced the possibility that private fee-for-service plans could become M+C plans. To date, no private FFS plans have joined, but one application for a plan awaiting HCFA approval would cover parts of 30 states. The BBA also provided for the creation of M+C plans attached to MSAs. As yet, there have been no MSA plan applications.¹

Bringing alternatives to the traditional program to rural and other markets

The M+C program has not been successful in expanding plan option choice to Medicare beneficiaries in general. Further, the BBA has not yet been successful in bringing new choices to areas lacking Medicare risk plans in the past. The differences in plan availability across M+C payment rate groups is striking (Table 5-3). Only 15 percent of beneficiaries in counties at the 2000 floor rate of \$401.61 (for aged beneficiaries) have a plan available, while 97 percent of beneficiaries in counties with rates above \$550 have access to plans.

¹ Section 552 of the BBRA directed MedPAC to study the lack of MSA participation and report to Congress in 2000 on specific legislative changes to make MSA plans a viable option under the M+C program.

**TABLE
5-3**

Availability of plans with selected benefits, 1999–2000

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

Source: MedPAC analysis of Medicare Compare data from HCFA website, August 1999 and January 2000.

The lack of availability of M+C plans in rural areas continues to be a concern. While 83 percent of beneficiaries living in urban counties have plans available, only 21 percent of those residing in rural counties have access. Withdrawals for 2000 hit rural enrollees especially hard; 18 percent of them lost their plans. Over the past year, the Commission staff has discussed plan withdrawals and rural Medicare issues with policy analysts and representatives of health plans. These discussions indicate that Medicare HMOs are unlikely to move into more rural areas in the foreseeable future, as is discussed later in this chapter.

Encouraging enrollment and richer benefit packages in Medicare+Choice plans

While overall M+C enrollment is higher than ever—accounting for 16 percent of the Medicare population—it is clear that the BBA has not yet produced the rapid increase in enrollment that policymakers expected. Instead, the growth in M+C enrollment slowed to 5 percent in 1999, from a high of more than 35 percent in 1995 (Figure 5-1).

Plan availability and the richness of benefits in the plans affect enrollment. Coupled with the decrease in overall plan availability, plans continuing in the M+C program have reduced average benefit packages and increased premiums. On average, people enrolled in a plan in 1999 that is still available in 2000 face a premium increase of \$11 per month for the basic benefit package (from \$5 in 1999 to \$16 in 2000) if they want to stay with that same M+C organization. For beneficiaries willing to switch organizations to pay a lower premium, the average minimum monthly premium in areas with at least one M+C plan increased from \$6 in 1999 to \$9 in 2000. Further, both the availability of zero-premium plans and of zero-premium plans that provide any outpatient drug coverage have fallen (Table 5-3).

The familiar patterns of availability along payment level and urban/rural groupings are magnified for the availability of zero-premium plans. In 2000, only 3 percent of beneficiaries living in counties with payment rates at the floor level have a zero-premium plan available, while 94 percent of beneficiaries in counties with rates of more than \$550 have such plans available. Two-thirds of beneficiaries in urban counties have access to a zero-premium

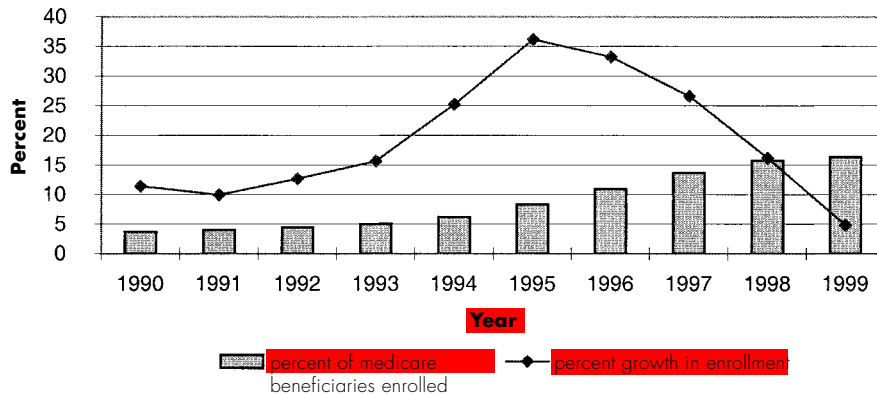
plan, while only 9 percent of rural beneficiaries do. Similarly, 79 percent of urban beneficiaries have access to a plan that offers some outpatient prescription drug coverage, while 16 percent of rural beneficiaries have such a plan available.

Why is it so hard to realize the Congress's goals?

Achieving all of the Congress's goals simultaneously has been difficult because they are partially at odds. For example, there is a basic conflict between the goals of controlling Medicare spending and of providing richer benefits for beneficiaries. If Medicare spending is controlled by bringing payments to M+C plans closer to the cost of providing the basic benefit, it becomes difficult to maintain generous benefit packages and zero premiums for the fortunate beneficiaries who have them, much less to extend those benefits to others. Without generous benefits, encouraging enrollment in M+C plans is more difficult; many people do not want to give up their choice of providers without a financial reward. The Congress wants to take advantage of the efficiencies to be gained from managed care, but it is

FIGURE 5-1

Medicare+Choice (risk) plan enrollment



Source: HCFA monthly managed care summary report.

still wrestling with how to share the savings from those efficiencies in a way that both attracts beneficiaries to the program and limits government spending.

As discussed later, even with additional spending, it is difficult to overcome the market-based obstacles to M+C program extensions to rural areas. Finally, the evolution of plan options may also be in conflict with the introduction of risk adjustment and other actions that make future revenue streams less certain for plans, even while they tend to control Medicare spending.

Controlling Medicare spending

How would we know if the Medicare+Choice program is helping to control spending in the Medicare program? By one definition, M+C controls spending if Medicare payments for beneficiaries enrolled in M+C plans are less than or equal to what payments would have been for those same beneficiaries under traditional FFS coverage.

Under this definition, before the BBA, the predecessor to the M+C program (the risk-HMO program) was not controlling spending. Plans enjoyed favorable selection—they enrolled beneficiaries with lower-than-average health care costs—and the program lost from 5 to 7 percent for each beneficiary enrolled in a risk-HMO (ProPAC 1997, PPRC 1996, Riley et al. 1996, Brown et al. 1993). The plans may have been delivering health care more efficiently than the traditional program (by negotiating lower rates, avoiding fraudulent or high-cost providers, and curtailing use), but administrative and marketing costs and plan profits offset some of the efficiency savings. Any remaining efficiency savings either were retained by the plan or passed on to beneficiaries in the form of more benefits, due to competition for enrollees in local markets. The plans almost never chose to return money to the Medicare program.

These findings prompted Congress to (1) include risk adjustment in the BBA to counteract favorable selection, so payments for plans would approximate

more closely the cost of care, and (2) try to decrease what was deemed to be excessive variability in county payments, by limiting payment increases in higher-payment counties and increasing payments in lower-payment counties. However, the Congress also mandated a 2 percent minimum increase in county rates. As a result, annual growth in counties in which more than 90 percent of M+C plan members lived was 2 percent in 1998 and 1999.

Did the Congress's actions control Medicare spending? Not relative to growth in Medicare program payments per beneficiary in the traditional program. Average Medicare spending per beneficiary in the FFS program increased by 0.2 percent in 1998 and actually fell by 2.5 percent in 1999. At the same time, average Medicare spending per M+C enrollee increased 2.5 percent in 1998 and 2.7 percent in 1999.² In addition, these larger increases were applied to 1997 base payment rates that themselves were too high, due to favorable selection and because they incorporated an overestimate of future spending. (The regulations in effect before BBA would have corrected for the overestimate, which was about 3 percent.)

Achieving other goals, such as expanding the population in M+C plans or expanding benefits, will not help control spending unless payments to plans reflect the health status of the beneficiaries and base payment rates are appropriate. Expanding the Medicare+Choice program to rural or formerly lower-payment counties by paying rates higher than FFS costs for the beneficiaries also will not control spending.

Providing more plan options for beneficiaries

The BBA permitted new kinds of plans to participate in the Medicare+Choice program. To date, few have joined the program. Why hasn't there been more participation?

² MedPAC calculations based on monthly Treasury statements and HCFA enrollee reports.

Obstacles to participation

Provider sponsored organizations were encouraged to enter the program by receiving waivers to certain technical HMO requirements. However, only one PSO joined the M+C program with a waiver, and several that had been participating in the Medicare Choices demonstration program dropped out. This suggests that the requirements waived by the BBA are not the primary obstacles to PSO participation. Two other reasons make it difficult to attract PSOs into Medicare+Choice. First, PSOs must be large enough to achieve economies of scale, make an up-front investment to establish and market themselves, and meet solvency requirements. Second, there is a basic contradiction between the way managed care plans achieve savings and the interests of providers. For example, a key technique used by managed care plans is the substitution of outpatient services for hospital inpatient admissions and longer lengths of stay. For a hospital-based PSO, the substitution of outpatient services for hospital admissions and longer lengths of stay decreases its hospital revenues. Similarly, limiting provider payments to achieve savings decreases provider revenues. This basic contradiction forced several of the PSOs in the demonstration program to leave it, and may be limiting the success of such ventures in the commercial arena as well.

Other types of managed care plans provided for in the BBA faced obstacles to participating in the M+C program. Preferred provider organizations, one of the more popular options for people with employer-sponsored insurance, have larger and looser networks than do other forms of managed care. Collecting the data and implementing the quality improvement programs required by HCFA, while limiting administrative costs, may have been significant obstacles to PPO participation. For these or other reasons, no PPOs have joined the program.

Medicare+Choice plans attached to medical savings accounts also have not entered the market, perhaps because of perceived risk aversion in the beneficiary population or unfamiliarity with the concept. Finally, one private fee-for-service plan has applied to be an M+C plan in 30 states. Because this application is the first of its kind, HCFA must work through all of the implementation and management issues that arise when setting up a private fee-for-service plan, and therefore has not yet approved the plan.

Uncertainty

One concern that may contribute to the lack of new plans and plan types (and which may be discouraging current participants) is uncertain future revenue streams for plans. This uncertainty makes it difficult to justify business plans for entering the program and tends to rule out an entry that might be profitable but also carries some risk of significant loss. One contributor to uncertainty is the advent of risk adjustment.

Risk adjustment Effective January 2000, payments to plans are adjusted based on each enrollee's inpatient hospital diagnoses in the preceding year, if any, as well as on traditional demographic factors. The Congress legislated risk adjustment to ameliorate the effect of favorable selection into Medicare+Choice plans and to move plan payments closer to costs. Because payments vary by enrollee over time, plans perceive that risk adjustment makes it more difficult to project future revenues than when payments varied only by enrollees' demographic characteristics. Forecast uncertainty discourages participation, particularly in counties where revenues and costs are projected to be close and the magnitude of a loss may be significant.

Other uncertainties Ironically, the very act of trying to encourage participation by changing payment rules increases the uncertainty of future revenue streams. It is difficult for managed care organizations (MCOs) to construct

business plans if each year the rules for phasing in risk adjustment change, the amount of GME 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. There may be an argument for allowing the marketplace to recalibrate to a known set of rules before making further innovations to payment policy.

Bringing alternatives to the traditional program to rural and other new markets

The goal of bringing more choices for Medicare beneficiaries to rural and lower-payment counties remains elusive. Although payment rates have increased, participation is still spotty and has decreased overall. This section examines why bringing more choice to underserved areas remains an intractable problem.

Rural areas

Rural areas remain unlikely to attract HMOs, even if the payments in those areas rise above fee-for-service costs. An expert panel convened by MedPAC staff suggested two reasons it is difficult to expand the Medicare+Choice program to rural areas.³

First, the structure of the marketplace in rural areas is not conducive to forming managed care networks. The rural marketplace is characterized by low population density and often by few or monopoly providers. To operate in a rural area, an MCO must form a network of providers accessible to all residents. If the population is dispersed, it may be difficult to have a network of providers that meets regulations on accessibility. In addition, marketing and overhead costs may be prohibitive, particularly when no commercial product exists to share overhead costs. At the same time, MCOs usually negotiate with providers to lower their rates or alter their practice patterns so that care can be purchased less expensively. Where there is a monopoly provider, the MCOs are in a weak

3 MedPAC expert panel on Medicare+Choice plan participation and withdrawals. September 16, 1999.

bargaining position to get lower rates, and may not convince providers to sign up with the network. Monopoly providers may reason that they will see the patients at Medicare rates in any case, so there is no need to enter into an agreement with an MCO at a discounted rate.

Second, M+C payment rates may be too low to encourage plan entry. Unless payments in rural counties are at the floor level, they are still tied to some extent to historical FFS costs. If so, the payment may be insufficient if FFS costs were depressed because of less use of medical services. The panel suggested that a decrease in use occurs when beneficiaries cannot afford medical care because Medicare coinsurance and deductibles are too expensive and they cannot afford Medigap premiums. When plans enter such areas and have no deductibles and low copayments, they sometimes experience a sudden spike in demand for medical services, and face payments insufficient to cover the medical costs of the population. Compared with urban areas—in which HMOs can often reduce use—rural areas appear particularly unattractive.

Plans at full risk may simply not make sense in some rural areas, said panelists who testified before the Commission.⁴ They discussed alternative models, including primary case management and sole source risk contracting, although they considered neither particularly promising. If the objective were to preserve access in rural areas by providing a predictable revenue stream to small medical groups, then some form of split capitation, with the local groups not being at risk for costs they could not control, might be preferable. Insisting on full-risk assumption by small groups or networks in rural areas will continue to discourage participation.

Lower-payment areas

Some counties have relatively low payment rates, compared with adjacent

areas, and have not been attractive to plans in the past. Plan participation in lower-payment areas may decrease as the uncertainties involved with the program grow and the cost of care rises. Although payments were historically tied to FFS spending, we analyzed the plans' Adjusted Community Rate Proposals for 2000 and found that the variation in payment rates to counties exceeds the variation in the underlying cost of providing basic benefits. This finding is corroborated by looking at average premium amounts in commercial HMOs, which show little correlation with Medicare payment rates. Both findings suggest that in lower payment areas, plans may have trouble providing even the basic benefit and making a profit. In some cases, plans may be active in lower- and higher-payment counties adjacent to one other. In the past, plans may have been willing to serve those lower-payment counties, even at a loss, because they made the plans' market areas more coherent. However, as losses have mounted, plans have become less willing to extend coverage to lower-payment counties.

Encouraging enrollment and richer benefit packages in Medicare+Choice plans

Although some beneficiaries are attracted to M+C plans because of the simpler coordination of benefits and cost-sharing structure, many beneficiaries want to enroll in M+C plans because they get more benefits at a lower cost than they would under traditional FFS Medicare coverage. Therefore, to encourage enrollment, plans must be able to offer benefits that are more generous than those in the traditional program, or the sum of premiums and expected cost sharing must be less than expected costs under the traditional program, or both.

Payment growth per capita in the traditional program was low or negative in 1998 and 1999. This resulted in the BBA minimum increase in county payment rates of 2 percent a year in the home

counties of more than 90 percent M+C plan members. At the same time, medical costs, commercial premiums, and other measures of cost growth in those counties increased at a higher rate. For example, average commercial HMO premiums increased more than 5 percent from 1997 to 1998 (Lauer et al. 1999).⁵ If costs are increasing faster than revenues, then plans must become more efficient, profits must fall, or benefits must be reduced. In some markets, the largest gains from productivity or efficiency from managed care have already been achieved, and remaining gains will be incremental. There are also limits to how low profits can fall. Theoretically, in competitive markets, profit margins should already be limited by competition. Also, some would argue that at this stage of the underwriting cycle, there is evidence that profits have already been limited by the drive to increase market share. Given that profit levels have already been limited and efficiencies achieved, it would be surprising if benefit levels could be maintained, much less increased.

Prescription drug cost growth

A key draw for many beneficiaries is coverage for outpatient prescription drugs. Although some successful M+C plans lack drug coverage, many beneficiaries cite drug coverage as a reason for joining an M+C plan.

The outpatient prescription drug benefit has been under considerable cost pressure. The well-publicized increases in outpatient prescription drug costs are not reflected in Medicare spending, because they are not part of the basic benefit package. Medicare+Choice plans that include outpatient prescription drug benefits must fund them from the difference between payment from Medicare and the cost of the basic benefit, or by a supplementary premium. Even if payments were to increase as fast as plans' costs of offering the basic benefit, prescription drug costs are increasing at a much faster rate. If plans continued

4 Panel on rural Medicare policy issues. November 18, 1999.

5 An exception to the pattern of increasing costs is expenditures per Medicare beneficiary, which decreased in 1999. However, the plans may not have shared in some of the savings that caused this decrease, such as less aggressive coding of hospital stays and less use of home health.

offering the same package, the money to fund drug coverage would not be sufficient unless plans reduced the cost of providing the basic benefit package. As long as prescription drug costs continue to increase faster than payments, prescription drug benefits will become more limited or beneficiaries will be charged a higher premium.

The pressure to reduce benefits and increase premiums is bound to continue. Evidence to date shows that enrollment has continued to grow, although at a lower rate than in past years. Whether that trend will continue if benefits are reduced and premiums increased is not known, and is something that MedPAC will monitor closely.

Addressing barriers to program goals through the Balanced Budget Refinement Act

In the Balanced Budget Refinement Act (BBRA), Congress attempted to help the M+C program make progress toward its goals. Many BBRA modifications attempt to help expand choice, and the Commission believes these changes have some potential to achieve this goal.

Controlling Medicare spending

The Congressional Budget Office estimates that over the next five years, the BBRA will lead to \$4.9 billion in increased spending in the M+C program. About 60 percent will result from increased spending in the traditional Medicare FFS program. Because M+C updates are tied to national FFS spending, the increases that Medicare's FFS providers received in the BBRA will translate into a larger national update factor. Several provisions, however, provide specifically for increased spending for the M+C program.

Slower phase in of risk adjustment

HCFA estimates that if plans maintained the same enrollee risk profile, payments to plans would decrease by about 5.8 percent if the principal inpatient diagnosis-diagnosis cost group (PIP-DCG) risk adjusters were fully implemented. HCFA scheduled a transition in which 10 percent of plan payments would be based on the risk adjusters in 2000, with the portion of payments determined by the risk adjusters gradually increasing until all payments will be risk adjusted in 2004 (at which point the PIP-DCG risk adjuster is expected to be replaced by a more comprehensive risk adjuster). The BBRA further backloaded the transition; the percentage of payments based on risk adjusters in 2001 and 2002 will be reduced, relative to HCFA's original schedule. As a result, average payments to M+C plans will be slightly higher during 2001 and 2002.

Other increases

M+C plans also are expected to receive higher payments due to two other provisions in the BBRA. First, the beneficiary education assessment—about \$1.50 per member per month—will be reduced by more than 80 percent. Second, the average plan payment will increase by 0.2 percent in 2002 and in all subsequent years, by virtue of an increase in the annual update in 2002.

Providing more plan options for beneficiaries

The Congress has expressed concern over the high rate of plan withdrawals over the past two years. The health plan industry has argued that these withdrawals have occurred primarily because of low payment rates and an unfavorable regulatory climate. In addition to raising payments as detailed above, the Congress heeded some of the regulatory concerns. Several BBRA provisions aim specifically at improving the regulatory climate for

plans in an effort to improve plan participation.

The Congress included two important provisions—recommended by MedPAC in June 1999—which HCFA was following but which were not in law. The first moves the deadline for plan applications for inclusion in the M+C program to July 1, rather than May 1, as stipulated in the BBA. Through this action, plans will be better able to forecast their program costs for the following year, and thus will have more confidence in the cost and benefit applications they submit. The second provision allows plans to “segment” service areas along county lines. Plans may thus charge higher premiums to beneficiaries that live in lower-payment areas, allowing the plans to better match revenues to costs and continue to service those counties, rather than withdrawing.

Preferred provider organizations exempt from quality assurance requirements

The BBRA reduced requirements of the M+C quality assurance program for preferred provider organizations.⁶ The Congress took this action in response to the lack of PPO participation in the M+C program. Because PPOs are believed to be more feasible than HMOs for rural areas, the Congress sought to encourage PPO participation in the program to promote health plan availability for beneficiaries in rural areas.

Continuous open enrollment for institutionalized individuals

Beginning in 2002, most beneficiaries enrolling in M+C plans will enroll at the beginning of each year. Except for beneficiaries new to Medicare or those with special circumstances, plans cannot accept new enrollees after June in 2002, or after March in later years. As a result, plans that specialize in treating the institutionalized might have a problem maintaining a stable population; many of

⁶ The BBA established certain minimal quality program requirements for all plans participating in the Medicare+Choice program, and a more extensive set of requirements for so-called coordinated-care plans (including health maintenance organizations, preferred provider organizations, and plans offered by provider-sponsored organizations) and network medical savings account plans. (MedPAC's March 1999 report to the Congress provides a description of the requirements and their application). In the BBRA, the Congress exempted PPOs from the more stringent requirements, categorizing them with private fee-for-service plans and non-network MSA plans for quality requirement purposes.

their enrollees die within a year. To avoid this problem, the BBRA provides that institutionalized beneficiaries may sign up or switch M+C plans at any time.

Bringing alternatives to the traditional program to rural and other markets

Congressional concern for the lack of progress in increasing the number of beneficiaries with alternatives to traditional Medicare prompted several provisions in the BBRA affecting both payments and participation requirements.

New area bonuses

The BBRA creates bonus payments for plans that enter areas where no other M+C plan is operating. Plans will receive a 5 percent bonus for one year and a 3 percent bonus during the second year. This provision is targeted to increase the number of beneficiaries with a plan available.

Shortening exclusion period

Under the BBA, most M+C plans that left the program were excluded from the M+C program for five years. The BBRA shortened the exclusion period to two years and provided an exception; plans may reenter the program immediately if new legislation raises payment rates and no more than one other plan is operating in a proposed county at that time.

Extension of Medicare cost contracts

At the end of 1999, HCFA had 46 cost-based contracts with managed care organizations. More than 300,000 beneficiaries were enrolled in plans under these contracts, some in areas without M+C plans. The BBA directed that these cost contracts could not be renewed after 2002; the BBRA extended the cost contract program through 2004.

Encouraging enrollment and richer benefit packages in Medicare+Choice plans

The higher payments resulting from BBRA provisions may increase plan

availability and the ability of plans to offer richer benefit packages. In addition, a number of provisions intended to make enrollment easier for beneficiaries. For example, the provision allowing continuous open enrollment for institutionalized beneficiaries may encourage those beneficiaries to enroll. Other provisions make it easier for enrollees in M+C and Program of All-inclusive Care for the Elderly plans to obtain Medigap coverage after they leave plans or when plans are terminated. The Medigap guarantee provisions, which are discussed more fully in Chapter 2, encourage beneficiaries to enroll in M+C plans by assuring that if they do not like the M+C plans, they can return to traditional Medicare within a year without forfeiting the ability to buy a Medigap supplement.

Will the Balanced Budget Refinement Act changes help achieve the Congress's goals for the Medicare+Choice program?

Because of the BBRA, payment rates for M+C plans should rise. Some provisions—including lowering the consumer education assessment fees and slowing the transition to the new risk-adjustment system—will have immediate impacts. Others, such as increasing the 2002 update and increasing payments to Medicare FFS providers, will have no effect until 2002. (Although the FFS provisions were not targeted to help M+C plans, plans will see increased payments nonetheless.)

Payment increases resulting from a higher update will also change the distribution of M+C payments. During 1998 and 1999, updates resulting from the BBA were so low that there was no money to fund blended payment rates above the minimum 2 percent update. The update for 2000 will allow blended rates for the

first time. Although HCFA does not formally announce the 2001 rates until March 1, 2000, the preliminary announcement on January 14 strongly suggested that all non-floor rates would increase by the minimum 2 percent, due to corrections to overestimates of growth in Medicare spending in 1998 and 1999. Therefore, it is unlikely there will be any further rate blending during 2001, but the higher spending in BBRA should allow for more blending in the future. Lower-rate counties should then continue to get larger updates than the 2 percent that will go to some of the higher-rate counties.

These payment changes may mean that more lower-rate counties without M+C plans may be able to attract them, and that plans in higher-rate counties may find it difficult to maintain their benefit packages and could lose enrollment to Medicare FFS.

Although the floor payment rates were designed to help attract plans to areas with low payment rates, few beneficiaries living in floor payment areas currently have access to M+C plans. Although bonus payments may entice plans into some areas, the gap between HMO costs and current payment rates is probably more than 5 percent in most floor counties. If temporarily raising payment rates does not attract HMOs to the lower-payment areas, the BBRA provision that makes it easier for PPOs to become M+C plans may help.

In summary, MedPAC believes that the Congress's attempt to increase plan participation and availability through several BBRA provisions has the potential to succeed in providing Medicare beneficiaries with more coverage choices. MedPAC supports the general thrust of the M+C provisions in the BBRA, will continue to monitor the program's progress towards its goals, and makes no further recommendations at this time. ■

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