CHAPTER 7

Reconciling Medicare+Choice payments and fee-for-service spending

RECOMMENDATIONS

7A The Medicare program should be financially neutral as to whether beneficiaries enroll in Medicare+Choice plans or in the traditional Medicare program. Therefore, Congress should make Medicare payments for beneficiaries in the two sectors of a local market substantially equal, after accounting for risk.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2

7B The Secretary should study variation in spending under the traditional Medicare program to determine how much is caused by differences in input prices and health risk and how much is caused by differences in provider practice patterns, the availability of providers and services, and beneficiary preferences. He should report to the Congress and make recommendations on whether and how the differences in use and preference should be incorporated into Medicare fee-for-service payments and Medicare+Choice payment rates.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2

7C The Secretary should study how beneficiaries, providers, and insurers each benefit from the additional Medicare+Choice payments made in floor counties.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2

7D In defining local payment areas, the Secretary should explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.

YES: 14 • NO: 0 • NOT VOTING: 0 • ABSENT: 2

***COMMISSIONERS' VOTING RESULTS**

CHAPTER 7

Reconciling Medicare+Choice payments and fee-for-service spending

In this chapter

The Congress had observed that when payments to plans were linked to fee-for-service spending in individual counties, payment levels varied widely and beneficiaries in different parts of the country had access to plans with very different levels of benefits—which seemed inequitable. To fix this problem, in the Balanced Budget Act of 1997 and subsequent legislation, the Congress changed the payment mechanism increasing payments to the lower-paid areas of the country and limiting increases in higher-paid areas. Decreasing the differences in plan payments across the country, however, may have introduced a different problem: if payments to plans diverge too much from Medicare fee-for-service spending in a market, that market may become distorted and the Medicare program can end up paying more than it would have before. No matter how payments to plans are manipulated, both problems cannot be solved simultaneously as long as there is significant underlying variation in fee-for-service spending across market areas.

During the early and mid 1990s, the Congress observed that in the Medicare risk-Health Maintenance Organization (HMO) program—where monthly payments to plans were linked to fee-for-service spending in individual counties—payment levels varied widely across the country, and beneficiaries in different parts of the country had access to plans with very different levels of benefits. That beneficiaries in some parts of the country had access to plans with many additional benefits and that others did not seemed inequitable. To address this inequity, the Balanced Budget Act of 1997 (BBA) created the Medicare+Choice (M+C) program, which changed the payment mechanism and lessened the link between payment rates for plans and local fee-for-service spending. Essentially, in the BBA and subsequently in the Balanced Budget Refinement Act and the Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA), the Congress has increased payments to plans offering services in areas of the country with low payment rates and limited increases to plan payments in higher-paid areas, thereby compressing the range of payments and progressively unlinking M+C payments and county-level fee-for-service spending.

Increasing equity in payments across markets, however, may have introduced problems in local markets in which payments made to M+C plans diverge significantly from the cost to the program of beneficiaries in traditional fee-for-service (FFS) Medicare. Because health care is delivered in local markets, this divergence can create market distortions. The result may be that in areas in which M+C plans were delivering a generous benefit package to a large number of beneficiaries at roughly the same (non-risk adjusted) cost to the program as the traditional FFS alternative, payments will diverge enough that plans may cut benefits or withdraw from the program. At the same time, payments have been raised in areas that have not been conducive to M+C plans and in which plan entry may not yield more efficient delivery of health care services. As a result, Medicare may pay plans for marketing and administration costs and beneficiaries may receive only slightly better benefit packages. The cost to the program could be disproportionately high.

The path to the current situation started with the observation that there was a significant inequity: some areas had managed care plans available with remarkably generous additional benefits, often at little or no additional cost to beneficiaries, other areas had managed care available but with additional premiums, and other areas had no managed care available at all. Because payment rates were still linked to the local level of FFS spending, this observation illuminated the underlying geographic variation in FFS program spending.

To some extent, these variations can be accounted for by differences in input prices,[1] in the health status of the people in different areas, and in graduate medical education payments to hospitals; in some cases variations can be exaggerated from year to year if counties with small populations are used as the basis for estimating spending and risk. However, even when appropriate adjustments are made, considerable variation remains in program costs per capita in different counties. This remaining variation must be attributed to differing practice patterns, consumer preferences for health care, and accessibility of providers, factors which may or may not represent efficient use of health care resources.

As long as substantial underlying variation in FFS spending exists, Medicare will face one of two problems. If M+C payments are tightly linked to FFS spending, there will be large variation between geographic markets in M+C payments and often in the benefit packages available to beneficiaries through M+C plans. If M+C payments are not linked, there will be large divergence within local markets between FFS spending and M+C payments. In this chapter, we examine whether M+C payments should be linked to FFS spending, consider why FFS spending varies so much between markets, look at the current divergence between FFS spending and M+C payments in local markets, and recommend enlarging some payment areas to better estimate spending and risk.

Minimize divergence between Medicare+Choice and fee-for-service payments within local markets

MedPAC believes that Medicare payment policy should be neutral as to whether beneficiaries enroll in traditional Medicare or in M+C plans. The M+C program should provide a choice of delivery systems and additional value for beneficiaries without costing Medicare more than it would cost to provide the basic Medicare package to enrollees through the traditional FFS program.

In practice, payment neutrality means that some of the other goals policymakers have for the M+C program must be subordinated. While the Commission supports having private sector alternatives to the traditional Medicare program, such alternatives should not be pursued at any cost. Instead, alternatives should be encouraged only when they can be competitive with the traditional Medicare program. Medicare's payments should not attempt to steer beneficiaries into either FFS Medicare or the M+C program.

Because health care is delivered in local markets, payment neutrality needs to be pursued at the local level. Failure to make

1 The relative prices of labor and other resources used in the production of Medicare services can be greater in some areas of the country than others. Calculating the ratio of these input prices can be difficult. See Chapter 4.

payments equal within a local market would give one sector—either M+C or traditional FFS—an advantage over the other. For example, if payment rates were lowered relative to FFS spending in areas that currently support M+C plans, the plans could have trouble attracting providers and offering the benefit packages that once attracted enrollees. If payments to the FFS program were much higher than the payments on behalf of M+C enrollees, M+C plans would not be able to compete effectively with traditional Medicare and would leave the program. Distortions in local markets could thus have the effect of limiting choice for Medicare beneficiaries.

If payments are higher in one sector than the other, beneficiaries will move to the higher-payment sector if higher payment is successfully translated into a higher-value product. This movement of beneficiaries will raise the cost of Medicare. For example, if in areas where plans have not existed, payments to the M+C plans were raised higher than FFS spending, plans might be more likely to participate but Medicare program expenditures will rise for the beneficiaries who choose to enroll in the new plans.

RECOMMENDATION 7A

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

Medicare+Choice payment rates

Before the Balanced Budget Act of 1997 (BBA), county payment rates (per beneficiary per month) were based on the fee-for-service (FFS) costs of Medicare beneficiaries in that county. The BBA established a new payment method, under which the county Medicare+Choice (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 based on the projected growth in Medicare expenditures per capita each year thereafter. As a result, the floor payment for 1999 was $380 and for 2000 $402. The Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) raised the floor rate to $475 for 2001, and established a new floor rate of $525 for counties in Metropolitan Statistical Areas (MSAs) with a population greater than 250,000.

The **minimum update** is 2 percent, with BIPA adding a one time increase to 3 percent for 2001.

The **blended rate** combines a national rate and the local rate. (The local rate is the 1997 payment rate trended forward by a national update factor.) The intent of blending was 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 was 10 percent national and 90 percent local. As of 2003 and thereafter, the blend is 50-50 national and local.

The actual computation of blended rates is complicated by several factors and the application of those rates is limited by a budget-neutrality provision. The provision limits total payments in the M+C program to what total spending would have been if county payments were based on strictly local rates. Because the floor payment rate and the minimum update percentage are set in law, total projected payments may nonetheless, equal or exceed the budget neutrality limit. When this happens all counties either receive the new floor rate or last year's rate raised by the minimum update and no county receives a blended rate. The budget neutrality provision resulted in no blended rates being applied in 1998 and 1999, some in 2000 and none in 2001.

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 by 20 percent a year to 100 percent by 2002.
- The update factor. Local rates for each year are calculated by multiplying the previous year's local rate and 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 Balanced Budget Refinement Act of 1999 changed the reduction to 0.003 for 2002.

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. ■

Assuring that payments for beneficiaries in traditional Medicare and M+C are substantially equal will require a reliable risk adjustment system to account for the relative health risks of the two groups of beneficiaries. The Commission is concerned about the reliability of proposed risk adjustment systems because current and proposed methods have not yet been shown to reliably explain the variation in spending due to health status. For purposes of the discussion in this chapter, however, let us posit that a risk adjustment system can be developed that will reliably measure the risk differences between the two sectors.[2]

Examine variation in fee-for-service spending between markets

The varying availability and benefit packages of M+C plans in different local markets has illuminated the geographic inequity in the FFS program.[3] There was tremendous variation in county-level per capita spending in the traditional Medicare program according to the data for 1997, the last time such data were collected. Per capita spending for beneficiaries in the traditional FFS program in the highest-spending county was about three-and-a-half times that of the lowest-spending county. Differences this large are unlikely to be accounted for by differences in health status and input prices; practice patterns, provider availability, and consumer preferences for medical care also play roles.

Some hold that these differences mean that people in different parts of the country effectively receive different benefit packages under the supposedly national traditional Medicare FFS program. Those perceptions are reinforced—but not caused by—the variation in M+C benefit availability. Areas where spending is relatively high in the traditional Medicare sector (and which have relatively high M+C payment rates as a result) are more likely to attract health maintenance organization plans, and the beneficiaries that live in those areas are more likely to have a choice of plans, including zero-premium HMOs and HMOs that offer some coverage for prescription drugs (see Table 7-1). Beneficiaries in rural areas are much less likely to have HMO options.

Through the blended rate mechanism, the Congress has attempted to limit the geographic variation in FFS practice patterns reflected in M+C payment rates. (See text box, page 113.) The fully blended rates, which take effect in 2003, would set county rates at a 50/50 blend of the updated 1997 rate and a national rate (adjusted for county input price levels). County payment rates would also be risk-adjusted for health status differences. Thus, when counties are paid blended rates, half of the payments would be made based on national average practice

TABLE 7-1

Availability of Medicare+Choice HMO plans with selected benefits in 2000, by payment amount and location

	Total eligible beneficiaries (in millions)	Any M+C HMO plan	Zero-premium plan	Plan with prescription drug coverage	Zero-premium plan with drug coverage
National	39	69%	53%	64%	45%
County M+C payment rate (per month)					
$401.61 (floor)	4	15%	3%	12%	2%
$401.62–$449.99	8	47%	18%	40%	14%
$450–$549.99	16	81%	67%	76%	52%
$550+	11	97%	94%	96%	91%
Rural areas	9	21%	9%	16%	6%
Urban areas	30	83%	66%	79%	57%

Note: HMO (health maintenance organization), M+C (Medicare+Choice).

Source: MedPAC analysis of Medicare Compare data from HCFA website January 2000.

2 If such a system cannot be developed, other solutions, such as moving to some form of partial capitation rather than full risk, as is now the case, may be appropriate. For a fuller discussion of the risk adjustment question see our recent report to the Congress on risk adjustment. Whatever the solution to the risk adjustment program, the concept of payment neutrality could be preserved, and the issue of variability in FFS payments remains.

3 Another issue that has become apparent is that many beneficiaries are dissatisfied with the basic benefit package available in traditional Medicare. (Only 15 percent of beneficiaries have no supplemental coverage.) When M+C plans have left some areas, the plans' enrollees complained, particularly about how expensive or impossible it would be to replace the prescription drug coverage. Also, many legislators were interested in attracting plans to their areas so that their constituents might have the opportunity to acquire the drug coverage that many beneficiaries in higher-spending areas had available in M+C plans. The Commission recognizes that the pursuit of the payment principle of equating Medicare payments between sectors within a local market will not address the adequacy of the basic benefit package, but the M+C program should not bear the burden of having to address those concerns for the entire program.

patterns. (Because of budget neutrality, these blended rates may not take effect in many counties for many years, in which case high-payment counties will be limited to the minimum update of 2 percent.)

However, the Congress has not addressed the issue of limiting variation in FFS practice patterns in traditional Medicare. Therefore, there can be divergence between M+C payments and FFS spending in local markets, and ironically beneficiaries may be financially encouraged to seek care in the sector that is the most costly to Medicare. For example, in areas where practice patterns result in relatively high use of health care, M+C plans have often been able to provide generous benefit packages. They have done this by some combination of using a more efficient mix of resources to provide the same product, decreasing excessive use, paying providers less, or enrolling healthier-than-average beneficiaries. If the M+C payment in those high-use areas is lowered toward the national average and health status is taken into account by the payment system, plans will no longer be able to provide as generous a package of additional benefits without raising premiums. Beneficiaries may then move back to traditional FFS, where Medicare will spend more for them than if they remained enrolled in M+C plans. Meanwhile, in low-use areas, Medicare will make higher payments for plan enrollees than for beneficiaries in the traditional program. Plans will be able to use the higher payments to attract providers and enrollees by paying providers more or providing a richer set of benefits than is available in the local version of the traditional program.

The Congress has chosen to address geographic differences in spending by mandating higher M+C rates in lower-payment areas. However, because doing so might increase the divergence of M+C payments and FFS spending within local markets, the Commission recommends addressing the underlying problem: variation in FFS spending.

RECOMMENDATION 7B

The Secretary should study variation in spending under the traditional Medicare program to determine how much is caused by differences in input prices and health risk and how much is caused by differences in provider practice patterns, the availability of providers and services, and beneficiary preferences. He should report to the Congress and make recommendations on whether and how the differences in use and preference should be incorporated into Medicare fee-for-service payments and Medicare+Choice payment rates.

The geographic variation in FFS spending should be examined so Congress can choose an appropriate policy to address it. If a large portion of the difference is due to differences in practice patterns that have no apparent effects on quality of care, then Congress may want to examine whether Medicare payment policy should accommodate that variation, both under the M+C program and under traditional Medicare. The answer will not lie in changing M+C payment policy alone. Policies to limit variation in practice patterns will have to be implemented in the FFS sector as well. Doing so however, will benefit not only M+C payment policy but the Medicare program as a whole.

Limiting variation in fee-for-service practice patterns

Payment policies to limit variation in local practice patterns under the FFS program will be difficult to formulate and even more difficult to implement. Determining what constitutes appropriate practice patterns is a complex undertaking that must take into account variables such as beneficiary population characteristics and health status, provider availability and training, and local market area characteristics. Although MedPAC has not at this time analyzed different options for limiting practice pattern variation, and therefore, does not advocate any particular option, policies that have been proposed include local service use or payment targets, national practice pattern benchmarking, and beneficiary liability modifications.

Local service use or spending targets would seek to tie payment rates for services to the volume of those services or the spending for those services in a local area. National spending targets have been used to determine payment updates for Medicare's physician fee schedule. However, it has not been established that the targets affected individual physician behavior; individual actions do not change the total spending appreciably but have a major effect on individual incomes. In addition, the fairness of an approach that punishes even those who exhibit desired behavior has been questioned.

Medicare could set national benchmarks for practice patterns or implement utilization review. Questions about Medicare's proper role in these areas abound. Should Medicare establish benchmarks based on cost-effectiveness? Should decisions be made on a national basis, or within the context of local medical cultures? Will decisions made at local levels allow more experimentation, which could lead to more effective or efficient care?

Beneficiary cost-sharing could be modified to address differences in use. For example, if the analysis of the geographic variation found that particular services were responsible for a great deal of overuse or underuse, then cost-sharing for those services could be adjusted to discourage or encourage use.

Implementing any of these policy options undoubtedly would be controversial and complex, and evaluation of their value will need to wait until the analysis of the geographic variation in FFS spending has determined the nature of the variation. Discussions of the potential value of these options would also benefit from the development of appropriateness measures and evidence-based practice guidelines. As can be seen by its effect on M+C payment policy, the geographic variation

in FFS practice patterns is a serious problem. Although the policy options noted appear to be blunt tools for attacking the problem, it is hoped that recognition and analysis of the underlying variation will contribute to developing better options for its solution.

Current status of divergence between fee-for-service spending and Medicare+Choice payments in local markets

Today, in most areas with significant M+C enrollment, within-market divergence is still small; that is, M+C payments are close to 100 percent of FFS spending without risk adjustment. Because we do not have current data on Medicare FFS spending for local markets, we analyzed relative M+C and FFS spending levels in aggregate (see text box).[4] Average payments in 2001 for beneficiaries enrolled in the M+C program will be about 98 percent of spending for those in the traditional FFS sector (without risk adjustment), but there is nothing in statute to assure that payments will remain near equality.

Significant divergence within some markets

Although FFS costs and M+C payments are, in aggregate, comparable in areas with high M+C enrollment, there are areas with significant divergence. Updates to the county payment rates under the BBA formula have varied considerably, as Congress intended. From 1997 to 2000, rates nearly doubled in some floor counties. In contrast, rates increased by less than 6.2 percent in about 300 counties where increases were limited to only 2 percent a year. If we assume that Medicare FFS spending rose the same 5 percent in all counties over the 1997–2000 period, we conclude that while counties with the lowest increases still have rates approximately equal to average FFS spending in the county, those with the largest increases have rates close to double the level of FFS spending.

When weighted by the number of Medicare beneficiaries, the average three-year increase was about 11 percent and the median increase was 9 percent. About a quarter of beneficiaries are in counties that received the minimum increase; another quarter are in counties that received increases in excess of 13 percent. These increases were designed by Congress in the BBA to compress the payment rates across the country; thus, we should not be surprised by the differences in updates or the resulting differences in the ratios of M+C payment rates to FFS

Are we far from payment rate equality?

Prior to the Balanced Budget Act of 1997 (BBA), capitated payments to Medicare risk plans were set at 95 percent of average per capita fee-for-service (FFS) spending by county. Despite BBA provisions intended to lower payments to Medicare+Choice (M+C) plans relative to FFS spending, evidence suggests that the rates are on average well over 95 percent of FFS spending. The per capita spending for Medicare beneficiaries grew 4.5 percent during 1997–2000. Also during that period, the average M+C payment rates under Medicare's demographically based system (used as a basis for 90 percent of M+C payments) rose by 8.1 percent when weighted by beneficiaries enrolled in M+C plans. The structure of the rate calculations set up in the BBA ended up prohibiting Health Care Financing Administration (HCFA) actuaries from correcting forecast errors, resulting in 1997 capitated rates 98.1 percent of the United States Per Capita Cost (USPCC), rather than the intended 95 percent. Combining these two factors, payment rates for M+C enrollees were about 1.016 times average FFS spending on Medicare beneficiaries in 2000 {0.981x1.081/1.045 = 1.016}. In other words, the ratio of spending in the M+C program was 1.016 times the spending for demographically similar beneficiaries in the traditional Medicare program.

Two other factors may further increase this ratio. First, there may be non-demographic risk differences in the two populations. If, as the Commission concluded in its recent work on risk adjustment, there is indeed positive selection into M+C plans, the ratio would increase. Second, graduate medical education (GME) payments to teaching hospitals that treat M+C beneficiaries are not currently included on the M+C side of the ledger, although they are a cost to the program for each M+C admission. In calculating the relative spending percentage, that spending should be included with M+C spending, and would thus raise the relative ratio.

For 2001, MedPAC estimates that payment rates for those enrolled in M+C plans will rise about 4.9 percent. HCFA's latest projections were that the USPCC would rise by 9.4 percent in 2001. If those projections bear out, M+C 2001 rates would be at about 98 percent of FFS spending, before accounting for risk differences and GME spending {1.016 × 1.049/1.094 = 0.98}. ■

4 After the BBA, the Health Care Financing Administration (HCFA) stopped computing county-level spending data because those data were no longer required to set payment rates. In the BBRA, HCFA was instructed to begin computing and publishing county-specific FFS spending again. When it does so, MedPAC will analyze county-specific within-market divergence rather than make aggregate assumptions.

TABLE 7-2

Average Medicare+ Choice payment rates as a percent of Medicare fee-for-service spending in 2000, by county payment update type for 2000

County update type*	Beneficiaries (in millions)	M+C payment relative to FFS spending (not risk adjusted)
Minimum	11	99%
Blend	25	104
Floor	4	119

Notes: M+C (Medicare+Choice), FFS (fee-for-service).
* The county payment rates for 2000 were updated to the maximum of: 102 percent of the 1999 rate (Minimum), a blend of local and national rates, and $401.61 (Floor)

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

spending. Counties that received the minimum 2 percent updates had rates approximately equal to FFS spending (Table 7-2). The floor counties in aggregate had rates about 19 percent above FFS costs.

The Congress has continued its effort to reduce rate variation between markets by raising the floor rates significantly. The BIPA raised the floor to $475 from $415 per month and introduced a separate floor of $525 for counties that are part of Metropolitan Statistical Areas (MSAs) containing more than 250,000 people. The act also provided that all counties would see their rates rise by at least 3 percent in 2001.

The increase in the floor rates under BIPA substantially changes the entire nature of the payment rate distribution. About half of Medicare beneficiaries live in the newly expanded set of floor counties. If these high floors are even moderately successful in attracting new plans and enrollees, counties with payments above the floors are likely to receive the minimum update, rather than a blended rate, for several years to come (see text box p. 113 on Medicare+Choice payment rates.)

Raising the floor raises concerns

The Commission is concerned about the divergence between the M+C payment rates and Medicare spending in the FFS sector. If, for example, an insurer were to set up a plan in floor counties that was exactly the same as the traditional Medicare plan, it would receive the higher M+C payments even though it is expected to have about the same medical costs as the traditional Medicare program. The plan could take the difference between its payment and its medical costs (after covering its administrative costs), then take some in profits and provide beneficiaries enhanced benefits, paid for by the Medicare program.

Because large updates have not led to more M+C HMOs in the past (see text box), the budgetary cost of maintaining the floor has been slight. However, increasing payment rates to the new floor rates is likely to attract more plans. A private FFS plan has been approved and has entered disproportionately into floor counties. HCFA is currently reviewing another application for a private FFS plan and one for an M+C Preferred Provider Organization plan. Even HMOs may be tempted to enter the program in floor counties if rates are high enough; above $450 per member per month, there is evidence of greater entry. If the result of higher floors and new plan structures led to M+C enrollment in floor counties proportional to enrollment across the country, then Medicare spending in 2001 would be, on average, 3 percent higher for M+C enrollees than for demographically similar beneficiaries in the traditional Medicare program.

The potential costs of increasing enrollment in floor counties could be substantial. More than 20 million beneficiaries reside in the newly expanded

HMO availability in floor counties

Congress enacted higher rates for areas where payment rates were relatively low to encourage health maintenance organizations (HMOs) to enter those areas. However, Medicare+Choice (M+C) HMOs have not entered these areas. In fact, areas that received higher updates actually lost their plans at a higher rate than areas that received lower updates. Counties with the highest updates (15 percent or more) had the lowest availability of M+C HMOs in both 1998 and 2001, and were much more likely to have lost access to those plans (Table 7-3). Twenty-seven percent of beneficiaries living in counties that received the highest updates and having access to an M+C HMO in 1998 had lost access to HMOs by the beginning of 2001. At the other end of the spectrum, beneficiaries living in counties that received updates of only 6 percent (the minimum 2 percent updated for each of the three years in the period) had the highest access to M+C HMOs, and only 4 percent of beneficiaries lost HMO availability over the period.

Congress hoped that the creation of floor rates would attract M+C HMOs to rural areas, but an analysis shows that even when payment rates in rural counties are similar to payment rates in urban areas, plans are much less likely to be available in rural areas (Table 7-4, p. 118). This bolsters the Commission's view that raising payment rates alone will not bring plans to rural areas. There are other non-payment barriers for HMOs to scale before they will enter rural areas. These barriers will be explored in the Commission's June 2001 report. ■

TABLE 7-3

Percentage of beneficiaries with a Medicare+Choice HMO available for 1998 and 2001 and the percent who lost availability between 1998 and 2001

	Percent of beneficiaries		
Payment update (1997-2000)	HMO available in 1998	HMO available in 2001	Lost availability (1998-2001)
15% or more	35%	26%	27%
10%–15%	64	47	27
6.2%–10%	83	72	14
<6.2%	95	92	4

Note: HMO (health maintenance organization).

Source: MedPAC analysis of Medicare Compare data from HCFA website November 1998 and October 2000.

set of floor counties. The existence of payment rates substantially above FFS costs (the average M+C payment in floor counties for 2001 would be 112 percent of FFS) could easily create opportunities for insurers to receive much higher payments from Medicare than the program would spend on its own beneficiaries; in return, enrollees would get enhanced benefits relative to their neighbors in the traditional Medicare program. While beneficiaries in higher-payment areas may also receive enhanced benefits, the Medicare program in those areas, aside from risk selection differences, is not paying more than FFS spending.

RECOMMENDATION 7C

The Secretary should study how beneficiaries, providers, and insurers each benefit from the additional Medicare+Choice payments made in floor counties.

Because the potential is so large for plans and providers to earn profits above their normal return by taking advantage of higher M+C payments in the floor counties, 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 administrative filings that plans make to HCFA and audits of them will provide data for this task. The Secretary may find it useful to analyze the data bearing in mind the relationship between M+C payments and FFS payments in a plan's service area and the level of competition among M+C plans in an area. The focus should be on areas with large divergence between M+C payment rates and FFS spending, and on areas with few plans available.

TABLE 7-4

Percent of beneficiaries who have a Medicare+Choice HMO available for 2001, by Medicare+Choice payment rate in county of residence

	Percent of beneficiaries with an HMO available		
Payment rate (2000)	All counties	Urban counties	Rural counties
$401.61 (Floor)	11%	20%	8%
$401.62—$449.99	30	43	12
$450–$549.99	67	77	25
$550+	96	98	25

Note: HMO (health maintenance organization).

Source: MedPAC analysis of Medicare Compare data from HCFA website, October 2000.

Enlarge some payment areas

Another source of variation in FFS spending, both across counties and within counties over time, is random measurement error attributable to small sample sizes. Many counties have few Medicare beneficiaries, and the presence or absence of a few large claims in a given year can drive the spending that year. While these measurement errors are presumably unbiased—meaning that the calculated averages are equally likely to be too high as too low—the errors are more likely to cause the calculated averages to be farther from the "true" average than would be the case if sample sizes were larger, and thus are more likely to cause payment rates to change more than they should.

To apply the principle of paying equally for coverage of beneficiaries in the M+C and traditional sectors, reliable spending and risk adjustment data are needed. County-level spending data are once again being collected and should be available soon. However, if local market data are again used to set rates, the stability and variation of those data must be addressed.

In its 1997 report, the Physician Payment Review Commission (PPRC), one of MedPACs predecessor commissions, questioned the use of counties as payment areas for Medicare capitated plans and recommended using larger units. The Commission remains concerned that counties are not the best approximation of market areas and that continued reliance on them will cause operational problems if M+C payments

are linked to FFS spending. Some of these problems include year-to-year instability and intra-regional instability.

RECOMMENDATION 7D

In defining local payment areas, the Secretary should explore using areas that contain sufficient numbers of Medicare beneficiaries to produce reliable estimates of spending and risk.

Payment areas should be large enough to provide for stable payments and should correspond to the extent possible, to the markets in which beneficiaries receive care. There are more than 3,000 counties in the United States and M+C payment rates must be calculated annually for each one. Setting payments accurately is especially challenging when the sample size on which the spending and risk factors are based is small. Moving toward basing payments more on the local FFS spending and risk factors raises the importance of assuring that local rates are based on adequate sample sizes to promote stability across areas and over time.

Problems with county-level sample size and spending variation

The smallest county has only 18 beneficiaries, 5 percent of counties have 600 or fewer Medicare beneficiaries, and half of all counties have 4,100 or fewer beneficiaries (Table 7-5). Setting rates based on so few beneficiaries can be problematic.

An alternative to basing payment rates on counties would be to use areas that include with more Medicare beneficiaries. To illustrate the benefits of using payment areas with more beneficiaries, we used the hospital labor market areas which are composed of MSAs and statewide rural areas, and are used to calculate the hospital wage index. Each of the 364 areas contains at least 9,900 beneficiaries. Although we use these areas as an illustration, we would not recommend using them as the basis for payment at this time because of other problems they raise (discussed later in this section).

TABLE 7-5

Distributions of beneficiaries and payment rates, by county and hospital labor market area,* 1997

	Number of beneficiaries		Payment rates, 1997	
	County	Hospital labor market area	County	Hospital labor market area
Maximum	1 Mil.	1.2 Mil.	$767	$748
95th percentile	49,000	356,000	639	622
75th percentile	9,200	136,000	527	525
50th percentile	4,100	50,000	460	460
25th percentile	2,000	23,000	388	391
5th percentile	600	13,700	325	334
Minimum	18	9,900	221	282

Notes: There are 3,126 counties and 364 Hospital labor market areas.
*Hospital labor market areas are defined as Metropolitan Statistical Areas and statewide rural areas.

Source: MedPAC analysis of Medicare Compare data from HCFA website, January 2000, and payment rate calculations from HCFA website, March 2000.

Using areas with greater numbers of beneficiaries will produce more accurate rate estimates and reduce variation in payment rates. The resulting simulated 1997 rates (Table 7-5) show that the distribution of rates is tighter for the larger areas. The ratio of the highest payment to the lowest payment is about 3.5 using county payment areas and about 2.5 using larger payment areas.

Problems with county-level year-to-year stability and cross-boundary differences

Basing payment rates on more populated areas also would result in more stable payment rates from year to year. The distribution of changes is much tighter when the more aggregated units are used (Table 7-6).

Some analysts have been concerned that using larger areas instead of counties could lead to larger differences in rates across counties, particularly between rural counties and those on the fringes of metropolitan areas. MedPAC calculated cross-boundary differences, both for all counties and for rural counties only, under the two systems and found that the differences were smaller under the hospital labor market area system. For example, under the county system 75 percent of people live in counties in which no adjacent county would have a payment rate more than 18 percent above that county's rate (see Table 7-7). Under the hospital labor market payment area system, 75 percent of people live in counties in which no adjacent county would have a payment rate more than 11 percent above that county's rate. This

TABLE 7-6

Percentage change in payment rates, by county and hospital labor market area,* 1997

	County	Hospital labor market area
Maximum	37%	14%
95th percentile	11	9
75th percentile	8	7
50th percentile	6	6
25th percentile	4	4
5th percentile	0	1
Minimum	−40	−3

Note: *Hospital labor market areas are defined as Metropolitan Statistical Areas and statewide rural areas.

Source: MedPAC analysis of historical payment rates from HCFA website, November 2000.

TABLE 7-7

Distribution of maximum payment rate percentage differences across payment area boundaries, by county and hospital labor market area*

	Maximum payment rate differences	
	County	**Hospital labor market area**
Maximum	106%	68%
95th percentile	36	32
75th percentile	18	11
50th percentile	11	0
25th percentile	2	0
5th percentile	0	0
Minimum	0	0

Note: *Hospital labor market areas are defined as Metropolitan Statistical Areas and statewide rural areas.

Source: MedPAC analysis of historical payment rates from HCFA website, November 2000.

pattern held for urban counties, rural counties, and counties that were not entirely bordered by only other counties in their hospital labor market payment areas.

Problems with more aggregated payment areas

The Commission believes that payment areas should be large enough to produce accurate and stable measurements, but small enough to reflect homogenous market areas. Aggregation in rural areas is essential because rural counties often have small numbers of Medicare beneficiaries. However, using MSAs may lead to grouping heterogenous populations. For example, under an MSA-based payment system, the Baltimore-Washington MSA would have a payment rate of about $600 per month in 2000. That MSA contains some floor counties in West Virginia. Thus, a plan could serve only the West Virginia counties and receive a much higher rate than the population would cost. Clearly, some modification of MSAs that cover large areas would be required for use in a payment rate system, or some other criteria for aggregating urban areas might be preferable. Actuaries at HCFA, and elsewhere, have been working on alternate formulations that may yield more promising ways to aggregate counties and create more homogenous market areas than MSAs.

Conclusion

Payments should be neutral between the M+C and FFS sectors within local markets; if they are not, local markets may become distorted and the Medicare program may end up paying more than it should. At the same time, benefits in M+C must be seen to be equal nationally or policymakers will be called upon to solve the problem through M+C payment policy, which has led to a large divergence between sector payments in some counties. This has come about because it is impossible to simultaneously keep payments neutral and have benefits perceived as equitable nationwide, given extreme underlying variation in FFS spending across market areas. M+C payment policy is not an effective or appropriate means to address underlying variation in FFS spending. Variation in FFS spending is a complex problem in itself and a clearer understanding of the sources of variation must be achieved before effective solutions can be proposed. ■