

C H A P T E R

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**Medicare+Choice:
A Program in Transition**

R E C O M M E N D A T I O N S

2A It is too soon to tell whether recent departures from the Medicare managed care program stem from systematic problems with the level or distribution of payment. The Commission plans to monitor and analyze the characteristics of departing plans and the areas they leave and consider general patterns of organization participation, benefits offered, and enrollment. Accordingly, the Congress should not modify payment rates at this time.

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2B The Secretary should continue to work with organizations offering plans and other interested parties to identify specific regulations or other program policies for which changes, delays in implementation, or administrative flexibility might reduce the burden of compliance without compromising the objectives of the Medicare+Choice program.

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2C As quickly as feasible, the Secretary should develop the capability to use diagnosis data from all sites of care for risk adjustment.

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2D The Secretary's plan to phase in the interim risk adjustment system—with a method that uses a weighted blend of the payment amounts that would apply under the interim system and those that would apply under the current system—is sound. The weight on the interim payment amounts should be back-end loaded. That is, the weights should be relatively low in the first years so that most organizations will not experience extreme changes in their total payments.

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2E The Congress should move the deadline for the adjusted community rate proposal submission to later in the year to allow organizations to include more of their cost information and more details of Medicare payment methods in their projections.

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2F Medicare+Choice organizations should continue to have the flexibility to tailor their benefit packages within their service areas as long as Medicare payments vary by county within a service area. Without this flexibility, organizations may withdraw from counties with lower payments, reducing beneficiary access to new options.

Medicare+Choice: A Program in Transition

The first year of Medicare+Choice has highlighted the need for corrections to policies in statute and the Secretary's regulations. Even though the Congress intended that the new program would offer more private insurance choices for Medicare beneficiaries, changes in several major rules have made payment less attractive and more uncertain than in earlier years, while simultaneously increasing short-term costs. As a result, the first year has found few new options and revealed declines among the traditional offerings. The Medicare Payment Advisory Commission plans to monitor and analyze changes in organizations' participation as a result of the transition to Medicare+Choice. The Commission urges the Health Care Financing Administration to explore ways in which to reduce the burden of compliance without compromising the goals of the program.

In this chapter

- Changes in Medicare's rules for organizations
 - Organization responses and the impact on beneficiaries
 - Assessing the performance of the Medicare+Choice program.
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When the Balanced Budget Act (BBA) was enacted in 1997, many hoped that the transition from Medicare's risk contracting program to the new Medicare+Choice program would be smooth. However, several developments during 1998 indicate that this may not be the case:

- In January the Secretary announced a relatively low projection of spending increase for the fee-for-service program. By law, this amount drives the Medicare+Choice payment rates. Because the increase was low, payment updates to most organizations were lower than in the past.
- Also early in the year, the Health Care Financing Administration (HCFA) issued a draft of its far-reaching plans for a quality improvement program for Medicare and Medicaid.
- In May, organizations participating under the old risk program and wishing to continue into Medicare+Choice had to submit their 1999 benefit packages and premiums. The May deadline for plans was more than six months earlier than had been the case under the former risk program.
- In June, HCFA published its regulation implementing Medicare+Choice. Although generally similar to the framework of the program set out in the BBA, some of the requirements included in the regulation involved far more extensive compliance efforts than under the earlier risk program. Moreover, this was the first opportunity for prospective entrants to the new program—such as provider-sponsored organizations, medical savings account plans, and preferred provider organizations—to evaluate in detail what participation would involve. For 1999, at least, many potential entrants decided to pass.
- In the beginning of September, health maintenance organizations (HMOs) participating in the risk program asked for permission to change the premiums or benefits they had filed for 1999 to reflect

more recent cost projections. HCFA did not allow any changes that would have decreased benefits or increased premiums or cost-sharing.

- A number of HMOs that had participated in the former risk program announced that they would not participate in Medicare+Choice or would participate only in some of the areas they had previously served.

The Medicare Payment Advisory Commission (MedPAC) has closely monitored these events, considering whether they require policy changes to keep the new Medicare+Choice program—representing about 15 percent of Medicare beneficiaries—on course. The Commission's comments on HCFA's Medicare+Choice regulation reflect its hope that the program can meet its legislative promise to improve Medicare by providing beneficiaries with a greater variety of plan choices. As demonstrated by revisions to the regulation and operational directives issued since publishing the Medicare+Choice rule, HCFA has begun to act on many of the changes suggested by the Commission and others.

MedPAC has two overarching recommendations on the Medicare+Choice program for 1999:

RECOMMENDATION 2 A

It is too soon to tell whether recent departures from the Medicare managed care program stem from systematic problems with the level or distribution of payment. The Commission plans to monitor and analyze the characteristics of departing plans and the areas they leave and consider general patterns of organization participation, benefits offered, and enrollment. Accordingly, the Congress should not modify payment rates at this time.

RECOMMENDATION 2 B

The Secretary should continue to work with organizations offering

plans and other interested parties to identify specific regulations or other program policies for which changes, delays in implementation, or administrative flexibility might reduce the burden of compliance without compromising the objectives of the Medicare+Choice program.

In addition, as detailed later in this chapter, the Commission recommends that: (1) a risk adjustment system using diagnosis information from all sites of care be implemented as soon as possible, (2) risk adjustment of payments be phased in using a blend approach, (3) the date for benefit package submission be moved to later in the year, and (4) the Secretary continue to allow Medicare+Choice organizations the flexibility to vary their benefit packages within their service areas.

It is not clear whether changes to the Medicare+Choice program will be sufficient to induce increased or even sustained program participation by organizations and beneficiaries, particularly in the short run. Important developments in commercial and other markets likely colored organizations' reactions to changes in Medicare. Industry analysts have described a year during which organizations were rethinking their earlier approach to pursuing market share over short-term profit. It may be that managed care organizations have realized any potential savings from efficiency gains and now will have to confront the drivers of health care costs—aging of the population and technology (Serb 1998). It also may be that the antimanaged care environment of the last several years has made it difficult for organizations to manage costs and use of medical services. Further, many organizations are devoting large shares of their budgets to ensuring that their data systems will function in the year 2000. Medicare is not alone in experiencing health plan departures this year. Both Medicaid and the Federal Employees Health Benefit Program have reported losses in health plan participation comparable to those in Medicare. These

trends may reflect an industry that is refocusing on core commercial business.

The year ahead also will bring new uncertainty to organizations as the new risk adjustment system is put in place, a development that MedPAC will monitor closely. HCFA's announcement of the new system in January, with details to follow in March, should allow organizations the opportunity to incorporate these important program changes into their expectations for payment and development of their benefit packages for 2000. HCFA's announcement of a five-year phase-in of the new system should soften the system's effect on organization payments. Nevertheless, MedPAC realizes that organizations that expect substantial decreases in payment may decide to withdraw, resulting in even more disruption to beneficiaries who must either change plans or return to the traditional fee-for-service program.

This chapter:

- describes the major changes to the Medicare managed care program rules that have affected managed care organizations; taken together they may have made payment less attractive than in earlier years and more uncertain, while at the same time increased organizations' costs of participating in the program—at least in the near term,
- reviews organization reactions to these and other market changes through 1998, and
- discusses the Congress's goals for the Medicare+Choice program and how best to evaluate whether the program is meeting these and other important policy goals.

Changes in Medicare's rules for organizations

Changes in Medicare's rules for Medicare+Choice organizations have had both intended and unintended consequences for organizations. Many of

the changes introduced under Medicare+Choice were designed to improve the program by increasing the fairness of both levels and distribution of payments, creating incentives to improve quality of care, or helping beneficiaries make more informed choices. But taken together from the organizations' perspective, they may make participation in Medicare less attractive. Many organizations expect that the minimum 2 percent increases to the base payment rate actually will be a maximum, with the potential for decreases from that base as risk adjustment is implemented. At the same time, they are expected to contribute to the beneficiary education campaign, renegotiate their contracts with providers to comply with data collection and other requirements, and expend additional resources to learn many new processes. Many of these changes create uncertainty among organizations as to how they will fare under the new program. Changes in five areas—payment rates; risk adjustment; premiums, benefits and service areas; beneficiary information; and quality standards—will have a particularly important impact on organizations' desire and ability to participate in Medicare+Choice.

Payment rates

In the BBA, the Congress made major changes to Medicare managed care by ending the existing programs and introducing the Medicare+Choice program. The Congress's major goals were to expand the private insurance product choices for Medicare beneficiaries and to obtain budget savings.

In response to widespread criticism of the payment system for managed care organizations, another objective was to reduce the disparity between high and low county payment rates. Medicare used to pay organizations based on the county level of per beneficiary spending in the traditional Medicare program (see Appendix A for detail on past and current payment specifications). The general sentiment was that organizations in high

payment counties were paid enough to allow them to provide generous extra benefits, such as drug coverage, to their enrollees, while organizations that chose to participate in low payment areas were not able to provide such generous extra benefits.

The Congress reduced the reliance on county historical spending when it set the new rates. While part of the base for future rates is the 1997 rate for each county, annual changes in fee-for-service spending at the county level will no longer determine payments. The BBA established a floor below which U.S. county rates cannot fall. The Act also established a minimum annual update of 2 percent for each county. In addition, the BBA established a long-term policy that rates will be based on a blend of historical spending in a county and national average costs adjusted for local price levels. These "blended rates" will be phased in over time. Organizations with enrollees in counties will be paid the highest of the county blended rate, the floor rate, and the county's previous year's rate increased by 2 percent. Through these changes, the Congress hoped to encourage growth in Medicare+Choice plans in rural counties that traditionally had payment rates thought to be too low to attract private organizations, while guaranteeing a minimum increase to counties with relatively high rates.

Other than creating a payment floor, the relative payment changes envisioned by the BBA have not yet been realized. Through the first two years under the new payment formula, counties' rates have been set either at the floor or at 2 percent above the previous year's rate. For two reasons—one related to the BBA and one related to overall spending in Medicare—there has been no reduction in the disparity between high and low rates above the floor.

First, the BBA protected high payment areas from decreases in payment rates. The minimum update is guaranteed even though overall rates are supposed to reflect the gradual removal of payments based on traditional Medicare's payment

for graduate medical education from Medicare+Choice rates. The funding for Medicare's additional costs from both the minimum update and the floor rates come from a budget neutrality adjustment in the calculation of the blended rates. The total spending resulting from the floor rates, the minimum updates, and the blended rates are intended to equal what spending would be in the absence of these three modifications to county rates.

Second, growth in spending per person in traditional Medicare determines the national growth in Medicare+Choice payment rates. Since enactment of the BBA, this growth—and HCFA's projections of future growth—has been very low. In March 1998—when the 1999 payment rates were set—HCFA projected growth at 2.7 percent in 1998 and 4.0 percent in 1999. Combined with the protection for high payment counties, this low growth has produced a situation where no counties have had payment rates based on the blend of local and national costs.

There would have been blend counties in 1999 if the difference between overall Medicare spending growth and the minimum update had been slightly larger.¹ An increase of just 0.2 percent more in Medicare per capita spending would have allowed some counties to receive blended rates (see Table 2-1). If Medicare spending had increased by an additional percentage point, more than 1,600 counties would have received blended payment rates that were higher than the floor or minimum update. These results reflect how close the overall effective update is to the 2 percent minimum update. Without a large enough difference between overall Medicare+Choice payment growth and the minimum update, there will not be enough savings from the high payment counties to fund the blended rates for the lower payment counties.

The difference between the 2 percent minimum update and overall

Medicare+Choice payment growth, however, is now projected to increase. In its 45-day notice released January 15, 1999, HCFA projected per capita Medicare cost growth of 5.8 percent for 2000 (HCFA 1999). This level of growth will produce blended rates for 2000. The HCFA Administrator stated that 60 percent of counties will have blended rates in 2000, based on preliminary estimates released January 15, 1999. The HCFA actuary will set the final Medicare+Choice payment rates in March using the latest demographic and cost trends available. Therefore, the rate disparity among counties will begin to be addressed for counties above the floor.

Risk adjustment

Medicare+Choice organizations are concerned about the effects of HCFA's new risk adjustment system on their future payments. Other things being equal, adoption of this new system on January 1, 2000, will change payments for individual organizations and reduce overall Medicare+Choice payments. The possibility of reduced payments may discourage some organizations from participating in Medicare+Choice or cause others to withdraw from the program. However, the full effects of the new system are somewhat uncertain because the data that HCFA will use to determine payments to organizations in 2000 will not be available until late in 1999.

The need for a new risk adjustment system

The BBA directed HCFA to develop a new risk adjustment system.² The Congress's rationale for mandating the new system was to make Medicare's payments to Medicare+Choice organizations more accurately reflect predictable differences in health spending by enrollees. This should improve Medicare+Choice by making payments more equitable across plans and making

TABLE 2-1
Number of blend counties in 1999 under different Medicare per capita growth rates

Increase in Medicare spending per capita for 1999 under alternate scenarios	Number of blend counties
4.0% ^a	0
4.2	144
5.0	1,647

Note: A blend county is a county whose blended payment rate is above the rates determined by the floor and the minimum update.

^aHCFA March 1998 projection.

Source: MedPAC simulations based on HCFA public data.

them reflect the generally better health of Medicare+Choice enrollees as compared to fee-for-service beneficiaries.

A common complaint about the current system is that there is significant risk selection (enrollment of relatively healthy beneficiaries), and this assertion is supported by empirical research using fee-for-service data (PPRC 1996). Some risk selection may be inevitable because organization recruitment methods might not reach people with poor health status, such as the institutionalized, or because healthy people may be more inclined to join a health plan that could require them to change physicians. Even if selection to organizations has been favorable in the aggregate, however, individual organizations, such as those who have participated in Medicare the longest, may not have favorable selection. Indeed, the Physician Payment Review Commission study shows that mortality and hospitalization rates rise as length of managed care enrollment increases, supporting the idea of "regression towards the mean," or new managed care enrollees becoming more like average fee-for-service beneficiaries over time.

Because organizations will be paid more appropriately for the risks they take

1 Even though the projected growth was 4.0 percent in 1999, the effective growth in per capita Medicare+Choice payments resulting from the update formula was around 2.0 percent. First, the BBA directed the update to be lowered by 0.5 percentage point in 1999. In addition, about 0.7 percent was removed by virtue of the gradual removal of graduate medical education costs. HCFA also lowered the update by 0.74 percent to account for an estimated over projection of growth in 1998.

2 HCFA has supported research to develop improved risk adjustment methods for more than a decade (for example, see Ellis et al. 1996). HCFA's proposed method is a culmination of this effort.

on, the new system is intended to encourage organizations to compete on the basis of how effectively they manage care and not to reward plans for attracting favorable risks. The current system, which is based on beneficiaries' demographic characteristics, rewards organizations that attract healthier enrollees because it does a very poor job of accounting for predictable differences in health spending (Ellis et al. 1996). Under this system, organizations are paid the same amount for two beneficiaries from the same county with identical demographic characteristics, even though differences in their health status would suggest that one will be much more costly than the other. In effect, organizations tend to be overpaid for relatively healthy enrollees and underpaid for those in poor health.

Also, the new system likely will reduce the extent to which HCFA overpays Medicare+Choice organizations in the aggregate. Recent studies show that Medicare risk plans have attracted beneficiaries with better than average health status, but current payments do not fully reflect the lower expected spending for these beneficiaries. For example, Riley and colleagues found that in 1994 the predicted costs of Medicare risk plan enrollees were 12 percent lower, on average, than the predicted costs of fee-for-service enrollees with the same demographic characteristics. Because payments currently are adjusted only for demographic differences, even setting rates at 95 percent of the amount Medicare expected to spend for a beneficiary in the fee-for-service program resulted in overpayments of as much as 7 percent (Riley et al. 1996, Hill et al. 1992).

Risk adjustment requirements in the Balanced Budget Act

The BBA required the new risk adjustment system to use enrollees' health status and demographic characteristics to account for variations in their expected spending. HCFA must implement this system by January 1, 2000, under a very tight time schedule. The agency must:

- publish a preliminary notice by January 15, 1999, describing the

changes in methods and assumptions it will use to determine payment rates for 2000, compared with those for 1999 (HCFA 1999),

- publish a final notice by March 1, 1999, on the payment rates for 2000 and the risk and other factors it will use to adjust those payment rates, and
- submit a report to the Congress that describes the risk adjustment method it will implement with the new payment rates, also by March 1, 1999.

To implement the new system, HCFA must measure health status for beneficiaries in the fee-for-service program and for those enrolled in Medicare+Choice plans. Health status measures for fee-for-service beneficiaries are needed for two reasons. First, HCFA must estimate risk scores that measure relative levels of expected spending for beneficiaries with different combinations of health conditions and demographic characteristics. These scores require beneficiary-specific data on health conditions, demographic characteristics, and annual Medicare spending for covered services that are currently available only for beneficiaries in the traditional fee-for-service program. Second, once the new risk scores are developed, HCFA must adjust the per capita monthly payment rate for each county in the county rate book to reflect its expected level of per capita spending for a beneficiary with national average health and demographic characteristics. The Medicare+Choice data are needed both to determine the monthly payments to organizations for each enrollee starting in 2000 and to inform Medicare+Choice organizations about the anticipated effects of the new risk adjustment system.

To facilitate these tasks, the BBA permitted HCFA to collect encounter (similar to claims) data on hospital inpatient stays from Medicare+Choice organizations, but not before January 1, 1998. Starting July 1, 1998, HCFA could collect encounter data from other providers of care such as physician offices, hospital outpatient departments,

skilled nursing facilities, and home health agencies. HCFA will be able to use the diagnoses reported in the encounter data to develop indicators of beneficiary health status.

HCFA has indicated it has been meeting the time requirements of the BBA and has collected almost complete hospital inpatient encounter data records from nearly all organizations. HCFA also has indicated that, due to various problems, it has not been able to collect complete data from a small number of organizations, but the agency is working with them to get complete data. Some organizations are less confident and believe the data generally are not complete due to systems problems. However, the actual risk scores will be based on the next round of data collection, which should afford an opportunity to work out existing problems.

HCFA's proposed risk adjustment system

The timing of the BBA requirements restricts HCFA to adopt, at least initially, an interim system in which health status is measured using only hospital inpatient diagnoses. Before the Congress passed the BBA, HCFA argued that it needed data as soon as possible to implement improved risk adjustment. However, HCFA and the Congress recognized that Medicare+Choice organizations could not establish systems for reporting data from sites of care other than hospital inpatient departments in time for implementation by January 1, 2000. Therefore, HCFA indicated to the Congress it needed inpatient data by a particular date and left the Congress to determine the remaining time frame.

In its January 15, 1999, 45-day risk adjustment notice, HCFA indicated it intends to replace the interim system on January 1, 2004, with a comprehensive system based on diagnoses from beneficiaries' encounters with all major types of providers. To make that possible, HCFA will require organizations to augment their hospital inpatient data with information from enrollees' encounters in physicians' offices, hospital outpatient

departments, skilled nursing facilities, and home health agencies. However, this requirement will not be implemented before October 1, 1999.

In the interim system, HCFA will determine payments to Medicare+Choice organizations according to the following process. First, HCFA will characterize each beneficiary based on:

- age and sex,
- diagnoses associated with any inpatient hospital stays during the previous year,³
- eligibility for Medicaid benefits at any time in the previous year, and
- previous eligibility of aged beneficiary (one who is 65 or older) for Medicare on the basis of a disability.

Next, HCFA will determine a prospective risk score for each Medicare+Choice enrollee (see Appendix B for more detail). The risk score is intended to measure an enrollee's expected spending in the forthcoming payment year relative to that of the average fee-for-service Medicare beneficiary. HCFA will estimate each enrollee's expected spending in the payment year as the sum of the amounts that each enrollee's demographic or health status factor is expected to add to the enrollee's costliness. As in the current risk adjustment system, spending patterns in the traditional fee-for-service program will be treated as the baseline, so the additional costliness associated with each demographic or health status factor will be estimated using fee-for-service data.⁴ Then, HCFA will determine the risk score as the ratio of the enrollee's expected spending to the overall average expected spending for fee-for-service beneficiaries.

In the last step, HCFA will calculate the payment for each enrollee as the product of three factors:

- the payment amount for 2000 for the enrollee's county of residence from the county rate book,
- a factor that will adjust the county payment rate to reflect the change in risk measurement methods, and
- the enrollee's risk score based on the interim system.

The county adjustment factors are needed to change the county payment amounts so they are consistent with the new system. Under the current system, each county payment rate is based on the 1997 payment rate standardized to reflect the expected fee-for-service spending per capita in the county for a beneficiary with the national average demographic profile. The standardization removes local demographic characteristics from the spending amounts. Because the new risk adjustment system captures risk differences among beneficiaries more precisely than does the current system, HCFA needs to restandardize the county amounts using the new adjusters. This method will ensure that the county payment rates reflect the 1997 expected fee-for-service spending per capita in the county for a national average beneficiary, as measured by the new system.

Interim system intended to improve payment equity

The interim risk adjustment system should be an improvement over the current system because payments to organizations will more accurately reflect the predictable differences in health spending by their enrollees. If the interim system works as intended, organizations will be paid more for enrollees with serious conditions who were hospitalized during the previous year and less for enrollees who were relatively healthy.

This system is consistent with the BBA's objectives for risk adjustment because:

- the interim system likely will encourage organizations to compete on factors other than risk selection because the profits from favorable selection are lower,
- organizations may have more resources for developing specialized care management programs for enrollees with serious conditions, which may lead to improvements in efficiency and in the quality of care enrollees receive, and
- in aggregate, overpayments to Medicare+Choice organizations that result from healthier Medicare beneficiaries leaving the traditional fee-for-service program may be reduced.

Potential problems under the interim system

Despite the improvement over the current system, the interim system's dependence on hospital inpatient diagnoses raises at least three potential problems that policymakers should monitor closely. One is that payments to Medicare+Choice organizations will not fully account for predictable differences in spending among their enrollees because there is diagnosis and health status information not reflected in the demographic and hospital diagnosis data used in the interim system. As a result, organizations that attract seriously ill enrollees within diagnostic groups still will be underpaid, while those that attract healthy ones will continue to be overpaid.

A second problem is that using hospital inpatient diagnoses to measure health status may create incentives for Medicare+Choice organizations to hospitalize enrollees inappropriately because organizations will receive the highest payments for hospitalized enrollees.

3 Inpatient diagnoses are based on encounter data submitted by organizations for current enrollees and on Medicare fee-for-service claims for new enrollees who were previously in the traditional program. Risk scores for beneficiaries who are newly eligible for Medicare and who enroll in a Medicare+Choice plan will be based solely on their demographic characteristics. This is necessary because HCFA lacks a claims history for these beneficiaries.

4 In principle, expected spending could (perhaps should) be estimated using Medicare+Choice spending patterns, but data on annual spending for covered services, which are needed to estimate expected spending given enrollees' diagnoses and demographic characteristics, are not available now for Medicare+Choice enrollees.

Several factors may combine, however, to reduce substantially the incentive for unnecessary hospitalizations or dampen organizations' responses:

- First, the payment adjustment is based on the enrollee's expected spending in the year following the hospital stay, so the incremental payment may be lower in many cases than the hospitalization cost the organization incurred.
- Second, an organization will not receive an increased payment until the calendar year after a hospitalization, and then only if the hospitalized beneficiary remains enrolled in the same organization.
- Finally, an organization would have to influence physicians to hospitalize more patients. This response would require it to overcome years of encouraging physicians to use alternatives to hospitalization.

To further counteract any incentive to hospitalize, HCFA has proposed treating enrollees with one-day inpatient stays and those with diagnoses for which hospitalization is discretionary the same as enrollees who were not hospitalized.⁵

A third potential problem is that risk scores based on fee-for-service hospitalization patterns may understate the health risk of certain Medicare+Choice enrollees. This understatement will occur if Medicare+Choice organizations tend to substitute other sites of care in place of hospitalizations more frequently than do providers in traditional fee-for-service Medicare. In this case, Medicare+Choice enrollees with serious conditions would be hospitalized less often and would receive lower risk scores, on average, than fee-for-service beneficiaries with comparable conditions and demographic characteristics. However, Hill and colleagues (1992) found that Medicare managed care organizations did not

reduce the hospitalization rate relative to fee-for-service Medicare.

But, Medicare+Choice organizations also have argued that they hospitalize comparable patients for shorter stays than do fee-for-service providers in traditional Medicare, and results from Hill and others support this argument. To the extent organizations shorten hospital stays, HCFA's proposed policy on one-day stays—treating enrollees with one-day stays the same as enrollees without inpatient stays—will compound any understatement caused by calibrating risk scores based on fee-for-service data.

RECOMMENDATION 2C

As quickly as feasible, the Secretary should develop the capability to use diagnosis data from all sites of care for risk adjustment.

All of these problems can be mitigated by replacing the interim system with a permanent one in which health status is based on diagnoses assigned during both inpatient hospital and other types of health care encounters. The quality of available diagnosis data should be evaluated before they are used.

Use of a phase-in to cushion the interim system's effects

A final issue is that implementing any improvements in risk adjustment will probably change payments substantially for some organizations while reducing aggregate Medicare+Choice payments. Under the interim system, these changes could affect some Medicare+Choice organizations' decisions to participate in the program or the market areas they serve and disrupt Medicare+Choice coverage for some beneficiaries.

RECOMMENDATION 2D

The Secretary's plan to phase in the interim risk adjustment

system—with a method that uses a weighted blend of the payment amounts that would apply under the interim system and those that would apply under the current system—is sound. The weight on the interim payment amounts should be back-end loaded. That is, the weights should be relatively low in the first years so that most organizations will not experience extreme changes in their total payments.

HCFA indicated in its January 15, 1999, 45-day risk adjustment notice that it will phase in the interim system. The phase-in should reduce the number of organizations that withdraw from the Medicare+Choice program, but it also will slow the benefits of adopting the interim risk adjustment system. In addition, the phase-in will raise Medicare spending because the reduction in payments that otherwise would occur under the interim system will not be fully realized.

The phase-in will last five years, 2000 through 2004, and the fifth year will start with the full implementation of a comprehensive risk adjustment system that uses data from all sites of care. The phase-in method will be a blend approach, meaning an organization's payment each year reflects a changing weighted combination of the payment amounts that would have applied under the current system and those that will apply under the interim system. The blending will apply the new person-level factors to the restandardized county payment rates and the old demographic factors to the old county rates. Table 2-2 displays the weights that will be used in each year of the phase-in. HCFA intentionally "back-end loaded" the phase-in—made the first year's changes small—so that organizations would have time to adjust.

⁵ HCFA considers a hospitalization to be discretionary if the principal diagnosis represents only a minor or transitory disease or disorder, is rarely the main cause of an inpatient stay, or is vague or ambiguous.

**T A B L E
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HCFA's proposed risk adjustment phase-in schedule

Year	Weight	
	Interim system	Current system
2000	0.10	0.90
2001	0.30	0.70
2002	0.55	0.45
2003	0.80	0.20
2004	1.00	0.00

Note: On January 1, 2004, HCFA intends to implement a comprehensive risk adjustment system using encounter data from all sites of care, so the 2004 interim system weight will be applied to the comprehensive system.

Source: HCFA, January 15, 1999, 45-day notice on risk adjustment.

As an example of how the blend will work, suppose in 2000 an organization would receive a \$470 monthly payment for an enrollee under the interim system and \$500 under the current system. In 2000, the blended monthly payment would be: $(.10) \times (\$470) + (.90) \times (\$500) = \$497$.

Premiums, benefits, and service areas

Medicare's rules on how organizations can set their premiums, benefits, and service areas are changing as a result of the BBA and new regulations, and the Commission recommends that two of these rules—the deadline for the benefit submission and organizations' flexibility to define benefit packages within their service areas—be changed.

Statutory changes to premiums and benefit packages

Under the old risk contracting and the new Medicare+Choice programs, organizations return to beneficiaries as extra benefits any difference between the payments from Medicare and the organizations' costs of providing Medicare benefits. Extra benefits—such as prescription drugs, eyeglasses, and physical exams as well as coverage of Medicare cost-sharing—have attracted growing numbers of beneficiaries into managed care.

The BBA made several changes to the way organizations submit their

benefit packages for the Secretary's approval. These changes will require participating organizations to learn the new process and invest in the data systems to support it. Most types of Medicare+Choice organizations must prepare an adjusted community rate proposal (ACRP) to show that the benefit packages they plan to market neither exceed cost-sharing for traditional Medicare benefits nor unfairly charge enrollees for additional benefits.

The BBA also moved up the deadline for the ACRP submission. Organizations must submit their proposals by May 1 of the year before the benefit packages are in effect. This is much earlier than the November 15 deadline for the risk contracting program. Moving the ACRP submission date from November 15 to May 1 of the previous year has appeared to create hardships for Medicare+Choice organizations.

RECOMMENDATION 2 E

The Congress should move the deadline for the adjusted community rate proposal submission to later in the year to allow organizations to include more of their cost information and more details of Medicare payment methods in their projections.

This earlier deadline means that Medicare+Choice organizations must now project future payments and costs six months further out. Actuaries find it more difficult to project expenditures for a year with only one quarter of financial data from the previous year, in part because spending for that quarter may be affected by seasonal patterns that might mask important trends, or unexpected seasonal events, such as an influenza epidemic. Because the spending data from the second and third quarters of 1998 produced different expectations for 1999 spending than the projections using only the first quarter of data, many organizations asked HCFA to let them adjust the amount of benefits in their 1999 ACRPs.

Organizations also stated that because the Medicare+Choice regulation was published after the May ACRP filing date, they were unable to include unanticipated costs for complying with the regulation in their proposals. HCFA denied the request, citing program difficulties in processing the revised ACRPs and concern about increased beneficiary cost-sharing or reduced benefits compared with the May ACRP submissions. As a result, some organizations that might have otherwise opted to raise their premiums or reduce their benefit packages, instead decided not to participate in Medicare.

One reason for the earlier ACRP submission deadline is to make sure HCFA has time to review and approve submissions and then compile benefit information for beneficiaries. The BBA specified that information about plan choices, including premiums and benefit structures, be mailed two weeks before the beginning of each annual open season to all 39 million Medicare beneficiaries. The open season allows changes in enrollment choices in November. If the ACRP deadline is moved to later in the year, other BBA deadlines may require corresponding adjustment to enable HCFA compliance.

Another statutory change to the ACRP is that the Secretary must audit one-third of organizations' ACRPs every year. In the earlier program, HCFA did audit ACRPs, but the statutory mandate likely will result in more audits than in the past. This implies a shift from the solely actuarial projection used previously to one with a cost-accounting base because the cost base is what auditors can verify. So, for future audits, organizations must retain Medicare+Choice cost-accounting information that supports their ACRPs.

Regulatory and administrative changes to premiums and benefit packages

HCFA is changing the ACRP process not only to be consistent with the BBA, but also to reflect the findings from the agency's earlier study (Logistics

Management Institute 1997) and internal work group discussions. These changes fall into three categories: clarify instructions and calculations where operational guidelines diverged from policy; simplify the calculations (although the resulting submission is longer than the old one); reduce the need for backup paperwork; and satisfy requirements that organizations be accountable for their financial data. Examples of the first category are:

- Report profit projections separately from administrative costs, which will allow auditors to match more easily the administrative cost amounts to organizations' financial records and make the organizations' profit expectations more visible; previously, administration and profit amounts were combined.
- Develop the initial rate—the starting place for calculating a Medicare benefit package—using all non-Medicare (including Medicaid) lines of business for a comparable type of product; previously, organizations used only commercial business for developing the initial rate.

Examples of simplifying the calculations are:

- Use Excel® software for the proposal; previously, HCFA used a noncommercial program.
- Multiply organizations' initial rates for non-Medicare lines of business by relative cost factors—the ratio of Medicare to non-Medicare costs; previously, organizations had to break out volume and complexity factors (variables that were rarely supported by organization data).

The final type of change to the ACRP will require Medicare+Choice organizations' chief executives, financial officers, and actuaries to attest to the proposal's accuracy to the best of their knowledge (DeParle 1998a). This is a more moderate requirement than the one in the Medicare+Choice regulation, which organizations believed required attestation to 100 percent accuracy of data (Thomas 1998).

Uniform benefits and plan service area policy

Medicare payment rates vary considerably, even between counties within a single metropolitan area. Medicare+Choice organizations have tended to locate plans in areas with the highest payment rates. Competition is the strongest in these areas, and plans tend to have the most generous benefit packages. Over time, organizations have expanded their service areas to adjacent counties. Because the payments are lower and there is less competition, benefit packages in these parts of the service areas are typically less generous. Medicare program operational instructions, as well as the Medicare+Choice interim final regulations, suggest that organizations will have less flexibility to vary their benefit packages within their service areas in the future as the BBA requirement for uniform packages across plan service areas is implemented.

RECOMMENDATION 2 F

Medicare+Choice organizations should continue to have the flexibility to tailor their benefit packages within their service areas as long as Medicare payments vary by county within a service area. Without this flexibility, organizations may withdraw from counties with lower payments, reducing beneficiary access to new options.

In the risk program prior to the BBA, managed care organizations could vary benefit packages by county under what was termed the “flexible benefits” policy. A risk contractor was required to comply with the statutory ACRP requirement under which any surplus in the Medicare capitation payment had to be returned to all beneficiaries enrolled in the plan's entire service area, on an equal basis, in the form of additional benefits or reduced cost-sharing. However, organizations were free to use

non-Medicare money to finance the cost of additional benefits provided in selected counties of their service area. Generally, counties in which there was more competition among plans were the ones where plans offered more generous packages.

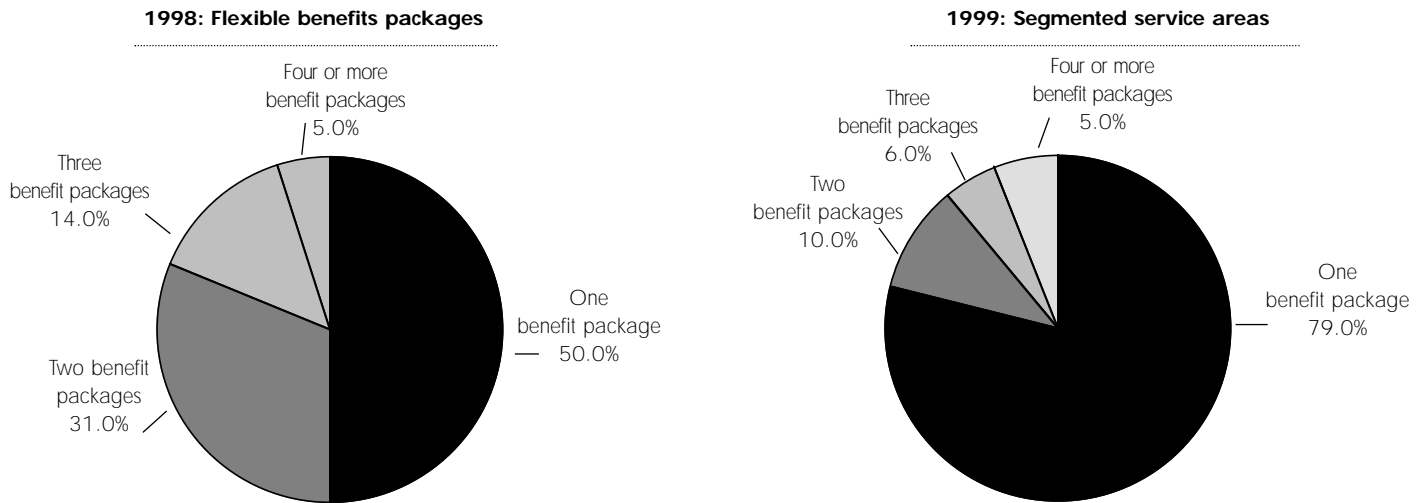
The BBA requires that Medicare+Choice organizations provide uniform benefits at a uniform price to all enrollees throughout their entire service areas, leading the agency to end the flexible benefits policy. Organizations may offer multiple plans (for example, both a basic and a high-option plan) as long as they are the same for everyone.

For 1999, though, as a transitional policy, organizations may provide different minimum packages in different segments of their service area—so long as the packages do not vary within the segments—but must file a separate ACRP for each plan offered in each segment (HCFA 1998b). An organization defines a single service area, which has to meet HCFA's criteria for nondiscrimination against beneficiaries and availability of services throughout. But the segments—defined as groups of counties—do not have to stand alone as meeting service area criteria; they are intended to allow organizations to continue to market more generous benefits to beneficiaries in areas with higher payments. Fewer organizations are taking advantage of the segmented service area policy than used the earlier flexible benefits policy, perhaps because of the additional burden of filing multiple ACRPs or HCFA discouraging organizations from taking advantage of the policy by labeling it transitional (see Figure 2-1).

Organizations' ability to segment service areas for plans appears to make coverage available to beneficiaries in more counties because organizations are more likely to include a county with a lower payment rate in their service area if they can offer a less generous package there (see Table 2-3). In examining this issue, the Commission looked at multicounty metropolitan statistical areas (MSAs) where there was at least one plan in at least one county. Each of these MSAs was then classified by two

**FIGURE
2-1**

Number of benefit packages offered within a plan's service area



Source: HCFA, Medicare Managed Care Report, October 1998, and Medicare Compare database, November 10, 1998.

variables: intra-MSA variation in payment rates and multiple segments within the MSA. The lower the ratio of the highest county payment rate to the lowest rate, the more likely that the entire MSA would have plans available. Also, the entire MSA is more likely to be served if plans in the MSA have taken advantage of segmenting their service areas within the MSA.

In future years, HCFA may discontinue this transitional policy and allow organizations to define only smaller service areas within which they meet both nondiscrimination and accessibility

criteria. This change could lead to organizations having difficulty providing uniform benefits across multicounty service areas because organizations with large service areas that include lower paying counties will be unable to provide the same level of benefits as organizations that serve only high-paying counties. Organizations with the larger service areas, then, would probably lose market share in the more profitable areas. In fact, some Medicare risk organizations have already pared back their service areas in rural and exurban counties. Organizations might even abandon lower paying counties in metropolitan areas.

The Commission recognizes that varying benefit packages within service areas may lead to confusion among beneficiaries who will see richer packages in some parts of a metropolitan area than in others. The potential for confusion, however, is outweighed by the potential for organizations to leave lower-paid counties altogether, resulting in no Medicare+Choice options at all.

Beneficiary information

Collecting and disseminating information on the health plans available to Medicare beneficiaries is both important and potentially expensive. The success of the Medicare+Choice program will hinge largely on how well beneficiaries can understand their new options and make informed decisions among them. But because participating organizations, providers, and ultimately beneficiaries bear the costs associated with making such information available, it is critical that care be taken in developing reporting requirements and dissemination strategies to maximize the value of those efforts. In its comments on HCFA's Medicare+Choice rule, MedPAC advised HCFA to weigh the expected benefits from any new information requirements against the costs associated with reporting each item (MedPAC 1998b).

**TABLE
2-3**

Medicare+Choice plan availability across multicounty metropolitan statistical areas, 1999

Of multicounty MSAs with plans, the percent that have plans in all counties

Variation between highest and lowest county payment rate	All MSAs	MSAs with segmented plans	MSAs without segmented plans
None	100%	N.A.	100%
Less than 10 percent	85	100%	83
10 to 20 percent	70	92	59
Above 20 percent	57	63	56

Note: For purposes of this analysis, segmented plans subdivide their service areas within an MSA. Variation is the highest county payment rate divided by the lowest county payment rate minus 100. Segmented service areas are where plans have broken up their service areas along county lines. MSA (metropolitan statistical area).

Source: HCFA, Medicare Compare Database, November 10, 1998.

New information reporting and disclosure requirements

The consumer information provisions of the BBA and HCFA's implementing rule were designed to ensure the availability of comparative information needed to promote value-based competition in Medicare. Such information can help Medicare beneficiaries make informed choices between traditional Medicare and private health plans and to choose among available plans. Before the Medicare+Choice program, no single source for comparative information existed to serve all beneficiaries. Instead, beneficiaries relied on health plans' individual marketing materials, current or former employers, and consumer assistance groups where available.⁶ Under Medicare+Choice, comprehensive comparative information will be compiled by HCFA and disseminated to all beneficiaries.

Collecting information, measuring performance, reporting data, and responding to beneficiary requests for information disclosure likely will increase the net costs to organizations of participating in Medicare. Medicare+Choice organizations are required to provide HCFA with information on their plans' benefits, premiums, costs, performance (as measured using specified quality indicators), and enrollees' out-of-pocket costs. They also must make available more detailed information to beneficiaries upon their request. HCFA proposed additional disclosure requirements in its interim final Medicare+Choice implementation rule, which requires organizations to attempt to notify the patients of physicians who stop participating with the organizations.

User fees to finance HCFA's information campaign

In addition to the costs of complying with new consumer information requirements, organizations participating in Medicare also face a new user fee, established by the BBA to defray the cost of HCFA's consumer information efforts.⁷ The total annual amount authorized for HCFA's collection is split among participating organizations according to a formula that assesses fees in direct proportion to the amount of money organizations receive from Medicare.⁸ Because the total amount is fixed in advance, a decrease in the total number of organizations participating in Medicare means that each organization will pay a higher share of the total amount than it otherwise would have. At the same time, increases in total beneficiary enrollment in Medicare+Choice plans will reduce the percentage of organization revenues attributable to the user fee.

Concerns persist regarding both the mechanisms for funding beneficiary information efforts and the levels of funding that have been made available. HCFA expected to spend \$114 million on beneficiary education in fiscal year (FY) 1998, a year in which the information program was conducted on a limited basis for evaluation purposes, and estimated that it would require \$173 million to conduct an effective nationwide education campaign in FY 1999 (DeParle 1998b). The Congress authorized \$95 million for HCFA's collection through user fees in both FY 1998 and FY 1999, an amount significantly less than the full \$200 million (FY 1998) and \$150 million (FY 1999) maximum specified in the BBA.

Funding and time constraints, along with uncertainty as to the best approaches

and techniques for informing beneficiaries, likely influenced HCFA's decision to undertake a test of its beneficiary education campaign in the first year, rather than begin with a nationwide initiative. The first-year demonstration and evaluation involves beneficiaries in five states: Arizona, Florida, Ohio, Oregon, and Washington. Beneficiaries residing in these states received comprehensive Medicare+Choice handbooks, including comparative information on their health plan options, and have access to a toll-free information hotline. HCFA plans to assess beneficiaries' use of these materials and services and to identify areas that need to be refined or revamped before the first coordinated annual enrollment period (and nationwide information campaign) begins in November 1999 (DeParle 1998b).

Quality standards

Extensive new quality assurance and improvement requirements may result in better health care for beneficiaries, greater accountability for performance, and increased information about differences in care across health plans, but they also entail significant new burdens on organizations participating in Medicare. In its comments on the Medicare+Choice rule, MedPAC advised HCFA to take several steps to minimize administrative burdens and maximize the opportunity to meet quality improvement objectives. First, MedPAC urged HCFA to undertake a careful and incremental implementation of the new quality requirements. The Commission also advised the agency to consult closely with other public and private sector purchasers who have instituted similar types of requirements for their own contractors. Finally, MedPAC called for

6 At least one HCFA regional office prepared comparative information on health plans for beneficiaries prior to the enactment of Medicare+Choice.

7 These efforts include mailing informational materials annually, operating a consumer assistance hotline, and maintaining an Internet site. MedPAC's June 1999 report to the Congress will include an analysis of HCFA's consumer information strategies and activities.

8 In an interim final rule published December 2, 1997 (Medicare+Choice Program: Collection of User Fees from Medicare+Choice Plan and Risk-Sharing Contractors, 42 CFR §417.470/417.472), HCFA described the method it would use to determine the user fee to be paid by participating organizations to support the beneficiary information campaign. Under the formula, HCFA divides the total amount authorized for collection (\$95 million in FY 1998) by the total projected revenues for the first nine months of the contracting year (\$22.181 billion in FY 1998) and arrives at a percentage (0.428 in FY 1998) to be deducted from the monthly capitation payments to contracting organizations. Monthly deductions continue until the total annual authorization is reached. The Congress also authorized \$95 million for collection in FY 1999, which HCFA determined would represent a deduction of 0.355 percent of payments.

HCFA to set up mechanisms to evaluate the effects of its performance standards on Medicare program participation and beneficiary access and satisfaction.

Important changes in quality assurance requirements

Although the quality-related requirements set forth in the BBA largely mirror those established for the Medicare risk program, HCFA introduced several important changes in the standards for organizations participating in Medicare through the Medicare+Choice regulatory framework and guidelines for compliance that HCFA issued separately.

At least two of the changes in the quality requirements represent important changes in participating organizations' relationships with Medicare as a health care purchaser. First, coordinated care plans are required not only to report on performance but also to meet performance standards that HCFA will establish.⁹ Second, coordinated care plans must not only maintain and operate a quality improvement program but also demonstrate that those programs have been successful by meeting improvement goals to be defined by HCFA.

The changes to Medicare's quality requirements reflect HCFA's decision to implement the Quality Improvement System for Managed Care (QISMC), a framework for quality assurance and improvement that it has been developing for several years. QISMC was conceived as a way to make quality requirements for Medicare and Medicaid managed care programs more comparable and bring both up to current best practices by large employers and other health care purchasers. Compliance with the system involves collecting and reporting information on performance and undertaking focused quality improvement projects.

MedPAC generally supports HCFA's harnessing Medicare purchasing power in

an effort to improve the quality of care received by beneficiaries. Establishing and enforcing minimum performance and improvement standards in Medicare+Choice could have positive implications for beneficiaries. If carefully designed and implemented, such standards may help to protect beneficiaries from substandard care and promote improvement in care. They also could offer beneficiaries assurance that participating plans had reached an established floor level of quality, leaving them free to choose an appropriate plan based on the most personally relevant differentiating factors.

However, managed care organizations and their industry representatives expressed considerable concerns about the new quality requirements (AAHP 1998). Many of the concerns were about the detailed requirements provided in HCFA's proposed QISMC standards, not the basic framework for quality improvement and accountability outlined in the Medicare+Choice regulation. Managed care organizations objected to the stringency of some of the proposed requirements and to the immediacy of the implementation timetable. They also expressed concerns that certain requirements deviated unnecessarily from current industry standards established by private sector accrediting bodies.

Because many of the new quality requirements reflected HCFA's discretionary choices, the agency has been able to scale them back or delay their implementation without awaiting legislative changes. HCFA has worked with managed care organizations to identify overly burdensome requirements and has taken steps to respond to these concerns. For example, in an operational policy letter issued on September 30, 1998, HCFA announced that it would modify the QISMC requirements in a number of respects. Among other changes, HCFA said it would:

- institute a phase-in period of three years before new contractors would be required to demonstrate performance improvement,
- reduce the number of annual performance improvement projects from as many as 13 to two (three for organizations with both Medicare and Medicaid contracts), and
- delay enforcement of minimum performance levels until 2001.

Such changes have as yet proved inadequate to fully stem plans' concerns, however, and discourse on the nature and scope of Medicare's quality requirements continues between the agency and health plan representatives (Ignagni 1998).

Common quality standards for coordinated care plans

Plans characterized by looser networks and fewer care management tools, such as preferred provider organizations (PPOs), will find compliance with Medicare+Choice quality requirements more challenging than will tightly organized and managed plans. Unless HCFA shows sensitivity to differences in health plan capacity in administering these requirements, certain types of plans may find Medicare participation too burdensome, resulting in less variety in the plans available to beneficiaries. The agency has testified that it intends to take needed steps to ensure that less structured plans can meet its quality requirements (Hash 1998). At the same time, administration officials have maintained that the agency is acting reasonably as a prudent purchaser by requiring plans to be accountable for the quality of care beneficiaries obtain and that coordinated care plans must be structured in such a way as to be able to provide that accountability.¹⁰

In the BBA, the Congress recognized that uniform quality standards would not

9 The BBA does not define coordinated care plans but designates health maintenance organizations (with and without point-of-service options), preferred provider organizations, and plans offered by provider-sponsored organizations in this category.

10 This position raises the question of accountability for quality under traditional fee-for-service Medicare, which MedPAC plans to address in its June 1999 report to the Congress.

be possible in a Medicare program that permitted more variation among health plans than was allowed under the risk-contracting program. The BBA provided that the quality requirements for coordinated care plans, private fee-for-service plans, and medical savings account plans would, in some cases, differ. For example, only coordinated care plans were required to “take action to improve quality and assess the effectiveness of such action through systematic follow up.” In general, the BBA required more in terms of quality assurance and improvement initiatives from plans structured around a defined network of providers.

In developing the Medicare+Choice regulations, HCFA made distinctions in quality requirements that reflected the plan categories set forth in the BBA but did not go as far as some felt necessary in accounting for structural differences among various types of coordinated care plans. PPOs, in particular, argued that they would not be able to offer the same types of accountability and quality improvement mechanisms offered by more tightly organized health maintenance organizations (BCBSA 1998). They asserted that the loose contractual arrangements with providers that allowed them to maintain large networks and offer beneficiaries choice lacked, by design, the care management tools needed to provide organizational responsibility for quality improvement. PPOs also noted that quality measurement by organizations that do not require members to obtain referrals from their designated gatekeepers is more costly and less reliable because such plans generally do not maintain a single comprehensive medical record for each member at the site of his or her usual source of care.

While data for objectively assessing differences in plan capacity are sparse, at least one study has called into question the premise that HCFA exceeded private sector norms in developing quality

requirements for PPOs. A 1998 report by the U.S. General Accounting Office noted that some of the largest health care purchasers in the country either collect or plan to collect performance data from all of the plans with which they contract, including PPOs. The agency also reported that industry accreditation organizations were updating PPO standards to include certain quality assurance and improvement activities.

Enforcement of quality improvement and performance standards

Organizations that do not meet quality requirements may be subject to new penalties under Medicare+Choice. The implementing rule specifies that HCFA may elect not to renew the contracts of organizations that fail to meet new program standards for quality improvement. In the past, the agency has been criticized for failing to take sufficient action against contractors that failed to fulfill the terms of their contracts, even when faced with evidence of continued problems (GAO 1995, GAO 1991, GAO 1988).

At least one recent development supports the notion that HCFA might need to have powerful sanctions available to promote compliance with some of the Medicare+Choice quality requirements. Of those health plans that in 1997 voluntarily provided quality and performance data for public disclosure through Quality Compass, a proprietary database developed by the National Committee for Quality Assurance (NCQA), nearly half chose not to participate in 1998. NCQA further reported that those plans that authorized public release of their performance data in 1998 outperformed those not willing to have their results publicly disclosed across every measure of performance (NCQA 1998). Although the dropouts were nearly offset by plans participating in Quality Compass for the first time in 1998, this development suggests that

demand for such data is presently insufficient to ensure voluntary disclosure by all plans that have the capacity to measure and report on their performance.¹¹

MedPAC, in its comments on HCFA's implementing rule, advised the agency to be cautious in enforcing new performance standards based on quality measurement results and called upon the agency to look for opportunities to institute performance incentives. The Commission advised HCFA to refrain from acting on organizations' quality reports until a reasonable degree of confidence in the accuracy, validity, and meaningfulness of the reported information has been attained. Once technical concerns have been resolved, HCFA should look into developing a system that features rewards for exceptional performance in addition to penalties for substandard performance.

Deemed status option for accredited plans

One change under Medicare+Choice offers the potential to reduce organizations' burdens associated with demonstrating compliance with Medicare participation requirements. The BBA gave HCFA the authority to allow health plans that have been accredited by certain private sector organizations to be deemed compliant with certain Medicare participation requirements, bypassing the need to undergo duplicative reviews and oversight procedures.

HCFA plans to set up a process for evaluating private sector accreditation standards and compliance procedures similar to those that already have been established for determining the Medicare equivalency of accreditation mechanisms for hospitals and other health care facilities. The agency will review relevant accreditation standards of organizations that apply for approval to determine their equivalence to Medicare standards and will determine whether the procedures used to determine compliance are at least

11 Several of the health plans that chose not to participate in the 1998 Quality Compass cited concerns about the validity of unaudited, self-reported data and the potential for making unfounded comparisons in cases where reported data were inaccurate. Unlike earlier performance data, those produced for the 1999 version of Quality Compass will be subject to an independent, external audit.

as stringent as Medicare's. It will periodically reassess the accreditation organization's review process and may conduct an onsite inspection of the organization's operations and offices under certain circumstances.

In its implementing rule, HCFA stated that eligible accreditation organizations would need to operate nationwide and be free from control by the organizations they accredit. The latter requirement may present problems for at least one accrediting body that has health plan representation on its board of directors (O'Kane 1998). This requirement appears inconsistent with similar regulations on deeming compliance with Medicare's conditions of participation for hospitals and other facilities.¹²

Further implementation challenges ahead

Many of the decisions HCFA faces as it moves forward in implementing QISMC are likely to have important implications for health care quality and the level of health plan participation in Medicare. Yet to be addressed are issues such as:

- how to set standards that assure minimum levels of safety, technical competence, and operational performance without unduly discouraging health plan participation,
- whether quality measures can be identified that provide comparable and meaningful information across different types of plans and traditional fee-for-service Medicare, and
- how to minimize the incentives for risk selection that might be instilled by comparative quality measurement, by adjusting for important differences in enrolled populations or by other means.

The success of the new approach will be significantly affected by how well these difficult issues are resolved.

Organization responses and the impact on beneficiaries

Organizations that had participated in the risk contracting program and were contemplating continuing in Medicare+Choice had several possible actions they could take to deal immediately with the relatively low growth in revenues from Medicare and the increased costs from complying with new program requirements:

- leave Medicare,
- reduce the benefits offered or charge more for them, or
- reduce costs.

While organizations pursuing the first of these options received widespread publicity, all three were likely pursued to some degree. In each case, an organization's actions probably reflected its market circumstances—its competitors, other purchasers, and providers—as well as state and local regulatory requirements. Notably, even with all the new types of organizations and products allowed to participate in the new program, only one new organization—a provider sponsored organization—joined eight HMOs to offer new plans in early 1999.

Departures from selected geographic areas

HMOs holding nearly 100 risk contracts (about one-quarter of all contracts) announced they were departing from Medicare or reducing their service areas for 1999. These organizations cited a number of reasons for their departures, including Medicare's payment rates, regulatory burdens, and changes in costs to provide certain benefits. Another contributing factor may have been that rules about barriers to organization reentry were not in force during the

transition between the risk contracting and Medicare+Choice programs.

These withdrawals and service area reductions were expected to affect 409,000 enrollees in Medicare risk contracts, representing approximately 6.5 percent of the more than 6 million risk contract enrollees (HCFA 1998a). Around 50,000 of these enrollees will not have access to another managed care plan in their areas.

All of the departures will affect the beneficiaries enrolled in plans offered by the organizations, but the effect will vary. At a minimum, beneficiaries will have to change health organizations, which in some cases may mean disrupting existing relationships with providers. Some beneficiaries also will stand to lose benefits, such as prescription drug coverage, that they now obtain through their departing risk plan. Finally, beneficiaries who live in areas without other Medicare+Choice options will have to return to the traditional fee-for-service program and buy individual supplemental (Medigap) policies if they want to maintain comparable protection from out-of-pocket expenses alone, much less coverage for additional services. Further, the beneficiaries who decide to return to fee-for-service Medicare face a complicated and confusing set of rules about their eligibility and premiums for Medigap policies.

Unless a sizable number of new plans enter during 1999, availability of plans in 1999 will be less than in 1998 (see Table 2-4). According to HCFA data as of November 1998, 29 percent of Medicare beneficiaries will not have access to a Medicare+Choice plan in 1999. In 1998, only 26 percent of beneficiaries lived in a county without a risk plan. Access is still greater than it was when the BBA was enacted in 1997, though. At that point, about 33 percent of beneficiaries lived in a county without a risk plan.

Access varies geographically: While 86 percent of Medicare beneficiaries

12 Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), for example, are deemed to have met Medicare's standards, although JCAHO's board of directors includes representation by the American Hospital Association.

**TABLE
2-4**

Counties and beneficiaries with and without risk plans

	1997		1998		1999	
	Number of counties	Percent	Number of counties	Percent	Number of counties	Percent
Counties with risk plans	740	24%	987	32%	896	29%
Counties without risk plans	2,387	76	2,140	68	2,231	71
Medicare beneficiaries (In millions)						
in counties with risk plans	26.2	67	28.6	74	27.7	71
in counties without risk plans	12.7	33	10.2	26	11.2	29

Notes: Puerto Rico is excluded from the analysis. Eligible beneficiary information is from September 1998 HCFA database.

Source: MedPAC computations based on HCFA public data.

living in metropolitan areas have access to plans, about 74 percent of beneficiaries living outside metropolitan areas do not (see Table 2-5). The availability of plans also varies with the Medicare+Choice payment rate level. Virtually all beneficiaries residing in counties with rates above \$550 a month have access to a Medicare+Choice plan, compared with only 23 percent of beneficiaries living in floor counties having plans available.

Reductions in enrollee benefit packages

Organizations can reduce their anticipated outlays by lowering the amount of

coverage in their benefit packages, or they can increase their revenues by charging beneficiaries higher premiums for the same packages. Under the risk contracting program, many organizations offered plans that included non-Medicare benefits, such as prescription drugs, health assessments, hearing aids, and eyeglasses, often at no additional premium. Generally, risk contract benefit packages were more generous in areas with higher payment rates (McBride 1998, ProPAC 1997). If managed care organizations' costs rise faster than payments, the prevalence and generosity of these benefits likely will decline.

One popular benefit for which costs are rising rapidly is prescription drugs. Between 1996 and 1997, drug costs per member for all managed care enrollees increased 13.7 percent, with about one-half of the increase because of higher use and the other half because of higher prices (Drug Trend Report 1998). In Medicare HMOs, a recent study found that prescription drug use rose 5 percent between 1997 and 1998 (Milliman and Robertson 1998).

Organizations likely will respond to these price and volume increases by reducing the amount of drug coverage. Possible changes include:

- increasing copayments,
- imposing dollar limits on coverage,
- limiting formularies to lower-cost options for certain conditions,
- counseling physicians to prescribe

fewer and less expensive drugs when medically appropriate,

- providing financial incentives for patients to use generic drugs instead of brand name drugs, and
- increasing premiums for the benefit.

Few organizations have dropped drug coverage altogether, perhaps because they could not change the benefit packages they submitted in May. Between December 1997 and July 1998, 4 percent of risk contract enrollees were in contracts that dropped prescription drug coverage altogether; this gap was only partially made up by 2.6 percent of enrollees in plans that added such coverage (McBride 1998). Another study found that the share of Medicare+Choice plans offering prescription drug benefits will decline from 72 percent in 1998 to 69 percent in 1999, with some plans including new limits on coverage and different cost-sharing requirements (Watson Wyatt 1998). If organizations had been able to change their packages, though, changes might have been more sizable.

More Medicare HMOs have dropped coverage of some other benefits, however. An early analysis of the change in benefit packages found that 14 percent of enrollees lost dental coverage, while 11 percent gained it; 21 percent lost coverage of eye lenses, while no recipients gained it; and 12 percent lost coverage of hearing aids, while no recipients gained it (McBride 1998).

Most plans continue to provide

**TABLE
2-5**

Percent of counties and beneficiaries with Medicare+Choice plans in 1999

	Medicare+Choice plans available in 1999	
	Percent of counties	Percent of beneficiaries
All counties	29%	71%
Metro area	65	86
Non-metro	15	24
Monthly payment rate		
Over \$550	62	97
\$450-\$550	51	86
\$379.85-\$450	27	55
\$379.84	12	23

Note: Puerto Rico is excluded from the analysis. Eligible beneficiary and enrollee information is from November 1998 HCFA database.

Source: MedPAC computations based on HCFA public data.

cheaper, more comprehensive, coverage than is available under traditional Medicare combined with an individually purchased Medicare supplemental (or Medigap) package. In Miami, Florida, for example, Medigap Plan C (which covers only the Part A and B deductibles, the skilled nursing facility coinsurance, and 80 percent of emergency care in a foreign country) costs from \$124 to \$169 per month in 1998. This package was less generous and more expensive than Medicare HMOs in the same area, which typically charged no premium for comprehensive coverage.

If organizations offer less generous benefit packages as a group, beneficiaries may find managed care options somewhat less attractive, and enrollment rates may slow. But price increases for non-Medicare benefits in other sectors—like Medigap and employer plans—may lead to comparable changes in benefit structures, so Medicare HMO coverage may still be a relatively good deal.

Despite these continuing price differences for coverage, enrollment growth has slowed appreciably. Enrollment in Medicare risk plans grew by about 900,000 members, from 5.2 million in December 1997 to 6.1 million one year later. That growth was lower than the 1.1 million enrollee growth during the previous year. The growth by month during 1998 slowed steadily, reaching a low of 38,000 in December. It is unclear whether this may be a response to withdrawals, benefit changes, decreased marketing efforts by organizations, or other factors, including negative publicity about managed care.

Other steps to respond to Medicare changes

Organizations might use other tools to lower their costs—managing care more tightly or lowering payments to providers—but their ability to use these tools is limited by constraints in their market and regulatory environments. For example, a focus of state legislation has been allowing providers to have more influence over utilization review and coverage denials, which may end up weakening these tools (AAHP 1998,

AAHCC 1999). State legislators also have passed laws against limits on site of care and length of stay. Some organizations have developed programs to provide targeted services to high-risk populations. These programs are resource intensive to develop, however, and take some time to pay off. But disease management programs for such common diseases as diabetes and heart disease may become adopted by managed care plans if these programs reduce their costs.

Another strategy organizations could pursue is passing on any lower Medicare revenues or higher Medicare costs (including the programs to comply with new regulations) to providers. This could take place either as lower increases in fees or shifting more of the insurance risk to providers. Some large Medicare contractors pass on risk to provider groups that are paid a percentage of the Medicare+Choice payment, and relatively lower payment levels then will result in smaller revenue growth for the provider groups or can result in the need to renegotiate the financial arrangements in the contract. Organizations' success in shifting costs back to providers will depend on the bargaining power of the two parties at the negotiating table. If providers are unwilling to lower their prices or take on more insurance risk, organizations may no longer be able to offer Medicare enrollees access to a sufficient provider network and may decide to withdraw from Medicare.

Assessing the performance of the Medicare+Choice program

In the BBA, the Congress made MedPAC responsible for evaluating and recommending changes to Medicare+Choice. MedPAC's recommendations in this chapter reflect its views of corrections to policies needed at this early stage of Medicare+Choice implementation. While the Commission

has been considering improvements to the program, we also have recognized that more information is needed to understand the reasons for and patterns behind organizations' and beneficiaries' participation decisions. Also, because the new program is not yet fully implemented, it is too soon to reach firm conclusions about the roles specific policies may have played—or may yet play—in influencing these decisions. Moreover, neither Medicare+Choice organizations nor beneficiaries make decisions in a vacuum. Consequently, program developments may be partly or wholly due to changes outside of the Medicare program, rather than to features of Medicare+Choice.

Assessing the performance of the Medicare+Choice program raises three issues. One is how to select measures that correspond to the program's goals because problems are indicated when those goals are not met. To develop useful performance measures, therefore, first requires identifying the program's major goals and important potential threats to their achievement. A closely related, but more difficult, issue is how to identify performance measures that can be linked to individual program policies. Attributing program performance to specific policies will often be difficult because some policies support more than one intermediate objective. A third issue is how to assess the extent to which the program's policies balance inherent conflicts between objectives.

Program goals and objectives

The Congress identified two primary goals in adopting the Medicare+Choice program:

- to "...allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare," and
- to "...enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options" (U.S. Congress 1997).

Many in the Congress anticipated that realizing these goals would benefit Medicare beneficiaries, the program, and its supporting taxpayers. Allowing a wider array of plan types to participate in the program would help foster competition among organizations and provide beneficiaries with more choices among private health insurance arrangements. Product design innovations could include coverage or benefits not available under traditional Medicare or open access to a broad range of health service providers. New reporting and disclosure requirements and other program changes to support informed beneficiary choice would promote competition among these new organizations on the basis of product design and performance. Organization performance would be captured through a variety of measures, including indicators of quality and access to care. Expanded choices would enable beneficiaries to tailor the program to reflect their individual preferences and circumstances. In addition, the policies and infrastructure implemented to secure these benefits would be compatible with a range of potential market-oriented reforms that might be adopted in the future.

To secure these benefits, the Congress enacted the wide-ranging policies described earlier in this chapter and others. Alone and in concert, these policies were designed to expand beneficiaries' choices by increasing the number and variety of available health plans, especially in areas that were previously unserved or underserved; reduce geographic variation in payment to allow organizations to offer similar benefits; and promote competition among organizations on the basis of benefits and performance. The legislation included other policies that reflected a variety of other intentions and goals that fall beyond the scope of this chapter.

Developing performance measures to evaluate policies

Medicare+Choice policies support each intermediate objective. These policies, in turn, can be evaluated using specific performance indicators. Examples of

these performance measures include the following:

- The goal of expanding beneficiary choices is supported by policies to expand the types of plans able to participate and to permit the Secretary to vary program standards to reflect plan types. Performance indicators include the prevalence of a variety of plans in the nation and within market areas.
- The goal of reducing variation in benefits is supported by policies to set a payment floor, blend local and national payment amounts, and remove graduate medical education payments. Performance indicators include the convergence of benefits and premiums across areas where rate disparities are reduced.
- The goal of promoting competition on the basis of value (cost and performance) is supported by the policies to improve risk adjustment and to distribute comparative information on plans to beneficiaries. Performance indicators include beneficiary understanding measured through surveys or focus groups and changes in enrollment and disenrollment.

These and other indicators will be monitored by HCFA, MedPAC, and policymakers. Not all are equally important to monitor in the short run, however. Some objectives are initially more critical than others, and some policies go into effect sooner than others. It is hard to imagine, for example, how the program could meet the Congress's objective of increases in choices without increases in geographic access to Medicare+Choice options and a greater variety of plans. Policies that have longer implementation time frames include improvements in risk adjustment, full information disclosure to beneficiaries, and blending of national and local payment rates. Because of the implementation schedule, initial monitoring probably should focus on changes in organizations' behavior, especially changes in the frequency and location of participation, service area

definitions, and plan benefits, copays, and premiums.

Changes in performance rarely will be attributable to a single policy. First, a number of Medicare+Choice policies contribute to more than one intermediate objective and often may have conflicting effects. For example, implementing improvements to risk adjustment is intended to allow organizations to compete on benefits and performance. But the change will make payment rates less attractive for organizations that attracted more healthy enrollees on average; those organizations may decide to leave the program if the rates are too low to support the benefit packages offered in the past. Providing beneficiaries with more information about options is intended to promote enrollment and competition among organizations, but providing the information is costly to organizations and, therefore, makes participation less profitable; organization decisions to leave the program could result in fewer options for beneficiaries.

Attributing changes in Medicare+Choice performance to specific policies is also difficult because both organizations and beneficiaries will be influenced by their individual characteristics and market circumstances. Organizations' decisions may be affected by anticipated financial pressure from their commercial and other government clients, the scale and geographic diversity of their operations, the stability of their relationships with health care providers, Medicare's relative importance in their overall business, and other anticipated claims on their resources in the near term (such as major investments in automated information systems). Organizations' willingness to offer a plan in a particular market area probably will be influenced by the size of the potential market (number of beneficiaries living in the area); the overall longevity and penetration of managed care; health service use patterns; the market power of competitors; and the mix and capacity of local health care providers. Similarly, beneficiaries will evaluate their Medicare+Choice options based on their preferences, financial circumstances,

retiree health insurance policies, and the cost of Medigap options.

The potential power of these individual and market factors to influence the Medicare+Choice program suggests that policy analysts and other observers should exercise great caution in attributing changes in organizations' and beneficiaries' behavior to specific policies or their initial implementation. It also highlights the importance of examining a wide array of performance measures and explicitly taking into account differences in circumstances across market areas.

Monitoring system for Medicare+Choice

An important tool that MedPAC will use to assess the performance of the Medicare+Choice program is a monitoring system. MedPAC will develop the system and update most data annually, with January 1998 as the baseline. This system will identify program changes and provide policy makers with up-to-date information about current trends. The monitoring system has four goals:

- track beneficiary access to plans,
- analyze characteristics of counties affected by changes in plan participation,
- monitor enrollment, and
- monitor plan characteristics and benefit packages.

The system described here focuses on performance indicators based on these goals. It represents a first iteration of a model that will evolve over time. Monitoring system changes may be necessary for two main reasons. First, as more data become available and provide better information, the system will expand to include them. Second, changes in statutory or regulatory policies could require collecting new data to assess the impacts of these policies.

Track beneficiary access to plans

MedPAC will develop a database on beneficiary access to Medicare+Choice

plans by county. This database will show the number of plans available by county, the type of plans, and their benefit packages. For illustrative purposes, MedPAC will develop a series of maps that show changes in beneficiary access to plans by county. For example, these maps will show counties where organizations have stopped offering plans.

Analyze characteristics of affected counties

The maps will highlight important issues that MedPAC will consider when analyzing data on the characteristics of affected counties. For example, how are counties with net withdrawals different from those with no organization pullouts? Are payment rates different? For each county, the monitoring system will measure changes in the number of plans per county. The monitoring system also will analyze the relationship between organization participation and such factors as the payment rate, the characteristics of organizations' commercial market, the percent of Medicare beneficiaries enrolled in the county, the number and type of health care providers in the county, and the type of county (urban versus rural).

Monitor enrollment

Because enrollment can change during the year, MedPAC also will monitor county enrollment data on a quarterly basis. These data will include changes in the number of enrollees, the percent of Medicare beneficiaries enrolled in Medicare+Choice in the market, the payment rate, and the type of county. Each year, the Commission will track what happens to beneficiaries who lose access to their HMO; that is, whether these beneficiaries join another HMO or return to traditional Medicare.

Monitor plan characteristics and benefit packages

MedPAC also will monitor the characteristics and benefit packages of plans participating in the Medicare program. For all plans, the Commission

will measure such characteristics as plan premiums, plan type (for example, those with point-of-service option, type of sponsorship), market share, and age of contract, and analyze relationships between these characteristics and organization participation.

Many seniors opt for HMOs because these plans offer lower premiums and more benefits than Medigap plans. As health care costs increase, however, organizations may begin to adjust their benefit packages. The monitoring system will track how benefit packages change over time within the Medicare+Choice program. MedPAC will analyze whether organizations pulling out of Medicare offer similar benefit packages to plans remaining in the program. If most organizations are pulling out because of increased drug costs, then one would expect that the plans remaining in the program might offer less generous drug coverage (for example, higher copays). However, if not all organizations stop participating in Medicare+Choice in a particular market, the organizations that remain there might be able to enroll a greater number of Medicare beneficiaries. If this shift in enrollment occurred, the remaining organizations might be able to take advantage of economies of scale to reduce their costs and offer more benefits.

Monitoring the effects of risk adjustment

MedPAC also will evaluate the effects of the new risk adjustment system on organization payments. Based on the effects of the new system, MedPAC will consider recommending changes to the risk adjustment system. It is important that all changes to the system improve upon the current system by lessening the undesirable incentive for organizations to attract low-risk beneficiaries and by making payments more closely match the predictable differences in health spending by beneficiaries. At the same time, MedPAC recognizes that if organizations face dramatic payment decreases, they might leave Medicare, resulting in decreased access to the managed care option. ■

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