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Staff Contact: Gina Fortum
~~(202) 401-8863~~
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Don Young

ENROLLMENT AND DISENROLLMENT EXPERIENCE IN THE MEDICARE RISK PROGRAM ⁷⁰¹⁻⁸⁹⁰⁶

Medicare beneficiaries may receive their care under traditional fee-for-service arrangements or from a managed care provider like a health maintenance organization (HMO). Approximately 5 percent of all Medicare beneficiaries are enrolled in the risk contracting program.

As in the private sector, beneficiaries who enroll in an HMO through the risk contracting program may receive more comprehensive benefits or face lower cost sharing than those using the traditional fee-for-service Medicare program. Their choice of health care providers, however, may be limited to those participating in their plan. Beneficiaries may choose on a monthly basis whether to stay in the HMO, unlike in the private sector. This monthly disenrollment policy was designed to ensure that HMOs delivered an acceptable standard of care and to encourage beneficiaries to enroll in HMOs.

Beneficiary HMO enrollment and disenrollment patterns may signal problems with quality of care or access to services. High disenrollment may indicate that beneficiaries are dissatisfied with their care or do not understand the HMO system when they enroll, or that plans encourage particular beneficiaries to disenroll. While we are not able to address these issues directly, this analysis examines characteristics of plans with high disenrollment rates and beneficiaries who have disenrolled.

This presentation will investigate the extent of beneficiary disenrollment from Medicare's risk-based, managed care program and the possible reasons for such action. Data will be presented on current disenrollment and enrollment rates and characteristics of plans with high disenrollment rates. Also, reasons for disenrolling from HMOs will be discussed as identified by recent survey results from the Office of Inspector General, Department of Health and Human Services.

No action is required of the Commission at the December meeting. We would like to know, however, if you would like to include any of this information in the alert on Medicare managed care to be included in the March Report to Congress.

Francisco area, with 10 new plans out of a total of 26 plans, certainly had a higher than average enrollment rate, but the disenrollment rate was average. This inconsistent pattern could be related to the area's general experience with HMOs. Dallas had low HMO penetration in the general population. Thus, it was more likely to have less experienced and smaller plans and enrollees unfamiliar with organized managed care. The San Francisco region, alternatively, had a high total and Medicare HMO enrollment, so new entrants to Medicare risk contracting may have been experienced plans enrolling experienced beneficiaries, resulting in average turnover rates.

Characteristics of Plans with High and Low Disenrollment Rates

Managed care plans with high disenrollment rates may differ from those with low disenrollments, providing some insights into the factors affecting disenrollment. The five plans with the highest Medicare risk contract disenrollment rates in 1993 were compared with the five plans with the lowest rates (see Table 3). This analysis excluded plans that had participated in the Medicare risk program for fewer than 2 years. The five plans with the highest Medicare disenrollment rates were all for profit, independent practice (IPA) model HMOs. In contrast, the five plans with the lowest disenrollment rates were all nonprofit and organized as either a staff or a group model HMO. These findings are consistent with previous research.¹

Chain affiliation, location, and enrollment levels did not appear to differentiate the two groups. Plans with low disenrollment rates generally had participated in the Medicare risk contract program longer. Two of the plans with low disenrollment rates had enrollment ratios close to or higher than the national average. This indicates that they must have enrolled new beneficiaries at a lower rate than most risk plans. The plan with a high enrollment ratio could have had either very low or very high new enrollments. Conversely, four plans with high disenrollment had enrollment ratios lower than or close to the national average. This indicates that their new enrollment probably was lower than the average. Although further study is necessary to understand the reasons for the variation in these patterns, it appears that newer plans, which tend to be IPA models, may need a few years' experience before their Medicare enrollment stabilizes.

Reasons for Disenrollment

Based on a recent survey of Medicare beneficiaries enrolled in risk-based HMOs, most beneficiaries are satisfied with their care.² However, between 16 and 19 percent leave their HMO annually. The majority of disenrollees in the survey joined another HMO after leaving their plan. This could indicate that Medicare beneficiaries were not necessarily dissatisfied with the HMO concept; rather, they may have been dissatisfied with the operation of a particular plan.

Reasons for leaving Medicare risk plans varied. The Office of the Inspector General's survey found that almost one-third of disenrollees (29 percent) left for administrative reasons.

NOTES

1. Mathematica Policy Research, Inc., *Disenrollment Experience in the TEFRA HMO/CMP Program, 1985 to 1988; Final Report*, May 19, 1989.
2. "Beneficiary perspectives of Medicare Risk HMOs - Working Draft", Office of Inspector General, November 1994, OEI 06-91-00730. Office of Inspector General's primary focus for this study was Medicare beneficiaries' perceptions of a risk HMO experience. A total of 4,132 surveys were mailed to beneficiaries in April 1993. Beneficiaries were randomly selected from a stratified random sample of HMOs that were from HCFA's Group Health Plan data base. Data collection was completed in July 1993. A total of 2,882 surveys were used, yielding an unweighted return rate of 70 percent overall, 77 percent for enrollees (N=1705) and 61 percent for disenrollees (N=1177).

Table 1. National Enrollment and Disenrollment Rates for Medicare Risk HMOs 1989-1993

Year	Enrollment Rate (in Percent) ^a	Disenrollment Rate (in Percent) ^b	Enrollment Ratio ^c
1989	34	16	2.1
1990	35	19	1.8
1991	30	18	1.7
1992	32	19	1.7
1993	37	18	2.1

^a Enrollment Rate = $\frac{\text{New enrollees during the period}}{\text{Total enrollees at beginning of period}}$

^b Disenrollment Rate = $\frac{\text{Disenrollees during the period}}{\text{Total enrollees at beginning of period}}$

^c Enrollment Ratio = $\frac{\text{New enrollees during the period}}{\text{Disenrollees during the period}}$

SOURCE: Health Care Financing Administration, Office of Prepaid Health.

Table 3. Characteristics of 10 Plans With the Highest and Lowest Medicare Risk HMO Disenrollment Rates, 1993

Plan	Disenrollment Rate	Plan Types	Model Type	Tax Status	Chain Affiliation	Region	Years In Medicare	Medicare Enrollment End of Year	Enrollment Ratio
High Disenrollment									
Health Maint. of Oregon	97	HMO	IPA	Profit	No	Seattle	5.5	2,876	0.2
Care Florida	40	CMP	IPA	Profit	Yes Heritage HP	Atlanta	5	22,191	1.5
Humana	32	HMO	IPA	Profit	Yes- Humana HP	San Francisco	5	12,101	1.9
Care America Plan	31	CMP	IPA	Profit	No	San Francisco	3	16,082	3.7
Health Options	28	HMO	IPA	Profit	No	Atlanta	8	21,746	1.8
Low Disenrollment									
Group Health Coop-Puget Sound	7.4	CMP	Staff	Non-profit	No	Boston	8.5	19,582	1.2
Kaiser Foundation HP of Col	7.2	HMO	Group	Non-profit	Yes, Kaiser Found.	Denver	8	28,375	2.2
Kaiser Foundation Health Plan	6.2	HMO	Group	Non-profit	Yes, Kaiser Found.	San Francisco	7.5	12,540	1.5
Fallon Community HP	6.1	HMO	Group	Non-profit	No	San Francisco	8	12,401	3.8
Health Care Plan	4.5	HMO	Staff	Non-profit	No	New York	4	5,313	2.4

Plans in operation less than 2 years are excluded.

SOURCE: Health Care Financing Administration, Office of Prepaid Health.

Calculation of Medicare Payments to Risk Contractors

1. Project national per capita expenditures for coming year (USPCC).
2. Adjust USPCC for geographic differences to determine county-level per capita expenditures (AAPCC).
3. Apply risk adjuster based on demographic characteristics (age, sex, disability status, and other factors) of individual enrollee to 95 percent of AAPCC.

Does Medicare Overpay Risk Plans in High-cost Areas?

A \$100 increase in Medicare payments is associated with a \$72 rise in the cost to risk plans' costs of providing Medicare-covered services.

Plans have to spend the \$28 difference; they do not get to keep it.

Does Medicare pay too little in markets with high HMO penetration?

A 10 percentage point increase in HMO market share is associated with a:

- 0.3 percentage point reduction in the rate of increase in the AAPCC (from 7.7% to 7.4% per year), and
- \$6.50 to \$7.00 reduction in the AAPCC (on a \$337 base).

Relationship of \$100 Increase in Medicare Payments to Medicare Non-covered Services

	Average Non-Covered Benefits	Effect of \$100 Increase In Payments	Total
Required	\$ 26	\$ 28	\$ 56
Supplemental	64	- 4	60
Total	\$ 90	\$ 24	\$116

Relationship of \$100 Increase in Medicare Payments to Amount of Waiver per \$1 of Allowable Premium

Waived Amount Per Dollar of Allowable Premium

Average	Effect of \$100 Increase In Payments	Total
\$0.37	\$0.15	\$0.52

Do Medicare risk plan enrollees receive different benefits based on HMO competition where they live?

A one-plan increase in the number of Medicare risk plans is associated with:

- \$1.42 reduction in supplemental services, and
- No difference in the premium for supplemental services.

Does Medicare adequately allow for reasonable profit?

- There was no association between Medicare payments and the administration-plus-profit share of a plan's cost of providing Medicare-covered services.

Questions for Further Analysis

- Do plans offer a set of additional benefits and establish their prices to compete with the combination of FFS Medicare plus Medicare supplemental insurance?
- Does the finding that plans offer fewer additional benefits in markets with more risk plan competitors indicate that plans providing additional benefits may face adverse selection?
- How should Medicare treat profits, and how much profit on Medicare enrollees is appropriate?

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RELATIONSHIP BETWEEN AAPCC PAYMENTS AND MEDICARE RISK PLAN COSTS

I. PURPOSE

At the December Commission meeting, staff described how Medicare determines the level of program payments to Medicare risk contractors, and how risk contractors determine the amount they are permitted to charge Medicare enrollees. We also identified several policy issues related to the appropriateness of both Medicare's cost-finding methods and the resulting payment rates. At the April Commission meeting, we will present the results of analyses that further address several of these issues.

II. INFORMATION TO BE PRESENTED

Each year, prospective Medicare risk contractors submit to HCFA an "Adjusted Community Rate" (ACR) proposal. This proposal is used to determine the actuarial value of Medicare non-covered services that each plan will be required to provide, (or may choose to provide), to Medicare enrollees, and the amount of the premium that plans may charge Medicare enrollees. Staff used data from the 1994 ACR proposals to conduct an exploratory examination of the relationships among payments, costs, benefits, and market characteristics to see if Medicare pays too much in some markets and not enough to attract risk contractors in other markets. The analyses addresses three sets of issues:

- Appropriateness of Medicare risk payment rates.
- Appropriateness of cost-finding methodology.
- The relationship between extra benefits and characteristics of the market.

III. SUMMARY OF FINDINGS

These findings are based on analyses of data for plans that, by entering into a risk contract, have indicated they believe Medicare payments are at least adequate. We cannot know whether the observed relationships would hold up if Medicare risk payment rules were applied to nonparticipating plans.

- Risk contractors' costs are higher in areas with higher fee-for-service (FFS) costs. Medicare payments, however, overcompensate for these higher costs. A \$1 increase in FFS costs is associated with only a \$0.72 increase in the cost to a risk plan of providing Medicare covered services. Consequently, plans in high cost FFS areas must provide "required non-covered benefits" to make up the difference (or reduce cost sharing).

RELATIONSHIP BETWEEN AAPCC PAYMENTS AND MEDICARE RISK PLAN COSTS

This paper addresses three issues related to the whether the Medicare risk contracting program pays appropriately. It examines whether:

- Medicare pays too much, relative to the costs that plans incur, in areas with high per capita fee-for-service costs,
- the treatment of profits in Medicare's cost-finding methodology distorts the costs reported by plans in high cost areas, and
- Medicare risk plan enrollees in high-cost areas receive more extra benefits, or pay less for these benefits, than enrollees in lower cost areas.

The data to answer these questions in a straightforward manner are not available. We used the 1994 Adjusted Community Rate (ACR) proposals to see what insights they provide on the appropriateness of Medicare's risk plan payments. The ACR proposals are submitted by plans that want to participate in the risk contracting program. Because the risk contracting program is voluntary, a plan's participation in a risk contract probably indicates that its Medicare payments are at least adequate.¹ Thus, we can examine data on Medicare payments, costs, benefits, and market characteristics to examine the appropriateness of Medicare payments to participating risk contractors in markets with high FFS-costs relative to other markets. However, we do not have information on plans that have chosen not to participate, so we cannot know whether the results of the analysis would hold up if Medicare risk payment methods were applied in markets that do not have participating plans.

The next section reviews how Medicare pays risk plans, and how plans determine the amount of extra benefits they will provide and the price they are permitted to charge for these benefits. This is followed by a discussion of the insights the ACR data provide into the appropriateness of Medicare risk plan payment methods. The paper concludes with a series of questions for potential follow-up analyses.

I. MEDICARE RISK PLAN PAYMENT METHODS

Each year, HCFA uses expected per capita Medicare costs in the fee-for service market to calculate the AAPCC for each county. Medicare payments to risk plans are based

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1. The statement that a plan's decision to participate in the Medicare risk program indicates that the plan has determined that Medicare payments are adequate does not necessarily mean that the plan expects to make a profit on Medicare patients. A plan may have reasons other than short-term profits, (such as market share, marketing strategy, spreading fixed costs over more enrollees, or long-term expectation of profits on Medicare enrollees), for deciding that Medicare payments are high enough for the plan to participate in the Medicare risk program.

II. ANALYSES OF ADJUSTED COMMUNITY RATE PROPOSAL DATA

A. Appropriateness of Medicare risk payment rates.

Does Medicare overpay risk plans in high-cost areas?--Medicare payments to risk plans are based on the AAPCC, which is intended to measure Medicare per capita costs in the FFS sector. If FFS costs were a perfect measure of the costs incurred by managed care plans, the AAPCC and risk plans' costs would rise at the same rate. The ACR data indicate that costs in the FFS sector and managed care sector move in the same direction. That is, managed care plans in areas with high FFS costs tend to have higher costs than plans in areas with lower FFS cost. However, the costs incurred by managed care plans rise more slowly than FFS costs (and Medicare payments).

In 1994, a \$1 increase in FFS costs (and the AAPCC) was associated with a \$0.72 rise in a plan's cost of providing Medicare-covered services. In other words, plans' costs tended to rise by only \$0.72 for every \$1 in additional Medicare revenue.

Medicare spending is not affected by the different relationship of FFS costs to plans' costs in high-cost and low-cost areas, because Medicare would save 5 percent of what it expected to pay in the fee-for-service sector in both cases (assuming no risk selection).

However, Medicare risk plan enrollees in high-cost and low-cost areas are affected the provision that plans must provide required non-covered services until they spend all of their Medicare revenue. Because there is only a \$.72 increase in costs for every \$1 increase in revenue, this means that a \$1 increase in revenue is also associated with a \$0.28 increase in the amount of required non-covered services provided to Medicare enrollees. Thus, Medicare risk plan enrollees in high-cost areas tend to get extra services, in the form of required Medicare non-covered services (or lower cost sharing), compared to risk plan enrollees in lower-cost areas.

Does Medicare pay too little in markets with high HMO penetration?--Risk plans in some markets with high HMO penetration and low AAPCCs claim that Medicare pays too little in these markets. The argument is that practice patterns in the FFS sector are affected by exposure to managed care, so markets with high HMO penetration will tend to have lower per capita FFS costs. This analysis compared three measures: FFS per capita costs in 1987 and in 1994, and the percentage of the MSA's population that was enrolled in HMOs in 1991.⁴

There was no relationship between HMO penetration rates and FFS costs in 1987. By

4. Year-to-year changes in the AAPCC reflect both Medicare expenditure patterns and changes in the demographic characteristics of the Medicare population. To eliminate the effect of demographic changes, we compared FFS costs with the AAPCC for 65-69 year old, non-institutionalized, non-Medicaid males in both years. We used the AAPCC for the county with the largest city.

C. Do the benefits provided to Medicare risk plan enrollees depend on characteristics of the market?

As discussed above, the quantity of "required non-covered services" that plans provide to Medicare enrollees tends to be rise with the level of per capita costs in the FFS sector. However, required non-covered services are only one component of the Medicare non-covered services that plans may provide. A plan may also provide "supplemental services" -- that is, non-covered services that raise the plan's cost above the amount of Medicare revenue. "Total extra benefits", therefore, comprise required non-covered services and supplemental services.

Plans may charge beneficiaries a combination of copayments and a monthly premium for the supplemental services.

This analysis examined whether the amount of supplemental services and total extra benefits vary across areas -- with risk plan enrollees in high-cost areas receiving more benefits, or paying lower premiums, than enrollees in lower-cost areas. The analysis also examined the effect of competition among risk plans to see if competition based on amenities or price competition affected either the level of extra benefits or the premiums that plans charge.

Risk plan enrollees in high-cost areas received fewer supplemental services than enrollees in lower-cost areas. A \$1 increase in FFS costs was associated with a \$0.04 reduction in supplemental services.

However, when we compare total extra benefits to FFS costs, we find that risk plan enrollees in high-cost areas received substantially more total extra benefits than enrollees in lower-cost areas. A \$1 increase in FFS costs was associated with a net \$0.24 increase total extra benefits.

Medicare risk plans are permitted to charge copayments and premiums up to the cost of supplemental services. However, many plans waive part or all of the premium. The evidence indicates that plans in high-cost areas tend to waive more of the premium than plans in lower-cost areas. A \$1 increase in FFS costs was associated with a \$0.15 reduction in the premium.

Risk plan enrollees in areas with more competing Medicare risk plans tended to receive less supplemental services than enrollees in areas with fewer plans. A one-plan increase in the number of plans in a metropolitan area was associated with a \$1.42 reduction in supplemental services. However, there was no relationship between the number of competing risk plans in a market and the premium for additional non-covered benefits.

III. SUMMARY

The evidence from the ACR data indicates that risk plan enrollees in high-cost areas tend to receive more benefits than enrollees in lower-cost areas.

**THE POINT OF SERVICE BENEFIT FOR MEDICARE
BENEFICIARIES ENROLLED IN RISK-PLANS**

GUIDELINES

**PHOTOCOPY
PRESERVATION**

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PHOTOCOPY
PRESERVATION

EXECUTIVE SUMMARY

I. INTRODUCTION

A number of risk contracting health maintenance organizations (HMOs) and competitive medical plans (CMPs) have requested guidance from the Health Care Financing Administration (HCFA) on whether they can offer an out-of-plan option for beneficiaries enrolled in their Plans. The out-of-plan option is also frequently referred to as an open-ended HMO, a self-referral option (SRO) or a point-of-service option (POS).

For Medicare risk plans we will refer to an option which allows beneficiaries to receive specified medical services out of their HMOs or CMPs (Plan's) established health care network as a point-of-service (POS) benefit. Emergency or urgently needed care are not affected by a POS benefit as risk plans are already required to provide coverage for out-of-network emergency or urgently needed health care services.

II. BACKGROUND

The POS option has achieved wide acceptance in the private sector. According to a recent industry survey, the number of state licensed HMOs offering a POS option for their commercial enrollment has increased from 20% in March of 1990 to 61% (or 349 HMOs) in 1994.

The value of an out-of-plan option was recognized by the Congress in 1988 when it authorized federally qualified HMOs (FQHMOs) to provide a POS benefit, referred to as a self-referral option (SRO), for their commercial members.

III. CONCLUSIONS

After reviewing the statutory and regulatory authorities under section 1876 of the Social Security Act and title 42 of the Code of Federal Regulations (42 CFR), we have determined that there is no legal barrier prohibiting Medicare contracting risk plans from offering an out-of-plan option for Medicare enrollees. However, there are a number of limitations imposed by Medicare statutes and regulations. In addition, Plans offering a POS benefit must comply with applicable state laws.

These guidelines describe two approaches for risk plans which choose to offer a POS benefit for their general Medicare enrollment. In addition, a POS product can be offered to members of an employer group.

Plans which offer a POS for Medicare beneficiaries will be subject to additional monitoring by HCFA to ensure the continued availability and accessibility of Medicare covered services in the Plan's established network and the continued financial soundness of the Plan.

I. INTRODUCTION

PHOTOCOPY
PRESERVATION

One managed care choice that is now frequently available in the private sector for members of health maintenance organizations (HMOs), including federally qualified HMOs (FQHMOs), but which is not available for Medicare beneficiaries enrolled in risk plans, is the out-of-plan option. The out-of-plan option is also frequently referred to as an open-ended HMO, a self-referral option or a point-of-service (POS) option. Typically, in return for higher cost sharing requirements, the out-of-plan benefit allows members the flexibility to receive certain services outside the Plan's established provider network.

A POS benefit will allow Medicare beneficiaries enrolled in a Medicare risk contracting HMO or CMP (Plan) to receive coverage for a limited amount of health care services outside their Plan's established health care delivery system. Emergency or urgently needed care would not be affected by a POS benefit as risk plans are already required to provide coverage for out-of-network emergency or urgently needed health care services.

A POS benefit can provide Medicare beneficiaries enrolled in risk plans with more choices in receiving their health care services. A POS benefit may encourage new Medicare enrollees who were previously reluctant to join an HMO because they wanted more flexibility in seeking care. In particular, a POS product may be attractive for beneficiaries who wish to see a provider not available in their Plan's network, or who travel and would like access to routine medical care when temporarily (less than 90 days) out of their Plan's service area. In these guidelines, we identify three approaches by which risk plans can offer a POS benefit.

Three POS Options

Under lock-in provisions, services that are covered under Part A or Part B when obtained through the risk-contracting HMO or CMP are not covered when they are obtained outside the Plan's network unless they are emergency or urgently needed, or are otherwise authorized by the Plan. However, there are approaches under which these services can be made available through an out-of-plan option. Based on a review of Medicare statutes and regulations, this paper will describe three approaches, listed below, which risk plans can use in offering a POS benefit. It should be noted that HCFA does not consider the POS benefit to be an "additional benefit" i.e., the POS cannot be financed from savings. Also, Plans must change their adjusted community rate (ACR) proposal to reflect out-of-plan utilization under their POS benefit.

1. As a mandatory supplemental benefit.
2. As an optional supplemental benefit.
3. As an employer group benefit.

POS Flexibility

In designing and managing a POS benefit under the three approaches

risk plans will have flexibility in the following areas:

- ▶ Plans will be able decide what services they will offer through the POS benefit;
- ▶ Plans can set annual dollar limits on services provided through the POS benefit;
- ▶ Plans can design their own beneficiary cost sharing (premium, coinsurance, copayments or deductible) for the POS. However, HCFA will review beneficiary cost sharing to ensure that it meets the adjusted community rate (ACR) limits; and
- ▶ Plans can pre-certify services provided through the POS benefit, including making medical necessity determinations.

While risk plans will have considerable flexibility in designing their POS benefit, they also must ensure that offering a POS product does not in any way undermine or detract from the requirement that all Medicare covered services in the Plan's established health care network are available and accessible to beneficiaries. In addition, Plans implementing a POS for Medicare beneficiaries will need to ensure that the following areas are adequately addressed:

- ▶ The importance of continuous educational support for Medicare enrollees about the use of the POS to prevent misunderstandings which could result in financial or medical problems for the beneficiary. This critical and essential educational process may be more difficult for Medicare beneficiaries than for commercial enrollees in an HMO.
- ▶ A POS product can only be used to allow beneficiaries to access care from providers outside the Plan's established provider network.
 - In-network use of a POS will undermine HCFA's ability to verify that required services are being provided in-network in accord with Medicare contract requirements (see 42 CFR 417.440(b)). Accordingly, Plans must ensure, through education and product design, that in-network use of the POS does not occur.
- ▶ The Plan must comply with any state requirements that apply to a POS product.

II. DESCRIPTION OF POS APPROACHES

1. A Mandatory Supplemental Benefit

Under a mandatory supplemental approach all beneficiaries in the risk plan will have the POS benefit. However, HCFA recommends that Plans charge at most a nominal premium for the POS benefit. HCFA must approve all mandatory supplemental benefits, and HCFA will not approve a mandatory benefit that discourages enrollment in the Plan, see 42 CFR 417.440(b)(iii). To ensure compliance beneficiary cost-sharing should be structured so that only those who actually use the benefit incur significant costs. Beneficiary cost-sharing could be imposed through coinsurance, copayments or a deductible. Imposition of more than a nominal premium might discourage enrollment by low income beneficiaries or those who do not want the benefit.

2. An Optional Supplemental Benefit

Under this approach, Plans can offer beneficiaries the option of a POS plan. Additional requirements which apply to risk plans which offer a POS option as a supplemental benefit, see (42 CFR 417.440(b)(2)-(3)) include the following:

- ▶ The optional benefit must be available to All Medicare beneficiaries (including beneficiaries in employer groups), enrolled under the risk contract; also
- ▶ the Plan cannot health screen enrollees who elect the optional benefit, (42 C.F.R. section 417.440 (b)(2)).

3. An Employer Group Benefit

For purposes of Medicare contracts with Plans under section 1876 of the Social Security Act, all Medicare beneficiaries are considered to be enrolled under the contract as individuals. HCFA must be able, through the ACR process, to verify that all Medicare requirements are met for these individuals. Many Medicare beneficiaries are also covered under private group health plans, usually through former employment.

The employer group may have a commercial contract with the same Plan that has a Medicare contract with HCFA. These commercial agreements might be found to affect the HMO/CMP's compliance with federal law and regulations. To ensure compliance, Plans must provide HCFA with a description of the POS plan including beneficiary cost sharing requirements, offered to an employer group so that HCFA can verify compliance with Medicare contract requirements, such as fiscal soundness and beneficiary charge limits.

In addition, while HCFA has not always reviewed marketing materials provided for employer group benefits, HCFA reserves the right to review POS marketing materials 45 days before their planned distribution to an employer group, see 42 CFR 417.428(a)(3) and

(b)(2).

III. GUIDELINES FOR RISK PLANS OFFERING A POS OPTION

Implementation of POS

1. Because the implementation of a POS product will have an impact on qualifying conditions for a risk contract, and on maintaining contract requirements, the Plan must demonstrate fiscal, and administrative capacity to manage the POS and its costs so as not to jeopardize the financial viability or organizational and administrative capacity of the Plan, see 42 CFR 417.412(b)(1) and 417.478(b) and (c). If the Plan cannot track who is going out of the Plan's established network for what services, and at what cost, HCFA would conclude that the Plan does not have the administrative capability to guarantee its financial soundness. If HCFA determines that a Plan does not have sufficient financial viability or organizational and administrative capacity to assure the delivery of health care services for enrollees, HCFA may discontinue the risk contract. Plans seeking to implement a POS plan are advised to receive prior approval from HCFA to make sure that it will not jeopardize their contract.
2. Medicare charge limits will apply to services provided through a POS benefit, see section 1876(j)(1)(A) of the Social Security Act.
3. Beneficiary charges for a POS product must be separately identified as part of the ACR submittal. Also, Plans must reflect out-of-plan utilization through their POS benefit in the ACR proposal submitted to HCFA. ACR proposals are not required for non-Medicare covered benefits provided free through employer group contracts.

Continuity of Care & Accessibility

4. Plans must continue to provide, in-plan, in an available and accessible manner, all Medicare-covered services and all services that they are obligated to provide as additional benefits or supplemental benefits, and they are financially responsible for emergency and urgent care. The POS plan cannot be a substitute for the continued availability and accessibility of all Medicare covered services in-network, see section 1876(c)(2)(A) of the Social Security Act.
5. Plans will provide HCFA with a description of how they will track and monitor use of the POS in order to provide continuity of care for beneficiaries. The regulation at 42 CFR 417.416(a) requires that all services, including supplemental services, be "available and accessible and furnished in a

manner that ensures continuity."

6. With respect to tracking the health care services beneficiaries receive through a POS product, Plans must maintain a record keeping system through which information relevant to the health care of enrollees (including services received through the POS) is accumulated and readily available to appropriate professionals (see 42 CFR 417.416(e)(2)).

Beneficiary Education And Disclosure

7. The Plan will maintain written rules on how the POS will function including what health care services can be utilized through the POS and what the beneficiary must do in order to access medical services through a POS, see 42 CFR 417.436. For example, beneficiaries will need to be clearly informed about the difference between emergency or urgently needed out-of-area services (which are covered for all beneficiaries in an HMO/CRP) and the out-of-network coverage available under the POS.
8. The Plan will inform beneficiaries about all costs and possible financial risks associated with using a POS, including the following information:
 - ▶ any premium and cost sharing charges beneficiaries will be responsible for;
 - ▶ annual out-of-pocket limits, deductibles, co-insurance, co-payments, and annual and lifetime maximum benefit limits for out-of-network coverage or services; and
 - ▶ potential beneficiary financial liability for medical services obtained outside the plan if the Plan subsequently denies payment for (in whole or in part) because the services:
 - were not covered under the terms of the POS; or
 - because the dollar limit on the POS is exceeded.
9. Appeal rights with respect to the POS option. If the POS is a mandatory supplement, the Medicare appeals process applies. If it is an optional supplement, the grievance process is applicable, see section 2403.2.E of the Medicare HMO/CRP manual.
10. To ensure effective beneficiary education, we recommend that beneficiaries receiving a POS benefit be provided with an evidence of coverage document providing full details of the POS and meeting all disclosure requirements regarding the POS. We suggest that this document is signed by the beneficiary indicating that the Plan has also verbally described all the requirements of the POS benefit.

Administrative Capacity

11. As noted above, Plans will need to have an information system consistent with the requirements of 42 CFR 417.412(b)(1). To track the individual beneficiary's use of the POS, we recommend that this capability be used to notify individuals on a timely basis when any limits on the POS are being approached as well as keeping track of overall utilization of the POS. To be most effective this information system would include a toll-free number beneficiaries can call for current information and assistance with the POS requirements and limitations.
12. Services provided through a POS are subject to the same prompt payment requirements as other out-of-plan services, see section 1876(g)(6)(A) of the Social Security Act.

Marketing Standards

13. All marketing and educational materials associated with the POS must be approved by HCFA prior to use, see 42 CFR 417.428(a)(3) and (b)(2). Also, plans cannot engage in marketing activities which would mislead or confuse Medicare beneficiaries, see 42 CFR 417.428(b)(2).

Physician Incentive Arrangements

14. If the Plan alters contracts with in-plan providers because of the availability of the POS:
 - the Plan must provide full disclosure to HCFA describing any changes in physician incentives or reimbursement resulting from a POS plan; and
 - any risk-sharing arrangements, including capitation, must conform to the incentive arrangements requirements of section 1876(i)(8) of the Social Security Act.

Financial Standards

15. 42 CFR 417.407(c)(3) incorporates sections 417.420(a)(1)(i) and (a)(1)(iv), and 417.122(a). The first two of these provisions require Plans to demonstrate a fiscally sound operation through total assets being greater than total un-subordinated liabilities, and through an insolvency protection plan. 42 CFR 417.122(a) requires that Plans must provide for continuation of benefits "for the duration of the contract period for which payment has been made." Thus, Plans must maintain additional reserves at least equal to the monthly cost of the POS.

Financial Reporting

The requirements in paragraphs 16 - 18 are based on 42 C.F.R. section 417.126(a) (as incorporated by reference in section 417.478(d)).

- 16. The plan must generate accurate financial, utilization data, and reports on a timely basis, so that HCFA can evaluate the Plan's experience with POS.
- 17. The Plan must have a system to record POS utilization in a manner that will permit reporting of utilization and costs as HCFA may require.
- 18. The plans will provide reports on the financial impact of the POS product as required by HCFA. Financial reports on the POS must include expenses paid, incurred and reported expenses not yet paid, and estimates of incurred but not yet reported expenses.

Solvency

- 19. 42 CFR 417.122(a) requires the Plan to "maintain arrangements satisfactory to HCFA to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the Plan. These arrangements "may include" contractual "hold harmless" clauses, insurance, financial reserves, and any other arrangements acceptable to HCFA.

IV. KEY AUTHORITIES GOVERNING MEDICARE POS OPTIONS

This is a listing of some of the statutory and regulatory provisions that the POS guidelines are based on. While not necessarily limited to these requirements, Plans providing a POS option for Medicare beneficiaries must ensure that the following requirements are met.

- o Section 1876(c)(2)(A) of the Social Security Act and 42 CFR 417.416(a) - Plans must provide in an available and accessible manner, all Medicare covered services
- o 42 CFR 417.412(b)(1) and 417.478(b) and (c) - The HMO/CMP must demonstrate the fiscal and administrative capacity to manage operations so as not to jeopardize its financial viability.
- o 42 CFR 417.414(c)(2) - An HMO or CMP must assume financial responsibility for services that the Medicare enrollee attempted to obtain from the HMO or CMP, but that the HMO or CMP failed to furnish or unreasonably denied, and that are found, upon appeal by subpart Q of this part, to be services that the enrollee was entitled to have furnished to him or her

by the HMO or CMP.

- o 42 CFR 417.418(a) - Requires HMOs/CMPs to insure that supplemental services for which the Medicare enrollee has contracted are furnished in a manner that ensures continuity.
- o 42 CFR 417.428(a)(3) and (b)(2) - these provisions include requirements that Plans submit all marketing materials to HCFA at least 45 days before their planned distribution. Also, Plans are prohibited from engaging in marketing activities that could mislead or confuse Medicare beneficiaries.
- o 42 CFR 417.436 - requires that written rules must be furnished to beneficiaries at the time of enrollment and then annually after that. These must include information about all benefits provided under the contract, including supplemental benefits (subsection (a)(2)); restrictions on coverage for services furnished from sources outside the HMO, other than for emergency or urgently needed services ((a)(3) and (a)(5)); and "any other matters that HCFA may prescribe" ((a)(12)).
- o 42 CFR 417.440(b)(1)-(3) - Requires that the optional benefit must be available to all Medicare enrollees enrolled under the risk-contract. Also, the Plan cannot health screen enrollees who elect to receive the optional benefit.
- o 42 CFR 417.440(b)(iii) - HCFA approves supplemental benefits if HCFA determines that imposition of the requirements will not discourage other Medicare beneficiaries from enrolling in the risk-plan.
- o 42 CFR 417.452(d)(3) - The sum of the amounts an HMO or CMP charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services.
- o 42 CFR 417.460(iv)(A)&(B) - Establishes that after a beneficiary is absent from the Plan's geographic service area for more than 90 days the Plan cannot impose restrictions on the scope of services provided the beneficiary as described in section 471.440.
- o 42 CFR 417.478 - incorporates provisions of the PHS Act (1301 and 1318) that require financial disclosure to enrollees.
- Section 1301(g)(8) of the PHS Act - requires, among other things, disclosure of information relating to cost of operations, patterns of utilization, and "such other matters as the Secretary may require."

- Section 1318 of the PHS Act requires reporting, and disclosure, of information demonstrating a fiscally sound operation "in accordance with regulations of the Secretary." Regulations at section 417.120 and 417.122 implement the latter provision, (they are also incorporated into the definition of a CMP in section 417.407).
- o 42 CFR 417.500(a)(5) - Among the violations that may be subject to the intermediate sanctions are occurrences where a Plan misrepresents or falsifies information that it provides under section 1876 of the Social Security Act to HCFA, an individual, or to any other entity. Accordingly, Plans must ensure that the information provided to HCFA and beneficiaries regarding a POS product does not misrepresent or falsify information regarding the benefit.
- o Additional authority for requiring beneficiary disclosure is contained in section 1876(e)(2) of the Social Security Act which states that if the HMO/CMP provides supplemental services, it "shall furnish [enrollees] with information on the portion of its premium rate or other charges applicable to such additional services...."
- o Plans must comply with applicable state requirements.

MANAGED CARE, VOUCHERS, AND MEDICARE SAVINGS

Republican proposals to make Medicare a voucher program do not produce savings by expanding choice, they reduce spending by shifting costs to beneficiaries and effectively forcing many of them into managed care.

Even a document prepared by the House Budget Committee concedes that: "Most likely, the beneficiary would have to pay an amount in addition to the voucher" to remain in the traditional Medicare benefit plan. (Draft House Republican Budget Committee Recommendations, May 3, 1995.)

Republican voucher proposals would effectively force Medicare beneficiaries into HMOs, because many of them could not afford to do anything else. This is coercion, not choice.

According to the Urban Institute, the elderly now pay over \$2,500 a year on average in out-of-pocket health care costs (about 21% of their income). Under the Republican voucher plan, beneficiaries would be required to pay an average of over \$1,000 per year more between 1996 and 2002 to retain traditional, Medicare fee-for-service coverage.

Republican voucher proposals would take away from Medicare beneficiaries their entitlement to health coverage.

Republican voucher proposals would give beneficiaries a capped voucher growing at an arbitrary rate that is lower than the expected increase in health care costs. This means that, every year as health care costs go up faster than the voucher, beneficiaries can buy less and less coverage.

Republicans call their voucher a defined contribution. This means that beneficiaries are no longer entitled to a set of health care services. Instead, they get an arbitrary amount as a voucher that may or may not be enough to buy health coverage.

In fact, a document prepared by the House Budget Committee concedes that a capped voucher might not be enough to obtain health coverage for all beneficiaries. To try to address this problem, they present an alternative -- tying the voucher to the cheapest plan in each area. However, they admit that this approach would not achieve the Medicare cuts they are counting on to provide tax cuts to the wealthy and balance the budget by 2002. (Draft House Republican Budget Committee Recommendations, May 3, 1995.)

Even this more "moderate" Republican plan says to our nation's seniors that we will only guarantee them the cheapest health coverage available, and that they can get better coverage only if they can afford it.

Republican voucher proposals rely on the private insurance market, yet they ignore many of its problems.

For example, private insurers discriminate against people based on their age, how sick they are, and where they live. Under the current Medicare program, everyone is treated the same.

Republican proposals would inevitably result in higher costs for people who are the sickest and need Medicare the most.

Under Republican proposals, younger and healthier beneficiaries would buy less expensive, catastrophic coverage and pocket the difference between the voucher amount and the catastrophic plan.

However, catastrophic coverage would not be cheaper for beneficiaries who have health problems because they have very large out-of-pocket expenses.

Thus, older and sicker beneficiaries would have little choice but to purchase more comprehensive coverage. However, because costs would be spread only over older and sicker beneficiaries, these health plans would be very expensive.

MANAGED CARE, VOUCHERS, AND MEDICARE SAVINGS

1. **Republican proposals to make Medicare a voucher program do not produce savings by expanding choice, they reduce spending by shifting costs to beneficiaries and effectively forcing many of them into managed care.**
 - a. Even a document prepared by the House Budget Committee concedes that: "Most likely, the beneficiary would have to pay an amount in addition to the voucher" to remain in the traditional Medicare benefit plan. (*Draft House Republican Budget Committee Recommendations, May 3, 1995.*)
 - b. Republican voucher proposals would effectively force Medicare beneficiaries into HMOs, because many of them could not afford to do anything else. This is coercion, not choice.
 - c. According to the Urban Institute, the elderly now pay over \$2,500 a year on average in out-of-pocket health care costs (about 21% of their income). Under the Republican voucher plan, beneficiaries would be required to pay an average of over \$1,000 per year more between 1996 and 2002 to retain traditional, Medicare fee-for-service coverage.

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 - a. Republican voucher proposals would give beneficiaries a capped voucher growing at an arbitrary rate that is lower than the expected increase in health care costs. This means that, every year as health care costs go up faster than the voucher, beneficiaries can buy less and less coverage.
 - b. Republicans call their voucher a defined contribution. This means that beneficiaries are no longer entitled to a set of health care services. Instead, they get an arbitrary amount as a voucher that may or may not be enough to buy health coverage.
 - c. In fact, a document prepared by the House Budget Committee concedes that a capped voucher might not be enough to obtain health coverage for all beneficiaries. To try to address this problem, they present an alternative -- tying the voucher to the cheapest plan in each area. However, they admit that this approach would not achieve the Medicare cuts they are counting on to provide tax cuts to the wealthy and balance the budget by 2002. (*Draft House Republican Budget Committee Recommendations, May 3, 1995.*)
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3. **Republican voucher proposals rely on the private insurance market, yet they ignore many of its problems.**
 - a. For example, private insurers discriminate against people based on their age, how sick they are, and where they live. Under the current Medicare program, everyone is treated the same.
 - b. Republican proposals would inevitably result in higher costs for people who are the sickest and need Medicare the most.
 - ▶ Under Republican proposals, younger and healthier beneficiaries would buy less expensive, catastrophic coverage and pocket the difference between the voucher amount and the catastrophic plan.
 - ▶ However, catastrophic coverage would not be cheaper for beneficiaries who have health problems because they have very large out-of-pocket expenses.
 - ▶ Thus, older and sicker beneficiaries would have little choice but to purchase more comprehensive coverage. However, because costs would be spread only over older and sicker beneficiaries, these health plans would be very expensive.

MEDICARE PAYMENTS TO RISK CONTRACTORS

I. PURPOSE

At previous Commission meetings, we have focused on describing the various forms of Medicare managed care contracts, (for example, risk contracts, cost contracts, health care prepayment plans, and social HMOs), and on trends in plan participation and Medicare enrollee participation in these managed care programs. This presentation will focus on how Medicare determines the level of program payments to Medicare risk contractors, and how risk contractors determine the amount they are permitted to charge Medicare enrollees. We will also describe analyses that will be presented at the January Commission meeting. These analyses will examine relationships among plans' costs, payments by the Medicare program and by enrollees, non-covered services provided by plans, and market characteristics.

No decisions will be required at the December meeting. We are seeking comments or suggestions, including points you would like to include in the "alert" on Medicare managed care (Tab M).

II. INFORMATION TO BE PRESENTED

We will describe the four step process used to determine the level of payments to risk plans by the Medicare program and by enrollees in Medicare risk plans. We will also highlight elements of this process about which the Commission may wish to comment. The four steps are:

1. Medicare calculates the average per capita expenditures by county for Medicare program enrollees who are not in managed care plans. Medicare Program payments to risk plans are based on this amount.
2. Plans employ a cost-finding methodology to determine the expected "cost" of providing Medicare-covered services to Medicare risk-plan enrollees.
3. Plans compare the expected payment (step 1) to the expected cost of providing Medicare-covered services (step 2). If these expected payments are greater than expected costs, plans are required to provide at least enough non-covered services to eliminate the difference between expected costs and payments. Plans may choose to offer additional non-covered services.
4. Plans may charge Medicare enrollees an amount based on the expected costs of Medicare-covered services and additional services that the plan may choose or be required to offer.

MEDICARE PAYMENTS TO RISK CONTRACTORS

Congress has long been interested in having Medicare take advantage of the potential of HMOs to provide cost savings compared with fee-for-service care. In 1972, Congress authorized Medicare to contract with HMOs to provide services to Medicare enrollees, but few HMOs chose to enter into Medicare contracts. Analysts have attributed the limited attractiveness of the original Medicare managed care program to the payment structure, which required that any profits be shared with the Medicare program and imposed a profit cap of 10 percent of Medicare program payments.

Congress modified Medicare's HMO payment system in 1982, when it created the Medicare risk contract program. Rather than imposing profit-sharing with the Medicare program, the risk contract program attempts to produce savings for the Medicare program by paying HMOs 95 percent of the amount that Medicare would expect to pay if a plan's Medicare enrollees were treated in the fee-for-service sector. Congress also tried to make HMOs more attractive to Medicare enrollees with provisions that require many participating risk plans to offer services that are not covered by Medicare in the fee-for-service (FFS) sector.

Despite these changes, participation in the Medicare risk contract program continues to be limited. The 136 plans with Medicare risk contracts cover two million Medicare enrollees. However, three-quarters of HMOs do not have a Medicare risk contract, and only 5 percent of all Medicare enrollees are in risk plans. By contrast, 17 percent of persons with private health insurance are enrolled in HMOs.

Medicare's method of establishing payment rates has been criticized for contributing to the low rate of plan participation in Medicare's risk contract program. Medicare risk plans are paid an amount for each Medicare plan member that is based on the FFS sector's average cost per Medicare enrollee in each plan member's county of residence. Because of risk selection, practice patterns, and other factors, it is not known whether actual per-member costs in managed care plans are related to per capita costs in the FFS sector. If there are substantial differences between per capita costs in the FFS and managed care sectors, the use of FFS costs to establish managed care payment rates may make it economically unattractive for managed care plans to participate in the Medicare risk contract program in some counties, while making participation very attractive in other counties.

There is no mechanism in the risk contract program to adjust managed care payments or benefits in counties where low FFS costs may make it unattractive for managed care plans to participate. (The cost-reimbursement program may also be an attractive alternative for managed care plans in such areas.) However, in risk contracts where Medicare's expected payment rate exceeds the managed care plan's expected cost per member, Medicare attempts to offset the difference by requiring plans to offer additional benefits that have an actuarial value equal to the "savings" (that is, the difference between the FFS-based payment rate and the expected cost to the plan of providing Medicare-covered services). These additional

In the third stage, HCFA calculates weights that reflect the relative Part A costliness and relative Part B costliness of Medicare enrollees in various demographic categories. At the county level, these "risk adjusters" are based on age (five categories), sex, working-aged status (beginning in 1995), and three groups based on institutional status and Medicaid status (non-institutionalized non-Medicaid, non-institutionalized Medicaid, and institutionalized). These weights are applied to the county-specific AAPCC to calculate the payment rate for each Medicare enrollee in a risk plan, based on the enrollee's county of residence and demographic characteristics. Medicare pays 95 percent of this amount. Medicare also pays 95 percent of the state-level ESRD AAPCC for enrollees with ESRD.

This methodology has been criticized on grounds that often involve issues related to whether HCFA measures FFS per capita costs appropriately and to the reasonableness of the assumption that costs incurred by managed care plans are related to Medicare expenditures in the FFS sector. The next section describes four such issues. This discussion does not address another major issue: the appropriateness of the risk adjusters used to determine enrollee-specific payments.

Is the county the appropriate geographic unit for payment rates?--The county is the unit on which Medicare risk payments are based. However, many plans and analysts argue that it often is inappropriate to use the county as the geographic unit. This argument has two elements. First, despite the use of five years of expenditure data to smooth changes in per capita spending, many counties--particularly counties with relatively small numbers of Medicare enrollees--experience substantial changes in the AAPCC from year to year. The unpredictability of the AAPCC may discourage HMOs from entering into a risk contract in such counties. Second, neighboring counties often have substantially different AAPCCs. For example, the AAPCC varies by more than \$180 per month in the six-county Washington DC metropolitan area, and by more than \$100 in both the Miami and Minneapolis markets. By contrast, a plan's costs probably do not vary significantly across its service area.

Last year, the health care reform bill approved by the House Ways and Means Committee directed HCFA to submit a proposal for revising the payment methodology to use alternative geographic classifications. The Senate Finance Committee's bill also called for using large service areas as the basis for determining rates. The Group Health Association of America (GHAA) has proposed using SMSAs to establish payment rates. The likely effect of such changes has not been evaluated.

Adjusting AAPCC rates to reflect the cost of services provided by military and VA facilities--The AAPCC is calculated for each county by dividing expected Medicare FFS expenditures by the number of Medicare enrollees in the FFS sector. However, in some areas, many Medicare enrollees obtain services from military or VA facilities. This reduces Medicare expenditures, and artificially reduces per capita costs. Because risk contractors are not likely to attract Medicare enrollees who also use military or VA facilities, the AAPCC no longer represents the costs that would have been incurred if the plan's enrollees had remained in the FFS sector.

In addition, the ACR proposal is used to calculate the cost and allowable beneficiary cost-sharing for optional supplemental benefit programs that beneficiaries may choose to enroll in.

Base rate for commercial members--The plan begins by calculating the average monthly premium per member for its commercial business. It then allocates this premium to direct patient care expense, administration, and other revenue categories. (The Base Rate column on page 1 of the pro forma ACR provides an example of these calculations.) The direct patient care expense categories include several Part A line items (inpatient hospital, skilled nursing, and home health services), Part B line items (such as physician, outpatient lab, and outpatient radiology services), and non-Medicare services (such as preventive care physical).

The other revenue categories include coordination of benefits revenue for members with other insurance coverage and copayments. Administration is the residual; that is, it is the difference between total revenue (commercial premiums plus other revenue) and direct patient care expenses. Thus, administration includes both costs incurred by the plan and profits on the plan's commercial business.

Cost of providing Medicare-covered services to commercial members--The services provided to commercial members may include some services that are not covered by Medicare, and they may exclude some services that are required by Medicare. Therefore, the plan adjusts the direct patient care expenses for its commercial members to reflect what those expenditures would have been if it had provided only Medicare-covered services.

The administration costs and profits for Medicare-covered services is calculated by applying the ratio of administration costs and profits to direct patient care expenditures from the base rate calculation.

Cost of providing Medicare-covered services to Medicare enrollees--Plans adjust the cost of each of the Medicare-covered service categories (for example, the inpatient hospital and skilled nursing categories) by utilization factors that reflect differences in the volume and complexity of services provided to Medicare and commercial members. In the first year of participation in the Medicare program, plans may use utilization factors provided by HCFA. These usually are the average utilization factors from the previous year for all risk plans in the state or region. In subsequent years, plans are supposed to use factors based on their own utilization data.

The expected cost of providing Medicare-covered services to Medicare enrollees is then divided into Part A services costs and Part B service costs to permit the separate calculation of allowable charges to Medicare enrollees with Part B coverage only and with both Part A and Part B coverage.

Administration costs and profits for Medicare-covered services provided to Medicare enrollees are again calculated by applying the ratio of administration to direct patient care

allowable beneficiary cost sharing and expected copayments. Plans may choose to waive part or all of this allowable premium.

Policy Issues--The methods used to calculate both Medicare program payments to risk plans and the allowable charge to Medicare enrollees in these plans raise several policy issues. We would like to know if you want to comment on any of these issues in the alert on Medicare managed care:

- Are the methods Medicare uses to determine payments to risk contractors reasonable?
- Does Medicare pay risk plans appropriately?
- Does Medicare adequately allow for reasonable profit on Medicare risk plan enrollees?
- Is it appropriate for Medicare risk plan enrollees to receive different benefits based on per capita FFS costs where they reside?
- Does Medicare's risk adjustment methodology deal adequately with risk selection?

PLANNED ANALYSES FOR PRESENTATION IN JANUARY

Staff plan a series of analyses using data from the ACR proposals to address the basic policy question of whether Medicare's risk contracting program pays appropriately. Alternatively, does Medicare's method of establishing risk contract payment rates systematically overpay in some markets while paying too little to attract managed care plans into the risk contract program in other markets. Unfortunately, we cannot answer this question directly. Because the risk contracting program is voluntary, a plan's participation in a risk contract probably indicates that its Medicare payments are at least adequate. We can, however, examine the relationships among payments, costs, benefits, and market characteristics to see if there is an association consistent with the hypothesis that Medicare pays too much in some markets and not enough to attract risk contractors in other markets. The analyses will use data on additional benefits provided by Medicare risk contractors to examine these relationships.

The analyses consist of five questions that address three sets of issues. The first two questions address the appropriateness of Medicare risk payment rates. Question one focuses on whether Medicare pays managed care plans more (relative to costs) for Medicare-covered services in markets with high per capita costs in the FFS sectors, since this would suggest that Medicare would pay too little in areas with low FFS costs. Question two examines whether Medicare risk payment rates are affected by HMO penetration of the non-Medicare market. Specifically, do HMOs affect practice patterns, such that FFS costs per capita are held down in markets with high HMO penetration rates? This might suggest that Medicare risk contract payment rates are too low in such areas.

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HMO, INC. (=== PLAN NAME
H1003 (=== PLAN NUMBER
01-Jan-95 (=== PERIOD BEGIN
31-Dec-95 (=== PERIOD END

ADJUSTED COMMUNITY RATE PROPOSAL

	BASE RATE	ADJ.	INIT RATE	UTIL. FACTOR	A/Std. ACR	PROJECTED ACR PART A	PROJECTED ACR PART B	A/B	FDC NO
1	INPATIENT HOSPITAL SERVICES	\$25.92	(\$0.95)	\$25.97	5.5627 A	\$144.46	\$144.46	\$144.46	
2	SKILLED NURSING SERVICES	\$0.23	\$0.01	\$0.24	45.8750 A	\$11.01	\$11.01	\$11.01	
3	HOME HEALTH SERVICES	\$0.34	\$0.00	\$0.34	26.8235 A	\$9.12	\$9.12	\$9.12	
4	PHYSICIAN SERVICES	\$31.65	\$0.16	\$31.81	2.9047 A	\$92.40	\$92.40	\$92.40	
5	OUTPATIENT LAB SERVICES	\$2.81	\$0.00	\$2.81	2.5359 A	\$7.13	\$7.13	\$7.13	
6	OUTPATIENT RADIOLOGY SERVICES	\$3.29	\$0.00	\$3.29	2.7736 A	\$9.13	\$9.13	\$9.13	
7	HOSPITAL OUTPATIENT SERVICES	\$5.15	\$0.00	\$5.15	2.8319 A	\$14.58	\$14.58	\$14.58	
8	PRESCRIPTION DRUGS	\$6.83	(\$6.79)	\$0.04	1.9232 A	\$0.08	\$0.08	\$0.08	
9	EMERGENCY SERVICES	\$2.32	\$0.00	\$2.32	2.4690 A	\$5.73	\$5.73	\$5.73	
10	MISCELLANEOUS SERVICES	\$1.54	\$0.22	\$1.76	4.5406 A	\$7.99	\$7.99	\$7.99	
11	NON-MEDICARE SERVICES								
A	PREVENTIVE CARE - PHYSICALS	\$1.53	(\$1.53)	\$0.00					
B	PREVENTIVE CARE - IMMUNIZATIONS	\$0.10	(\$0.10)	\$0.00					
C	PREVENTIVE CARE - HEALTH EDUCATION	\$0.25	(\$0.25)	\$0.00					
D	PREVENTIVE CARE - OTHER	\$0.00	\$0.00	\$0.00					
E	DENTAL	\$0.00	\$0.00	\$0.00					
F	EYE CARE	\$1.44	(\$1.44)	\$0.00					
G	EAR CARE	\$0.22	(\$0.22)	\$0.00					
H	PODIATRY	\$0.00	\$0.00	\$0.00					
I	MISCELLANEOUS ADDITIONAL BENEFITS	\$2.14	(\$2.14)	\$0.00					
12	SUBTOTAL	\$85.76	(\$13.03)	\$73.73		\$301.63	\$164.59	\$137.04	\$301.63
13	ADMINISTRATION (16% profit) →	\$15.31	(\$2.30)	\$13.01		\$53.23	\$29.05	\$24.18	\$53.23
14	SUBTOTAL	\$102.07	(\$15.33)	\$86.74		\$354.86	\$193.64	\$161.22	\$354.86
15	LESS: COB-WORKING MEDICARE	\$0.00	(\$3.55)	(\$3.55)	1.0000	(\$3.55)	(\$1.94)	(\$1.61)	(\$3.55)
16	LESS: COB-OTHER	(\$1.44)	\$0.00	(\$1.44)	0.4172 A	(\$0.60)	(\$0.33)	(\$0.27)	(\$0.60)
17	REVENUE REQUIREMENT	\$100.63	(\$18.88)	\$81.75		\$350.71	\$191.37	\$159.34	\$350.71
18	LESS: COMMERCIAL COPAY		(\$2.08)						
19	COMMERCIAL PREMIUM AMPM	\$98.55							
20	LESS: DED./COINS. (PARTS A&B) <i>design - NAT'L # - issued by AFCC by Albany</i>						(\$21.20)	(\$42.99)	(\$64.19)
21	LESS: ADJ./OUTPATIENT PSYCH.							(\$0.95)	(\$0.95)
22	ADJUSTED ACR					\$170.17	\$115.40	\$285.57	
23	AVERAGE PAYMENT RATE					\$196.22	\$119.45	\$315.67	ATT.
24	LESS: ADJUSTED ACR					\$170.17	\$115.40	\$285.57	
25	SAVINGS					\$26.05	\$4.05	\$30.10	

*Medicare
Managed Care*

A Draft Proposal for Market-Based Medicare Reform
(for discussion purposes only)

The federal governments' cost for each Medicare beneficiary doubled from 1988 to 1991. The government has attempted to reduce these costs by controlling prices of the services charged by doctors and hospitals. However, providers have recouped their losses by increasing the volume of services they perform for Medicare beneficiaries and by shifting costs to the private sector. For example, physicians have offset 50% of the price cuts enacted by Congress with volume increases, and they charge private payers 70 percent more than what Medicare pays for the same services. More of the same kind of cuts may also reduce the quality and access to care as providers drop out of Medicare.

Yet as Congress attempts to balance the federal budget, controlling Medicare costs is essential. The government acting alone through price controls cannot control costs. Instead, it must give incentives for beneficiaries to demand that providers deliver efficient, high quality care. Employers and employees, who have such incentives, are increasingly choosing managed care plans. This year, 64% of the nation's private work force are enrolled in managed care plans, but only 7% of Medicare beneficiaries receive their health care through managed care. This disparity not only perpetuates inefficient markets, it also creates inequities for workers now enrolled in managed care, who as they reach retirement, will lose access to their managed care plan.

The current Medicare managed care program is flawed because it doesn't give beneficiaries and providers an incentive to save money, thereby preventing the government from saving money. Instead, it pays managed care plans based on the money that's available. The premise of this scheme is to entice older Americans into managed care with better benefits as long as the managed care plans, which charge a fixed sum for each person, cost less than Medicare's payments under fee-for-service medicine. In areas of the country where fee-for-service costs are high, managed care plans are delivering better benefits to many beneficiaries. But rather than saving the federal government money, the Medicare managed care program is a boon to older Americans living in high cost areas who are relieved from having to purchase supplemental insurance that covers the gaps in Medicare benefits: prescription drugs, dental, out-of-pocket spending limits, and copayments.

A better approach is to let competition among health plans set the limit on what the government pays for Medicare managed care. The government would establish a standard set of benefits for the competition and beneficiaries would have to pay with their own money for benefits not included and for plans that cost more than the limit.

The following proposal draws, in part, on the Sen. Durenberger's bill, The Medicare Choice Act, (S. 1996) and the House Bipartisan bill (H.R. 5228), to

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ect the flaws in the Medicare payments to managed care, encourage more
spread participation in managed care, and reduce Medicare expenditures.

• Establish an annual competition among health care plans in a metropolitan statistical area to determine the Medicare payment to all area plans. This "benchmark" monthly premium for a market region would be set between the lowest bid and the average bid according to the following formula, which is similar to that in the Durenberger Bill:

Benchmark premium = lowest bid + applicable % X (average bid minus the lowest bid).

The applicable percentage would be set at 50 percent, initially and then gradually reduced to zero (unlike the Durenberger bill, which begins at 80% and is gradually reduced to 20%). For efficiency's sake, it would be best for the benchmark to be set at the lowest bid, but many fear that a low-bid mentality would drive health plans to inappropriate shortcuts. Yet as quality assurance systems develop and health plans adopt practices that reduce costs while improving quality that fear will dissipate. Thus, a gradual move toward the lowest bid is prudent.

The bid would be based on a set of standard benefits similar to those currently being offered by managed care plans, including: outpatient prescription drugs, out-of-pocket maximum payments for catastrophic care, and standard HMO benefits. But the overall value of the benefits could not be greater in actuarial value than those offered today by Medicare through fee-for-service medicine.

Payments to each plan would also be adjusted to reflect the health risks of its enrollees. All Medicare beneficiaries would continue to pay Part B premiums equal to 25 percent of the expenditures of Part B services, although the premiums could be adjusted to reflect local costs in order to end Part B subsidies of inefficient, high cost markets.

• Provide a voucher, equal to the benchmark premium for the area, to all newly eligible Medicare beneficiaries in order to purchase a health plan. Beneficiaries would be able to choose any plan that they wished. If the selected plan charged more than the benchmark premium, the beneficiary would pay the difference. Conversely, if the plan charged less than the benchmark, the beneficiary would receive a premium rebate directly from the health plan.

Low-income Medicare beneficiaries would continue to receive coverage for benefits not covered under standard Medicare benefits, but are covered under Medicaid.

- Provide a choice to those already enrolled in Medicare between remaining in the Fee-For-Service (FFS) system or joining a private health plan. Current beneficiaries would be able to participate in the same voucher system as the new beneficiaries. However, they would also have the option of remaining in the FFS market. Beneficiaries choosing to stay in the FFS market would be provided an allowance, actuarial equivalent to the voucher amount, for the purchase of private insurance. These beneficiaries would be given the same rebate incentive to choose the most economical insurance plan available.

FFS beneficiaries would also retain the option of purchasing Medigap insurance policies. However, these policies will be standardized to eliminate "first dollar" coverage. IICFA will be responsible for assigning the monetary limits to be placed on Medigap coverage. This is to provide beneficiaries with an incentive to become cost-conscious consumers of health care.

- Establish an annual open enrollment period during which beneficiaries would receive information on every plan contracting with Medicare in their area and would be able to change plans. This information would be compiled by HCFA and would include: a comparison of supplemental benefits offered by each plan, the premium charged by each plan, the benchmark premium paid by Medicare, and outcomes data on each plan. This information should be published and mailed to every Medicare beneficiary each year. Medigap enrollment would also be coordinated with this annual enrollment process in order to allow FFS beneficiaries to compare managed care and Medigap policies.

Providing this information to beneficiaries may also improve access to managed care. Currently, HMOs are largely able to control the composition of beneficiaries in their plans through specific marketing practices designed to attract healthy beneficiaries. This is one of the reasons that the government has not saved any money through its risk contracts. However, with the government taking the responsibility to provide standard information to beneficiaries on managed care options, favorable selection will be less likely.

An additional issue:

Could a voucher be used to purchase a health plan offering benefits less comprehensive than those on which plans bid, for instance, a high deductible plan?