

Medicare Managed Care Options File**HHS NEWS****DRAFT**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: HCFA Press Office  
(202) 690-6145**HCFA ANNOUNCES 25 MANAGED CARE PLANS AS CANDIDATES  
TO PARTICIPATE IN MEDICARE CHOICES DEMONSTRATION PROJECT**

The Health Care Financing Administration today announced that 25 managed care plans in eight cities and five rural areas have been selected as final candidates in the new Medicare Choices demonstration, which is designed to give Medicare beneficiaries expanded choices among types of managed care plans.

Most of the plans are located in market areas that currently have limited Medicare enrollment in managed care.

The eight cities are: San Diego, Calif.; Jacksonville and Orlando, Fla.; Atlanta, Ga.; New Orleans, La.; Columbus, Ohio; Philadelphia, Pa.; and Houston, Texas. Award candidate organizations also are located in rural areas in Illinois, Montana, New York, North Carolina and Virginia. Site awards are expected to begin in early summer.

"Medicare Choices will offer beneficiaries real and varied alternatives to fee-for-service care," said HCFA Administrator Bruce C. Vladeck. "The demonstration is part of a larger HCFA initiative to ensure that the nation's 37 million elderly have a full range of health plan options available to them."

Beneficiaries currently can obtain managed care through the nearly 300 health maintenance organizations nationwide that participate in the Medicare program. Under the Choices demonstration, beneficiaries living in the selected cities and

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rural areas will have the option of joining new types of managed care plans, most of which currently are not available in the Medicare program.

The final candidates include nine provider-sponsored networks, eight provider-owned HMOs or providers with HMO partners, and eight HMOs or preferred provider organizations.

The selected organizations will begin the final steps of the Choices Demonstration award process late this month. This includes obtaining certification by HCFA's Office of Managed Care. Once plans complete this process, they will become Choices Demonstration sites and can begin enrolling Medicare beneficiaries. Some sites might begin as early as this summer, with the remainder expected to be in operation by December.

The Medicare Choices demonstration was designed and will be conducted by HCFA's Office of Research and Demonstrations.

The final candidates by metropolitan area are:  
Atlanta, Ga.

Georgia Baptist Health Care System  
The Morgan Health Group, Inc./NYLCare  
St. Joseph's Hospital  
Value Health, Inc.

Columbus, Ohio

IDS Consortium  
Mount Carmel Health Systems  
Nationwide HMO

Houston, Texas

Memorial Sisters of Charity Health Network  
NYLCare of Houston

Jacksonville, Fla.

HealthCare USA

New Orleans, La.

Advantage Health Care  
New Orleans Regional Physician Hospital (Tenet)  
Ochsner/Sisters of Charity Health Plan  
Value Health, Inc.

- More -

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## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

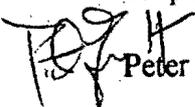
Health Care Financing Administration

Washington, D.C. 20201

April 11, 1996

MEMORANDUM TO: Chris Jennings, Lorrie McHugh, Jennifer Klein, Diana Fortuna

SUBJECT: Proposed HCFA Press Briefing

FROM:  Peter Garrett, Director, HCFA Office of Media Relations

CC: Kevin Thurm, Melissa Skolfield, Kathy King

HCFA would like to hold a press briefing on Monday, April 15 at 10:30 am, to announce the final candidates for "Medicare Choices," a demonstration project that will give Medicare beneficiaries expanded choices among types of managed care plans.

Bruce Vladeck and Barbara Cooper, Director of the Office of Research and Demonstrations would brief reporters on the technical aspects of the project. HCFA would invite reporters from city and regional publications, as well as national and health care trade media.

Attached is a draft of the press release for your review. Please note that it is embargoed until April 15. I will give you a call later today to see if you have any concerns.

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**Orlando, Fla.**

Florida Hospital HealthCare System

**Philadelphia, Pa.**

Crozer-Keystone Health Systems, IDS  
Health Partners of Philadelphia  
Independence Blue Cross  
Mercy Health Corporation

**San Diego, Calif.**

University of California at San Diego HealthCare

The final candidates in rural areas are:

Compre-Care, Inc. (Upstate New York)  
Health Alliance Medical Plans, Inc. (Illinois)  
Qual-Choice of North Carolina  
Qual-Choice of Virginia  
Yellowstone Community Health, Inc. (Montana)

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EXECUTIVE OFFICE OF THE PRESIDENT

COUNCIL OF ECONOMIC ADVISERS

WASHINGTON, D.C. 20500

April 26, 1995

MEMORANDUM FOR LAURA TYSON  
CAROL RASCO  
ALICE RIVLIN

FROM: MARK MAZUR *mm*  
CHRIS JENNINGS *CJ*  
JENNIFER KLEIN *JK*

SUBJECT: Maximum Medicare Managed Care Savings  
(Preliminary)

You asked about the maximum budget savings that could occur from a rapid build-up in managed care participation in Medicare. Some analysts have claimed that full-scale adoption of managed care in the Medicare program could lead to very large spending reductions. This memo attempts to set an upper bound on the savings that could be achieved, using some "back of the envelope" calculations. HHS and OMB are engaged in a more rigorous attempt to model the budget effects of Congressional Republican plans to give lower-cost vouchers to Medicare beneficiaries. These forthcoming calculations will be helpful in determining if significant savings can be achieved through increased use of managed care in Medicare.

Summary

The attached spreadsheet indicates that the upper bound of budget savings which could be derived from Medicare managed care is about \$126 billion over 10 years. This certainly overstates the actual savings that any policy could generate, perhaps by as much as 50 percent. Reasons for the overstatement are outlined below and include: a need to change reimbursement rates for managed care providers (which will reduce the incentive for providers to enroll beneficiaries); a lack of capacity to accommodate all Medicare beneficiaries in managed care plans; and, if enrollment is non-coercive, probable resistance to entering managed care plans unless benefits are more generous than in fee-for-service.

For a more ratable increase in managed care enrollment (new beneficiaries are enrolled beginning in 1997), the estimated upper bound budget savings are much more modest (\$32 billion over 10 years). This smaller figure is to be expected, since about 2 million people reach 65 each year and there are about 35 million current Medicare beneficiaries. Therefore, it would take several years before the bulk of beneficiaries is enrolled in managed care plans.

If you have any questions about this analysis, please let us know.

## Background

The analysis starts with some facts about Medicare and managed care:

- Under current law, about 6-7 percent of Medicare beneficiaries are in managed care programs. This figure is expected to rise to about 15 percent in the next 10 years.
- The view of many analysts is that managed care lowers cost in the private sector on a one-time basis by about 5 to 15 percent. There is little documented effect of managed care lowering long-term cost growth. Part of the one-time cost reduction occurs from obtaining discounts (e.g., from hospitals) and other uses of market power possessed by a managed care provider. Access to market discounts may be less significant in Medicare managed care operations.
- Under current law, managed care providers are compensated based on a fraction (95 percent) of the estimated local average costs of fee-for-service beneficiaries. This means that managed care providers can make profits on enrolled beneficiaries by providing care at costs more than 5 percent below the average for fee-for-service beneficiaries in the same area.

## Assumptions used in the analysis

The main assumptions in this analysis are that:

- "Spreadsheet economics" is useful in this context. The analysis abstracts from any program details and therefore does not represent analysis of any particular proposal.
- Managed care yields a one-time reduction in costs of 5 percent (consistent with OMB estimates). Subsequent costs grow at the current projected rate of Medicare spending.
- Medicare reimbursement rates are immediately changed to reflect the actual costs of providing managed care. This captures the full amount of cost reductions for the Federal Government. Note that this change, by itself would reduce the incentive for managed care providers to enroll Medicare beneficiaries.
- Medicare beneficiaries are placed into managed care programs either immediately (the "maximum saving case") or ratably over a number of years (the "new beneficiaries" case). This abstracts from the practical problems of enrolling beneficiaries and the lack of managed care capacity in all areas of the country (e.g., rural areas).

- Managed care enrollment is mandatory. If managed care enrollment increases are done in a voluntary manner, the cost savings would shrink dramatically and likely disappear. Note that some Republican proposals would use financial coercion to increase Medicare managed care enrollment. These proposals would increase the out-of-pocket cost of those beneficiaries choosing fee-for-service (essentially levying a tax on this choice), and financially tilting decisions toward managed care.

### Caveats

Some caveats to accompany this analysis are:

- The political opposition to moving Medicare beneficiaries from fee-for-service (where people can choose their own physicians) to managed care (where choice is generally limited) should not be underestimated. The logistical difficulties also would be substantial.
- The estimated one-time savings estimates are derived from the experience of the population as a whole. There is no guarantee that these savings can be achieved in the Medicare population which is more expensive to treat and may be less likely to reap the benefits of preventive care.

Attachment

**POTENTIAL SAVINGS FROM MEDICARE MANAGED CARE PROPOSALS**

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
Medicare baseline	175	192	209	228	249	273	298	326	357	392	2699
Implicit growth rate		9.71	8.85	9.09	9.21	9.64	9.16	9.40	9.51	9.80	
Assumed managed care spending (one-time saving of 5%)	175	182	199	217	237	259	283	310	339	372	2573
Estimated maximum saving from managed care	0	10	10	11	12	14	15	16	18	20	126

**POTENTIAL SAVINGS IF ONLY NEW BENEFICIARIES ARE PLACED IN MANAGED CARE**

Assumed managed care spending (one-time savings of 5%) (new beneficiaries placed in managed care beginning in 1997)	175	192	208	226	247	270	294	321	351	384	2667
Estimated saving from option	0	0	1	2	2	3	4	5	6	8	32

THE WHITE HOUSE  
WASHINGTON

April 26, 1995

MEMORANDUM TO THE PRESIDENT

FROM CAROL RASCO and LAURA TYSON

SUBJECT: STATE OF HEALTH CARE MARKET IN THE PRIVATE SECTOR

As background material for your health care briefing tomorrow, we are providing you with a brief two-part analysis of the most up-to-date information on cost and coverage trends. In short, our summary concludes that the number of uninsured continues to increase and health care inflation is moderating. Having said this, health care costs are still growing at about twice the general inflation rate and it is unclear whether the recent growth declines can be sustained over a period of time.

**Employer Market for Health Care Benefits**

Recently released data suggest a slowing in the rate of increase in the cost of employer health benefit plans.

A number of recent private sector surveys indicate that employer health benefit plans grew at a slower rate in 1994 than in 1993. Six surveys show growth rates ranging from 4% to 22% in 1993, and from (-1.1%) to 14% in 1994. Since these surveys focus on different types of employers (e.g., different size firms, industries, etc.) and are generally limited in scope, the results only can be suggestive of trends taking place nationwide. However, the surveys all show a slowing in the rate of growth between 1993 and 1994, and they show that health insurance costs for smaller businesses continue to grow significantly faster than costs for larger businesses. The 1.1% decline in costs found in a widely reported Foster Higgins survey appears to be out of step with result from other surveys.

Recent projections from the Congressional Budget Office (CBO) and the Health Care Financing Administration (HCFA) also show a slowdown in the rate of growth in private insurance. CBO projects that private insurance costs will grow at about 7 percent through the end of the decade, while HCFA estimates increases of about 8 percent for the same time period. While lower than previous projections, these estimates show private health insurance costs continuing to grow more than twice as fast as general inflation.

## Possible Reasons for Slowdown

There are several potential reasons for the slowing in the growth of private health insurance costs:

- **Health care reform:** Several analysts have pointed to the recent efforts at health care reform as a reason for moderate price inflation. Historically, when the Federal government considers or imposes cost constraints, price increases have been limited.
- **Lower inflation:** Since 1990, the Medical Care Price Index has dropped each year. In 1994, this price index increased 4.9 percent, its lowest inflation rate in over 20 years. A large portion of this slowing can be attributed to low inflation in the entire economy.
- **Shift toward managed care:** Many believe that recent increases in managed care enrollment has helped contain employer costs. For large employers, enrollment in managed care plans has reached over 60 percent of employees. For example, Foster Higgins suggests that one of the primary reasons for the slowed rate of growth is one-time savings that result from shifts into lower cost plans.
- **Shifting of costs to employees:** Several surveys indicate that employers have been increasing the employee share of premiums (especially for coverage other than managed care), increasing deductibles, increasing co-payments, and dropping coverage for dependents or making it more expensive in other ways. All these changes reduce the employer costs at the expense of employees.
- **The insurance underwriting cycle:** When insurers are profitable, they tend to compete on price, limiting premium increases to modest amounts. At present, the health insurance industry is in an extended period of profitability, resulting in moderate premium increases over the past couple of years. However, in the past two weeks, several leading managed care companies have experienced dramatic drops in their stock prices (one immediately after it announced that premiums would not be increased this year), indicating investor concern that low premium growth may be threatening managed care plan profitability. This could signal higher future price increases as health plans change their pricing to maintain profitability and investor confidence.

## Health Insurance Coverage Trends

Recently released data show a continuing decline in employer-sponsored health insurance, and a continuing increase in the number of people who are uninsured or are covered by Medicaid. From 1989 to 1993, the number of people with employer-sponsored insurance decreased by 4 million. Over that same time period, the number of uninsured increased from by 5 million, and the number of people covered by Medicaid increased by more than 8 million. The number of uninsured -- particularly among children -- would be even higher today if not for recent expansions in Medicaid eligibility. In addition, as you would expect from these coverage reduction numbers, the increase in the uninsured population has contributed to a lower growth in private insurance costs.

This decrease in employer-sponsored insurance and increase in the number of uninsured is a cause for concern, and the trend shows no signs of abating. Economists have no simple answer for the decline, but it may be due to continuing shifts in the workforce towards jobs that often do not come with health insurance (e.g., jobs that are temporary, non-union, in the service sector, or in small firms).



CONGRESSIONAL BUDGET OFFICE  
U.S. CONGRESS  
WASHINGTON, D.C. 20515

Medicare Managed Care File

June E. O'Neill  
Director

MEMORANDUM

April 26, 1995

TO: Health Staff

FROM: Sandra Christensen

SUBJECT: Managed Care and the Medicare Program

In the past few years, premiums charged by employment-based insurance plans have increased more slowly than Medicare's per enrollee costs. Many people attribute the slowdown in the rate of growth in private health plan costs to the now widespread adoption of managed care techniques and believe that growth in Medicare's costs might also be slowed by expanding enrollees' options for managed care.

This memorandum addresses a number of questions that arise about managed care in the Medicare program. It also compares the extent and nature of managed care arrangements in Medicare and in the private sector.

**What is managed care?**

The term "managed care" has come to encompass almost any intervention in health care delivery intended to reduce unnecessary and inappropriate care or to reduce costs. It is useful, however, to distinguish between managed care plans and certain managed care techniques, some of which are now used by most health insurance plans.

The health maintenance organization (HMO) is the prototype of a managed care plan because of its integrated financing and delivery systems. In return for a fixed payment per enrollee per period (the capitation rate), an HMO agrees to provide plan enrollees with any medical services they may require during the period. An HMO, like any insurer, is at risk for whatever the costs of care for its enrollees may be. However, an HMO generally differs from an indemnity insurer in the fee-for-service sector in

that it shares insurance risk with the providers who treat the HMO's enrollees. HMOs share risk either by paying physicians on a capitated basis for the patients they treat, or by using a system of withholds and bonuses to reward salaried or fee-for-service physicians based on their adherence to cost-effective treatment patterns.

There are two main types of HMOs--the group/staff model, in which the plan either contracts with or employs a group of physicians who serve only the HMO's enrollees; and the Independent Practice Association (IPA), in which the plan contracts with a number of separate practices whose physicians treat other patients along with the IPA's enrollees.

When providers share insurance risk as they do in an HMO, they have financial incentives to avoid providing unnecessary services. By contrast, in a traditional indemnity plan with fee-for-service reimbursement, providers do not share insurance risk and they have a financial incentive to provide more services than may be necessary. To counteract this incentive, most indemnity insurers have adopted some managed care techniques in an attempt to control enrollees' use of services. Most indemnity plans now have utilization review programs through which they may limit access to certain services or providers. In addition, some plans have established networks of "preferred" providers that enrollees are encouraged to use because these providers accept the plan's cost control measures. These latter plans are called preferred provider organizations (PPOs).

### **How do Group/Staff HMOs Differ from IPAs?**

In a group or staff model, the plan either contracts with or employs a group of physicians who serve only the HMO's enrollees. In an IPA, the plan contracts with a number of separate practices whose physicians treat other patients along with the IPA's enrollees. Because of its exclusive contract with plan providers, the group/staff model tends to be more effective than the IPA model at controlling use of services.

Most HMOs of both types require prior authorization for nonemergency inpatient care and concurrent review during an inpatient stay. Most group/staff HMOs permit access to specialists only after referral by the patient's primary care physician, who serves as a gatekeeper. IPAs are more likely to permit patients to self-refer to in-plan specialists. In recent years, HMOs (especially IPAs) have also begun to offer an open-ended or "point-of-service" option, which permits members to use out-of-plan providers but subjects them to greater cost-sharing when this option is used.

### **What techniques to control costs does a Preferred Provider Organization (PPO) Use?**

PPOs provide coverage on a fee-for-service basis, but they encourage patients to use their network of "preferred" providers by reducing cost-sharing requirements when they do so. Patients are generally free to see out-of-plan providers as well. The preferred providers agree to accept the PPO's utilization management techniques and typically treat the PPO's patients at discounted prices. The evidence to date indicates that most savings achieved by PPOs are the result of the discounted prices they negotiate. It appears that PPOs' interventions to change use of services are barely enough to offset the increased demand for services by patients that results in response to PPOs' low in-plan cost-sharing requirements.<sup>1</sup>

### **What does utilization review mean?**

Today, most indemnity plans have utilization review programs in place. Utilization review may include prior authorization for certain services (especially for nonemergency hospital admissions), gatekeepers (primary care physicians who must be seen first to obtain referrals to specialists), concurrent review of hospital use (to ensure the patient's discharge to a less intensive setting as soon as medically indicated), and profiling of physician practices to identify those with inappropriate treatment patterns. There is evidence that the most effective forms of utilization review focus on hospital inpatient stays, through preadmission certification and concurrent review for hospitals stays<sup>2</sup>

### **How much do these different managed care arrangements reduce use of health care services and health care costs?**

Evidence from privately insured people indicates that most managed care techniques currently reduce patients' use of services somewhat compared with unmanaged care, although the extent of this effect varies significantly by technique and even among plans using the same techniques (see table below). In general, managed care arrangements become more effective as they mature. With longer experience, it is possible that the relatively poor average performance of IPAs and PPOs (most of which were only recently formed) would improve.

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<sup>1</sup>See "Effects of Managed Care: An Update," CBO Memorandum (March 1994).

<sup>2</sup>Ibid.

### Average Reduction in Use of Services by Type of Managed Care Arrangement<sup>3</sup>

<b>Managed Care Plans</b>	
Group/Staff HMOs	22 percent
Independent Practice Associations (IPAs)	4 percent
<b>Fee-for-Service Plans</b>	
With Utilization Review Programs	2-4 percent
With Preferred Provider Organizations (PPOs)	0-2 percent.

Some of the savings from a reduction in use of services are used up in the process of achieving that reduction because monitoring providers and utilization of services raises a plan's administrative costs. But, in addition to savings from a reduction in use of services, large network plans (IPAs and PPOs) are often able to negotiate price discounts with their providers, who agree to accept lower payment rates in return for a larger number of patients. Whether the overall savings to the plans are passed on to consumers through lower premiums depends on whether the plans are in a competitive market.

#### **What is Medicare's experience with alternative cost control techniques, including managed care?**

Medicare implemented both price controls and utilization review during the 1970s, in response to rapid growth in Medicare's costs. These early attempts at control were not notably effective, though, and dissatisfaction with them led to three innovations enacted during the 1980s. First, legislation to facilitate Medicare enrollment in HMOs was passed in 1982 and implemented in 1985. Second, Medicare's retrospective cost-based reimbursement system for hospital services in the fee-for-service sector was replaced by the prospective payment system (PPS), which was enacted in 1983 and implemented in 1984. Third, Medicare's charge-based reimbursement system for physicians' services in the fee-for-service sector was replaced by the Medicare fee schedule (MFS), enacted in 1989 and implemented in 1992.

Currently, about 7 percent of Medicare enrollees are in managed care plans--capitated risk-based HMOs. Another 2 percent are enrolled in HMOs that have opted to participate in Medicare on a cost basis; these enrollees may receive services either

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<sup>3</sup>From "The Effects of Managed Care and Managed Competition," CBO Memorandum (February 1995).

through the HMO (which is reimbursed by Medicare on the basis of a cost report) or in the fee-for-service sector. The remaining 91 percent of Medicare enrollees are in Medicare's fee-for-service sector, where a number of managed care techniques are in place.

By contrast, about 20 percent of privately insured people are enrolled in risk-based HMOs. Of the 80 percent in the fee-for-service sector, about half are in plans with effective utilization review and the rest are in plans with relatively ineffective utilization controls.

### **What techniques are used to control costs in Medicare's fee-for-service sector?**

Medicare exercises control over use of hospital services in two ways. First, Medicare's Peer Review Organizations monitor the necessity for hospital admissions and the appropriateness of the care provided in hospital. Second, through its prospective payment system, Medicare has given hospitals strong incentives to minimize enrollees' length of stay, making explicit controls through concurrent review less important. Medicare also monitors physicians' treatment practices in an attempt to identify those with inappropriate patterns of care, although these controls are relatively weak.

In addition, Medicare pays substantially discounted prices for both hospital and physician services--about 60 percent of charges and 70 percent of the average amount paid by private insurers for a given set of services. All Medicare-certified hospitals and 83 percent of physicians who treat Medicare patients accept Medicare's payment rates, meaning that they may collect nothing from patients beyond the cost-sharing requirements imposed by Medicare. In particular, these "participating" providers may not bill the patient for the difference between their charges and Medicare's rates, a practice known as balance-billing. For the minority of physicians who do balance bill, the amount is limited by law to no more than 15 percent of Medicare's payment rate, which is set at 95 percent of the Medicare fee schedule amount for these nonparticipating physicians.

### **What about the Medicare Select Program? Doesn't it add some elements of managed care to Medicare's fee-for-service sector?**

Medicare Select is a demonstration program featuring a medigap PPO that has been available since 1992 in 14 states but would be available nationwide if H.R. 483 is enacted. (Medigap is private insurance that covers some or all of enrollees' cost-sharing liabilities under Medicare.) Enrollees who purchase medigap plans through the Medicare Select program get full coverage for their Medicare cost-sharing

liabilities when they are treated by providers in the PPO's network, but they are fully liable for cost sharing when treated by out-of-plan providers. Select enrollees pay medigap premiums that are typically lower than premiums charged by other medigap plans in the same area. So far, however, these savings have come almost entirely from persuading hospitals to waive Medicare's inpatient deductible amount. There is no evidence that the Medicare Select program has increased the number of networks with cost-effective providers. In fact, most of the enrollment in Select plans currently has come from reclassification of existing medigap enrollment in Blue Cross/Blue Shield network plans in the states selected for the demonstration, a reclassification the plans believed was required under the legislation authorizing the Medicare Select demonstration. An unintended consequence of the demonstration program was that medigap plans with restrictive networks had to be discontinued in the states not participating in the demonstration.<sup>4</sup>

### **Why is Medicare's HMO participation rate lower than the private sector's?**

While about 20 percent of privately insured people are in HMOs, only 9 percent of Medicare enrollees are--7 percent on a risk basis and 2 percent on a cost basis. Initially, Medicare's exclusive reliance on a fee-for-service payment system made it difficult for HMOs to serve Medicare enrollees on a risk basis. It was not until 1982 that legislation was passed to facilitate Medicare enrollment in HMOs on a prepaid risk basis, and regulations to implement the legislation were not final until 1985. Since then, growth in risk-based enrollment has been steady, while cost-based enrollment has grown little (see table).

#### Growth in Medicare HMO Enrollment (in thousands)

	<u>1985</u>	<u>1990</u>	<u>1995</u>
Cost-Based Enrollment	731	732	758
Risk-Based Enrollment	441	1264	2340

Since 1989, the rate of growth in HMO enrollment for the Medicare population has exceeded the growth rate for HMO enrollment in the non-Medicare population. In 1994, HMO risk-based enrollment increased by 25 percent, while HMO enrollment for the non-Medicare population grew by 11 percent.

Currently, about 75 percent of Medicare enrollees have access to either a risk- or a cost-based HMO. One reason that Medicare enrollees are less likely to enroll in

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<sup>4</sup>See "Medicare Select," Congressional Research Service, Report 94-962 EPW (December 2, 1994).

HMOs than does the working-age population is that, unlike those with employment-based health plans, Medicare enrollees have no ready source of information about the HMO options available to them. Another reason is that most Medicare enrollees who were not already in an HMO offered through an employment-based plan prior to retirement will have established ties to fee-for-service providers that they may be reluctant to leave.

Medicare's HMO enrollment rates are highly correlated with, but generally lower than private sector HMO penetration in each area. About 70 percent of HMOs offer a Medicare product--either a risk-based, cost-based, or Select plan. HMO participation on a risk basis in Medicare may be impeded by the volatility of Medicare's payment rates, which are set each year separately by county based on Medicare's costs in the fee-for-service sector.<sup>5</sup> Other reasons are that the medical needs of the Medicare population differ significantly from the needs of the younger groups that have been the primary market for HMOs, and that HMOs' marketing and administrative costs tend to be higher for Medicare enrollees. One impediment that sometimes prevents Medicare enrollees from continuing with an employment-based HMO on a risk basis after retirement is the requirement that Medicare HMOs be open to anyone in the area, while some employment-based plans are limited to current and former employees.

### **Why Do Some HMOs participate on a Cost Basis?**

Participation on a cost basis was the only way Medicare enrollees could be served by HMOs prior to 1985, at which time Medicare established a risk-based capitated payment system for HMOs while retaining the option of cost-based participation as well. Plans commit to either a risk or cost basis for only a year at a time. Plans may choose the cost basis for a number of reasons, some related to Medicare's payment rates and others related to Medicare's administrative requirements for HMOs.

Plans that expect to incur costs for Medicare enrollees in excess of Medicare's payment rate for them--whether because of poor management, high provider costs, or adverse selection--will opt to participate on a cost basis to avoid losses. Even some well-managed plans may choose to participate on a cost basis in preference to the uncertainty and volatility of Medicare's risk-based payment rates.

In addition, Medicare imposes a number of administrative requirements--intended to protect enrollees--on risk-based HMOs that may cause some of them to prefer participation on a cost basis. For example, the minimum benefit package required for

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<sup>5</sup>Physician Payment Review Commission. *Annual Report to Congress, 1995*, Chapter 5.

Medicare enrollees includes some services, such as skilled nursing, that HMOs often do not provide their non-Medicare enrollees, and which they may have to purchase from nonplan providers. Further, risk-based HMOs are responsible for maintaining a number of information, enrollment, and grievance procedures for Medicare enrollees that may not be required for their non-Medicare enrollees. Finally, risk-based HMOs are not permitted to restrict enrollment to certain groups in the area; because some employment-based plans restrict HMO enrollment to current and former employees, Medicare retirees can continue in those HMOs only on a cost basis.

Medicare's costs for those enrolled in cost-based HMOs are probably higher than they would have been in the fee-for-service sector. One reason for this is that cost-based HMOs are generally free to pay providers at rates higher than Medicare's rates in the fee-for-service sector. Another reason is that enrollees are free to use both HMO and fee-for-service providers, so that neither system can exert significant control over use of services.

**Do risk-based HMOs save as much for Medicare as they do in the private sector?**

Our best guess is that HMOs achieve about the same average percentage reduction in use of services among Medicare enrollees as they do for non-Medicare enrollees. However, under Medicare's payment system these savings benefit enrollees or the HMOs rather than reducing Medicare's costs.

CBO's analysis of the 1992 National Health Interview Survey data indicates that HMOs reduce use of services by about 8 percent for privately insured people and by about 7 percent for Medicare enrollees, on average, when compared with similar people in the fee-for-service sector. For both Medicare and non-Medicare groups, this overall HMO effect is the average of a relatively large effect for group/staff HMOs and a much smaller effect for IPAs.

However, HMOs' effects on use of services do not necessarily lead to savings for payers. In the private sector, savings will typically result when there is sufficient competition among health insurers to induce them to reduce premiums (and profits) in order to maintain or build enrollment. But under Medicare's current payment system for HMOs, it is believed that Medicare spends more for HMO enrollees than it would have spent on them had they remained in the fee-for-service sector. Thus, in the absence of a major increase in enrollment that would alter the current extent of favorable selection among Medicare HMO enrollees, Medicare's costs are likely to increase for each fee-for-service enrollee who switches to an HMO even though use of services by those enrollees might fall.

A recently completed study of Medicare's risk-based HMOs estimated that Medicare

pays 5.7 percent more, on average, for risk-based HMO enrollees than it would have paid had those people stayed in the fee-for-service sector.<sup>6</sup> This occurs because Medicare's capitation payment to HMOs does not adequately reflect the favorable selection that most HMOs experience with the Medicare population. Medicare's payment for each enrollee is equal to 95 percent of the AAPCC (adjusted average per capita cost). The AAPCC is an estimate of Medicare's cost per enrollee in the fee-for-service sector in the same county, adjusted to reflect the enrollee's age, sex, disability, institutional status, and Medicaid eligibility. If Medicare's payments to risk-based HMOs are 5.7 percent higher than they would have been for the same enrollees in the fee-for-service sector, this means that the AAPCC--which is supposed to represent the expected cost in the fee-for-service sector for enrollees of a given type--is about 11 percent higher than that expected cost.<sup>7</sup> This 11 percent excess is a measure of the extent of favorable selection experienced by Medicare's risk-based HMOs that is not accounted for in the AAPCC. The experience of individual HMOs doubtless varies around this average, however.

#### **Why is there favorable selection in Medicare's Risk-Based HMOs?**

There would tend to be favorable selection among new enrollees for any plan with a restricted panel of providers. This effect is more pronounced among older sicker groups, such as the Medicare population, because most of them have established ties to providers that they may be reluctant to sever. But Medicare's provisions that permit beneficiaries to enroll or disenroll from HMOs on a monthly basis, together with provisions that permit HMOs to switch between cost-based and risk-based reimbursement each year, further contribute to favorable selection for risk-based HMOs.<sup>8</sup>

**Isn't there some mechanism to ensure that Medicare doesn't pay HMOs too much for the Medicare people they enroll?**

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<sup>6</sup>R.S. Brown et al., "The Medicare Risk Program for HMOs--Final Summary Report on Findings from the Evaluation," Mathematica Policy Research, Inc., Princeton, N.J. (February 1993).

<sup>7</sup>If  $.95 * AAPCC = 1.057 * FFS \text{ costs}$ , then the  $AAPCC = (1.057 / 0.95) FFS \text{ costs}$ , or the  $AAPCC = 1.11 * FFS \text{ costs}$ .

<sup>8</sup>F.W. Porell et al., "Factors Association with Disenrollment from Medicare HMOs: Findings from a Survey of Disenrollees," Report to the Health Care Financing Administration, Cooperative Agreement No. 99-C99256/11-06 (July 1992).

Under current law, if a risk-based HMO's profit rate on Medicare enrollees exceeds its profit rate on other enrollees, it is required to return the excess either to the Medicare program or to enrollees. All HMOs in this situation choose to return the excess to enrollees through waived premiums for benefits beyond the basic Medicare package, such as eliminating Medicare's cost-sharing requirements and providing coverage for prescription drugs. The value of additional benefits that the HMO must provide at no additional premium cost is set by the difference between Medicare's average capitation payment to the HMO and the HMO's adjusted community rate (ACR), which is the HMO's estimate of the premium it would charge its Medicare enrollees for the basic Medicare package in the absence of Medicare's capitation payment. HMOs submit an ACR proposal to the Health Care Financing Administration each year.

Estimates for 1991 show that HMOs returned about 9 percent of Medicare's capitation payments to enrollees through additional benefits. This implies that HMOs were able to provide Medicare's basic benefit package for about 86 percent of the AAPCC, on average.<sup>9</sup> If, because of favorable selection, the AAPCC was 11 percent higher than HMO enrollees' expected costs in the fee-for-service sector, this means that HMOs covered Medicare's basic benefit package for about 96 percent of what those enrollees would have cost in the fee-for-service sector.<sup>10</sup>

#### **What changes in Medicare's payment system would generate savings from HMO enrollment in Medicare?**

One way to generate savings from HMO enrollment in Medicare might be to add a health status measure to the other factors used to calculate the AAPCC, which is the capitation rate Medicare pays HMOs for each enrollee. According to one study, if a health status indicator for whether the enrollee had a history of cancer, heart disease, or stroke was added to the AAPCC, then Medicare's current payments to HMOs (capitation rates set at 95 percent of the AAPCC) would be about 1 percent lower than Medicare would have paid for those same enrollees in the fee-for-service

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<sup>9</sup>Medicare's payments equal  $.95 \times \text{AAPCC}$ , and HMOs returned 9 percent of those payments to enrollees in extra benefits. Hence, HMOs provided the basic Medicare benefit package for  $.91 \times .95 \times \text{AAPCC}$ , or for  $.86 \times \text{AAPCC}$ . Again, this no doubt varies by HMO.

<sup>10</sup>Because  $0.86 \times 1.11 = 0.96$ . Thus, if Medicare had claimed all of the excess payments identified through the ACR mechanism in 1991, it would have saved 4 percent of its costs for every enrollee who moved from the fee-for-service sector to an HMO, and 9 percent for every enrollee already in a risk-based HMO.

sector.<sup>11</sup> The same study indicates that Medicare currently pays 5.7 percent more for HMO enrollees than they would have cost in the fee-for-service sector. This means that adding health status to the AAPCC would reduce Medicare's costs for current or currently projected HMO enrollees by more than 6 percent. In fiscal year 1995, this would have reduced Medicare spending by about \$900 million.

Another way to generate savings (without changing the AAPCC) would be to claim more of the excess payments identified through the ACR mechanism for Medicare, instead of permitting HMOs to return all of the excess to enrollees through additional benefits. If, for example, Medicare required that half the excess be returned to Medicare, and if the excess remained at its 1991 level of 9 percent, then Medicare's HMO costs would be lower by 4.5 percent. In fiscal year 1995, this would have reduced Medicare spending by \$640 million.

Alternatively, as the Physician Payment Review Commission has suggested, Medicare's capitated payments to HMOs could be set by competitive bidding in areas with adequate competition among plans.<sup>12</sup> The ACR mechanism now in place is already an implicit bidding system whose benefits accrue to enrollees. An explicit bidding system in competitive areas could lead to more aggressive bidding among plans, perhaps inducing plans to reduce their profit rates on Medicare enrollees below current levels.

Relative to current law, however, each of these options for generating savings from HMO enrollment in Medicare would reduce enrollees' incentives to choose an HMO over the fee-for-service sector, because it would either reduce the supplemental benefits HMOs provide or increase the supplemental premiums HMOs charge. In many areas, though, enrollees would still be able to get comprehensive coverage through an HMO for less than they would pay for medigap coverage in the fee-for-service sector. Stronger incentives to choose lower-cost alternatives could be created by charging supplemental premiums to enrollees who remain in Medicare's fee-for-service when lower-cost alternatives are available in the area.

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<sup>11</sup>R.S. Brown et al, "The Medicare Risk Program for HMOs--Final Summary Report on Findings from the Evaluation," Mathematica Policy Research, Inc., Princeton, N.J. (February 1993).

<sup>12</sup>See PPRC's *Annual Report to Congress, 1995*, Chapter 5.

## Managed Care

### Medicare

This does not mean that we oppose improving Medicare — quite the contrary. We share a commitment to expanding and improving the managed care choices available to Medicare beneficiaries.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll one. 1994 was a year of impressive growth in Medicare managed care, we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent. And, the number of our Medicare managed care plans increased by 20 percent.

We are working on ways to make our existing managed care program work better. Examples include our work with the industry to improve quality measures and the AAPCC methodology for the Medicare risk contracting program, and our collaboration with Alain Enthovan to design a competitive bidding demonstration.

We also are working to make a new preferred provider organization (PPO) option available to beneficiaries. This option has proven to be very popular in the commercial market, and many of us have access to PPOs. We believe that Medicare beneficiaries should have the same range of choices.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission: Ninety percent of Medicare's hospital and skilled nursing facility claims and 67 percent of its physician claims are submitted electronically. In contrast, 60 percent of Blue Cross' hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is 10 percent for all claims. And, in Medicaid, we are working collaboratively with National Committee for Quality Assurance (NCQA), State Medicaid agencies, consumer advocates and managed care organizations to adapt the commercial sector's state-of-the-art performance measurement tool HEDIS (Health Plan Employer Data and Information Set) to the needs of the Medicaid program.

### Medicaid

In the past two years, the Medicaid program has been transformed in ways that make the program more efficient, flexible and responsive to local needs.

- The annual increase in Medicaid spending has dropped from almost 30% during the last two years of the Bush administration to under 9% in the first two years of the Clinton Administration.
- Medicaid is now projected to grow at about 9% annually over the next ten years. Over

40% of this growth is due to projected increases in enrollment. Looking at per capita costs alone, Medicaid is now growing at about the same rate as private health insurance.

- Over one-third of AFDC and noncash Medicaid beneficiaries are now enrolled in managed care. This percentage will grow significantly over the next few years.
- The process for granting demonstration waivers has been streamlined. Over the past two years, we have approved } statewide demonstration waivers for states seeking to implement innovative programs to expand coverage and cut costs.

8 or 9

*one - final over five?*

## Questions for GHAA

Favorable Selection -- The Mathematica study has persuaded many, including CBO, that HMOs participating in the Medicare risk program engage in favorable risk selection.

- Any comment on the Mathematica study and its methodology?
- Do you have any evidence that contradicts the results of the study?
- Do you have any conceptual arguments to refute the practice of favorable selection? Is favorable selection less likely in high penetration markets?
- Do you have evidence about the incidence and patterns of disenrollment? Where do Medicare beneficiaries go upon disenrolling from a plan?

Data Collection -- Many argue that managed care results in more efficient delivery of care. We are interested in data that could confirm this perception.

- Do plans engage in data-based monitoring of their practitioners (e.g. provider profiling)?
- Do plans track encounter level data? How uniform is data collection practices?
- Are you aware of any comparisons of how delivery of care and outcomes differ between fee-for-service and managed care plans?

Quality of Care -- There is a perception that managed care plan enrollees benefit from greater continuity of care and a focus on preventive services.

- Do you have any empirical evidence indicating improved continuity and quality of care, more preventive care and/or improved health status for managed care plan enrollees?

Spillover Effect -- It has been argued that managed care market penetration results in more efficient practice patterns in the fee-for-service sector.

- Do you have empirical evidence supporting this claim?

AAPCC flaws -- The AAPCC is widely acknowledged to be flawed in numerous ways.

- How would you suggest reforming the AAPCC and HMO options to achieve savings for the Medicare program?
- Any thoughts on a competitive bidding approach?
- Any thoughts on limiting the geographic variation due to fee-for-service utilization differences?

PPO Option -- Thought has been given to expanding the ability of beneficiaries to participate in managed care options such as PPOs or POS plans that provide some coverage for beneficiaries seeking care out-of-network.

- What are your thoughts on this type of proposal? Why do so few managed care plans currently offer the self-referral option allowed under the risk program?

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## **TRENDS IN THE USPCCs AND AAPCCs**

**Not Just Knowledge. Know How.<sup>sm</sup>**

## TRENDS IN THE USPCCs AND AAPCCs

This report looks at the five year trend in the capitation rate the Health Care Financing Administration (HCFA) pays to health maintenance organizations (HMOs) that have signed a Medicare risk contract. Under this contract, the HMO agrees to provide all of the Medicare-covered benefits to Medicare beneficiaries who elect to enroll in the plan, without the payment of coinsurance and deductibles. In turn, the beneficiary agrees to receive all of their benefits from the HMO's providers.

Each year on September 7, HCFA announces the capitation rates for each county and each type of beneficiary for the upcoming year. The capitation rate is the projected Medicare program expenses for non-HMO beneficiaries residing in the county. To do this, HCFA first projects a national per capita Medicare expenditure, known as the United States Per Capita Cost (USPCC). HCFA then localizes the national expenditures through several steps that take into account the trend in historical county expenditures and the local demographic characteristics of beneficiaries in the county. The final capitation rate is 95% of the projected local Medicare expenditures, known as the Adjusted Average Per Capita Cost (AAPCC).

### USPCCs

Table 1 and Figure 1 show the Part A, Part B, and total USPCCs for the aged, disabled, and end-stage renal disease (ESRD) beneficiaries for the 11 years HCFA has computed the rates. The 1995 total aged USPCC is double that of 1985 (\$400.52 vs. \$190.85), but the expenditures in the two programs increased at different rates: Part A USPCCs increased 94%, while Part B USPCCs increased more rapidly at 143%.

The 5.9% rate of increase in the total aged USPCC is somewhat lower than the overall annual average of 8.3%. The 1994 - 1995 Part A rate of increase (6.3%) is almost exactly average (6.6%), while the Part B rate of increase (5.3%) is about half of the average (11.7%). This reflects the relatively greater difficulty in projecting Part B expenditures as the new resource-based relative value scale payment method is being phased in over time, beginning in 1993. The reduced rates of increase in Part B USPCCs in 1994 and 1995 are adjusting for an over-estimate in 1993.

## AAPCCs

Tables 3-6 take a closer look at the AAPCCs of those counties with the largest numbers of risk enrollees. Roughly 80% of the 2 million risk enrollees reside in the counties listed. *The rest of this analysis refers only to the counties listed, not all counties in the country.*

Exhibits 1 and 2 list the five counties with the largest and least total aged AAPCC from 1994; Exhibits 3 and 4 list the five counties with the largest and least percentage increases. Of the counties shown, the AAPCCs ranged from a high of \$646.88 in New York City to about half that in Portland, Oregon (\$350.45). The percentage increases ranged from 2.1% in Cleveland to 7.7% in Las Vegas. Unlike prior years, some areas with the highest rates of HMO penetration received large percentage increases, notably Portland, Oregon. Interestingly, Minneapolis received one of the lowest rates of increase (3.1%) while neighboring St. Paul received one of the highest rates of increase (6.0%).

**Exhibit 1. Ten Major Counties with the Largest AAPCCs.**

City or Area	County	State	Total AAPCC
New York	Kings	NY	\$646.88
Philadelphia	Philadelphia	PA	625.81
Miami	Dade	FL	615.57
New York	Queens	NY	592.89
Los Angeles	Los Angeles	CA	558.76
Miami	Broward	FL	544.02
Los Angeles	Orange	CA	523.12
New York	Nassau	NY	514.93
Chicago	Cook	IL	485.26
Boston	Middlesex	MA	480.33

*Coopers & Lybrand, LLP analysis of HCFA data.*

**Exhibit 2. Ten Major Counties with the Smallest AAPCCs.**

City or Area	County	State	Total AAPCC
St. Paul	Ramsey	MN	\$379.82
Seattle	King	WA	377.09
Portland, OR	Washington	OR	374.82
Portland, OR	Multnomah	OR	373.35
Daytona Beach	Volusa	FL	364.98
Seattle	Snohomish	WA	364.28
Minneapolis	Hennepin	MN	362.85
Honolulu	Honolulu	HI	352.89
Albuquerque	Bernalillo	NM	352.38
Portland, OR	Clackamas	OR	350.45

*Coopers & Lybrand, LLP analysis of HCFA data.*

**Exhibit 3. Ten Major Counties with the Largest Percentage Increase in AAPCCs.**

City or Area	County	State	Total Change
Las Vegas	Clark	NV	7.7%
Portland	Clackamas	OR	7.1%
Miami	Dade	FL	7.0%
Tampa-St. Petersburg	Pinellas	FL	6.8%
Tampa-St. Petersburg	Pasco	FL	6.6%
New York	Nassau	NY	6.2%
Daytona Beach	Volusa	FL	6.1%
Portland	Washington	OR	6.0%
St. Paul	Ramsey	MN	6.0%
New York	Kings	NY	6.0%

*Coopers & Lybrand, LLP analysis of HCFA data.*

Exhibit 4. Ten Major Counties with the Least Percentage Increase in AAPCCs.

City or Area	County	State	Total Change
Seattle	Snohomish	WA	4.0%
Philadelphia	Montgomery	PA	3.9%
Tucson	Pima	AZ	3.7%
Seattle	King	WA	3.6%
Boston	Middlesex	MA	3.6%
Worcester	Worcester	MA	3.5%
Minneapolis	Hennepin	MN	3.1%
Philadelphia	Philadelphia	PA	2.9%
Albuquerque	Bernalillo	NM	2.9%
Cleveland	Cuyahoga	OH	2.1%

*Coopers & Lybrand, LLP analysis of HCFA data.*

### AAPCC / USPCC Index

Table 5 shows the ratio of the AAPCC divided by the USPCC in each year from 1991 through 1995. An index of 1.00 means that the county's AAPCC equals the USPCC. If the index moves toward 1.00, then the county's projected Medicare fee-for-service reimbursement, less 5%, is becoming more similar to the national average. In the past, these trends were fairly constant: that is, they were steadily increasing, steadily decreasing, or stable. However, we can no longer make this generalization. The indices for 1995 show a marked similarity to the indices for 1994; in fact, only a few of the indices varied by more than 2 one-hundredths, and were unchanged in 12 of the 40 counties analyzed. This suggests a "leveling off" of the movement of each county's reimbursement relative to the national average, especially for Part A. The Part B index shows more movement, and probably reflects the phasing-in of the new physician fee schedules. However, since the Part A payment comprises most of the total payment (see next section), its stability may offset the movement in Part B. If the combined index continues to remain stable, it will be a useful planning tool for Medicare risk contractors when HCFA releases the preliminary USPCCs each June.

## Part A AAPCC as a Percentage of the Total AAPCC

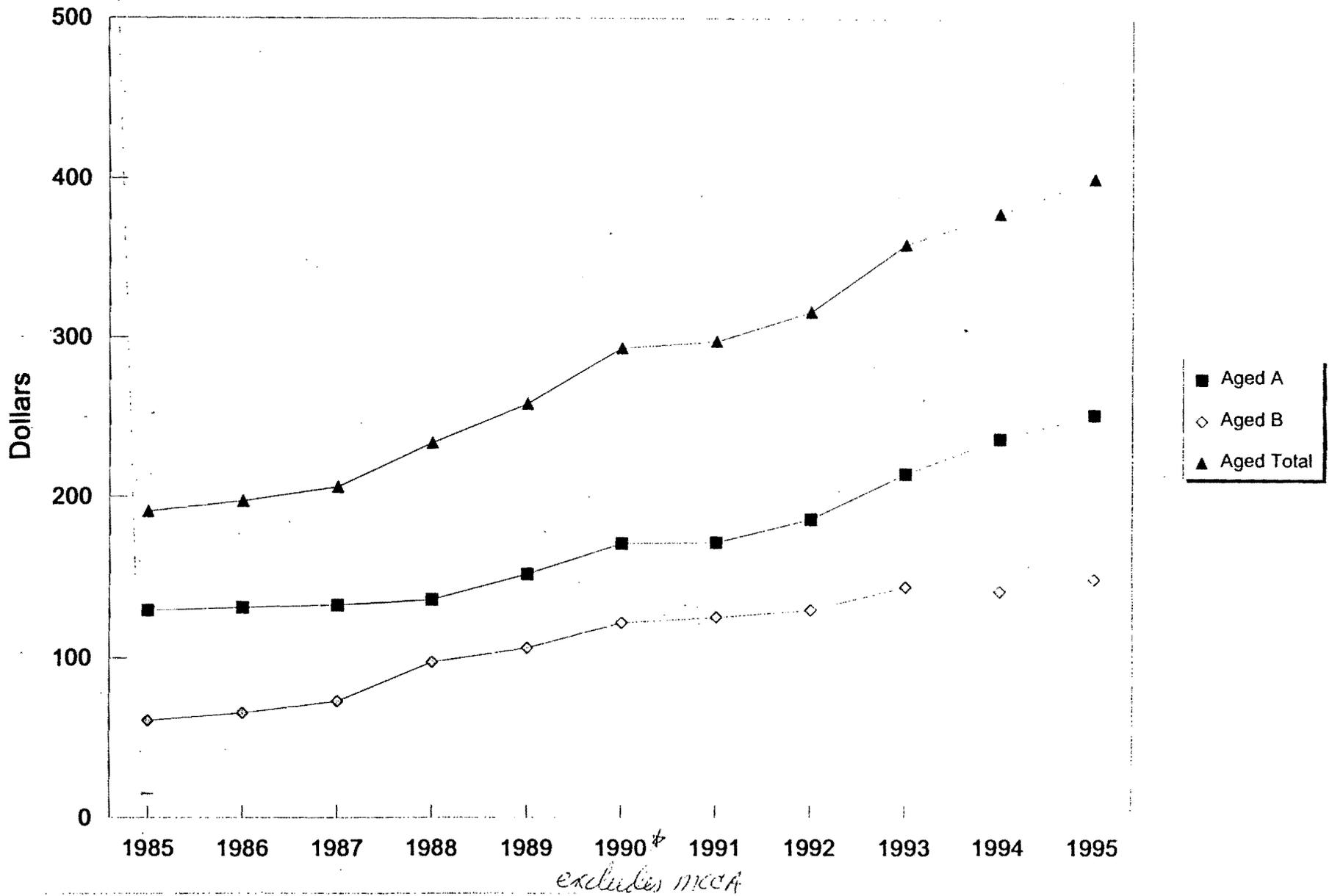
Table 6 expresses the percentage of the total AAPCC which comes from Part A payments. Nationally, projected Part A expenditures have contributed an increasing percentage of the total payments, from 58% of the total USPCC in 1991 to 63% of the total USPCC in 1995.

The percentages vary by geographic area. In New York City, for example, 70% of the total AAPCC comes from Part A payments. In contrast, about half of the total AAPCC comes from Part A payments in the southern Florida counties. This reflects a complex combination of different practice styles and reimbursement levels in the two areas. There is no obvious relationship between the percentages and the HMO penetration rate.

Over the five year period, the percentage of the total AAPCC coming from Part A has jumped as much as 13 points to 65% (Portland, Oregon's Clackamas county), yet it remained unchanged at 58% in Bernalillo county, New Mexico. Most areas have shown a slow, but steady increase.

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Figure 1. Aged USPPCs, 1985-1995



**Table 1. USPCCs, 1985-1995**

Year	1995	1994	1993	1992	1991	1990*	1989	1988	1987	1986	1985
Aged A	\$251.61	\$236.69	\$214.40	\$186.29	\$171.93	\$171.35	\$152.28	\$136.44	\$132.92	\$131.32	\$129.66
Aged B	148.91	141.44	144.24	129.78	125.40	121.98	106.32	97.65	73.20	66.01	61.19
<b>Aged Total</b>	<b>400.52</b>	<b>378.13</b>	<b>358.64</b>	<b>316.07</b>	<b>297.33</b>	<b>293.33</b>	<b>258.60</b>	<b>234.09</b>	<b>206.12</b>	<b>197.33</b>	<b>190.85</b>
Disabled A	223.99	219.17	198.13	170.19	163.50	159.33	160.74	143.29	140.11	140.98	138.46
Disabled B	131.82	117.86	115.71	107.86	105.42	115.87	95.91	86.96	84.22	77.52	73.07
<b>Disabled Total</b>	<b>355.81</b>	<b>337.03</b>	<b>313.84</b>	<b>278.05</b>	<b>268.92</b>	<b>275.20</b>	<b>256.65</b>	<b>230.25</b>	<b>224.33</b>	<b>218.50</b>	<b>211.53</b>
ESRD A	1520.42	1327.28	1108.09	1220.91	1046.25	930.85	884.01	886.97	795.27	723.71	751.14
ESRD B	2153.81	2018.62	1803.83	1679.29	1346.15	1305.99	1020.05	1107.55	1389.31	1531.72	1,522.80
<b>ESRD Total</b>	<b>3674.23</b>	<b>3345.90</b>	<b>2911.92</b>	<b>2900.20</b>	<b>2392.40</b>	<b>2236.84</b>	<b>1904.06</b>	<b>1994.52</b>	<b>2184.58</b>	<b>2255.43</b>	<b>2,273.94</b>

\*excludes MCCA

**Table 2. Percentage Change in USPCCs, 1985-1995**

Year	1994- 1995	1993- 1994	1992- 1993	1991- 1992	1990- 1991	1989- 1990	1988- 1989	1987- 1988	1986- 1987	1985- 1986
Aged A	6.3%	10.4%	15.1%	8.4%	0.3%	12.5%	11.6%	2.6%	1.2%	1.3%
Aged B	5.3%	-1.9%	11.1%	3.5%	2.8%	14.7%	8.9%	33.4%	10.9%	7.9%
<b>Aged Total</b>	<b>5.9%</b>	<b>5.4%</b>	<b>13.5%</b>	<b>6.3%</b>	<b>1.4%</b>	<b>13.4%</b>	<b>10.5%</b>	<b>13.6%</b>	<b>4.5%</b>	<b>3.4%</b>
Disabled A	2.2%	10.6%	16.4%	4.1%	2.6%	-0.9%	12.2%	2.3%	-0.6%	1.8%
Disabled B	11.8%	1.9%	7.3%	2.3%	-9.0%	20.8%	10.3%	3.3%	8.6%	6.1%
<b>Disabled Total</b>	<b>5.6%</b>	<b>7.4%</b>	<b>12.9%</b>	<b>3.4%</b>	<b>-2.3%</b>	<b>7.2%</b>	<b>11.5%</b>	<b>2.6%</b>	<b>2.7%</b>	<b>3.3%</b>
ESRD A	14.6%	19.8%	-9.2%	16.7%	12.4%	5.3%	-0.3%	11.5%	9.9%	-3.7%
ESRD B	6.7%	11.9%	7.4%	24.7%	3.1%	28.0%	-7.9%	-20.3%	-9.3%	0.6%
<b>ESRD Total</b>	<b>9.8%</b>	<b>14.9%</b>	<b>0.4%</b>	<b>21.2%</b>	<b>7.0%</b>	<b>17.5%</b>	<b>-4.5%</b>	<b>-8.7%</b>	<b>-3.1%</b>	<b>-0.8%</b>

Coopers & Lybrand, LLP analysis of HCFA data.

**Table 3. Five Year Trend in Aged AAPCCs for Selected Counties, 1991-1995**

City or Area	County	State	1995			1994			1993			1992			1991		
			Part A	Part B	Total												
Phoenix	Maricopa	AZ	\$264.02	\$176.62	\$440.64	\$248.55	\$169.56	\$418.11	\$239.06	\$173.93	\$412.99	\$205.25	\$155.50	\$360.75	\$193.12	\$145.46	\$338.58
Tucson	Pima	AZ	236.30	163.51	399.81	227.24	158.43	385.67	209.80	158.85	368.65	185.11	140.30	325.41	171.83	131.06	302.89
Los Angeles	Los Angeles	CA	340.59	218.17	558.76	317.52	214.51	532.03	285.88	229.40	515.28	246.94	213.72	460.66	228.33	210.03	438.36
	Orange	CA	310.31	212.81	523.12	289.82	209.19	499.01	269.48	224.12	493.60	227.93	209.53	437.46	212.03	205.15	417.18
	Riverside	CA	276.36	187.64	464.00	260.97	184.45	445.42	238.57	199.29	437.86	199.91	184.33	384.24	184.78	180.33	365.11
	San Bernardino	CA	294.38	172.54	466.92	276.96	168.21	445.17	248.98	179.02	428.00	209.92	165.29	375.21	189.93	160.49	350.42
	Ventura	CA	256.56	187.11	443.67	239.23	183.11	422.34	241.65	194.53	436.18	187.86	179.96	367.82	183.09	175.60	358.69
San Diego	San Diego	CA	277.67	181.14	458.81	256.51	178.46	434.97	232.82	192.93	425.75	199.56	180.36	379.92	185.27	179.22	364.49
San Francisco	San Francisco	CA	308.37	158.66	467.03	292.51	153.62	446.13	282.23	161.85	444.08	247.80	154.19	401.99	225.61	157.02	382.63
	San Mateo	CA	251.55	146.18	397.73	238.53	141.17	379.70	236.74	152.38	389.12	212.37	146.02	358.39	200.24	149.14	349.38
Denver	Denver	CO	289.39	146.24	435.63	271.42	140.58	412.00	252.02	143.23	395.25	217.92	131.30	349.22	196.78	126.64	323.42
Daytona Beach	Volusia	FL	210.78	154.20	364.98	196.31	147.75	344.06	186.18	151.05	337.23	165.96	132.23	298.19	159.85	124.50	284.35
Miami	Broward	FL	298.88	245.14	544.02	277.48	239.73	517.21	261.29	249.13	510.42	225.47	229.88	455.35	218.21	212.36	430.57
	Dade	FL	315.00	300.57	615.57	292.00	283.52	575.52	261.85	286.64	548.49	246.68	260.68	507.36	239.43	241.13	480.56
	Palm Beach	FL	245.66	227.75	473.41	231.51	220.52	452.03	217.35	227.39	444.74	184.78	202.31	387.09	178.08	185.07	363.15
Orlando	Orange	FL	252.35	181.15	433.50	237.36	174.45	411.81	224.47	174.99	399.46	185.84	150.19	336.03	178.65	140.14	318.79
Tampa-	Pinellas	FL	238.35	171.73	410.08	219.63	164.28	383.91	208.24	170.73	378.97	179.03	148.44	327.47	169.02	137.94	306.96
	St. Petersburg Hillsborough	FL	243.91	170.13	414.04	228.79	164.52	393.31	211.97	171.69	383.66	194.01	153.05	347.06	184.31	150.28	334.59
	Pasco	FL	252.94	185.86	438.80	233.64	177.89	411.53	219.44	182.97	402.41	184.73	156.18	340.91	174.78	145.80	320.58
Honolulu	Honolulu	HI	226.86	126.03	352.89	214.31	124.28	338.59	200.89	133.66	334.55	174.59	130.56	305.15	165.95	120.84	286.79
Chicago	Cook	IL	332.68	152.58	485.26	315.33	145.84	461.17	289.34	152.04	441.38	250.31	139.62	389.93	233.04	136.15	369.19
Boston	Middlesex	MA	321.49	158.84	480.33	308.66	154.83	463.49	272.12	159.19	431.31	233.71	145.38	379.09	222.25	143.82	366.07
Worcester	Worcester	MA	311.07	142.02	453.09	299.61	138.21	437.82	251.85	144.14	395.99	217.51	134.83	352.34	202.52	128.99	331.51
Minneapolis-	Hennepin	MN	236.28	126.57	362.85	233.01	119.09	352.10	235.27	117.80	353.07	216.47	111.17	327.64	203.07	118.91	321.98
St. Paul	Ramsey	MN	257.80	122.02	379.82	243.42	115.06	358.48	241.67	115.41	357.08	215.77	109.90	325.67	199.10	114.08	313.18
Albuquerque	Bernalillo	NM	204.86	147.52	352.38	202.55	140.06	342.61	195.44	146.25	341.69	170.01	130.36	300.37	171.27	122.87	294.14
Las Vegas	Clark	NV	274.33	188.50	462.83	246.64	183.18	429.82	242.02	195.24	437.26	198.25	177.21	375.46	189.13	172.80	361.93
New York	Kings	NY	453.64	193.24	646.88	429.07	181.48	610.55	339.04	186.32	525.36	279.33	170.40	449.73	252.27	168.49	420.76
	Queens	NY	414.97	177.92	592.89	392.06	168.09	560.15	314.01	172.31	486.32	259.09	155.36	414.45	234.18	153.11	387.29
	Nassau	NY	341.80	173.13	514.93	322.96	161.85	484.81	275.97	164.14	440.11	229.92	149.93	379.85	208.91	148.85	357.76
	Suffolk	NY	312.20	165.63	477.83	298.14	158.13	456.27	244.34	160.83	405.17	211.25	147.05	358.30	193.40	145.03	338.43
Cleveland	Cuyahoga	OH	312.03	162.42	474.45	308.89	155.90	464.79	294.46	159.91	454.37	251.58	142.05	393.63	226.80	135.92	362.72
Portland OR	Multnomah	OR	250.07	123.28	373.35	235.98	120.59	356.57	232.82	127.71	360.53	205.10	122.82	327.92	182.22	120.46	302.68
	Clackamas	OR	229.51	120.94	350.45	211.30	115.89	327.19	197.98	122.60	320.58	172.71	115.22	287.93	148.32	133.89	282.21
	Washington	OR	251.87	122.95	374.82	234.84	118.82	353.66	219.82	123.42	343.24	192.08	119.19	311.27	181.07	118.28	299.35
San Antonio	Bexar	TX	249.22	155.15	404.37	234.99	146.87	381.86	206.73	149.84	356.57	175.29	133.90	309.19	161.87	129.30	291.17
Seattle	King	WA	237.32	139.77	377.09	225.24	138.62	363.86	219.53	138.38	357.91	203.41	129.56	332.97	193.85	123.07	316.92
	Snohomish	WA	225.88	138.40	364.28	212.05	138.15	350.20	204.15	138.17	342.32	192.09	128.27	320.36	181.73	120.52	302.25
Philadelphia	Philadelphia	PA	422.51	203.30	625.81	407.92	200.41	608.33	370.06	210.83	580.89	311.58	194.79	506.37	280.22	192.96	473.18
	Montgomery	PA	291.11	173.93	465.04	279.32	168.15	447.47	262.92	172.61	435.53	228.36	157.99	386.35	210.17	154.80	364.97

Coopers & Lybrand, LLP analysis of HCFA data.

**Table 4. Five Year Trend in Percentage and Absolute Dollar Change of Aged AAPCCs, Selected Counties**

City or Area	County	State	1994-1995				1993-1994				1992-1993				1991-1992			
			Percent Difference			Dollar Change												
			Part A	Part B	Total		Part A	Part B	Total		Part A	Part B	Total		Part A	Part B	Total	
Phoenix	Maricopa	AZ	6.2%	4.2%	5.4%	\$22.53	4.0%	-2.5%	1.2%	\$5.12	16.5%	11.9%	14.5%	\$52.24	6.3%	6.9%	6.5%	\$22.17
Tucson	Pima	AZ	4.0%	3.2%	3.7%	\$14.14	8.3%	-0.3%	4.6%	\$17.02	13.3%	13.2%	13.3%	\$43.24	7.7%	7.1%	7.4%	\$22.52
Los Angeles	Los Angeles	CA	7.3%	1.7%	5.0%	\$26.73	11.1%	-6.5%	3.3%	\$16.75	15.8%	7.3%	11.9%	\$54.62	8.2%	1.8%	5.1%	\$22.30
	Orange	CA	7.1%	1.7%	4.8%	\$24.11	7.5%	-6.7%	1.1%	\$5.41	18.2%	7.0%	12.8%	\$56.14	7.5%	2.1%	4.9%	\$20.28
	Riverside	CA	5.9%	1.7%	4.2%	\$16.58	9.4%	-7.4%	1.7%	\$7.56	19.3%	8.1%	14.0%	\$53.62	8.2%	2.2%	5.2%	\$19.13
	San Bernardino	CA	6.3%	2.6%	4.9%	\$21.75	11.2%	-6.0%	4.0%	\$17.17	18.6%	8.3%	14.1%	\$52.79	10.5%	3.0%	7.1%	\$24.79
	Ventura	CA	7.2%	2.2%	5.1%	\$21.33	-1.0%	-5.9%	-3.2%	(\$13.84)	28.6%	8.1%	18.8%	\$68.36	2.6%	2.5%	2.5%	\$9.13
San Diego	San Diego	CA	8.2%	1.5%	5.5%	\$23.84	10.2%	-7.5%	2.2%	\$9.22	16.7%	7.0%	12.1%	\$45.83	7.7%	0.6%	4.2%	\$15.43
San Francisco	San Francisco	CA	5.4%	3.3%	4.7%	\$20.90	3.6%	-5.1%	0.5%	\$2.05	13.9%	5.0%	10.8%	\$42.09	9.8%	-1.8%	5.1%	\$19.36
	San Mateo	CA	5.5%	3.5%	4.7%	\$18.03	0.8%	-7.4%	-2.4%	(\$9.42)	11.5%	4.4%	8.6%	\$30.73	6.1%	-2.1%	2.6%	\$9.01
Denver	Denver	CO	6.6%	4.0%	5.7%	\$23.63	7.7%	-1.9%	4.2%	\$16.75	15.6%	9.1%	13.2%	\$46.03	10.7%	3.7%	8.0%	\$25.80
Daytona Beach	Volusia	FL	7.4%	4.4%	6.1%	\$20.92	5.4%	-2.2%	2.0%	\$6.83	12.2%	14.2%	13.1%	\$39.04	3.8%	6.2%	4.9%	\$13.84
Miami	Broward	FL	7.7%	2.3%	5.2%	\$26.81	6.2%	-3.6%	1.3%	\$6.79	15.9%	8.4%	12.1%	\$55.07	3.3%	8.3%	5.8%	\$24.78
	Dade	FL	7.9%	6.0%	7.0%	\$40.05	11.5%	-1.1%	4.9%	\$27.03	6.1%	10.0%	8.1%	\$41.13	3.0%	8.1%	5.6%	\$26.80
	Palm Beach	FL	6.1%	3.3%	4.7%	\$21.38	6.5%	-3.0%	1.6%	\$7.29	17.6%	12.4%	14.9%	\$57.65	3.8%	9.3%	6.6%	\$23.94
Orlando	Orange	FL	6.3%	3.6%	5.3%	\$21.69	5.7%	-0.3%	3.1%	\$12.35	20.8%	16.5%	18.9%	\$63.43	4.0%	7.2%	5.4%	\$17.24
Tampa-	Pinellas	FL	6.5%	4.5%	6.8%	\$26.17	5.5%	-3.8%	1.3%	\$4.94	16.3%	15.0%	15.7%	\$51.50	5.9%	7.6%	6.7%	\$20.51
	St. Petersburg Hillsborough	FL	6.6%	3.4%	5.3%	\$20.73	7.9%	-4.2%	2.5%	\$9.65	9.3%	12.2%	10.5%	\$36.60	5.3%	1.8%	3.7%	\$12.47
	Pasco	FL	8.3%	4.5%	6.8%	\$27.27	6.5%	-2.8%	2.3%	\$9.12	18.8%	17.2%	18.0%	\$61.50	5.7%	7.1%	6.3%	\$20.33
Honolulu	Honolulu	HI	5.9%	1.4%	4.2%	\$14.30	6.7%	-7.0%	1.2%	\$4.04	15.1%	2.4%	9.6%	\$29.40	5.2%	8.0%	6.4%	\$18.36
Chicago	Cook	IL	5.5%	4.8%	5.2%	\$24.09	9.0%	-4.1%	4.5%	\$19.79	15.6%	8.9%	13.2%	\$51.45	7.4%	2.5%	5.6%	\$20.74
Boston	Middlesex	MA	4.2%	2.6%	3.6%	\$16.84	13.4%	-2.7%	7.5%	\$32.18	16.4%	9.5%	13.8%	\$52.22	5.2%	1.1%	3.6%	\$13.02
Worcester	Worcester	MA	3.8%	2.8%	3.5%	\$15.27	19.0%	-4.1%	10.6%	\$41.83	15.8%	6.9%	12.4%	\$43.65	7.4%	4.5%	6.3%	\$20.83
Minneapolis-	Hennepin	MN	1.4%	6.3%	3.1%	\$10.75	-1.0%	1.1%	-0.3%	(\$0.97)	8.7%	6.0%	7.8%	\$25.43	6.6%	-6.5%	1.8%	\$5.66
St. Paul	Ramsey	MN	5.9%	6.0%	6.0%	\$21.34	0.7%	-0.3%	0.4%	\$1.40	12.0%	5.0%	9.6%	\$31.41	8.4%	-3.7%	4.0%	\$12.49
Albuquerque	Bernalillo	NM	1.1%	5.3%	2.9%	\$9.77	3.6%	-4.2%	0.3%	\$0.92	15.0%	12.2%	13.8%	\$41.32	-0.7%	6.1%	2.1%	\$6.23
Las Vegas	Clark	NV	11.2%	2.9%	7.7%	\$33.01	1.9%	-6.2%	-1.7%	(\$7.44)	22.1%	10.2%	16.5%	\$61.80	4.8%	2.6%	3.7%	\$13.53
New York	Kings	NY	5.7%	6.5%	6.0%	\$36.33	26.6%	-2.6%	16.2%	\$85.19	21.4%	9.3%	16.8%	\$75.63	10.7%	1.1%	6.9%	\$28.97
	Queens	NY	5.8%	5.8%	5.8%	\$32.74	24.9%	-2.4%	15.2%	\$73.83	21.2%	10.9%	17.3%	\$71.87	10.6%	1.5%	7.0%	\$27.16
	Nassau	NY	5.8%	7.0%	6.2%	\$30.12	17.0%	-1.4%	10.2%	\$44.70	20.0%	9.5%	15.9%	\$60.26	10.1%	0.7%	6.2%	\$22.09
	Suffolk	NY	4.7%	4.7%	4.7%	\$21.56	22.0%	-1.7%	12.6%	\$51.10	15.7%	9.4%	13.1%	\$46.87	9.2%	1.4%	5.9%	\$19.87
Cleveland	Cuyahoga	OH	1.0%	4.2%	2.1%	\$9.66	4.9%	-2.5%	2.3%	\$10.42	17.0%	12.6%	15.4%	\$60.74	10.9%	4.5%	8.5%	\$30.91
Portland OR	Multnomah	OR	6.0%	2.2%	4.7%	\$16.78	1.4%	-5.6%	-1.1%	(\$3.96)	13.5%	4.0%	9.9%	\$32.61	12.6%	2.0%	8.3%	\$25.24
	Clackamas	OR	8.6%	4.4%	7.1%	\$23.26	6.7%	-5.5%	2.1%	\$6.61	14.6%	6.4%	11.3%	\$32.65	16.4%	-13.9%	2.0%	\$5.72
	Washington	OR	7.3%	3.5%	6.0%	\$21.16	6.8%	-3.7%	3.0%	\$10.42	14.4%	3.5%	10.3%	\$31.97	6.1%	0.8%	4.0%	\$11.92
San Antonio	Bexar	TX	6.1%	5.6%	5.9%	\$22.51	13.7%	-2.0%	7.1%	\$25.29	17.9%	11.9%	15.3%	\$47.38	8.3%	3.6%	6.2%	\$18.02
Seattle	King	WA	5.4%	0.8%	3.6%	\$13.23	2.6%	0.2%	1.7%	\$5.95	7.9%	6.8%	7.5%	\$24.94	4.9%	5.3%	5.1%	\$16.05
	Snohomish	WA	6.5%	0.2%	4.0%	\$14.08	3.9%	-0.0%	2.3%	\$7.88	6.3%	7.7%	6.9%	\$21.96	5.7%	6.4%	6.0%	\$18.11
Philadelphia	Philadelphia	PA	3.6%	1.4%	2.9%	\$17.48	10.2%	-4.9%	4.7%	\$27.44	18.8%	8.2%	14.7%	\$74.52	11.2%	0.9%	7.0%	\$33.19
	Montgomery	PA	4.2%	3.4%	3.9%	\$17.57	6.2%	-2.6%	2.7%	\$11.94	15.1%	9.3%	12.7%	\$49.18	8.7%	2.1%	5.9%	\$21.38

Coopers & Lybrand, LLP analysis of HCFA data.

**Table 5. 5-Year Trend in the Ratio of the AAPCC to the USPCC .**

City or Area	County	State	Part A Aged					Part B Aged					Total Aged					
			1995	1994	1993	1992	1991	1995	1994	1993	1992	1991	1995	1994	1993	1992	1991	
Phoenix	Maricopa	AZ	1.05	1.05	1.12	0.96	1.04	1.19	1.20	1.21	1.20	1.16	1.11	1.11	1.15	1.14	1.14	
Tucson	Pima	AZ	0.94	0.96	0.98	0.86	0.92	1.10	1.12	1.10	1.08	1.05	1.01	1.02	1.03	1.03	1.02	
Los Angeles	Los Angeles	CA	1.35	1.34	1.33	1.15	1.23	1.47	1.52	1.59	1.65	1.67	1.41	1.41	1.44	1.46	1.47	
	Orange	CA	1.23	1.22	1.26	1.06	1.14	1.43	1.48	1.55	1.61	1.64	1.32	1.32	1.38	1.38	1.40	
	Riverside	CA	1.10	1.10	1.11	0.93	0.99	1.26	1.30	1.38	1.42	1.44	1.17	1.18	1.22	1.22	1.23	
	San Bernandino	CA	1.17	1.17	1.16	0.98	1.02	1.16	1.19	1.24	1.27	1.28	1.18	1.18	1.19	1.19	1.18	
	Ventura	CA	1.02	1.01	1.13	0.88	0.98	1.26	1.29	1.35	1.39	1.40	1.12	1.12	1.22	1.16	1.21	
San Diego	San Diego	CA	1.10	1.08	1.09	0.93	0.99	1.22	1.26	1.34	1.39	1.43	1.16	1.15	1.19	1.20	1.23	
San Francisco	San Francisco	CA	1.23	1.24	1.32	1.16	1.21	1.07	1.09	1.12	1.19	1.25	1.18	1.18	1.24	1.27	1.29	
	San Mateo	CA	1.00	1.01	1.10	0.99	1.07	0.98	1.00	1.06	1.13	1.19	1.00	1.00	1.08	1.13	1.18	
Denver	Denver	CO	1.15	1.15	1.18	1.02	1.06	0.98	0.99	0.99	1.01	1.01	1.10	1.09	1.10	1.10	1.09	
Daytona Beach	Volusa	FL	0.84	0.83	0.87	0.77	0.86	1.04	1.04	1.05	1.02	0.99	0.92	0.91	0.94	0.94	0.96	
Miami	Broward	FL	1.19	1.17	1.22	1.05	1.17	1.65	1.69	1.73	1.77	1.69	1.37	1.37	1.42	1.44	1.45	
	Dade	FL	1.25	1.23	1.22	1.15	1.29	2.02	2.00	1.99	2.01	1.92	1.55	1.52	1.53	1.61	1.62	
	Palm Beach	FL	0.98	0.98	1.01	0.86	0.96	1.53	1.56	1.58	1.56	1.48	1.19	1.20	1.24	1.22	1.22	
Orlando	Orange	FL	1.00	1.00	1.05	0.87	0.96	1.22	1.23	1.21	1.16	1.12	1.09	1.09	1.11	1.06	1.07	
Tampa-	Pinellas	FL	0.95	0.93	0.97	0.84	0.91	1.15	1.16	1.18	1.14	1.10	1.03	1.02	1.06	1.04	1.03	
	St. Petersburg	Hillsborough	FL	0.97	0.97	0.99	0.90	0.99	1.14	1.16	1.19	1.18	1.20	1.04	1.04	1.07	1.10	1.13
	Pasco	FL	1.01	0.99	1.02	0.86	0.94	1.25	1.26	1.27	1.20	1.16	1.11	1.09	1.12	1.08	1.08	
Honolulu	Honolulu	HI	0.90	0.91	0.94	0.81	0.89	0.85	0.88	0.93	1.01	0.96	0.89	0.90	0.93	0.97	0.96	
Chicago	Cook	IL	1.32	1.33	1.35	1.17	1.25	1.02	1.03	1.05	1.08	1.09	1.22	1.22	1.23	1.23	1.24	
Boston	Middlesex	MA	1.28	1.30	1.27	1.09	1.19	1.07	1.09	1.10	1.12	1.15	1.21	1.23	1.20	1.20	1.23	
Worcester	Worcester	MA	1.24	1.27	1.17	1.01	1.09	0.95	0.98	1.00	1.04	1.03	1.14	1.16	1.10	1.11	1.11	
Minneapolis-	Hennepin	MN	0.94	0.98	1.10	1.01	1.09	0.85	0.84	0.82	0.86	0.95	0.92	0.93	0.98	1.04	1.08	
	St. Paul	Ramsey	MN	1.02	1.03	1.13	1.01	1.07	0.82	0.81	0.80	0.85	0.91	0.96	0.95	1.00	1.03	1.05
Albuquerque	Bernalillo	NM	0.81	0.86	0.91	0.79	0.92	0.99	0.99	1.01	1.00	0.98	0.89	0.91	0.95	0.95	0.99	
Las Vegas	Clark	NV	1.09	1.04	1.13	0.92	1.02	1.27	1.30	1.35	1.37	1.38	1.17	1.14	1.22	1.19	1.22	
New York	Kings	NY	1.80	1.81	1.58	1.30	1.35	1.30	1.28	1.29	1.31	1.34	1.63	1.61	1.46	1.42	1.42	
	Queens	NY	1.65	1.66	1.46	1.21	1.26	1.19	1.19	1.19	1.20	1.22	1.50	1.48	1.36	1.31	1.30	
	Nassau	NY	1.36	1.36	1.29	1.07	1.12	1.16	1.14	1.14	1.16	1.19	1.30	1.28	1.23	1.20	1.20	
	Suffolk	NY	1.24	1.26	1.14	0.99	1.04	1.11	1.12	1.12	1.13	1.16	1.21	1.21	1.13	1.13	1.14	
Cleveland	Cuyahoga	OH	1.24	1.31	1.37	1.17	1.22	1.09	1.10	1.11	1.09	1.08	1.20	1.23	1.27	1.25	1.22	
Portland OR	Multnomah	OR	0.99	1.00	1.09	0.96	0.98	0.83	0.85	0.89	0.95	0.96	0.94	0.94	1.01	1.04	1.02	
	Clackamas	OR	0.91	0.89	0.92	0.81	0.80	0.81	0.82	0.85	0.89	1.07	0.88	0.87	0.89	0.91	0.95	
	Washington	OR	1.00	0.99	1.03	0.90	0.97	0.83	0.84	0.86	0.92	0.94	0.95	0.94	0.96	0.98	1.01	
San Antonio	Bexar	TX	0.99	0.99	0.96	0.82	0.87	1.04	1.04	1.04	1.03	1.03	1.02	1.01	0.99	0.98	0.98	
Seattle	King	WA	0.94	0.95	1.02	0.95	1.04	0.94	0.98	0.96	1.00	0.98	0.95	0.96	1.00	1.05	1.07	
	Snohomish	WA	0.90	0.90	0.95	0.90	0.98	0.93	0.98	0.96	0.99	0.96	0.92	0.93	0.95	1.01	1.02	
Philadelphia	Philadelphia	PA	1.68	1.72	1.73	1.45	1.50	1.37	1.42	1.46	1.50	1.54	1.58	1.61	1.62	1.60	1.59	
	Montgomery	PA	1.16	1.18	1.23	1.07	1.13	1.17	1.19	1.20	1.22	1.23	1.17	1.18	1.21	1.22	1.23	

Coopers & Lybrand, LLP analysis of HCFA data.

Table 6. Part A as a Percentage of Total AAPCC, 1991-1995

City or Are County	State	1995	1994	1993	1992	1991
National USGCC:		63%	63%	60%	59%	58%
Phoenix Maricopa	AZ	60	59	58	57	57
Tucson Pima	AZ	59	59	57	57	57
Los Angeles Los Angeles	CA	61	60	55	54	52
Orange	CA	59	58	55	52	51
Riverside	CA	60	59	54	52	51
San Bernan	CA	63	62	58	56	54
Ventura	CA	58	57	55	51	51
San Diego San Diego	CA	61	59	55	53	51
San Franci San Franci	CA	66	66	64	62	59
San Mateo	CA	63	63	61	59	57
Denver Denver	CO	66	66	64	62	61
Daytona Be Volusa	FL	58	57	55	56	56
Miami Broward	FL	55	54	51	50	51
Dade	FL	51	51	48	49	50
Palm Beac	FL	52	51	49	48	49
Orlando Orange	FL	58	58	56	55	56
Tampa- Pinellas	FL	58	57	55	55	55
St. Peter Hillsboroug	FL	59	58	55	56	55
Pasco	FL	58	57	55	54	55
Honolulu Honolulu	HI	64	63	60	57	58
Chicago Cook	IL	69	68	66	64	63
Boston Middlesex	MA	67	67	63	62	61
Worcester Worcester	MA	69	68	64	62	61
Minneapolis Hennepin	MN	65	66	67	66	63
St. Paul Ramsey	MN	68	68	68	66	64
Albuquerque Bernalillo	NM	58	59	57	57	58
Las Vegas Clark	NV	59	57	55	53	52
New York Kings	NY	70	70	65	62	60
Queens	NY	70	70	65	63	60
Nassau	NY	66	67	63	61	58
Suffolk	NY	65	65	60	59	57
Cleveland Cuyahoga	OH	66	66	65	64	63
Portland O Multnomah	OR	67	66	65	63	60
Clackamas	OR	65	65	62	60	53
Washington	OR	67	66	64	62	60
San Antoni Bexar	TX	62	62	58	57	56
Seattle King	WA	63	62	61	61	61
Snohomish	WA	62	61	60	60	60
Philadelph Philadelphia	PA	68	67	64	62	59
Montgomer	PA	63	62	60	59	58

Coopers & Lybrand, LLP analysis of HCFA data.

Medical HMO - ~~PRG~~ Managed Care

## TALK POINTS ON NY TIMES GRIJALVA STORY

Contact: Peter Garrett 690-6149

**BACKGROUND:** The New York Times on Oct. 31 published a Robert Pear story on an Oct. 17 ruling in the Grijalva case, in which Secretary Shalala was sued for not ensuring sufficient rights to appeal decisions by HMOs to deny care to Medicare enrollees. The judge ruled for plaintiffs that beneficiaries have constitutional due process rights to appeal HMO decisions, and that the Secretary violated the Medicare statute by entering into contracts that do not meet appeal standards created by the judge.

**1) The Clinton Administration is committed to quality care and appeal rights for our Medicare beneficiaries in HMOs.**

Our HMO enrollees already have more immediate appeal rights than most private sector HMO enrollees, and than in Medicare's fee-for-service system.

**2) This Administration does have an interest in medical decisions made by HMOs for our beneficiaries.**

The quote in the sixth graph of the story is taken out of context from legal arguments over a narrow question. The brief was simply stating the obvious: that when an HMO physician makes a decision about care for one of our beneficiaries, that physician is speaking for the HMO, not for the government.

We wholeheartedly agree that Medicare HMO enrollees must have strong appeal rights. But the finding of a constitutional due process right to appeals could have far-reaching unintended consequences.

**3) We are developing even tougher new rules to protect beneficiaries who feel their HMO is denying urgently needed care.**

HCFA is preparing to publish a proposal to require plans to respond very rapidly to appeals regarding urgently needed care, and to require HCFA itself to respond very quickly to denials of these appeals (within days).

## TALK POINTS ON GAO REPORT ON MEDICARE HMOS

Contact: Peter Garrett/HCFA Press Office/690-6145

**BACKGROUND:** A General Accounting Office report is expected to be released on Thursday, "*HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance.*" It says Medicare beneficiaries should be given comparative consumer guides for managed care plans.

Here is our response:

1) This Administration stands behind its record of offering greater choice to Medicare beneficiaries. Each month more than 80,000 seniors voluntarily choose Medicare managed care plans. The total number of beneficiaries in managed care is doubling every three years.

2) We agree with the GAO report that more can and should be done to help our beneficiaries make informed choices about managed care plans. As the GAO report notes and Senator Pryor from the Aging Committee acknowledges, HCFA has several initiatives underway which "move in the right direction."

*If asked:*

3) The consumer information system proposed in the GAO report could potentially be worthwhile. But because of Medicare's size and the continuous enrollment policies of most of our contracting plans, it would require a much more expensive, extensive and complicated effort than in the private sector. Within current budget constraints, we are working to make more information available in an economical and easy-to-update electronic format.

###

Grijalva, et al. v. Shalala, (U.S.D.C. Arizona, Oct. 17, 1996)  
[Senior District Judge Alfredo C. Marquez]

The federal District Court for Arizona, in a nationwide class action by Medicare HMO enrollees, ruled against the Secretary for failing adequately to ensure that HMOs provide all Medicare covered benefits and afford enrollees proper appeal rights.

The court ruled that (i) Medicare HMO enrollees are denied constitutional due process under the current enrollee appeals process, and (ii) that the Secretary has violated the Medicare statute by entering into Medicare contracts with HMOs that do not meet appeal standards created by the judge.

The decision is confused and confusing but seems to say that HMO Medicare beneficiaries seeking acute care services are entitled, by constitutional and statutory right, to immediate hearings at their HMOs and appeals to contest decisions not to provide those services.

While federal law grants such beneficiaries the right to contest service denials, the judge determined that much speedier hearings were required and that certain very specific processes (beyond those in our statutes and regs) must be implemented by Medicare HMOs.

The court ordered the plaintiffs, within 20 days, to propose a form of judgment to implement the court's decision.

If this decision were affirmed on appeal -- which is unlikely -- it would have implications for fee-for-service Medicare beneficiaries as well. For example, it could be read to make an individual provider's decision to refuse services to a Medicare beneficiary subject to immediate constitutional due process challenge.

HCFA's HMO unit is currently reviewing our regs on hearings and appeals to make them both more consumer friendly and to insure their widespread implementation. Also, we anticipate the imminent release of an IG report finding that over 3/4 of Medicare HMO beneficiaries know they have appeal rights though most don't use them because most such procedures are consumer unfriendly.

The Justice Department will appeal in Grijalva because the legal basis of the ruling is badly flawed. Nonetheless, the Department will take care to distinguish our litigation posture from our commitment HMO Medicare beneficiaries' consumer rights including those that allow challenges to service denials.

File: Medicare HMO's

October 31, 1996

FOR IMMEDIATE RELEASE

**GAO REPORT SAYS GOVERNMENT SHOULD DO A BETTER JOB  
OF GETTING INFORMATION ON HMOS TO MEDICARE BENEFICIARIES**

WASHINGTON, D.C. -- Senator Bill Cohen, R-Maine, and Senator David Pryor, D-Ark., chairman and ranking member respectively of the Senate Special Committee on Aging, released a report today outlining the difficulties facing Medicare beneficiaries seeking unbiased, comparative information on health maintenance organizations (HMOs).

Joining Cohen and Pryor in releasing the study, prepared by the General Accounting Office, were committee members Charles Grassley, R-Iowa; John Breaux, D-La.; Russ Feingold, D-Wis.; and Ron Wyden, D-Ore.

The report, "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance," also analyzed disenrollment rates in the Los Angeles and Miami Medicare HMO markets and found large differences in how many Medicare beneficiaries leave their HMOs within short periods of time.

"Almost four million Medicare beneficiaries are now enrolled in HMOs and this number is growing rapidly. But even though Medicare is the largest purchaser of managed care services in the nation, it lags far behind other purchasers in telling how plans compare and how well plans are doing," Cohen said.

"The hoops that we make Medicare beneficiaries jump through to get accurate and understandable information are absurd. We have to do a much better job of making information available to senior citizens so they can have confidence that they are making the correct decision for themselves."

"The findings," Pryor said, "show how challenging it currently is for beneficiaries to

decide which HMO is best for them. I am heartened, however, by the recently announced initiatives by the Health Care Financing Administration (HCFA) to help beneficiaries make more informed choices by making available current, comparative information on cost and benefits, and other plan information, for all health plans. I also want to commend the government for requiring in 1997 Medicare HMOs to report on HEDIS (Health Plan Employer Data Information Set) measures."

"Without a doubt, Medicare beneficiaries need reliable information about available benefit packages in order to choose a plan that meets their needs," said Grassley. "This report illustrates that HCFA could do more for Medicare beneficiaries by making available the vast amount of information it collects on HMOs serving Medicare beneficiaries."

"The more older Americans know about their health care options, the more likely they are to choose a plan that meets their medical needs," Breaux said. "I would support any additional efforts the administration can make to provide seniors with quality information about their Medicare options."

Wyden noted that "the burden of figuring out benefit and cost comparisons among HMOs falls exclusively on the beneficiary. This is not right. We cannot expect beneficiaries to rely solely on television ads when deciding whether to join an HMO. Seniors need truthful, standardized plan descriptions in order to make appropriate choices."

"It is time," said Feingold, "to follow the lead of other large purchasers of health care that start their beneficiaries' decision process with summary charts comparing plans."

In the last two years there has been a dramatic increase in the number of Medicare beneficiaries who have signed up for Medicare HMOs, and Medicare is now the largest purchaser of managed care services. But it does not provide the same help as other large purchasers in helping beneficiaries choose among HMO plans, according to GAO. Medicare beneficiaries have the option of leaving traditional fee-for-service Medicare and enrolling in a Medicare-approved "risk" HMO if one is available in their area. Such enrollments rose more than 80 percent between August 1994 and August 1996.

Other private and public organizations, such as the federal employees' health benefit

program, the California Public Employees' Retirement System and many private companies provide comparative information and guidance about HMO options and services. But the report pointed out that it is often confusing and difficult for Medicare beneficiaries to get the same information.

GAO found that a beneficiary would have to call a toll-free number from Medicare to get the names of available HMOs and contact each individual plan to get details about premiums, benefits and providers. Beneficiaries would then have to compare each plan's benefits, which would not be in a standard format or terminology.

GAO focused its study on Medicare HMOs in Los Angeles and Miami, which together enroll 89 percent of Medicare beneficiaries who are in managed care.

To remedy the problems, GAO recommended that the secretary of Health and Human Services:

- \* Require standard formats and terminology for key aspects of HMO information materials for beneficiaries.

- \* Produce benefit and cost comparison charts.

- \* Widely publicize the availability of the charts to all beneficiaries in markets served by Medicare HMOs.

- \* Annually analyze, compare and disseminate widely HMOs voluntary disenrollment rates, rates of inquirers and complaints and the summary results of HCFA's monitoring visits.

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Medicare HMO Risk

## **Medicare at Thirty**

### **A Program in Need of Strengthening**

*A GHAA Discussion Paper*

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## Introduction

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When Medicare, the national program of health insurance for the elderly, was enacted in 1965, the overwhelming majority of insured Americans received their health care under the then-predominant fee-for-service approach. At a time when health care was generally much less complex and bewildering than today, coordination of care was not as essential as it is now. At a time when treatment costs were a fraction of what they are today, cost containment was not an urgent national concern.

Measured in terms of the security that it brought to the elderly, Medicare has been — despite limitations in coverage — a success. Measured by other criteria, however, Medicare after 30 years is clearly in need of modernization.

When Medicare was enacted, health maintenance organizations and other integrated health plans were not yet available to most Americans. And the advantages of coordinated care — including preventive care, quality measurement, management of chronic conditions, and the ability to provide comprehensive care within a budget — were not yet fully apparent.

Thirty years later, much has changed. Americans by the millions have joined HMOs and, as consumer satisfaction surveys show, are overwhelmingly satisfied with the care they and their families receive. The disadvantages of the old fee-for-service approach — including poor coordination of services, limited accountability, and high costs — are prompting more consumers to choose coordinated-care plans as a superior alternative.

As a result, more than 60 percent of all working Americans with private health insurance coverage now receive their care through HMOs or other network-based plans. Change is coming to government insurance plans, also. About 35 percent of federal employees have chosen HMOs from among the wide array of coverage choices offered. Medicare, too, is changing — but more slowly. Only about 10 percent of today's Medicare beneficiaries are in HMOs — in part because of unfamiliarity with the advantages of coordinated care, and in part because of limited choices.

Working Americans have many choices and many reasons to choose HMOs, including the quality of care and the availability of superior benefits at predictable cost. Under Medicare's prevailing fee-for-service structure, however, beneficiaries have been offered no such advantages — and Medicare has lagged far behind the private sector in implementing reforms.

Without reform, Medicare faces insolvency in just a few years. But the good news is that modernization of Medicare is feasible and within reach. The key is to rely more on high-quality, cost-effective coordinated care — by providing Medicare beneficiaries with the health plan choices that are already available to Members of Congress and other working Americans.

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## Guiding Principles for Discussion

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The Group Health Association of America (GHAA) believes that Medicare must be changed to reflect the dramatic developments that have occurred in the private sector since the program began. Medicare can best be strengthened by offering beneficiaries the same kinds of choices that are already available to millions of working Americans both in the private sector and in the federal government. Medicare beneficiaries should have the opportunity to choose from a broad array of options that compete on the basis of quality, service, and cost and are held to comparable accountability standards. When beneficiaries can choose the option that best meets their needs, Medicare will at last benefit from the progress that has been made in the private sector.

**Beneficiary choices:** Medicare reforms should be consistent with the promise of providing access to basic Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population.

- ▶ Beneficiaries should be able to choose from an expanded range of options, including benefit offerings by HMOs, PPOs, PHOs and other entities, as well as the traditional fee-for-service Medicare program, and should have the opportunity to change options periodically. All benefit offerings should meet comparable standards.
- ▶ Beneficiaries should receive information that allows them to compare all options available to them in order to choose the one that best meets their needs.
- ▶ Attempts to limit choice by inhibiting the development of HMOs and other network-based options, such as anti-managed care proposals and changes to current anti-trust law, should be rejected and where such anti-managed care laws exist, they should be preempted.

**Medicare standards:** All network-based offerings and providers under the fee-for-service Medicare program should meet comparable standards.

- ▶ Standards should be designed to address quality of care, access, grievance procedures and, for options other than the Medicare fee-for-service program, solvency.
- ▶ All network-based offerings and fee-for-service providers should be accountable for their performance in providing services to Medicare beneficiaries and should provide reports based upon comparable measures of quality.

- ▶ HCFA should make administrative improvements to the regulatory process, including:
  - Promoting consistency of regional office decisionmaking in such areas as approval of contracts, products, and marketing materials;
  - Simplifying application, review, and approval processes for initial applications and service area expansions;
  - Streamlining oversight of multi-state organizations; and
  - Providing better information to beneficiaries about the types of choices available to them.

**Medicare payments:** Medicare payments should permit widespread availability of network-based and fee-for-service options to Medicare beneficiaries nationwide.

- ▶ The Medicare program would act in a fashion similar to private sector purchasers by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis. Total expenditures should be trended forward on an appropriate basis to meet goals for program growth.
  - + Participating entities should establish their premiums for Medicare covered benefits and any additional benefits they offer to Medicare beneficiaries through network-based options. Medicare establish payment amounts on a basis that results in an equitable allocation of resources between these options and the fee-for-service program.
  - + Medicare should continue to pay claims under the fee-for-service Medicare program as it currently does. A periodic determination should be made about whether expenditures are within the desired range, and a framework should be established for adjusting the program in light of this determination.
- ▶ Problems that exist in low payment areas under the current payment system for HMOs should be addressed, but any change must preserve the vitality of markets in which significant numbers of Medicare beneficiaries have already joined HMOs.

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## Where to Begin

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To begin updating the Medicare program, changes should be phased-in to provide the capacity and experience to prepare for a future Medicare program that relies extensively on beneficiary choice and private sector market forces. The following changes are designed to foster expansion in existing Medicare markets, encourage new Medicare markets to emerge, permit the development of increased capacity for Medicare beneficiaries to enroll in network-based options offered by HMOs and other entities, and provide the experience necessary to permit informed decision-making by the Congress on the future design of the Medicare program.

### Improve Beneficiary Information, Awareness, and Enrollment Process

- ▶ Information/awareness: The Health Care Financing Administration (HCFA) should work with entities that participate in the Medicare program, including HMOs and in the future, other arrangements, to develop information that HCFA could disseminate to beneficiaries about the enrollment options available to them. This information should be sent to all prospective beneficiaries in the six-month period prior to their becoming eligible for Medicare, and periodically thereafter.
- ▶ Enrollment: HCFA should develop a mechanism that would allow newly-eligible beneficiaries to elect HMO enrollment that is effective the first month they become entitled to Medicare, rather than requiring them to wait (and be uncovered for supplemental benefits) until the second month.

### Expand the Infrastructure of Health Plan Choices Available to Beneficiaries

- ▶ Self-referral option: HCFA should continue its work to develop guidelines that would permit HMOs to offer a point-of-service (POS) product through what HCFA is referring to as a "self-referral option" (SRO) for Medicare beneficiaries. Plans would then be allowed to offer beneficiaries a product that would enable them to go outside their network to receive covered services.
- ▶ Expanded array of choices: A broader spectrum of choices should be phased-in for Medicare beneficiaries by encouraging the availability of an expanded array of benefit offerings by HMOs and other entities under rules that permit all to participate on an equal footing.
- ▶ Reformed medical education system to enhance effectiveness of practitioners in new environment: The growth of HMOs and other organized delivery systems requires reform of medical education programs and funding designed to increase the supply of primary care physicians and to improve and expand training opportunities that

will prepare physicians to practice effectively in HMOs and other network-based settings.

### Phase-in Improvements in Medicare Payment Methodologies

- ▶ Immediate improvements in AAPCC: Make immediate improvements in the current methodology for paying HMOs:
  - + The "adjusted average per capita cost " (AAPCC) is currently calculated for each county. In order to make rates more stable and reflective of area-wide service costs, the AAPCC should be calculated for each Metropolitan Statistical Area or New England County Metropolitan Area and for the remaining portion of the state that does not fall within such areas.
  - + The unadjusted fee-for-service component of the AAPCC should be calculated directly. At present, this estimate of per capita spending for the Medicare "fee-for-service" program is calculated indirectly, by taking historical data on total Medicare spending (including payments to HMOs) and historical data on payments to HMOs, "trending" both forward by the same inflation factor, and subtracting the latter from the former. Instead, Medicare should simply use historical data on fee-for-service spending and trend it forward for inflation in the fee-for-service sector.
- ▶ Phasing-in a revised Medicare payment mechanism: Phase-in a method of payment that would provide greater opportunities for beneficiaries to choose options that deliver high quality, cost-effective care. The payment mechanism would permit network-based options to establish premiums for the benefits they offer and would establish a government contribution on a basis that results in an equitable allocation of resources between these options and the fee-for-service Medicare program.

Medicare would pay a risk-adjusted amount on behalf of beneficiaries who elect to enroll under a network-based option and would continue to pay claims as it currently does for beneficiaries in the fee-for-service program. Total funding could be trended forward on whatever basis is appropriate to meet program goals. Such a system would promote the expansion of existing markets and the creation of new markets for private sector offerings for Medicare beneficiaries.

- + Payments should be structured to support the objective of making network-based options available in all areas of the country and to address problems that exist in low payment areas.
- + The starting point should be the payment methodology under the current Medicare risk contracting program. Any change in that methodology should be phased-in in a manner that does not disrupt health care for beneficiaries who have already elected HMO membership and that

preserves the vitality of markets in which significant numbers of Medicare beneficiaries have already joined HMOs.

- + Under this system, network-based options would have the flexibility to offer benefit packages that include standard Medicare benefits, or greater coverage, for the premiums they have developed, whether those premiums are greater than, equal to, or less than the government contribution.
- + Under rules that preserve marketplace equity among participating offerings, network-based options should be permitted to elect cost-based reimbursement under the fee-for-service program, as well as risk-based payment.
- ▶ Demonstrations on implementing risk adjusters: HCFA should conduct research and demonstrations on mechanisms for implementing the different types of risk adjusters that have been identified to make incremental improvements in the accuracy of payment calculations. The demonstrations should be designed to identify the administrative issues and costs involved for HMOs and other entities offering network-based options and for HCFA in implementing these models. Progress on these issues will permit the agency to work with participating entities to move to the next step of implementing appropriate risk adjusters.
- ▶ Demonstrations on alternative payment methods: HCFA should continue to explore the feasibility of alternative payment systems, such as other market-based approaches and mechanisms that will support participation by entities offering network-based options in rural and other less populous areas. The projects should continue to encourage voluntary participation and should identify issues related to the design and implementation of alternative systems.

### Maintain Strong Standards for Health Plans Participating in Medicare

- ▶ Comparable standards for options: All network-based offerings, such as those offered by HMOs, PPOs, and PHOs, and providers under the Medicare fee-for-service program should meet comparable standards designed to address quality of care, access, grievance procedures and, in the case of network-based offerings, solvency.
- ▶ 50/50 rule: Statutory criteria in connection with waiving the 50/50 enrollment requirement for HMOs and other organizations offering network-based options should be developed.
- ▶ Deemed status: To enhance and streamline Medicare's quality assurance program, network-based offerings that meet accreditation standards of private sector organizations designated by the Secretary should be deemed to comply with applicable Medicare quality standards.

## Improve HCFA Administrative/Processing Mechanisms

- ▶ Administrative procedures and processing of applications: HCFA should take immediate steps to improve administrative procedures and processing time:
  - + reduce the time it takes to process and approve two types of applications from HMOs: initial applications from HMOs to serve Medicare beneficiaries and applications from approved plans to expand their service areas and be able to serve additional Medicare beneficiaries;
  - + simplify administrative procedures for submission and processing of applications (i.e., permit information associated with the application to be submitted on computer disk); and
  - + streamline oversight of multi-state organizations, for example by eliminating duplicative filing requirements and facilitating communications among regions.
  
- ▶ Beneficiary information: HCFA should provide educational information to beneficiaries about the basic characteristics of the choices available to them.
  
- ▶ Regional variations in policy guidance and decision making: HCFA should take steps to narrow the variation in interpretation of HCFA policies by regional offices and promote consistency in decision making by regional offices in such areas as review and approval of contracts, products and marketing materials; this should include the development and issuance of guidelines for regional offices.

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Medicare HMO File

# MEDICARE AT 30:

*An Opportunity for  
All Americans*

**A GHAA Discussion Paper  
July 1995**

**GHAA**

**GROUP HEALTH ASSOCIATION OF AMERICA**



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March 23, 1995

Chris Jennings  
Health Policy Advisor  
Room 216  
Old Executive Office Building  
Washington, D.C. 20500

Dear Chris:

Thank you for meeting with Dennis Hall, Homer Lloyd and me during our recent visit to Washington.

As mentioned, we have sincere concerns regarding the magnitude of proposed cuts in the Medicare and Medicaid programs. During our visit to Washington, members of the Alabama Congressional delegation warned us that total Medicare cuts could amount to between \$85 billion and \$110 billion. In addition, Medicaid will be shifted entirely to the states and financed by a federal block grant. Since the adoption of these proposed changes would significantly impact us, we would appreciate your keeping us informed as to the status of these proposals.

It would be a distinct honor for the Baptist Health System to work with the Administration on health care reform issues. Perhaps we could testify to the success associated with the Medicare HMO program.

Please don't hesitate to call on us if we can be of any assistance in the important work that lies ahead.

Sincerely,

Judi McGuire  
Corporate Director  
Governmental Relations

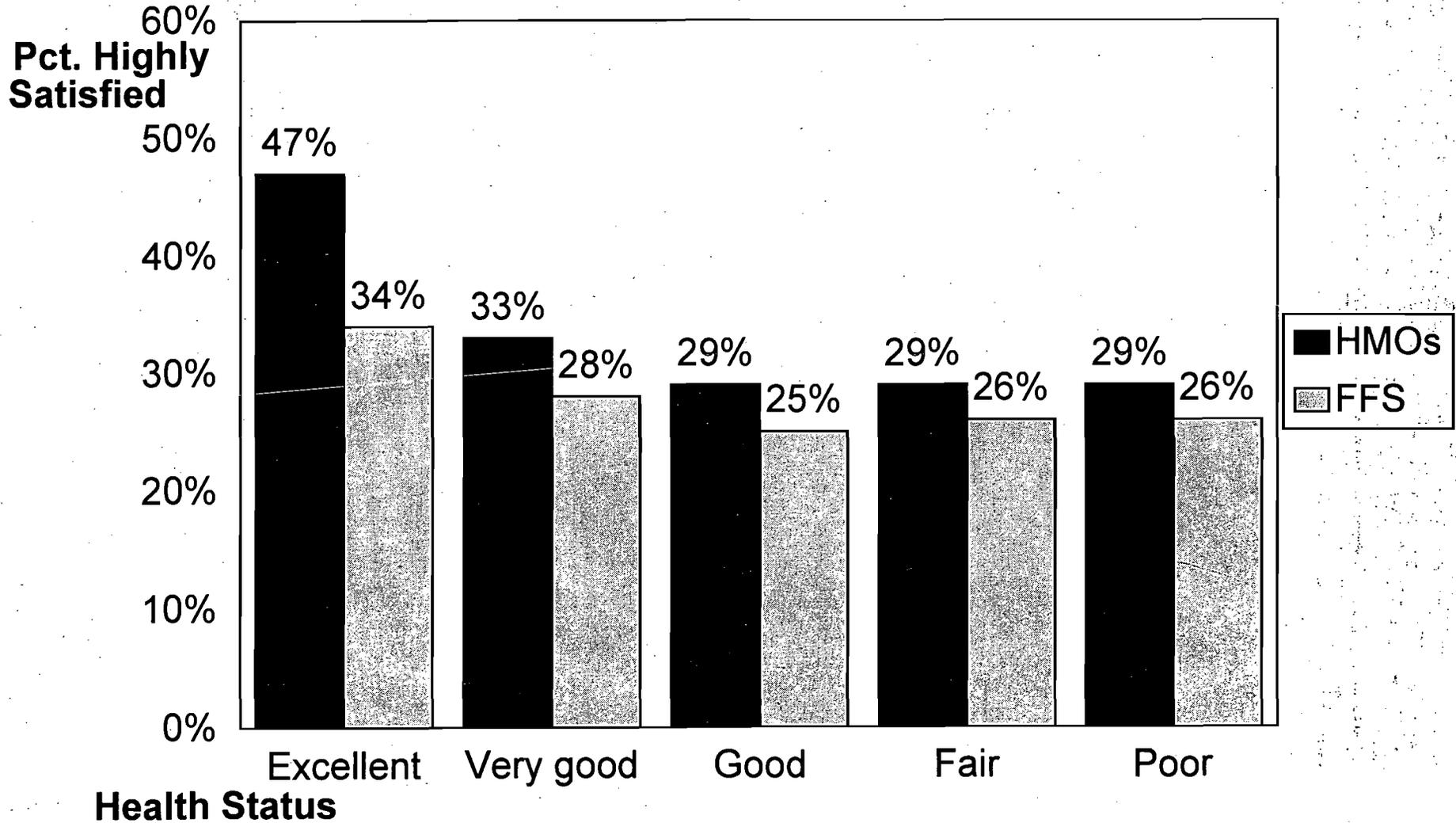
JMcG/cr

Stacey  
Pl. Forward to  
Marilyn & Barbara FUS  
Thanks

Figure 1

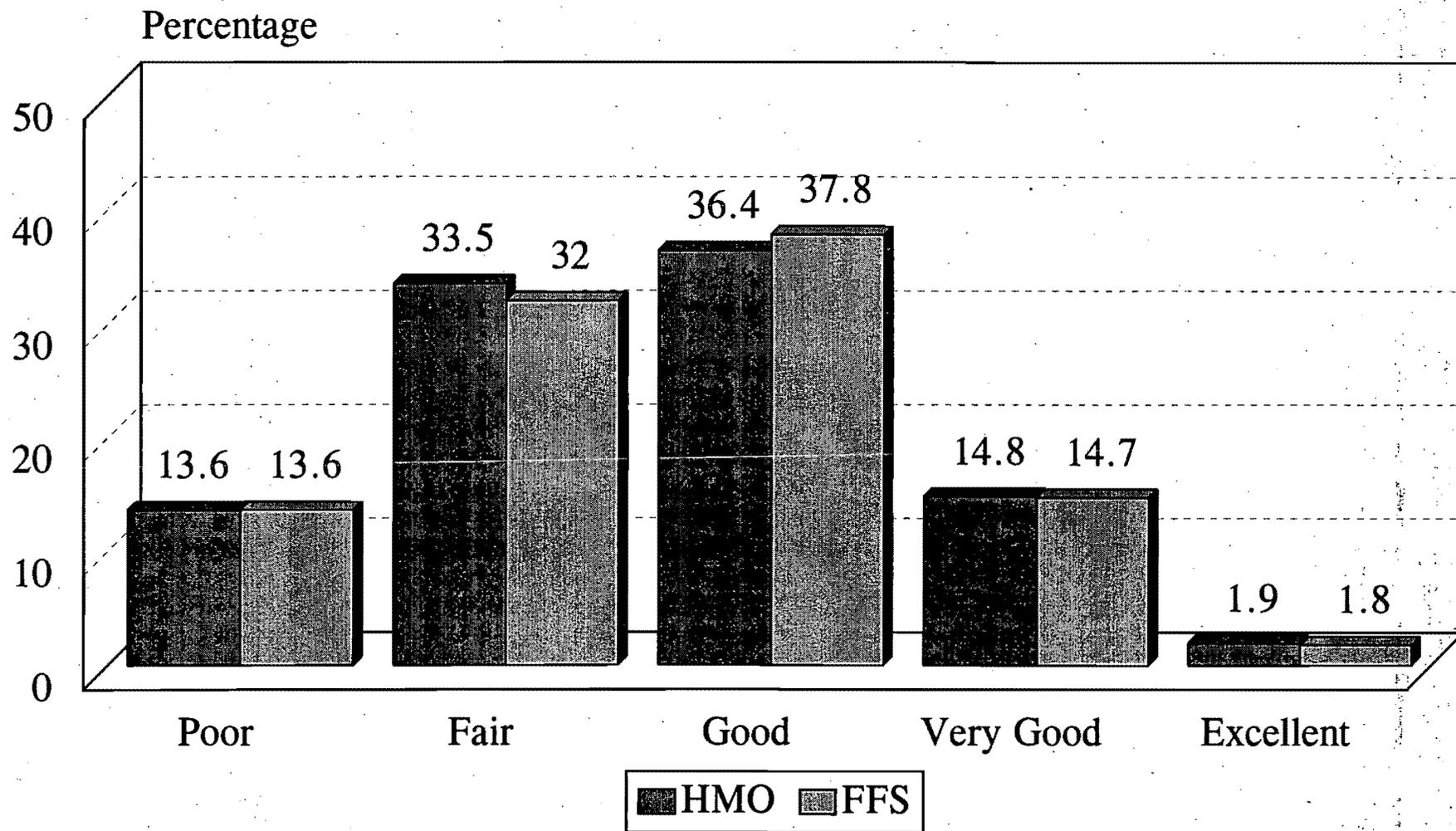
Medicare HMO file

# Medicare HMO Members Are More Satisfied with Their Coverage than Medicare Fee-for-Service Beneficiaries, for All Levels of Health Status.



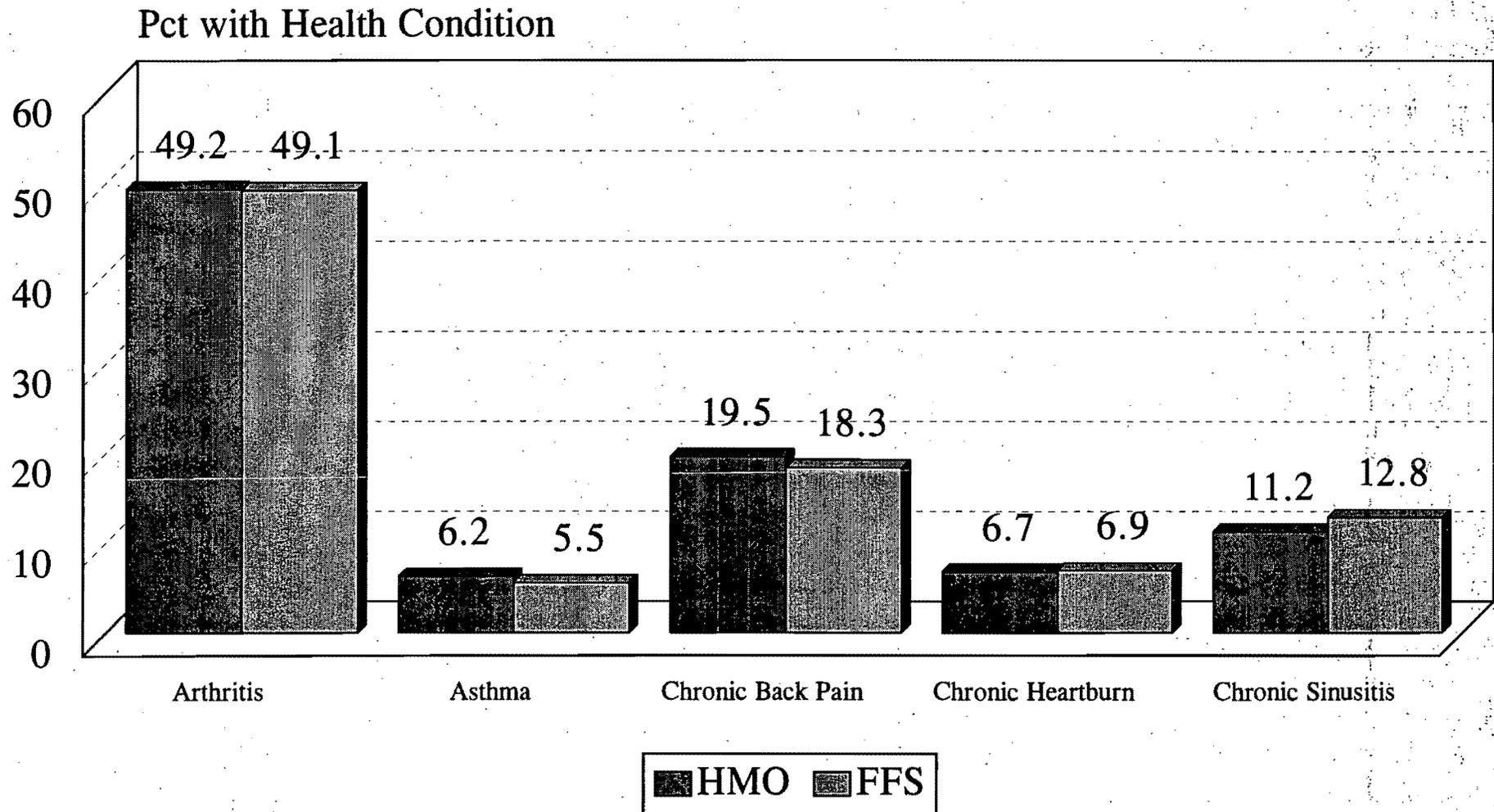
National Research Corporation Survey of 19,523 Elderly Households, 1994

# Elderly Members in an HMO or FFS Have Similar Perceived Health Status



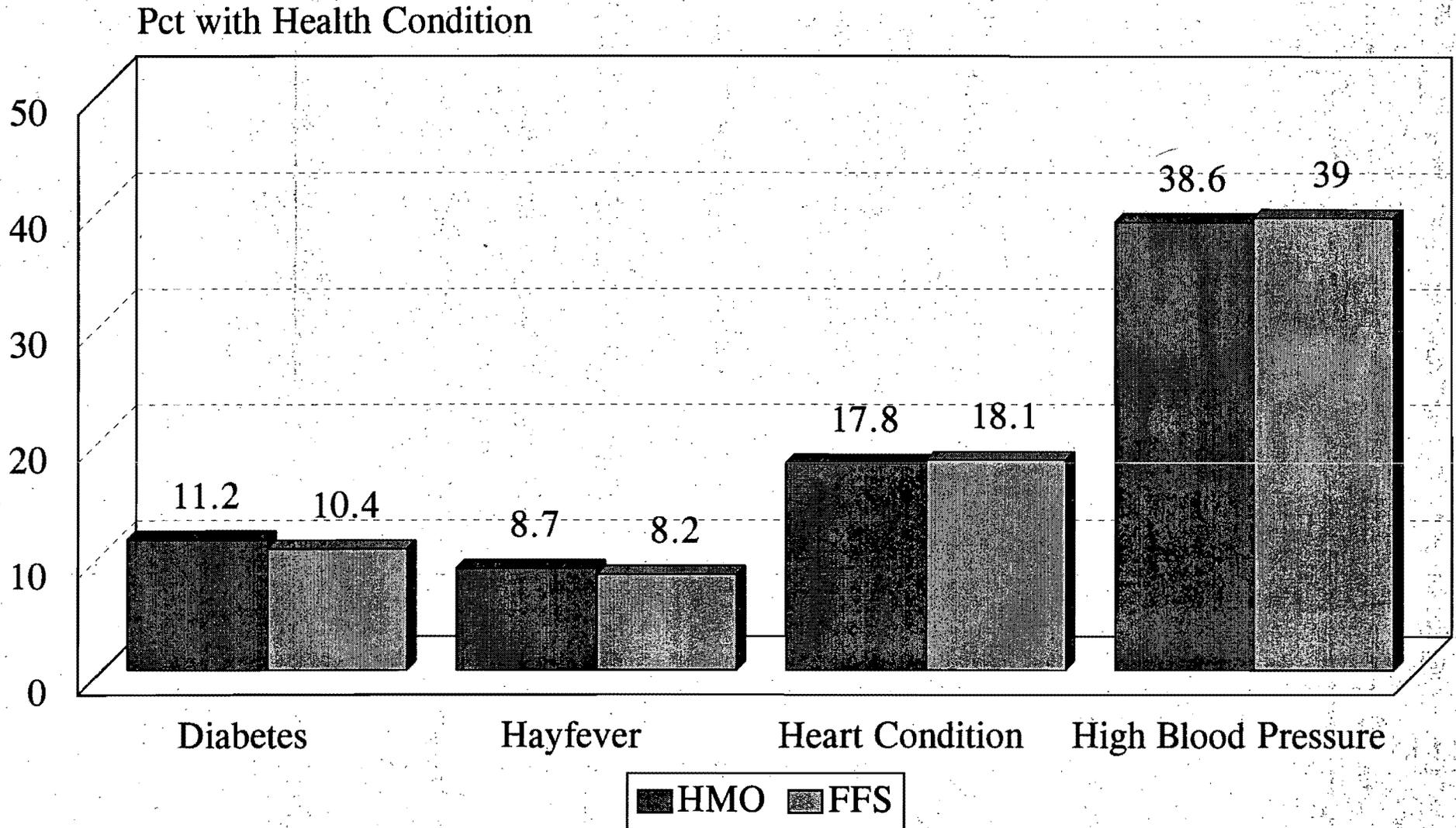
Source: National Research Corporation Healthcare Market Guide, 1994  
Sample size: 14,695

# HMO Elderly Members with Chronic Health Conditions Look Similar to FFS Members



Source: National Research Corporation Healthcare Market Guide, 1994  
Sample size: 14,695

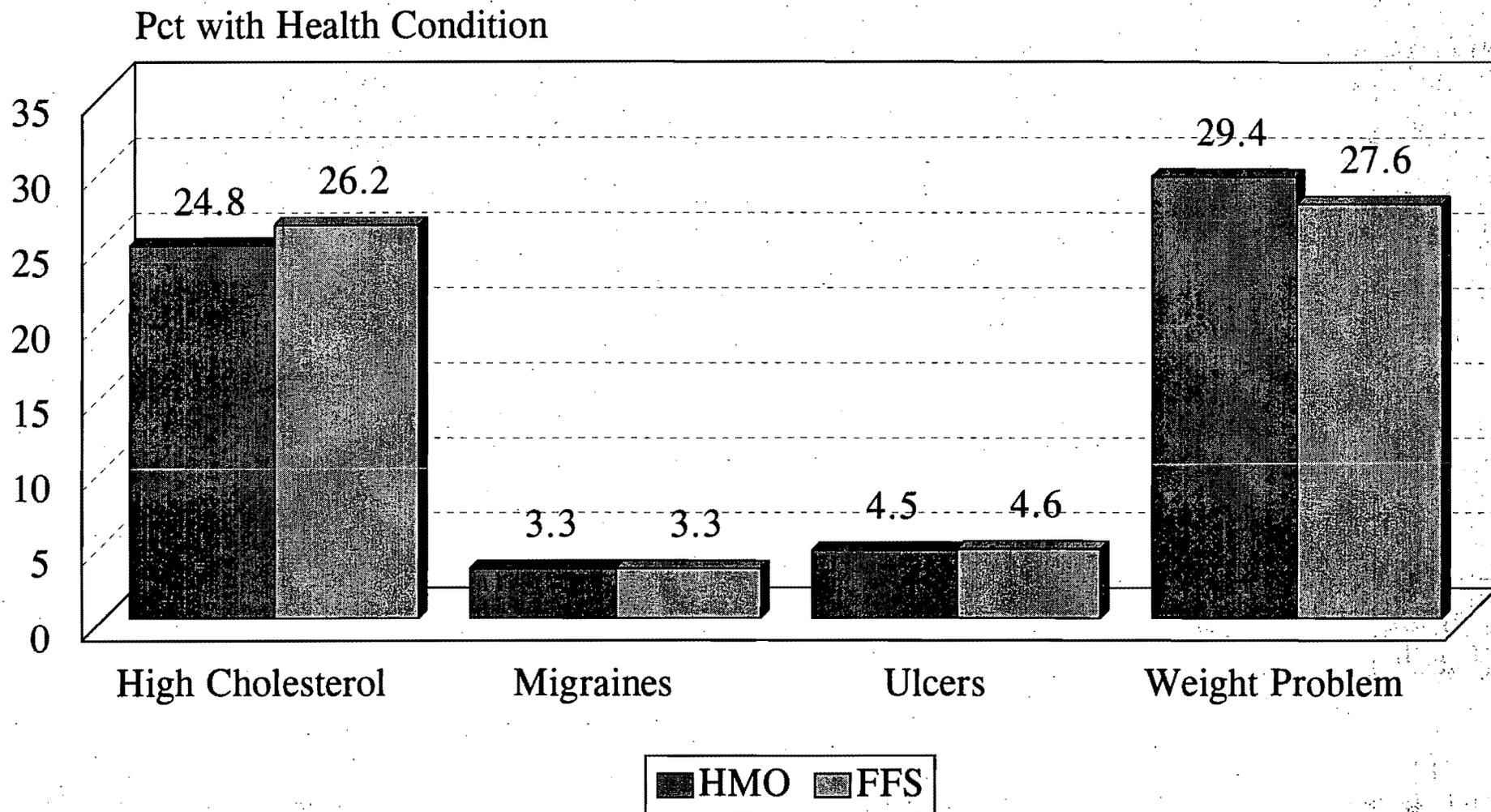
# HMO Elderly Members with Chronic Health Conditions Look Similar to FFS Members (cont.)



Source: National Research Corporation Healthcare Market Guide, 1994

Sample size: 14,695

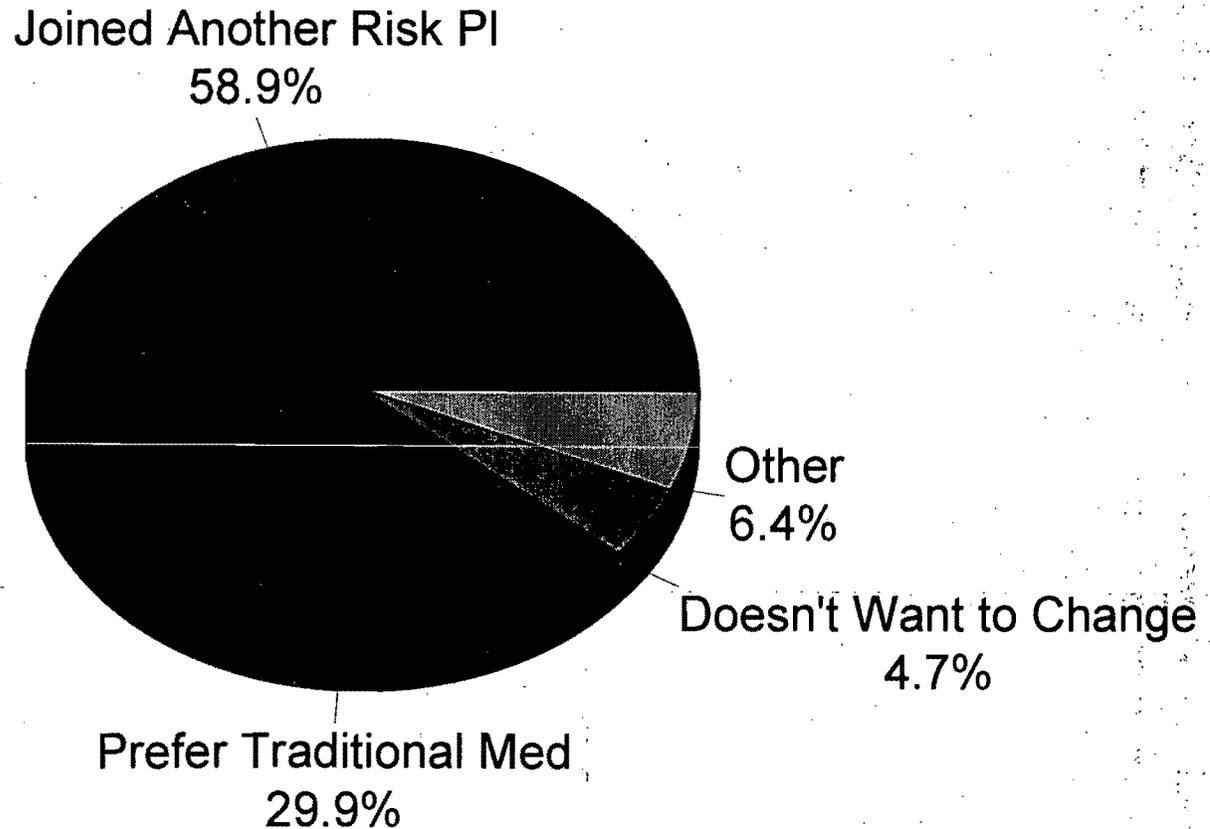
## HMO Elderly Members with Chronic Health Conditions Look Similar to FFS Members (cont.)



Source: National Research Corporation Healthcare Market Guide, 1994  
Sample size: 14,695

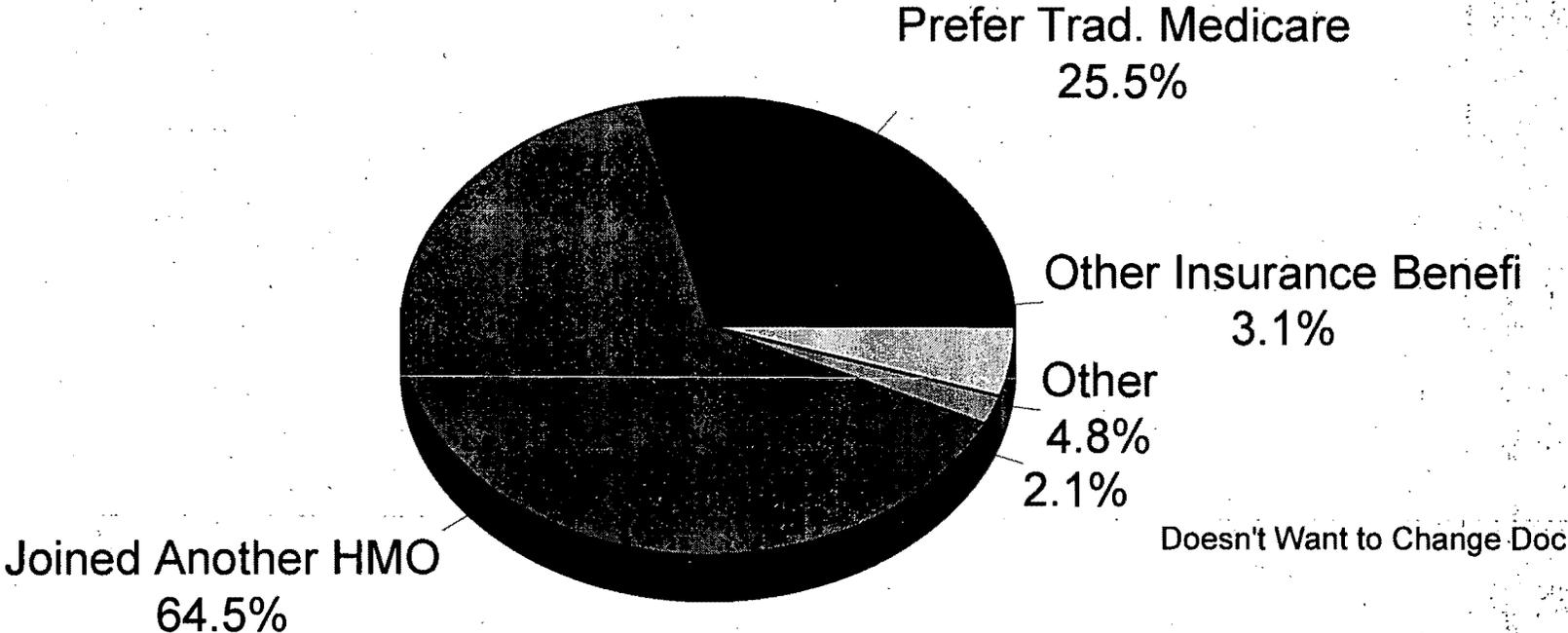
# Plan Y

## Most Voluntary Disenrollees Move to Another Risk Plan

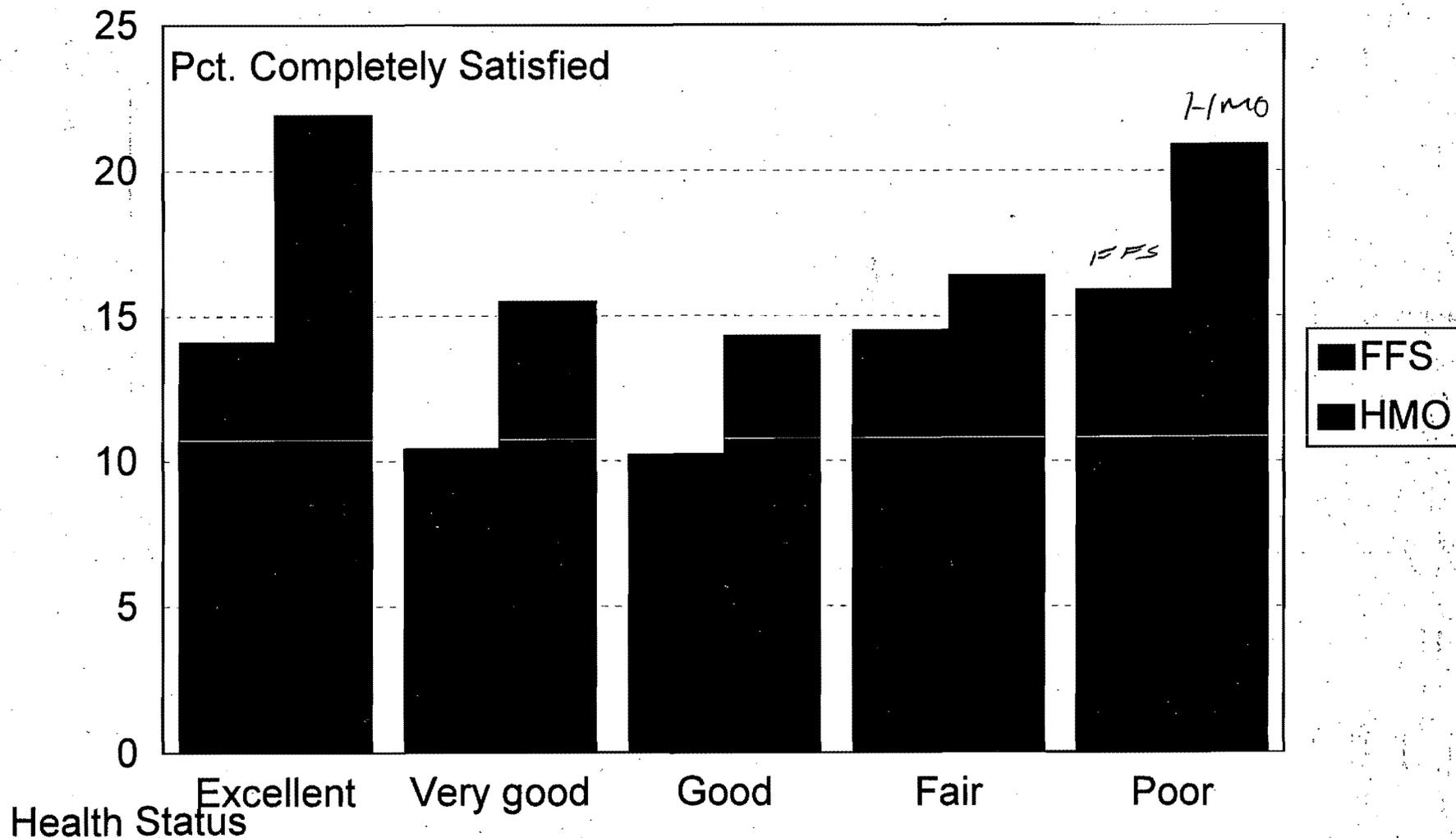


Note: Voluntary Disenrollments Constitute .68 Percent of membership.

# Plan X: Most Voluntary Disenrollees Joined another HMO

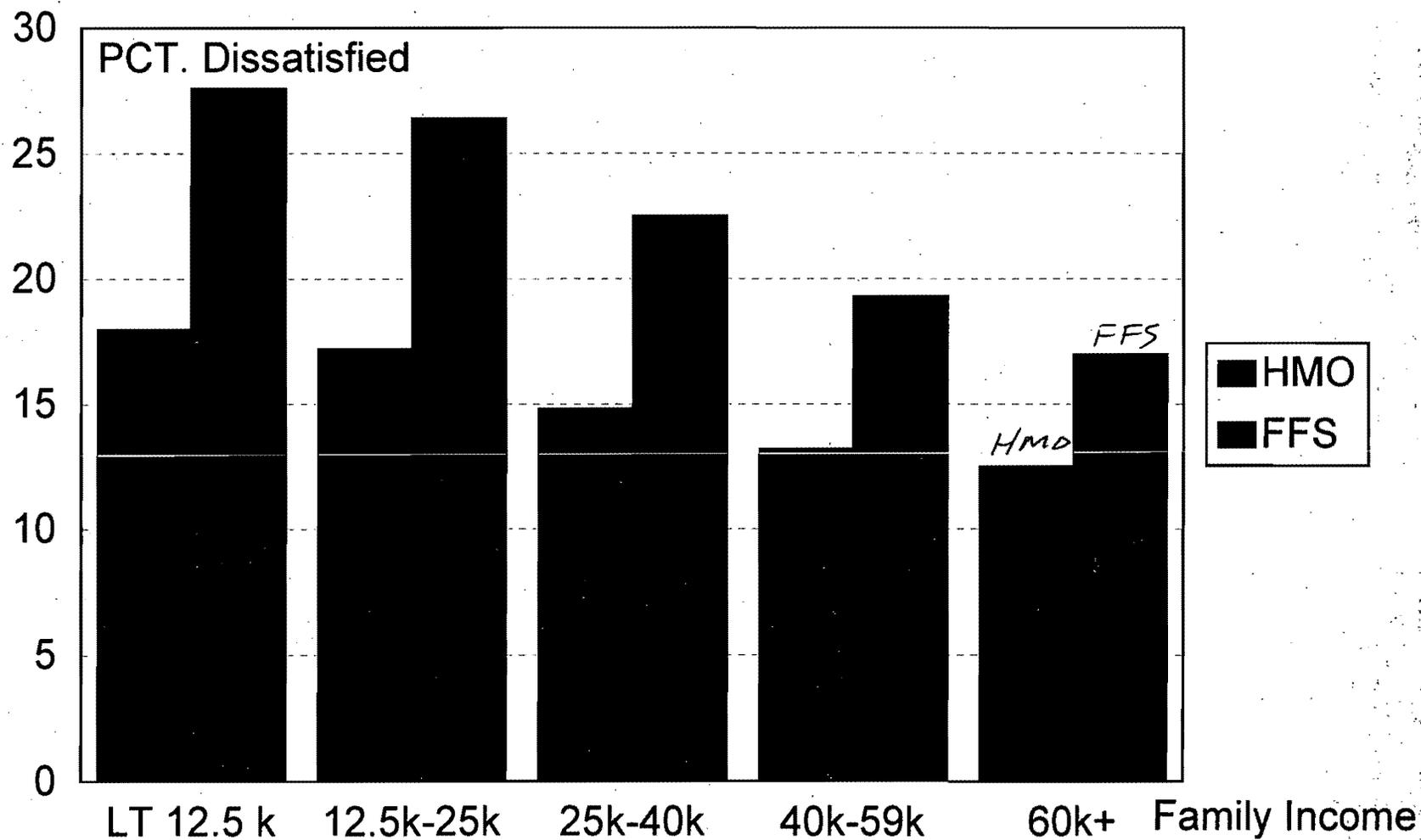


For All levels of Health Status, HMOs Outscore FFS in Percentage of Subscribers That Are "Completely Satisfied" Overall with their Health Plan.



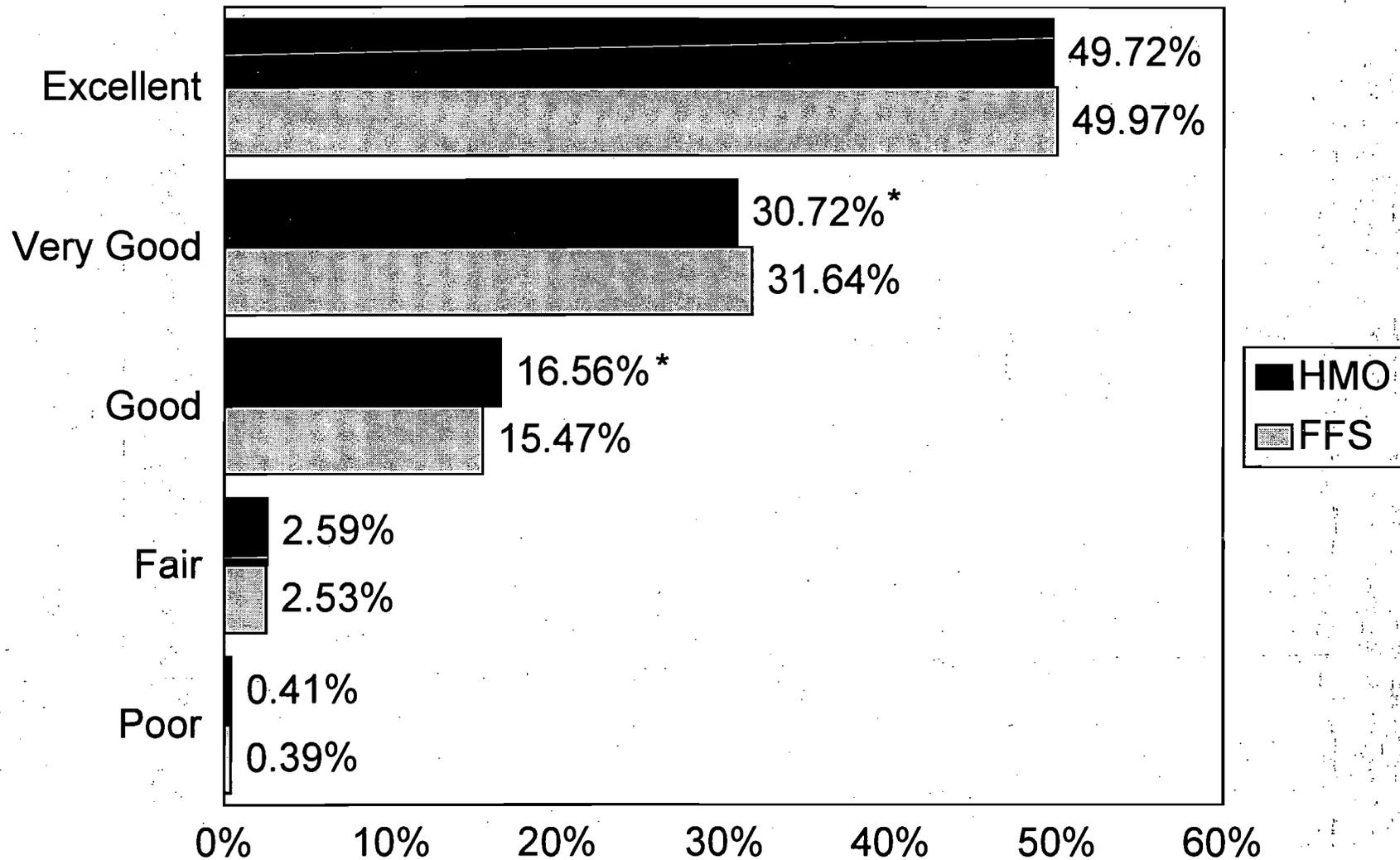
Source: NRC survey of 72,442 Households (Under 65)

For all income levels, fewer Americans are dissatisfied with HMO than FFS coverage.



Source: NRC Survey of 132,014 U.S. Households

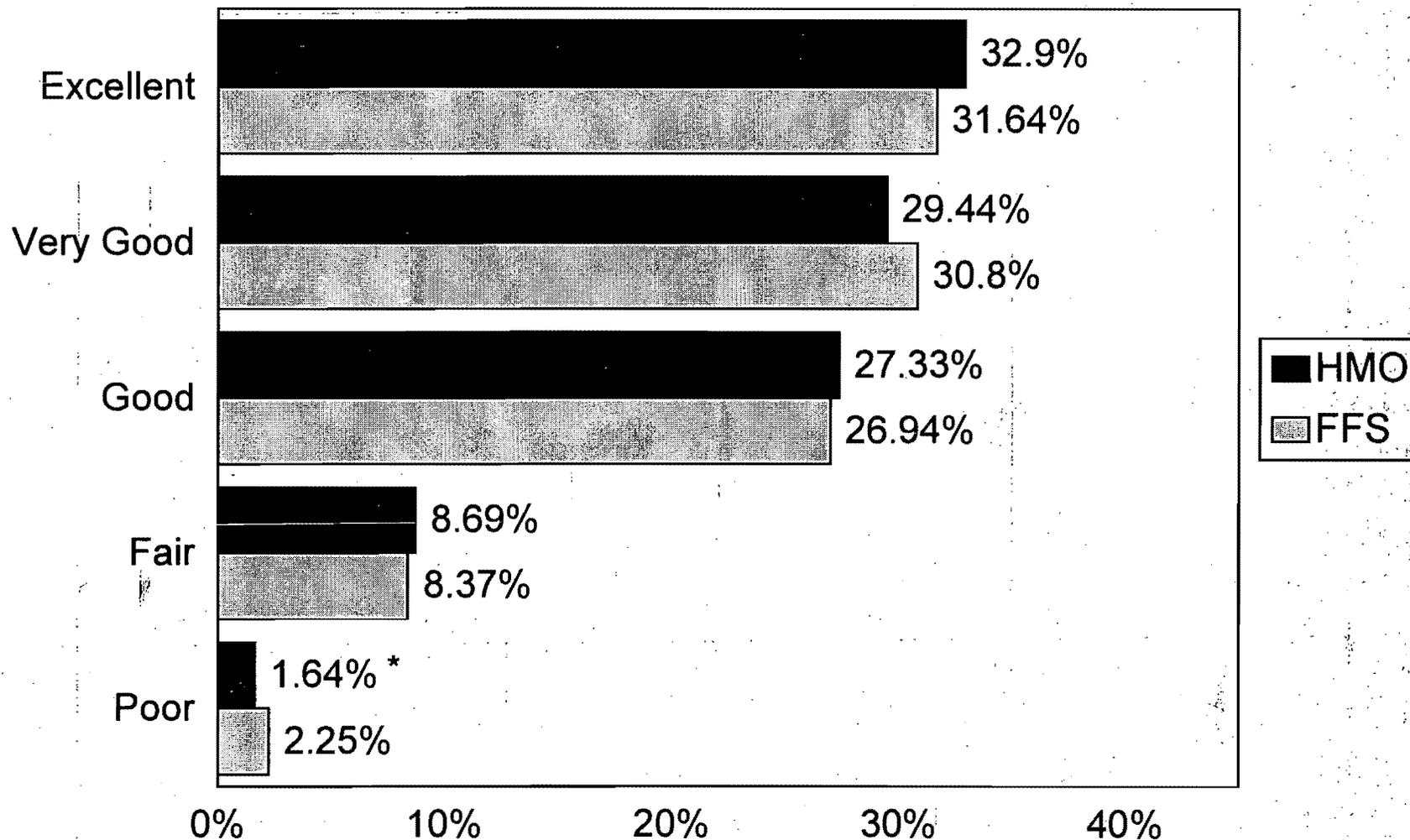
# Self-reported Health Status, HMO versus FFS, Under Age 45



\*Percentage is significant at  $p < .05$ , compared with indemnity plans.

Source: National Center for Health Statistics, 1992 Health Interview Survey

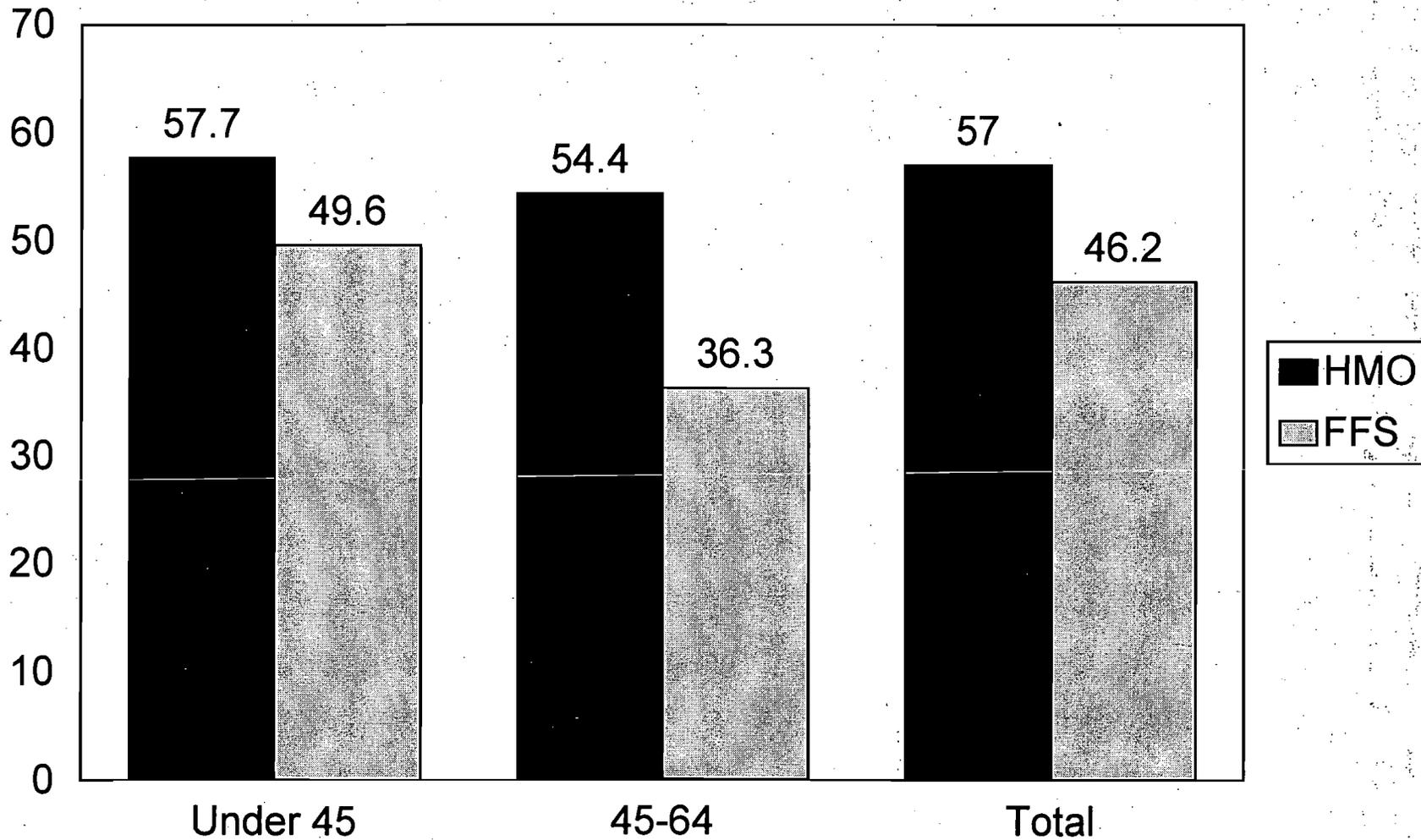
# Self-reported Health Status, HMO versus FFS, Age 45-64



\*Percentage is significant at  $p < .05$ , compared with indemnity plans.

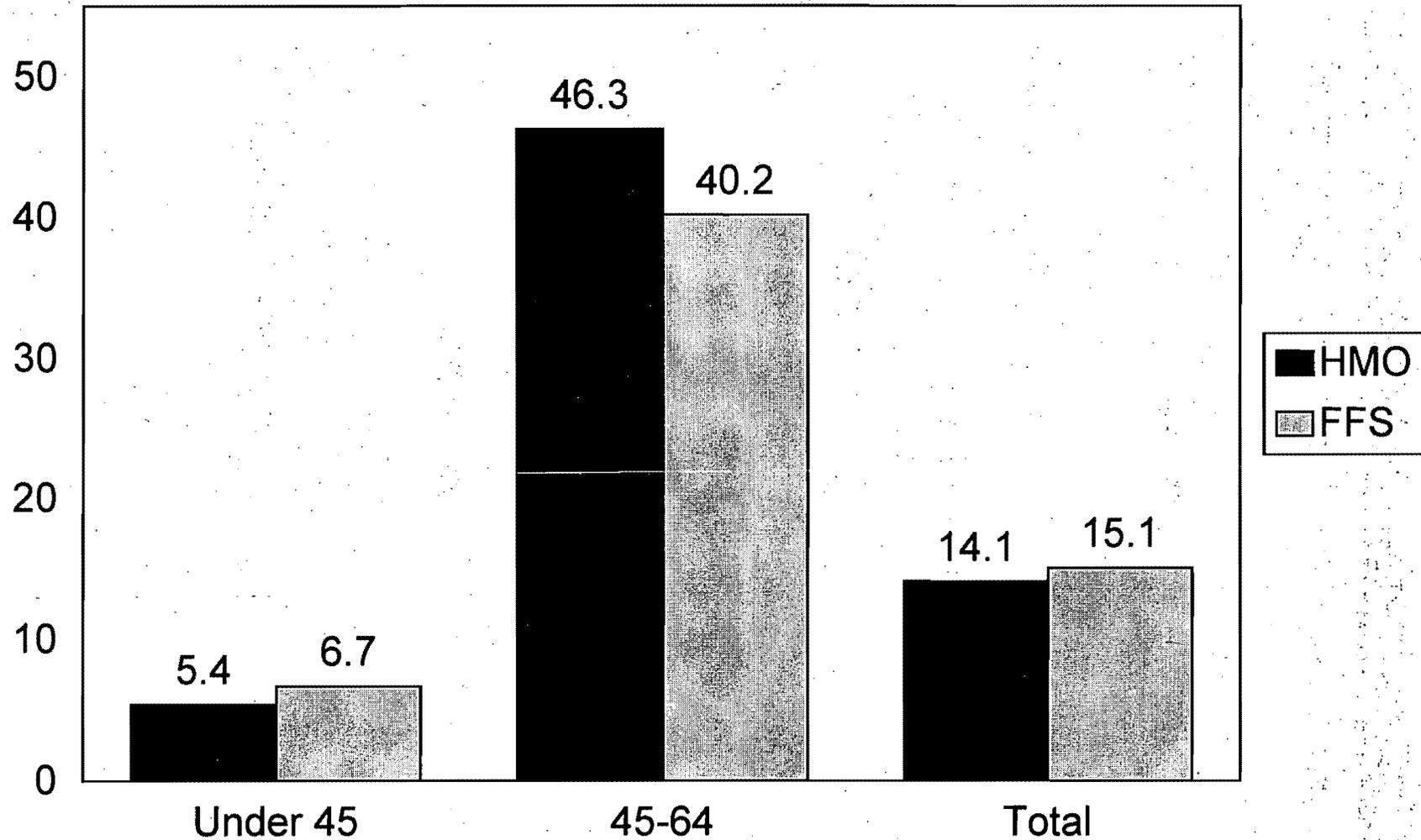
Source: National Center for Health Statistics, 1992 National Health Interview Survey

# Number of Reported Asthma Cases per 1,000 Persons, HMO versus FFS



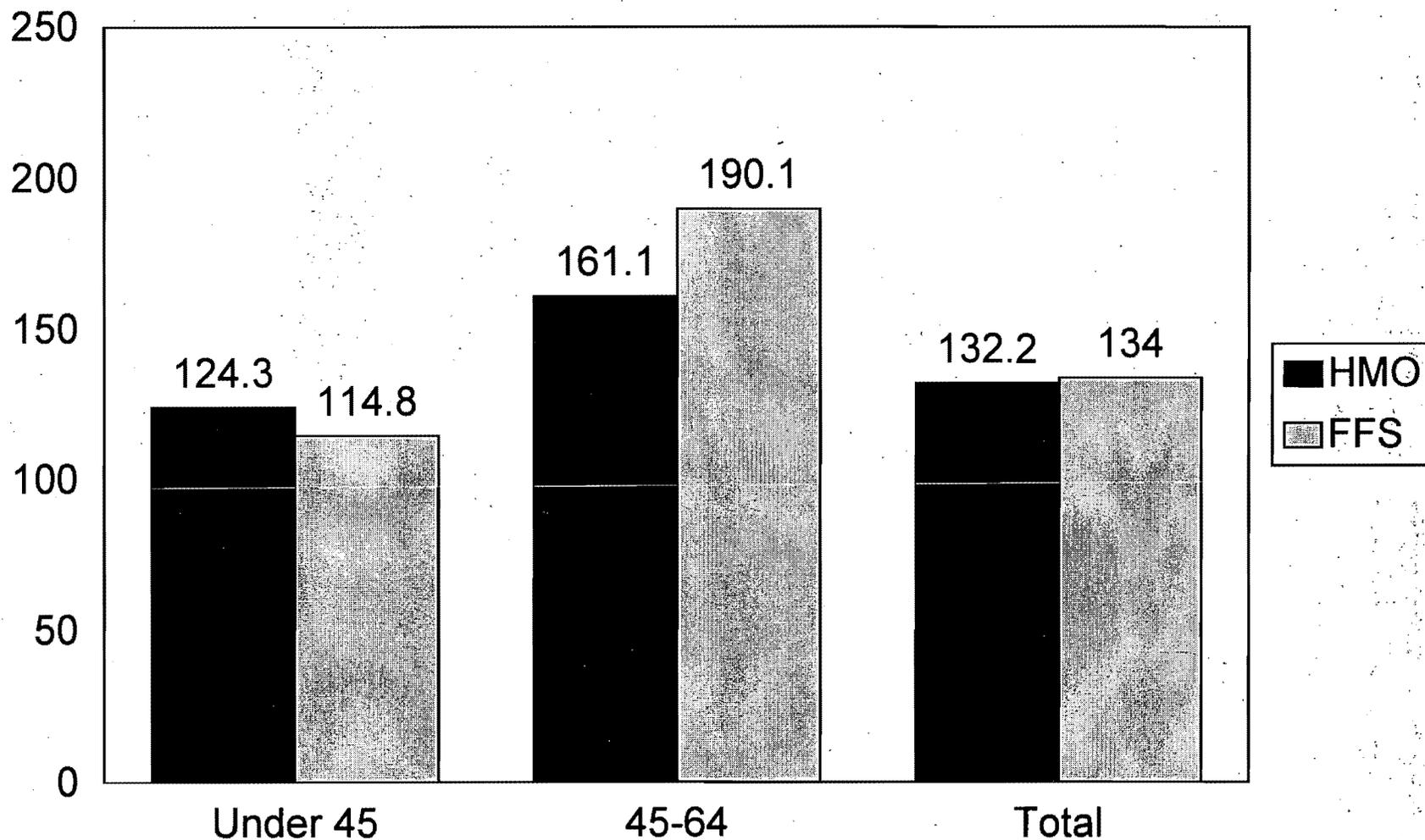
Source: National Center for Health Statistics, 1992 National Health Interview Survey.

# Number of Reported Diabetes Cases per 1,000 Persons, HMO versus FFS



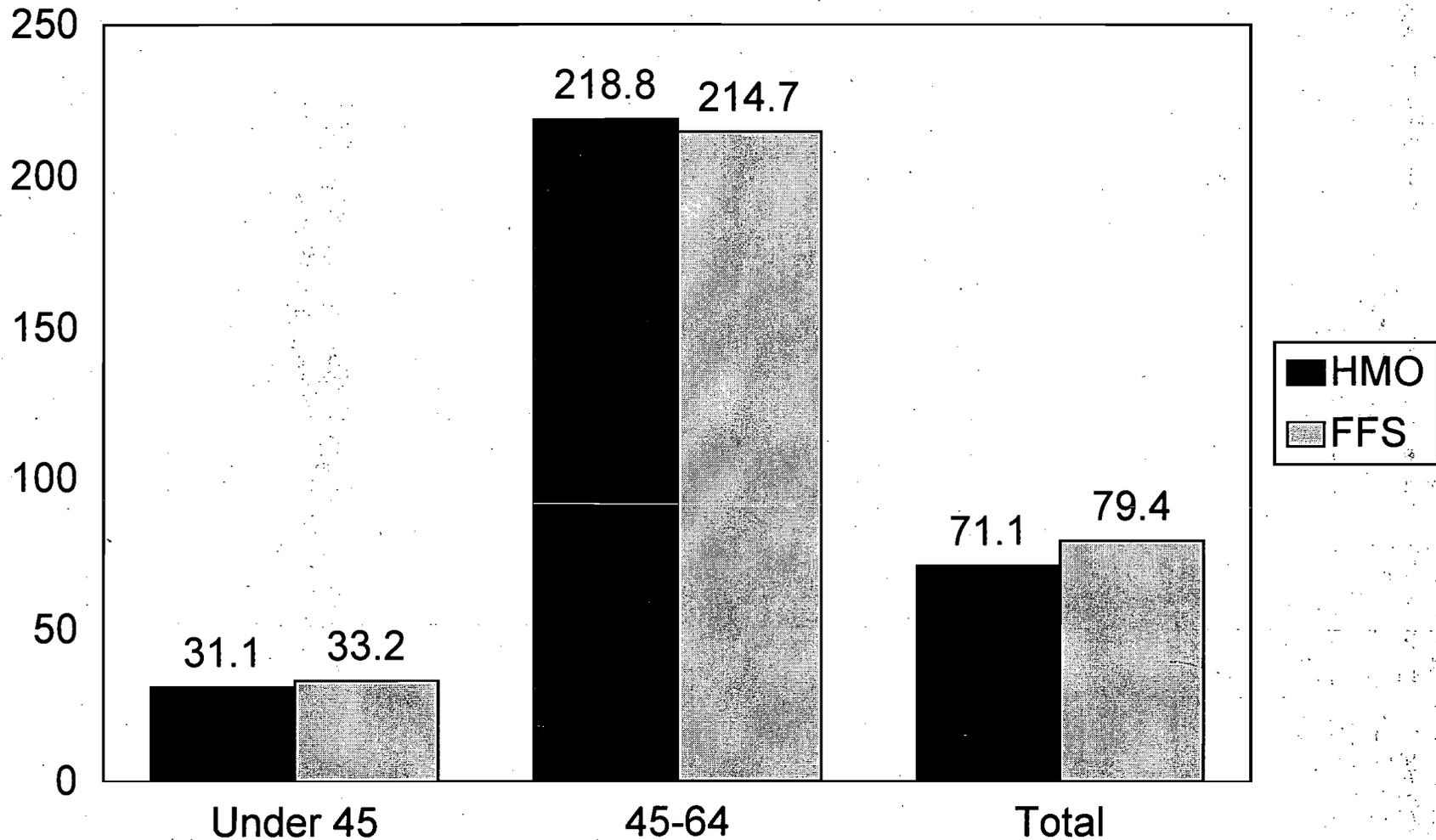
Source: National Center for Health Statistics, 1992 National Health Interview Survey.

# Number of Reported Orthopedic Impairment Cases per 1,000 Persons, HMO versus FFS



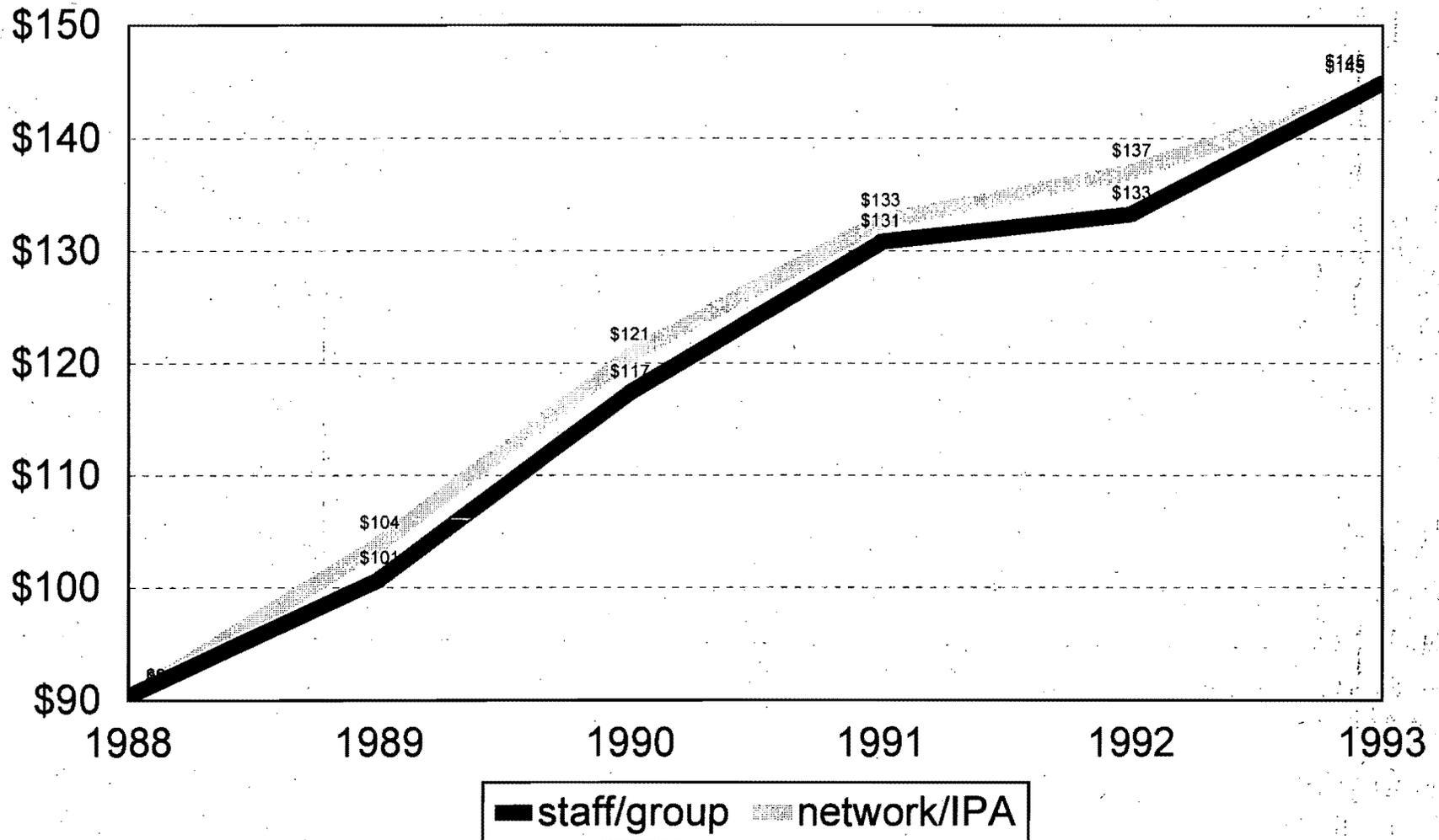
Source: National Center for Health Statistics, 1992 National Health Interview Survey.

# Number of Reported Hypertension Cases per 1,000 Persons, HMO versus FFS



Source: National Center for Health Statistics, 1992 National Health Interview Survey.

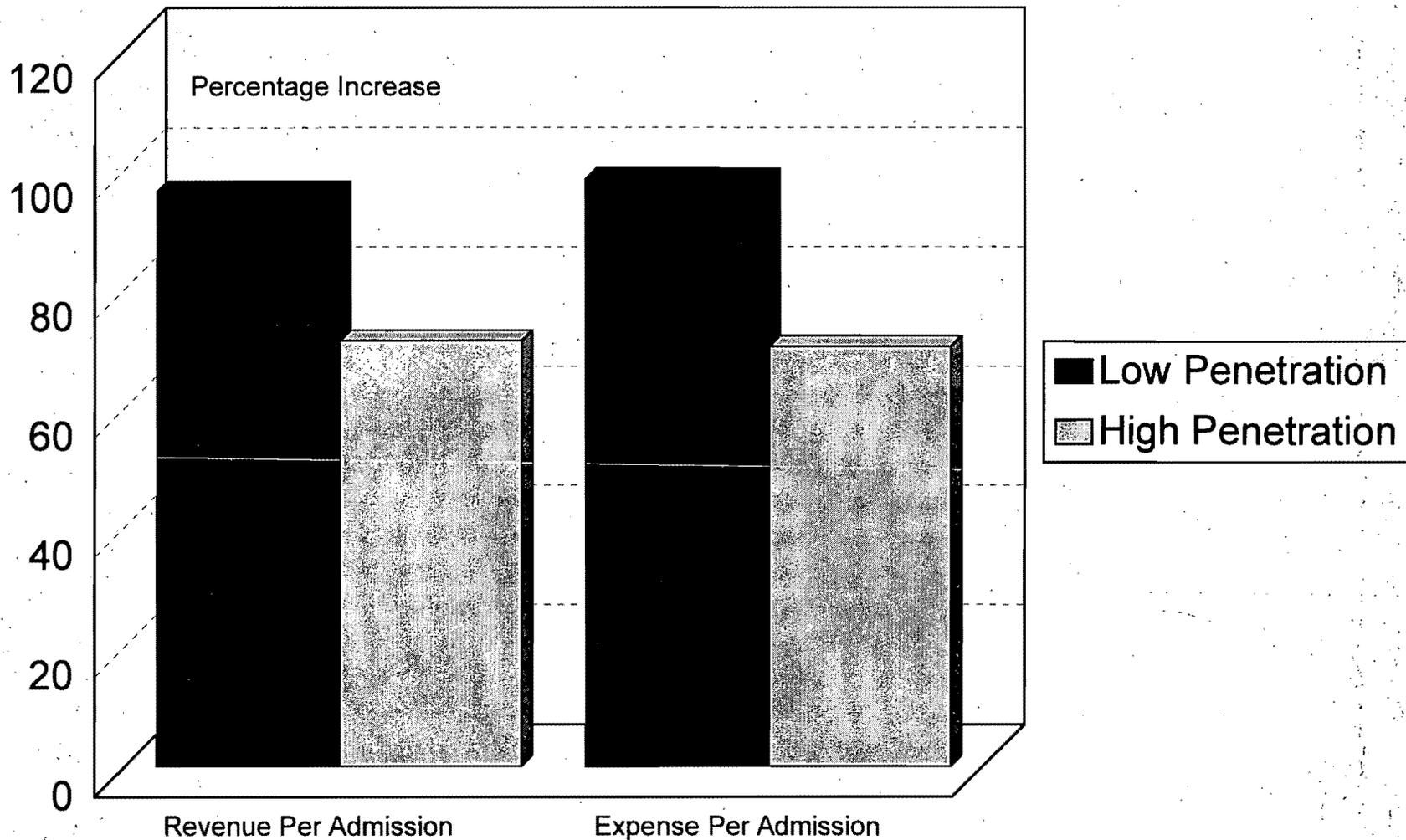
# Unweighted Single Premium Trends by Primary Model Type, 1988-1993



Source: GHAA's Annual HMO Industry Survey

Figure 2

Hospital Expenses Rise More Slowly in Metropolitan Areas With High HMO Market Penetrations, 1984-1991.



Source: J. Hadley and D. Gastkin, Georgetown University

THE WHITE HOUSE  
WASHINGTON

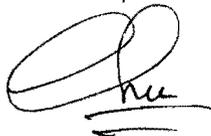
Medicare Cost-Shift  
file

Gene:

Here is the draft analysis I received from OMB on the cost-shift issue. As I noted, CBO (last year) did score a 25% cost shift resulting from deep Medicare cuts.

As you'll note from the enclosed, the latest available analysis suggests that cost-shifting may be less prevalent (or even non-existent) in those places where a heavy managed care presence makes it very difficult to do.

The other <sup>relevant</sup> cite listed in the enclosed is from the Medicare Prospective Payment Commission 1994 report. I'll type these up to be used as sources & look elsewhere as well. Give me half a day before you call Treasury, ok?



**DRAFT**Medicare Cost-Containment and Cost-Shifting I**CBO and Cost-Shifting**

\* During the health reform legislative process, CBO decided to include the impacts of cost-shifting from Medicare price reductions.<sup>1</sup> For a health reform proposal financed through Medicare price reductions, CBO would assume that 25% of the Medicare reductions are "cost-shifted" on to private payers. If one accepts CBO arguments, this shifting raises private insurance premiums by 25%. Increased private insurance premiums require additional federal subsidies to help cover individuals eligible for subsidies. Thus, other things being equal, a \$100 Medicare price reduction will result in a \$25 increase in private premiums. Since many employers pay some or all of their employee's health insurance premiums, increased premiums translate into lower wages which, in turn, result in lower federal tax revenues. Although we are not privy to CBO's estimation process, based on a 25 % cost-shift we estimate that a \$100 Medicare price reduction translates into roughly \$8 of lost federal tax revenue.

The implications of the decision are broader than health reform if CBO scores any Medicare price reduction as having a negative revenue impact. Informal communication with CBO suggests that they may not score cost-shifting impacts if Medicare reductions are proposed as part of a "normal" deficit reduction package (although no logical argument is offered).

*Inconsistencies in CBO's Scoring Approach*

- CBO scores cost-shifting impacts for hospital and physician price reductions only.
- It stands to reason that a threshold effect might govern cost-shifting--is there some dollar amount that triggers cost-shifting? CBO scores cost-shifting with no threshold effect. CBO would likely acknowledge a threshold effect, but assert that their 25% assumption accounts for both the threshold and the rate.
- If there is a threshold effect, logic dictates that it should be proportional to revenue and provider specific. In scoring cost-shifting impacts, CBO should be able to offer some evidence that providers cost-shift when some proportion of their revenues are threatened. Moreover, hospital price reductions should not trigger physician cost-shifting, and vice-versa.
- To our knowledge, only Medicare price reductions have been treated as having cost-shifting effects. Presumably, any federal reduction in Medicaid spending that could be interpreted as a price reduction could also cost-shifting impacts. For

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<sup>1</sup>An example of a Medicare price reduction is to reduce the hospital market basket index used to update Medicare payments to hospitals under PPS or to lower the Medicare economic index used to update Medicare physician fees. In contrast, the decision to impose copayments on beneficiaries for certain services would not be considered a price reduction.

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example, how would CBO score a cap on federal Medicaid payments? The implications of federal Medicaid cost-containment efforts may need to be pursued with CBO as well.

- Finally, providers supposedly cost-shift to recapture revenues lost from caring for the uninsured and revenues lost from public insurers paying less than costs. Thus CBO must also assume reductions in private premiums for many health reform proposal that results in increases in the number of uninsured. We need to more fully explore CBO's assumptions regarding increases in the number of uninsured.

### Comments on CBO Cost-Shifting Assumption.

Most of the cost-shifting research pertains to hospitals, is dated (i.e., data from the early 1980s), and has produced mixed results. To the extent cost-shifting is found, this research estimates the shift to be very incomplete.<sup>2</sup>

The research ignores fundamental changes in the private insurance market over the last five years. Private insurers have become much more cost conscious, thereby reducing the opportunity to cost-shift. For example, as of 1992, 54% of the population with private insurance was enrolled in managed care plans.<sup>3</sup> The percentage of traditional, fee-for-service insurance plans with some form of utilization review has increased from 41% in 1987 to 95% in 1990.<sup>4</sup>

There is considerable evidence that hospitals deliver care inefficiently,<sup>5</sup> and the most recent research indicates that hospitals subject to fiscal pressure respond by controlling cost per case rather than by cost-shifting.<sup>6</sup>

Given the individual physician's smaller market power and given that, as of 1993, 75% of physicians participated in private managed care plans,<sup>7</sup> the opportunities for physicians to cost-shift appear limited. Moreover, the Physician Payment Review

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<sup>2</sup>Zuckermann, S. "Commercial Insurers and All-payer Regulation: Evidence on Hospitals' Responses to Financial Need," Journal of Health Economics, 1987: 165.

<sup>3</sup>Employee Benefits Research Institute. 1994. The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence. EBRI Issue Brief No. 154, October 1994.

<sup>4</sup>Hoy, E.W., R.E. Curtis, and T. Rice. 1991. "Change and Growth in Managed Care," Health Affairs, 10 (Winter): 18-36.

<sup>5</sup>See for example Chassin, M.R. et al., (1987) "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures" JAMA 258(18): 2533-7.

<sup>6</sup>Hadley, J., S. Zuckerman, and L. Iezzoni. 1994. "Hospitals' Responses to Financial Pressure" (manuscript under review at Medical Care).

<sup>7</sup>Iglehart, J. 1994. "Health Policy Report--Physicians and the Growth of Managed Care," New England Journal of Medicine, 331 (October 27, 1994): 1167-1171.

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Commission staff reported in the September 1994 meeting that private payer visit fees are moving closer to Medicare visit fee levels, again suggesting limited opportunities to cost-shift.

Finally, both CBO and the HCFA Office of the Actuary assume volume responses to Medicare price reductions. For example, physicians are assumed to recover 50% of any Medicare price reduction through increases in service volume. Given the weak evidence for cost-shifting, it seems excessive to assume both a volume offset within Medicare and that providers pass-on 25% of the reduction to private payers.

Taken together, we believe that the empirical evidence does not support CBO's assumption of cost-shifting. If hospitals have engaged in cost-shifting in the past they have done so as much to maximize operating margins as to survive. Changes in the insurance market make it unlikely they will be able to cost shift in the future. Indeed a report sponsored by the American Hospital Association<sup>8</sup> concludes that opportunities to cost-shift are past. There is no sound empirical analyses suggesting that physicians cost-shift, and the available evidence suggests they do not.

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<sup>8</sup>Lewin-VHI, Inc (1994) "Analysis of Medicare PPS Operating Margins Under the Ways and Means Committee Health Care Reform Proposal", Prepared for American Hospital Association.

**DRAFT**Medicare Cost-Containment and Cost-Shifting II**Congressional Budget Office (CBO)**

- In a 1994 report, entitled "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift?," CBO argues that hospitals cost-shift and projects that further attempts to control public-sector spending would probably produce additional cost-shifting to the private sector.
- CBO presents data comparing sources of revenue to costs, and demonstrates that government programs are underpaying hospitals. In contrast, private payers are paying well above cost.<sup>1</sup> (Based on 1991 data)

<u>Payment Source</u>	<u>Payment to Cost Ratio</u>
Medicare	0.88
Medicaid	0.82
Other Gov't Payers	1.00
Uncompensated Care	n.a.
Private Insurers	1.30

- CBO notes that patients treated by facilities that were least able to cost-shift -- because of patient mix or market conditions -- could be adversely affected. For example, hospitals with a large share of uninsured or publicly insured patients might be less able to cover their unreimbursed costs, both because those costs are a larger share of their total costs and because they have a smaller pool of privately insured patients.

**Prospective Payment Commission (ProPAC)**

- In its June 1994 report, ProPAC asserts that hospital cost-shift to compensate for the losses they incur on one set of patients by increasing revenues received from others.
- ProPAC notes that between 1980 and 1992, gains from private payers as a percentage of costs almost exactly matched total losses from Medicare, Medicaid and other government programs.
- ProPAC claims that the variance in payment to cost ratios is evidence of cost-shifting (using 1992 data)<sup>2</sup>:

**DRAFT**

<u>Payment Source</u>	<u>Payment to Cost Ratio</u>
Medicare	0.89
Medicaid	0.91
Other Gov't Payers	0.98
Uncompensated Care	0.19
Private Insurers	1.31

**Lewin-VHI**

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- In its "Analysis of Medicare PPS Operating Margins Under the Ways and Means Committee Health Care Reform Proposal," Lewin-VHI finds that hospitals have historically offset Medicare losses by increasing the amounts they charge to private payers. However, the report points out that as purchasers of care become more price sensitive and a growing number of patients are enrolled in managed care plans, hospitals will encounter increasing difficulty in cost-shifting to private payers.

Endnotes

1. The use of cost-per-case as the metric for judging the adequacy of payment is questionable. Reported hospital costs are not necessarily justified and may reflect inefficient service delivery.
2. Upon closer examination however, the data suggests an inconsistency in ProPAC's argument. Despite the fact that between 1990 and 1993 Medicare's payment-to-cost ratio was relatively constant and Medicaid's ratio actually increased substantially, the private payer payment-to-cost ratio increased 3 percent.

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