

September 2000

MEDICARE+CHOICE

Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings



G A O

Accountability * Integrity * Reliability

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Abbreviations

AAHP	American Association of Health Plans
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BCBSA	BlueCross BlueShield Association
CBO	Congressional Budget Office
ESRD	end-stage renal disease
FEHBP	Federal Employees Health Benefits Program
FFS	fee-for-service
GME	graduate medical education
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIAA	Health Insurance Association of America
HMO	health maintenance organization
OIG	Office of Inspector General



B-293906

September 7, 2000

Congressional Requesters

Through most of the 1990s, enrollment in Medicare managed care plans grew rapidly.¹ The number of beneficiaries enrolled in these plans increased from almost 2 million in 1993 to over 6 million in 1998 (16 percent of all Medicare beneficiaries), and the number of participating plans more than tripled. Many beneficiaries were attracted to managed care plans because they typically offered services not covered under Medicare's traditional fee-for-service (FFS) program—such as routine physical examinations and outpatient prescription drugs—and because members generally paid less out of pocket than they would in FFS. However, many areas of the country were not served by these plans. About 30 percent of the nation's 39 million Medicare beneficiaries—particularly those living in rural areas—had no alternative to the FFS program. A second problem was that Medicare was not realizing the expected savings from managed care. A number of studies by GAO, other government agencies, and researchers had concluded that plan payments were not adequately adjusted to reflect the fact that plans tended to attract beneficiaries with lower-than-average health costs.

In the Balanced Budget Act of 1997 (BBA), the Congress sought to address some of these concerns by creating the Medicare+Choice program. To expand Medicare beneficiaries' health plan options, the BBA included payment and other changes to encourage the wider availability of health maintenance organizations and permitted other types of health plans, such as preferred provider organizations, to participate. Medicare+Choice was also expected to improve Medicare's financial posture by better controlling spending. Accordingly, the BBA contained provisions to temporarily slow the growth of plan payment rates relative to FFS spending and required

¹Prior to 1998, Medicare managed care plans that were paid a fixed amount per enrollee were known as risk plans. Other types of Medicare plans included cost contract and health care prepayment plans, which differed substantially from risk plans both in how they operated and how Medicare paid them. Nonrisk plans are being phased out. Risk plans, along with new types of plans authorized by the Balanced Budget Act of 1997, are now known as Medicare+Choice plans. When we refer to a “plan” in this report, we mean either a risk plan or a Medicare+Choice plan.

that future payments better reflect the expected health care utilization of Medicare beneficiaries enrolled in plans.

Following the implementation of Medicare+Choice, nearly 100 plans either terminated their contracts and fully withdrew from the program or partially withdrew by reducing the geographic areas they served for the 1999 contract year. We previously reported that these plans tended to be recent market entrants, had low enrollment, or faced competition from larger plans, and that the withdrawals may have largely resulted from competitive market forces.² Since then, more plans have either withdrawn for the 2000 contract year or announced that they will withdraw for the 2001 contract year. Because of your continuing interest in the Medicare+Choice program, you asked us to (1) determine the geographic distribution and the distribution among plans of enrollees affected by the recent plan withdrawals, (2) identify the factors associated with plans that terminated or reduced their participation in the program, and (3) examine the likely role of payment rates in affecting plans' decisions. (Requesters are listed at the end of this letter.) To answer these questions, we analyzed enrollment and plan participation data from the Health Care Financing Administration (HCFA) and synthesized findings from our previous reports. Appendix I presents the details of our methodology. Our work was done from August 1999 to September 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Of 309 plans serving Medicare beneficiaries at the end of 1999, 99 plans terminated their contracts or reduced the number of counties they served for the 2000 contract year, and 118 have announced they will terminate their contracts or reduce service areas for the 2001 contract year. These withdrawals affected about 328,000 enrollees in 2000 and will affect almost 1 million enrollees in 2001. The number of enrollees affected accounts for about 5 percent of Medicare+Choice enrollees in 2000 and about 15 percent in 2001. A disproportionate number of affected enrollees live outside of major urban areas. A portion of these enrollees, approximately 79,000 in 2000 and 159,000 in 2001, will have no other Medicare managed care option available in their area and must either switch to a non-managed care option, if one is available in their area, or return to traditional FFS Medicare. These withdrawals can mean higher out-of-pocket costs and be

²*Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

disruptive for those beneficiaries who lose access to relatively inexpensive prescription drug benefits or must switch health care providers. While a new private FFS plan has begun to offer services in many of the affected areas as an alternative to the traditional public FFS HCFA manages, it does not offer a prescription drug benefit.

Some factors are common to plan withdrawals occurring in 2000 and 2001, but there are some differences. In January 2000, Medicare+Choice plans tended to withdraw from more difficult to serve rural counties or large urban areas that they had entered more recently or where they failed to attract sufficient enrollment. In 2001, the trend is essentially the same for the service area reductions but somewhat different for the contract terminations, which involve some older, more established plans. The pattern of Medicare+Choice withdrawals shares common elements with plan participation in the similarly choice-based health insurance program for federal employees. That program also experienced a period of rapid expansion between 1994 and 1997 followed by the withdrawal of newer, relatively small plans. In both 2000 and 2001, other factors, such as problems contracting with health care providers, may also have contributed to the Medicare plan withdrawals.

Industry representatives contend that the BBA's payment rate changes were too severe and that low Medicare payment rates are largely responsible for the plan withdrawals. However, since the BBA was enacted, Medicare+Choice payment rates have risen faster than per capita FFS spending. In addition, many plans have attracted beneficiaries who have lower-than-average expected health care costs, while Medicare+Choice payments are largely based on the expected cost of beneficiaries with average health care needs. The result is that Medicare can pay more for a beneficiary who enrolls in a plan than if the beneficiary had remained in FFS. As we recently reported, these additional payments amounted to \$5.2 billion, or 21 percent, more in 1998 than the FFS program would have spent to provide Medicare-covered benefits to plans' enrollees.³ Similarly, many of the withdrawing plans reported that Medicare's payment rates substantially exceeded their own estimated costs (including allowed profits) of providing Medicare-covered benefits. On average, plans that terminated their contracts in 2000 or 2001 reported spending 22 percent of their Medicare payments, or about \$1,200 per beneficiary, on benefits that

³*Medicare+Choice: Payments Exceed Cost of Benefits in Fee-for-Service, Adding Billions to Spending* (GAO/HEHS-00-161, Aug. 23, 2000).

are not available in the FFS program—such as routine physical examinations or prescription drugs.

Although industry representatives have called for Medicare+Choice payment rate increases, it is unclear whether increases would affect plans' participation decisions. In 2000, 7 percent of the counties with a Medicare+Choice plan in 1999 received a payment rate increase of 10 percent or more. Nonetheless, nearly 40 percent of these counties experienced a plan withdrawal. This suggests that the magnitude of rate increases needed to make participating in Medicare a sufficiently attractive business option for some plans may not be reasonable in light of countervailing pressures to make the Medicare program financially sustainable for the long term.

Background

As of July 2000, about 6.2 million people—or approximately 16 percent of Medicare's 39 million beneficiaries—were enrolled in Medicare+Choice plans. These plans receive a fixed monthly payment for each beneficiary, regardless of what an individual enrollee's care actually costs. Higher costs reduce a plan's profits or result in losses, while lower costs can enable it to offer additional benefits that help it to retain existing enrollees and attract new enrollees. Because managed care plans have a financial incentive to provide care efficiently, policymakers have long looked to them to curb unnecessary spending and produce savings for Medicare. Among BBA's major reforms to contain Medicare spending was the creation of Medicare+Choice, which was also designed to increase the plan options available to Medicare beneficiaries.

Medicare Managed Care Before the BBA

Before the BBA, numerous studies by us, the Physician Payment Review Commission—which has been incorporated into the Medicare Payment Advisory Commission—HCFA, and others demonstrated that the Medicare program spent hundreds of millions more on beneficiaries enrolled in health plans than it would have spent if the same individuals had remained in traditional FFS Medicare.⁴ This occurred because Medicare payments were based on the estimated cost of FFS beneficiaries with average health and were not adequately adjusted to reflect the fact that plans tended to enroll beneficiaries in better-than-average health who had lower health care costs—a phenomenon known as favorable selection.

Before 1998, base payment rates to plans in each county were set at 95 percent of the estimated FFS cost of the average beneficiary. The wide variation in local FFS expenditures, caused by local differences in both the prices of medical services and in beneficiaries' use of services, led to corresponding variation in these base rates. This variation may have accounted for some of the unevenness in plan availability across the country. Other factors, such as the higher concentration of Medicare beneficiaries, may have prompted plans to serve primarily urban areas. Beneficiaries in most rural areas lacked access to plans.

BBA Changes to Medicare Managed Care

Beginning in 1998, the BBA substantially changed the method used to set plan payment rates. The new method involves paying the highest of three alternative rates: a minimum amount, or “floor”; a minimum increase over the previous year's payment rate; or a blend of historical FFS spending in a county and national average costs adjusted for local price levels. Some of the new payment provisions were designed to reduce excess payments, while others were designed for different purposes—such as increasing plan participation in geographic areas that had low payment rates.

The BBA aims to reduce the excess in Medicare's health plan payments primarily by holding down per capita payment increases for 5 years and by mandating a new health-based risk adjustment system. In January 2000,

⁴Our studies include *Medicare Plans: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (GAO/HEHS-97-16, Apr. 25, 1997). Other studies include G. Riley, C. Tudor, Y. Chiang, and M. Ingber, “Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994,” *Health Care Financing Review*, Vol. 17, No. 4 (Summer 1996), pp. 65-76 and Physician Payment Review Commission, “Risk Selection and Risk Adjustment in Medicare,” *Annual Report to Congress*, ch. 15 (Washington, D.C.: Physician Payment Review Commission, 1996).

HCFA implemented a method for adjusting plan payments based on beneficiary health status, as required by the BBA. The new method, to be phased in over time, will pay plans more for serving Medicare beneficiaries with serious health problems and less for serving relatively healthy ones.

The BBA also contains provisions to gradually remove graduate medical education (GME) payments from plan payments and provide for teaching hospitals to receive these payments directly from Medicare.⁵ Because GME spending is concentrated in high-payment-rate counties, its removal is expected to slow payment rate growth more in those areas.

Another BBA objective is to reduce the geographic disparity in payment rates. A methodological approach known as “blending” will, over time, move all rates closer to the national average by providing for larger payment increases in low-rate counties and smaller payment increases in high-rate counties. In addition, the BBA established a minimum payment rate, known as a “floor,” to encourage plans to offer services in areas that historically had low payment rates and few participating plans—primarily rural counties. The BBA also eliminated the requirement that no more than 50 percent of a plan's enrollment may consist of Medicare and Medicaid beneficiaries. This means that Medicare plans can now serve areas without first building a commercial base.

Medicare+Choice Plan Participation in 1999

In 1999, 45 of the 346 plans that participated in 1998 terminated their Medicare contracts and 54 others reduced the number of counties they served. These withdrawal decisions affected about 407,000 enrollees (7 percent of the managed care population) who had to choose a new plan (if one was available in their county) or switch to FFS. About 61,000 of these enrollees, or 1 percent of the total Medicare managed care population, lived in counties in which no other plan was offered. Even if another plan was available, the approximately 450 beneficiaries affected by the withdrawals who had end-stage renal disease (ESRD) had to return to FFS.⁶ Medicare

⁵Medicare FFS payments include payments to teaching hospitals for Medicare's share of the costs of providing GME, such as resident and faculty salaries and overhead costs related to teaching activities.

⁶ESRD is the stage of kidney impairment that is considered irreversible and requires either regular dialysis treatments or a kidney transplant to maintain life. It is an uncommon but expensive disease.

prohibits beneficiaries with ESRD from joining a health plan, although they may stay in one if they develop the disease while enrolled.

Plan withdrawals can be disruptive and costly for affected beneficiaries. Although many affected beneficiaries can enroll in another plan, this option may require them to switch health care providers and accept different benefit coverage. Those who return to FFS may be able to retain their providers, but typically face out-of-pocket costs that are higher than they incurred as managed care enrollees. For example, most plan enrollees receive some coverage for outpatient prescription drugs, a benefit not offered in the FFS program. Although the BBA guarantees beneficiaries affected by plan withdrawals the right to purchase certain supplemental insurance policies (known as Medigap), none of the guaranteed policies cover prescription drugs.

Officials from organizations representing plans reported that the BBA changes to the payment rates and the increased administrative burden of the new regulations were largely responsible for the plan withdrawals. According to the officials, Medicare payment rate increases did not keep pace with plans' costs or medical inflation.

Our analysis indicated that a combination of market factors may have influenced plans' participation decisions. Plans more frequently withdrew from counties they had entered more recently, where they had attracted fewer enrollees, or where they faced larger competitors. Some plans indicated that they withdrew from areas where they were unsuccessful in establishing sufficient provider networks. The effect of Medicare's payment rates on withdrawals was much less obvious. For example, about 90 percent of high-payment-rate counties experienced a plan withdrawal compared with only 34 percent of low-payment counties. Taken as a whole, these findings suggested that a portion of the withdrawals may have been the result of plans that were less able to compete effectively in certain areas.

Post-BBA Legislative Changes

In November 1999, the Congress passed the Balanced Budget Refinement Act of 1999 (BBRA). The BBRA contains provisions designed to encourage plan participation in Medicare+Choice. Among other changes, the BBRA provides a new entry bonus to plans that begin serving currently unserved areas. It also increases plans' flexibility to vary benefits within a geographic area and reduces some administrative requirements. In addition, the act slows the phase-in of the new risk adjustment methodology, reducing the

short-term effect of the new methodology on plan payments. The BBRA also reduces the length of time that a plan has to wait to reenter the program after terminating its Medicare contract. The effect of these provisions on future plan participation is uncertain.

Withdrawals Widespread but Disproportionately Affect Rural and Smaller Urban Areas

In 2000, 41 of 309 participating plans terminated their Medicare+Choice contracts and another 58 plans reduced the number of counties they serve. This pattern will continue in 2001, when 65 of 261 plans currently participating in Medicare+Choice have announced they will terminate and another 53 plans will change their service areas. Combined, these plan withdrawals directly affect about 1.3 million Medicare+Choice enrollees. The 2001 withdrawals affect a much larger percentage of enrollees, approximately 15 percent, compared with the 2000 withdrawals that affected about 5 percent of all enrollees. All affected enrollees have to choose a new plan (if a plan accepting new enrollees is available in their county) or switch to FFS. By 2001, almost 75 percent of the counties that had a Medicare+Choice plan in 1999 will have been affected.⁷ About 238,000, or approximately 19 percent, of the affected enrollees live in counties in which no other managed care plan is being offered. Some of these beneficiaries may have the option of enrolling in a new private FFS plan, but the remainder will have no alternative to the traditional FFS program. The 1,940 beneficiaries in withdrawing plans who have ESRD must return to FFS.

Plan withdrawals in both years disproportionately affect beneficiaries living in small urban, fringe, and rural counties.⁸ In 2000, approximately 65 percent of the 328,000 beneficiaries affected by the withdrawals lived in one of these types of counties even though these areas accounted for less than 33 percent of Medicare's managed care enrollees. (See fig. 1.) In contrast, the effects of the 2001 withdrawals will be more widespread and more representative of the distribution of Medicare+Choice enrollees. In both years, beneficiaries living in less densely populated areas were also likelier to be left only with the FFS alternative compared to affected beneficiaries in major urban areas. (See table 1.)

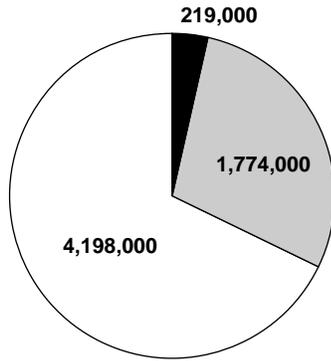
⁷Of the approximately 3,100 counties in the United States, about 28 percent had a plan in 1999. In total, 644 counties are affected by the 2000 and 2001 withdrawals.

⁸Small urban counties are defined as those counties located in urban areas with populations under 1 million. Fringe counties are nonurban counties adjacent to metropolitan areas.

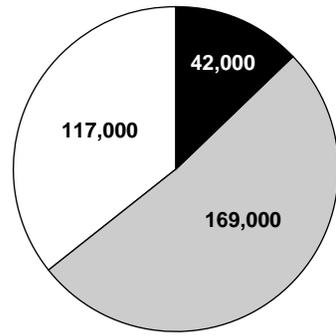
A small number of plans accounted for a substantial portion of the affected enrollees in both years—the 10 largest withdrawing plans accounting for 45 percent in 2000 and 37 percent in 2001. (See tables 2 and 3.) Whereas the largest plans that withdrew in 2000 were concentrated in small urban, fringe, and rural counties, the largest withdrawing plans in 2001 are more uniformly distributed among these and major urban areas. Also, the withdrawing plans in 2001 tend to have significantly larger enrollments than the withdrawing plans in 2000.

Figure 1: Proportion of Medicare+Choice and Affected Enrollees in Rural, Fringe/Small Urban, and Large Urban Areas

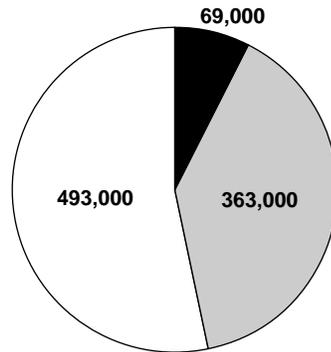
Medicare+Choice Enrollment
Total = 6,191,000



2000 Affected Enrollees
Total = 328,000



2001 Affected Enrollees
Total = 925,000



■ Rural
■ Small Urban/Fringe
□ Major Urban

Note: Approximately 8,400 of the affected enrollees for 2001 live outside of the withdrawing plans' service areas. These enrollees are excluded from this analysis.

Source: Medicare Compare Database, 1999 and 2000; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999 and Mar. 2000, www.hcfa.gov/medicare/; Bureau of Health Professions, Area Resource File, Feb. 1999; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Table 1: Medicare Managed Care Enrollment and Geographic Impact of the 2000 Withdrawals

	Rural counties	Small urban/ fringe counties	Major urban areas	Nationwide
1999				
Medicare+Choice enrollment	219,000	1,774,000	4,198,000	6,191,000
Percentage of total	3.5	28.7	67.8	100
2000				
Enrollees affected by withdrawals	42,000	169,000	117,000	328,000
Percentage of total	12.7	51.7	35.6	100
Affected enrollees with no other managed care option	30,000	35,000	14,000	79,000
Percentage of total	37.5	44.7	17.8	100
2001				
Enrollees affected by withdrawals	69,000	363,000	493,000	925,000
Percentage of total	7.5	39.2	53.3	100
Affected enrollees with no other managed care option	44,000	93,000	22,000	159,000
Percentage of total	27.5	58.6	13.9	100

Note: Approximately 8,400 of the affected enrollees for 2001 live outside of the withdrawing plans' service areas. These enrollees are excluded from this analysis.

Source: Medicare Compare Database, 1999 and 2000; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999 and Mar. 2000, www.hcfa.gov/medicare/; Bureau of Health Professions, Area Resource File, Feb. 1999; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Table 2: Largest Withdrawing Medicare+Choice Plans, January 2000

Plan name	Number of enrollees affected	Percentage of affected enrollees in rural, fringe, or small urban counties
Humana HP of Texas ^a	23,500	39
Ochsner Health Plan ^a (La.)	17,000	100
United Health Care of Louisiana	17,000	64
Florida Health Choice, Inc.	14,700	88
Free State Health Plan ^a (Md.)	14,700	100
Blue Cross/Shield of Arizona	14,500	28
Optima Health Plan (Va.)	13,800	2
Healthsource New Hampshire	13,400	100
Capital Area Community HP (N.Y.)	9,700	100
Humana Health Plan, Inc. (Nev.)	9,500	100
Affected enrollees in 10 plans	147,800	69
Affected enrollees in 89 other withdrawing plans	180,200	61

^aPlan remained in Medicare but reduced the number of counties served.

Sources: Medicare Compare Database, 1999; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999, www.hcfa.gov/medicare/; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Table 3: Largest Withdrawing Medicare+Choice Plans, January 2001

Plan name	Total number of enrollees affected	Percent of affected enrollees in rural, fringe, or small urban counties
NYLCare Health Plans (Tex.)	71,600	42
NYLCare Health Plans (Tex.)	56,200	21
Aetna U.S. Healthcare (N.Y.) ^a	34,900	22
Free State Health Plan (Md.)	31,400	0
HMO of Northeastern PA	30,700	100
Aetna U.S. Healthcare (Ohio)	27,800	30
Humana Medical Plan (Fla.) ^a	25,600	64
Anthem Health Plans (Conn.)	23,500	50
Humana HP of Texas ^a	20,500	12
Aetna U.S. Healthcare (Pa.) ^a	18,100	100
Affected enrollees in 10 plans	340,300	40
Affected enrollees in 108 other withdrawing plans	585,000	50

Note: Approximately 8,400 of the affected enrollees for 2001 live outside of the withdrawing plans' service areas. These enrollees are excluded from this analysis.

^aPlan will remain in Medicare but reduce the number of counties served.

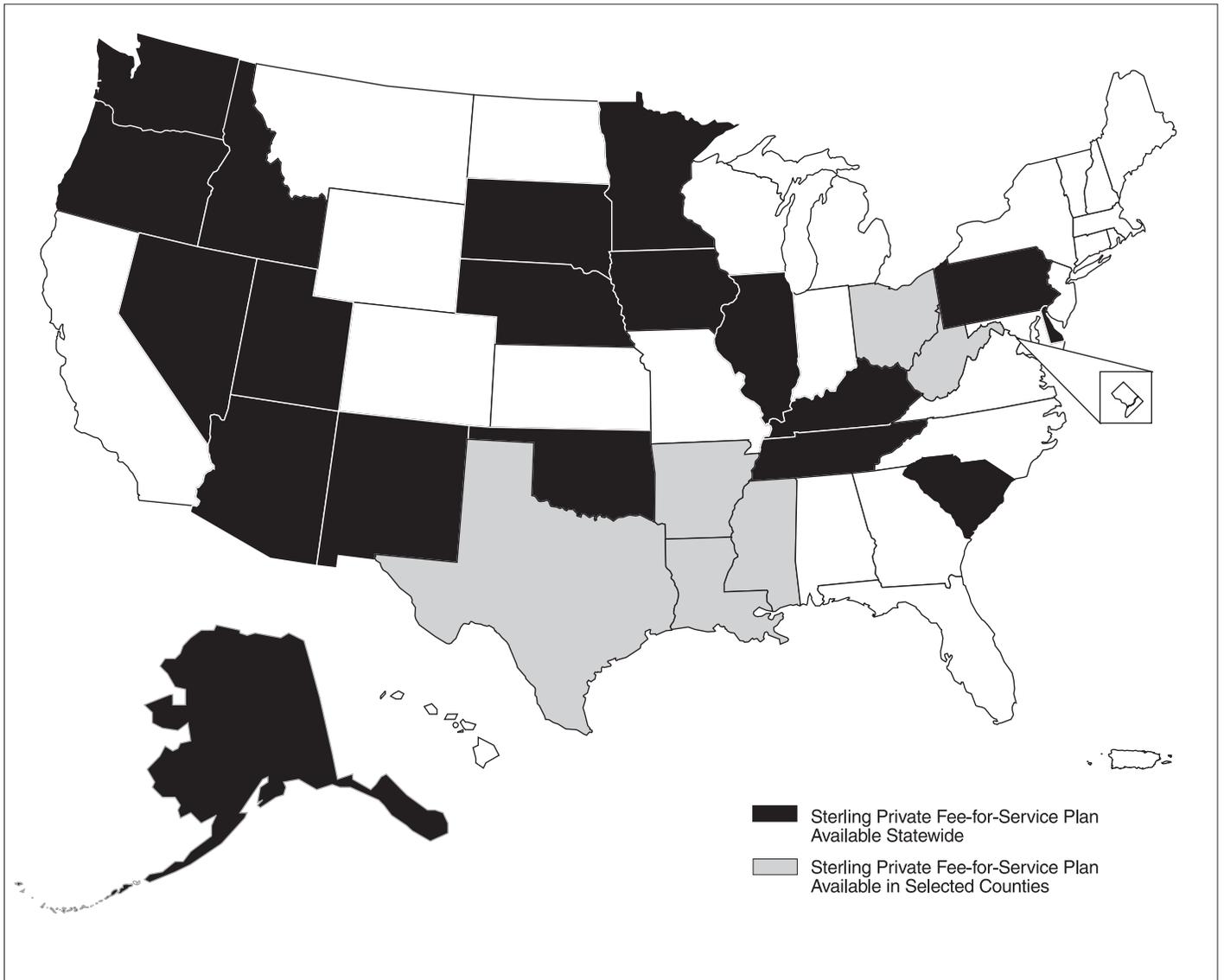
Sources: Medicare Compare Database, 2000; Medicare Managed Care Market Penetration State/County/Plan Data Files, Mar. 2000, www.hcfa.gov/medicare/; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Although some plans continue to submit applications to enter the Medicare+Choice program or expand their service areas, the volume of applications has decreased from 30 in 1999 to 10 in 2000. HCFA has already approved many of the applications submitted since July 1998, including one for a private FFS plan called Sterling Option I that initially will serve 1,221 counties in 17 states.⁹ The new plan's service area encompasses 940 counties, including many rural counties, previously not served by a Medicare+Choice plan. Since the initial offering, Sterling has added 8 more states to its service area.¹⁰ (See fig. 2.) Beneficiaries who enroll in Sterling will pay a \$55 monthly premium (in addition to the Medicare part B premium) in exchange for reduced out-of-pocket costs for many services and extended coverage for hospitalizations, among other benefits. However, Sterling Option I does not offer prescription drug coverage.

⁹A private FFS plan is an insurance plan under contract to HCFA that pays providers for each covered service they deliver and allows enrollees to obtain health care services from any provider willing to accept the plan's payments (which are based on the Medicare FFS payment schedule). Medicare pays the plan a fixed amount per enrollee. The plan may collect a monthly premium from enrollees and require cost-sharing.

¹⁰As of Sept. 1, 2000, fewer than half of the enrollees affected by recent plan withdrawals will have this option available in their areas.

Figure 2: Areas Where Sterling Option I Is Available, 2000



Source: HCFA press release, May 2000.

Many Recent Market Entrants With Relatively Low Enrollment Withdrew in 2000; This Pattern Less Evident in 2001

Plan participation in Medicare managed care increased rapidly after 1993, peaked in 1998, and began declining in 1999. This experience is not unique to Medicare and, in fact, closely tracks plan participation in the Federal Employees Health Benefits Program (FEHBP), another large program offering multiple health plan choices. The withdrawals in 2000 followed a pattern that is similar to the pattern of withdrawals in FEHBP, as well as the pattern we found in our prior analysis of the 1999 Medicare plan withdrawals.¹¹ Nearly all of the plans that terminated their Medicare contracts for 2000 or reduced their service areas were relatively new entrants in their respective markets, had attracted few beneficiaries, or had only a small share of the local Medicare managed care market. The plan withdrawals for 2001 deviate somewhat from this pattern in that some older, more established plans are terminating. However, the service area reductions in 2000 and 2001 are consistent with the 1999 pattern of withdrawals. In both years, other factors—such as plans' inability to establish sufficient provider networks—are often evident.

Several Years of Rapid Program Expansion Preceded Recent Plan Withdrawals From Medicare and FEHBP

Between 1993 and 1998, the Medicare managed care program grew rapidly and the number of plans more than tripled—from about 110 plans to 350 plans.¹² Since 1998, however, 151 plans have terminated their Medicare contracts or announced that they will, and few new plans have joined the program. Despite the drop in plan participation, enrollment has continued to increase—although at a slower pace—with the result that the total number of Medicare managed care enrollees has remained approximately the same or even increased slightly over the past 2 years. However, the substantial decline in plan participation next year may cause total enrollment to fall.

FEHBP experienced a similar rapid rise in the number of participating plans followed by a decline.¹³ (See fig. 3.) Between 1994 and 1997, the

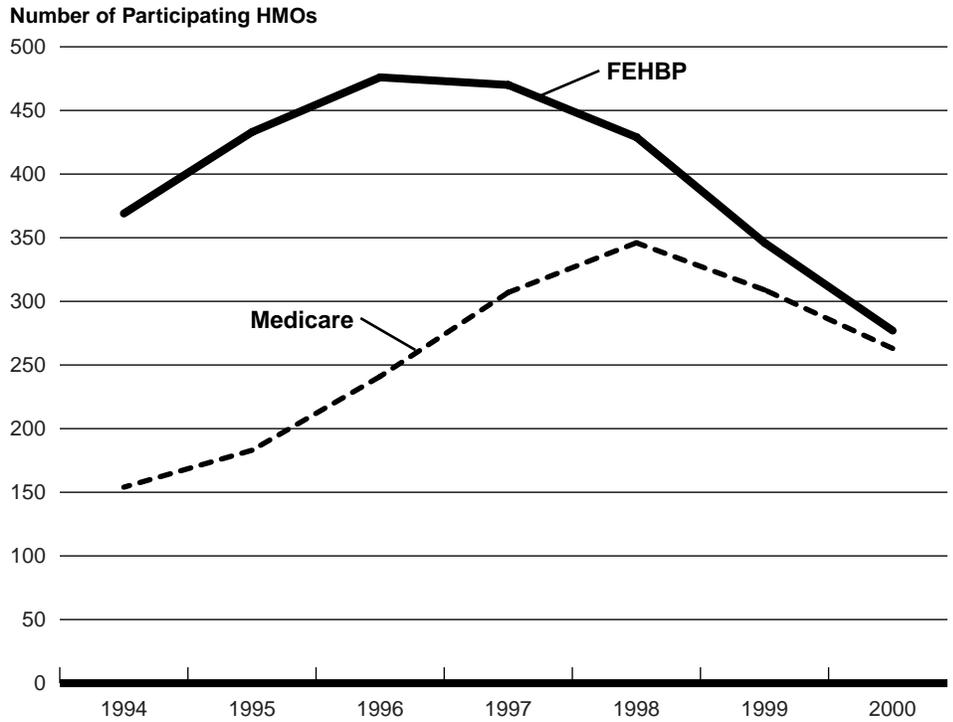
¹¹*Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

¹²Plan participation in Medicare has grown substantially, but not consistently, since the risk contract program began in 1985. There was a rapid increase in the number of participating plans between 1985 and 1987, from about 100 to 165. By 1991, the number of plans had fallen to 93.

¹³*Federal Employees Health Program: Reasons Health Maintenance Organizations Withdrew in 1999 and 2000* (GAO/GGD-00-100, May 2, 2000).

number of plans participating in FEHBP increased from 369 to 470. Since then, the number of FEHBP plans has declined steadily and may fall to approximately 240 next year. This roughly 50 percent decline in the number of FEHBP plans is similar to the approximately 57 percent decline experienced in Medicare over the same period. However, the percentage of FEHBP enrollees affected is substantially smaller than the percentage of Medicare+Choice enrollees affected. In 2001, for example, FEHBP plan withdrawals are expected to affect about 1 percent of enrollees, compared to Medicare+Choice withdrawals affecting 15 percent of enrollees.

Figure 3: Plan Participation in Medicare and FEHBP, 1994-2000



Source: GAO analysis of HCFA and Office of Personnel Management data.

At the same time new plans were joining the Medicare program, many existing plans expanded their geographic service areas. Some plans entered previously unserved rural counties while others entered urban counties with one or more existing Medicare plans. As a result, the percentage of rural beneficiaries with access to Medicare managed care increased from about 10 percent in 1993 to over 31 percent in 1998. Because of recent plan withdrawals, however, the percentage of beneficiaries in rural areas with access to a Medicare managed care plan has fallen to about 21 percent in 2000.

Urban beneficiaries, nearly all of whom already had access to at least one plan in 1993, had a wider choice of plan options. In recent years, however, even large urban areas have seen a decline in plan participation. The percentage of beneficiaries living in large urban areas with access to at least one plan has declined from 99 percent in 1999 to 97 percent in 2000 and is expected to fall again in 2001.

In 2000, Most Terminating Plans Were Recent Entrants With Relatively Low Enrollments; Pattern Less Evident in 2001

The vast majority of Medicare+Choice plans that terminated their Medicare contracts in 2000, as opposed to reducing the number of counties they served, were recent entrants into urban areas that already had substantial plan participation. Many terminating plans had few beneficiaries or a relatively small share of the local Medicare managed care enrollment. These factors are the same ones that were associated with the 1999 withdrawals. In 2000, 38 of the 41 terminating plans were either recent entrants, had attracted fewer than 200 enrollees, or had less than a 15 percent share of the local Medicare plan market in each of the counties they served.¹⁴ (See table 4.) Plans that terminated their participation in FEHBP had similar characteristics: 42 percent of the terminating plans had fewer than 300 enrollees and many of those were recent entrants.

¹⁴We define a plan's market share as its percentage of total Medicare+Choice enrollment in an area.

The pattern of plan withdrawals is different in 2001 in that some older, larger, and more established plans are also terminating their Medicare contracts. For example, almost 43 percent of terminating plans entered the market before 1996 and 29 percent had total plan enrollments that exceeded 10,000 enrollees.

Table 4: Key Characteristics of Plans That Terminated Their Medicare Contracts in 2000 and 2001

Key characteristics	Number of plans			
	Participating in July 1999	Terminated in 2000	Participating in March 2000	Terminating in 2001
Year of entry				
Before 1996	160	8 (20%)	136	28 (43%)
In 1996/97	84	15 (37%)	57	24 (37%)
Since 1998	55	18 (44%)	39	13 (20%)
Enrollment				
Fewer than 1,000 enrollees	27	11 (27%)	13	3 (5%)
Between 1,000 and 10,000 enrollees	136	25 (61%)	102	43 (66%)
More than 10,000 enrollees	136	5 (12%)	117	19 (29%)
Market share				
Less than 15%	82	22 (54%)	52	21 (32%)
More than 15%	217	19 (46%)	180	44 (68%)
Total	299^a	41	232^b	65

^aMedicare+Choice plans as of July 1999.

^bMedicare+Choice plans as of Mar. 2000.

Sources: Medicare Compare Database, 1999 and 2000; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999 and Mar. 2000, www.hcfa.gov/medicare/; and files of contract terminations and service area reductions for 2000 and 2001 from the Center for Health Plans and Providers at HCFA.

Plans That Reduced Their Service Areas Dropped Recently Entered and Relatively Low-Enrollment Counties in 2000 and 2001

Although the patterns of contract terminations in 2000 and 2001 appear to be somewhat different, the patterns of service area reductions in the 2 years are similar. In both years, plans that withdrew from only a portion of the counties they served tended to pull out of counties that they had more recently entered or where they had relatively low enrollment. In the majority of cases—92 percent in 2000 and 79 percent in 2001—plans withdrew from counties where they had recently entered, where they enrolled fewer than 200 beneficiaries, or where they enrolled fewer than 15 percent of the Medicare managed care enrollees. This pattern was more pronounced in 2000 than in 2001, but the 2001 service area reductions still follow the same general trend. In some cases, plans consolidated into one or more core areas where they were most strongly established.

Service area reductions have been more concentrated in rural areas. Despite the floor payment rates, enacted in BBA, which make payments to plans considerably higher than FFS costs in many rural counties, the challenge of providing managed care in rural areas may be a significant contributing factor. The sparseness of both beneficiaries and providers may present difficulties for plans. Without sufficient beneficiary populations, plans say they cannot enroll enough individuals to spread risk and cover fixed operating costs.¹⁵ In addition, plans may have difficulty obtaining discounts and negotiating contracts with physicians and hospitals when an area has few competing providers.

Humana Health Plan of Texas Provides One Example of Plans' Consolidation Behavior

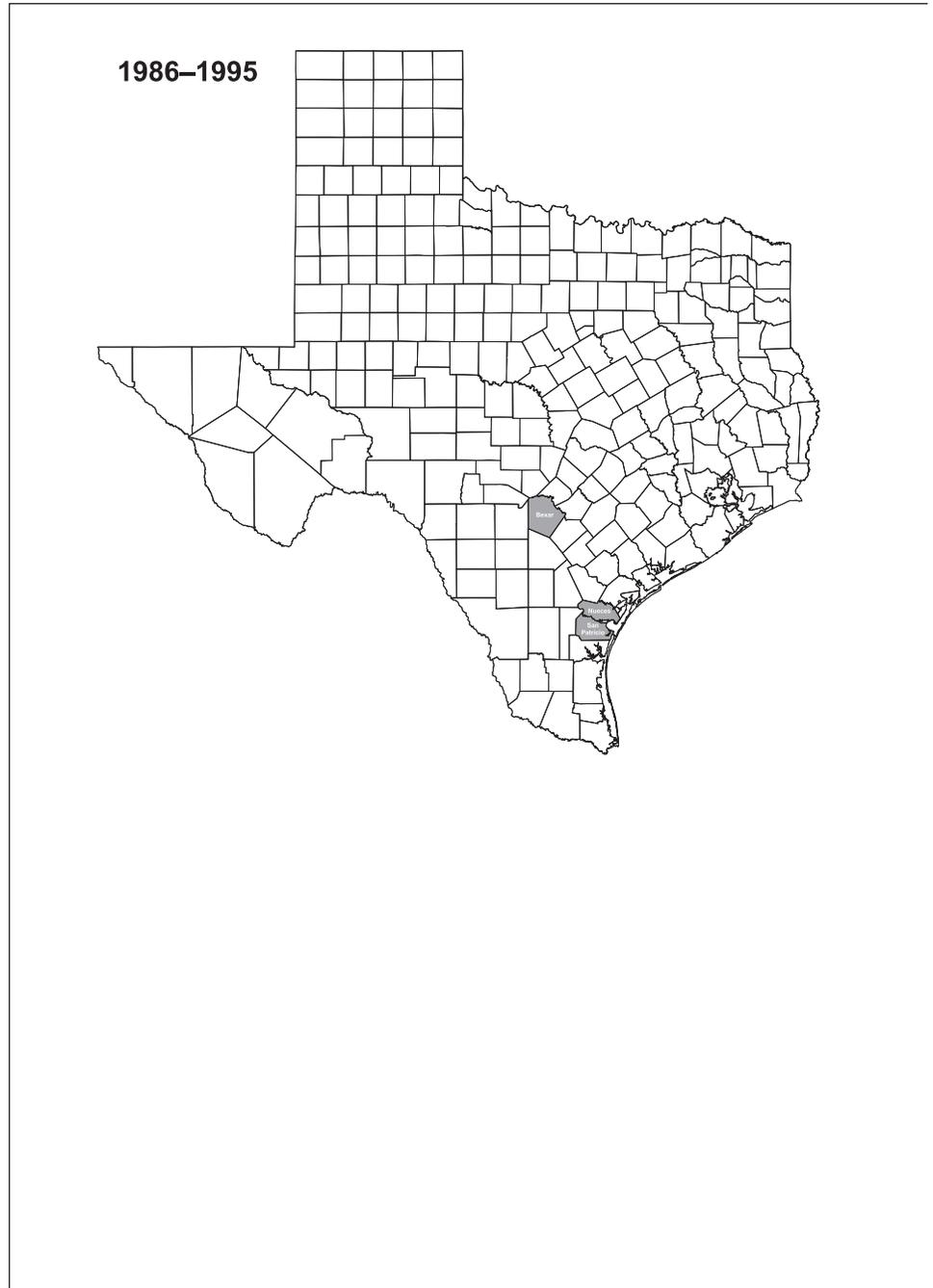
Humana Health Plan of Texas, the plan with the single largest number of affected enrollees in 2000, illustrates the consolidation behavior exhibited by a number of the plans that reduced their service areas. Humana started serving Medicare beneficiaries in areas around Corpus Christi, Texas, in 1986 and added San Antonio in 1988. It more recently expanded its service area by adding a total of 23 counties in 1995, 1997, and 1999. (See fig. 4.) In 2000, the plan withdrew from 16 of the counties, both urban and rural, it entered in 1997 and 1999, as well as a few it entered in 1995. The plan remained in the central counties encompassing San Antonio and Houston, both urban areas where the plan had by far its largest concentration of enrollment, and the Corpus Christi area. Humana remained in San Antonio despite the fact that the county's monthly payment rate for 2000 was, on

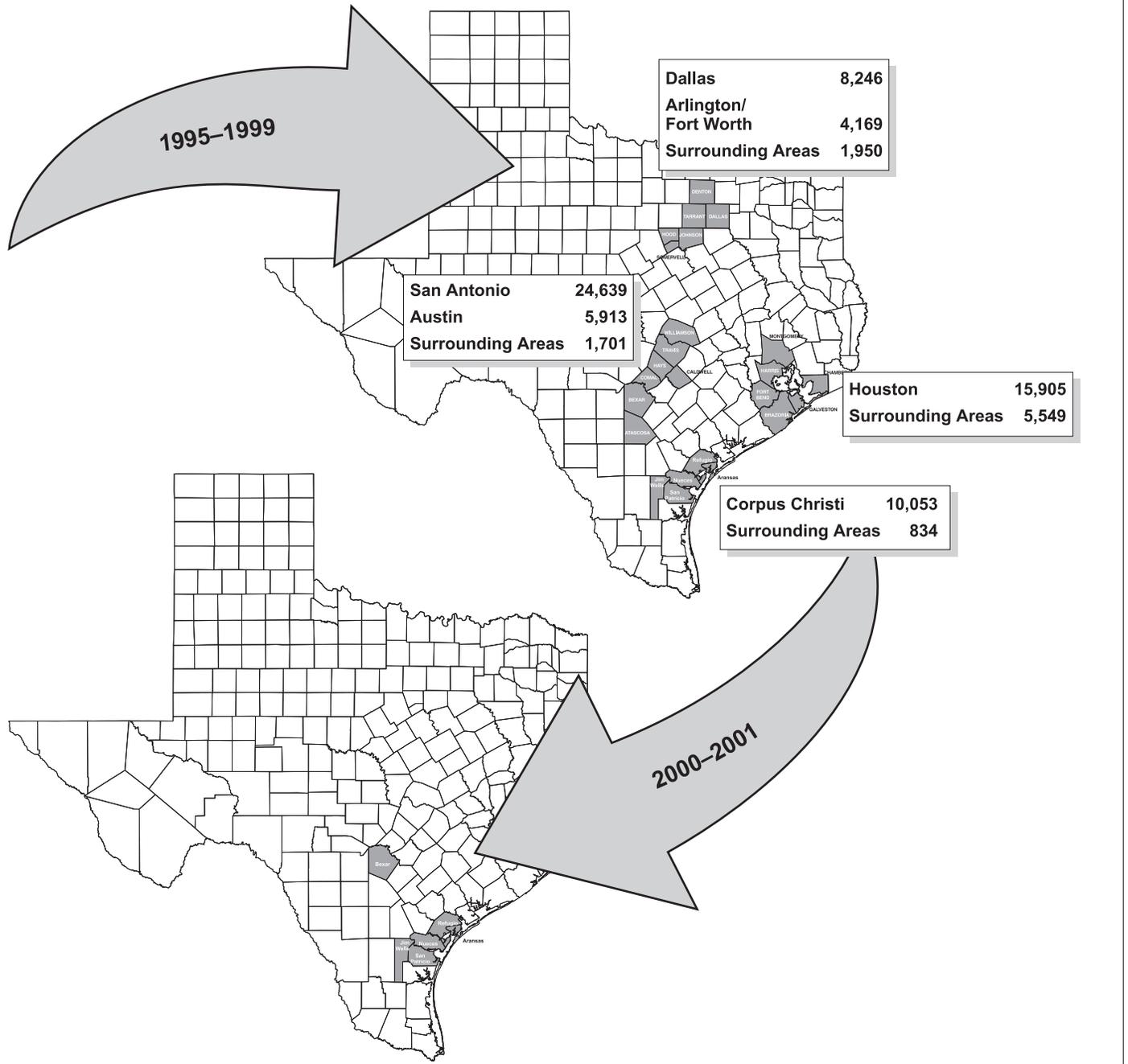
¹⁵Because plans are paid a fixed amount per enrollee, they rely on a large enrollment population to spread the costs of the relatively few very costly enrollees.

average, \$26 lower than payments in the four urban counties it dropped. The 10 counties it retained in 2000 accounted for 70 percent of its Medicare managed care enrollees in Texas.

In 2001, Humana will consolidate even further, serving only the San Antonio and Corpus Christi areas. This time, the 2001 monthly payment rate in San Antonio is, on average, \$147 lower than the six counties the plan is dropping. Humana recently stated that it incurred pre-tax losses exceeding \$26 million during 1999 in the counties it will leave in 2001. However, only a fraction of these losses may be due to providing Medicare covered benefits. The plan is currently offering, at no additional charge, an unlimited generic prescription drug benefit and a brand name benefit up to \$1,400 per year, in addition to some coverage for physical exams and vision services, to the beneficiaries in these Texas counties.

Figure 4: Humana's Participation in Texas, 1986-2001





Sources: Medicare Compare Database, 1999; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999, www.hcfa.gov/medicare/; Historical Service Area File, Feb. 1999; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Medicare Managed Care Experience in Maryland Provides Another Example of Plan Consolidations

The Medicare managed care experience in Maryland illustrates both the service area reductions that occurred in 2000 and the trend toward larger, more established plans terminating their contracts in 2001. In 2000, plans withdrew from recently entered rural counties while continuing to serve more heavily populated urban areas. In 2001, these plans are continuing the exodus from Medicare by withdrawing from these urban areas and terminating their contracts.

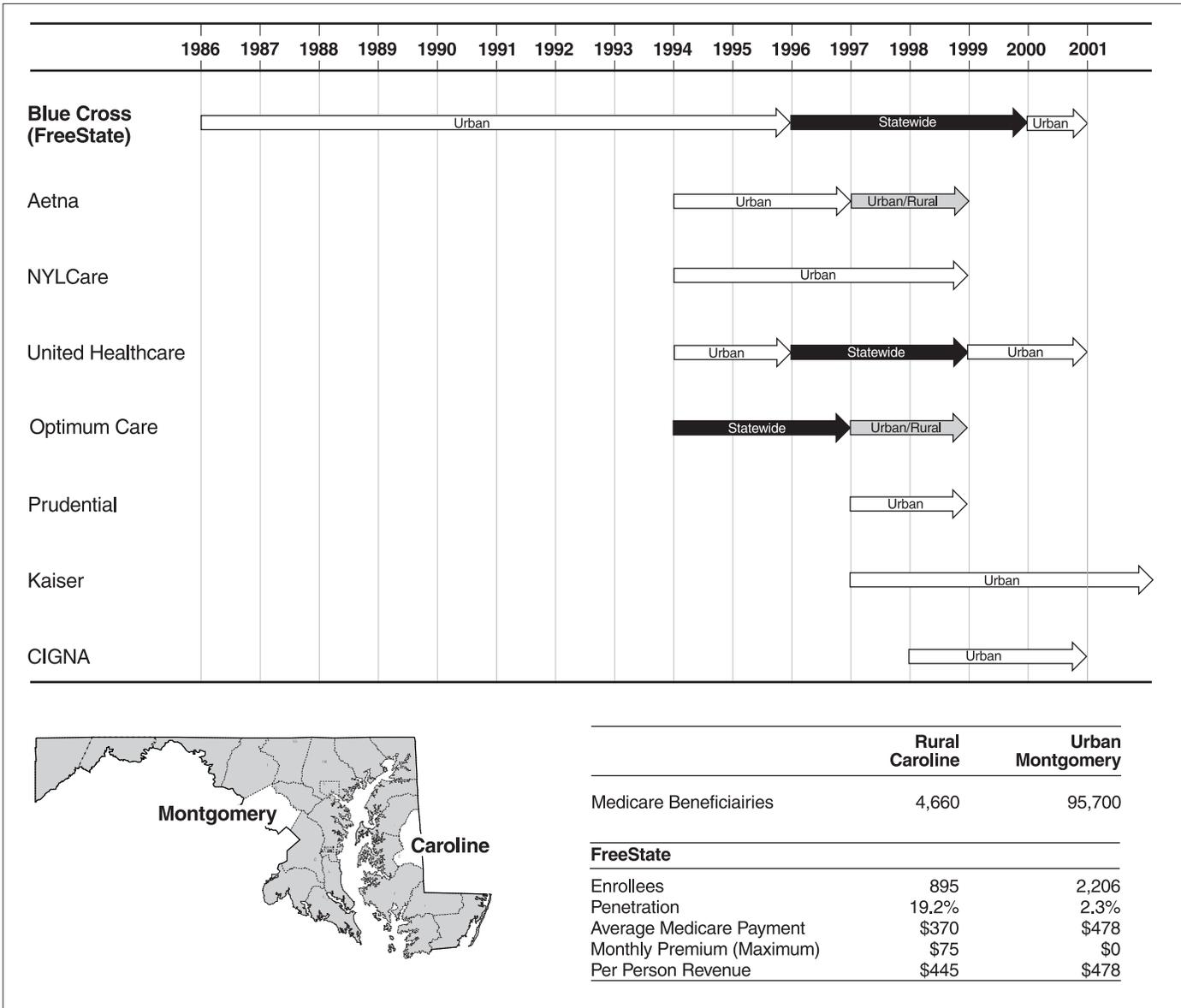
Between 1986 and 1993, only one plan, Freestate Health Plan—sponsored by Blue Cross—operated in Maryland. Its service area included only 6 of Maryland's 24 counties, all located in Maryland's major metropolitan area—the areas surrounding Baltimore and Washington, D.C. Over time, new plans began operation in the state, mostly in the same Baltimore-Washington corridor. (See fig. 5.) One plan, Optimum Choice, began offering service statewide in 1994, followed by 2 more statewide plans in 1996. Between 1997 and 1999, however, these 3 plans reduced their service areas until, by 1999, only Freestate continued to serve Maryland's rural counties. In 2000, Freestate reduced its service area to the Baltimore-Washington area—its historical core service area. Rural Maryland beneficiaries, who had a managed care option between 1994 and 1999, were left with no alternative to traditional FFS Medicare.¹⁶

The difficulty of serving sparsely populated rural areas may have been an important factor in the Maryland plans' withdrawal decisions for 2000. Freestate Health Plan, for example, withdrew from rural Caroline County where it faced no competition and enrolled nearly one in five of the county's beneficiaries despite charging a \$75 per month enrollee premium. However, the plan's relatively large market share in the county amounted to only 895 enrollees. In contrast, the plan's 2 percent market share in urban Montgomery County, an area it continued to serve, resulted in more than 2,000 enrollees. In addition, Medicare payment rates were increasing faster in the rural counties the plan left because of the floor and the blend provisions in the BBA.

¹⁶Plan mergers and contract terminations have reduced to four the number of plans serving Maryland in 2000.

Freestate has announced it will terminate its contract in Maryland for 2001, leaving Kaiser Health Plan as the only remaining Medicare plan serving the state. Freestate has said that it expects to incur losses of \$7.5 million by the end of 2000.

Figure 5: Plan Participation in Maryland, 1986-2001



Sources: Medicare Compare Database, 1999; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999, www.hcfa.gov/medicare/; Historical Service Area File, Feb. 1999; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Other Factors, Including Provider Contracting Problems, May Have Contributed to Plan Withdrawals

Although recent entry, low enrollment, or low market share are characteristics of most withdrawing plans, in some cases plan withdrawals appear to have little to do with these factors. In one case, a merger caused a plan to change operations to avoid anti-trust violations and subsequently resulted in termination of selected contracts. In other cases, plans terminated all operations—Medicare, Medicaid, and commercial—in an area. Finally, some plans have reported that providers in some areas are becoming increasingly resistant to contracting with them, making it more difficult for plans to assemble viable provider networks in certain areas. The following examples illustrate other factors that may have contributed to plan withdrawals.

- Aetna U.S. Healthcare acquired NYLCare Health Plans in July 1998, and later purchased Prudential Health Care in August 1999. Because Texas officials were concerned that Aetna would have too large a share of the state's market after it acquired Prudential, they agreed to the purchase under the condition that Aetna sell its NYLCare business in the state. However, under special agreement, Aetna was allowed to continue managing the Medicare component. Aetna subsequently terminated this contract.
- Capital Area Community Health Plan of Albany, NY, was affiliated with Kaiser Permanente, which withdrew from all of its operations in the entire northeast region in 2000.
- Humana terminated all of its business—commercial and Medicare—in Nevada.
- United Health Care of Louisiana was one of the first national plans to buy out local plans in Louisiana. Local providers, who preferred dealing with the local plans, resisted contracting with United. The plan eventually withdrew from these areas.
- Oxford Health Plans of NY had trouble assembling a viable provider network in one of the large counties it served, so it withdrew from that county.

Medicare+Choice Payment Rates Exceed Costs of Covered Benefits

Industry representatives have stated that low Medicare payments, resulting from BBA provisions designed to control program spending, are primarily to blame for the recent plan withdrawals. The American Association of Health Plans contends that the BBA created a “fairness gap” by decreasing payments to health plans relative to spending on beneficiaries in the FFS program. However, since the BBA was enacted the increase in Medicare+Choice payment rates has exceeded the growth in per capita

FFS spending. Furthermore, our recent study of plan payments found that Medicare paid plans \$5.2 billion (or about 21 percent) more than it would have spent in 1998 if plan enrollees had received standard Medicare covered services through the traditional FFS program. According to reports that plans submit to HCFA, Medicare's payments are also substantially higher than the average plan's projected costs of providing Medicare-covered benefits. Moreover, although industry representatives have called for higher payment rates, the extent to which rate increases would affect plans' decisions to participate in Medicare is unclear. In 2000 and 2001, withdrawals have not been confined to counties where payment rate increases, or payment rates, were low.

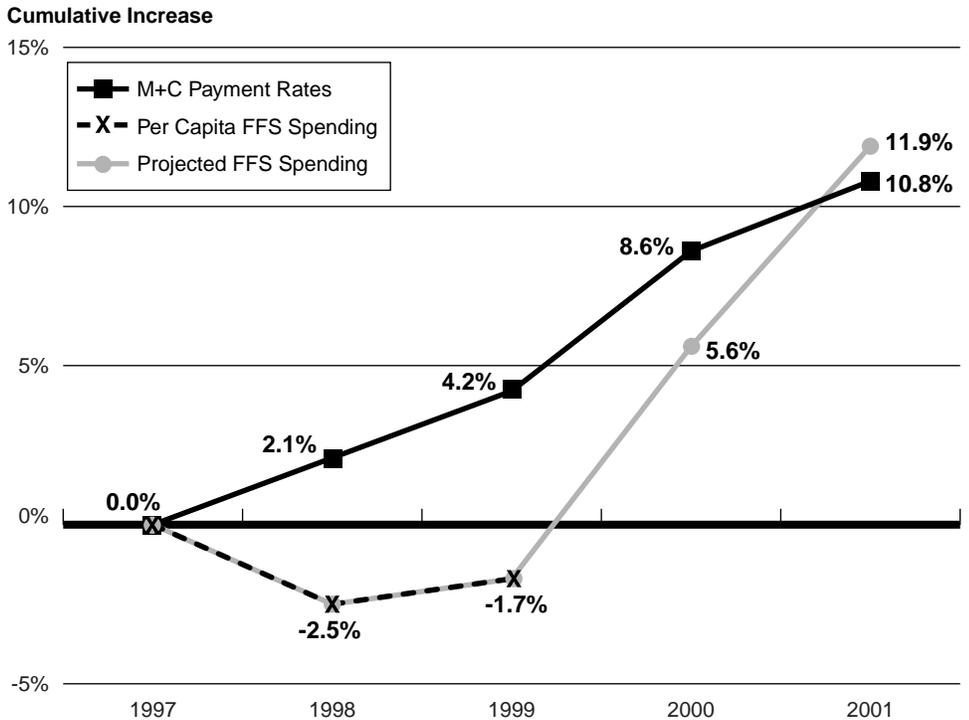
Plan Payment Rate Growth Since 1997 Exceeds FFS per Capita Spending Increase

Between 1997—the year the BBA was enacted—and 1999, Medicare+Choice payment rates increased on average by about 4.2 percent.¹⁷ (See fig. 6.) Furthermore, the payment rate increase was applied to 1997 rates that HCFA now estimates were inflated by about 3 percent because of an error in the spending forecast used to set the rates.¹⁸ In contrast, per capita FFS spending fell 1.7 percent during the same period.

¹⁷Calculated as the change in county payment rates for aged beneficiaries, weighted by the number of aged beneficiaries in each county in 1997.

¹⁸See GAO/HEHS-00-161 for a discussion of the forecast error and its consequences.

Figure 6: Cumulative Increase in Average Medicare+Choice County Rates and per Capita FFS Spending, 1997-2001



Note: Medicare+Choice payment rate increases were calculated as the change in county payment rates for aged beneficiaries, weighted by the number of aged beneficiaries in each county in 1997. Medicare+Choice payment rates for 2001 were announced in Mar. 2000. Per capita FFS spending for 2000 and 2001 is based on HCFA projections.

Source: 2001 Medicare+Choice County Payment Rate Calculation Worksheet, www.hcfa.gov/medicare/.

HCFA estimates that between 1999 and 2001, per capita FFS spending will grow faster than Medicare+Choice payment rates. If these estimates prove accurate, the cumulative increase in Medicare+Choice payment rates between 1997 and 2000 will still exceed the growth in per capita FFS spending, but the gap will be much narrower. By 2001, HCFA's current projections indicate that average spending in the traditional program will have increased 11.9 percent, while plan payment rates will have increased 10.7 percent.

Medicare Payments Exceed Estimated Costs of Providing Benefits in Traditional FFS Program

Recently, we reported that Medicare+Choice plan payments likely exceed the amount that beneficiaries enrolled in plans would cost in the traditional FFS program.¹⁹ In 1998, aggregate payments exceeded enrollees' estimated FFS costs by about 21 percent—or approximately \$5.2 billion. On a per enrollee basis, Medicare paid plans about \$1,000 more than the FFS program would have spent to provide Medicare-covered benefits.

A portion of the estimated \$5.2 billion in annual excess plan payments may diminish over time. Approximately \$2 billion of these excess payments resulted from FFS spending forecast errors built into the 1997 county payment rates due to the BBA provisions that based future county rates on the 1997 rates and guaranteed 2 percent minimum annual rate increases. The effect of the 1997 forecast error will largely be mitigated by the BBA provision that slows Medicare+Choice rate increases relative to the growth in FFS spending between 1998 and 2002.

The bulk of the excess payments we estimated for 1998 (\$3.2 billion) will persist each year until payments on behalf of individual enrollees better match their expected health care costs. Medicare+Choice plans attracted a disproportionate selection of healthier and less-expensive beneficiaries relative to traditional FFS Medicare (a phenomenon known as favorable selection), while payment rates largely continued to reflect the expected FFS costs of beneficiaries in average health. Consequently, we estimate that the program spent about 13.2 percent more on plan enrollees than if they had received services through the traditional FFS program. This year, HCFA implemented a new methodology to adjust payments for beneficiary health status. However, our results suggest that this new methodology, which will be phased in over several years, may ultimately remove less than half of the excess payments caused by favorable selection.²⁰ HCFA expects to introduce a more refined methodology in 2004 that may better adjust payments to reflect enrollees' expected health care costs.

¹⁹*Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (Aug. 23, 2000, GAO/HEHS-00-161).

²⁰Based on the first year of plan-submitted data, HCFA estimates that the new methodology would reduce average payments by 5.9 percent if fully implemented. In 2000, only 10 percent of plan payments were adjusted using the new method. Consequently, plan payments were reduced by less than 1 percent. In 2002, the portion of plan payments adjusted by the new methodology will rise to 20 percent.

Payment Rates Exceed Plans' Costs of Providing Medicare-Covered Benefits

Medicare+Choice payment rates not only surpass what the FFS program would spend to provide Medicare-covered benefits to plans' enrollees, but data submitted by plans show that rates also generally exceed plans' estimated costs to provide those same benefits. As part of the annual contracting process, each Medicare+Choice plan is required to project its per enrollee cost of providing Medicare-covered benefits.²¹ If estimated Medicare payments exceed a plan's projected costs, the plan must use the difference to provide additional benefits during the contract year or contribute to an escrow account and use the funds to provide benefits in future years. To fulfill Medicare's requirement, plans choose to provide additional benefits—such as routine vision care, dental care, and coverage for outpatient prescription drugs—that are not covered in the traditional FFS program.

In their 1999 contract submissions, the average plan—including plans that withdrew in 2000—projected that its costs would be substantially less than its Medicare payment. On average, plans estimated that they could provide Medicare-covered services for about 89 percent of Medicare's payment.²² Plans indicated that they would provide additional benefits to make up the difference. Most plans' benefit packages exceeded the minimum requirements. Consequently, the average plan in 1999 estimated it would spend about \$1,300 per enrollee, an amount equal to about 22.5 percent of its Medicare payment, on benefits that are not covered in the FFS program. Among plans that terminated their contracts or reduced their service areas in 2000, the average annual amount spent on additional benefits was slightly lower—about \$1,100, or 21.6 percent of Medicare's payment. (See table 5.)

²¹These projections are included in each plan's adjusted community rate proposal. Costs are calculated on the basis of how much a plan would charge a commercial customer to provide the same benefit package if its members had the same expected use of services as Medicare beneficiaries, and therefore these "costs" include expected profits from commercial customers.

²²According to the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the difference may be even greater. In several plan audits, the OIG concluded that the plans had overstated their Medicare costs. HHS OIG, *Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated*, A-14-97-00202 (July 1998).

Plans' contract submissions for 2000 exhibited a similar pattern of additional benefits.²³ Plans that will terminate their contracts in 2001 projected that they would spend an average of about \$1,200 per enrollee, or 22 percent of their Medicare payment, on additional benefits in 2000. Plans that will reduce their service areas projected they would spend slightly less, about \$1,000 or 18 percent of their Medicare payment, on additional benefits. In contrast, spending on additional benefits was estimated at nearly \$1,500 per enrollee, or about 25 percent of 2000 Medicare payments, for plans that will remain in the program in 2001.

Table 5: Average Annual Amount Spent per Enrollee on Non-Medicare Benefits, 1999 and 2000

	Amount spent per enrollee	
	1999	2000
Plans remaining in Medicare+Choice for 2001	1,308	1,259
Plans terminating their contracts for 2001	1,164	1,202
Plans reducing their service areas for 2001	1,080	1,010

Note: The number of enrollees in each plan was used to compute the weighted average.

Source: 1999 and 2000 Adjusted Community Rate Proposals submitted by Medicare+Choice plans.

Relationship Between Payment Rates and Plan Withdrawals Difficult to Interpret

The effect of payment rates on Medicare+Choice plan participation is ambiguous. While changes in payment rates are an important influence on plans' participation decisions, we found that plan withdrawals were not limited to counties with low payment rates.

²³Plans' adjusted community rate proposals for 2001 have not yet been approved. Although an analysis of these proposals would provide updated information on plans' projected costs, this information will be available only for those plans that will participate in Medicare+Choice next year.

On the one hand, plan withdrawals appear to be more extensive in the 2 years with lower payment rate increases. In both 1999 and 2001, county rates increased by an average of 2 percent. In 1999, plan withdrawals affected 42 percent of counties that previously had a managed care plan, and in 2001 plan withdrawals will affect 58 percent of such counties. In contrast, a smaller proportion of counties—approximately 37 percent—were affected in 2000 when rates increased by about 4 percent. The extensiveness of plan withdrawals may also be related to the gap between average county rate increases and the change in expected per capita FFS spending. For example, the projected increase in per capita FFS spending is much higher for 2001 than it was for 1999 and withdrawals will be more extensive.²⁴ Therefore, withdrawals may moderate after 2002 when payment rate increases will mirror expected increases in per capita FFS spending except for adjustments to correct prior spending forecast errors.

The relationship across counties between plan participation and payment rates, and rate increases, is not clear. Both high-payment rate and low-payment rate counties are affected by the 2000 and 2001 plan withdrawals, although the relationship between payment rates and withdrawals is somewhat different in the two years. In 2000, approximately 39 percent of the non-floor counties that had at least one plan in 1999—those with payment rates set above the minimum payment of \$402—were affected by a plan withdrawal. A slightly higher proportion of counties in the middle payment categories were affected compared to the proportion of affected counties in the highest rate category and the rate category just above the floor. (See table 6.) In 2001, about 80 to 90 percent of counties in the higher payment ranges, but less than two-thirds of the counties in the lower payment ranges will be affected. (See table 7.) The 2001 withdrawal pattern is similar to the one that occurred in 1999 in that a disproportionate number of high payment rate counties were affected by withdrawals. In both 2000 and 2001, floor counties that previously had a Medicare+Choice plan will be proportionately less affected by the withdrawals compared to counties that receive payment rates above the floor. However, the difference between floor and nonfloor counties is less pronounced in the 2001 withdrawals.

²⁴When the 1999 county rates were established in 1998 (and plans made their 1999 participation decisions) per capita FFS spending was expected to increase.

Table 6: Counties With Medicare+Choice Plans in July 1999 Affected by 2000 Withdrawals, by Year 2000 Payment Rates

	Year 2000 payment rates ^a					Total
	\$402 (floor rate)	\$402– \$505	\$505– \$608	\$608– \$711	\$711– \$814	
Counties with plan(s) affected by 2000 withdrawals	8	187	109	22	3	329
Counties with plan(s) in July 1999	64	522	243	48	10	887
Percentage of all counties with plan(s) in July 1999 affected by withdrawals	13%	36%	45%	46%	30%	37%

Notes: Only Medicare+Choice plans are used for this analysis. Payment rates are rounded to the nearest dollar. The actual categories are \$401.61, \$401.62-\$504.78, \$504.79-\$607.96, \$607.97-\$711.14, and \$711.15-\$814.32.

^aPayment rate categories were determined by dividing the range into 4 equal intervals (with a payment range of approximately \$103). The floor rate is the fifth category.

Sources: Medicare Compare Database, 1999; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999, www.hcfa.gov/medicare/; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Table 7: Counties With Medicare+Choice Plans in March 2000 Affected by 2001 Withdrawals, by Year 2001 Payment Rates

	Year 2001 payment rates ^a					Total
	\$415 (floor rate)	\$415– \$519	\$519– \$623	\$623– \$727	\$727– \$831	
Counties with plan(s) affected by 2001 withdrawals	39	242	139	36	9	465
Counties with plan(s) in March 2000	90	444	217	45	10	806
Percentage of all counties with plan(s) in March 2000 affected by withdrawals	43%	55%	64%	80%	90%	58%

Notes: Only Medicare+Choice plans are used for this analysis. Payment rates are rounded to the nearest dollar. The actual categories are \$415.01, \$415.02-\$518.91, \$518.92-\$622.81, \$622.82-\$726.71, and \$726.72-\$830.61.

^aPayment rate categories were determined by creating four equal rate categories (with a payment range of approximately \$104). The floor rate is the fifth category.

Sources: Medicare Compare Database, 2000; Medicare Managed Care Market Penetration State/County/Plan Data Files, Mar. 2000, www.hcfa.gov/medicare/; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

The relationship between payment rate increases and plan participation in a particular county is unclear. In 2000 and 2001 floor counties may have been less affected by the withdrawals because the BBA substantially increased payment rates in those counties, and those rates remain considerably above the average cost of Medicare benefits in the traditional FFS program. Between 1997 and 2001, payment rates in floor counties increased by 27 percent. In contrast, payment rate increases have been more modest in nonfloor counties, around 11 percent.²⁵ However, the pattern of plan withdrawals in 2000 suggests that even relatively large payment rate increases may not be enough to keep some plans in certain counties. While county payment rates increased by an average of 4 percent in 2000, the BBA's rate "blending" provision increased rates by 10 percent or more in certain counties.²⁶ Nonetheless, 40 percent of these counties with large increases were affected by plan withdrawals in 2000—about the same as the percentage of affected counties among those that received the lowest (2 percent) rate increase.²⁷ (See table 8.) Some areas may have too few beneficiaries or providers to support multiple plans, or even a single plan. Moreover, plans that fail to attract a sufficient number of enrollees will not realize their revenue goals even if payments are adequate on a per capita basis.

²⁵Floor counties are defined as those counties assigned the minimum rate of \$415 in 2001. The average increase is computed for those counties with Medicare plans in 1997, weighted by total plan enrollment in 1997. County-level data on FFS spending since 1997 are not available.

²⁶In 2001, rates in about 31 percent of counties will equal the floor payment rate of \$415. The remaining county rates will equal the minimum 2 percent increase over the 2000 rates. The blended rate will not be paid in any county. The BBA included a budget neutrality requirement that specifies that total payments based on the minimum increase, the floor rate, and the blended rates must equal the aggregate payments that would have been made if payments were based on area specific rates only. Only blended rates may be adjusted to fulfill the budget neutrality requirement. In 2001, funding the minimum increase and floor amounts will push aggregate spending above the budget neutrality amount. Therefore, the blended rates cannot be funded.

²⁷Among counties that had a Medicare+Choice plan in 1999.

Table 8: Counties With Medicare Plans in July 1999 Affected by Withdrawals, by Percentage Increase in 2000 Payment Rates

	Percentage change in payment rates, 1999-2000				Total
	2%	2-5% ^a	5-10% ^a	More than 10%	
Number of counties affected by 2000 withdrawals	72	96	137	24	329
Number of counties with plan(s) in 1999	179	213	435	60	887
Percentage of counties with plan(s) in 1999 affected by the withdrawals	40%	45%	31%	40%	37%

^aThe range for each of these categories begins slightly above the lower number and includes the higher number.

Sources: Medicare Risk Monthly Payment Rates, 2000, www.hcfa.gov/; Medicare Compare Database, 1999, www.hcfa.gov/; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999, www.hcfa.gov/medicare/; and files of contract nonrenewals and service area reductions from the Center for Health Plans and Providers at HCFA.

Conclusions

Medicare+Choice is at a crossroads. Because of contract terminations and service area reductions, by January 2001 more than 1.6 million beneficiaries will have had to switch to a different plan or the traditional fee-for-service program since 1999. Industry representatives contend that payment rate increases are necessary to keep the program viable.

However, the Medicare+Choice program has already been expensive for taxpayers. As our work on payment rates shows, the vast majority of plans have gotten paid more for their Medicare enrollees than the government would have paid had these enrollees remained in the traditional fee-for-service program. Raising payment rates to a level sufficient to retain the plans leaving Medicare would mean increasing the excess that currently exists in payments for plan enrollees relative to their expected fee-for-service costs. In areas of the country where there are few beneficiaries and providers are in short supply, no reasonable payment rate increase is likely to entice plans to participate in Medicare. Thus, a trade-off exists between the significant additional costs that would be needed to keep more plans in the program and the benefits of providing more beneficiaries with options for accessing Medicare covered services. Such a trade-off raises questions about the equity of providing a greater array of benefits to a fraction of the

Medicare beneficiary population. In our view, efforts to protect the viability of Medicare+Choice plans come at the expense of ensuring Medicare's financial sustainability over the long term.

Agency Comments and Our Evaluation

In commenting on our report, HCFA stated that our findings confirmed its own analysis of Medicare+Choice plan withdrawals. HCFA noted that the pattern of withdrawals, analyzed at the corporation level instead of at the individual plan level, reinforces our finding that factors besides payment rates likely influenced plans' participation decisions. For example, HCFA said that in 2001, 54 percent of Aetna's Medicare+Choice enrollees and 69 percent of Cigna's enrollees will be affected by plan withdrawals, but less than 2 percent of Pacificare's enrollees and only 0.1 percent of Kaiser's enrollees will be affected. The agency contends that these differences provide evidence that the withdrawals reflect corporations' strategic business decisions that go beyond Medicare payment adequacy. HCFA also said that it believes the Administration's proposal to provide a prescription drug benefit to all enrollees would both reduce inequities in benefit availability and increase payments to Medicare+Choice plans that cover prescription drugs. (HCFA's comments appear in app. IV.)

We also provided representatives of the American Association of Health Plans (AAHP), the BlueCross BlueShield Association (BCBSA), and the Health Insurance Association of America (HIAA) an opportunity to comment on the report. All three groups disagreed with our conclusions and stated that our report did not touch on important issues relevant to plan withdrawals. They also said that withdrawals can be costly for beneficiaries because Medicare+Choice plans typically provide preventive care services and other benefits that are not covered in the traditional FFS program. (AAHP's, BCBSA's, and HIAA's comments appear in apps. V, VI, and VII.)

AAHP, BCBSA, and HIAA believe that inadequate Medicare+Choice payment rates are a principal cause of plan withdrawals. BCBSA stated that many plans could not afford to continue providing sufficient additional benefits (beyond those covered in FFS) to attract beneficiaries. All three industry groups stated that it is inappropriate to compare Medicare+Choice payment rate increases with changes in per capita FFS spending (as we did in fig. 6) because plans' costs have been growing faster than per capita FFS spending. HIAA said that FFS spending slowed only as a result of BBA's unprecedented reductions in Medicare reimbursements and that the Congress began correcting these reductions with the enactment of BBRA in

1999. BCBSA commented that the comparison is unfair because the traditional program can control costs in ways that are unavailable to plans. In our report, we acknowledge that plans typically provide benefits that are not available in the FFS program. However, we found that Medicare+Choice payments substantially exceeded plans' projected costs (including normal profits) of providing Medicare-covered benefits and that plans contracted with Medicare to use the difference to provide benefits that are not available in the FFS program. Furthermore, the contention that plans' costs have grown more rapidly than per capita FFS spending, or that plans have a limited ability to control their own cost increases, does not alter our finding that Medicare+Choice payments exceed the estimated amount that the traditional program would spend on the individuals enrolled in plans.

AAHP and HIAA stated that our methodology for estimating the FFS costs of plan enrollees, based on enrollees' prior use of services in the FFS program, underestimates the health care costs of plan enrollees and therefore overestimates excess payments to plans. In developing our methodology, however, we employed assumptions that would tend to underestimate excess payments.²⁸ Therefore, we believe our findings likely represent a lower bound on the estimated excess payments plans receive and the potential savings from improved risk adjustment. HIAA stated that services are overutilized in the FFS program and that by using FFS spending as a comparison we overestimated the degree of favorable selection and the extent of excess payments to plans. In our analysis, we did not attempt to quantify an appropriate level of care. If services are overutilized in the FFS program, a comparison of plan payments with a more efficient delivery system might indicate less favorable selection, but it would not alter our finding that current Medicare+Choice payment rates—largely based on FFS spending patterns—exceed the estimated cost of providing Medicare-covered benefits in the FFS program.

AAHP, BCBSA, and HIAA said that we did not address the issue of regulatory burden in our report. They believe that recent regulations have increased plans' administrative costs and discouraged plan participation. Because many of the recent regulations resulted from provisions in BBA designed to increase plan accountability, facilitate informed choice and

²⁸Our methodology for estimating these costs is described in *Medicare+Choice: Payments Exceed Cost of FFS Benefits, Adding Billions to Spending* (GAO/HEHS-00-161, Aug. 23, 2000).

plan comparisons, protect beneficiary rights, or foster quality improvement efforts, a comprehensive analysis of this issue would require an assessment of the regulations' benefits as well as their costs. Such an analysis was beyond the scope of our report.

Finally, AAHP and BCBSA stressed that plans typically provide benefits not covered in the traditional FFS program and that plan withdrawals are not only disruptive for beneficiaries but can also result in beneficiaries having to pay more in out-of-pocket costs. Although we agree, and did discuss this issue in the report, it was not the focus of our study.²⁹

We are sending copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration, and other interested parties who request them.

If you or your staffs have any questions about this report, please call me on (202) 512-7114 or Laura A. Dummit, Associate Director, on (202) 512-7119. Other major contributors included George Duncan, Beverly Ross, and Susanne Seagrave under the direction of James C. Cosgrove.



William J. Scanlon
Director, Health Financing and
Public Health Issues

²⁹A recent report by the Department of Health and Human Services Office of Inspector General, *HMO Withdrawals: Impact on Medicare Beneficiaries*, OEI-04-00-00390 (Aug. 2000), addresses this issue directly and contains the results of surveys of beneficiaries affected by the 2000 withdrawals.

List of Requesters

The Honorable Charles E. Grassley
Chairman

The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable William V. Roth, Jr.
Chairman

The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable William M. Thomas
Chairman

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Scope, Methodology, and Data Sources

We reviewed pertinent laws, regulations, HCFA policies, and research by others to obtain information on the Medicare+Choice program, including revisions to the payment methodologies. To obtain different perspectives on why plans withdrew or reduced their service areas, we interviewed officials at HCFA's regional offices and representatives from the American Association of Health Plans and Blue Cross/Blue Shield of Maryland, one of the plans that withdrew. To do our analysis, we obtained data files from HCFA, which the agency uses to compute Medicare+Choice plan payments and which are widely used by researchers.

To identify counties with a plan in 1999, we used HCFA's 1999 Medicare Compare Database combined with HCFA's July 1999 Medicare Managed Care Market Penetration for All Medicare Plan Contractors—Quarterly State/County/Plan Data Files. We excluded cost, demonstration, and health care prepayment plans from our analysis and used only those plans identified as Medicare+Choice. We concluded that a plan was offered in a particular county only if both databases agreed. The count of enrollees by plan by county in a plan's service area as of July 1999 was obtained from the State/County/Plan Penetration Files, except in four cases where plans reduced their service areas and withdrew from only part of a county. In these cases, we obtained the actual number of enrollees affected from HCFA's Center for Health Plans and Providers.

Similarly, we identified counties with a plan in 2000 using HCFA's 2000 Medicare Compare Database combined with HCFA's March 2000 Medicare Managed Care Market Penetration for All Medicare Plan Contractors—Quarterly State/County/Plan Data Files. Again, we excluded cost, demonstration, and health care prepayment plans from our analysis and used only those plans identified as Medicare+Choice. We concluded that a plan was offered in a particular county only if both databases agreed. HCFA's Center for Health Plans and Providers gave us a list of contract consolidations that occurred in 2000, and we adjusted our information accordingly. The count of enrollees by plan by county in a plan's service area as of March 2000 was obtained from the State/County/Plan Penetration Files.

To analyze the changes in plan participation in the Medicare+Choice program in 2000 and 2001, we used HCFA data on Medicare+Choice plan contracts. In July 1999, HCFA provided us with a list of plans that had announced they were withdrawing from the program or reducing their service areas as of January 1, 2000, and the counties and number of

enrollees affected. In July 2000, HCFA provided us with the same information for plans that had announced changes for 2001.

We excluded Guam, Puerto Rico, and the Virgin Islands from all county-level analyses. In some of the analyses, the same counties are defined as separate entities if plans can contract with them separately. For example, Los Angeles County, California, is divided into Los Angeles-1 and Los Angeles-2; they are counted separately because plans may contract with them separately. The independent cities of Virginia are also counted as separate counties because their payment rates differ from those of their counties, and plans contract to serve these areas as if they were independent counties.

We classified counties as urban, rural, or small urban/fringe using the rural/urban continuum codes in the February 1999 Area Resource File, which we obtained from the Bureau of Health Professions, Health Resources and Services Administration of the Department of Health and Human Services. We defined urban counties as the central counties of metropolitan areas of 1 million population or more and rural counties as all nonmetropolitan counties. Finally, included in the small urban/fringe counties are counties in metropolitan areas of less than 1 million population and fringe counties of metropolitan areas of 1 million population or more. The February 1999 Area Resource File combines the Virginia independent cities into their original counties and does not report separate rural/urban continuum codes for these. We kept these cities separate in keeping with the HCFA data, and we assigned these cities the same rural/urban continuum codes as their original counties.

To analyze geographic differences in beneficiaries' access to a plan from 1993 to 1998, we used the December 1993-1998 State/County/Plan Penetration Files and deleted all plan/county combinations where a plan enrolled fewer than 10 enrollees. Because we were not able to obtain actual contract information on plan service areas before 1997, this provided an approximation of plans' service areas. We then used the same urban, rural, and small urban/fringe county designations as before from the February 1999 Area Resource File to determine the percentage of beneficiaries with access to a Medicare+Choice plan in these different areas.

We obtained county-level payment rate information for 1997 through 2001 for Medicare risk plans and Medicare+Choice plans, including payment reductions resulting from the removal of graduate medical education (GME) spending, from HCFA's Web site. In addition, we used a February

Appendix I
Scope, Methodology, and Data Sources

1999 file from HCFA's Office of Information Systems containing historical county-level information on the year that plans first entered individual counties.

Plans Withdrawing From Medicare+Choice, January 2000

Plan name	Total number of enrollees affected
Arkansas	
Healthsource, Arkansas, Inc.	2,100
United Healthcare of Arkansas, Inc. ^a	200
Arizona	
Blue Cross/Shield of Arizona	14,500
United Healthcare of Arizona ^a	5,200
Premier Healthcare, Inc. ^a	4,500
Humana Health Plan, Inc. ^a	3,900
Health Plan of Nevada, Inc. ^a	3,200
California	
Blue Cross of California ^a	3,600
Cigna Healthcare of California ^a	3,400
Pacificare of California, Inc. ^a	3,100
United Healthcare of California	1,600
National Med, Inc. ^a	1,400
Aetna U.S. Healthcare of California ^a	900
Health Net ^a	200
Health Net ^a	0
Colorado	
Cigna Healthcare of Colorado, Inc.	6,000
Qual-Med, Inc., Denver	5,000
HMO Colorado, Inc. ^a	2,700
Qual-Med, Inc., Pueblo	500
Qual-Med, Inc., Colorado Springs	200
Connecticut	
Kaiser Foundation Health Plan of Connecticut	3,400
Physicians Health Service of Connecticut, Inc. ^a	3,100
Connecticare, Inc. ^a	2,100
Florida	
Florida Health Choice, Inc.	14,700
Community Health Care Systems, Inc.	3,200
Humana Medical Plan, Inc. ^a	3,000
HIP Health Plan of Florida, Inc.	2,600
Cigna Healthcare of Florida, Inc. ^a	2,100
Av-Med Health Plan, Inc. ^a	1,900
Av-Med Health Plan, Inc. ^a	1,600

**Appendix II
Plans Withdrawing From Medicare+Choice,
January 2000**

(Continued From Previous Page)

Plan name	Total number of enrollees affected
Health Options, Inc. ^a	20
Georgia	
United Healthcare of Georgia, Inc. ^a	600
Kaiser Foundation Health Plan of Georgia, Inc. ^a	600
Iowa	
Exclusive Healthcare, Inc.	1,500
Illinois	
Humana Health Plan, Inc. ^a	1,300
Accord Health Plan	700
Kansas	
Humana Kansas City, Inc. ^a	700
United Healthcare of the Midwest, Inc.	500
Cigna Healthcare of Kansas/Missouri	300
Louisiana	
Ochsner Health Plan ^a	17,000
United Health Care of Louisiana	17,000
Massachusetts	
Harvard Pilgrim Health Care ^a	3,400
United Health Plans of New England ^a	2,100
Maryland	
Free State Health Plan ^a	14,700
United Healthcare of the Mid-Atlantic ^a	600
Minnesota	
Medica ^a	2,800
Missouri	
Cigna Healthcare of Kansas/Missouri	1,200
United Healthcare of the Midwest, Inc.	800
Nebraska	
Exclusive Healthcare, Inc.	5,500
New Hampshire	
Healthsource New Hampshire, Inc.	13,400
New Jersey	
United Healthcare of New Jersey, Inc.	2,300
Physicians Health Services of New Jersey, Inc.	2,200
Cigna Healthcare of New Jersey, Inc. ^a	1,400
Cigna Healthcare of New Jersey, Inc.	40

Appendix II
Plans Withdrawing From Medicare+Choice,
January 2000

(Continued From Previous Page)

Plan name	Total number of enrollees affected
New Mexico	
Presbyterian Health Plan ^a	20
Nevada	
Humana Health Plan, Inc.	9,500
New York	
Capital Area Community Health Plan	9,700
Oxford Health Plans (New York) Inc. ^a	9,100
Capital Area Community Health Plan	7,800
Physicians Health Service of New York, Inc. ^a	4,200
United Healthcare of New York, Inc. ^a	3,400
Capital Area Community Health Plan	2,500
Vytra Healthcare	900
Cigna Healthcare of New York ^a	800
Hum/Healthcare Systems, Inc. ^a	300
Ohio	
Pacificare of Ohio, Inc. ^a	4,200
Cigna Healthcare of Ohio, Inc.	3,700
Summacare, Inc. ^a	1,700
Community Health Plan of Ohio ^a	1,400
Qualchoice Health Plan ^a	1,300
Aetna U.S. Healthcare, Inc. ^a	600
Health Alliance Plan of Michigan ^a	0
Family Health Plan, Inc. ^a	0
Oklahoma	
Bluelincs HMO, Inc. ^a	1,200
Oregon	
Pacificare of Oregon II	1,400
Pacificare of Oregon, Inc. ^a	1,000
Providence Health Plan ^a	700
Pennsylvania	
Healthamerica of Central Pennsylvania ^a	800
Cigna Healthcare of Pennsylvania, Inc.	0
Rhode Island	
United Health Plans of New England, Inc. ^a	2,100
South Carolina	
Companion Healthcare Corporation	1,100

Appendix II
Plans Withdrawing From Medicare+Choice,
January 2000

(Continued From Previous Page)

Plan name	Total number of enrollees affected
Tennessee	
United Healthcare of Tennessee, Inc.	500
United Healthcare of Tennessee, Inc.	100
Tennessee Health Care Network, Inc. ^a	40
United Healthcare of Tennessee, Inc.	20
Texas	
Humana Health Plan of Texas ^a	23,500
Healthcare Partners Plans, Inc.	4,400
Cigna Healthcare of Texas, Inc.	2,700
HMO Blue, Northeast Texas	1,300
Humana Health Plan of Texas ^a	300
United Healthcare of Texas, Inc.	80
Virginia	
Optima Health Plan	13,800
Healthkeepers, Inc.	2,900
Washington	
Pacificare of Washington, Inc. ^a	6,000
Group Health Cooperative of Puget Sound	3,300
Healthplus ^a	1,400
Group Health Cooperative of Puget Sound ^a	900
Options Health Care, Inc. ^a	90
First Choice Health Plan ^a	10
Wisconsin	
Humana Wisconsin Health Organization Insurance Corporation	4,200
Primecare Health Plan, Inc. ^a	2,600
West Virginia	
Carelink	0

^aPlan remained in Medicare but reduced the number of counties served.

Sources: Medicare Compare Database, 1999; Medicare Managed Care Market Penetration State/County/Plan Data Files, July 1999, www.hcfa.gov/medicare/; Bureau of Health Professions, Area Resource File, Feb. 1999; and files of contract nonrenewals and service area reductions from the Center for Health Plans and Providers at HCFA.

Plans Withdrawing From Medicare+Choice, January 2001

Plan name	Total number of enrollees affected
Alabama	
Health Partners of Alabama, Inc. ^a	2,500
Arkansas	
HMO Partners ^a	300
Arizona	
United Healthcare of Arizona	12,300
Intergroup Prepaid Health Service of Arizona ^a	7,500
Cigna Healthcare of Arizona, Inc. ^a	4,300
Pacificare of Arizona, Inc. ^a	200
California	
Cigna Healthcare of California	16,400
Aetna U.S. Healthcare of California	14,500
Blue Cross of California ^a	5,500
National Med, Inc. ^a	5,200
California Physicians Services ^a	4,300
Health Net ^a	3,100
Maxicare, A California Corporation ^a	3,000
Blue Cross of California	400
Colorado	
Pacificare of Colorado, Inc. ^a	4,000
Mutual of Omaha of Colorado, Inc.	500
Connecticut	
Anthem Health Plans, Inc. (CT)	23,500
Aetna U.S. Healthcare, Inc.	14,500
Cigna Healthcare of Connecticut, Inc.	10,500
Physicians Health Service of Connecticut ^a	2,700
District of Columbia	
Free State Health Plan	700
Cigna Healthcare Mid-Atlantic, Inc.	200
Delaware	
Cigna Healthcare of Delaware, Inc.	3,600
Florida	
Humana Medical Plan, Inc. ^a	25,600
Prudential Health Care Plan, Inc.	10,200
Cigna Healthcare of Florida, Inc.	8,600

**Appendix III
Plans Withdrawing From Medicare+Choice,
January 2001**

(Continued From Previous Page)

Plan name	Total number of enrollees affected
Prudential Health Care Plan, Inc.	8,300
Cigna Healthcare of Florida, Inc.	7,300
Prudential Health Care Plan, Inc.	7,200
United Healthcare of Florida, Inc. ^a	7,000
Aetna U.S. Healthcare, Inc.	6,900
Prudential Health Care Plan, Inc.	5,200
Av-Med Health Plan, Inc. ^a	900
Physicians Healthcare Plans, Inc. ^a	300
Preferred Medical Plan, Inc.	200
Georgia	
Cigna Healthcare of Georgia, Inc.	10,000
Aetna U.S. Healthcare of Georgia, Inc.	6,700
United Healthcare of Georgia, Inc.	2,800
HMO Georgia, Inc. ^a	300
Illinois	
Humana Health Plan, Inc. ^a	7,200
Aetna Health Plan of Illinois, Inc.	6,400
United Healthcare of the Midwest, Inc. ^a	4,200
Mercy Health Plans of Missouri ^a	400
Indiana	
MaxiCare Indiana, Inc.	6,100
Anthem Insurance Companies, Inc.	2,500
Aetna Health Plan of Illinois, Inc.	500
Kentucky	
Aetna U.S. Healthcare, Inc.	3,800
Pacificare of Ohio, Inc.	2,700
Humana Health Plan of Ohio, Inc.	2,700
Louisiana	
HMO Louisiana, Inc.	9,400
Ochsner Health Plan ^a	5,900
Aetna U.S. Healthcare, Inc.	5,200
Gulf South Health Plans, Inc. ^a	4,600
Maxicare Louisiana, Inc. ^a	0
Massachusetts	
Harvard Pilgrim Health Care ^a	10,800
United Health Plans of New England, Inc. ^a	10,100

**Appendix III
Plans Withdrawing From Medicare+Choice,
January 2001**

(Continued From Previous Page)

Plan name	Total number of enrollees affected
Fallon Community Health Plan, Inc. ^a	900
Maryland	
Free State Health Plan	30,700
United Healthcare of the Mid-Atlantic	15,100
Cigna Healthcare Mid-Atlantic, Inc.	7,300
Maine	
NYLCare Health Plans of Maine, Inc.	1,600
Michigan	
Care Choices HMO ^a	100
Minnesota	
Medica Health Plans	14,300
Missouri	
HMO Missouri, Inc.	4,800
Group Health Plan, Inc. ^a	3,500
Humana Kansas City, Inc. ^a	1,800
North Carolina	
Wellpath Select, Inc.	3,800
Qualchoice of North Carolina, Inc. ^a	80
New Hampshire	
Harvard Pilgrim Health Care of New Hampshire ^a	500
New Jersey	
Oxford Health Plans (New Jersey), Inc. ^a	7,000
Cigna Healthcare of New Jersey, Inc.	4,400
Amerihealth HMO, Inc. ^a	800
Qualmed Plans for Health, Inc. ^a	200
New Mexico	
Lovelace Health Plan, Inc. ^a	5,800
St. Joseph Healthcare PSO, Inc.	5,600
Presbyterian Health Plan ^a	2,400
Qualmed, New Mexico	2,100
New York	
Aetna U.S. Healthcare, Inc. ^a	34,900
HIP of Greater New York ^a	11,300
Cigna Healthcare of New York	7,200
MDNY Healthcare, Inc.	6,500
Health Services Medical Corps Central New York	2,300

**Appendix III
Plans Withdrawing From Medicare+Choice,
January 2001**

(Continued From Previous Page)

Plan name	Total number of enrollees affected
Physicians Health Service of New York, Inc. ^a	2,100
Ohio	
Aetna U.S. Healthcare, Inc.	27,800
Prudential Health Care Plan of Northern Ohio	14,400
Humana Health Plan of Ohio, Inc.	8,500
Aetna U.S. Healthcare, Inc.	5,600
Pacificare of Ohio, Inc.	2,900
Paramount Care, Inc. ^a	2,900
Community Health of Ohio ^a	2,400
Kaiser Foundation HP of Ohio ^a	700
Summacare, Inc. ^a	600
Oklahoma	
Blueincls HMO, Inc.	3,600
Community Care HMO, Inc. ^a	3,600
Oregon	
Providence Health Plan ^a	5,800
Pennsylvania	
HMO of Northeastern Pennsylvania, Inc.	30,700
Aetna U.S. Healthcare ^a	18,100
Penn State Geisinger Health Plan ^a	16,600
Keystone Health Plan Central, Inc. ^a	6,100
Healthcentral, Inc.	5,900
Healthguard of Lancaster, Inc.	5,200
Healthamerica of Central Pennsylvania ^a	3,400
Qualmed Plans for Health, Western Pennsylvania	3,000
Qualmed Plans for Health, Inc. ^a	500
Rhode Island	
United Health Plans of New England, Inc. ^a	1,700
Tennessee	
Health 1*2*3	13,700
Tennessee Health Care Network, Inc.	3,300
Healthsource Tennessee, Inc.	2,900
Texas	
NYLCare Health Plans, Inc.	71,600
NYLCare Health Plans, Inc.	56,200
Humana HP of Texas ^a	20,500

**Appendix III
Plans Withdrawing From Medicare+Choice,
January 2001**

(Continued From Previous Page)

Plan name	Total number of enrollees affected
Prudential Health Care Plan, Inc.	6,500
Seton Health Plan	6,100
Presbyterian Health Plan, Inc.	5,400
Methodistcare, Inc.	5,100
Pacificare of Texas, Inc. ^a	5,000
Cigna Healthcare of Texas, Inc.	2,500
Texas Health Choice, L.C. ^a	1,500
Prudential Health Care Plan, Inc., San Antonio	333
Virginia	
Cigna Healthcare of Virginia, Inc.	13,700
Cigna Healthcare Mid-Atlantic, Inc.	1,000
Washington	
Aetna U.S. Healthcare, Inc.	10,600
Regencecare	7,900
Healthplus	7,100
First Choice Health Plan	3,600
Providence Health Plan ^a	1,600
Pacificare of Washington, Inc. ^a	1,400
Wisconsin	
Network Health Plan of Wisconsin, Inc.	1,400

Note: Approximately 8,400 of the affected enrollees for 2001 live outside of the withdrawing plans' service areas. These enrollees are excluded from this analysis.

^aPlan remained in Medicare but reduced the number of counties served.

Sources: Medicare Compare Database, 2000; Medicare Managed Care Market Penetration State/County/Plan Data Files, Mar. 2000, www.hcfa.gov/medicare/; and files of contract terminations and service area reductions from the Center for Health Plans and Providers at HCFA.

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

AUG 31 2000

Office of the Administrator
Washington, D.C. 20201

TO: Laura A. Dummit
Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: GAO Draft Report: "Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings (GAO/HEHS-00-183)

Thank you for the opportunity to review your draft report to Congress on Medicare+Choice and plan withdrawals. We agree with your findings and found your report to be valuable and informative. Your report also confirms our own analysis and findings about Medicare+Choice withdrawals.

We would note that while your report did look at the largest withdrawing Medicare plans, an additional fact would further support your conclusions. For 2001, Aetna and CIGNA are choosing to leave virtually all of their Medicare managed care markets, affecting 54 percent of Aetna Medicare+Choice enrollees and 69 percent of CIGNA Medicare+Choice enrollees. In contrast, less than 2 percent of Pacificare's and only 0.1 percent of Kaiser's Medicare+Choice enrollees were affected by the withdrawals. Indeed, Aetna and CIGNA withdrawals are responsible for nearly 50 percent of the 934,000 beneficiaries affected by withdrawals. Aetna and CIGNA's withdrawals are a prime example of how factors other than payment levels, in this case, strategic business decisions, influence Medicare+Choice participation decisions.

You note in your conclusion the equity issues raised by increasing payments to Medicare+Choice in order to provide "a greater array of benefits to a fraction of the Medicare beneficiary population." This is why the Administration is pushing to secure a meaningful prescription drug benefit for all beneficiaries. The Administration's proposal would assure access to this important benefit, regardless of whether beneficiaries live in areas where Medicare+Choice plans have chosen to operate or how beneficiaries have chosen to receive their Medicare benefits. This proposal would also provide an estimated \$2 billion in new revenues to Medicare+Choice plans in 2001 and \$25 billion over 5 years.

Another key to stabilizing the Medicare+Choice program is to move away from a fixed, statutory formula for determining payment to Medicare+Choice plans. The President had proposed to move toward a payment system based on a bidding process under his competitive defined benefit program. Under this program, beneficiaries choosing more efficient, lower cost plans could reduce their Part B premiums and choose to purchase supplemental benefits they need.

Again, thank you for the opportunity to review this report. We look forward to continuing our work with you on this important issue.

Comments From the American Association of Health Plans



American Association of
HEALTH PLANS

William J. Scanlon
Director, Health Financing
and Public Health Issues
U.S. General Accounting Office
NGB/Health Finance
441 G Street, NW
Washington, DC 20548

Dear Mr. Scanlon:

Thank you for the opportunity to comment on the General Accounting Office's (GAO's) draft report "Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings." The American Association of Health Plans (AAHP) supports the need to inform various stakeholders about the Medicare+Choice program's experience to date. As indicated in the comments below, AAHP does, however, have concerns about several aspects of the report and believes that the omission of crucial information undermines its usefulness. The broad dislocations experienced in the Medicare+Choice program over three consecutive years indicate the presence of systemic problems that have not been accounted for by GAO's analysis, but that must be solved to restore stability to Medicare+Choice for beneficiaries.

General Comments

As you know, the "Medicare risk" program served as the foundation for establishing the Medicare+Choice program in the Balanced Budget Act of 1997 (BBA). Although achieving savings was among the Medicare risk program's goals, an equally important objective was expanding beneficiaries' coverage choices – choices through which health plans could offer beneficiaries additional benefits not available in fee-for-service (FFS) Medicare. In several instances, the report notes that payments to plans exceed their costs to provide "Medicare-covered benefits" (i.e., FFS benefits). The report states that health plans use "savings" to provide additional benefits, but does not acknowledge that providing beneficiaries the opportunity to receive additional benefits in exchange for accepting alternative models of coverage was an envisioned outcome of the Medicare risk and Medicare+Choice programs.

Further, like last year's report, the draft notes that plans' participation decisions may have been influenced by a combination of market factors without a clear recognition that BBA changes to payment and regulatory requirements have directly influenced current "market" conditions. The BBA changes have had unintended consequences and have challenged plans' abilities to participate in the Medicare+Choice program. These consequences include: (1) annual payment updates in payment far below projections; (2) HCFA's implementation of the health status risk-adjuster in a manner that will significantly reduce Medicare+Choice payments; and (3) excessive regulatory requirements. These unintended consequences clearly have hindered newer and/or smaller plans' abilities to participate over the long term. Equally important, the GAO's finding that in 2001, plans with larger enrollments and longer program history have been forced to withdraw suggests that rather than normal reaction to competition, these unintended consequences have created obstacles that even these more established plans cannot overcome.

1129 Twentieth Street, NW • Suite 600 • Washington, DC 20036 • 202-778-3200 • FAX: 202-331-7487

Appendix V
Comments From the American Association of
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Finally, AAHP continues to disagree with the GAO's conclusions presented throughout the report regarding the health status and "costliness" of beneficiaries who enroll in Medicare+Choice plans. As expressed in our August 14th letter, AAHP believes that the measure used in GAO's analysis, which is based on pre-managed care enrollment fee-for-service (FFS) expenditures (i.e., "prior use") as a measure of the health status of beneficiaries who are enrolled in M+C plans, bears little relationship to health plan enrollees' actual health status and health care needs.

Additional Comments

- **Comparison to Growth in Per Capita FFS Spending.** The GAO reports that Medicare+Choice payments have risen faster than per capita FFS spending between 1997 and 1999; that this trend – though narrower -- will continue for the period 1997 to 2000; and that by 2001, cumulative growth in FFS will slightly exceed growth in Medicare+Choice payments.

AAHP Comment. It is widely recognized that the BBA has reduced Medicare spending far beyond the original Congressional Budget Office (CBO) estimate of \$115 billion over five years. Last year, Congress approved the Balanced Budget Refinement Act (BBRA) in an effort to ease the impact of the BBA. More recently, the House of Representatives by an overwhelming margin approved House Resolution 535, which explicitly recognizes that the BBA has resulted in payment rates for classes of providers below the rate previously anticipated.

The comparison to FFS spending growth belies the reality that costs are rising faster than payments not only for health plans, but also for other providers who serve Medicare beneficiaries. Notwithstanding the recent FFS trends, information released by plans in July indicates that plans are sustaining significant Medicare losses. That costs are rising much faster as indicated by FFS trends, is evidenced in the FEHB Program in which total premiums collected by health plans (from OPM and from enrollees), for the average beneficiary, increased by total of 29.1 percent between January 1997 and December 2000.

- **Disruptive Effect of Withdrawals.** The GAO notes that plan withdrawals and service area reductions are disruptive and costly for beneficiaries.

AAHP Comment: Given the emphasis on the hardships faced by beneficiaries affected by withdrawals and service area reductions, AAHP urges GAO to: (1) articulate more fully the reasons beneficiaries join health plans; and (2) report on their high level of satisfaction with health plans. With respect to first point, AAHP has shared with GAO two AAHP analyses of Health Care Financing Administration (HCFA) data that demonstrate the important contributions that plans have made in providing a strong value, particularly for financially vulnerable beneficiaries. With regard to the second point, HCFA's Consumer Assessment of Health Plans Survey (CAHPS) showed that on a scale of "1 to 10," with 10 being the highest rating, fully 50 percent of all beneficiaries enrolled rated their health plan as a "10." An additional 34 percent of enrollees rated their health plan as an "8" or "9." This HCFA finding is just one of many reports of strong satisfaction among Medicare+Choice enrollees.

- **Comparison to FEHBP.** In several places, the report compares health plans withdrawing from the Medicare+Choice program to those withdrawing from the Federal Employees Health Benefit (FEHB) program. One passage states that FEHBP "experienced a period of rapid expansion between 1994 and 1997 followed by the withdrawal of newer, relatively small plans."

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AAHP comment: AAHP appreciates the report's recognition that in 2001, approximately one percent of beneficiaries are expected to be affected by health plan decisions to no longer participate in FEHBP, substantially less than the 15 percent of Medicare beneficiaries affected by health plan withdrawals. However, the comparison could use further clarification since GAO found that unlike the newer plans with smaller enrollments that withdrew from FEHBP, more established plans with larger enrollments withdrew from Medicare+Choice in 2001.

- **Inability to Establish Provider Networks. The GAO notes that providers in some areas are becoming increasingly resistant to contracting with health plans, making it more difficult to assemble viable provider networks.**

AAHP comment: The GAO report does not identify the factors that produced this result, or identify plans' withdrawal decisions as the result of providers' decisions to not participate in Medicare+Choice. Difficulty in maintaining provider networks is directly related to constrained Medicare+Choice payment rates, and in some cases, may have had an impact on plan decisions to withdraw from certain markets. In addition, several of the regulatory requirements with which health plans must comply spill over to require similar efforts by their network providers. One such example is the physician encounter data requirements under the Medicare+Choice risk adjustment initiative. Preparations for their implementation involve an enormous commitment of resources by Medicare+Choice plans and providers. Rather than face this and other Medicare+Choice requirements, many providers are opting not to participate health plans' networks.

In June, HCFA recognized concerns about the effect of regulatory burden on plans' abilities to participate in the Medicare+Choice program. Some regulatory provisions were modified to streamline administrative procedures in an effort to lead to more efficient and consistent program oversight. AAHP believes that this is a significant first step in addressing some of the unintended consequences of the BBA.

- **Description of Medicare+Choice Payment Methodology. Although the draft report describes the Medicare+Choice payment methodology, including its intended goals, its omits crucial information about its effectiveness in achieving those goals.**

AAHP Comment: As mentioned in the report, the "blend" was intended to reduce geographic disparity in payments across the country. Using the CBO projections, the Medicare Payment Advisory Commission (MedPAC) presented simulation results in its March 1998 Report, which suggested that beginning in 2000, the blend would produce the highest of the three preliminary rates for more than 40 percent of counties and that the majority of counties would receive the blended amount in 2001 and beyond. Although some counties received blended payments in 2000, 40 percent of enrollees lived in areas that received a 2 percent update and that more than 57 percent of enrollees live in areas that received updates of 3.5 percent or less. In 2001, no counties will receive blended payments.

With respect to the BBA-mandated risk-adjuster, AAHP believes that its impact on Medicare+Choice payments merits attention in the body of the report, rather than in a footnote. The estimated 5.9 percent reduction is in addition to the \$22.5 billion in savings from the Medicare+Choice program upon the BBA's approval. Moreover, HCFA's approach contravenes Congressional intent to implement risk adjustment in a budget-neutral manner, which it expressly stated in the conference report accompanying the BBRA.

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Finally, although Medicare+Choice payments exclude payments for graduate medical education (GME), plans have had limited ability to offset reductions in their payments to these facilities. Cost to plans of covering care in academic medical centers has not been reduced to reflect the exclusion of GME from payments to plans.

- **Fairness Gap Relative to FFS. The report states that AAHP contends that the BBA created a fairness gap by decreasing Medicare+Choice payments relative to per capita FFS spending.**

AAHP Comment: Notwithstanding any recent fluctuations in FFS spending, the BBA changes to the Medicare+Choice payment methodology clearly produces a large gap between per capita FFS spending and Medicare+Choice payments in the near-term.

- **Relationship between payments and withdrawals. The draft report states that the effect of payments on plans' participation decisions is less obvious than other factors.**

AAHP Comment: The GAO notes that the 80 percent to 90 percent of "higher payment counties" will be affected by withdrawals compared to two-thirds of "lower payment counties." In addition, the report notes that the pattern of withdrawals in 2000 suggests that even relatively large payment increases may not be enough to keep some plans in certain counties. However, many of these "higher payment counties" have been held to 2 percent increases in each of the last four years, when costs have been increasing faster. Although some counties affected by withdrawals received higher payment updates in 2000, these payments in these counties also were set at the 2 percent update or floor amounts in the other three years. Thus, the average annual growth rate in these counties has been much lower.

- **Volume of Medicare+Choice Applications. The GAO notes that although the volume has decreased, plans continue to submit Medicare+Choice applications, and that HCFA has already approved many of the applications since July 1998.**

AAHP Comment: It is worth noting that since July 1998, only one provider sponsored organization (PSO) received approval to participate in the Medicare+Choice program. In July, that PSO announced that it would withdraw from the Medicare+Choice program effective January 2001, leaving the private fee-for-service (PFFS) plan offered by Sterling as the only new type of plan participating in the Medicare+Choice program. The reluctance of new types of organizations to seek Medicare+Choice contracts underscores the difficulties in developing and offering a Medicare+Choice plan in the current payment and regulatory environment.

Again, thank you for the opportunity to provide comments on the GAO's draft report. AAHP and its member plans remain firmly committed to the success of the Medicare+Choice program. We appreciate the opportunity to share with you some of the significant concerns about the program's experience. If you have any questions concerning our comments, please call me at (202) 778-8464.

Sincerely,



Richard I. Smith
Vice President
Public Policy and Research

Comments From the BlueCross BlueShield Association



**BlueCross BlueShield
Association**

An Association of
Independent Blue Cross
and Blue Shield Plans

1510 G Street, N.W.
Washington, D.C. 20005
Telephone 202.626.4781
Fax 202.626.4855

Mary Nell Lehnhard
Senior Vice President
Office of Policy and Representation

September 5, 2000

Mr. William J. Scanlon, Director
Health Financing and Public Health Issues
United States General Accounting Office
Health, Education, and Human Services Division
Washington, D.C. 20005

Dear Mr. Scanlon:

The Blue Cross and Blue Shield Association is appreciative of the opportunity to review your report: *Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Saving.*

Blue Cross and Blue Shield Plans have a long history of involvement in the Medicare program. Collectively, Blue Cross and Blue Shield Plans provide Medicare HMO coverage to approximately one million Medicare beneficiaries, which makes the Blue system the largest Medicare HMO provider in the country. Blue Cross and Blue Shield Plans are firmly committed to the Medicare program and hope to remain integral players in Medicare under Medicare+Choice.

However, the future of Medicare+Choice is now very much in doubt, for two reasons: (1) inadequate and uncertain payments; and (2) excessive regulatory requirements and business risks. Unfortunately, the GAO report dismisses the former, and totally ignores the latter.

Medicare+Choice is a program in extremis. In 2001, more than 900,000 Medicare beneficiaries, about 15 percent of current HMO enrollees, will lose their current coverage through service area reductions or plan withdrawals (at least 17 percent, and possibly more, will not have another Medicare+Choice option). The GAO report plays down the magnitude of this change by noting that "enrollment has continued to increase although at a slower pace with the result that the total number of Medicare managed care enrollees has remained approximately the same or even increased slightly over the past 2 years." In fact, recent statistics for August 2000 show that Medicare+Choice enrollment has actually *declined* by about 1 percent since the same time a year earlier. More important, today's enrollment is *considerably* behind the projections of growth that were made at the start of the Medicare+Choice program: it seems hard to imagine that the Congressional Budget Office once projected that enrollment would rise to 20.8 percent in 2000 and 33 percent by 2005.

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The stagnation in enrollment owes in part to the erosion of benefits. A recent report released by the Commonwealth Foundation, *Medicare+Choice In 2000: Will Enrollees Spend More and Receive Less?*, found that “BBA-related changes have begun to affect the generosity of benefits and the premiums charged for them in 2000... [including] substantial increases in premiums and/or out-of-pocket expenses in the form of copayments.” The reason: “The changes in 2000 Medicare+Choice benefits are a response to payment rate changes ... [and] the BBA and related regulations [that] increased the administrative requirements on Medicare+Choice plans in areas such as provider contracting and quality management.”

To put the “BBA-related changes” in context, in 1998 the Congressional Budget Office estimated that the Balanced Budget Act of 1997 would reduce managed care payments by \$57 billion over a five year period (more than twice the reduction that the Congress originally intended in 1997). In addition, HCFA decided unilaterally to implement the new risk adjuster required by the BBA in a manner designed further to reduce program payments. Indeed, HCFA has previously estimated that its risk adjuster would produce five-year payment reductions for Medicare+Choice plans of \$11.2 billion. In a prescient forecast, CBO warned that such a reduction, “would be likely to cause plans to drop out of the program and enrollment in Medicare+Choice plans to drop sharply.”

The findings by the Commonwealth Foundation’s report confirm our concern that low Medicare payments resulting from BBA provisions designed to control spending, *and* increased administrative requirements and business risks, are primarily to blame for the current plan withdrawals.

Payment Growth

We believe GAO’s analysis falls short in rejecting contentions that payment rates in many areas are inadequate. A central point in GAO’s analysis is that “since the BBA was enacted the increase in Medicare+Choice payment rates has exceed the growth rate in per capita [Medicare] FFS spending,” the implication being that private plans are being paid more than adequately. However, the comparison with FFS payment rates is irrelevant. Medicare’s FFS spending has been contained by severe statutory reductions to providers; Medicare+Choice plans have no such power to slash payments to providers. Whereas the fee-for-service Medicare program has the clout unilaterally to set prices, private plans must negotiate with providers who, as your report points out, “in some areas are becoming increasingly resistant to contracting with them.”

Moreover, Medicare+Choice plans have experienced significant medical cost increases, especially for prescription drugs. Increases in the cost of drugs ranged from 12 percent to 17 percent in 1998 and 13 percent to 19 percent in 1999. National health spending more generally is also increasing by more than 5 percent a year. These cost increases far outweigh the 2 percent payment increases that most Medicare+Choice Organizations received in 1998 and 1999 and expect to receive in 2001. Thus, payment increases to Medicare+Choice plans have fallen far below the growing cost of plans’ benefit packages in most areas of the country.

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Excessive Regulations

Inadequate payment rate changes are not the only reason for plan withdrawals. Regrettably, the GAO report does not identify the role of administrative requirements and business risks in inducing plan withdrawals.

HCFA's Medicare+Choice regulations set a level of micromanagement that raises health plan costs and limits innovation. Importantly, every dollar spent on a proscriptive standard of dubious value is one less dollar that will be available for added benefits that enrollees value highly (such as prescription drugs). For example, HCFA's inordinately excessive Quality Improvement System for Managed Care (QISMC) ultimately discourages participation by setting rigid, arbitrary, one-size-fits-all requirements that *exceed* private sector standards.

Moreover, by generating a continuous flow of Operational Policy Letters and other directives, HCFA is forever changing or increasing its operational requirements in such areas as marketing, enrollment, claims processing, compliance, provider relations, finance and rate development, auditing and other functional areas.

HCFA's Medicare+Choice regulations also create serious business compliance risks that intensify concerns about participating in the program. To be clear, all Blue Cross and Blue Shield Plans are committed to complying with all applicable laws and regulations. But because of HCFA's uncertain or unclear requirements in some critical areas and proscriptiveness in others, any Medicare+Choice Organization must seriously consider the risk of unintentionally failing to comply with some requirements – and the consequences could be severe.

In recent weeks, HCFA has announced a number of welcomed administrative improvements that will doubtless offer some administrative relief in the future. Still, more must be done to relieve the regulatory burden on Medicare+Choice plans if the program is ever to realize the Congress's original goal: to expand significantly the types and numbers of private health plans offered to Medicare beneficiaries.

Thank you again for the opportunity to offer these comments on your report. Please direct any questions to Brian Webb at 202.626.8653 or Jane Galvin at 202.626.8651.

Sincerely,


Mary Nell Lehnhard
Senior Vice President

Comments From the Health Insurance Association of America



Health Insurance Association of America

Charles N. Kahn III
President

September 5, 2000

William J. Scanlon, Director
Health Financing and Public Health Issues
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Scanlon:

Thank you for providing the Health Insurance Association of America (HIAA) with an opportunity to comment on the GAO draft report "Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings."

HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. It is the nation's premiere provider of self-study courses on health insurance and managed care. HIAA members have long served Medicare beneficiaries through the Medicare+Choice program and by offering Medicare Supplement and Medicare Select coverage.

This new GAO report documents Medicare+Choice organizations' decisions in 2000 to withdraw M+C plans or reduce M+C plan service areas for the year 2001. It assesses the impact of these withdrawals on beneficiaries, and seeks to determine the extent to which the withdrawals are the result of insufficient payments, as stated by Medicare+Choice organizations and their representatives.

The report asserts that the Medicare+Choice program, rather than yielding savings, has raised total Medicare program outlays because the risk adjuster used was inadequate. It concludes that, going forward, Congress faces an inherent trade-off: the federal government must either continue to "overpay" Medicare+Choice plans and incur greater Medicare program outlays in order to provide beneficiaries with private plan options; or continue on the course set by the Balanced Budget Act of 1997 (BBA) of making "correct" payments and accepting the likely consequence of fewer private options and fewer beneficiaries enrolled.

Setting aside for the moment concerns we have about the reliability of the underlying analysis, HIAA believes that the report's conclusion reflects shortsightedness. With hindsight, it is clear that the BBA provider payment and other provisions have had the unintended effect of cutting too deeply. Congress began making corrections with the Balanced Budget Refinement Act of 1999. Now, the urgent question before Congress is "What further adjustments are needed to stabilize the Medicare program and to set the stage for broader Medicare program reform?"

555 13th Street, NW Suite 600 East Washington, DC 20004-1109 202-824-1858 Fax 202-824-1859

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HIAA strongly believes that private managed care plan participation in Medicare is not only desirable but also essential over the long run. Demands on the program will soon swell as baby boomers qualify for Medicare. As the report acknowledges, the original fee-for-service Medicare system has shortcomings in that it encourages over utilization, whereas private managed care plans have incentives to deliver appropriate care efficiently. While the pre-BBA and the immediate post-BBA program arguably may not be yielding the intended savings to the Treasury, the future of Medicare would be ill served by allowing the Medicare+Choice program to wither.

It is important to understand that any lack of savings to the Treasury there may be results from the way the Medicare+Choice program is designed, and that beneficiaries (and the federal government) obtain full value for the payments made, in terms of extra benefits provided to enrollees through health care delivery arrangements oriented to prevention and long-run health. Further, the geographic variation in M+C plan benefits is a direct result of the historical variations in original fee-for-service Medicare spending.

HIAA views many of the goals embodied in the BBA as laudable (e.g. to provide beneficiaries with a greater range of private plan options; to increase the availability of private plans in rural areas; to reduce the wide historical county-to-county differences in Medicare expenditures; to restructure federal support of graduate medical education). However, implementation of the BBA has been overwhelming for many Medicare+Choice organizations and devastating for affected beneficiaries. As we have stated elsewhere, and documented in the recent report "The Medicare+Choice Program: Is it Code Blue?" by Bruce Merlin Fried and Janice Ziegler, Congress and the Administration set overly ambitious goals vis-à-vis the range and timing of payment and quality-related program changes. And cuts in the current and future stream of M+C plan payments were deeper than Congress intended (in terms of both the occurrence of the minimum 2% increase and the Administration's non-budget-neutral approach to risk adjustment).

The report raises a fair question in asking what level of payment increase would be necessary to retain and expand Medicare+Choice organization participation? Relevant considerations differ between urban and rural markets. Medicare+Choice program experience thus far suggests that the private managed care plan model may not work in rural areas, with their small supply of providers and relatively low plan enrollments. However, the BBA's incentives for increasing the availability of rural M+C plans have not had a reasonable test. Adjustments in the payment formula "budget neutrality" requirement are needed to allow the implementation of blended rates. Adjustment in regulatory requirements for rural plans may also be necessary in order to reduce overhead costs for low-enrollment plans. And then more time is needed to allow these incentives to work.

For urban markets, which are better suited to the managed care plan model, there is no straightforward answer as to how much more money is needed. The Medicare+Choice program is destabilized. Much damage has been done in these rocky start-up years, in terms of beneficiaries' wariness about electing a private plan option, and Medicare+Choice organizations' concerns about the federal government as a business partner. What is

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reasonably certain is that *not* increasing payments will result in the continued unraveling of the program. We believe that some increase in M+C payments, along with measures taken by Congress and the Administration to lessen the burdens of program participation and improve program management, can make a difference in enabling M+C organizations to continue some plans, and perhaps inducing some organizations to enter or reenter the market, until the next round of Medicare reforms establishes a sounder basis for plan payments and participation requirements.

As to the report's findings regarding "excess payments" to Medicare+Choice organizations, we have several comments. The authors report that M+C plan payment growth since 1997 exceeds fee-for-service Medicare's spending growth. This happened only because the overly deep BBA cuts in hospital, skilled nursing facility, home health agency and other Medicare provider reimbursement, together with stepped-up Medicare anti-fraud activities, brought original Medicare spending growth to an unprecedented -- and unexpected -- standstill. The relevant fact is that M+C plan payment growth did not keep up with underlying increases in medical costs for core Medicare benefits (and were significantly below increases for extra prescription drug benefits).

The report points out that plan payment rates exceed Medicare+Choice organizations' costs of providing Medicare core benefits. This has always been the pattern, and per Congressional intent, the excess payments are used to provide beneficiaries with extra benefits. The finding that M+COs spent slightly more on extra benefits for continuing plans than for terminating plans the year before termination only suggests that there was somewhat more capacity to deal with plan reimbursement decreases for continuing than for terminating plans.

The new finding cited in this report, and presented in the "companion" GAO report "Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending," August 2000, is that plan payments in 1998 appear to have exceeded what these same enrollees would have cost, had they been enrolled in original fee-for-service Medicare. Although the report identifies this finding as an estimate rather than a fact, any uncertainty about the existence or the magnitude of the described overpayments are under played. We believe at a minimum, the report should present estimates within a range, for a greater level-of-confidence, considering that the final numbers are built on a long sequence of assumptions, each with some degree of uncertainty. More importantly, the report's approach to estimating the degree of favorable selection experienced by M+C plans relies on original Medicare as the "gold standard," i.e. as what a beneficiary's costs should have been. A much more appropriate measuring stick for assessing selection bias is outlays under a relatively efficient delivery system. If the baseline had assumed certain Medicare program efficiencies -- and thus lower spending -- for beneficiaries in the higher spending categories (where the majority of the efficiencies would be realized), the benchmark average spending per beneficiary in 1997 would be lower than the one computed by the GAO. More to the point, efficiencies at the high end of the distribution would lower the nonjoiner's mean more than the joiner's mean, and consequently the difference between the joiners and non-joiners average spending would be less than the 30% the authors observed. Thus GAO's methodology exaggerates the degree of any favorable selection experienced by M+C plans, increasing the uncertainty of their findings.

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Also, as the authors, themselves, point out, the BBA called for implementation of a more sophisticated health status-related risk adjuster, to better match plan payments with beneficiary health needs. Within the framework of the GAO's assumptions and analysis, they could expect, and should have stressed that excess payments resulting from the demographic risk adjuster would be significantly reduced with implementation of the new risk adjuster.

The BBA was crafted under great pressure to find budget-balancing savings. By now it is clear that the BBA resulted in more severe cuts than envisioned for most all Medicare provider groups. Furthermore, BBA authors assumed that M+C plan payment rates could be lowered, particularly in higher-paid areas, with minimal impact on the rapid enrollment growth observed just prior to BBA enactment. While it is reasonable to expect that the M+C program could weather some very gradual lowering of payments in higher payment areas, experience demonstrates that this was not a sound assumption given the amount and speed of payment reduction that BBA payment cuts produced.

HIAA continues to strongly support a major private insurer role in Medicare, both now and in the future. Those HIAA members that have withdrawn M+C plans since 1998 have done so reluctantly. We are convinced that "staying the course" set by BBA in 1997 will severely damage the prospects for a beneficial and much-needed private plan role in Medicare in the future. HIAA looks forward to working with Congress and the Administration to develop new payment and participation standards for Medicare+Choice that work in beneficiaries' best interests, and that also support regulator's oversight needs and health plan organizations' ability to provide efficient, high quality medical care and good customer service to the nation's Medicare beneficiaries.

Thank you again for inviting our comments.

Sincerely,



Charles N. Kahn III

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