APPENDIX E. MEDICARE+CHOICE

CONTENTS

INTRODUCTION

Medicare has a longstanding history of offering its beneficiaries an alternative to the traditional fee-for-service program, in which a payment is made for each individual Medicare-covered service provided to a beneficiary. Beginning in the 1970s, private health plans were allowed to contract with Medicare on a cost-reimbursement basis. In 1982, Medicare's Risk Contract Program was created, allowing private entities, mostly health maintenance organizations (HMOs), to contract with Medicare. In exchange for a preset monthly per capita payment from Medicare, private health plans agreed to furnish all Medicare-covered items and services to

each enrollee. By 1997, 15 years after the start of the Risk Contract Program, Medicare managed care covered more than 5 million people or about 14 percent of beneficiaries.

Then, in 1997, Congress passed the Balanced Budget Act of 1997 (BBA, Public Law 105–33), replacing the Risk Contract Program with the new Medicare+Choice (M+C) Program. The M+C Program established new rules for beneficiary and plan participation, along with a new payment methodology. The M+C Program was designed to expand the availability of health plans in markets where access to managed care plans was limited or nonexistent, and to offer new types of health plans in all areas. The M+C Program has not been as successful at expanding coverage as originally envisioned, and as a result, enrollment has grown moderately to about 16 percent of the Medicare population, or over 6 million beneficiaries.

Most recently, Congress enacted legislation in order to address some of the issues arising from the BBA changes. The Balanced Budget Refinement Act of 1999 (BBRA, Public Law 106–33) changed the M+C Program in an effort make it easier for Medicare beneficiaries and plans to participate in the program.

This appendix describes the current status of the M+C Program, as revised by the BBRA, along with the rules and standards under which the program operates. Data for 1998 and preceding years covers the Medicare Risk Contract Program and beginning in 1999, data covers the M+C Program.

OVERVIEW OF THE MEDICARE+CHOICE PROGRAM

In order to increase enrollment in Medicare managed care, and to allow beneficiaries access to similar options available in the non-Medicare market for meeting their health care needs, the M+C Program offers a diverse assortment of managed care plans. M+C options include not only coordinated care plans, but also private fee-for-service plans, and on a demonstration basis a combination of a medical savings account (MSA) plan and contributions to an M+C MSA. Coordinated care plans are plans that provide a full range of services in exchange for a per capita payment, the most typical of which is the HMO. An HMO is a type of managed care plan primarily owned and operated by insurers, that acts as both the insurer and the provider of health care services to an enrolled population. The BBA also allows for contracts with provider-sponsored organizations (PSOs), which are coordinated care plans owned and operated by providers, as well as preferred provider organizations (PPOs), which are groups of doctors and hospitals that contract with an insurer to offer their services on a fee-for-service basis at negotiated rates that are lower than those charged to nonenrollees. PPOs do not traditionally have primary care gatekeepers, who oversee health care services provided by a plan.

Alternatively, a beneficiary may select a private fee-for-service plan, that covers enrollees through a private indemnity health insurance policy for which the Health Care Financing Administration (HCFA) makes per capita payments to the insurer for each enrollee. The insurer then reimburses hospitals, doctors, and other providers at a rate determined by the plan on a fee-for-service basis without placing the providers at financial risk. It also does not vary rates based on utilization and does not restrict the selec-

tion of providers among those who agree to the plan's terms and meet the necessary qualifications.

Finally, the demonstration MSA plans reimburse Medicare-covered services after a specified high deductible is met. The difference between the premium for the high-deductible plan and the applicable M+C per capita payment would be placed into an account for the beneficiary to use to meet medical expenses below the deductible.

However, to date no Medicare beneficiary has enrolled in an MSA and there are no contracts for PPOs. Two PSOs are available to beneficiaries, one in Oregon and the other in New Mexico. The PSO in New Mexico obtained a Federal waiver from State licensing requirements to contract directly with Medicare. Beginning July 1, 2000, a private fee-for-service plan will be available to Medicare beneficiaries in 17 States (Alaska, Idaho, Kentucky, Minnesota, Nebraska, New Mexico, Nevada, Oregon, South Dakota, Tennessee, and Utah, along with selected counties in Arkansas, Louisiana, Mississippi, Ohio, Texas, and West Virginia). Enrollees may see any Medicare-approved provider who agrees to furnish services under the plan's terms and conditions of payment.

In addition to expanding options for Medicare managed care coverage, the BBA also substantially restructured the system for setting Medicare payment rates. Under the M+C Program, the per capita rate for a payment area is set at the highest of three amounts. The new payment structure will be phased in and is designed to reduce the variation in payments across the country by increasing payments in areas with traditionally low payments and slowing the rate of growth in areas with higher payments. Although variations in payments have been somewhat reduced, substantial payment differentials remain nationwide.

Initially, M+C payments were also adjusted for demographic risk factors, such as age, gender, and coverage by Medicaid to account for variations in health care costs. The BBA required the Secretary of the U.S. Department of Health and Human Services (DHHS) to develop a method for risk adjusting payments which includes health status in order to account for a larger share of the variation in costs. The method established by the Secretary adjusts for health status based on diagnoses for prior year inpatient hospitalizations. Phase-in of these health-based risk adjusters began in January 2000. However, the BBRA slowed down the Secretary's planned phase-in schedule and, as a result, a smaller portion of M+C payments than originally intended will be adjusted for the health status risk factors through 2002.

The BBRA made several other revisions to the M+C Program. It effectively raised future payments to plans by decreasing the scheduled reduction in the national per capita M+C growth percentage and by reducing the user fee that plans are required to provide DHHS for enrollment and other beneficiary activities. It established bonus payments for plans that enter areas where no other plan is in operation to encourage participation in rural areas. It moved the deadline for plans to submit their adjusted community rate (ACR) proposals from May 1 to July 1 of each year, and allowed plans to segment their service areas along county lines, in

order to better match revenues to cost. It also reduced the quality assurance program requirements for PPOs.

CURRENT STATUS OF THE MEDICARE+CHOICE PROGRAM

Achieving the goals of the M+C Program has been difficult, in part because the goal to control Medicare spending may have dampened interest by managed care entities in developing new markets, adding plan options, and maintaining their current markets. This cautious behavior may partially be a reaction to a slowdown in the rate of increase for both Medicare managed care payments and Medicare traditional fee-for-service payments.

Further, beneficiaries in rural areas still have limited access to managed care plans and enrollment growth has slowed across all geographic areas. Beneficiaries have also been offered less generous benefit packages and fewer options for zero or low monthly M+C premiums. Obstacles relating to data collection and quality improvement requirements may make it more difficult for some plans to meet these requirements, therefore further discouraging participation in the Medicare Program. Finally, as plans withdraw from the M+C Program, enrolled beneficiaries are forced to choose new M+C plans, while others are left without any access to Medicare managed care. Even among those who still have an option to choose a health plan, some beneficiaries have selected Medicare's fee-for-service program because they are concerned that additional plan withdrawals could be disruptive to their health care coverage.

By March 2000, M+C plans were available to about 72 percent of the 39 million Medicare beneficiaries, and about 16 percent of all beneficiaries chose to enroll in one of over 260 available M+C plans. The rapid growth rate of Medicare managed care enrollment in the 1990s has leveled off since the implementation of the M+C Program, and there was even a small decline in enrollment in 2000. Despite this recent trend, in their March 2000 baseline, the Congressional Budget Office projects that M+C enrollment will almost double by 2010, covering 31 percent of the Medicare population, or about one out of every three Medicare beneficiaries.

Enrollment is widely segmented across the country, however, with the majority of enrollees in just four States—California, New York, Florida, and Pennsylvania. Not surprisingly, Medicare beneficiaries in urban areas have greater access to plans. While 99 percent of beneficiaries in center cities have access to at least one plan, this number declines to less than 10 percent in the most rural areas.

TRENDS IN MEDICARE+CHOICE PLAN/CONTRACT AVAILABILITY AND ENROLLMENT

AVAILABILITY OF MEDICARE MANAGED CARE PLANS/CONTRACTS

The Medicare+Choice (M+C) Program began operation on January 1, 1999,[1] as authorized by BBA 1997. By March 2000, over 260

[1] Although most of the components of the M+C Program were effective in 1999, the M+C payment structure was implemented in 1998.

HMOs had contracted with HCFA under the M+C Program.[2] Over time, the number of plans choosing to participate in Medicare managed care has fluctuated. From 1987 to the early 1990s many plans terminated existing contracts, decreasing the number of available plans from 161 in 1987 to 93 in 1991. Then, the trend shifted as the number of Medicare risk plans began increasing in 1992, more than tripling from 110 in 1993 to 346 participating plans in 1998. With the implementation of the M+C Program in 1999, the downward cycle of contract availability began once again, as several M+C contracting organizations withdrew from the Medicare Program (or reduced the size of their service area). As shown in chart E–1, these reductions have resulted in fewer providers of Medicare managed care under the M+C Program than previously existed, dropping from a high of 346 plans in 1998 to 263 contracts as of March 2000.

MEDICARE MANAGED CARE TERMINATIONS, 1999–2000

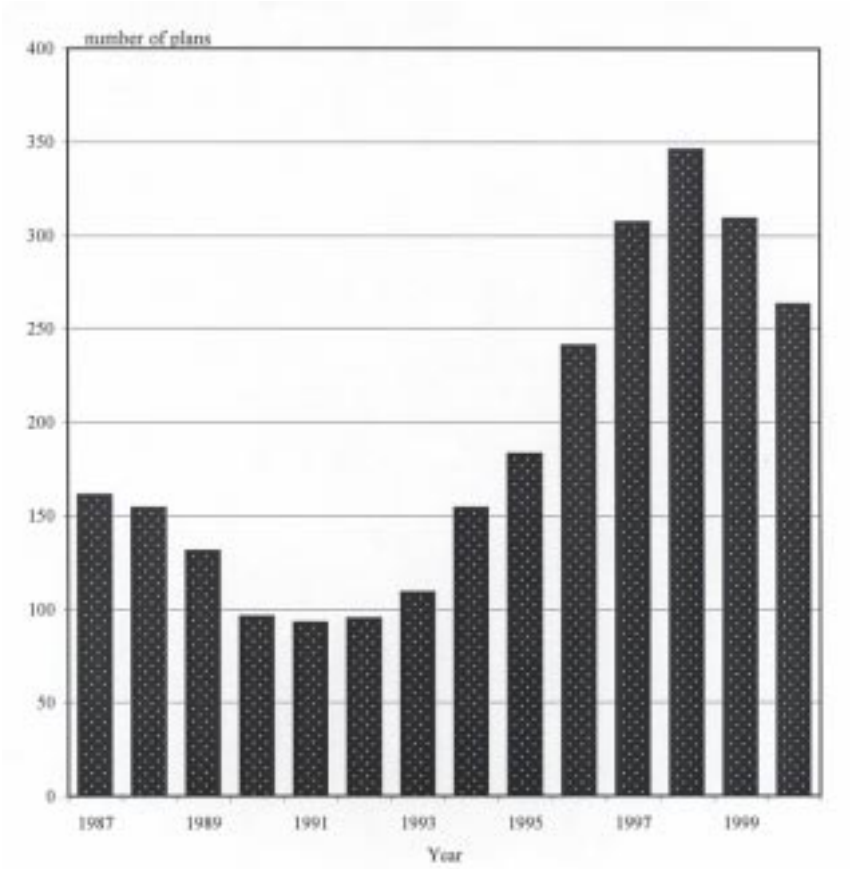
Since the implementation of the M+C Program, a significant number of managed care organizations have either terminated contracts or reduced their service area, as shown in table E–1. The contract terminations and service area reductions in January 1999 affected about 407,000 (6.5 percent) of the more than 6 million Medicare beneficiaries enrolled in managed care, leaving 50,000 (less than 1 percent) of the M+C population without any access to M+C plans. About half of the beneficiaries who had access to other M+C plans chose a new plan, while the other half chose Medicare fee-for-service. In total, 372 counties were affected by the withdrawals or service area reductions and 72 counties lost access to Medicare managed care. Then in January 2000, additional contract terminations and service area reductions affected 327,000 (5 percent) of M+C enrollees in 329 counties, some of whom had also been affected the previous year. This cycle of contract changes left 79,000 (1.3 percent) of the managed care enrollees in 105 counties without access to any other M+C plan. Initial reports of contract terminations for 2001 indicate that about 934,000 M+C enrollees may be affected in 2001. As plans withdraw from areas, they not only affect current plan enrollees, but they also affect both current Medicare fee-for-service beneficiaries and newly eligible Medicare beneficiaries who are entitled to enroll in an available managed care plan if they choose to do so.

ENROLLMENT TRENDS FOR MEDICARE MANAGED CARE

While the number of plans/contracts participating in Medicare managed care has fluctuated over time, the actual number of individuals enrolled in Medicare managed care continued to increase until recently. The most rapid growth occurred prior to implementation of the M+C Program in 1999. As shown in chart E–2, in 1990 only about 3 percent of Medicare beneficiaries were enrolled in the managed care program, but by 1998 this figure had in-

[2] The BBA changed the designation of "plans," beginning in 1999. The old definition of "plans" is now referred to as "contracts" and each contracting M+C organization may offer several different "plans." In 2000 there are about 800 plans available through over 260 M+C contracts. For example, the M+C organization may offer one plan providing only the basic Medicare-covered benefits and other plans that also include optional supplemental benefits.

CHART E–1. NUMBER OF MANAGED CARE PLANS/CONTRACTS PARTICIPATING IN MEDICARE, 1987–2000



Note.—Medicare managed care plans include risk plans through 1998 and Medicare+Choice contracts beginning in 1999.

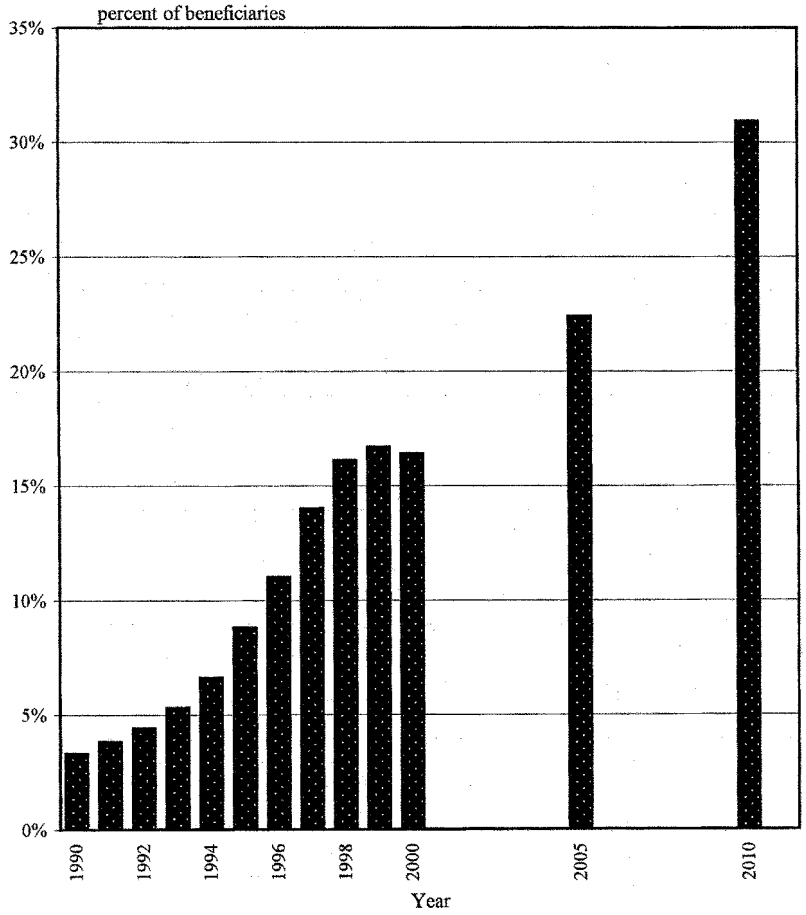
Source: Prepared by the Congressional Research Service based on December Health Care Financing Administration Medicare Managed Care Contract (MMCC) Monthly Reports, 2000 data from March.

TABLE E–1.—MEDICARE+CHOICE CONTRACT TERMINATIONS AND SERVICE AREA REDUCTIONS

	Effective January 1999	Effective January 2000
Terminations	45	41
Service area reductions	54	58
Enrollees who could not stay in their plan	407,000	327,000
Enrollees in counties without any access to plans	50,000	79,000

Source: Medicare Payment Advisory Commission (2000).

CHART E–2. PERCENT OF BENEFICIARIES ENROLLED IN MEDICARE MANAGED CARE PLANS, ACTUAL AND PROJECTED, 1990–2010



Note.—Medicare managed care plans include risk plans through 1998 and Medicare+Choice plans beginning in 1999.

Source: Prepared by the Congressional Research Service based on Medicare Payment Advisory Commission (1997), chart 3; Health Care Financing Administration, Medicare Managed Care Reports, December 1998, December 1999 and March 2000; and Congressional Budget Office March 2000 baseline for projections.

creased significantly to 16.1 percent of Medicare beneficiaries. Since the implementation of the M+C Program, enrollment growth has slowed and today is only moderately higher than the 1998 level; reaching 16.7 percent of beneficiaries in December 1999, and declining slightly to 16.4 percent by March 2000. Still, the Congressional Budget Office projects that enrollment in M+C plans will reach about 22 percent of all beneficiaries by 2005 covering about 9 million enrollees, and 31 percent by 2010, covering about 14 million enrollees. Increased M+C enrollment will occur, in part, as

younger non-Medicare individuals, currently enrolled in and familiar with HMOs, become eligible for the Medicare Program.

Although over 260 M+C organizations participate in Medicare, enrollment in any individual plan is available only to those beneficiaries living in a specific service area. Plans define a service area as a set of counties and county parts, identified at the zip code level.[3] As a result, not all Medicare beneficiaries have access to an M+C plan. As of 2000, Medicare managed care is available in only 35 percent of counties (table E–2). However, while 65 percent of counties did not offer M+C plans in 2000, most Medicare beneficiaries had access to an M+C plan. This occurred because the population and plans are not distributed equally across counties, but rather they are concentrated in the more urban counties. In December 1999, only 28 percent of all Medicare beneficiaries lived in a zip code that had no access to an M+C plan (table E–3). Among the 72 percent of beneficiaries with access to the M+C Program, over 60 percent had a choice of at least two plans; 27 percent had a choice of two to four plans and 34 percent had five or more plans available to them.

TABLE E–2.—COUNTIES WITH AND WITHOUT MEDICARE MANAGED CARE PLANS, SELECTED YEARS 1997–2000

	1997		1999		2000	
	Number of counties	Percent	Number of counties	Percent	Number of counties	Percent
Counties with plans	740	24	896	29	1,095	35
Counties without plans	2,387	76	2,231	71	2,049	65

Note.—Puerto Rico is excluded from the analysis. Medicare managed care plans include risk plans through 1998 and Medicare+Choice plans beginning in 1999.

Source: Medicare Payment Advisory Commission computations based on Health Care Financing Administration public data; Congressional Research Service analysis of Health Care Financing Administration data for 2000.

TABLE E–3.—PERCENT DISTRIBUTION OF MEDICARE BENEFICIARIES BY MANAGED CARE PLANS AVAILABLE IN THEIR AREA, SELECTED YEARS 1995–99

Number of plans available	June 1995	June 1997	December 1999
None	45	33	28
One	16	9	11
Two to four	26	24	27
Five or more	14	34	34

Note.—Medicare managed care plans include risk plans through 1998 and Medicare+Choice plans beginning in 1999.

Source: Table prepared by the Congressional Research Service based on Medicare Payment Advisory Commission (1998, Chart 2–10), and unpublished data from Mathematica Policy Research, Inc. (1999).

[3] M+C organizations can vary premiums, benefits, and cost sharing across individuals enrolled in a plan, so long as these are uniform within segments of a service area. A segment is defined as one or more counties within the plan's service area.

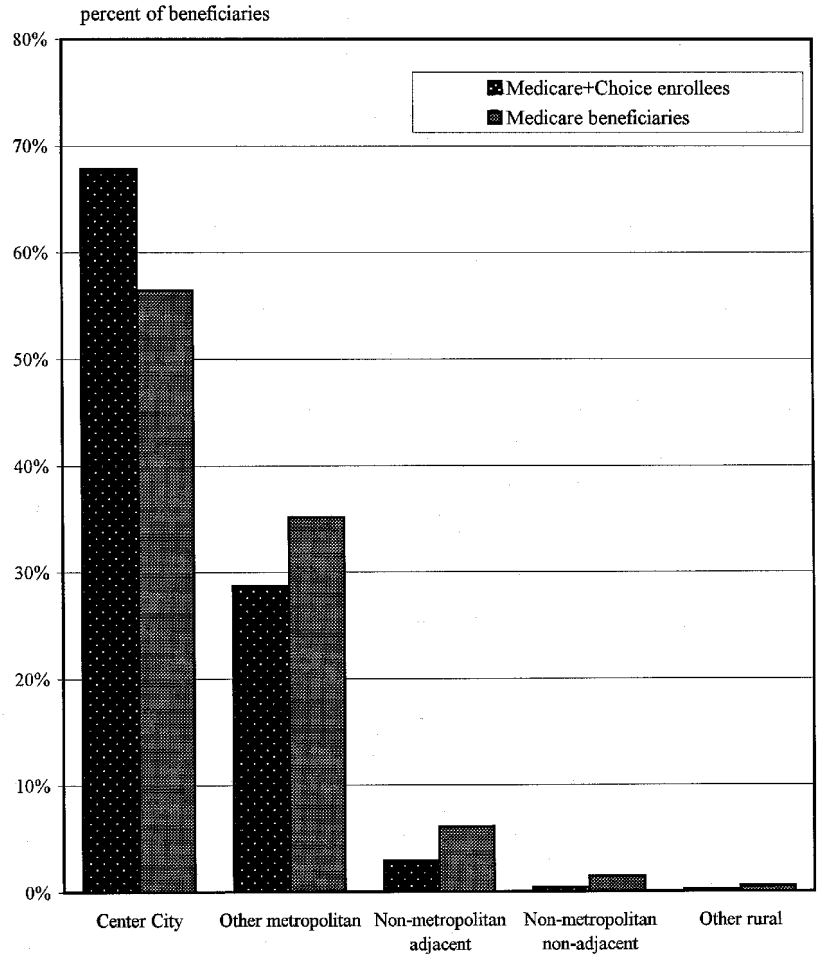
ENROLLMENT PATTERNS IN URBAN AND RURAL LOCATIONS

Patterns of M+C enrollment are not uniform across urban and rural locales, as shown in chart E–3. The geographic areas are defined as follows:

—Center city—central counties of metropolitan areas of at least 1 million population;

—Other metropolitan—either fringe counties of metropolitan areas of at least 1 million population or counties of metropolitan areas up to 1 million population;

CHART E–3. PERCENT OF MEDICARE BENEFICIARIES AND MEDICARE+CHOICE ENROLLEES IN URBAN AND RURAL LOCATIONS, DECEMBER 1999



Source: Prepared by the Congressional Research Service based on Mathematica analysis of Health Care Financing Administration data.

—Nonmetropolitan, adjacent—urban population of at least 2,500 adjacent to a metropolitan area;
—Nonmetropolitan, nonadjacent—an urban population of at least 2,500, not adjacent to a metropolitan area; and
—Rural—completely rural (no places with a population of 2,500 or more).

Most M+C enrollees reside in center cities; about 68 percent of the M+C population as of December 1999. However, a smaller proportion, only 56 percent of all Medicare beneficiaries reside in the center city. In all other geographic areas, from other metropolitan to rural areas, the percentage of M+C enrollees is less than the percentage of Medicare beneficiaries. Thus, a larger proportion of the Medicare population in the city chooses to enroll in managed care than in all other geographic areas. This occurs because of a combination of interrelated factors, such as availability of M+C plans and payment rates.

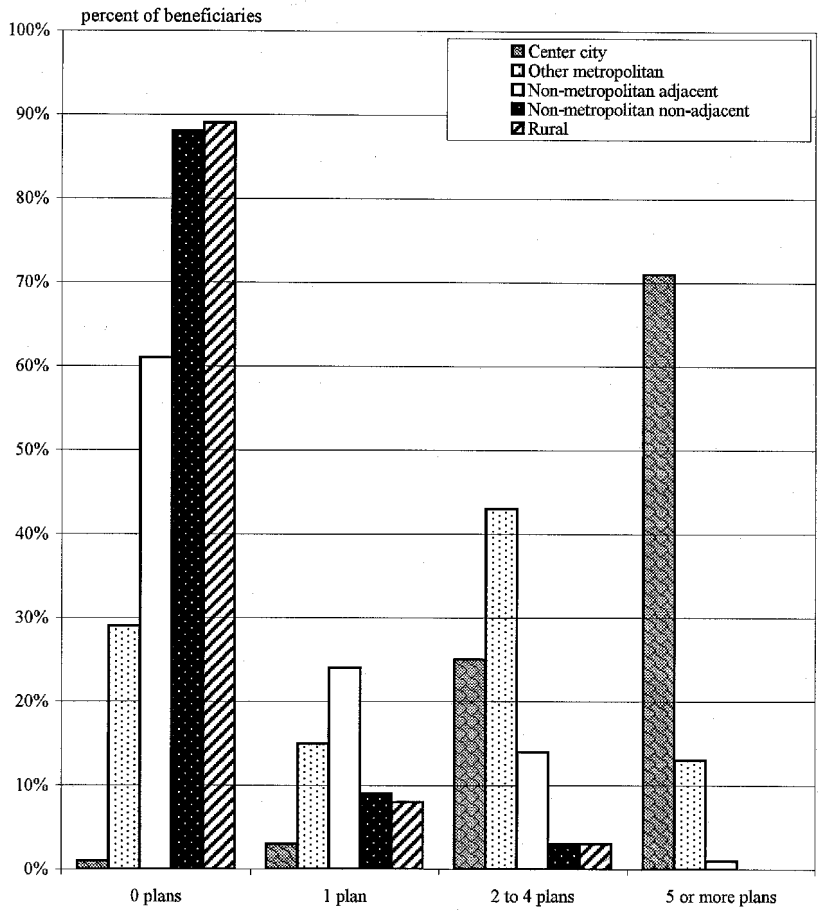
As shown in chart E–4, access to M+C plans is much greater in urban areas than in rural areas. Only 1 percent of beneficiaries in center cities have no access to M+C plans. Among the 99 percent of Medicare beneficiaries with access to such plans, 71 percent have a choice of at least five different plans and 25 percent have a choice of two to four plans. By contrast, Medicare beneficiaries living in rural or nonmetropolitan nonadjacent areas rarely have even a single plan available to them, leaving most of these beneficiaries (almost 90 percent) with no access to plans. Among the beneficiaries in these areas who have access to Medicare managed care, most have only one available plan.

Regional and Geographic Variations in Enrollment

In addition to rural and urban variations, enrollment patterns also vary on a regional basis. M+C enrollment is much higher in western and southwestern States, as shown in chart E–5. In particular, over one-third of the beneficiaries in Arizona (38 percent) and California (39 percent) are in M+C plans. The highest levels of enrollment in eastern States are in Rhode Island (40 percent), Florida (28 percent), Pennsylvania (27 percent) and Massachusetts (23 percent). In contrast, 13 States have no (or marginal) plan enrollment, and an additional 18 States have between 2 and 10 percent of their Medicare beneficiaries enrolled in an M+C plan.

M+C enrollees are far more concentrated geographically than Medicare beneficiaries as a whole. In fact, four States account for over half of all M+C enrollment: California, Florida, Pennsylvania, and New York. These four States, alone, account for 53 percent of all M+C enrollees, but they are home to only 29 percent of all Medicare beneficiaries. Table E–4 compares the percentage of M+C enrollment to the percentage of the total Medicare population for each of these four States.

CHART E–4. PERCENT VARIATION IN NUMBER OF MEDICARE+CHOICE PLANS AVAILABLE TO MEDICARE BENEFICIARIES IN URBAN AND RURAL LOCATIONS, DECEMBER 1999



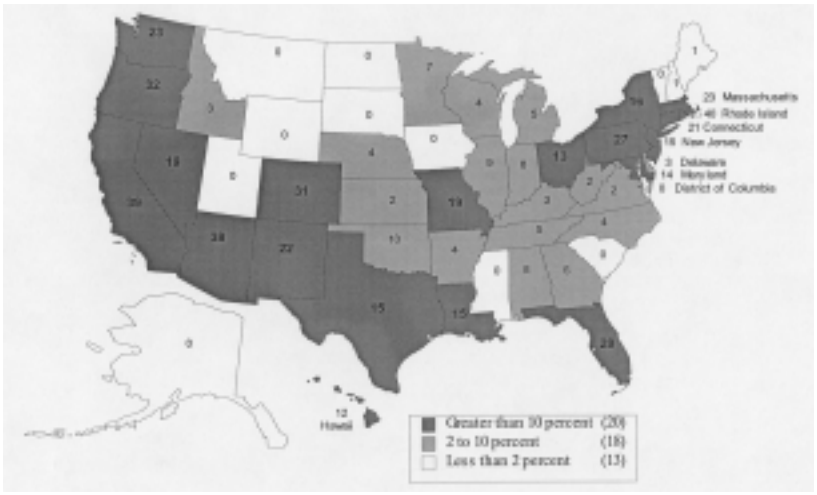
Source: Prepared by the Congressional Research Service based on Mathematica analysis of Health Care Financing Administration data.

CONTRACTS BY PLAN MODEL

In addition to regional and geographic variation, M+C plans also vary by contract model and plan ownership. M+C contract models include independent practice associations (IPAs), group models, and staff models. Plan ownership can either be for-profit or non-profit. Table E–5 displays the distribution of M+C plans by plan contract model and type of ownership.

The majority of M+C contracts are for IPA models. An IPA is a managed care organization that contracts with physicians in solo

CHART E–5. PERCENT OF MEDICARE BENEFICIARIES ENROLLED IN MEDICARE+CHOICE, BY STATE, MARCH 2000



Note.—State numbers represent percents.

Source: Prepared by the Congressional Research Service based on Medicare Managed Care Contract Reports, March 2000.

TABLE E–4.—PERCENT OF MEDICARE+CHOICE ENROLLEES AND MEDICARE POPULATION RESIDING IN FOUR STATES, 2000

State	Percent of total M+C enrollment	Percent of total Medicare population
California	24	10
Florida	12	7
Pennsylvania	10	6
New York	7	7
Total	53	29

Source: Prepared by the Congressional Research Service based on Health Care Financing Administration Managed Care Contract Reports, March 2000.

practice or with associations of physicians that, in turn, contract with their member physicians to provide health care services. Many physicians in IPAs have a significant number of patients who are not IPA enrollees. Group model managed care organizations contract with one or more group practices of physicians to provide health care services, and each group primarily treats the plan's members. Staff model managed care organizations employ health providers, such as physicians and nurses, directly. The providers are employees of the plan and deal exclusively with their enrollees. The great majority of M+C contracts are with for-profit organiza-

tions. As of March 2000, 65 percent of contractors were with for-profit entities.

TABLE E–5.—MEDICARE+CHOICE CONTRACTS BY PLAN MODEL, MARCH 2000

	Number of contracts	Percent of contracts	Number of enrollees	Percent of enrollees
Model:				
IPA	168	64	4,027,304	65
Group	81	31	1,533,845	25
Staff	14	5	614,994	10
Ownership:				
Profit	182	69	4,068,248	65
Nonprofit	81	31	2,152,895	35

Source: Prepared by the Congressional Research Service based on Health Care Financing Administration Medicare Monthly Contract Reports, March 2000.

RULES FOR ENROLLMENT IN MEDICARE+CHOICE PLANS

Medicare beneficiaries are eligible to enroll in any M+C plan that serves their area, with the following restrictions: (1) beneficiaries must be entitled to benefits under part A of Medicare and enrolled in part B of Medicare, and (2) beneficiaries who qualify for Medicare solely on the basis of end-stage renal disease (ESRD) may not enroll in an M+C plan (however, an enrolled beneficiary who later develops ESRD may continue to remain enrolled in that plan).

In general, M+C organizations are required to enroll eligible individuals during election periods, and they cannot deny enrollment on the basis of health status related factors. These factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. However, an organization may deny enrollment if it has reached the limits of its capacity. Organizations may only terminate an enrollee's election for failure to pay premiums on a timely basis, disruptive behavior, or because the plan ends for all M+C enrollees.

The Secretary is authorized to collect a user fee from each M+C organization for use in carrying out enrollment and information dissemination activities for the program as well as the health insurance and counseling assistance program. The fee is based on the ratio of the organization's number of Medicare enrollees to the total number of Medicare beneficiaries.

Through 2001, individuals are able to make and change election to an M+C plan on an ongoing basis. Beginning in 2002,[4] elections and changes to elections will be available on a more limited basis. Individuals will be able to make or change elections each November, during the annual coordinated election period. In addition, current Medicare beneficiaries may also change their election at any

[4] Institutionalized beneficiaries will continue to have access to ongoing open enrollment for purposes of enrolling in an M+C plan or changing from one M+C plan to another.

time during the first 6 months of 2002 (or the first 3 months of any subsequent year). Although individuals are limited to only one change during this 6 (or 3) month period, this limit does not apply to either changes made during the annual coordinated election period in November or to special enrollment periods. Special enrollment periods are provided for limited situations such as an enrollee who changes place of residence. For newly eligible aged beneficiaries, their 6 (or 3) month period for making elections or changes to elections begins once the individual is eligible for an M+C plan.

Any request to enroll or disenroll in an M+C plan made after the 10th of the month will not be effective until the 1st day of the 2d calendar month thereafter. Additional election periods (called special election periods) will apply to newly eligible aged (not disabled) Medicare beneficiaries and beneficiaries who experience certain events, such as their plan terminating its Medicare contract.

Furthermore, beneficiaries enrolled in an M+C plan that terminates its contract with Medicare are guaranteed access to certain Medicare supplemental insurance policies (i.e., "Medigap" policies) within either 63 days from the date: (1) they receive notice from their M+C organization that their plan is leaving the program; or (2) coverage is terminated. A plan leaving a payment area (typically a county) may also offer enrollees in that county the option of continuing enrollment in the plan, so long as the enrollee agrees to obtain all basic services through plan providers located in other counties.

MEDICARE+CHOICE PAYMENTS TO PLANS

The BBA substantially restructured the system for setting the rates by which Medicare pays plans, beginning in 1998.[5] In general, Medicare makes monthly payments in advance to participating health plans for each enrolled beneficiary in a payment area (typically a county). The Secretary of DHHS is required to determine annually, and announce by March 1 in the year before the calendar year affected, the annual M+C per capita rate for each payment area, and the risk and other factors to be used in adjusting such rates. Payments to M+C organizations are made from the Medicare Trust Funds in proportion to the relative weights that benefits under parts A and B represent of the actuarial value of Medicare benefits.

The major factors for determining Medicare's annual M+C per capita rates are summarized in table E–6. The annual M+C per capita rate for a payment area (for a contract for a calendar year) is set at the highest of one of three amounts calculated for each county:

1. A rate calculated as a blend of an area-specific (local) rate and a national rate,

[5] Prior to enactment of the BBA, payments for care of Medicare beneficiaries in risk health maintenance organizations (HMOs) were based on the adjusted average per capita costs (AAPCC). The AAPCC represented a monthly payment to cover the cost of treatment in a Medicare risk HMO. It was calculated according to a complex formula based on the cost of providing Medicare benefits to beneficiaries in the fee-for-service portion of the Medicare Program. The per capita payment was set at 95 percent of the AAPCC, and was adjusted for certain demographic characteristics of HMO enrollees. Payments based on the AAPCC varied widely across the country. Additionally, county payments fluctuated, year to year.

TABLE E–6.—MAJOR FACTORS FOR DETERMINING MEDICARE PAYMENTS TO MEDICARE+CHOICE PLANS

Factor		Rule established in either the BBA 1997 or BBRA 1999
Blend of local and national rates	General	Transition over 6 years to 50–50 blend of local and national rates. National rates are adjusted for differences in input prices.
	1998	90 percent local, 10 percent national
	1999	82 percent local, 18 percent national
	2000	74 percent local, 26 percent national
	2001	66 percent local, 34 percent national
	2002	58 percent local, 42 percent national
	2003 and after	50 percent local, 50 percent national
Minimum payment (''floor'') rate	1998	Minimum of $367 (or 150 percent of 1997 payment outside the United States)
	1999 and after	Previous year's payment times annual percentage increase ($380 for 1999, $402 for 2000, and $415 for 2001)
Minimum percent increase	1998	102 percent of 1997 AAPCC payment rate
	1999 and after	102 percent of prior year's rate
Graduate medical education (GME) and disproportionate share hospital payments	General	GME payments excluded (from blended rate only) in equal increments over 5 years. Disproportionate share hospital payments not excluded.
Budget neutrality	General	Total M+C payments may not exceed what would have been spent if payments were entirely based on local rates (except no rate can be reduced below the floor or minimum)
National growth percentage	1998	Increase in Medicare per capita expenditures minus 0.8 percentage points
	1999–2001	Increase in Medicare per capita expenditures minus 0.5 percentage points
	2002	Increase in Medicare per capita expenditures minus 0.3 percentage points
	After 2002	Increase in Medicare per capita expenditures
Risk adjustment	2000–2001	10 percent health status, 90 percent demographic
	2002	Up to 20 percent health status, at least 80 percent demographic
	2003 and after	Phase-in not specified in law. In 2004, Secretary of DHHS plans to implement a new risk adjustment method based on inpatient and outpatient settings.

Source: Congressional Research Service analysis of provisions in the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999.

2. A minimum payment (or floor) rate, or
3. A rate reflecting a minimum increase from the previous year's rate.

Each part of the system is described in more detail below.[6]

BLENDED RATES

The blended per capita rate shifts county rates gradually away from solely local (generally county) rates, which reflect the wide variations in fee-for-service costs, toward a national average rate. Blending is designed to reduce payments in counties where the AAPCCs historically were higher than the national average rate, and to increase payments in counties where AAPCCs were lower. The blended rate is defined as the weighted sum of:

—a percentage of the annual area-specific M+C per capita rate for the year for the payment area, and

—a percentage of the input-price adjusted annual national M+C per capita rate for the year.

The component of the blend determined by the area-specific (local) rate is based on the 1997 AAPCC for the payment area with two adjustments. First, the area-specific rate is reduced to remove an amount corresponding to graduate medical education (GME)[7] payments. Second, rates are updated each year by a national growth percentage (described below).

The component of the blend determined by the national rate is the weighted average of all local area-specific rates. This component of the blend is adjusted to reflect differences in certain input prices, such as hospital labor costs, by a formula stated in the law. The Balanced Budget Act (BBA) allows the Secretary to change the method for making input-price adjustments in the future.

Under current law, the percentage in the blend assigned to the area-specific rate is reduced in increments over 6 years from 90 percent in 1998 to 50 percent in 2003, while the corresponding percentage for the national component is increased from 10 percent to 50 percent. In 2003, the blended rate will be based on 50 percent of the area-specific rate and 50 percent of the national, input-price adjusted rate. Each year, the blended rates may be raised or lowered to achieve budget neutrality (explained below).

MINIMUM PAYMENT (FLOOR) RATE

Each county is also subject to a floor rate, designed to raise payments in certain counties more quickly than would occur through the blend alone. The minimum rate is $402 for 2000 and will be $415 for 2001. As required by law, each year this payment amount is increased by a measure of growth in program spending (see discussion of national growth percentage, below). The 2001 rate, announced in March 2000, will set the M+C payment rate at the floor rate in about one-third of all counties.

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[6] Payment rates for disabled and ESRD beneficiaries are set using a similar method as that for aged beneficiaries except that ESRD rates are calculated on a statewide basis.

[7] Medicare pays for both the direct and indirect costs of GME. Direct payments include payment for expenses such as salaries of residents, interns and faculty. The indirect adjustment accounts for factors not directly related to education which may increase the costs in teaching hospitals, such as more severely ill patients and increased testing.

MINIMUM PERCENTAGE INCREASE

The minimum increase rule protects counties that would otherwise receive only a small (if any) increase. In 1998, the minimum rate for any payment area was 102 percent of its 1997 AAPCC. For each subsequent year, it will be 102 percent of its annual M+C per capita rate for the previous year.

EXCLUSION OF PAYMENTS FOR GRADUATE MEDICAL EDUCATION

Payments for GME are excluded or "carved out"' of the payments to M+C plans over 5 years. GME payments are only excluded from the blended rate but not from the floor rate or minimum increase levels. Specifically, in determining the local rate prior to determining the blended rate, amounts attributable to payments for GME costs were deducted from the 1997 payment amount. The percent of GME payments excluded began at 20 percent in 1998, rising in equal amounts until it is fully deducted in 2002. Payments for disproportionate share hospitals[8] are not carved out.

BUDGET NEUTRALITY

Once the preliminary rate is determined for each county, a budget neutrality adjustment is required to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. A budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. As a result of this limitation, it is not always possible to achieve budget neutrality. The law makes no provision for achieving budget neutrality after all county rates are assigned either the floor or minimum increase. When this situation occurred for the 1998, 1999, and 2001 rates, HCFA chose to waive the budget neutrality rule rather than the floor or minimum rate rules. While the cost of waiving budget neutrality was not significant in 1998 and 1999 (less than $100,000 each year), it is estimated to cost about $1 billion in 2001.

NATIONAL GROWTH PERCENTAGE

The national per capita M+C growth percentage is defined as the projected per capita increase in total Medicare expenditures minus a specific reduction set in law. Because this increase is tied to total Medicare expenditures, it maintains a link between Medicare fee-for-service and managed care spending. In 1998, the reduction was 0.8 percentage points, from 1999 through 2001 it is 0.5 percentage points, and in 2002 the Balanced Budget Refinement Act (BBRA) set the reduction at 0.3 percentage points. There is no reduction after 2002. Starting with the 1999 M+C payments, adjustments were also made for errors in the previous years' spending projection.

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[8] Disproportionate share hospital payments are a payment adjustment for the higher costs that hospitals incur as a result of serving a large number of low-income patients.

The national growth percentage for 2001, after the reduction and adjustments, is −1.3 percent. This figure[9] is based on a 6.0 percent projected per capita increase in total Medicare expenditures, a −0.5 percent reduction set by the BBA, and a −6.5 percent adjustment for errors in the previous years' projection of spending (1998–2000). However, the adjustment for 1998 errors (in the calculation of the previous years' projections of spending) is excluded when updating the floor rates. This results in an overall increase of 3.3 percent to be used for calculating the floor rate, for 2001, as opposed to the −1.3 percent national growth percentage.

VARIATIONS IN MEDICARE+CHOICE PAYMENT RATES

A Medicare+Choice (M+C) payment area is defined as a county or equivalent area specified by the Secretary. (In the case of individuals with ESRD, the M+C payment area is each State, or other payment areas as the Secretary specifies.) Upon request of a State for a contract year, the Secretary will redefine Medicare+Choice payment areas in all or a portion of the State to: (1) a single statewide payment area; (2) a metropolitan system; or (3) a single payment area consolidating noncontiguous counties (or equivalent areas) within a State.

COUNTY PAYMENT RATES

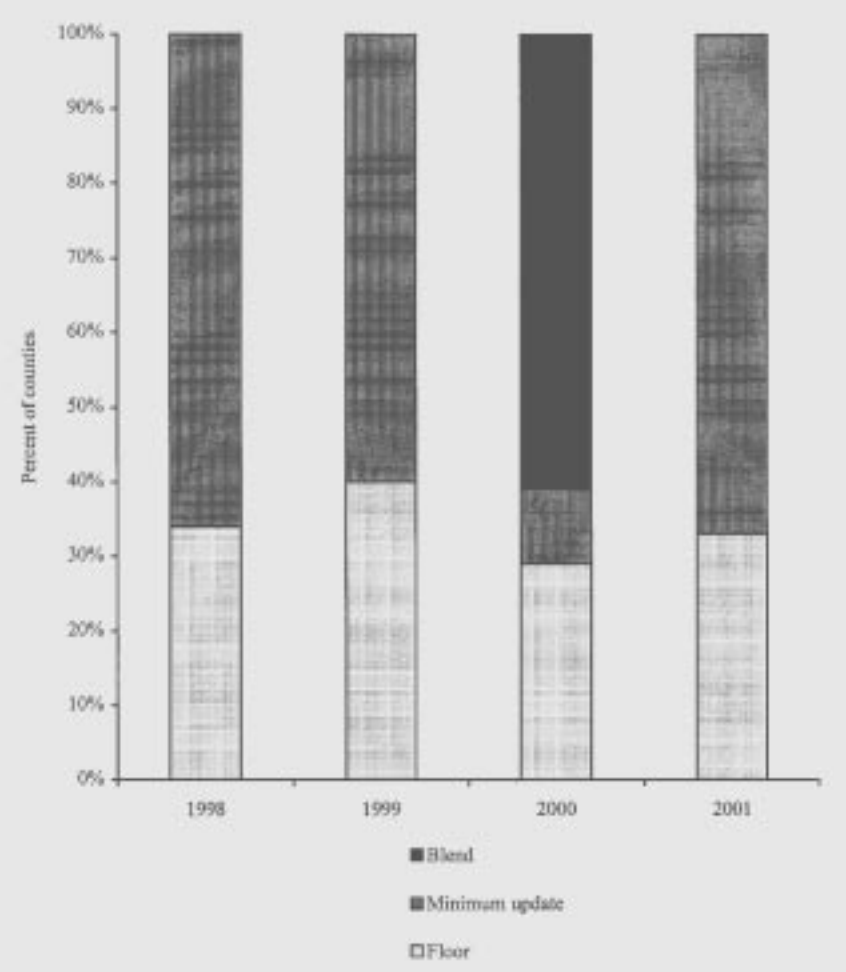
As noted above, each county rate is set at the highest amount calculated under three rules (blend, minimum increase, or floor), and then adjusted for budget neutrality. Because of the low national growth percentage in 1998 and 1999, no county rate was set by the blended rate rule after applying the budget neutrality adjustments (chart E–6). In 2000, the national growth percentage was sufficiently large (5 percent), so that payments in 60 percent of counties were based on the blended rate rule. However, the national growth percentage for 2001 will be −1.3 percent, as previously discussed. Therefore, in 2001, no county will be paid using the blended rate rule and about one-third of all counties will be set at the floor, with the remainder receiving the minimum 2 percent increase.

Calculations for selected 2001 county payment rates are shown in table E–7. The table shows the calculation under the three rules, as well as the rates before and after any budget neutrality adjustments. For the six counties selected, before application of budget neutrality, there are four whose rates are set using the minimum increase amount (Los Angeles, California; Dade, Florida; Hennepin, Minnesota; and Fairfax, Virginia), one set at the floor (Arthur, Nebraska), and one set at the blended rate (Haines, Alaska). Among the six selected counties, the budget neutrality adjustment can only be applied to Haines, Alaska, whose rate was initially set using the blend and then reduced to the minimum increase amount by the budget neutrality adjustment. For the 2001 payment rates, the adjustment to the blended rate across all affected counties was insufficient to completely achieve budget neutrality. However, if the budget neutrality adjustment had been smaller, then rates for

[9] Numbers are not exact, due to rounding.

these counties would have been set between the minimum increase and blended amounts.

CHART E–6. RULE USED TO DETERMINE COUNTY PAYMENT RATES, 1998–2001



Source: Congressional Research Service analysis of Health Care Financing Administration data.

GEOGRAPHIC PAYMENT RATE VARIATIONS

Large variation in county payment rates was one of the motivating forces behind changes enacted in the BBA. The M+C payment method is designed to reduce this variation. However, in order for more of this variation across counties to be reduced, two events must occur: (1) the national growth rate must be sufficiently large, so that a greater number of M+C payments to plans are based on the blend rate rather than the floor or minimum rate; and (2) the

blended rate must be weighted more by the national, rather than the area-specific rate. Additionally, as more M+C payments are based on the blend, the budget neutrality adjustment will diminish.

TABLE E–7.—CALCULATION OF MONTHLY PAYMENT RATES FOR SAMPLE COUNTIES, 2001

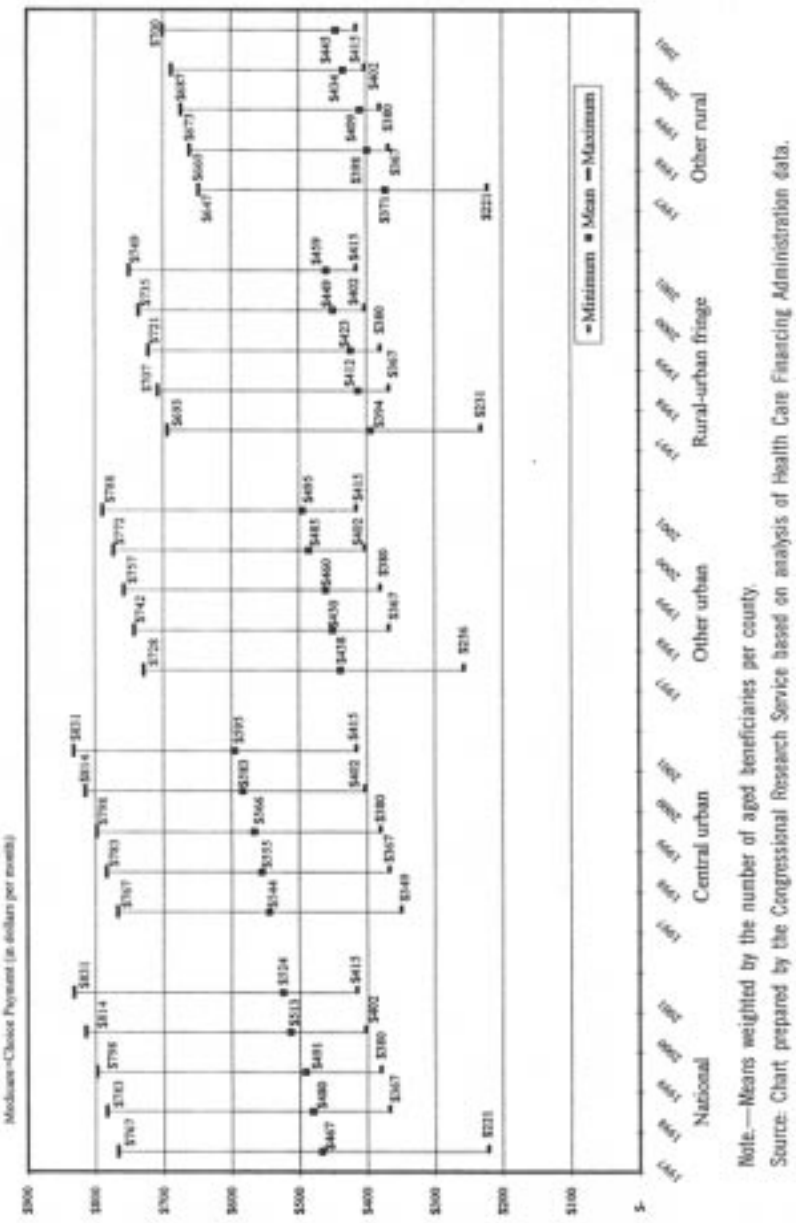
County	Calculation using each of the three separate rules			Determination of rates	
	Minimum update	Floor	Blend (90 : 10)	Before budget neutrality adjustment	Actual rate (after budget neutrality adjustment)
Los Angeles, CA ..	$673.86	$415.01	$628.71	$673.86	$673.86
Dade, FL	809.90	415.01	705.95	809.90	809.90
Hennepin, MN	466.81	415.01	454.01	466.81	466.81
Fairfax, VA	469.66	415.01	460.36	469.66	469.66
Arthur, NE	409.64	415.01	313.29	415.01	415.01
Haines, AK	432.37	415.01	434.29	434.29	432.37

Source: Congressional Research Service analysis of Health Care Financing Administration data.

Examining variations across all counties, chart E–7 shows that the substantial range above and below the average payment rate is expected to continue through 2001. For example, in 1997, the average payment rate weighted by the number of Medicare beneficiaries in each county was $467. The lowest rates in the country were $221 in two rural Nebraska counties (Arthur and Banner counties). The highest rates in 1997 were $767 and $748, respectively, in Richmond County, New York (Staten Island), and Dade County, Florida (Miami). Examining the variation, from highest to lowest payments, the range was $546 in 1997. By 2001, the floor rate will reach $415, and the highest rate (Richmond County) will be $831, with an average payment rate of $524 and a range of $416.

Payment rates vary geographically, as well, with higher payments generally occurring in more urban areas (chart E–7). The 2001 floor rate mostly affects rural counties, but it will raise rates for some urban counties as well. Because no county will receive the blended rate in 2001, large variations in payment rates will not be significantly reduced. Therefore, payments will continue to be higher in urban areas and lower in the most rural areas. The 2001 average payment is $595 in central urban counties, $100 above that for other urban counties, $136 above that for rural-urban fringe counties, and $150 above that for other rural counties. The range within each of the urban-rural categories remains substantial as well.

CHART E–7. RANGE OF COUNTY MEDICARE MANAGED CARE PAYMENTS FOR THE AGED, BY LOCATION, 1997–2001



Note.—Means weighted by the number of aged beneficiaries per county.

Source: Chart prepared by the Congressional Research Service based on analysis of Health Care Financing Administration data.

Payment rates range widely regionally, as well as geographically, as shown in table E–8. For example, plans serving Miami will be paid an average of $810 per month in 2001, compared with $467 in Minneapolis. But even within a region, there can be wide variation in payment rates. The 2001 payment rate for Dade County in Southern Florida is almost $200 more than the rate for Palm Beach County. Furthermore, plans competing in the same market may receive substantially different payments for beneficiaries who live on opposite sides of a county boundary. As illustrated in the Washington, DC, metropolitan area, these differing payment levels may affect plan participation and enrollment. The BBA will eventually reduce some of this variation, but generally not until increases are high enough to support blended rates.

TABLE E–8.—MONTHLY PAYMENT RATES FOR AGED ENROLLEES IN SELECTED AREAS, 2001

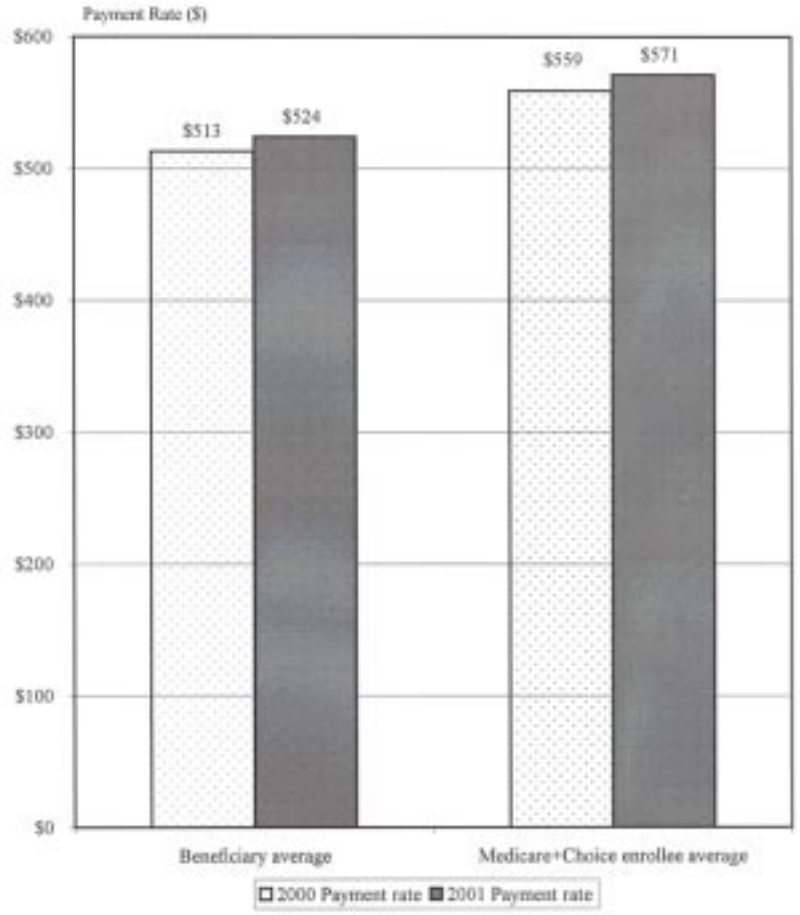
County	Payment rate
Washington, DC-Maryland-Virginia:	
Prince George's County, MD	$652
Washington, DC	632
Montgomery County, MD	546
Alexandria City, VA	512
Arlington County, VA	511
Falls Church City, VA	508
Fairfax City, VA	483
Loudoun, VA	478
Fairfax County, VA	470
Minneapolis-St. Paul, MN metropolitan area:	
Ramsey (St. Paul)	480
Hennepin (Minneapolis)	467
Anoka	462
Dakota	448
Washington	437
Carver	428
Scott	415
Southern Florida:	
Dade (Miami)	810
Broward (Ft. Lauderdale)	704
Palm Beach	613
Southern California:	
Los Angeles	674
Orange	622
San Bernardino	577
Riverside	565

Source: Health Care Financing Administration.

Chart E–8 compares average payment rates for two groups: (1) the hypothetical rate if all Medicare beneficiaries were enrolled in M+C plans; and (2) the rate for beneficiaries currently enrolled in M+C plans. The average payment rate across all beneficiaries is lower than the average for actual M+C enrollees because M+C en-

rollment tends to concentrate in areas with higher payment rates. If enrollment were higher across all areas of the country, especially in low-payment rural areas, the actual average M+C payment would be lower and thus closer to the beneficiary average.

CHART E–8. COMPARISON OF AVERAGE MONTHLY AGED MEDICARE+CHOICE PAYMENT RATES FOR ALL BENEFICIARIES AND CURRENTLY ENROLLED MEDICARE+CHOICE BENEFICIARIES. 2000 AND 2001



Source: Congressional Research Service analysis of Health Care Financing Administration data.

RISK ADJUSTMENT

M+C payments are also risk adjusted to control for variations in the cost of providing health care among Medicare beneficiaries. For example, if sicker and older patients all sign up for one M+C plan, risk adjustment is designed to compensate the plan for their increased health expenses. The former Medicare Risk Contract Program adjusted the AAPCCs for demographic risk factors, and when

the M+C Program was implemented, it also used these demographic risk adjusters. Demographic risk adjusters include adjustments for age, gender, working status, Medicaid coverage, whether the beneficiary originally qualified for Medicare on the basis of disability, and institutional (nursing home) status.

Each aged Medicare beneficiary can be categorized according to these demographic factors, as shown in table E–9. Separate demographic adjustments are made for part A and part B of the Medicare Program (part A adjustments apply to about 57 percent of the payment and part B adjustments apply to the remaining 43 percent). The payment to the M+C plan for an individual is adjusted by the relevant factors. For example, the part A share of the payment to an M+C plan for a male beneficiary, aged 75–79 who was

TABLE E–9.—MEDICARE DEMOGRAPHIC ONLY BASED RISK ADJUSTMENT FACTORS FOR AGED BENEFICIARIES, 2001

Sex and age group	Institutional	Noninstitutional		
		Medicaid	Non-Medicaid	Working aged
	Part A—hospital insurance			
Male:				
65–69	1.75	1.15	0.65	0.40
70–74	2.25	1.50	0.85	0.45
75–79	2.25	1.95	1.05	0.70
80–84	2.25	2.35	1.20	0.80
85 and older	2.25	2.60	1.35	0.90
Female:				
65–69	1.45	0.80	0.55	0.35
70–74	1.80	1.05	0.70	0.45
75–79	2.10	1.45	0.85	0.55
80–84	2.10	1.70	1.05	0.70
85 and older	2.10	2.10	1.20	0.80
	Part B—supplementary medical insurance			
Male:				
65–69	1.60	1.10	0.80	0.45
70–74	1.80	1.35	0.95	0.65
75–79	1.95	1.55	1.10	0.80
80–84	1.95	1.70	1.15	0.90
85 and older	1.95	1.70	1.15	1.00
Female:				
65–69	1.50	1.05	0.70	0.40
70–74	1.65	1.15	0.85	0.55
75–79	1.65	1.25	0.95	0.70
80–84	1.65	1.25	0.95	0.75
85 and older	1.65	1.25	1.00	0.85

Note.—Values indicate the multiplier used for a beneficiary with a particular set of characteristics; average beneficiary has a multiplier of 1.00. A separate set of risk adjusters is used for disabled beneficiaries.

Source: Health Care Financing Administration.

not working, not in an institution and not on Medicaid would be increased by 5 percent (multiplied by 1.05 as shown in the table). The part B share of the payment for that same beneficiary would be multiplied by a factor of 1.10. For an individual of the same age, who was institutionalized, the payment would be multiplied by 2.25 for the part A share and 1.95 for the part B share.

However, these demographic risk adjusters account for only a very limited portion of the variation in health care costs, and as a result, the BBA required the Secretary of the U.S. Department of Health and Human Services (DHHS) to develop a new risk adjustment mechanism that would also account for variations in health status. Beginning in January 2000, the Health Care Financing Administration implemented this new risk adjustment mechanism built on 15 principal inpatient diagnostic cost groups (PIP–DCGs) in order to predict incremental costs above the average.[10] Table E–10 displays the 15 PIP–DCGs including the various diagnoses in each category. Payments are adjusted based on inpatient data using the PIP–DCG adjuster and demographic factors (tables E–11a and b), so that this new system accounts for both demographic and health status variations. Under this mechanism, the per capita payment made to a plan for an enrollee is adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments are used for aged persons newly eligible for Medicare, newly disabled Medicare enrollees, and others without a medical history.

The BBRA slowed down the implementation of the Secretary's proposed phase-in schedule of this new system through 2002. Plans were concerned, because this new risk adjustment methodology reduces aggregate M+C payments; slowing down its implementation lessens the reduction. In 2000 and 2001, 10 percent of payments will include risk adjustment using the PIP–DCG method and 90 percent will be based solely on the older demographic method. In 2002, up to 20 percent of the payments will be adjusted under the new system, with the remainder of the payment based on adjustments under the old method. After 2002, the splits are not set in law, although the Secretary originally planned to: (1) base 80 percent of payments on the PIP–DCG system in 2003; and (2) develop a new risk adjustment system for 2004 and beyond that would incorporate both inpatient and outpatient diagnoses, in order to account for more of the variation in health status.

The following illustration examines calculations of risk factors in 2001, based on two scenarios: (1) the demographically-based risk adjustment system used prior to 2000, and (2) the actual system in place for 2001, using a combination of 10 percent of the new health status based system and 90 percent of the old demographically-based system. Comparing these two scenarios provides an evaluation of the impact of including adjustments for health status on M+C payments.

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[10] In a March 1999 report to Congress, HCFA calculated that the PIP–DCG model offered a substantial improvement in explaining variations in health spending over the demographic risk adjustment model. The demographic adjusters were estimated to explain about 1 percent of the variation in health spending among individuals, while the PIP–DCG model was estimated to explain about 6 percent of individual variation.

TABLE E–10.—DIAGNOSES INCLUDED IN EACH PIP–DCG

PIP–DCG 29	
HIV/AIDS [1]	Blood, lymphatic cancers/neoplasms [2]
PIP–DCG 26	
Metastatic cancer [2]	Brain/nervous system cancer [2]
PIP–DCG 23	
Liver/pancreas/esophagus cancer [2]	End-stage liver disorders
Cardiorespiratory failure and shock	Decubitus and chronic skin ulcers
PIP–DCG 20	
Diabetes with chronic complications	Coma and encephalopathy
Aspiration pneumonia	Renal failure/nephritis
PIP–DCG 18	
Cancer of placenta/ovary/uterine adnexa [2]	Paralytic and other neurologic disorders
Blood/immune disorders	Gram-negative/staphylococcus pneumonia
PIP–DCG 16	
Chronic obstructive pulmonary disease	Mouth/pharynx/larynx/other respiratory cancer [2]
Lung cancer [2]	Cirrhosis, other liver disorders
Congestive heart failure	Atherosclerosis of major vessel
PIP–DCG 14	
Septicemia (blood poisoning)/shock	Adrenal gland, metabolic disorders
Delirium/hallucinations	Paranoia and other psychoses
Anxiety disorders	Personality disorders
Degenerative neurologic disorders	Spinal cord injury
PIP–DCG 12	
Tuberculosis	Pleural effusion/pneumothorax/empyema
Pulmonary fibrosis and bronchiectasis	Stomach, small bowel, other digestive cancer [2]
Rectal cancer [2]	Cancer of bladder, kidney, urinary organs
Benign brain/nervous system neoplasm	Diabetes with acute complications/hypoglycemia coma
Inflammatory bowel disease	Drug/alcohol psychoses
Bone/joint infections/necrosis	Dementia
Rheumatoid arthritis and connective tissue disease	Major depression/manic and depressive disorders
Epilepsy and other seizure disorders	Cerebral hemorrhage
Stroke	Peripheral vascular disease
PIP–DCG 11	
Gastrointestinal hemorrhage	Gastrointestinal obstruction/perforation
Paroxysmal ventricular tachycardia	Bacterial pneumonia
Cellulitis and bullous skin disorders	
PIP–DCG 10	
Colon cancer [2]	Schizophrenic disorders
Postmyocardial infarction	Unstable angina
Vertebral fracture without spinal cord injury	Kidney infection
	Thromboembolic vascular disease
PIP–DCG 9	
Other cancers [2]	Pancreatitis/other pancreatic disorders
Acute myocardial infarction	Transient cerebral ischemia
Fractures of skull/face	Pelvic fracture

TABLE E–10.—DIAGNOSES INCLUDED IN EACH PIP–DCG—Continued

Internal injuries/traumatic amputations/third degree burns	Hip fracture
PIP–DCG 8	
Cancer of uterus/cervix/female genital organs [2]	Artificial opening of gastrointestinal tract status
Valvular and rheumatic heart disease	Hypertension, complicated
Coronary atherosclerosis	Angina pectoris
Atrial arrhythmia	Precerebral arterial aneurysm
Aortic and other arterial aneurysm	Asthma
Brain injury	Peptic ulcer
PIP–DCG 7	
Central nervous system infections	Abdominal hernia, complicated
Alcohol/drug dependence	
PIP–DCG 6	
Cancer of prostate/testis/male genital organs [2]	
PIP–DCG 5	
Ongoing pregnancy with complications	Ongoing pregnancy with no or minor complications
Breast cancer [2]	
PIP–DCG 4	
No or excluded [3] inpatient admissions	Completed pregnancy with major complications
Miscarriage/terminated pregnancy	Ectopic pregnancy
Completed pregnancy with complications	Completed pregnancy without complications (normal delivery)

[1] Includes principal and secondary inpatient diagnosis of HIV/AIDS.
[2] Includes principal diagnoses and secondary diagnoses when the principal diagnosis is chemotherapy.
[3] Excluded admissions are for those conditions that would not be likely to (or could not) reoccur in the following year, such as appendicitis or fractures of a lower limb.

Source: Health Care Financing Administration, 1999, Appendix 2.

Three beneficiaries were considered; each was male, aged 75. The illustration assumes that none of these beneficiaries was disabled, institutionalized, covered by Medicaid, or working. Because the system is prospective, hospitalization in the prior year, 2000, will determine the health status adjustment factor used in 2001. The first beneficiary was not hospitalized in 2000. The second was hospitalized in 2000, with a diagnosis of kidney infection (PIP–DCG code 10), while the third was hospitalized with a diagnosis of lung cancer (PIP–DCG code 16).

As shown in the scenarios below, monthly payments to plans for beneficiaries with no prior year hospitalization will be lower using the new risk adjustment methodology, compared with payments using the old demographically-based methodology. In 2000 and 2001, only 10 percent of the payments will be based on the new methodology, with the bulk of the payment, 90 percent, based on the old demographic-only adjusters. Payments for beneficiaries with no prior year hospitalization will decline even more, as a larger percentage of the payment is based on the new risk adjusters. Alternatively, for any enrollee with a prior year hospitalization,

payments under the new system will be higher than payments under the old risk-based system.

TABLE E–11a.—MEDICARE DEMOGRAPHIC RISK ADJUSTMENT FACTORS, FOR AGED BENEFICIARIES WITH ONE OR MORE YEARS EXPERIENCE, 2001

Age	Base	Previously disabled	Medicaid
Male:			
65–69	0.541	0.415	0.440
70–74	0.705	0.398	0.457
75–79	0.907	0.334	0.461
80–84	1.077	0.287	0.445
85–89	1.258	0.237	0.404
90–94	1.376	0.189	0.331
95 and older	1.357	0.141	0.242
Female:			
65–69	0.453	0.605	0.433
70–74	0.588	0.576	0.440
75–79	0.747	0.519	0.454
80–84	0.918	0.415	0.423
85–89	1.096	0.313	0.327
90–94	1.162	0.232	0.231
95 and older	1.128	0.152	0.168

Source: Health Care Financing Administration.

TABLE E–11b.—MEDICARE HEALTH STATUS BASED RISK ADJUSTMENT FACTORS, FOR AGED BENEFICIARIES WITH ONE OR MORE YEARS EXPERIENCE, 2001

PIP–DCG group	Factor
29	5.189
26	4.375
23	3.823
20	3.392
18	2.656
16	2.438
14	2.000
12	1.662
11	1.271
10	1.170
9	0.915
8	0.822
7	0.697
6	0.458
5	0.375

Source: Health Care Financing Administration.

Scenario 1: Demographically-based risk adjustment (old system)

Under the old risk adjustment system in place prior to 2000, a plan's payment was adjusted to reflect the gender and age of the

enrollee. The same adjustments were assigned to all male beneficiaries ages 75–79, who were not disabled, institutionalized, covered by Medicaid, or working, regardless of health status. As shown in table E–9, separate demographic adjustments are made for parts A and B of the Medicare Program, as follows:

—Part A coverage increased by 5 percent (i.e., 1.05 percent of the payment), and

—Part B coverage increased by 10 percent (i.e., 1.10 percent of the payment).

The adjustment for part A applies to about 57 percent of the payment and the adjustment for part B applies to the remaining 43 percent, resulting in a weighted adjustment of about 1.072 to each county payment, regardless of health status.

As shown below, using the demographically-based method, payments to plans for these three beneficiaries will only vary across counties and not within counties, from a low of $445 per month per beneficiary in Arthur, NE (one of the counties with floor payments in 2001) to a high of $890 per month per beneficiary in Richmond, NY (the county with the highest M+C rate nationwide in 2001).

CALCULATION OF MONTHLY PAYMENT RATE UNDER SCENARIO 1

	Reason for hospitalization (if any) in 2000		
	None	Kidney infection (PIP–DCG 10)	Lung cancer (PIP–DCG 16)
Factors:			
Medicare part A	1.05	1.05	1.05
Medicare part B	1.10	1.10	1.10
Total weighted adjustment (based on a weight of 57 percent for part A and 43 percent for part B)	1.072	1.072	1.072
Adjusted monthly payment in selected counties:			
Richmond, NY	$890	$890	$890
Dade, FL	868	868	868
Hennepin, MN	500	500	500
Arthur, NY	445	445	445

Source: Congressional Research Service analysis of data from the Health Care Financing Administration.

Scenario 2: Phased-in health status based risk adjustment (using a combination of 10 percent of the new system and 90 percent of the old system)

Scenario 2 represents the expected payment for 2001 when risk adjustment is based on 10 percent of the new health status method and 90 percent of the old demographic method. The factors used to calculate the adjustment under the new methodology are found in tables E–11a and b. For each beneficiary, there is a single adjustment for demographics (no split between parts A and B of Medicare). The base adjustment for a 75-year-old male who is not dis-

abled, not a Medicaid beneficiary and was not hospitalized during the previous year is 0.907. Adjustments for prior year hospitalizations are added to the base adjustment. However, only 10 percent of the payment for each of the three beneficiaries would be based on the following applicable adjustment:

—0.907 for no prior year hospitalization,

—0.907 + 1.170 = 2.077 for kidney infection (PIP–DCG 10), and

—0.907 + 2.438 = 3.345 for lung cancer (PIP–DCG 16).

The remaining 90 percent of the payment is risk adjusted using the old methodology (i.e., 90 percent of the 1.072 adjustment for demographics, found in scenario 1).

As shown below, payments to plans for these three beneficiaries range from a low of $438 for a beneficiary in Arthur, NY, with no prior year hospitalization to a high of $1,062 in Richmond, NY, for a beneficiary with a prior year hospitalization for lung cancer.

CALCULATION OF MONTHLY PAYMENT RATES UNDER SCENARIO 2

	Reason for hospitalization (if any) in 2000		
	None	Kidney infection (PIP–DCG 10)	Lung cancer (PIP–DCG 16)
Factors:			
Old method (demographic)	1.072	1.072	1.072
New method (health status)	0.907	2.077	3.345
Adjusted monthly payment in selected counties:			
Richmond, NY	$872	$963	$1,062
Dade, FL	884	934	1,028
Hennepin, MN	494	551	613
Arthur, NY	438	486	539

Source: Congressional Research Service analysis of data from the Health Care Financing Administration.

ADJUSTED COMMUNITY RATES

Medicare+Choice (M+C) plans are required to include all Medicare covered services. In some circumstances, plans may also be required to offer additional benefits or reduced cost sharing to their beneficiaries. The basic benefit package includes all of the Medicare-covered benefits (except hospice services) as well as the additional benefits, as determined by a formula which is set in law. The adjusted community rate (ACR) mechanism is the process through which health plans determine the minimum amount of additional benefits they are required to provide to Medicare enrollees and the cost sharing they are permitted to charge for those benefits. This system was in place for the Risk Contract Program and continued with only a few changes under the M+C Program.

No later than July 1 of each year, each M+C organization is required to submit to the Secretary of DHHS, for each of its M+C plans, specific information about premiums, cost sharing, and additional benefits (if any). Under Medicare's rules, a plan may not earn a higher return from its Medicare business than it does in the

commercial market. The Secretary reviews this information and approves or disapproves the premiums, cost sharing amounts, and benefits. The Secretary does not have the authority to review the premiums for either medical savings account (MSA) plans or private fee-for-service plans.

Beneficiaries share in any projected cost savings between Medicare's per capita payment to a plan and what it would cost the plan to provide Medicare benefits to its commercial enrollees. To accomplish this, plans must either provide reduced cost sharing or additional benefits to their Medicare enrollees that are valued at the difference between the projected cost of providing Medicare-covered services and the expected revenue for Medicare enrollees.[11] Plans can choose which additional benefits to offer, however, the total cost of these benefits must at least equal the "savings" from Medicare-covered services.[12]

ADDITIONAL OR SUPPLEMENTAL BENEFITS

Nearly all plans offer some benefits to enrollees beyond those in traditional Medicare (chart E–9). For example, in December 1999, 98 percent of M+C enrollees were offered vision care as part of their lowest premium package, 95 percent were offered routine physicals, and 84 percent were offered some coverage of prescription (outpatient) drugs. Hearing care was offered to four out of five enrollees. Other services offered include preventive dental care, podiatry, and chiropractic services. While plans may offer even more services, those shown in chart E–9 are the most frequently offered benefits.

COVERAGE FOR PRESCRIPTION DRUGS

One of the advantages of Medicare managed care, over traditional fee-for-service Medicare, is that most plans included some prescription drug coverage. However, according to HCFA data, M+C prescription drug coverage has become less generous over time. Although the number of beneficiaries with access to plans offering drug coverage remained about the same from 1999 to 2000, the value of that benefit declined. Plans are simultaneously decreasing the amount of covered drug spending while also increasing out-of-pocket costs. Most plans (86 percent) will limit drug benefits in 2000 and an increasing number of plans will set annual benefit limits at $500 or less (21 percent of plans in 1999 and 32 percent of plans in 2000). Furthermore, only 18 percent of plans in 2000 will offer drug coverage above a $2,000 level.

All plans require some level of copayment for prescription drug coverage in 2000 and the copayment amount has increased. About 20 percent of beneficiaries were offered plans with copayments

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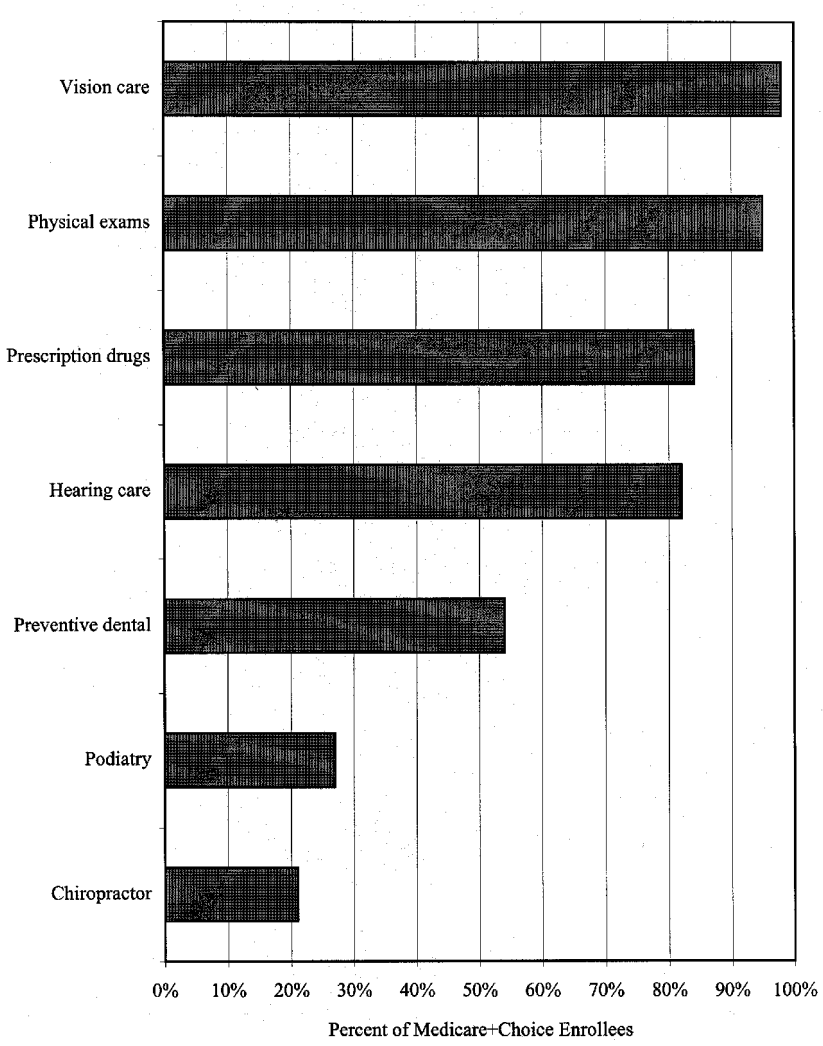
[11] Alternatively, under the ACR process, plans may also charge a premium if they demonstrate higher "costs," rather than "saving" for providing the basic benefit package.

[12] Plans may also offer extra benefits, beyond the "additional" benefits required to spend the "savings" calculated in the ACR process. These extra benefits are referred to as "supplemental" benefits. Plans are permitted to charge Medicare enrollees the expected cost of these supplemental benefits, plus the national average amount of beneficiary cost sharing for Medicare-covered services. Plans can collect these payments through a combination of copayments and premiums, but premiums cannot exceed the difference between total allowable beneficiary cost sharing (premiums plus copayments) and expected copayments. Plans may choose to waive part or all of this allowable premium for all enrollees.

averaging $5 or less for generic drugs in 1999, compared to 3 percent in 2000. As shown in table E–12, the average copayment level will increase by 21 percent for brand name drugs and 8 percent for generic drugs, between 1999 and 2000.

CHART E–9. PERCENT OF MEDICARE+CHOICE ENROLLEES OFFERED BENEFITS BEYOND TRADITIONAL MEDICARE COVERED SERVICES, IN THE LOWEST PREMIUM PACKAGE AVAILABLE, 1999



Source: Chart prepared by the Congressional Research Service based on Mathematica analysis of Health Care Financing Administration data.

TABLE E–12.—AVERAGE COPAYMENT LEVELS IN MEDICARE+CHOICE PLANS WEIGHTED BY ENROLLMENT, 1999 AND 2000

Year	Brand name copayment: enrollment weighted average	Generic copayment: enrollment weighted average
1999	$14.34	$6.88
2000	17.30	7.42
Percent increase 1999 to 2000	21	8

Note.—This chart includes data from plans with any level of drug coverage in the basic plan.

Source: Health Care Financing Administration data.

MEDICARE+CHOICE PREMIUMS

Plans are permitted to charge enrollees additional out-of-pocket fees, such as premiums and coinsurance, depending on which plan the individual elects. However, organizations may decide to offer zero-premium plans.[13] If Medicare's per capita payment to a plan exceeds its costs (a "savings" in the terms of the ACR), the plan may choose to add only enough benefits to match the savings, allowing no additional premium under the ACR rules. Another rationale for waiving premiums is to stay competitive in local markets. In this latter case, the plan may not be at risk of taking a loss on its Medicare business because profits and overhead based on commercial rates are included in its allowed costs under the ACR calculation.

Comparing 1999 to 2000, there has been a decline in both the percentage of beneficiaries with access to any M+C plans and the number of zero premium plans available to Medicare beneficiaries. More than 3 million Medicare beneficiaries lost access to at least one zero premium plan, decreasing the percentage of beneficiaries with access to any plan that does not charge a premium from about 85 percent in 1999 to 77 percent in 2000. The impact on rural areas was even greater, especially since these individuals have fewer opportunities for enrolling in the M+C Program and fewer choices among plans. Among those with access to Medicare managed care, zero premium plans will be available to 40 percent of the beneficiaries in rural areas in 2000, compared to 63 percent in 1999.

For beneficiaries with access to only one plan, increases in premiums may be especially severe because their only alternative is Medicare fee-for-service. As shown in table E–13, in 2000, many of these beneficiaries will lose access to zero premium plans, no one who pays a premium will pay less than $20 and an increasingly large number will pay premiums over $80.

[13] All M+C enrollees (as well as fee-for-service Medicare beneficiaries enrolled in part B) are required to pay the Medicare part B monthly premium. The monthly premium was set at $45.50 for 1999 and remained the same for 2000.

TABLE E–13.—MEDICARE BENEFICIARY POPULATION (TOTAL), WITH ACCESS TO ONLY ONE PLAN

Minimum premium	Year 1999		Year 2000	
	Beneficiaries	Percent	Beneficiaries	Percent
Zero	803,162	31.6	599,553	28.4
$0.01–$19.99	17,614	0.7	—	0.0
$20.00–$39.99	467,284	18.4	410,662	19.5
$40.00–$59.99	716,662	28.2	683,029	32.4
$60.00–$79.99	499,095	19.6	220,237	10.4
$80.00–$99.99	39,742	1.6	195,432	9.3

Source: Health Care Financing Administration data.

BENEFICIARY PROTECTIONS

The M+C Program includes requirements designed to limit beneficiaries' financial liability and to assure beneficiaries of certain rights and remedies. M+C significantly changed provisions included with the Risk Contract Program, relating to beneficiary liability, access to emergency medical services, and quality assurance.

Beneficiary financial liability

Enrollees in M+C coordinated care plans are likely to experience the least amount of out-of-pocket costs (compared to other M+C options). For them, the amount of cost sharing per enrollee (including premium) for covered services can be no more than the actuarial value of the deductibles, coinsurance, and copayments under traditional Medicare (table E–14). Neither a contracting nor a noncontracting physician, hospital, or other provider can impose balance billing charges on coordinated care enrollees. Coordinated care plans must pay noncontracting providers at least the same amount they would have received if the enrollee was in traditional Medicare, including allowed balance billing amounts.

The rules for private fee-for-service plans and MSA plans are different (table E–14). Generally, contract providers will be allowed to bill enrollees in private fee-for-service plans up to 15 percent above the fee schedule the plan uses. In contrast to traditional Medicare, this privilege extends to all categories of providers, including hospitals. The term "contract provider" refers to providers who have entered into an explicit agreement with a plan establishing payment amounts for services rendered to the plan's enrollees. A provider can be deemed to have a contract with an M+C private fee-for-service plan if, before furnishing services to the enrollee of such a plan, the provider: (1) received a notice of the individual's enrollment in a private fee-for-service plan and had been informed of the terms and conditions of the plan's payment or (2) if the provider was given reasonable opportunity to obtain such information. For MSA plans, unlimited balance billing is allowed, regardless of whether the deductible has been met. Plans could determine whether they count these amounts toward the deductible.

TABLE E–14.—BENEFICIARY COST SHARING AND PROVIDER REIMBURSEMENT UNDER MEDICARE+CHOICE PLANS FOR BASIC BENEFIT PACKAGE

Item	Coordinated care plan	Private fee-for-service plan	MSA plan
Beneficiary out-of-pocket costs (premium plus any deductibles, coinsurance, and copayments).	Premium and actuarial value of other cost sharing (for example, coinsurance) on average cannot exceed the actuarial value of the cost sharing applicable on average under traditional Medicare.	The actuarial value of the cost sharing (not including the premium) on average cannot exceed the actuarial value of cost sharing on average under traditional Medicare.	A deductible of no more than $6,000 (indexed for inflation). Amounts above traditional Medicare payments (including coinsurance) do not have to be counted toward satisfying the deductible. Once deductible is met, MSA plan would have to pay for all Medicare-covered expenses including cost sharing. Plans are allowed to charge beneficiary for services not covered by Medicare (for example, very long hospital stays or experimental treatments).
Beneficiary liability for balance billing.	Beneficiaries are not liable for any balance billing amounts.	Contract providers can bill 15 percent above the private fee schedule (or other provider reimbursement amount). Noncontract providers cannot balance bill beneficiaries.	Balance billing is allowed and would not be subject to any limits, regardless of whether the deductible has been met.

TABLE E–14.—BENEFICIARY COST SHARING AND PROVIDER REIMBURSEMENT UNDER MEDICARE+CHOICE PLANS FOR BASIC BENEFIT PACKAGE—Continued

Item	Coordinated care plan	Private fee-for-service plan	MSA plan
Medicare+Choice plan payment obligation to physicians, hospitals, and other providers.	Contract providers are paid fees or rates that are privately negotiated by the plan with them. Noncontract providers must accept as payment in full Medicare's fee schedule (or other Medicare reimbursement rate) including the allowed balance billing amounts (if any) allowed under Medicare.	Contract providers are paid private fees (or rates) minus beneficiary cost sharing amounts. Fee schedule or rates must be as generous as Medicare unless plan has a sufficient number and range of provider contracts. Noncontract providers same as for noncontract providers in coordinated care plans.	Above the deductible, plan reimburses provider for traditional Medicare amounts including coinsurance.
Medicare+Choice payments received by physicians, hospitals, and other providers.	Contract providers receive payments based on a privately negotiated fee schedule. Noncontract providers receive payments based on traditional Medicare payment systems, including allowable balance billing (paid by the plan).	Contract providers receive payments based on a private fee schedule and can collect up to 15 percent additional from the beneficiary. Noncontract providers same as for noncontract providers in coordinated care plans.	Providers receive payments based on their charges. After the beneficiary's deductible is met, the plan's payment is based on traditional Medicare payment systems, but unlimited balance billing is allowed.

Source: Congressional Research Service and Medicare Payment Advisory Commission analysis of provisions in the Balanced Budget Act of 1997.

Access to emergency services

Each M+C plan must ensure access to emergency services for emergency medical conditions, using the prudent layperson standard. This definition states that an emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy (and in case of a pregnant women, her health or that of her unborn child); (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Quality standards

M+C plans must have a quality assurance program that: (1) stresses health outcomes and provides data permitting measurement of outcomes and other indices of quality; (2) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; (3) evaluates the continuity and coordination of care that enrollees receive; (4) is evaluated on an ongoing basis as to its effectiveness; (5) includes measures of consumer satisfaction, and (6) provides the Secretary with certain information to monitor and evaluate the plan's quality. Only certain coordinated care plans (not private fee-for-service, preferred provider organizations, and nonnetwork MSA plans) have to comply with other quality assurance requirements, such as providing for internal peer review, establishing written protocols for utilization review, and establishing mechanisms to detect under and over utilization.

Most M+C organizations must obtain external review of the quality of their inpatient and outpatient services and of their response to written complaints about poor quality of care from an independent quality review and improvement organization (such as a peer review organization or PRO). The external review requirement does not apply to private fee-for-service plans and nonnetwork MSA plans that do not have utilization review programs.

The Secretary is required to ensure that the external review activities do not duplicate the review activities conducted as part of the accreditation process. The Secretary may waive the external review requirement if she determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other M+C requirements. Plans may be deemed to have met all these requirements if they are accredited by an organization approved by the Secretary, according to statutory requirements.

Grievances and appeals

An M+C organization must have meaningful procedures for hearing and resolving grievances between the organization and enrollees. It also must maintain a process for determining whether an individual enrolled within the plan is entitled to receive a health service and the amount (if any) that the individual must pay for the service. These determinations must be made on a timely basis, appropriate to the urgency of the situation. The explanation of the determination of a denial of coverage must be in understandable

language and state the reasons for the denial. A description of the reconsideration and appeals processes must be provided.

Upon request by the enrollee, the organization generally will have to provide for reconsideration of a determination. The reconsideration must occur within a time period specified by the Secretary, but (except where an expedited process is appropriate) no longer than 60 days after receipt of the request. A reconsideration of a denial of coverage based on lack of medical necessity must be made by a physician with appropriate expertise who was not involved in the initial determination.

An enrollee in an M+C plan or a physician may request an expedited determination or reconsideration. If the request is made by a physician, an M+C organization is required to expedite the determination or reconsideration if the request indicates that the normal time frame for making the determination or reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

PLAN STANDARDS

Minimum enrollment requirements

The M+C standards and requirements draw extensively from those under the Risk Contract Program. Contracts with M+C organizations are made for at least 1 year and are automatically renewable in the absence of notice by either party of intention to terminate. Organizations must have at least 5,000 individuals (or 1,500 in the case of a PSO) who are receiving health benefits through the organization or at least 1,500 individuals (or 500 in the case of a PSO) who are receiving health benefits if the organization primarily serves individuals residing outside of urbanized areas.

State preemption

The Secretary established, by regulation, standards for M+C organizations and plans. In certain areas, these Federal standards preempt any State law or regulation with respect to M+C plans to the extent such law or regulation is inconsistent with the Federal standards. State standards that are preempted are: (1) benefit requirements, (2) requirements relating to inclusion or treatment by providers, and (3) coverage determinations (including related appeals and grievance processes).

Organizational and financial requirements

In general, an M+C organization must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers an M+C plan. An M+C organization must assume full risk for Medicare benefits on a prospective basis. However, an organization may obtain insurance or make other arrangements to cover: (1) aggregate costs in excess of a level specified by the Secretary; (2) medically necessary services provided by nonnetwork providers; and (3) no more than 90 percent of the amount by which its costs exceed 115 percent of its income. The organization also may make arrangements with physicians or other health care professionals and health care institutions to assume all or part of the financial

risk on a prospective basis for the provision of Medicare benefits by these individuals and entities.

Provider-sponsored organizations

Special rules apply to provider-sponsored organizations (PSOs). A PSO is defined as a public or private entity that is established or organized and operated by a health care provider or group of affiliated providers. A PSO must provide a substantial proportion of health care under an M+C contract directly through the provider or affiliated group of providers. The affiliated providers must share, directly or indirectly, substantial financial risk with respect to Medicare benefits and have at least a majority financial interest in the entity.

A PSO may seek a waiver of State law by filing an application with the Secretary by no later than November 1, 2002. The waiver will be effective for 3 years and is not renewable. The Secretary will have to approve the waiver application if the State denied the PSO's licensing application based on its failure to meet solvency requirements that are the same as the Federal ones or that the State imposed as a condition of approval procedures or standards regarding solvency that were different from those applied under Federal law. Waivers are also available if the State fails to act on a substantially complete license application within 90 days.

A waiver granted to a PSO will depend on the organization's compliance with all State consumer protection and quality standards insofar as such standards: (1) would apply to the organization if it were licensed under State law; (2) are generally applicable to other M+C organizations and plans in the State; and (3) are consistent with the Federal standards established under the act. Certain State standards will be preempted as they apply to PSOs and M+C plans more generally. The Secretary is required to report by December 31, 2001 on whether the waiver process should be continued after December 31, 2002. The report must consider the impact of the waiver process on beneficiaries and the long-term solvency of Medicare.

The Secretary established final standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. In establishing the standards for PSO solvency, the Secretary was required to take into consideration any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

Provider protections and requirements

Each M+C organization is required to establish reasonable procedures relating to the participation of physicians in any M+C plan it offers. The procedures include: (1) providing notice of the rules regarding participation; (2) providing written notice of adverse participation decisions; and (3) providing a process for appealing adverse decisions. The organization must consult with contracting physicians regarding the organization's medical policy, quality, and medical management procedures. The use of gag clauses (restricting communications between providers and their patients) is prohibited. The use of physician financial incentive plans is also limited. (A financial incentive plan is any compensation arrangement

between the organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to enrollees.)

Protections against fraud

M+C requires contractors to comply with various disclosure and notification requirements. M+C organizations are required to report financial information to the Secretary, including information demonstrating that the organization is fiscally sound, a copy of the financial report filed with HCFA containing information on ownership, and a description of transactions between the organization and parties in interest.

The Secretary is also required to audit annually the financial records of at least one-third of the M+C organizations (including data relating to utilization, costs, and computation of the ACR). In addition, the Secretary has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services, as well as the organization's facilities, if there is reasonable evidence of need for such inspection. Also, the Secretary has the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or pertain to services performed or determinations of amounts payable under the contract. M+C contracts must require the organization to provide and pay for advance written notice to each enrollee of a plan termination, along with a description of alternatives for obtaining benefits. They must also require that organizations notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

Sanctions and termination of contracts

The Secretary is authorized to carry out specific remedies in the event that an M+C organization: (1) fails substantially to provide medically necessary items and services required to be provided, if the failure adversely affects the individual; (2) imposes premiums on individuals that are in excess of those allowed; (3) acts to expel or refuses to reenroll an individual in violation of Federal requirements; (4) engages in any practice that would have the effect of denying or discouraging enrollment (except as permitted by law) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (5) misrepresents or falsifies information to the Secretary or others; (6) fails to comply with rules regarding physician participation; or (7) employs or contracts with any individual or entity that has been excluded from participation in Medicare. The remedies include civil money penalties, and suspension of enrollment until the Secretary is satisfied the deficiency has been corrected and is not likely to recur. A noncomplying plan can also be terminated from participation in M+C if the Secretary determines that the organization: (1) fails substantially to carry out the contract; (2) is carrying it out in a manner substantially inconsistent with the efficient and effective administration of M+C; or (3) no longer substantially meets M+C conditions.

DEMONSTRATIONS AUTHORIZED BY THE BALANCED BUDGET ACT

The Balanced Budget Act (BBA) authorized several demonstrations in conjunction with the M+C Program. The most important of these are an MSA option for Medicare beneficiaries and a test of whether savings can be achieved by setting payments to plans through competitive pricing of plan premiums.

Medical savings account (MSA) demonstration

The BBA authorized a demonstration to test the feasibility of MSAs for the Medicare Program. However, to date, no Medicare beneficiaries are enrolled in a Medicare MSA.

The M+C option is a combination of an MSA plan providing health insurance with an annual deductible initially limited to $6,000 and an M+C MSA. Under the terms of the demonstration, new enrollments will not be allowed after 2002 or after the number of enrollees reaches 390,000.

MSA plans are not available to certain low-income or disabled individuals, among others. When enrolled in an MSA plan, individuals will not be able to have other health insurance (including Medigap policies), with some exceptions, and they must reside in the United States for at least half the year. Individuals will be able to disenroll from an MSA plan only during an annual election period or under special circumstances.

MSA plans provide reimbursement for items and services covered under parts A and B of Medicare, though only after the enrollee incurs countable expenses equal to the annual deductible (limited to $6,000, indexed for inflation). Countable expenses include at least those payable by Medicare under parts A and B as well as the deductibles, coinsurance, and copayments the enrollee would have paid under those parts. At a plan's option, other expenses (such as prescription drugs or charges that exceed what Medicare would have paid) may also be counted.

After the deductible is met, the plan must reimburse at least 100 percent of parts A and B expenses (the provider charges) or 100 percent of what Medicare would have paid for these expenses without regard to deductibles or coinsurance, whichever is less. Providers delivering services to those with MSA plans are not subject to balance billing limitations, and the plans are not required to pay any balance billing charges, though some might do so (see table E–14).

Contributions to an M+C MSA are made annually from the enrollee's capitation rate after the MSA plan insurance premium has been paid. Contributions to accounts are exempt from taxes, as well as account earnings. Withdrawals are likewise not taxed nor subject to penalties if they are used to pay unreimbursed enrollee medical expenses that are deductible under the Internal Revenue Code. However, qualified withdrawals cannot be made to pay insurance premiums other than for long-term care insurance, continuation coverage (such as COBRA), or coverage while an individual is receiving unemployment compensation.

Nonqualified withdrawals are included in the individual's gross income for tax purposes. Withdrawals are also subject to an additional 50-percent penalty to the extent they exceed the amount by

which the account balance on December 31 of the prior year is greater than 60 percent of the MSA plan deductible for the year of withdrawal. For example, if the account balance on December 31 were $3,500 and the plan deductible the next year were $5,000, the amount that could be withdrawn for nonqualified purposes without the penalty is $500 (that is, $3,500 minus 60 percent of $5,000). The 50-percent penalty will not apply in cases of death or disability. Account balances at death will be subject to various tax treatments depending on their disposition.

If MSA plan enrollees switch to another M+C option or traditional Medicare, they will be able to maintain their account and use it to pay qualified medical expenses. No additional contributions will be allowable unless enrollees elect an MSA plan again.

Medicare competitive pricing demonstration

Under its demonstration authority, HCFA attempted to initiate a project to determine whether changes in methods for paying health plans, specifically a shift to some form of negotiated rates, would have the effect of increasing the efficiency and economy of providing Medicare services through coordinated care plans. HCFA's plan called for the application of competitive bidding as a method for establishing payments for risk contract health maintenance organizations (HMOs) in either the Baltimore or the Denver area. Through a combination of court and legislative decisions, these demonstrations have been terminated.

BBA 1997 required the Secretary of the U.S. Department of Health and Human Services (DHHS) to establish a demonstration project under which payments to M+C organizations in certain areas are determined in accordance with a competitive pricing methodology.

The Secretary was required to designate, in accordance with recommendations of the newly created Competitive Pricing Advisory Committee (CPAC), up to seven Medicare payment areas in which the project would be conducted. The BBA defined the composition and responsibilities of the CPAC, which will terminate in 2004. The CPAC is required to recommend to the Secretary four specific areas to be included.

For each Medicare payment area in the project, the Secretary was to (in accordance with recommendations of the CPAC), establish the benefit design among plans, structure the method for selecting plans, establish methods for setting the price to be paid to plans, and provide for the collection and dissemination of plan information.

However, both the Balanced Budget Refinement Act (BBRA) as well as the Consolidated Appropriations Act of 2000 altered the terms of this demonstration. The Appropriations Act disallowed any finding of the demonstration for 2000 in Arizona and parts of Kansas and Missouri. The BBRA delays implementation of the project until January 1, 2002, or, if later, 6 months after CPAC submits reports on: (1) incorporating original fee-for-service Medicare into the demonstration; (2) quality activities required by participating plans; (3) the viability of expanding the demonstration project to a rural site; and (4) the nature of the benefit structure required from plans that participate in the demonstration. The Sec-

retary is also required, subject to recommendations by CPAC, to allow plans that make bids below the established government contribution rate, to offer beneficiaries rebates on their part B premiums.

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