APPENDIX E – MEDICARE+CHOICE

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INTRODUCTION

Medicare has a long-standing 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.

In 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), replacing the risk contract program with the 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 successful at expanding coverage, and the initial moderate growth through 1999, which increased M+C enrollment to about 17 percent of beneficiaries, has since taken a downward turn. In March 2003 about 12 percent of the Medicare population (4.7 million enrollees) remained in the M+C program, compared to the 14 percent of the Medicare population who were enrolled in Medicare managed care prior to the enactment of BBA.

The 106th Congress enacted legislation in order to address some issues arising from the BBA changes. The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) as well as the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA P.L. 106-554) amended the M+C program in an effort to increase reimbursement and to make it easier for Medicare beneficiaries and plans to participate in the program.

The 107th Congress passed The Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188) which included a few temporary changes to deadlines in the Medicare+Choice program. Additionally, the 107th Congress considered, but was not able to reach agreement on major legislative changes to the Medicare+Choice program. The House passed H.R. 4954 on June 28, 2002, a bill that would have increased M+C payments in 2003 and 2004 and then in 2005 would have created a new Medicare+Choice competition program and a demonstration program. Two bills were introduced in the Senate that also would have made major changes to the M+C program. S. 3018 (introduced by the Senators Baucus and Grassley et al.) contained provisions similar to H.R. 4954 to increase M+C payments 2003 and 2004. S. 2729 (introduced by Senator Grassley et al. - the tripartisan bill) would have based payments in M+C on competitive bids by plans. Neither bill was passed by the Senate. The 108th Congress is considering similar options to revise the M+C program.

This appendix describes the current status of the M+C program, as amended, 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 was created to offer 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 non-enrollees. Unlike other managed care plans, PPOs do not traditionally have primary-care gatekeepers, who oversee health care services.

Alternatively, a beneficiary may select a private fee-for-service (PFFS) plan that covers enrollees through a private indemnity health insurance policy for which the Centers for Medicare and Medicaid Services (CMS) 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 any additional financial risk. It also does not vary rates based on utilization. Enrollees may see any Medicare-approved provider who agrees to furnish services under the plan's terms and conditions of payment.

Finally, the demonstration MSA plans reimburse enrollees for their expenses for 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. Three PPOs serve 2,241 beneficiaries through the M+C program. PPOs are more widely available through a demonstration program, with 56,677 enrollees as of March 2003. On July 1, 2000, a private fee-for-service (PFFS) plan, Sterling Life Insurance Company, became available to Medicare beneficiaries. Beginning January 2003, a second PFFS plan, Humana, Inc. also become available to Medicare beneficiaries. As of March 2003 there were 20,761 enrollees in the two PFFS plans throughout the country.[1] Additionally, there are another 1,748 enrollees in a PFFS demonstration program.

In addition to expanding options for Medicare managed care coverage, the BBA also substantially restructured the system for setting Medicare payment rates to private plans. 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 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 also were 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 Health and Human Services (HHS) to develop a method for risk adjusting payments to include health status, in order to account for a larger share of the variation in costs. The interim method established by the Secretary adjusted for health status based on diagnoses for prior year inpatient hospitalizations. Although phase-in of these health-based risk adjusters began in January 2000, the BBRA slowed down the Secretary's planned phase-in schedule. Further refinements included in BIPA extended the current risk-adjustment methodology through 2003 and then, beginning in 2004, a new methodology based on disease grouping will be phased-in based on data from inpatient hospitals and ambulatory settings. This system will be fully phased in beginning in 2007.

The BBRA and BIPA made several other revisions to the M+C program, raising M+C payments to plans and providing bonus payments for certain plans that enter areas where no other plan is in operation to encourage participation in rural areas. The BBRA 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

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[1] For a more detailed analysis of PFFS plans see CRS Report RL31122, *Medicare+Choice: Private Fee-for-Service Plans*, by Paulette Morgan and Madeleine Smith.

match revenues to costs. Additional changes in BIPA permit M+C plans to offer reduced Medicare Part B premiums beginning in 2003 and revised payments for End Stage Renal Disease (ESRD) M+C enrollees.

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 partially may be a reaction to a slowdown in the rate of increase for Medicare managed care payments, the initial slowdown in spending for Medicare traditional fee-for-service payments following the passage of the BBA, and the uncertainty about the future of the payments or organization of the M+C program.

Further, beneficiaries in rural areas still have limited access to managed care plans and enrollment growth has slowed or declined across all geographic areas. Beneficiaries also have 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, further discouraging participation in the Medicare program. M+C plans increasingly have noted that in addition to concerns about payment amounts, the regulatory requirements are burdensome and make it difficult for them to participate in the program.

As plans withdraw from the M+C program, some enrolled beneficiaries are forced to choose new M+C plans, while others are left without any access to Medicare managed care. They are forced to return to Medicare's fee-for-service program. Even among those who still have an option to choose another 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.

In 2003, M+C plans are available to about 59 percent of the more than (40 million) Medicare beneficiaries, and in March 2003 about 12 percent of all beneficiaries chose to enroll in one of the 146 (includes two PFFS plan) available M+C plans. The rapid growth rate of Medicare managed care enrollment in the 1990s leveled off and although enrollment initially increased moderately with the implementation of the M+C program, by March 2003 enrollment was two percentage points below pre-BBA enrollment. The Congressional Budget Office (CBO) projects that M+C enrollment will decline moderately through 2008, when it will reach about 9 percent of the Medicare population and then slowly decline to about 8 percent by 2013. CBO estimates that in 2003 Medicare will spend $35.9 billion for all Medicare group plans, (including M+C and other private Medicare arrangements, such as demonstrations). By 2013 the projected spending for Medicare group plans will increase to $46.9 billion.

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 92 percent of beneficiaries in center cities have access to at least one plan, only 6 percent have access in the most rural areas.

TRENDS IN MEDICARE+CHOICE PLAN/CONTRACT AVAILABILITY AND ENROLLMENT

AVAILABILITY OF MEDICARE MANAGED CARE PLANS/CONTRACT

The M+C program began operation on January 1, 1999,[2] as authorized by the BBA. By March 2003, there were 146 M+C contracts with CMS under the M+C program.[3] Over time, the number of M+C contracts has fluctuated. From 1987 to the early 1990s many risk plans terminated existing contracts, decreasing the number of available plans from 161 in 1987 to 93 in 1991. The trend shifted as the number of Medicare risk plans began increasing in 1992, more than tripling from 110 in 1993 to 346 in 1998. With the implementation of the M+C program in 1999, the downward cycle of availability began once again, as several M+C organizations withdrew from the Medicare program (or reduced the size of their service area). As shown in ChartE-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 (267 contracts) in 2000 and then to 146 as of March 2003.

MEDICARE MANAGED CARE TERMINATIONS

Since the implementation of the M+C program, a substantial number of managed care organizations either have 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 51,000 (less than 1 percent) of all M+C enrollees 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. In January 2000, additional contract terminations and service area reductions affected 327,000 (5 percent) of M+C

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

[3] The BBA changed the designation of "plans", beginning in 1999. The old definition of "plans" is now referred to as "contracts" and each contract may include several different "plans". In Mar. 2003 there were about 442 plans available through 146 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.

enrollees in 329 counties, some of whom also had been affected the previous year. This cycle of contract changes left 79,000 (1.3 percent) of all managed care enrollees in 105 counties without access to any other M+C plan.

Prior to the passage of BIPA, CMS released information about contract terminations, effective January 2001. Those figures were expected to affect about 934,000 M+C enrollees, leaving almost 159,000 of these enrollees with no access to Medicare managed care. After the passage of BIPA, M+C organizations were given an opportunity to reconsider their earlier decision and as a result four M+C organizations decided to return to the program. In total these organizations had provided serviced to approximately 13,000 beneficiaries in 2000, covering 11 counties. In five counties, there were no other M+C plans offered. Despite the changes made to contract terminations after BIPA, this series of contract terminations affected more beneficiaries than the combined total for the previous 2 years. Nationwide, just two managed-care companies, AETNA and CIGNA, accounted for about half of the total number of beneficiaries affected by these withdrawals.

TABLE E-1--MEDICARE+CHOICE CONTRACT TERMINATIONS AND SERVICE AREA REDUCTIONS

	Effective January 1999	Effective January 2000	Pre-BIPA Effective January 2001	Effective January 2002	Effective January 2003
Terminations	45	41	65	22	9
Service area reductions	54	58	53	36	24
Number of enrollees before withdrawals	6,056,000	6,347,000	6,242,000	5,600,000	4,939,000
Total enrollees affected	407,000	327,000	934,000	536,000	215,000
Affected enrollees with no access to any plan	51,000	79,000	159,000	38,000	29,000
Affected enrollees with access limited to PFFS plan	NA	NA	NA	52,000	3,000
Affected enrollees with access limited to Demonstration PPO plan	NA	NA	NA	NA	3,000

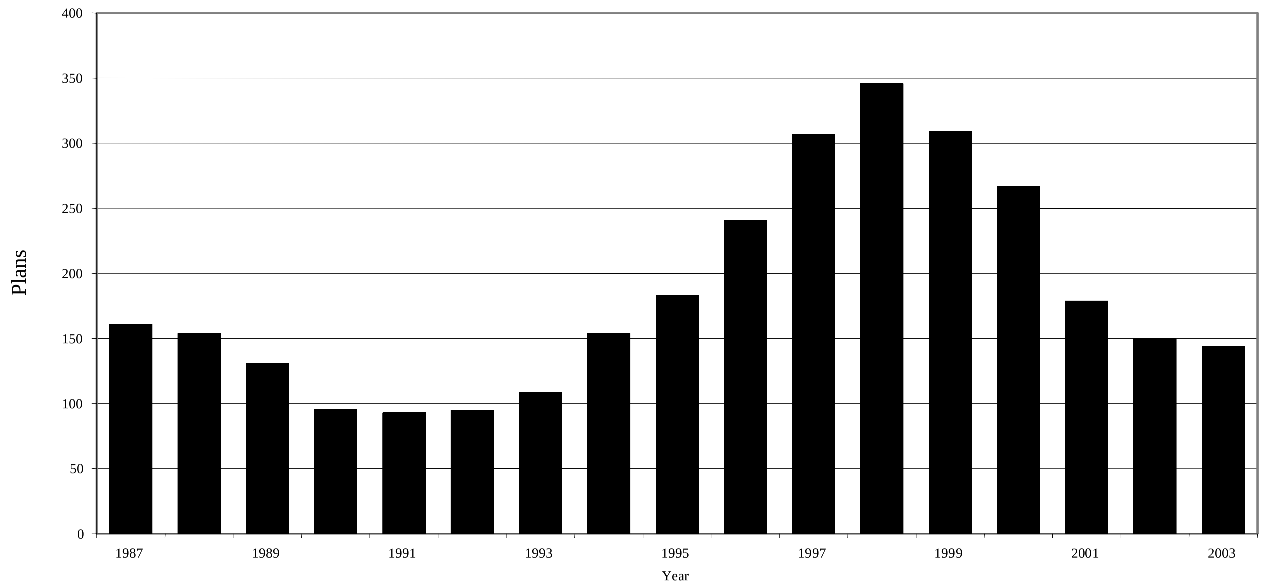
Note: Enrollee counts rounded to the nearest thousand and enrollee count before January 2002 withdrawals represents data from March 2003.

NA – Not available.

Source: Prepared by the Congressional Research Service (CRS) based on data from the CMS.

For contract renewals effective on January 1, 2002, 36 plans reduced their service area and 22 did not renew their contract. This round of withdrawals affected more than 536,000 M+C enrollees, leaving about 38,000 without access to any M+C plan. For an additional 52,000 individuals, their only M+C option was the Sterling private-fee-for-service plan and they had no access to any other type of M+C plan, such as an HMO. For contract renewals effective

CHART E-1--NUMBER OF MANAGED CARE PLANS/CONTRACTS PARTICIPATING IN MEDICARE, 1987-2003



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 CMS Medicare managed Care Contract (MCCC) Monthly Reports; 2003 data from March.

January 2003, nine plans terminated their contracts, and 24 reduced their service area, affecting 215,000 enrollees and leaving 29,000 with no M+C options. For 3,000 enrollees, their only option was a PFFS plan and for another 3,000 their only option was the PPO demonstration program. Plans withdrawing from the M+C program affect not only current M+C enrollees, but also affect both current Medicare fee-for-service beneficiaries and newly eligible Medicare beneficiaries who might choose to enroll in an available managed care plan.

ENROLLMENT TRENDS FOR MEDICARE MANAGED CARE

While the number of plans/contracts participating in Medicare managed care has fluctuated over time, the percent of beneficiaries enrolled in Medicare managed care continued to increase until 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 increased significantly to 16 percent of Medicare beneficiaries, covering just over 6 million enrollees. Since the implementation of the M+C program, enrollment growth increased through 1999, but today has declined below the 1998 level; reaching almost 17 percent of beneficiaries in December 1999 (6.3 million enrollees), declining slightly to 16 percent (6.2 million enrollees) by December 2000, and to about 12 percent (5.6 million enrollees) by March 2003. CBO projects that enrollment in M+C plans will reach about 9 percent of all beneficiaries by 2008 covering about 3.9 million enrollees. CBO projects that by 2013 M+C will have the same number of enrollees, 3.9 million; however, because of the growth in the overall Medicare population, the percentage of enrollees in M+C actually will decline to about 8 percent of all Medicare beneficiaries.

Enrollment in any individual plan is open 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.[4] As a result, not all Medicare beneficiaries have access to an M+C plan. As of 2003, Medicare managed care was available in only 17 percent of counties (Table E-2). However, while 83 percent of counties did not offer M+C plans in 2003, 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 January 2003, only 41 percent of all Medicare beneficiaries lived in an area that had no access to an M+C plan (Table E-3). Among the 59 percent of beneficiaries with access to the M+C program, 40 percent had a choice of at least two plans; 30 percent had a choice of two to four plans and another 10 percent had five or more plans available to them. By comparison, in December 1999, not only did more beneficiaries have access to an M+C plan, but they also had more choices.

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[4] 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.

TABLE E-2 --COUNTIES WITH AND WITHOUT MEDICARE MANAGED CARE PLANS, SELECTED YEARS 1997-2003

Year	Existing plans in county		No existing plans in county	
	Number of counties	%	Number of counties	%
1997	740	24%	2,387	76%
1999	896	29%	2,231	71%
2000	1,095	35%	2,049	65%
2001	636	20%	2,509	80%
2002	575	18%	2,570	82%
2003	549	17%	2,597	83%

Note: Does not include PFFS plans, demonstration plans, cost plans, or plans serving Puerto Rico. Medicare managed care plans include risk plans through 1998 and M+C plans beginning in 1999.

Source: MedPAC Computations based on CMS public data for 1997 and 1999; CRS analysis of CMS data for 2000-2003.

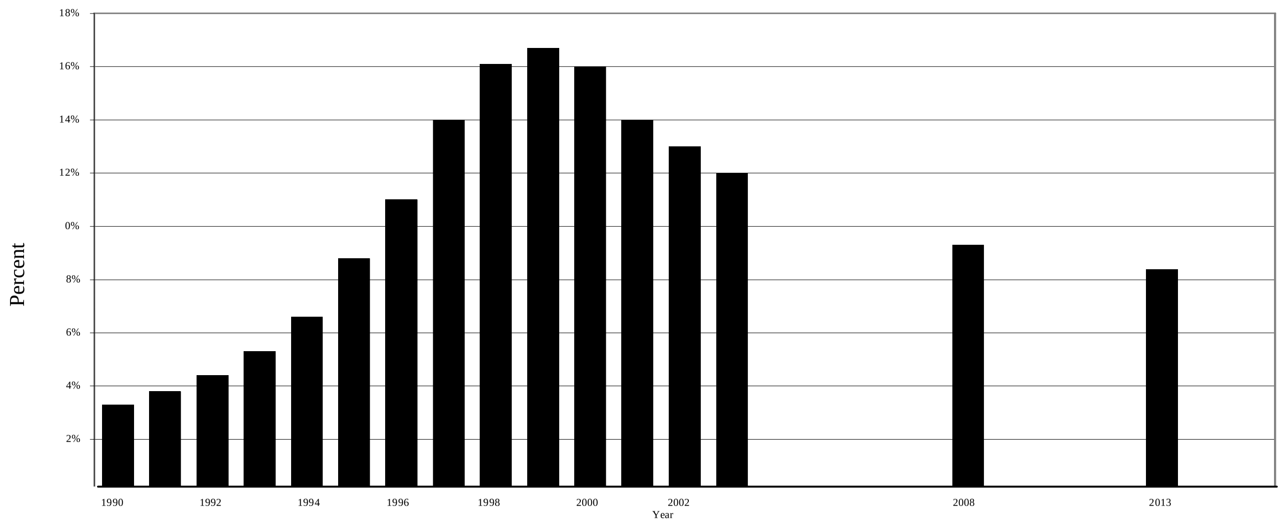
TABLE E-3--PERCENT DISTRIBUTION OF MEDICARE BENEFICIARIES BY MANAGED CARE PLANS (AVAILABLE IN THEIR AREA, 1995-2003)

Number of plans available	June 1995	June 1997	December 1999	February 2001	February 2002	January 2003
None	45%	33%	28%	36%	39%	41%
One	16%	9%	11%	12%	18%	19%
Two to four	26%	24%	27%	37%	33%	30%
Five or more	14%	34%	34%	14%	10%	10%

Note: Does not include PFFS plans, demonstration or cost plans, or plans serving Puerto Rico. Medicare managed care plans include risk plans through 1998 and M+C plans beginning in 1999. Totals may not add due to rounding.

Source**:** Prepared by CRS based on *MedPAC Chart Book*, July 1998, Chart 2-10, Mathematica analysis of CMS data for 1999, and CRS analysis of CMS data for 2001, 2002 and 2003.

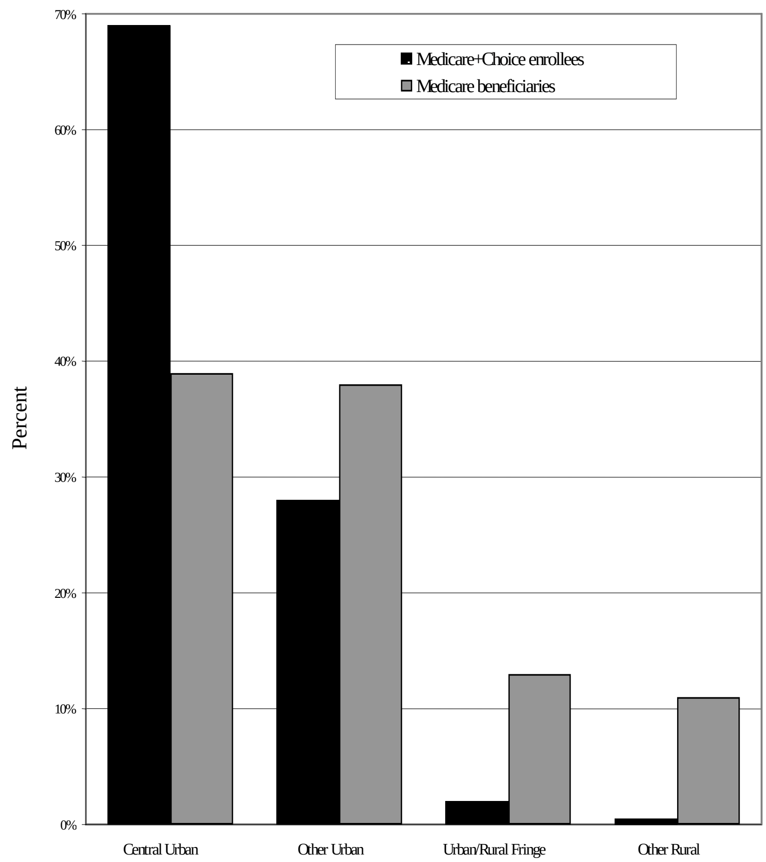
CHART E-2--PERCENT OF BENEFICIARIES ENROLLED IN MEDICARE MANAGED CARE PLANS, ACTUAL AND PROJECTED, SELECTED YEARS 1990-2013



Note: Medicare Managed Care Plans include risk plans through 1998 and Medicare+Choice plans beginning in 1999.
Source: Prepared by CRS based on MedPAC Chart Book, October 1997, chapter 3. CMS, Medicare Managed Care Reports, December 1998, 1999, 2000, 2001, 2002, 2003 and CBO March 2003 Baseline for projections for 2008 and 2013.

ENROLLMENT PATTERNS IN URBAN AND RURAL LOCATIONS

CHART E-3--PERCENT OF MEDICARE BENEFICIARIES AND MEDICARE+CHOICE ENROLLEES IN URBAN AND RURAL LOCATIONS, 2003



Source: Prepared by CRS based on CMS data.

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:

1. Central urban – central counties of metropolitan areas of at least 1 million population;
2. Other urban – either fringe counties of metropolitan areas of at least 1 million population or counties of metropolitan areas up to 1 million population;

3. Urban/rural fringe – urban population of at least 2,500 adjacent to a metropolitan area;
4. Other rural– includes urban population of at least 2,500, not adjacent to a metropolitan area, and rural areas (defined as places with a population of less than 2,500).

Most M+C enrollees reside in central urban areas; about 69 percent of the M+C population as of 2003. However, a smaller proportion, only 39 percent of all Medicare beneficiaries reside in the central urban areas. In all geographic areas, except central urban 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 plan benefits.

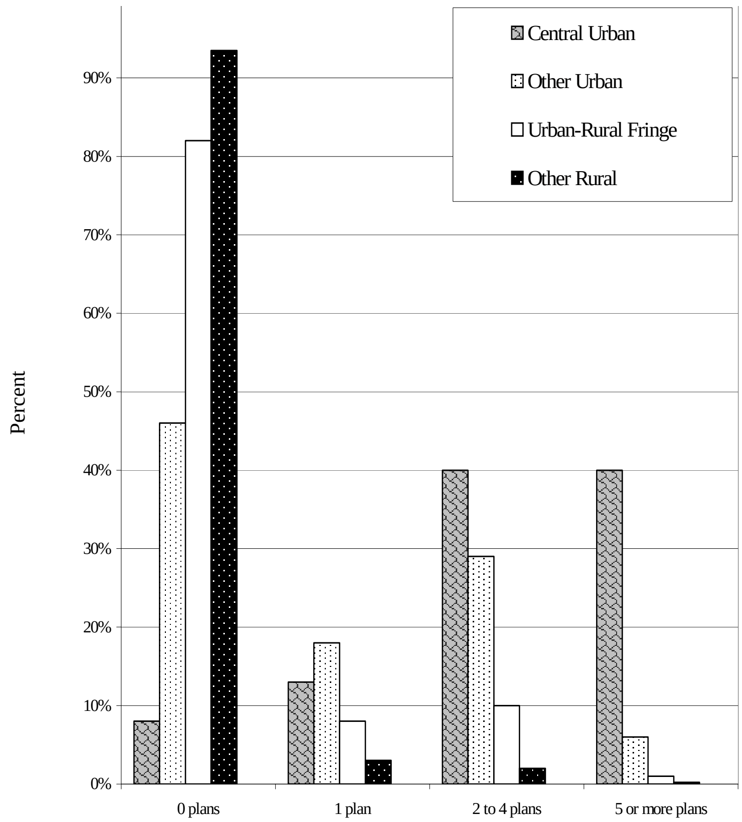
As shown in Chart E-4, access to M+C plans is much greater in urban areas than in rural areas. Only about 8 percent of beneficiaries in central urban areas lack access to M+C plans. Among the 92 percent of Medicare beneficiaries with access to such plans, 40 percent have a choice of at least five different plans and another 40 percent have a choice of two to four plans. By contrast, Medicare beneficiaries living in rural areas rarely have even a single plan available to them, leaving most of these beneficiaries (about 94 percent) with no access to plans. Among the beneficiaries in these areas who have access to Medicare managed care, about 2 percent have a choice of two to four plans and 4 percent have access to only one 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. Approximately 30 percent of the beneficiaries in Arizona, 33 percent of the beneficiaries in California, and 28 percent of the beneficiaries in Oregon are in M+C plans. The highest levels of enrollment in the eastern states are in Rhode Island (34 percent), Florida (19 percent), Pennsylvania (23 percent) and Massachusetts (18 percent). In contrast, 22 states have no (or marginal) plan enrollment, and an additional 13 states have between 2 percent and 10 percent of their Medicare beneficiaries enrolled in an M+C plan, which is lower than the U.S. average enrollment of 12 percent of beneficiaries.

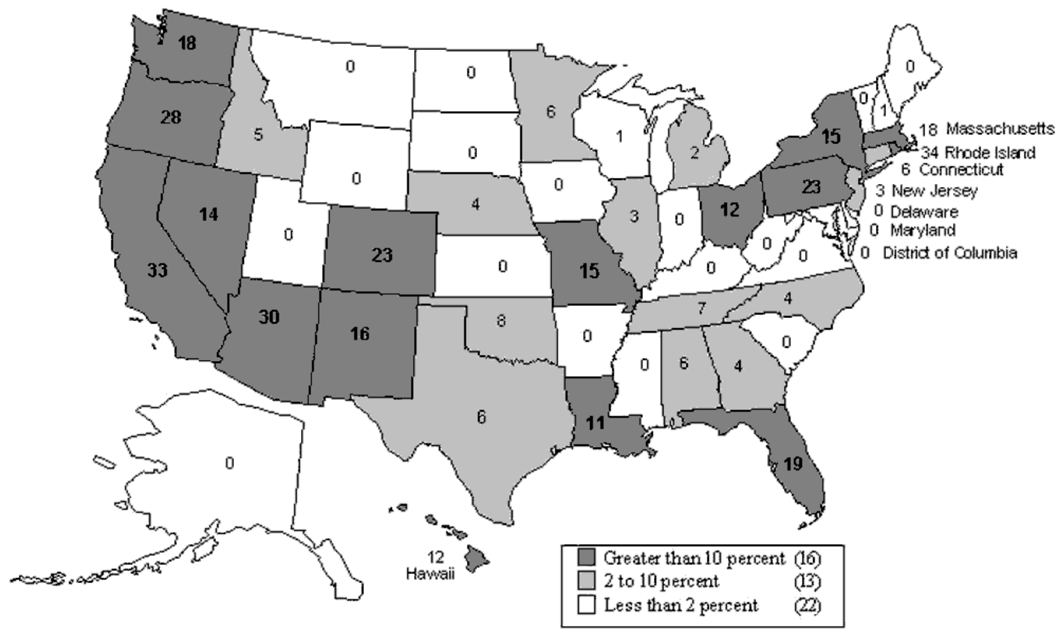
M+C enrollees are far more concentrated geographically than Medicare beneficiaries as a whole. In fact, four states account for over half of all M+C enrollment: California, Florida, Pennsylvania, and New York. These four states account for 59 percent of all M+C enrollees, but they are home to only 30 percent of all Medicare beneficiaries. Table E-4 compares the percent of M+C enrollment to the percent of the total Medicare population for each of these four states.

CHART E-4--PERCENT IN VARIATION IN NUMBER OF MEDICARE+CHOICE PLANS AVAILABLE TO MEDICARE BENEFICIARIES IN URBAN AND RURAL LOCATIONS, JANUARY 2003



Source: Prepared by CRS based on CMS data from Medicare compare database.

CHART E-5--PERCENT OF MEDICARE BENEFICIARIES ENROLLED IN MEDICARE+CHOICE, BY STATE, MARCH 2003



Note- State numbers represent percents.
Source: Prepared by CRS based on *Medicare Managed Care Contract Reports*, March 2003.

TABLE E-4 --SHARES OF MEDICARE+CHOICE ENROLLMENT AND MEDICARE POPULATION RESIDING IN FOUR STATES, MARCH 2003

State	% of Total M+C Enrollment	% of Total Medicare Population
California	28	10
Florida	12	7
Pennsylvania	10	5
New York	9	7
Total	59	30

Note – Numbers may not add due to rounding
Source: Prepared by CRS, based on CMS, *Managed Care Contract Reports*, March 2003.

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 nonprofit. 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 IPAs models. An IPA is a managed care organization that contracts with physicians in solo 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 organizations. As of March 2003, 66 percent of contractors were with for-profit entities.

TABLE E-5--MEDICARE+CHOICE CONTRACTS BY PLAN MODEL, 2003

	Number of Contracts	Percent of Contracts	Number of Enrollees	Percent of Enrollees
Model				
IPA	76	54	2,585,090	57
Group	55	39	1,482,730	33
Staff	11	8	474,595	10
Ownership				
Profit	96	66	2,635,306	57
Non Profit	49	34	1,960,335	43

Source: Prepared by CRS based on CMS, Medicare Managed Care Contract Report, March 2003.

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 state renal disease (ESRD) may not enroll in an M+C plan. Two exceptions apply to individuals with ESRD: 1) a beneficiary enrolled in an M+C plan who later develops ESRD may continue to remain enrolled in that plan; and 2) if a plan terminates its contract or reduces its service area (for an enrollee this is referred to as an involuntary termination), ESRD enrollees may enroll in another M+C plan. The second exception is retroactive for an involuntary termination occurring on or after December 31, 1998.

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 terminate an enrollee’s election only 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 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 2004,[5] individuals are able to make and change election to an M+C plan on an ongoing basis. Beginning in 2005, elections and changes to elections will be available on a more limited basis.[6] Individuals will be able to make or change elections each November, during the annual coordinated election period. In addition, current Medicare beneficiaries also may change their election at any time during the first 6 months of 2005 (or 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 either to 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

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[5] Prior to the passage of the Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188), individuals were able to make and change elections on an ongoing basis only through 2002.

[6] 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.

changes to election begins once the individual is eligible for an M+C plan. Special election periods also apply to newly eligible aged (not disabled) Medicare beneficiaries. BIPA required that beginning in June 2001 requests to enroll or disenroll in an M+C plan are effective on the first day of the next calendar month. (Prior to the passage of BIPA, requests to enroll or disenroll in an M+C plan made after the 10th of the month were not effective until the first day of the second subsequent calendar month.)

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 portion of its service area may offer enrollees the option of continuing enrollment in the plan, only if there is no other M+C plan offered in the affected area at that time. However, the plan may require the enrollee to obtain all basic (except for emergency or urgently needed care) services exclusively at the facilities designated by the organization within the plan's service area.

A further protection made available with the passage of BIPA extended the period for Medigap enrollment for M+C enrollees affected by termination of coverage during their "trial period." (The trial period allows individuals to try out Medicare managed care for 12 months, while guaranteeing them access to a Medigap plan if they chose to return to Medicare fee-for-service). For individuals enrolled in an M+C plan during their initial 12-month trial period, their trial period begins again if they re-enrolled in another M+C plan because of an involuntary termination. During this new trial period, they retain their rights to enroll in a Medigap policy; however the total time for a trial period cannot exceed 2 years from the time they first enrolled in an M+C plan.

MEDICARE+CHOICE PAYMENTS TO PLANS

The Balanced Budget Act substantially restructured the system for setting the rates by which Medicare pays plans, beginning in 1998.[7] 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 HHS is required to determine annually, and announce by the second Monday in May for 2003 and 2004 (and then not later than March 1 for subsequent years) in the year before the calendar year affected, the annual M+C per capita

[7] 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. In addition, county payments fluctuated year to year.

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 (approximately 56 percent: and 44 percent, respectively).

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*:

– A rate calculated as a blend of an area-specific (local) rate and a national rate,
– A minimum payment (or floor) rate, or
– A rate reflecting a minimum increase from the previous year's rate.

Each part of the system is described in more detail below.[8] For a more detailed analysis of M+C payments, see CRS Report RL30587, *Medicare+Choice Payments*.

BLENDED RATES

The blended per capita rate was intended to shift 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 was designed to reduce payments in counties where the adjusted average per capita costs (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)[9] payments. Second, rates are updated each year by a

[8] A state may request a geographic adjustment to a payment area to establish a single statewide M+C area, a metropolitan based system, or the consolidation into a single area of noncontiguous counties. For disabled and ESRD beneficiaries, payment rates are set using a similar method as that for aged beneficiaries, except that ESRD rates are calculated on a statewide basis. Beginning in January 2002, BIPA required that the Secretary increase the M+C payment rates for enrollees with ESRD to reflect the demonstration rate (including the risk-adjustment methodology) of social health maintenance organizations' (SHMO) ESRD capitation demonstrations. The revised rates increased the base rate by 3 percent and also included adjustments for age and sex factors. Beginning January 2005, CMS plans to incorporate M+C enrollees with ESRD into the new risk adjustment model (using a ESRD specific version of the model) in an effort to further align payments with the method used in the ESRD SHMO demonstration.

[9] 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

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 labor costs, by a formula stated in the law. The 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 was reduced in increments over 6 years from 90 percent in 1998 to 50 percent in 2003, while the corresponding percentage for the national component was increased from 10 percent to 50 percent. In 2003 and beyond, the blended rate is 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 also is subject to a floor rate, designed to raise payments in certain counties more quickly than would occur through the blend alone. Initially, the BBA provided for a floor rate that would apply to all counties *within* the United States; for 2000 this minimum rate was $402 per month. A separate minimum also was established for areas *outside* (i.e., territories) the United States. Beginning March 2001,[10] BIPA established multiple floor rates, based on population and location. For 2001, the floor was $525 for aged enrollees *within* the 50 states and the District of Columbia residing in a Metropolitan Statistical Area (MSA) with a population of more than 250,000. For all other areas *within* the 50 states and the District of Columbia, the floor was $475. For any area *outside* the 50 states and the District of Columbia, the $525 and $475 floor amounts also were applied, except that the 2001 floor could not exceed 120 percent of the 2000 floor amount. As required by law, these payment amounts are increased annually by a measure of growth in program spending (see discussion of national growth percentage, below). In 2002, the floor was $553 for the larger MSAs and $500 for the smaller MSAs. The 2003 floors are lower than the 2002 floors; $548 for the larger MSAs and $495 for the smaller MSAs.[11] In 2003, M+C payments in only 6 counties are based on the floor payments, because these counties were able to change their designation from a low floor county payment area to a high floor county payment area.[12]

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factors not directly related to education which may increase the costs in teaching hospitals, such as more severely ill patients and increased testing.

[10] Generally, increases in M+C payments are effective on January 1 of each year. However, the changes resulting from BIPA were effective on March 1, 2001. As a result, M+C plans were paid at a pre-BIPA rate for January and February of 2001, and then beginning in March the new rates went into effect. In future years, increases are effective on January 1.

[11] See discussion of national growth percentage for an explanation of how the adjustment for prior year's errors actually lowers the floor payments in 2003.

[12] M+C payments for five of these counties were set at the lower floor rate in 2002, while payments for the sixth county were set at the minimum update rate in 2002. Regardless of their actual 2002

The 2003 payment to M+C organizations in these counties is based on the floor payment of $548. For 2004, the floor amounts will be $592 for larger MSAs and $536 for smaller MSAs.

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 1999 and 2000, the increase was 102 percent of the annual M+C per capita rate for the previous year. BIPA applied a 3 percent minimum update for 2001, beginning in March for subsequent years, the minimum increase returned to an annual January update of an additional 2 percent over the previous year's amount. The minimum percentage increase is the only positive update for 2003 M+C payments.[13]

EXCLUSION OF PAYMENTS FOR GRADUATE MEDICAL EDUCATION

Payments for Graduate Medical Education (GME) are excluded or "carved out" of the payments to M+C plans, phased-in over 5 years. 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. Beginning in 2002, GME payments were set to be fully deducted each year. However, the GME "carve out" will not occur in a year in which no payment is based on the blended rate, because this carve out applies only to the blended rate and not to either the minimum percentage increase or the floor rate. Payments for disproportionate share hospitals (DSH)[14] are not carved out.

BUDGET NEUTRALITY

Once the preliminary rate is determined for each county, a budget neutrality adjustment is required by law 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

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payment amount, the high floor amount yields the highest M+C payment for each of these six counties in 2003.

[13] If the Secretary determines that a change in the Medicare covered benefits would result in a significant increase in cost to M+C plans, the Secretary is required to adjust appropriately the M+C payments to reflect this greater cost. In 2004, an adjustment of 0.2 percent will be added to M+C payments to account for changes in Medicare coverage. The 0.2 percent adjustment will result in a 2.2 percent increase above the 2003 payment for counties receiving the minimum percentage increase payment in 2004.

[14] DSH payments are a payment adjustment for the higher costs that hospitals incur as a result of serving a large number of low income patients.

on area-specific rates. A budget neutrality adjustment may be applied only 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, 2001, 2002, and 2003 rates, the Centers for Medicare and Medicaid Services (CMS) 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), the estimated cost was about $1 billion in 2001, $900 million in 2002, $2.9 billion in 2003, and $1.1 billion in 2004.

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 was 0.5 percentage points, and in 2002 the BBRA set the reduction at 0.3 percentage points. There is no reduction after 2002. Starting with the 1999 M+C payments, adjustments also were made for errors in the previous years' spending projection.

The national growth percentage for 2001, after the reduction and adjustments, was -1.3 percent. However because BIPA set the floor rates in 2001, the national growth percentage was not used to calculate the floor rate in 2001. It was used only to calculate the blend rate for 2001.

For 2002, the estimated national growth percentage increase over the pre-BIPA payment amount (used for January and February 2001) was 8.3 percent.[15] This figure was based on a 5.6 percent projected per capita increase in total Medicare expenditures, a 0.3 percentage point reduction, a minus 0.3 percent adjustment for errors in the previous years' projection of spending (1998-2001), and an increase of 3.2 percent to account for the impact of BIPA. The increase used to calculate the floor payment for 2002 was 5.3 percent, reflecting only the projected per capita increase in total Medicare expenditures of 5.6 percent and the 0.3 percentage point reduction. There was no adjustment for prior years' errors, as the floor amounts were reset by the amounts established in BIPA.

For 2003, the projected national growth percentage increase is actually a decrease of 2.9 percent. This decrease reflects a 0.9 percent increase in per

[15] Because BIPA increased M+C payments beginning in March 2001, CMS calculated a revised national growth percentage of 4.9 percent for 2002 to be applied to these new BIPA payment levels. The difference between the revised national growth percentage increase and the original increase is the 3.2 percent increase for BIPA adjustments. It was not necessary to include this 3.2 percent adjustment in the revised increase, as it was already reflected in the Mar. 1, 2001 payment levels.

capita costs and a negative 3.8 percent adjustment for prior years' errors. The -2.9 percent factor is used to update the 2002 blend rate. The 2003 update for the floor is -1 percent, reflecting the same 0.9 percent increase in per capita costs, but only a 1.9 percent decrease for prior year error in 2002 estimates.[16] Because both of these updates are negative, the minimum percentage increase is the only positive update for 2003, yielding the highest M+C payment for most counties.

The projected national growth percentage increase in 2004 is 9.5 percent. This increase reflects a 3.7 percent increase in per capita costs and a positive 5.6 percent adjustment for prior years' errors. The 9.5 percent factor is used to update the 2003 blend rate. The 2004 update for the floor is 8.2 percent, reflecting the same 3.7 percent increase in per capita costs, but only a 4.3 percent increase for prior year error in 2003 estimates.

BONUS PAYMENTS

BBRA established a bonus payment to encourage new M+C plans to enter counties that otherwise would not have a participating plan. The first plan to enter a previously unserved county (or an area where all organizations announced their withdrawal from the area as of October 13, 1999) would receive a 5 percent added payment during their first year and a 3 percent added payment during their second year. BIPA further extended these bonus payments for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans would be available January 1, 2001. For 2003, 6 M+C contracts qualified for these bonus payments for some of the counties located in the following States; Maryland, Missouri, New York, Virginia, and Puerto Rico, as well as for some counties in States served by the Sterling Private Fee-for-Service Plan.[17]

RISK ADJUSTMENT

M+C payments are 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 its increased health expenses. By 2004, three different risk adjustment methods will have been used to adjust Medicare+Choice payment rates:

- Demographic method (through 1999);

[16] Because BIPA reset the floor payments in 2001, adjustments will only be made for prior year errors occurring in 2002 and beyond.

[17] Sterling qualified for a bonus in some of the counties located in Alaska, Arizona, Iowa, Illinois, Montana, Oklahoma, Pennsylvania, South Carolina and Washington State. (For a more detailed discussion of Medicare private fee-for-service plans, See CRS Report, RL31122, *Medicare+Choice Private Fee-for-Service Plans*, by Paulette Morgan and Madeleine Smith.)

– Principal Inpatient Diagnostic Cost Group (PIP-DCG), which uses hospital inpatient and demographic data (2000-2003); and
– CMS Hierarchical Condition Category Risk Adjustment Model (CMS-HCC), which uses ambulatory, inpatient; and demographic data (beginning in 2004).

The former Medicare risk contract program adjusted the AAPCCs for demographic risk factors, and when the M+C program was implemented, it also used only these demographic risk adjusters until 2000. 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-7. Separate demographic adjustments are made for Part A and Part B of the Medicare program (Part A adjustments apply to about 56 percent of the payment and Part B adjustments apply to the remaining 44 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 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.

These demographic risk adjusters account for only a very limited portion of the variation in health care costs. As a result, the BBA required the Secretary of HHS to develop a new risk adjustment mechanism that also would consider variations in health status. Beginning in January 2000, the Centers for Medicare and Medicaid Services (CMS) 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.[18] Table E-8 displays the 15 PIP-DCGs including the various diagnoses in each category. Per capita payments to plans are adjusted based on inpatient data using the PIP-DCG adjuster, for those enrollees with an inpatient stay during the previous year. Additionally, adjustments are made for demographic factors (see Table E-9), so that this new system accounts for both demographic and health-status variations.

The BBRA slowed down the implementation of the Secretary's proposed phase-in schedule of this new system through 2002, and BIPA made further revisions to the risk adjustment system. (Plans were concerned because this new

[18] In a March 1999 report to Congress, CMS calculated that the PIP-DCG model offered a substantial improvement in explaining variations in health spending over the demographic risk adjustment model. The demographic adjuster model was 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. According to CMS, the new CMS-HCC model described below is estimated to explain approximately 9.8 percent of the variation in health care spending among individuals.

risk adjustment methodology reduces aggregate M+C payments; slowing down its implementation lessens the reduction.) Through 2003, 10 percent of payments will include introduction of risk adjustment using the PIP-DCG method and 90 percent will be based solely on the older demographic method.

One further change required by BIPA, although temporary, fully implemented risk adjustment based on inpatient hospital diagnoses for an individual who had a qualifying congestive heart failure inpatient diagnosis between July 1, 1999 and June 30, 2000, if that individual was enrolled in a coordinated care plan offered on January 1, 2001. This applied for only 1 year, beginning on January 1, 2001. This payment amount was excluded from the determination of the budget neutrality factor.[19]

RISK ADJUSTMENT METHOD IN PLACE FOR 2003

The following illustration examines calculations of risk factors in 2003, based on two scenarios: 1) the demographically-based risk adjustment system in place prior to 2000, and 2) the actual system in place for 2003, which uses a combination of 10 percent of the current health-status-based system and 90 percent of the old demographic-based system. Comparing these two scenarios provides an evaluation of the impact of the different risk adjustment methodologies on M+C payments.

Three beneficiaries are considered; each is male, aged 75. The illustration assumes that none of these beneficiaries is disabled, institutionalized, covered by Medicaid, or working. Because the system is prospective, hospitalization in the prior year, 2002, would determine the health-status adjustment factor used in 2003. The first beneficiary was not hospitalized in 2002. The second was hospitalized in 2002, 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 current risk adjustment methodology, compared with payments using the old demographically-based methodology. Through 2003, 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 more comprehensive risk adjusters. Alternatively, for any enrollee with a prior year hospitalization, payments under the new system will be higher than payments under the old demographic-only based system. In 2004, the new risk adjustment methodology

[19] This payment adjustment is different from CMS's initiative for the "Extra Payment in Recognition of the Costs of Successful Outpatient Congestive Heart Failure Care."

will begin to be phased in, taking into account data from both inpatient and ambulatory settings.

TABLE E-6--MAJOR FACTORS FOR DETERMINING MEDICARE PAYMENTS TO MEDICARE+CHOICE PLANS

Factor	Rule established in BBA 97, BBRA 99, or BIPA
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 U.S.). 1999 and after ....Previous year's payment times annual percentage increase, except for 2001 when the amount was set in law ($380 for 1999, $402 for 2000, and $525/$475 for 2001-or 120 percent of 2000 payment outside U.S., $553/$500 for 2002, $548/$495 for 2003 and $592/$536 for 2004.)
Minimum percent increase	1998 ....102 percent of 1997 AAPCC payment rate 1999 to 2000 ....102 percent of prior year's rate 2001 ....103 percent of prior year's rate 2002 and after ....102 percent of prior year's rate
GME and DSH payments	General.................GME payments excluded (from blended rate only) in equal increments over 5 years, fully phased in by 2002. DSH 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 (MPCE) minus 0.8 percentage points 1999-2001 ....Increase in MPCE minus 0.5 percentage points 2002 ....Increase in MPCE minus 0.3 percentage points 2003 and after Increase in MPCE per capita expenditures
Risk Adjustment	1998-1999 ....100% demographic 2000-2003 ....10% health status 2004 ....30% inpatient and ambulatory, 70% demographic 2005 ....50% inpatient and ambulatory, 50% demographic 2006 ....75 inpatient and ambulatory, 25% demographic 2007 and after ....100% inpatient and ambulatory

Source: Congressional Research Services analysis of provisions in BBA, BBRA, and BIPA.

TABLE E-7--MEDICARE DEMOGRAPHIC-ONLY RISK ADJUSTMENT FACTORS FOR AGED BENEFICIARIES, 2003

Gender and Age Group	Institutional	Non-institutional		
		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				
Gender and Age Group	Institutional	Non-institutional		
		Medicaid	Non-Medicaid	Working aged
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 over	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 over	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 under the age of 65.

Source: Centers for Medicare and Medicaid Services.

TABLE E-8--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
Cardio-Respiratory 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	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
Post-Myocardial 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
Internal Injuries/Traumatic Amputations/Third Degree Burns	Hip Fracture

TABLE E-8--DIAGNOSES INCLUDED IN EACH PIP-DCG - continued

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) re-occur the following year, such as appendicitis or fractures of the lower limb.

Source: Health Economics Research, Inc.

TABLE E-9--MEDICARE DEMOGRAPHIC AND HEALTH-STATUS BASED RISK ADJUSTMENT FACTORS, FOR AGED BENEFICIARIES WITH ONE OR MORE YEARS OF EXPERIENCE, 2003

Gender	Demographic Adjusters			
	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+	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+	1.128	0.152	0.168

Health Status Adjusters	
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	1.622
11	1.271
10	1.170
9	0.915
8	0.822
7	0.697
6	0.458
5	0.375

Source: CMS

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 to 79, who were not disabled, institutionalized, covered by Medicaid, or working, regardless of health status. As shown in Table E-7 separate demographic adjustments are made for Part A and Part 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 56 percent of the payment and the adjustment for Part B applies to the remaining 44 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 vary only across counties and not within counties, from a low of $547 per month per beneficiary in Arthur, NE to a high of $935 per month per beneficiary in Richmond, NY (the county with the highest Medicare+Choice rate nationwide in 2003).

Calculation of Monthly Payment Rate Under Scenario 1

	Reason for hospitalization (if any) in 2002		
Factors	None	Kidney Infection (PIP-DCG 10)	Lung Cancer (PIP-DCG 16)
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 56 percent for Part A and 44 percent for Part B)	1.072	1.072	1.072
	Adjusted monthly payment in selected counties		
Richmond, NY	$935	$935	$935
Dade, FL	$912	$912	$912
Hennepin, MN	$605	$605	$605
Arthur, NE	$547	$547	$547

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 2003 when risk adjustment is based on 10 percent of the health-status method and 90 percent of the old demographic method. The factors used to calculate the adjustment under this methodology are found in Table E-9. 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 disabled, 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 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 $539 for a beneficiary in Arthur, NE with no prior year hospitalization to a high of $1,134 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 2002		
Factors	None	Kidney infection (PIP-DCG 10)	Lung cancer (PIP-DCG 16)
Old method (demographic)	1.072	1.072	1.072
Current method (health-status)	0.907	2.077	3.345
	Adjusted monthly payment in selected counties		
Richmond, NY	$921	$1,023	$1,134
Dade, FL	$898	$998	$1,106
Hennepin, MN	$595	$661	$733
Arthur, NE	$539	$598	$663

NEW RISK ADJUSTMENT METHOD IN PLACE FOR 2004

As required by BIPA, beginning in 2004, a new risk adjustment method will be used to account for more of the variation in health care expenditures than is accounted for using prior methods. The new model, the CMS Hierarchical Condition Category Risk Adjustment Model (CMS-HCC), incorporates data from both inpatient hospital and ambulatory settings, as well as demographic factors.[20] The CMS-HCC model categorizes approximately 3,300 International Classification of Disease (ICD-9) codes into approximately 800 disease clusters, and further aggregates those into 64 disease categories. The CMS-HCC also includes several condition-interactions[21] and demographic factors, such as age, sex, Medicaid eligibility, and original disability status. Table E-10 displays a list of disease groups, interactions, and demographic factors included in the CMS-HCC model.

TABLE E-10--MEDICAL CONDITIONS, MEDICAL CONDITION INTERACTIONS, AND DEMOGRAPHIC FACTORS INCLUDED IN THE CMS HIERARCHIAL CONDITION CATEGORY RISK ADJUSTMENT MODEL FOR 2004

Variable	Description	Community Factor	Institutional Factor
Disease groups			
HCC1	HIV/AIDS	0.685	1.344
HCC2	Septicemia/Shock	0.890	0.946
HCC5	Opportunistic Infection	0.652	1.344
HCC7	Metastatic Cancer, Acute Leukemia	1.464	0.540
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.464	0.540
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.690	0.452
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.233	0.259
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestations	0.764	0.612
HCC16	Diabetes with Neurologic or Other Specified Manifestations	0.552	0.612
HCC17	Diabetes with Acute Complications	0.391	0.612
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestations	0.343	0.612
HCC19	Diabetes without Complications	0.200	0.255

[20] On May 25, 2001 CMS announced that M+C organizations would not be required to submit hospital outpatient or physician encounter data for dates of service prior to July 1, 2002. Data collection requirements and procedures were revised to reduce administrative burden, and data collection began in July 2002. Data collected between July 1, 2002 and June 30, 2003 will be used to calculate risk adjustment factors for CY2004 M+C payments.

[21] Separate adjustment factors are listed for certain combinations of conditions, such as diabetes and congestive heart failure, because the cost of treating a beneficiary with the combination is greater than could be accounted for by the sum of the two separate risk adjustment factors.

TABLE E-10--MEDICAL CONDITIONS, MEDICAL CONDITION INTERACTIONS, AND DEMOGRAPHIC FACTORS INCLUDED IN THE CMS HIERARCHIAL CONDITION CATEGORY RISK ADJUSTMENT MODEL FOR 2004-continued

Variable	Description	Community Factor	Institutional Factor
HCC21	Protein-Calorie Malnutrition	0.922	0.427
HCC25	End-Stage Liver Disease	0.900	0.268
HCC26	Cirrhosis of Liver	0.516	0.268
HCC27	Chronic Hepatitis	0.359	0.268
HCC31	Intestinal Obstruction/Perforation	0.408	0.268
HCC32	Pancreatic Disease	0.445	0.268
HCC33	Inflammatory Bowel Disease	0.307	0.268
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.496	0.495
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.322	0.285
HCC44	Severe Hematological Disorders	1.011	0.448
HCC45	Disorders of Immunity	0.830	0.448
HCC51	Drug/Alcohol Psychosis	0.353	0.221
HCC52	Drug/Alcohol Dependence	0.265	0.221
HCC54	Schizophrenia	0.543	0.221
HCC55	Major Depressive, Bipolar and Paranoid Disorders	0.431	0.221
HCC67	Quadriplegia/Extensive Paralysis	1.181	0.098
HCC68	Paraplegia	1.181	0.098
HCC69	Spinal Cord Disorders/Injuries	0.492	0.098
HCC69	Spinal Cord Disorders/Injuries	0.492	0.098
HCC70	Muscular Dystrophy	0.386	0.098
HCC71	Polyneuropathy	0.268	0.098
HCC72	Multiple Sclerosis	0.517	0.098
HCC73	Parkinsons and Huntingtons Disease	0.475	0.098
HCC74	Seizure Disorders and Convulsions	0.269	0.098
HCC75	Coma, Brain Compression/Anoxic Damage	0.568	0.098
HCC77	Respirator Dependence/Tracheostomy Status	2.102	1.415
HCC78	Respiratory Arrest	1.429	1.415
HCC79	Cardio-Respiratory Failure and Shock	0.692	0.289
HCC80	Congestive Heart Failure	0.417	0.176
HCC81	Acute Myocardial Infarction	0.348	0.288
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.348	0.288
HCC92	Specific Heart Arrhythmias	0.266	0.187
HCC95	Cerebral Hemorrhage	0.392	0.151
HCC96	Ischemic or Unspecified Stroke	0.306	0.151
HCC100	Hemiplegia/Hemiparesis	0.437	0.098
HCC101	Cerebral Palsy and Other Paralytic Syndromes	0.164	0.098

TABLE E-10--MEDICAL CONDITIONS, MEDICAL CONDITION INTERACTIONS, AND DEMOGRAPHIC FACTORS INCLUDED IN THE CMS HIERARCHIAL CONDITION CATEGORY RISK ADJUSTMENT MODEL FOR 2004-continued

Variable	Description	Community Factor	Institutional Factor
HCC104	Vascular Disease with Complications	0.677	0.509
HCC105	Vascular Disease	0.357	0.114
HCC107	Cystic Fibrosis	0.376	0.230
HCC108	Chronic Obstructive Pulmonary Disease	0.376	0.230
HCC111	Aspiration and Specified Bacterial Pneumonias	0.693	0.463
HCC112	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.202	0.463
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.349	0.995
HCC130	Dialysis Status	3.076	3.112
HCC131	Renal Failure	0.576	0.420
HCC132	Nephritis	0.273	0.420
HCC149	Chronic Ulcer of Skin, Except Decubitus	0.484	0.262
HCC150	Extensive Third-Degree Burns	0.962	0.248
HCC154	Severe Head Injury	0.568	0.248
HCC155	Major Head Injury	0.242	0.248
HCC157	Vertebral Fractures without Spinal Chord Injury	0.490	0.098
HCC158	Hip Fracture/Dislocation	0.392	0.000
HCC161	Traumatic Amputation	0.843	0.248
HCC164	Major Complications of Medical Care and Trauma	0.262	0.263
HCC174	Major Organ Transplant Status	0.722	0.882
HCC176	Artificial Openings for Feedings or Elimination	0.790	0.882
HCC177	Amputation Status, Lower Limb/Amputation Complications	0.843	0.248
Disabled/disease interactions			
D-HCC5	Disabled and Opportunistic Infections	0.789	0.000
D-HDD44	Disabled and Severe Hematological Disorders	0.893	0.000
D-HCC51	Disabled and Drug/Alcohol Psychosis	0.509	0.000
D-HCC107	Disabled and Cystic Fibrosis	1.861	0.000
Disease interactions			
INT1	Diabetes Mellitus and Congestive Heart Failure[1]	0.253	0.207
INT2	Diabetes Mellitus and Cerebrovascular	0.125	0.000
INT3	Congestive Heart Failure and Chronic Obstructive Pulmonary	0.241	0.372

TABLE E-10--MEDICAL CONDITIONS, MEDICAL CONDITION INTERACTIONS, AND DEMOGRAPHIC FACTORS INCLUDED IN THE CMS HIERARCHIAL CONDITION CATEGORY RISK ADJUSTMENT MODEL FOR 2004-continued

Variable	Description	Community Factor	Institutional Factor
INT4	Chronic Obstructive Pulmonary and Cerebrovascular and Coronary Artery	0.079	0.000
INT5	Renal Failure and Congestive Heart Failure[1]	0.234	0.000
INT6	Renal Failure and Congestive Heart Failure and Diabetes Mellitus[1]	0.864	0.000
Medicaid and originally disabled interactions with age and sex			
Medicaid female, disabled		0.221	0.000
Medicaid female, aged		0.183	0.000
Medicaid male, disabled		0.115	0.000
Medicaid male, aged		0.184	0.000
Originally disabled female		0.236	0.000
Originally disabled male		0.148	0.000
Demographic factors:			
Men, age 0-34		0.068	1.104
Men, age 35-44		0.120	1.104
Men, age 45-54		0.190	1.104
Men, age 55-59		0.270	1.104
Men, age 60-64		0.342	1.104
Men, age 65-69		0.346	1.450
Men, age 70-74		0.453	1.238
Men, age 75-79		0.577	1.211
Men, age 80-84		0.657	1.209
Men, age 85-89		0.790	1.241
Men, age 90-94		0.901	1.049
Men, age 95+		1.035	0.836
Women, age 0-34		0.117	1.064
Women, age 35-44		0.197	1.064
Women, age 45-54		0.214	1.064
Women, age 55-59		0.265	1.064
Women, age 60-64		0.375	1.064
Women, age 65-69		0.307	1.164
Women, age 70-74		0.384	1.179
Women, age 75-79		0.483	0.992
Women, age 80-84		0.572	0.938
Women, age 85-89		0.665	0.880
Women, age 90-94		0.795	0.789
Women, age 95+		0.805	0.581

[1] These interaction terms are not additive; a beneficiary's payment will be based on the most severe, but not multiple diagnoses. All other interaction terms are additive.

Source: CMS, http://www.cms.hhs.gov/healthplans/rates/2004/cover-exhibit-1.asp

The payment for an aged beneficiary under the CMS-HCC model is calculated by summing all of the relevant condition adjustment factors for the prior year with the demographic adjustment factors and multiplying that sum by the average payment rate for the beneficiary's county of residence. Any event which occurs during the year would be incorporated into the risk adjusted payment for the following year. Unlike the PIP-DCG method, which allows only one inpatient diagnosis to modify the payment rate, in general, the CMS-HCC model takes into account multiple diagnoses.[22] For example, if in the previous year, a beneficiary has been diagnosed with congestive heart failure, a hip fracture, and cancer, all of these conditions would be factored into the risk adjustment for the beneficiary's 2004 payment. The new risk adjustment will be phased in at a rate of 30 percent in 2004, 50 percent in 2005, 75 percent in 2006, and 100 percent beginning in 2007. The portion of the payment not weighted by the CMS-HCC will be weighted by the demographic-only method.

ADJUSTED COMMUNITY RATES

M+C plans are required to include all Medicare-covered services. In some circumstances, plans also may 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.

In general, no later than July 1 of each year, each M+C organization is required to submit to the Secretary of HHS, for each of its M+C plans, specific information about premiums, cost sharing, and additional benefits (if any). However, as specified below, this deadline has been and will continue to be shifted through 2004. Because BIPA was enacted after the July deadline, there was a special timeline devised for 2001. Plans that previously provided notice of their intention to terminate contracts or reduce their service area for 2001 had until January 18, 2001 to rescind their notice and submit ACR information. Further, any M+C organization that would receive higher capitation payments as a result of BIPA was required to submit revised ACR information by January 18, 2001. Plans could only reduce premiums, reduce cost sharing, enhance benefits, utilize stabilization funds, or stabilize or enhance beneficiary access to providers (as long as this did not result in increased beneficiary premiums, increased cost-sharing, or reduced benefits). Any regulations that limited stabilization fund amounts were waived, with respect to ACR submissions.

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[22] If a beneficiary's illness progresses within a disease process, such as diabetes with increasing severity, only the most costly diagnosis made for the beneficiary will be applied to the payment rate.

For 2002, an M+C organization's deadline for notifying CMS of its intention to renew its contract as well as a final ACR submission was extended to September 17, 2001. M+C organizations only had to submit a one-page summary on July 2, 2001 and this was not binding on the organization. CMS announced this extension in order to give organizations more time to gather data for forecasting costs. As part of the Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188) Congress legislated the deadline change for 2002, and further, set the deadline for 2003 and 2004 at no later than the second Monday in September. Under current law, the deadline will return to July 1st of each year, beginning in 2005.

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 MSA plans or private fee-for-service plans. Beginning May 1, 2001 ACR submissions are reviewed by the CMS Chief Actuary.

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 provide either 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.[23] Additionally, beginning in 2003, plans also may reduce the Medicare Part B premium.[24] 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.[25] Plans may also place the additional funds in a stabilization fund or return funds to the Treasury.

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[23] Alternatively, under the ACR process, plans also may charge a premium if they demonstrate higher "costs", rather than "savings" for providing the basic benefit package. For the basic benefit package and any required additional services in an M+C plan, the beneficiary premium and actuarial value of the deductibles, coinsurance, and copayments on average to enrolled individuals may not exceed the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to Part A and enrolled under Part B if they were not in an M+C plan.

[24] All M+C enrollees (as well as FFS 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 2000, $50 for 2001, $54 for 2002 and $58.70 for 2003. Beginning in 2003, an M+C organization may elect to reduce its M+C payment up to 125 percent of the annual Part B premium. However, only 80 percent of this amount can be used to reduce an enrollee's actual Part B premium. This has the effect of returning up to 100 percent of the beneficiary's Part B premium. The reduction applies uniformly to each enrollee in the plan. Plans must include information about Part B premium reductions as part of the required information that is provided to enrollees for comparing plan options.

[25] 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.

ADDITIONAL OR SUPPLEMENTAL BENEFITS

Nearly all plans offer some benefits to enrollees beyond those in traditional Medicare (Chart E-6). For example, in 2002, about 87 percent of M+C enrollees were offered vision care as part of their lowest premium package, 100 percent were offered routine physicals, and about 72 percent were offered some coverage of prescription (outpatient) drugs. Hearing care was offered to slightly more than half of all enrollees. Other services offered included preventive dental care, podiatry, and chiropractic services. While plans may offer even more services, those shown in Chart E-6 are the most frequently offered benefits. Chart E-6 shows that the percent of enrollees offered these benefits has declined for all services, except routine physicals between 1999 and 2002. However, this figure does not show how the generosity of benefits or the level of cost sharing may have declined over the time period.

TABLE E-11--M+C ENROLLEES WITH DRUG COVERAGE IN A BASIC PLAN, 1999-2003

	1999	2000	2001 (pre-BIPA)	2001 (post-BIPA)	2002	2003
Number of enrollees	4,947,098	4,437,416	3,771,551	3,832,308	3,480,000	3,140,000
% of enrollees	84%	72%	69%	70%	71%	69%

Source: Centers for Medicare and Medicaid Services (CMS) data.

COVERAGE FOR PRESCRIPTION DRUGS

One of the advantages of Medicare managed care, over traditional fee-for-service Medicare, is that most plans include some outpatient prescription drug coverage. However, according to CMS data, currently fewer enrollees have M+C prescription drug coverage and among those with coverage, the drug benefit has become less generous over time. As shown in Table E-11, about 84 percent of enrollees had prescription drug coverage through a basic plan in 1999, declining to about 69 percent by 2003. Plans are simultaneously decreasing the amount of covered drug spending while also increasing out-of-pocket costs. As shown in Table E-12, very few plans had no limits (1.4 percent) on drug benefits in 2003 and an increasing number of plans set annual benefit limits at $500 or less (10.6 percent of plans in 1999 compared to 53.4 percent of plans in 2003).

Plans can collect these payments through a combination of cost sharing and premiums, but the sum of the premiums and the actuarial value of the deductibles, coinsurance and copayments for such benefits may not exceed the adjusted community rate for these benefits. Plans may choose to waive part or all of this allowable premium for all enrollees.

As shown in Table E-13, almost all plans required some level of copayment for prescription drug coverage in 2003 and the copayment amount has increased over time. About 92 percent of beneficiaries were offered plans with copayments of $10 or less (including no copayments) for generic drugs in 1999, compared to 77 percent in 20030. For brand name drugs, the percentage of enrollees with increased required copayment amounts over time has been even greater. In 1999, 14 percent of enrollees paid more than a $20 copay for brand name drugs, compared to over 73 percent in 2003.

TABLE E-12--PERCENT OF ENROLLEES WITH AN ANNUAL DRUG CAP IN BASIC M+C PLANS, WEIGHTED BY ENROLLMENT, 1999-2003

Annual drug cap	1999	2000	2001	2002	2003
$500 or less	10.6%	20.8%	28.2%	50.1%	53.4%
$501-$1000	36.4%	38.0%	21.5%	26.4%	35.2%
$1001-$2000	27.2%	32.9%	34.8%	18.5%	16.7%
$2001 or more	4.1%	3.4%	5.2%	2.9%	3.4%
No cap	21.7%	14.9%	10.4%	2.2%	1.4%

Note: Plans with generic-only benefits are classified as having a benefit limit of less than $500 per year.
Source: Mathmatica Policy Research Analysis of CMS data: Lori Achman, and Marsha Gold, "Medicare+Choice Plans to Continue to Shift More Costs to Enrollees," April 2003.

TABLE E-13--PERCENT OF M+C ENROLLEES BY PRESCRIPTION DRUG CO-PAYMENTS, WEIGHTED BY ENROLLMENT, 1999-2003

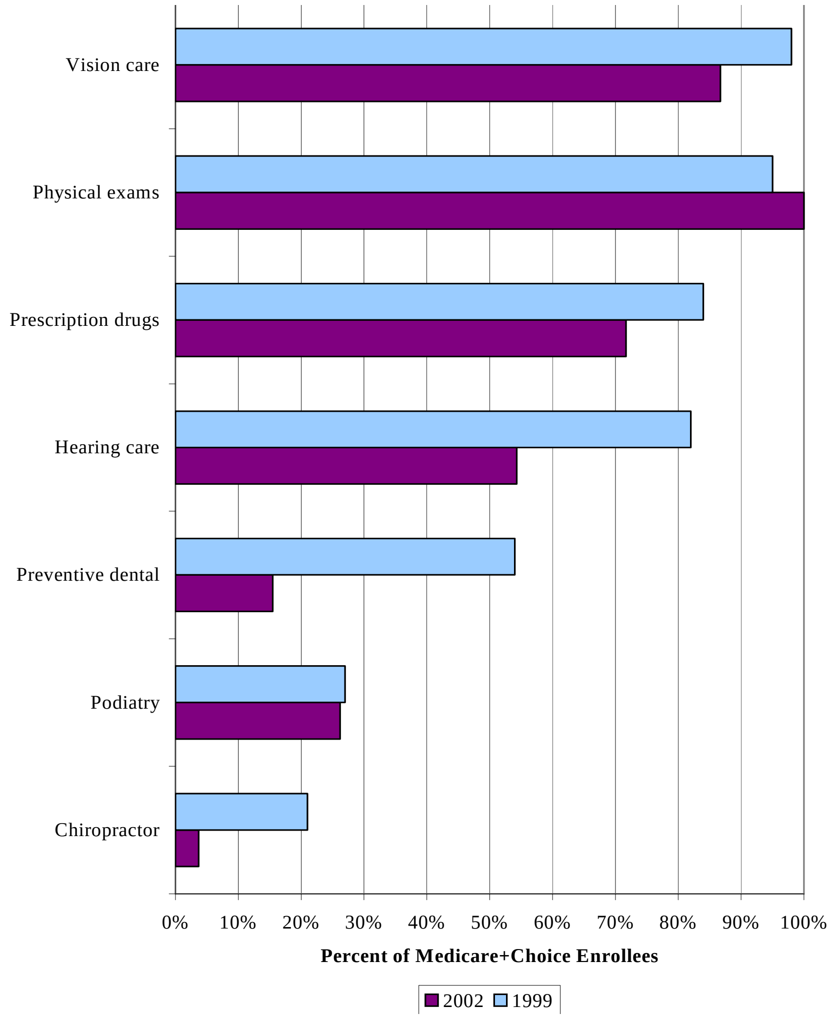
	1999	2000	2001	2002	2003
Generic					
None	7.60%	7.10%	7.80%	7.10%	5.10%
$10.00 or less	84.40%	90.40%	83.40%	73.10%	71.90%
$10.01 or more	8.00%	2.50%	8.80%	19.80%	23.00%
Brand-name					
None	6.30%	5.50%	2.40%	0.00%	0.70%
$10.00 or less	35.90%	19.80%	21.70%	4.60%	5.70%
$10.01 to $20.00	43.80%	54.30%	43.60%	14.80%	20.10%
$20.01 or more	14.00%	20.40%	32.30%	80.60%	73.50%

Source: Mathematica Policy Research Analysis of CMS data: Lori Achman, and Marsha Gold, “Medicare+Choice Plans Continue to Shift More Costs to Enrollees,” April 2003.

MEDICARE+CHOICE PREMIUMS

In addition to the Part B premium, 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. 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, requiring 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.

CHART E-6--PERCENT OF M+C ENROLLEES OFFERED BENEFITS BEYOND TRADITIONAL MEDICARE COVERED SERVICES, IN THE LOWEST PREMIUM PACKAGE AVAILABLE 1999 AND 2002



Source: Chart prepared by CRS based on Mathematica Analysis of CMS data. Lori Achman, and Marsha Gold, "Trends in Medicare+Choice Benefits and Premiums, 1999-2002," The Commonwealth Fund.

Between 1999 and 2003, the percentage of beneficiaries nationally with access to a zero premium plan has declined. As shown in Table E-14, the availability of these plans nationally dropped in half, from over 60 percent to just under 30 percent. Although, the data for urban and rural areas were available only through 2001, the trend seems to indicate that the impact on rural areas was even greater, especially since these individuals had fewer opportunities for enrolling in the M+C program and fewer choices among plans.

TABLE E-14--PERCENT OF MEDICARE BENEFICIARIES WITH ACCESS TO A ZERO-PREMIUM M+C PLAN, BY AREA, 1999-2003

Area	1999	2000	2001	2002	2003
National	61%	53%	39%	32%	29%
Urban areas	75%	66%	50%	NA	NA
Rural areas	14%	9%	4%	NA	NA

NA - Not available.

Source: MedPAC analysis of Medicare Compare data from CMS website, August 1999, January 2000, and February 2001; CMS analysis 2002 and 2003.

Table E-15 shows the distribution of M+C enrollees by the monthly premium amount. Between 2000 and 2003, the percent of enrollees in zero premium plans declined significantly, so that the majority of Medicare enrollees were no longer enrolled in zero premium plans. At the same time, the percent of enrollees paying over $50 in monthly premiums increased from 7 percent to 35 percent. In 2003, 0.2 percent of all M+C beneficiaries (or 9,129 individuals) were enrolled in plans that reduced their monthly Part B premium, while 4.2 percent of all beneficiaries had access to such a plan. For comparison, a recent study (see http://caregivers-usa.org/news/weiss_medigap.html) found that average Medigap premiums ranged widely, with the national average Medigap premium rate in 2003 for a 65-year-old female for all plans being $1,412, or nearly $120 per month.

BENEFICIARY PROTECTIONS

The M+C program includes requirements designed to limit beneficiaries' financial liability and to assure beneficiaries of certain rights and remedies. Beneficiary protections or rights include established beneficiary liability standards, quality standards, information and disclosure requirements, a grievance and appeals process, and access to services.

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). Cost sharing per enrollee (including premiums) for covered services cannot be more than the actuarial value of the deductibles, coinsurance, and copayments under traditional

Medicare (Table E-16). However, while the *total* of cost sharing is limited, the plan may set different amounts for specific services, such as a lower (or higher) deductible for hospital inpatient services or skilled nursing care services. Enrollees in an M+C coordinated care plan cannot be charged additional balanced billing amounts by any providers.[26]

The rules for private fee-for-service (PFFS) plans and PPO demonstration plans are different (Table E-16). 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.[27] In contrast to traditional Medicare, this privilege extends to all categories of providers, including hospitals. For the PPO demonstration project, the terms of each individual demonstration proposal specify if, and to what extent, providers may balance bill.

QUALITY STANDARDS

M+C plans must have a quality assurance program focused on outcomes for services it provides to enrollees. M+C regulations established guidelines for organizations to examine the continuity and coordination of care. These quality standards focus on items such as high volume, high risk, acute care and chronic care services. The program must provide the Secretary with information to monitor and evaluate the plan's quality. Only certain M+C plans (not PFFS, PPOs, and PPO demonstration plans if so specified in their proposal) 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 overutilization.

Additionally, most Medicare+Choice organizations are subject to external review for both the quality of their service and their response to written complaints about poor quality of care. M+C plans may use Peer Review Organizations (PROs), which also are used for these functions in traditional fee-for-service Medicare. Private fee-for-service plans and PPO Demonstration Plans (if specified in their proposal) that do not have utilization review programs are exempt from this requirement.

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 requirements (except in the case of complaints about quality) for organizations with an excellent record of quality and compliance with other Medicare+Choice requirements. Plans may be

[26] Coordinated care plans must pay a noncontracting provider at least the same amount they would have received if the enrollee was in traditional Medicare, including allowed balance billing amounts. A "contract provider" is a provider who enters into an explicit agreement with a plan establishing payment amounts for services rendered to the plan's enrollees. A non-contracting provider also may provide services, but does not have an explicit agreement with the plan.

[27] The two PFFS plans currently offered in the M+C program do not allow providers to balance bill.

TABLE E-15--DISTRIBUTION OF M+C ENROLLEES, BY BASIC PREMIUM LEVELS, 2000-2003

Date	Enrollees with reduced Part B premium		Enrollees in zero premium plan		Enrollees in $0.01 to $20.00 premium plan		Enrollees in $20.01 to $50.00 premium plan		Enrollees in over $50.00 premium plan	
	#	%	#	%	#	%	#	%	#	%
June 2000	NA	NA	3,735,524	61%	783,611	13%	1,168,828	19%	426,388	7%
January 2001[1]	NA	NA	2,465,295	45%	636,100	12%	1,517,169	28%	856,569	16%
March 2002	NA	NA	2,020,351	41%	238,272	5%	1,131,794	23%	774,305	32%
March 2003	9,129	0.20%	1,738,980	38%	59,335	1%	1,150,192	25%	1,606,617	35%

NA - Not available.

[1] Post-BIPA premium levels.

Source: Mathematica Policy Research Analysis of CMS data: Lori Achman, and Marsha Gold, "Medicare+Choice Plans Continue to Shift More Costs to Enrollees," April 2003.

deemed to have met all these requirements if they are accredited by an organization approved by the Secretary, according to statutory requirements.

INFORMATION AND DISCLOSURE REQUIREMENTS

The M+C program requires the Secretary to provide for activities to disseminate certain information to Medicare beneficiaries so that they may make informed choices about their Medicare coverage. This information includes notice of an open season, a list of plans and plan options, a general description of the benefits covered under traditional Medicare, a description of grievance and appeals procedures, and comparative plan information (such as benefits, premiums, service area, and quality and performance indicators).

When an M+C organization terminates its contract with CMS, it must provide and pay for advance written notice to each of its enrollees, along with a description of alternatives for obtaining benefits.

Further, M+C organizations must disclose to each enrollee (at time or enrollment and at least annually) information on their service area, benefits, the number, mix, and distribution of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, plan grievance and appeals procedures, and the quality assurance program. Other information is available upon request, such as information on procedures used by the organization to control utilization of services and expenditures.

GRIEVANCES AND APPEALS

An M+C organization must have 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. A denial of coverage explanation must state the reasons for the denial, in understandable language, and also must provide information about the reconsideration and appeal processes.

An enrollee may request a 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. M+C organizations must expedite a physician's request for a determination or reconsideration, if the physician indicates that the normal time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

ACCESS TO SERVICES

Each plan must make benefits available and accessible to its enrollees within the service area with reasonable promptness, and must ensure continuity in providing benefits. This care must be available, when necessary, 24-hours 7 days per week.

Coverage of emergency services for emergency medical conditions is subject to 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 woman, her health or that of her unborn child); 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

M+C organizations are financially responsible for emergency and urgently needed services. There is no prior authorization requirement for these services and no requirement that services must be obtained within the M+C organization. Further, the physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge. That decision is binding on the M+C organization.

CURRENT PROGRAM STANDARDS AND CONTRACT REQUIREMENTS

MINIMUM ENROLLMENT STANDARDS

Contracts between M+C organizations and CMS are made for at least 1 year and are automatically renewable, unless either party gives notice to terminate the contract. 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. These minimum requirements may be waived during the first 3 years of the contract, if the organization can demonstrate to CMS that it can administer and manage an M+C contract and also manage the level or risk required under the contract.

STATE PREEMPTION

Federal standards for M+C plans preempt any inconsistent state law or regulation with respect to: 1) benefit requirements – including cost-sharing requirements or summaries and schedules of benefits; 2) requirements relating to inclusion or treatment by providers; 3) coverage determinations – including related appeals and grievance processes; and 4) marketing materials. No premium, tax, fee, or other similar assessment may be imposed on a plan by any State.

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. A Medicare+Choice organization must assume full risk for Medicare benefits on a prospective basis. However, this doesn't preclude an organization from obtaining insurance or making other arrangements to cover certain costs, such as medically necessary services provided by non-network providers and part of the costs exceeding its income. The organization also may make arrangements with providers to assume some or all of the financial risk for covered benefits they provide; however, PFFS organizations cannot put providers at risk.

PROVIDER PROTECTIONS AND REQUIREMENTS

Each M+C organization (other than a PFFS) must establish physician participation procedures that provide: 1) notice of the participation rules; 2) written notice of adverse participation decisions; and 3) a process for appealing adverse decisions. The organization must consult with contracting physicians regarding the organization's medical policy, quality, and medical management procedures.

Although plans may include providers only to the extent necessary to meet the needs of their enrollees, they cannot discriminate with respect to providers who are acting within the scope of their license or certification under applicable state law, solely on the basis of such license or certification. Restricting communications between providers and their patients (a gag clause) is prohibited. The use of physician financial incentive plans, (compensation arrangements between organizations and individual or groups of physicians that may reduce or limit services) is also limited.

PROTECTIONS AGAINST FRAUD

M+C organizations also must comply with disclosure and notification requirements. They must report financial information to the Secretary covering ownership, transactions between the organization and parties in interest, and evidence that they are fiscally sound.

The Secretary must conduct annual audits of the financial records of at least one-third of the M+C organizations (including data relating to utilization, costs, and computation of the adjusted community rate). In addition, the Secretary has the right to examine the quality, appropriateness, timeliness of services, ability to bear risk of a plan, as well as the organization's facilities, if

TABLE E-16--BENEFICIARY COST SHARING AND PROVIDER REIMBURSEMENT UNDER MEDICARE+CHOICE PLANS FOR BASIC BENEFIT PACKAGE

Item	Coordinated Care Plan	Private Fee-for-Service	PPO demonstration
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.	Plans may propose to waive any M+C statutes, regulations or policies related to premiums, cost-sharing, payments to plans, such as actuarial equivalence. Beneficiaries may face cost sharing that can be higher than FFS.
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.	Balanced billing requirements may vary by plan and are specified in each individual demonstration application. In the demonstration application, plans should describe the procedure for enrollee complaints relating to balance billing requests from providers.

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 non-contract providers in coordinated care plans.	Contract providers are paid fees or rates that are privately negotiated by the plan with them. Plans pay FFS out of network.
Plans accept full risk of all costs beyond the monthly capitated payment made by CMS on behalf of the beneficiary	Same as for Coordinated Care Plans.	Plans have the option of sharing financial risk with CMS, according to the particular risk sharing agreement made between the plan and CMS.	
Enrollee choice of providers generally restricted to a closed network	Enrollees may seek care from any provider willing to accept the plan's terms and conditions of participation. The plan does not provide enrollees with a financial incentive for choosing particular providers.	Enrollees may seek care from any willing provider, but they have a financial incentive to seek care from providers in the plan's network.	

Source: Congressional Research Service and Medicare Payment Advisory Commission Analysis.

there is reasonable evidence of need for such inspection. M+C organizations must notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

SANCTIONS AND TERMINATIONS OF CONTRACTS

In certain circumstances, such as a plan that fails to carry out its contract, the Secretary may impose civil monetary penalties, temporary suspension of enrollment or even termination of a contract. 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 in excess of those allowed; 3) acts to expel or refuses to reenroll an individual in violation of stated 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; 7) employs or contracts with any individual or entity that has been excluded from participation in Medicare; or 8) terminates its contract other than at an appropriate time after providing appropriate notice.

MEDICARE+CHOICE OPTIONS

In addition to the coordinated care plans typically associated with managed care, the M+C program offers a variety of optional arrangements, either through a standard program arrangement or on a demonstration basis.

PRIVATE FEE-FOR-SERVICE PLANS

Private fee-for-service (PFFS) plans are one of the new types of private plans available to Medicare beneficiaries as a result of the Balanced Budget Act of 1997.[28] A PFFS plan has three defining characteristics that distinguish it from other Medicare+Choice options: 1) it allows any provider to participate who is both lawfully authorized to serve Medicare beneficiaries and who accepts the plan's terms of payment; 2) it pays providers at a rate determined on a fee-for-service basis without placing providers at financial risk; and 3) it does not vary payment rates based on how often a particular service is provided.

PFFS plans, like traditional Medicare, allow providers to deliver medical care without joining a network. Providers are paid on a fee-for-service basis so

[28] For a more detailed analysis of PFFS plans, see CRS Report RL31122, *Medicare+Choice: Private Fee-for-Service Plans*, by Paulette Morgan and Madeleine Smith.

they do not accept financial risk or reduced payments and, they do no face incentives to either limit services or limit referrals to specialists. Providers under PFFS plans may bill enrollees up to 15 percent more than the plan's allowable rate, while providers in other types of M+C plans may not "balance bill."[29] Moreover, PFFS plans have fewer restrictions on balance billing than traditional fee-for-service Medicare. Unlike Medicare providers; however, PFFS providers can lose reimbursements if the PFFS plan becomes insolvent.

Beneficiaries choosing a PFFS plan can choose any provider who is willing to provide services and who accepts the PFFS plan's terms of payment. The beneficiary must inform the provider of his or her enrollment in the PFFS plan. The PFFS plan may offer additional benefits beyond those covered under traditional Medicare, but also may charge an additional premium for these services. If providers choose not to accept a PFFS plan, beneficiary choice would be limited, much as it would be under a network.

Currently, Sterling Life Insurance Company and Humana Inc. offer the only Medicare PFFS plans.[30] They operate in 27 States,[31] over half of all United States counties, and are available to about 37 percent of all Medicare beneficiaries. Sterling and Humana primarily serve rural counties that previously did not have a M+C option. Possible reasons for serving those areas are: 1) on average, Medicare+Choice rates are higher than the average cost of traditional Medicare in those counties; 2) an organization receives a bonus (5 percent the first year and 3 percent the second year[32]) for serving counties not served by any other Medicare+Choice plan; 3) PFFS does not require a network of providers, which is difficult to assemble in rural areas; and 4) for Sterling, its parent company has specialized in serving rural areas. Both organizations pay providers the same rate they would receive from traditional Medicare, and prohibit balance billing.

Sterling provides very few additional benefits beyond the required Medicare benefit package. It provides worldwide emergency hospital care, but does not provide coverage for outpatient prescription drugs, eye exams, hearing aids, or glasses. For 2003, Sterling enrollees must pay between $88 and $108 in monthly premiums depending on where they live, in addition to the standard Medicare Part B premium of $58.70. Humana provides a limited drug benefit

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[29] Both of the PFFS plans currently available to beneficiaries (Sterling and Humana) do not allow providers to balance bill enrollees.

[30] Beneficiaries in Sterling's service area were able to enroll as of July 2000. Beneficiaries in Humana's service area were able to enroll as of January 2003. In addition to the two standard PFFS plans, there is also a PFFS demonstration plan available in 2003, with 1,748 enrollees as of March 2003.

[31] A PFFS plan is available to beneficiaries in all or part of the following States: Alaska, Arizona, Arkansas (part), Delaware, Idaho, Illinois, Iowa, Kentucky, Louisiana (part), Minnesota, Montana (part), Nebraska, Nevada, New Mexico, North Dakota (part), Ohio (part), Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota (part), Tennessee (part), Texas (part), Utah, Washington, West Virginia (part), and Wisconsin.

[32] While bonus payments may have been an incentive for PFFS plans in previous years, these bonus payments will no longer be available to plans beginning in 2004.

under one of its plans, but few additional benefits. Humana enrollees pay $19 in monthly premiums, except for those in DuPage, Illinois who pay $89 per month, in addition to the Part B premium. Humana enrollees have an out-of-pocket limit of $5,000. PFFS enrollees might experience lower (or higher) cost sharing under either Sterling and Humana than under fee-for-service Medicare, depending on the exact quantity and mix of services that they use.

As of March 2003, approximately 21,000 of the over 14 million Medicare beneficiaries who had access to a PFFS plan chose to enroll in one. Though most of the 27 States served by a PFFS plan have received some enrollment, the highest proportion of enrollees live in Louisiana (16 percent), Texas (15 percent), Washington (13 percent), Illinois (9 percent), and Pennsylvania (8 percent). About two-thirds of PFFS enrollees did not have a choice of another Medicare+Choice plan.

As PFFS plans have been available only since July 2000, it will take some more time to determine: 1) their ability and desire to remain in the M+C program; 2) the impact of these kinds of plans on beneficiary and provider satisfaction; and 3) the relative cost of PFFS plans compared to other M+C options as well as fee-for-service.

PREFERRED PROVIDER ORGANIZATION DEMONSTRATION

On April 15, 2002, CMS announced a 3-year Preferred Provider Organization (PPO) demonstration project within the M+C program. A PPO is a type of managed care plan arrangement under which insurers contract with doctors and hospitals who agree to provide their services on a fee-for-service basis at negotiated rates which are lower than those charged to non-enrollees. PPOs are not a new option for the M+C program as they have been able to serve beneficiaries since the passage of BBA. However, in 2003, only three PPOs participate in the M+C program. The PPO demonstration differs from standard PPOs in that it is designed to test whether or not changes in payment rates, risk sharing, and administrative requirements will encourage greater plan participation.[33] First, while PPO plans outside of the demonstration are paid under the regular M+C payment system, plans in the PPO demonstration are paid the largest of either the M+C payment rate, or 99 percent of per capita fee-for-service in the county (excluding all graduate medical education expenditures). Second, non-demonstration PPO plans are at full financial risk for higher-than-expected medical costs accrued by their enrollees. Plans in the PPO demonstration have the option of sharing financial risk with CMS, according to a risk-sharing agreements which may vary from plan to plan. A risk-sharing agreement defines a target medical loss ratio, or the percent of revenue devoted to providing medical services. Plans are at financial risk if

[33] 42 U.S.C. 1395b-1(a)(1)(A) grants the Secretary of Health and Human Services the authority to conduct demonstration projects to determine if changes in methods of payment would increase the efficiency and economy of health services.

their actual medical loss ratio is 2 percentage points above or below the target. Beyond 2 percentage points, CMS and the plan share the risk according to their agreement, though CMS is never at risk for more than 80 percent of the amount beyond 2 percentage points from the target. The risk-sharing agreements are symmetrical, so if the actual medical loss ratio is less than 2 percentage points from the target, CMS shares in the excess profit, and if it is more than 2 percentage points from the target, CMS shares in the additional costs. The third difference between a PPO within and outside of the demonstration pertains to quality assurance requirements. PPOs outside of the demonstration must comply with the same quality assurance requirements as health maintenance organizations (HMOs). PPOs in the demonstration, however, may comply with the "less prescriptive quality requirements" required of private fee-for-service plans.[34] The higher payment rate, the risk sharing agreements, and the decreased quality assurance requirements may encourage greater plan participation, though to what extent it will encourage participation is uncertain.

PPOs participating in the demonstration must offer beneficiaries the standard Medicare fee-for-service benefits, and they may offer additional benefits such as prescription drugs. CMS expects the monthly premium and cost sharing of the demonstration plans to be higher than those of M+C HMOs, but less than the premiums of Medicare supplemental insurance policies. Beneficiaries enrolled in a PPO may seek care from any provider, though they have a financial incentive to use doctors and hospitals in the PPO's network. For some beneficiaries, the additional benefits (if offered) and greater provider choice may be worth the higher cost sharing required under the demonstration plans.

In 2003, PPO demonstration plans are offered by 17 organizations in 23 States, with an enrollment of 56,667 as of March 2003 – the first 3 months of the program. Approximately 11 million beneficiaries in 243 counties have access to one of the demonstrations, of which about 2.2 million already are enrolled in a Medicare+Choice plan. The organizations offering the PPO demonstrations have chosen to offer them primarily in areas that already are being served by M+C organizations, possibly to capitalize on their existing provider networks, or because of favorable market conditions. Only 4 percent of beneficiaries in the PPO demonstration service area do not have another M+C option.

For 80 percent of counties served by a PPO demonstration in 2003, the M+C payment rate is higher than 99 percent of fee-for-service expenditures in the county, thus plan payment rates will be based on the M+C rate.[35] PPO demonstration plans serving the remaining 20 percent of counties will be paid the 99 percent of FFS rate, which is higher than the M+C rate.

[34] Solicitation for Proposals for Medicare Preferred Provider Organization (PPO) Demonstrations in the Medicare+Choice program [CMS-4042-N].
[35] Information on FFS expenditures per county can be found at [http://www.cms.hhs.gov/healthplans/research/ppodemo.asp], last accessed March 31, 2003.

REASONABLE COST CONTRACTS

The BBA included provisions to phase out the reasonable cost contracts. Cost-based contracts are paid on the basis of the reasonable cost actually incurred to provide Medicare covered services to enrollees. Reasonable cost contract plans are paid a monthly interim per capita rate for each Medicare enrollee. Total monthly payments are determined by multiplying the interim per capita rate by the number of the enrollees, plus or minus adjustments made by CMS. Further adjustments may be made at the end of the contract period to reconcile interim payments with reimbursement amounts payable for services furnished to Medicare enrollees during that period. Since the passage of BBA, the contracts have been extended and currently, the Secretary cannot extend or renew a reasonable cost reimbursement contract for any period beyond December 31, 2004. As of March 2003, there were over 334,000 Medicare enrollees in cost contract plans.

A Health Care Prepayment Plan (HCPP) is another type of managed care arrangement created prior to the BBA. HCPPs cover only Part B services of Medicare. HCPPs are a specific type of cost-based plan which is either 1) sponsored by a union or an employer, or 2) does not provide or arrange for the provision of any inpatient hospital services. HCPPs are responsible for the organization, financing, and delivery of covered Part B services on a prepayment basis.[36] In March 2003, 15 HCPPs provided Part B services to 101,728 enrollees.

PROGRAM FOR ALL INCLUSIVE CARE OF THE ELDERLY (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) was created as a demonstration project in Omnibus Budget Reconciliation Act (OBRA) of 1986. The Secretary was required to grant waivers of certain Medicare and Medicaid requirements to community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of being institutionalized. BBA made PACE a permanent part of Medicare and a State option for the Medicaid program.

The PACE model was developed to address the needs of long-term care clients, providers, and payers. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. The Medicare portion of the provider payment is based on the M+C capitation rate with a frailty adjuster. PACE providers assume full financial risk for participants' care, without limits on amount, duration, or scope of services. As of March 2003, there were about 2,000 Medicare enrollees in PACE plans.

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[36] 42 C.F.R. 417.800.

SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION

The Deficit Reduction Act of 1984 established a 3-year Social Health Maintenance Organizations (SHMO) demonstration to provide prepaid, capitated payments for integrated health and long-term care services. Payments are based on adjustments to the M+C capitation rate. The demonstration has been extended several times.

MEDICAL SAVINGS ACCOUNT DEMONSTRATION

The Balanced Budget Act authorized a demonstration to test the feasibility of medical savings accounts for the Medicare program. The M+C option combined a health insurance plan with a large deductible and an M+C MSA. Contributions to an M+C MSA would be made annually from the enrollee's capitation rate after the plan's insurance premium had been paid. These contributions as well as account earnings would be exempt from taxes. Withdrawals used to pay unreimbursed enrollee medical expenses (that are deductible under the Internal Revenue Code) would not be taxed. New enrollments would be allowed after 2002 or after the number of enrollees reached 390,000. However, no private plans established an M+C MSA for Medicare beneficiaries before the deadline.

MEDICARE COMPETITIVE PRICING DEMONSTRATION

Under its demonstration authority, CMS attempted to initiate a project to determine if negotiated rates could increase the efficiency and economy of providing Medicare services through coordinated care plans. CMS's initial plan called for the application of competitive bidding as a method for establishing payments for risk contract HMOs in either the Baltimore or the Denver area. Through a combination of court and legislative decisions, these demonstrations have been terminated.

The Balanced Budget Act of 1997 required the Secretary of HHS 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 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. The first two sites chosen were Phoenix, Arizona, and Kansas City, Kansas/Kansas City, Missouri.

However, both the BBRA and the Consolidated Appropriations Act of 2000 altered the terms of this demonstration. The Appropriation Act disallowed any funding of the demonstration for 2000 in Arizona and parts of Kansas and Missouri. The BBRA delayed 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 Secretary also is required (subject to CPAC recommendations) to allow plans that make bids below the established government contribution rate to offer beneficiaries Part B premium rebates.

CPAC submitted its report to Congress in January 2001. In its report, CPAC highlighted several lessons learned from the competitive bidding demonstrations. Though the demonstrations never were implemented, CPAC noted that the preliminary stages were completed expeditiously and without administrative difficulties. The latest round of demonstrations showed how benefits could be standardized under competitive bidding, particularly a prescription drug benefit. Area Advisory Committees (AAC) for each area helped to develop a standardized benefit which reflected local market characteristics and the views of the various stakeholders. However, according to CPAC, the proposed demonstration project underestimated the importance of educating and communicating with health plans, health care providers, and other stakeholders. Further, because the demonstrations never were implemented, they did not provide information about whether competitive bidding would result in more efficient Medicare+Choice payments.[37]

[37] For more information about Competitive Bidding, please see CRS Report RL31434 *Medicare+Choice: Using Competitive Bidding to Determine Payments*, by Christopher J. Sroka.