United States General Accounting Office

GAO

Report to the Honorable
John F. Kerry, U.S. Senate

May 1997

MEDICARE HMO ENROLLMENT

Area Differences Affected by Factors Other Than Payment Rates

GAO/HEHS-97-37

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-276654

May 2, 1997

The Honorable John F. Kerry
United States Senate

Dear Senator Kerry:

Enrollment nationwide in the Medicare managed care program has more than tripled in the last decade—growing from about 1 million enrollees in 1987 to about 3.8 million in 1996—but differences in enrollment by state and by market area are striking. In some metropolitan areas like Portland, Oregon, and Tucson, Arizona, the dominant form of Medicare managed care—the health maintenance organization (HMO)—has enrolled more than 40 percent of the Medicare beneficiaries. By contrast, HMO enrollment in most rural areas, and even in some metropolitan markets, is negligible.

Although such large disparities are sometimes attributed to areas' Medicare payment rates for HMOs, studies have identified this as only one of several influences at work. In a recent report prepared at your request, we identified a number of areas where Medicare HMO enrollment was higher despite lower payment rates and others where higher payments had failed to generate enrollment.[1] To explore this issue further, you asked us to

- identify patterns in HMO enrollment and Medicare payment rates, and
- examine selected geographical areas—in particular, some with higher enrollment/lower payment rates and some with lower enrollment/higher payment rates—and describe how the presence or absence of certain factors could affect enrollment.

To identify where beneficiaries were enrolled in HMOs and the rates that Medicare paid to HMOs, we used data obtained from the Health Care Financing Administration's (HCFA) Office of Managed Care.[2] For each of 3,141 counties in 1995, the latest data available at the time of our review, these data showed (1) the number of eligible Medicare beneficiaries, (2) the number enrolled in managed care plans with Medicare risk

[1]Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

[2]HCFA, part of the Department of Health and Human Services, administers Medicare's fee-for-service and managed care programs. The Office of Managed Care within HCFA provides national direction and leadership for Medicare managed care operations.

contracts,[3] and (3) the per enrollee amount that Medicare paid plans (that is, the adjusted average per capita cost (AAPCC) rate for the county).[4] We categorized county enrollment as lower, intermediate, or higher, and in a similar manner categorized counties by payment rates. We then placed each county in one of nine categories based on its combination of risk HMO enrollment and payment rate. We focused our work primarily on counties in three of the categories: lower enrollment/lower payment, lower enrollment/higher payment, and higher enrollment/lower payment.

To identify factors that are likely to affect risk HMO enrollment, we interviewed officials at HMO plans in three markets that had different patterns of AAPCC payments and risk HMO enrollment—Boston, Detroit, and Portland. To obtain more information on factors related to enrollment, we interviewed officials at HCFA's regional offices, six national HMO chains, four additional regional HMOs, five management consulting firms, and five employers. Appendix I presents a more detailed discussion of our methodology.

Results in Brief

Medicare payment rates to HMOs are often considered to be the primary influence on Medicare HMO enrollment. However, our analysis suggests that several other factors also play a key, and sometimes, dominant role. These factors include HMO presence, number of Medicare beneficiaries, and employers' policies toward retiree health benefits. Their relative importance varies across the country. Moreover, in markets such as Detroit and Portland, the influence of Medicare payment rates is not decisive.

Enrollment in risk HMOs was virtually nonexistent in most counties with lower Medicare payment rates, but these lower rates were one of a constellation of factors that make such counties unattractive business propositions for Medicare HMOs. Our analysis showed that these counties typically had few or no HMOs in their health care markets. Lower enrollment counties were primarily rural—only 16 percent fell within a

[3]Both HMOs and competitive medical plans enter into risk contracts with HCFA to provide Medicare-covered services to beneficiaries who enroll. Although competitive medical plans are subject to regulatory requirements similar to those for HMOs, they have greater flexibility in setting commercial premium rates and in the services they offer to their commercial members. In this report, our use of the term HMO includes competitive medical plans. HMOs entering into risk contracts assume all the financial risk associated with providing Medicare-covered services to enrolled beneficiaries. They receive a monthly per capita premium—the adjusted average per capita cost payment—from HCFA for each Medicare beneficiary enrolled. These amounts vary by county.

[4]HCFA pays some HMOs on a cost-reimbursement basis. This approach is similar to reimbursement on a fee-for-service basis in that the provider assumes no risk that fees will be insufficient to cover costs and therefore does not have the same incentive to reduce costs. We did not include cost-reimbursement HMOs in our analysis.

metropolitan statistical area (MSA)—and had fewer people overall and, in particular, averaged a small number of Medicare beneficiaries.

Lower enrollment in risk HMOs did not occur in every county with lower payment rates. Risk HMOs enrolled large numbers of beneficiaries in 92 lower payment counties in which factors other than payment rates were more favorable. These counties were mostly in the West, where HMOs are prevalent and many consumers have embraced this form of health care delivery. A prime example is Portland, where about 41 percent of the Medicare beneficiaries are enrolled in risk HMOs. HMOs have a long history in the Portland area, and the share of the population enrolled in them is high. Moreover, the risk HMO option has been available to Medicare beneficiaries there for more than a decade. Finally, Portland illustrates a pattern found in some other areas: higher enrollment in risk HMOs has spread beyond the counties within the Portland MSA to the counties that border Portland and three other Oregon MSAs.

In contrast, higher payment rates were no guarantee that risk HMO enrollment would also be high. About one-third of the 100 counties with the highest Medicare HMO payment rates in 1995 had risk HMO enrollments that were slight or nonexistent. Most of these higher payment/lower enrollment counties were in the South, where the presence of HMOs was limited. However, several of these counties were in three Michigan urban areas: Detroit, Ann Arbor, and Flint. Although the presence of HMOs in the health care market was generally greater in the Michigan MSAs than in the South, employers' provision of richer retiree health benefits made the risk HMO option less attractive to Medicare beneficiaries in Michigan.

In addition to population density and other factors external to HMOs, HMOs' individual business strategies for the Medicare market are likely to affect the future direction of risk HMO enrollment. The officials of multistate HMOs we interviewed said they are seeking to expand their Medicare business. Some HMOs emphasize expanding into contiguous service areas. Some enter into new risk contracts for HMOs they already own, while others focus on acquiring new HMOs with risk contracts. All these strategies are likely to boost risk enrollment and, sometimes, to change the market dynamics in certain areas. In Boston, for example, risk HMO enrollment grew by 158 percent during a 2-year period after a new player entered the market and offered a no-cost option to Medicare beneficiaries, causing existing HMOs to change their offerings to remain competitive.

Background

Medicare helps the elderly and certain disabled people meet the costs of health care services. Medicare is primarily a federally financed and administered health insurance program, which reimburses fee-for-service providers for each covered service rendered. However, Medicare also offers beneficiaries the option of enrolling in managed care plans—mostly risk contract HMOs. While nearly two-thirds of beneficiaries have access to at least one Medicare HMO that provides service in their zip code areas, only about 10 percent of beneficiaries belong to a Medicare HMO. Most beneficiaries are still enrolled in the traditional fee-for-service program.

Under Medicare's initial authority for paying HMOs that provided care to beneficiaries, few HMOs contracted with Medicare. As enacted in 1972, the legislation limited a participating HMO's profit potential while losses had to be fully absorbed. Consequently, most Medicare HMOs chose to be paid on a cost basis. Facing neither profit nor loss from serving Medicare beneficiaries, cost contract HMOs lacked a strong incentive to reduce unnecessary care and deliver care efficiently.

Legislation changed Medicare's payment mechanism in 1982.[5] Since then, HMOs have been able to enter into more attractive risk contracts with HCFA. The HMO receives a fixed monthly capitation payment—the AAPCC rate—for each beneficiary enrolled[6] in exchange for providing all Medicare part A and part B services.[7] The risk to the HMO is that for any particular beneficiary, the cost of care may exceed the prepaid amount.[8]

Each year, a risk HMO must estimate what it would charge Medicare beneficiaries for Medicare-covered services if they were commercial enrollees. The estimate of the premiums it would charge to provide such services to non-Medicare enrollees is adjusted to reflect the differences in

[5]The change was made through the Tax Equity and Fiscal Responsibility Act of 1982 (sec. 114, P.L. 97-248).

[6]AAPCC rates are set at 95 percent of the average amount that HCFA estimates it would spend reimbursing fee-for-service providers who deliver medical care to a typical beneficiary in a county. HCFA adjusts payments for different categories of beneficiaries on the basis of age, sex, Medicaid eligibility, institutional status, and working status. The AAPCC rates change every calendar year.

[7]Medicare part A—Hospital Insurance—covers services provided by hospitals, skilled nursing facilities, hospices, and home health agencies. Medicare part B—Supplemental Medical Insurance—covers physician and outpatient hospital services as well as other services and supplies received on an outpatient basis, such as laboratory services and medical supplies.

[8]Cost contracts are still an option. (An HMO that is losing money under a risk contract may switch to a cost contract.) In August 1996, 34 plans had cost contracts and had 182,494 beneficiaries enrolled. Also, a plan can contract with HCFA as a health care prepayment plan (HCPP). As an HCPP, a plan is paid on a cost basis for Medicare part B services. Part A services are not covered by HCPPs and remain under the fee-for-service program. There were 50 HCPPs with 300,108 enrollees in August 1996.

(1) the benefits provided to Medicare enrollees and (2) the use of services by Medicare beneficiaries. This estimate (which includes the normal profit of a for-profit HMO) is used to identify any excess profits the HMO will derive from the Medicare business. The HMO is permitted to retain all profits up to the level earned on its non-Medicare business. If the expected Medicare profit exceeds the estimated profit on its non-Medicare business, the HMO must either return the excess to Medicare or provide additional supplemental benefits or reduced copayments or deductibles to beneficiaries. Virtually all HMOs faced with this choice have opted to provide increased benefits, which Medicare beneficiaries can find very attractive.

Before an HMO can enter into a risk contract, the law requires it to have at least 5,000 commercial enrollees. An HMO serving primarily rural areas must have at least 1,500 members. In addition, the Medicare law's "50-50 rule" states that no more than 50 percent of an HMO's enrollment may be Medicare beneficiaries and Medicaid recipients.

Medicare beneficiaries enrolled in a risk HMO face a "lock-in" requirement. Once they enroll, they must receive virtually all their health care services through the HMO.[9] If a beneficiary goes outside the HMO for any health care services, neither the HMO nor Medicare is required to pay the cost. Exceptions are made for emergency and similar type care, which can be obtained anywhere in the country, and for which the HMO should pay. A few risk HMOs now offer a "point of service" option through which beneficiaries can receive certain services outside the plan's network of providers but must pay more than for "within-plan" services.

Beneficiaries consider a number of factors when deciding whether to enroll in a Medicare risk HMO, including (1) their familiarity with managed care, (2) their attachment to current health care providers, (3) whether they travel out of the area or live part of the year in another state, and (4) likely out-of-pocket costs in a risk HMO versus the fee-for-service program (plus the cost of a Medigap policy[10]). In a risk HMO, the beneficiary may be charged a fixed monthly premium and a copayment

[9]Medicare beneficiaries may choose to disenroll from a risk HMO at any time.

[10]Medigap insurance provides benefits that help fill the gaps in Medicare coverage. Federal law requires Medigap plans to offer 1 of 10 standard benefit packages—labeled plan A through plan J. These private, supplemental plans cover various combinations of Medicare cost-sharing requirements. Some plans also include services not covered by Medicare—for example, outpatient prescription drugs. Plan A is the most basic while plan J is the most comprehensive. Insurance companies are not allowed to change the letter designations or the combination of benefits offered. Although the benefits are the same for all Medigap plans, premiums may vary greatly across companies.

each time a service is used.[11] Depending on the additional benefits a Medicare HMO provides, enrolling may be an alternative to buying Medigap insurance, often at a lower cost to the beneficiary.

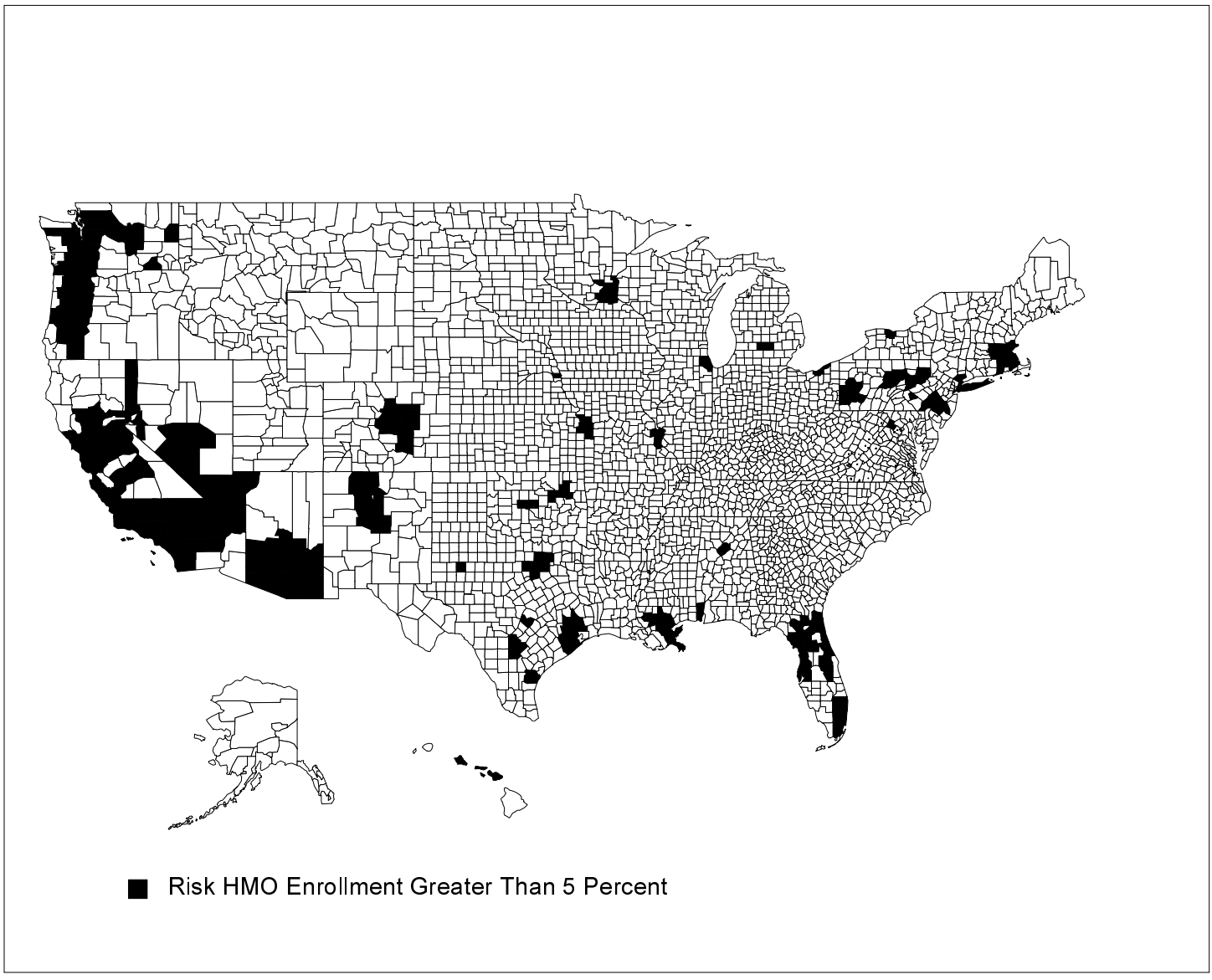
Many employers provide health benefits to retired employees who receive Medicare. Some employers, faced with rising retiree health care costs and new accounting rules,[12] believe they can reduce costs when their Medicare-eligible retirees enroll in risk HMOs. As a result, some employers are providing retirees with incentives to join risk HMOs. They may limit their contribution to just cover the cost of a Medicare risk HMO, thereby causing retirees who do not join an HMO to face increased health care costs. To remain in Medicare's fee-for-service plan these beneficiaries may have to buy a Medigap policy and pay the difference between the premium and the employer's contribution.

About 3.8 million Medicare beneficiaries were enrolled in risk HMOs in August 1996, but enrollment was concentrated primarily in urban areas in the West and in Florida. Only a handful of counties in the East, South, and Midwest had more than 5 percent of their Medicare population enrolled in risk HMOs. (See fig. 1.) In total, 242 of 3,141 counties had more than 5 percent enrollment in the Medicare risk HMO program—a level that for this study we classify as "higher enrollment." In contrast, however, 2,663 of the counties—about 85 percent—had either no beneficiaries or fewer than 1 percent enrolled in risk HMOs. (We classify these areas as "lower enrollment.")

[11]This is in addition to the premium that all beneficiaries must pay to receive physician services under Medicare part B.

[12]Starting in 1993, Financial Accounting Standards Board rule 106 required that private-sector employers with 500 or more plan participants treat health benefit obligations for present and future years on an accrual instead of a pay-as-you-go basis.

Figure 1: Counties With Higher Risk HMO Enrollment, December 1995



Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA.

Risk HMO Enrollment Linked to Payment and Other Factors

Our analysis of counties grouped by their AAPCC rates and risk HMO enrollment levels suggests that while AAPCC rates play a role, other factors also affect enrollment. (See table 1.) In addition to HMO presence in the health care market, such factors as population density, the number of Medicare beneficiaries, and employers' policies on retiree health benefits can influence risk enrollment. The studies we reviewed all found that several factors—usually including AAPCC rates and HMO presence—help account for the differences in risk HMO enrollment from county to county.[13] Moreover, a study using recent data found that the factor with the strongest influence was HMO presence.[14] Greater HMO presence establishes more familiarity in an area for managed care in general and for a particular plan. HMOs can draw on that when trying to attract Medicare beneficiaries.

[13]See Physician Payment Review Commission, Annual Report to Congress, Physician Payment Review Commission, 1995 (Washington, D.C.: 1995), pp. 92-94; Physician Payment Review Commission, Annual Report to Congress, Physician Payment Review Commission, 1996 (Washington, D.C.: 1996), pp. 80-81; and Carl Serrato, Randall S. Brown, and Jeanette Bergeron, "Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?" Health Care Financing Review, Vol. 17, No. 1 (Fall 1995), pp. 85-97.

[14]W. Pete Welch, "Growth in HMO Share of the Medicare Market, 1989-94," Health Affairs, Fall 1996, pp. 201-214.

Table 1: Number of Counties With Lower, Intermediate, and Higher Enrollment in Risk HMOs by Lower, Intermediate, and Higher AAPCC Rates, December 1995

Monthly AAPCC payment rates (per person)[a]	Enrollment in Medicare risk HMOs			
	Lower[b]	Intermediate[c]	Higher[d]	Total
Lower (under $375)[e]	2,257[f]	125	92	**2,474**
Intermediate ($375 to $464)[g]	373	93	101	**567**
Higher (top 100 payments—$464 to $679)[h]	33	18	49	**100**
Total	**2,663**	**236**	**242**	**3,141**

Note: Payment rates are rounded to the nearest dollar.

[a]The lower, intermediate, and higher AAPCC rate and enrollment designations were chosen for analytic purposes. The designations are relative and do not imply that such levels are appropriate or not appropriate.

[b]Counties had 1 percent or less of their beneficiaries enrolled or none enrolled.

[c]Counties had more than 1 percent but no more than 5 percent of their beneficiaries enrolled.

[d]Counties had more than 5 percent of their beneficiaries enrolled.

[e]The average AAPCC rate was $306; the median, $310.

[f]Of the 2,257 counties, 552 had no risk HMO enrollment. According to HCFA data, an additional 1,604 counties had fewer than 25 enrollees.

[g]The average AAPCC rate was $408; the median, $403.

[h]The average AAPCC rate was $512; the median, $496.

Sources: Medicare Market Penetration Report File and AAPCC Rate File, Office of Managed Care, HCFA.

Most Counties With Lower Payment Rates Are Less Urban and Lack Strong HMO Presence

Medicare risk HMO enrollment in 2,257 counties that had lower AAPCC rates was minimal or nonexistent, but the principal barrier to risk HMO enrollment was not the payment level. On average, the 2,257 counties with lower AAPCC rates and lower enrollment had fewer people per square mile, and only about 16 percent of these counties were urban in that they were included in an MSA. For the most part, the 2,257 counties were mainly rural or sparsely populated and consequently, most had few or no HMOs serving non-Medicare residents.

Generally, HMOs thrive and exert a stronger presence in counties that are part of metropolitan areas. In the 10 states with the highest percentage of people enrolled in HMOs in 1994, about 92 percent of the population lived in an MSA. Markets need to be of sufficient size to generate an HMO presence

in general and a risk HMO program in particular. According to one study, the most remote counties with the smallest populations are not likely to be included in HMO markets.[15] Table 2 compares characteristics of the 10 states with the lowest level of total HMO market share (that is, commercial, Medicaid, and Medicare enrollment) and the 10 states with the highest total HMO market share.[16] The 10 states with the lowest total HMO market shares averaged less than two HMOs each.

Table 2: Selected Characteristics of the 10 States With Lowest and Highest Total HMO Market Share

Characteristic	Data for 10 states with lowest share[a]	Data for 10 states with highest share[b]
Total HMO market share[c]	1.9%	32.9%
Average number of HMOs[c]	1.6	16.6
Percentage of Medicare beneficiaries enrolled in risk HMOs[d]	0.1%	17.2%
Percentage of counties in an MSA	9.7%	41.4%
Percentage of population living in an MSA	38.0%	92.0%

[a]The 10 states with the lowest total HMO market share at the end of 1994 were Alaska, West Virginia, Wyoming, Mississippi, North Dakota, Idaho, Montana, South Dakota, Arkansas, and Iowa.

[b]The 10 states with the highest total HMO market share at the end of 1994 were California, Oregon, Maryland, Arizona, Massachusetts, Rhode Island, Connecticut, Minnesota, Colorado, and New York. We did not include the District of Columbia, which had the ninth highest total HMO market share in 1994.

[c]As of year-end 1994.

[d]As of December 1995.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; Group Health Association of America, Patterns in HMO Enrollment, June 1995; and HCFA, 1995 Data Compendium.

Even if the counties that had lower payment rates and lower enrollments had an HMO present, most lacked a Medicare population of sufficient size to attract an HMO into the risk contract program. Table 3 shows these counties had an average of about 5,600 Medicare beneficiaries. According to officials at several multistate HMO chains we interviewed, one of the factors they consider most when selecting areas of the country in which to pursue the Medicare business is the size of the Medicare population. An official at one company estimated that no more than 20 to 30 percent of the beneficiaries in a new market will join a risk HMO, which suggests that

[15]See Thomas C. Ricketts, Rebecca T. Slifkin, and Karen D. Johnson-Webb, "Patterns of Health Maintenance Organization Service Areas in Rural Counties," Health Care Financing Review, Vol. 17, No. 1 (Fall 1995), p. 110.

[16]We used state data on total HMO enrollment because reliable data for all counties were not available.

only about 1,100 to 1,700 beneficiaries in each of these counties may join. In addition, officials at multistate HMOs said that they need to enroll at least 10,000 beneficiaries within a few years to spread the risk. In another study, HMO officials said that they do not enroll Medicare beneficiaries in rural areas because the Medicare population is not large enough to cover the fixed costs associated with this coverage.[17]

Table 3: Selected Characteristics of Counties With Lower AAPCC Rates and Lower Enrollment in Risk HMOs

Characteristic	
Lower payment/lower enrollment counties	2,257
Counties in an MSA	16%
Rural counties	84%
Median population per square mile	31
Average Medicare beneficiaries	5,603
Counties with 10,000 or more Medicare beneficiaries	13%

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994); and U.S. Bureau of the Census data.

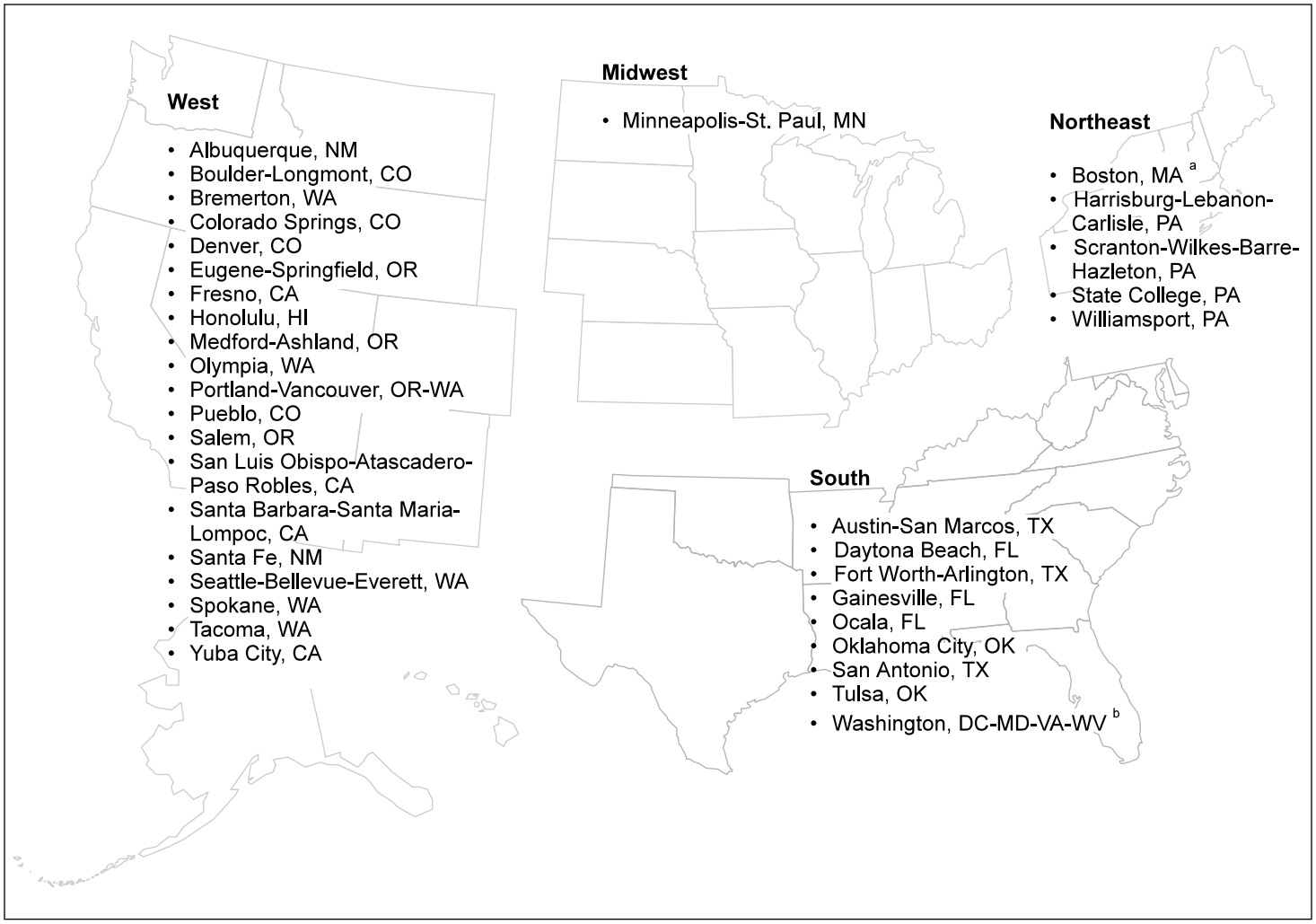
Certain Factors Foster Risk HMO Enrollment in Some Areas Despite Lower Payment Rates

In a number of counties where AAPCC payments were relatively low, the rate of Medicare risk HMO enrollment was relatively high, our analysis showed. Risk HMO enrollment flourished because of other factors, including urban settings and stronger HMO presence. Most of these primarily urban counties were in the West, where HMOs have a longer history than in many other parts of the country. The counties in and around the Portland MSA and three other MSAs in Oregon illustrate how factors other than payment rates serve to raise risk HMO enrollment.

A large number of Medicare beneficiaries were enrolled in risk HMOs that serve more urban, lower payment counties. About 400,000 beneficiaries—nearly 18 percent of those eligible—were enrolled in risk HMOs in 92 counties that had lower payment rates (less than $375) and higher enrollment (greater than 5 percent). Most of these 92 counties were urban—or closer to urban areas—rather than rural; about 62 percent were part of the 35 MSAs shown in figure 2. Another 33 percent bordered these or other MSAs. Some of the 35 MSAs were scattered throughout the country, but most were in the West.

[17]See Serrato, Brown, and Bergeron, p. 93.

Figure 2: 35 MSAs With One or More Counties With Lower AAPCC Rates and Higher Enrollment in Risk HMOs, December 1995



[a]One county in the Boston metropolitan area—Bristol County—had a lower AAPCC payment and higher enrollment. The county is on the Rhode Island border near the Providence MSA. Generally, the counties in the Boston MSA had relatively high AAPCC rates. We discuss the Boston MSA later in this report.

[b]One county in the Washington MSA—Loudoun County, Virginia—had a lower AAPCC payment and higher enrollment. The county is on the West Virginia border and is primarily rural with the exception of the Leesburg and Sterling Park areas, which are within commuting distance of Washington, D.C.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA.

In many of the 35 MSAs, HMO presence was high, which is favorable to enrollment in risk HMOs. Table 4 illustrates the total HMO enrollment for 10 of the 35 MSAs. Every county included in 8 of these 10 MSAs had lower AAPCC payments and higher enrollment in risk HMOs—the two exceptions were the Santa Fe MSA (where one of two counties did not have lower AAPCC payments and higher enrollment) and the Denver MSA (where three of five counties did not have lower AAPCC payments and higher enrollment). While most of the 10 MSAs had a relatively high percentage of their total populations enrolled in HMOs, enrollment was particularly high in four Oregon MSAs. In the Oregon MSAs, total HMO enrollment ranged from about 42 percent in Portland-Vancouver to about 56 percent in Medford-Ashland.

Table 4: Risk HMO Enrollment, Total HMO Enrollment, and Number of HMOs in 10 MSAs, 1995

MSA/state	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs[a]	Percentage estimated total HMO enrollment in MSA[b]	Number of HMOs serving MSA[c]
Portland-Vancouver, OR-WA	41.3	41.8	10
Albuquerque, NM	33.6	33.2	5
Denver, CO	30.3	27.4	9
Salem, OR	19.5	41.9	6
Boulder-Longmont, CO	18.6	49.2	4
Pueblo, CO	17.3	26.0	4
Santa Fe, NM	16.6	8.2	4
Medford-Ashland, OR	12.8	55.9	5
Colorado Springs, CO	11.7	19.1	4
Eugene-Springfield, OR	10.8	52.0	5

[a]As of December.

[b]As of January, includes estimated commercial, Medicare, and Medicaid enrollment.

[c]The same HMO can serve more than one MSA. Data were as of January.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and InterStudy, Competitive Edge, 5.2 ed. (Minneapolis, Minn.: 1995).

Portland Area's Experience Illustrates Role of Greater HMO Presence

We took a closer look at Portland, an area where higher enrollment in risk HMOs coexisted with an equally strong total HMO presence and lower AAPCC payment rates. Portland's risk HMO enrollment rate of about 41.3 percent

was among the highest in the country, even though its payment rates were relatively low.[18]

As table 5 shows, Portland and the three other Oregon MSAs have had an active risk program. Four of the counties in the Portland market rank among the top seven counties nationwide in terms of the percentage of their Medicare beneficiaries enrolled in risk HMOs.

Table 5: Risk HMO Enrollment for 13 Oregon Counties, December 1995

	County	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs
MSA		
Portland-Vancouver[a]	Columbia	45.2
	Washington	44.8
	Multnomah	44.7
	Clackamas	44.1
	Yamhill	21.8
Salem	Marion	20.4
	Polk	15.0
Medford-Ashland	Jackson	12.8
Eugene-Springfield	Lane	10.8
Non-MSA		
Borders Salem and Eugene-Springfield	Benton	35.8
Borders Portland-Vancouver	Clatsop	16.2
Borders Salem and Eugene-Springfield	Linn	15.2
Borders Eugene-Springfield and Medford-Ashland	Douglas	6.0

[a]Clark County, Washington, is also a part of the Portland-Vancouver MSA. It had risk enrollment of 30.2 percent.

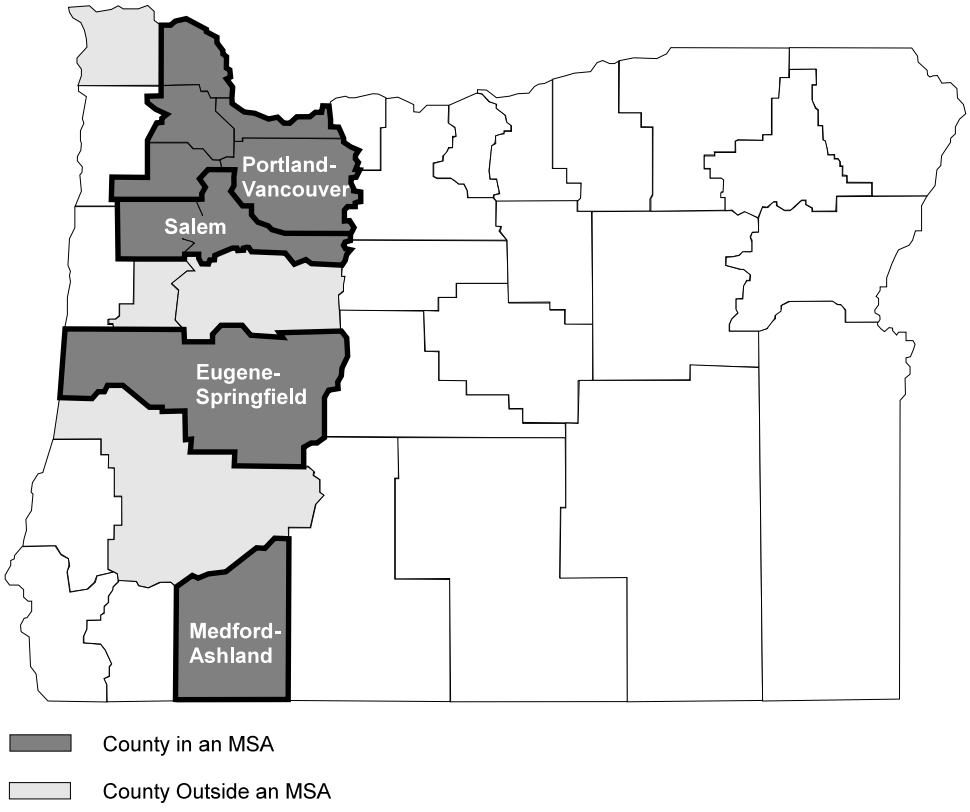
Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

Portland and Oregon's three other MSAs are clustered along the Interstate 5 corridor in the western part of the state where risk HMO enrollment has concentrated. Figure 3 shows that the nine counties in the four Oregon

[18]Like Portland, and the surrounding MSAs in Oregon, several MSAs in other western states had relatively low AAPCC rates and higher enrollment in risk HMOs. Appendix II provides additional information on these and similar areas.

MSAs—Portland-Vancouver, Salem, Eugene-Springfield, and Medford-Ashland—all had higher enrollment in risk HMOs. Where higher enrollment has occurred outside the MSAs, in every case it has been in a county bordering one of Oregon's MSAs. A substantial share of the populations in the bordering counties has access to HMO providers in the neighboring MSAs.

Figure 3: 13 Oregon Counties With Lower AAPCC Rates and Higher Enrollments in Risk HMOs, December 1995



Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

About 75 percent of Oregon's Medicare beneficiaries live in the 13 counties. HMOs have thus far expressed no interest in expanding into the

eastern parts of the state because the numbers of beneficiaries needed to induce an HMO to enter into a risk contract with HCFA appear to be absent.

In the Portland area, enrollment of Medicare beneficiaries in risk HMOs seems to have been facilitated by consumer acceptance of HMOs. The Portland community's familiarity with HMOs—Kaiser introduced the concept in Portland in the 1940s—is believed to have increased the willingness of beneficiaries to participate in the risk program. Officials of two Oregon risk HMOs with whom we spoke both cited beneficiaries' familiarity with the HMO concept as the primary reason for the high enrollment rate. Consistent with consumers' apparently favorable attitude toward HMOs, beneficiaries were willing to enroll in risk HMOs even though most charge a premium.[19]

Because Portland's HMOs were well-established for many years, they could participate in the risk program when it began. This early participation has increased beneficiary acceptance of HMOs and allowed more time for enrollment to develop and grow, according to HMO officials we spoke with. Kaiser participated in a Medicare risk demonstration project in 1980 and has been enrolling beneficiaries ever since. Even before 1980, Kaiser enrolled beneficiaries through a cost contract with HCFA. Two other HMOs in the Portland area began to participate in the risk program in the mid-1980s.

Employers have played a role in fostering Portland's risk enrollment. About half of Kaiser's risk HMO enrollees come from employer groups. As employees retire and age into Medicare, they are able to remain covered by Kaiser, the plan through which they may have been receiving their health care coverage for many years. In contrast, PacifiCare, which has about as many risk enrollees as Kaiser, receives only about 5 percent of its enrollment from employer groups. Its enrollment grew more than Kaiser's between 1993 and 1995, however, primarily because of its marketing to the beneficiaries not enrolled through employers.

[19]HMOs that project Medicare profit rates near or below those for commercial enrollees are unlikely to offer the richer level of benefits that HMOs offer where the AAPCC rate and profit levels are considerably higher.

Lack of HMO Presence Can Impede Risk HMO Enrollment Where Payments Are Higher

Higher payment rates were no guarantee that risk HMO enrollment would also be higher. Our analysis showed that a third of the counties ranked among the highest AAPCC payment areas in the country had no, or virtually no, Medicare beneficiaries enrolled in risk HMOs. About 82 percent of these counties were in the South, where HMOs generally have not achieved the high levels of enrollment attained by those in the West. The lack of a strong HMO presence contributed to the lower enrollment in risk HMOs that occurred in these counties.

Few Medicare beneficiaries were enrolled in risk HMOs in one-third of the counties that were among the highest payment areas. Our analysis showed that 1 percent or less of the eligible beneficiaries were enrolled in risk HMOs in 33 counties that numbered among the top 100 AAPCC payment areas in 1995. (See table 1 for our payment/enrollment analysis.) Twenty-seven of these counties were in the South; of these, 12 were located in 8 MSAs—Atlanta, Biloxi-Gulfport-Pascagoula, Birmingham, Chattanooga, Lubbock, Nashville, Savannah, and Stubenville-Weirton—and 9 bordered these or other MSAs.

HMO presence, a factor facilitating risk HMO enrollment, was relatively low in most of the eight southern MSAs. Even larger southern metropolitan areas like Atlanta and Birmingham, with about 15 percent total HMO enrollment, had lower Medicare risk HMO enrollment in most of their areas. Atlanta, where 3 of the 20 counties in the MSA had higher payment rates, still had risk HMO enrollment below 1 percent. Only one of the four counties in the Birmingham MSA had a higher payment rate, but risk HMO enrollment in this county and two others was minimal.[20]

Employer Policies Can Hinder Risk HMO Enrollment When Other Factors Are Favorable

In southeastern Michigan, higher payment rates in the Detroit, Flint, and Ann Arbor MSAs have not been enough to stimulate risk HMO enrollment. However, this modest enrollment performance cannot be ascribed to weak HMO presence. Compared with HMOs in some southern MSAs, HMOs in Michigan have generated stronger total enrollment—as high as about 26 percent in Flint and Ann Arbor. While the combination of attractive payment rates, a large potential market, and an active HMO industry are all present, the Medicare risk program has been slow to take root. In these Michigan MSAs, the retiree benefits provided by the automobile industry reduces the attractiveness of risk HMOs and contributes to lower enrollment by Medicare beneficiaries.

[20]Jefferson County, the primary county in the Birmingham MSA, had an intermediate payment rate (between $375 and $464) and risk HMO enrollment of 7.3 percent. The remaining three counties in the Birmingham MSA had risk enrollment of less than 1 percent.

Six of the 33 counties that had lower enrollment in risk HMOs, despite being among the 100 highest payment areas, were in Michigan. All six of these counties were in three MSAs—Ann Arbor, Detroit, and Flint. In addition to being higher payment, urban areas, these three MSAs had a fairly strong HMO presence. Both Ann Arbor and Flint had total HMO enrollment of about 26 percent; in Detroit, enrollment approached 21 percent. While low compared with some areas in the West, this level of total HMO enrollment was considerably higher than in most of the eight southern MSAs that also had higher payment rates and lower enrollment in risk HMOs. Despite the presence of these factors, only about 0.5 percent of the eligible Medicare beneficiaries in the three Michigan MSAs were enrolled in risk HMOs.

A key factor in the Michigan MSAs, according to HMO officials, is the benefit package available to retired autoworkers and retirees from other firms that patterned their benefit packages on the auto industry's. These benefit packages provide employer-sponsored comprehensive coverage of health benefits with little or no out-of-pocket payments for the retiree. As officials at the HMOs we interviewed in Detroit confirmed, beneficiaries receiving these benefits have little incentive to switch to risk HMOs.

Excluding beneficiaries covered by rich benefit packages, the Medicare population in the Michigan MSAs is still relatively large and hence attractive to risk HMOs. Two plans whose officials we spoke with had left the risk program in the late 1980s because they were losing money but now have risk contract applications pending with HCFA and hope to begin enrolling beneficiaries in 1997. The HMOs plan to target Medicare beneficiaries not covered by rich retiree health benefits. One HMO suggested that by the end of 1998 it expects about 30,000 Medicare beneficiaries to be enrolled. However, if the HMO could contract with one of the "big three" automakers, it expects that number to double.

HMO Business Strategy May Affect Risk Enrollment

Several multistate HMOs have been pursuing the Medicare risk market. As the market for employer-sponsored health coverage has become more saturated, HMOs have realized that the Medicare market is large and potentially lucrative, that the demand for a Medicare risk product is increasing, and that competitors are ready to move into the market. In addition, HMOs have been encouraged by increases in the AAPCC payment rates in some areas. Finally, publicly traded HMO companies, which are especially concerned with short-term profits, are seeking new ways in which to expand and grow.

Companies' business strategies for expanding their involvement with the risk HMO program include enlarging existing risk HMO contracts through service area expansions, applying for new risk contracts, and acquiring other HMOs. Officials of one large multistate HMO articulated a strategy of expanding from existing service areas into contiguous areas and contiguous states. While acquisitions were for the most part made to obtain a share of the commercial managed care market, with the decision to start a risk program coming later, some acquisitions were made specifically with the Medicare risk market in mind. For example, PacifiCare Health Systems announced in August 1996 that it would buy FHP International in part to ensure its dominance in the Medicare risk market.

According to the officials we interviewed at multistate HMOs, their risk HMO expansion efforts targeted markets with certain characteristics. Markets were more attractive if they had a concentrated number of beneficiaries and limited competition for them. To spread the risk, most said that an HMO must have the opportunity to enroll at least 10,000 beneficiaries in a few years. Also, officials at the HMOs said that the payment rate in a market must be high enough for a risk plan to be financially viable. Furthermore, markets must have a concentration of non-Medicare beneficiaries to be attractive because HMOs must have at least 5,000 commercial enrollees to apply for a risk contract. And the more people who are enrolled in the commercial sector of a local market, the easier it is to enroll beneficiaries because of the familiarity with managed care.

Officials at multistate HMOs had different views of the role that payment rates play in their decisions to move into or out of a market. Officials at one multistate company said that while they consider the AAPCC payment rate when making a decision, a low payment would not automatically disqualify a market. For example, they said they were considering expanding into a low-payment market because an employer group had specifically expressed interest in the risk program in that area. Another company indicated that the payment rate needs to be high enough to adequately pay health care providers. Officials at a third multistate company believed that there were no parts of the country where the payment rate would be too low for them to enter if the large numbers of Medicare beneficiaries needed for the program to be successful were present. Officials at two multistate HMOs held divergent views on the AAPCC rate reduction that would induce their companies to leave the risk HMO program. While officials at one company, citing "slim margins," thought a moderate rate reduction would induce them to switch to a Medicare cost

contract, officials at another company stated that they would consider leaving the risk contract program only if the rate reduction was "drastic."

Expansion by dominant Medicare HMO companies can help fuel the growth of risk enrollment in locations where it has been slow. In Boston, for example, HMO and HCFA officials credit the entrance of a PacifiCare risk product with sparking the growth of Boston's risk market. As the PacifiCare product began obtaining market share, local HMOs realized they needed to target the Medicare market more aggressively if they wanted to stay competitive. Their pursuit of the Boston market resulted in greatly increased risk enrollment.

Boston's Risk Program Stimulated When Beneficiaries Could Enroll at No Cost

The Boston risk market is an attractive market because of the large base of Medicare beneficiaries, some of the highest AAPCC rates in the country, and a strong HMO presence. However, the number of risk HMOs pursuing the Boston market peaked during 1987 through 1988, then declined until 1993, when only three HMOs were left serving the market. According to HCFA officials, a number of HMOs dropped out of the risk program because they did not understand how to manage the senior population and did not control enrollee costs.

The market started to turn around in Boston in 1994. According to HCFA and HMO officials, HMOs were returning to the risk market or entering for the first time because the industry was learning how to manage the Medicare business. However, it took a new entrant to the risk market, challenging the market share of the established HMOs, for risk enrollment in Boston to take off.

Tufts Associated reentered Boston's risk market in 1994,[21] with a franchise of SecureHorizons, the Medicare HMO product of California-based PacifiCare. To attract beneficiaries, Tufts began offering a zero-premium risk product—Medicare beneficiaries could enroll without having to pay any additional premiums to the HMO. The introduction of a zero-premium product transformed the Boston market, according to HCFA and HMO officials. Tufts' action created competition among HMOs for Medicare

[21]Tufts Associated HMO began operations in the Boston area in 1981 and started a risk program in 1985. However, it dropped out of the risk program in 1988. According to Tufts officials, the HMO was unsuccessful in the risk program because it did not develop a specifically tailored program to manage seniors as a distinctly different population from the non-elderly and failed to manage them effectively. As a result, Tufts had lost money. Like other HMOs, Tufts began reconsidering the risk market in 1992 as it became apparent that some HMOs were able to manage their risk programs profitably. Tufts negotiated a franchise of PacifiCare's SecureHorizons product as a way of gaining the expertise necessary to run a successful Medicare risk program.

beneficiaries and spurred stronger beneficiary demand for risk products. As a result, enrollment in the MSA grew 158 percent between 1993 and 1995. Prior to the introduction of the zero-premium product, HMO risk premiums had ranged from $90 to $120 per month, and according to HCFA officials, were hardly distinguishable from premiums for Medigap insurance.

Conclusions

Despite the considerable momentum of risk HMO enrollment growth, its uneven pattern across the country focuses attention on understanding why such disparities occur. Although the linkage of Medicare payment rates to risk HMO enrollment may be important in some areas, dramatic differences in enrollment are often associated with other factors. The presence of HMOs, the density of population, and the number of Medicare beneficiaries, especially those familiar with managed health care, all facilitate growth in enrollment—and their absence hinders it. In addition, the health care benefits provided by employers in a market area can affect beneficiaries' willingness to enroll in risk HMOs. The rapid growth in risk HMO enrollment during the past several years, which has occurred without any major federal policy changes, is likely to continue as employers encourage retirees to join HMOs and as HMOs pursue varied strategies for expanding their Medicare business.

We provided a draft of this report to officials in HCFA's Office of Managed Care. These officials agreed with the information presented. We are sending copies of this report to the Secretary of Health and Human Services and other interested parties, and we will make copies available to others on request. If you or your staff have any questions, please call me at (202) 512-7114 or Michael F. Gutowski, Assistant Director, at (202) 512-7128. Other major contributors to this report include Howard Cott, Aleta Hancock, Joseph Petko, Wayne Turowski, and Joan Vogel.

Sincerely yours,

Jonathan Ratner
Associate Director, Health Financing and
Systems Issues

Contents

Figures

Abbreviations

AAPCC	adjusted average per capita cost
HCFA	Health Care Financing Administration
HCPP	health care prepayment plan
HMO	health maintenance organization
MSA	metropolitan statistical area

Methodology

Health maintenance organizations (HMO) enter into risk contracts with the Health Care Financing Administration (HCFA) to provide Medicare-covered services to beneficiaries who enroll.[22] Risk plans assume all the financial risk associated with providing Medicare-covered services to enrolled beneficiaries in return for a monthly per capita premium—the adjusted average per capita cost (AAPCC) payment—from HCFA for each Medicare beneficiary enrolled. The amount of these AAPCC-based payments varies by county. HCFA pays some HMOs on a cost-reimbursement basis, with these HMOs assuming no risk that fees will be insufficient to cover costs; our work focused only on managed care plans that had entered into risk contracts with HCFA.

We first obtained data from the Office of Managed Care at HCFA headquarters. For each of 3,141 counties in the nation, these data showed the (1) number of eligible Medicare beneficiaries, (2) number of beneficiaries enrolled in managed care plans with a risk contract with HCFA, and (3) AAPCC rate paid by HCFA for each Medicare beneficiary enrolled in a risk plan. These data were as of December for 1993, 1994, and 1995, the latest data available at the time of our review. Data did not include Guam, Puerto Rico, or the Virgin Islands.

To identify counties with similar risk enrollment and AAPCC rates, we determined the percentage of Medicare beneficiaries enrolled in Medicare risk plans in December 1995 and the AAPCC rates paid by HCFA in 1995 for each of the 3,141 counties. Using these data, we placed each county into one of nine categories based on whether it had a higher, intermediate, or lower AAPCC rate and higher, intermediate, or lower Medicare risk enrollment.

We placed counties with the top 100 AAPCC rates in 1995 in the higher category. These rates ranged from $463.89 to $678.90. There were 2,474 counties with AAPCC rates under $375.00 that we considered as having lower payments (their rates ranged from $177.32 to $374.86[23]). We defined the remaining 567 counties as having intermediate AAPCC rates. Again using December 1995 data, we placed the 2,663 counties with no Medicare risk enrollment or enrollment of 1 percent or less in the lower enrollment category. Of these 2,663 counties, 618 had no Medicare risk enrollment at

[22]Managed care plans that enter into risk contracts include both HMOs and competitive medical plans. Although competitive medical plans are subject to regulatory requirements similar to those for HMOs, they have greater flexibility in setting commercial premium rates and the services offered to their commercial members. In this report, our use of the term HMO includes competitive medical plans.

[23]HCFA data showed that 13 areas, most of which were in Alaska, had AAPCC rates of zero.

all, and 2,045 had enrollments of 1 percent or less. For the purposes of our study, we placed the 242 counties that had enrollments of more than 5 percent in the higher enrollment category. Although 5 percent would not be considered high for private sector managed care enrollment, it is high for the Medicare risk program—only about 8 percent of the counties had Medicare risk enrollments of more than 5 percent. We placed the remaining 236 counties in the intermediate category (enrollments greater than 1 percent and less than or equal to 5 percent). For the distribution of the 3,141 counties in the nine categories, see table 1.

We focused our study on the following three categories: counties that had (1) lower AAPCC rates and lower risk enrollment (2,257 counties), (2) lower AAPCC rates and higher risk enrollment (92 counties), and (3) higher AAPCC rates and lower risk enrollment (33 counties). Using HCFA data, we converted the county data into metropolitan statistical area (MSA) data for the three study categories.

In addition to analyzing data for the three study categories, we selected three markets in which to perform more detailed work: (1) Portland, Oregon—a market in the lower AAPCC rate and higher enrollment category; (2) Detroit—a market in the higher AAPCC rate and lower enrollment category; and (3) Boston—a market in which risk enrollment grew considerably in a relatively short time. In these markets, we interviewed officials at the applicable HCFA regional offices and at selected HMOs that had entered into or were planning to enter into Medicare risk contracts.

Finally, we interviewed officials at all 10 HCFA regional offices, 6 national HMO chains, and 12 regional HMOs to obtain more information and get opinions on (1) the Medicare risk program in general, (2) enrollment trends in particular, (3) reasons managed care plans and beneficiaries participate in Medicare risk programs, (4) factors that made the risk market attractive, and (5) factors affecting risk program enrollment. All of the 18 HMOs had risk contracts or were planning to enter into contracts with HCFA. Also, we interviewed representatives from five management consulting firms involved in bringing employers and Medicare risk plans together to cover Medicare-eligible retirees and five employers regarding their efforts to enroll a portion of their retirees in Medicare risk plans. Table I.1 shows the HMOs, employers, and management consultants we interviewed.

Table I.1: National HMO Chains, Regional HMOs, Employers, and Management Consultants Contacted

Group contacted	Location
National HMO chains	
FHP, Inc.	Fountain Valley, CA
Health Systems International	Woodland Hills, CA
Kaiser Foundation Health Plan, Inc.	Oakland, CA
PacifiCare Health Systems	Cypress, CA
Prudential Health Care Senior Care	Roseland, NJ
United HealthCare Corporation	Minnetonka, MN
Regional HMOs	
Blue Care Network of Southeast Michigan	Southfield, MI
FHP of Utah	Salt Lake City, UT
Harvard Pilgrim Health Care	Dedham, MA
Health Alliance Plan	Detroit, MI
Intermountain Health Care of Utah	Salt Lake City, UT
Kaiser Foundation Health Plan, Northern California Region	Oakland, CA
Kaiser Foundation Health Plan of the Northwest	Portland, OR
Mercy Health Plan	Farmington Hills, MI
PacifiCare of Oregon	Lake Oswego, OR
Tufts/SecureHorizons	Waltham, MA
United HealthCare of Utah	Salt Lake City, UT
U.S. Healthcare, New England Region	Burlington, MA
Employers	
Chevron Corporation	San Francisco, CA
General Motors Corporation	Detroit, MI
McKesson Corporation	San Francisco, CA
Sears, Roebuck and Company	Hoffman Estates, IL
University of California	Oakland, CA
Management consultants	
Foster Higgins and Company, Inc.	Los Angeles, CA
KPMG Peat Marwick	San Francisco, CA
Price Waterhouse	San Francisco, CA
Towers Perrin	San Francisco, CA; New York City, NY
William Mercer, Inc.	Richmond, VA

We performed our work between February 1996 and February 1997 in accordance with generally accepted government auditing standards.

Risk HMO Enrollment Substantial in Several Western Markets With Stronger HMO Presence

Counties in Oregon were not the only counties where risk HMOs had enrolled substantial numbers of Medicare beneficiaries despite having lower payment rates. Other counties in or bordering several western MSAs also followed this pattern. As in Oregon, these more urban counties were located in or bordered MSAs that usually had a strong total HMO presence—an important factor that can affect risk enrollment. The Albuquerque and Santa Fe MSAs in New Mexico and the Denver, Boulder-Longmont, Colorado Springs, and Pueblo MSAs in Colorado most closely followed the pattern exhibited in Oregon. Clearly, factors other than payment rates affected risk HMO enrollment in these MSAs.

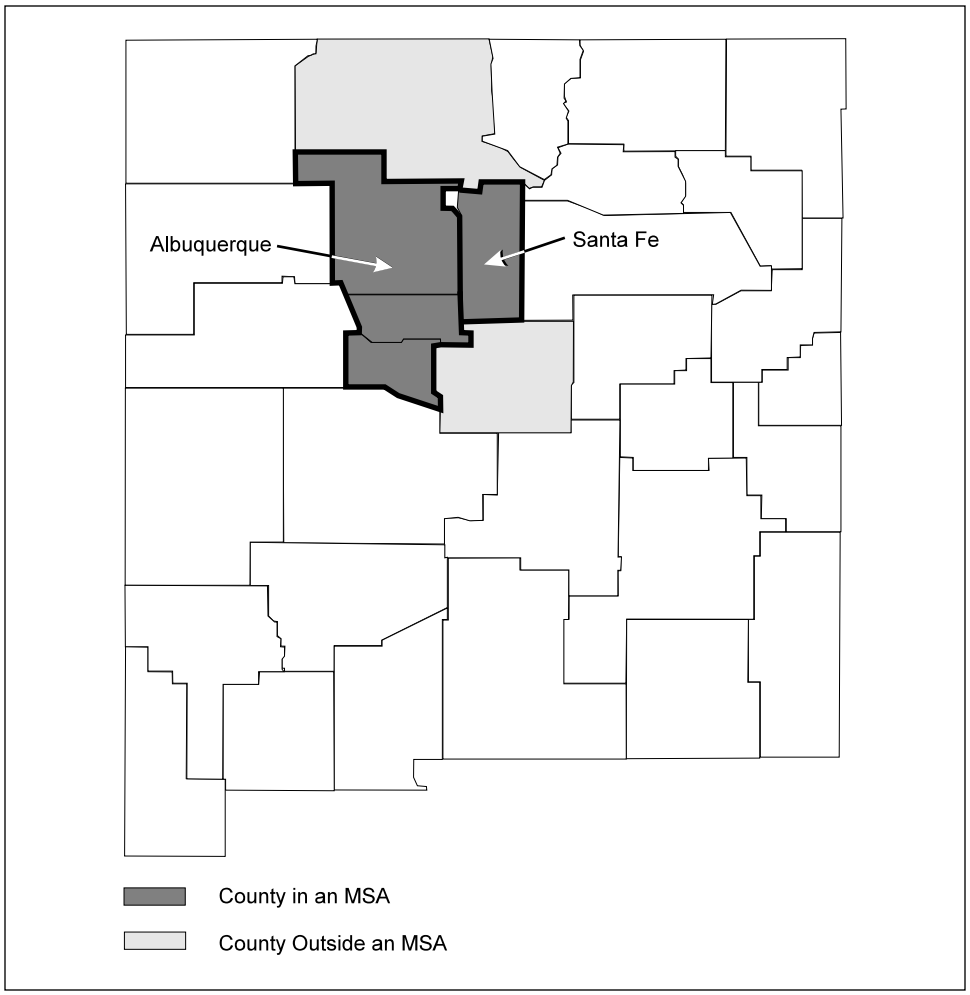
Risk HMO enrollment patterns for lower payment/higher enrollment counties in Washington and Arizona were not nearly as clear as for those in Oregon. In Washington, where HMOs generally had a strong presence, counties exhibited the lower payment/higher risk enrollment mix, but that enrollment was not as clearly concentrated. Higher risk enrollment extended beyond the counties located in MSAs and bordering MSAs with higher enrollment in risk HMOs to counties not directly adjacent to these MSAs. Counties in two Arizona MSAs—Tucson and Phoenix-Mesa—had higher risk HMO enrollment and, in Tucson in particular, had a strong HMO presence. Their payment rates were in the intermediate category. Counties bordering the MSAs, however, had the higher enrollment/lower payment pattern. The higher enrollment/lower payment pattern also appeared in counties located in MSAs in seven other states in different parts of the country.

New Mexico and Colorado: Higher Risk HMO Enrollment Clustered in and Around MSAs

Counties in both New Mexico and Colorado exhibited the pattern described previously for Oregon. HMO presence was generally strong and higher levels of risk HMO enrollment were coupled with lower payment rates in several of the more urban counties in MSAs with a few adjoining counties also having higher enrollments in risk HMOs. Elsewhere in the two states, enrollment rates were considerably lower.

In New Mexico, the counties with higher enrollments in Medicare risk HMOs were in and around the Albuquerque and Santa Fe MSAs and had lower AAPCC rates. (See fig. II.1.) About 48 percent of New Mexico's Medicare beneficiaries lived in the six counties in and around the two MSAs, but about 98 percent of the risk HMO enrollees in the state lived there. Risk HMO enrollment was particularly high in the Albuquerque MSA—about 34 percent of the Medicare beneficiaries in the MSA's three counties were enrolled.

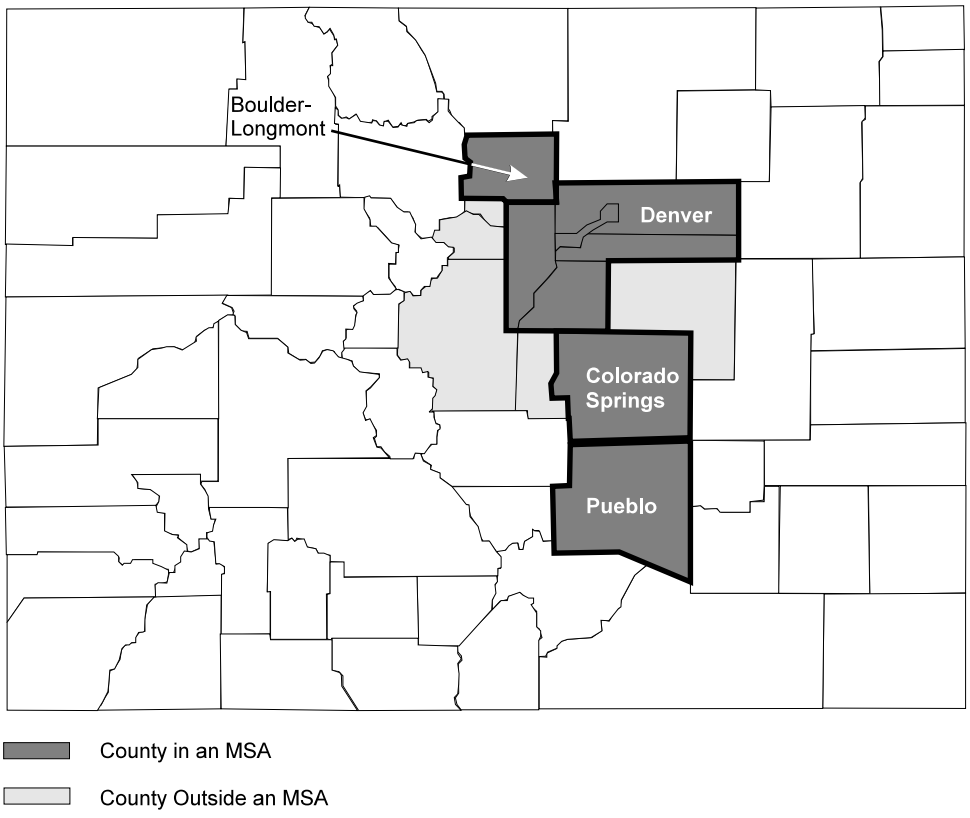
Figure II.1: Six New Mexico Counties With Higher Enrollment in Risk HMOs and Lower AAPCC Rates, December 1995



Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

In Colorado, about two-thirds of the Medicare beneficiaries and about 99 percent of the Medicare risk HMO enrollees lived in and around four MSAs—Boulder-Longmont, Colorado Springs, Denver, and Pueblo. (See fig. II.2.) Risk enrollment was highest in the Denver MSA—about 30 percent of the Medicare beneficiaries were enrolled in December 1995. Table II.1 shows risk HMO enrollment figures for counties in and around selected New Mexico and Colorado MSAs.

Figure II.2: 13 Colorado Counties With Higher Enrollment in Risk HMOs and Lower and Intermediate AAPCC Rates, December 1995



Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

Table II.1: Risk HMO Enrollment for Six New Mexico and Eight Colorado Counties, December 1995

	County	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs
New Mexico		
Albuquerque	Sandoval	37.6
	Valencia	35.8
	Bernalillo	32.8
Santa Fe	Santa Fe[a]	18.4
Borders Albuquerque and Santa Fe	Torrance	17.6
Borders Albuquerque and Santa Fe	Rio Arriba	9.4
Colorado		
Denver	Jefferson	31.2
	Douglas[b]	22.8
Boulder-Longmont	Boulder	18.6
Pueblo	Pueblo	17.3
Colorado Springs	El Paso	11.7
Borders Denver and Colorado Springs	Elbert	10.0
Borders Denver	Park	9.7
Borders Denver and Colorado Springs	Teller	6.7

[a]The other county in the Santa Fe MSA—Los Alamos—had 4.2 percent risk HMO enrollment.

[b]The three other counties in the Denver MSA had intermediate AAPCC rates and higher enrollments in risk HMOs: Adams County, 34.4 percent enrollment; Arapahoe County, 29.9 percent; and Denver County, 28.3 percent. Two counties bordering the Denver MSA also had intermediate AAPCC rates and higher enrollments in risk HMOs: Gilpin County, 15 percent enrollment, and Clear Creek County, 11 percent.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

Of the six New Mexico and Colorado MSAs shown in table II.2, the two with the highest enrollment in risk HMOs—Albuquerque and Denver—also had a strong HMO presence.

Table II.2: Risk HMO Enrollment, Total HMO Enrollment, and Number of HMOs in New Mexico and Colorado MSAs, 1995

MSA/state	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs[a]	Percentage estimated total HMO enrollment in MSA[b]	Number of HMOs serving MSA[c]
Albuquerque, NM	33.6	33.2	5
Denver, CO	30.3	27.4	9
Boulder-Longmont, CO	18.6	49.2	4
Pueblo, CO	17.3	26.0	4
Santa Fe, NM	16.6	8.2	4
Colorado Springs, CO	11.7	19.1	4

[a]Data as of December.

[b]Includes estimated commercial, Medicare, and Medicaid enrollment; data as of January.

[c]The same HMO can serve more than one MSA; data as of January.

Sources: Medicare Market Penetration Report File and other selected files, Office of Managed Care, HCFA; and InterStudy, Competitive Edge, 5.2 ed. (Minneapolis, Minn.: 1995).

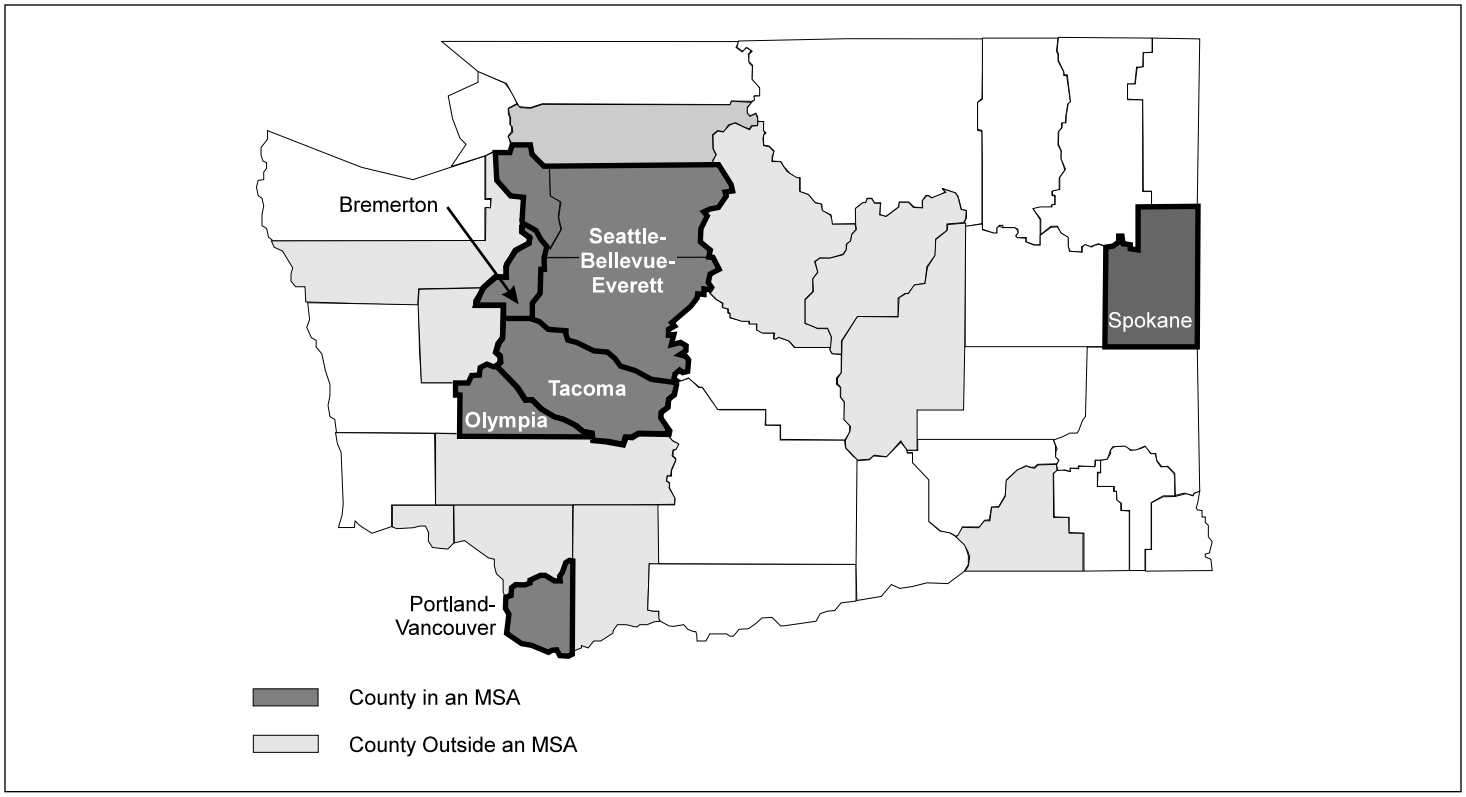
Washington: Risk HMO Enrollment Extends Beyond MSAs

As in Oregon, New Mexico, and Colorado, higher enrollment in risk HMOs in Washington was primarily concentrated in counties with lower AAPCC rates that were also in and around MSAs—Seattle-Bellevue-Everett,[24] Tacoma, Olympia, and Bremerton in the western part of the state and Spokane in the eastern part.[25] But as figure II.3 shows, in Washington higher enrollment in risk HMOs also exists in counties that are neither in nor adjacent to MSAs with higher enrollment.

[24]One county, King, had higher enrollment in risk HMOs and intermediate AAPCC rates. King is part of the Seattle-Bellevue-Everett MSA.

[25]Clark County, Washington, is part of the Portland-Vancouver MSA.

Figure II.3: 19 Washington Counties With Higher Enrollment in Risk HMOs and Lower and Intermediate AAPCC Rates, December 1995



Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

Table II.3 shows that HMO presence was relatively strong in several of the six Washington MSAs. Overall, total HMO enrollment ranged from about 50 percent in Olympia to about 11 percent in Tacoma.

Table II.3: Risk HMO Enrollment, Total HMO Enrollment, and Number of HMOs in Six Washington MSAs, 1995

MSA/state	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs[a]	Percentage estimated total HMO enrollment in MSA[b]	Number of HMOs serving MSA[c]
Portland-Vancouver, OR-WA[d]	41.3	41.8	10
Seattle-Bellevue-Everett, WA	24.7	17.3	8
Olympia, WA	20.3	50.3	6
Tacoma, WA	12.4	11.1	4
Bremerton, WA	8.8	18.5	3
Spokane, WA	6.8	36.0	7

[a]Data as of December.

[b]Includes estimated commercial, Medicare, and Medicaid enrollment; data as of January.

[c]The same HMO can serve more than one MSA; data as of January.

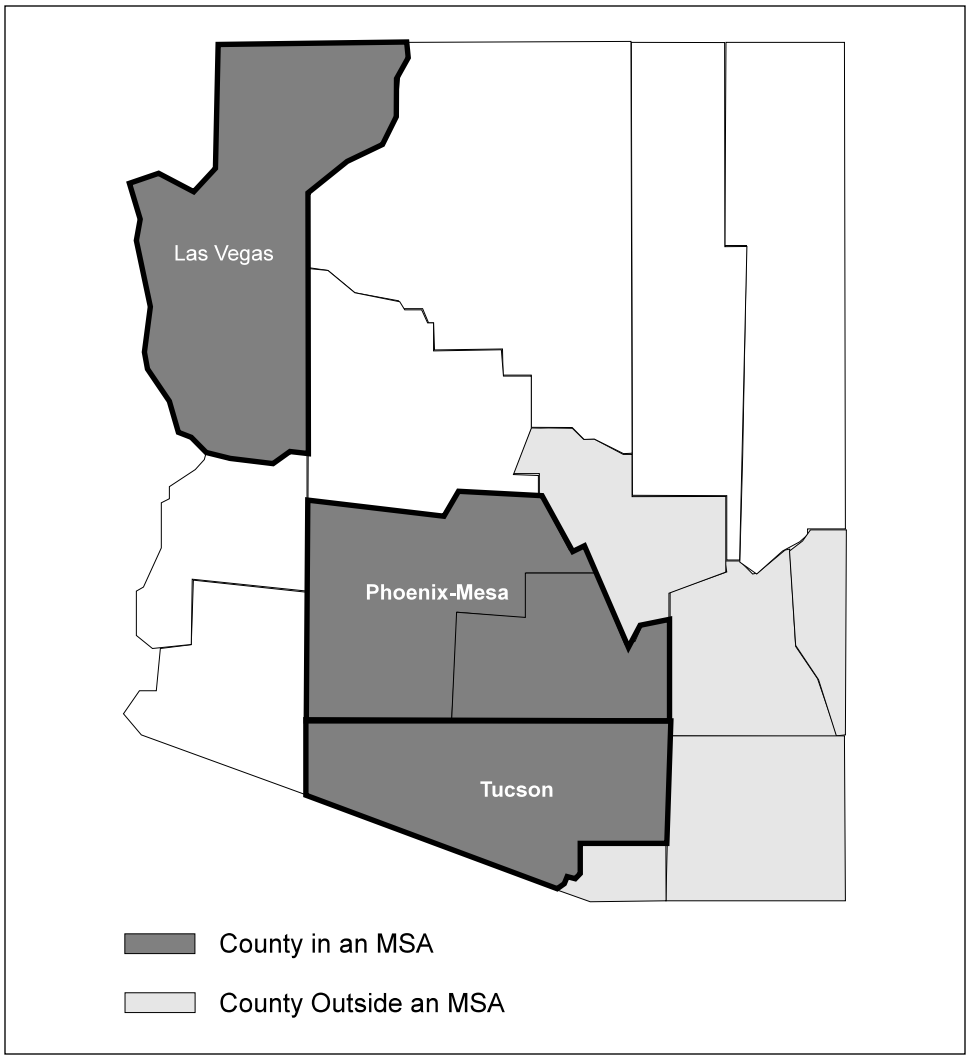
[d]Only one Washington county—Clark—is in this MSA. The remaining counties in this MSA are in Oregon.

Sources: InterStudy, Competitive Edge, 5.2 ed. (Minneapolis, Minn.: 1995); and Medicare Market Penetration Report File and other selected files, Office of Managed Care, HCFA.

Arizona: Risk HMO Enrollment Concentrated in MSAs With Higher Payment Rates

In Arizona, higher enrollment in risk HMOs was primarily concentrated in two MSAs—Tucson and Phoenix-Mesa. The counties in the MSAs all had higher AAPCC rates than those in such MSAs as Albuquerque and Portland. The payment rates in Tucson and Phoenix-Mesa fell in the intermediate category. But for the counties outside Arizona's MSAs where enrollment was higher for risk HMOs, the payment rates were usually lower. Figure II.4 shows the Arizona counties with higher enrollments in risk HMOs.

Figure II.4: Nine Arizona Counties With Higher Enrollment in Risk HMOs and Lower and Intermediate AAPCC Rates, December 1995



Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; and U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994).

Tucson, which had an especially high enrollment for risk HMOs—nearly 42 percent—also had a strong HMO presence as table II.4 shows.

Table II.4: Risk HMO Enrollment and Total HMO Enrollment for Nine Arizona Counties, 1995

	County	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs[a]	Percentage estimated total HMO enrollment in MSA[b]
Tucson	Pima[c]	41.7	42.0
Phoenix-Mesa	Maricopa[c]	34.7	25.3
	Pinal[c]	33.7	
Borders Tucson and Phoenix-Mesa	Graham	28.5	[d]
Borders Tucson	Santa Cruz	26.0	[d]
Borders neither Tucson nor Phoenix-Mesa	Greenlee	24.4	[d]
Borders Tucson	Cochise	21.8	[d]
Borders Phoenix-Mesa	Gila[c]	21.9	[d]
Las Vegas	Mohave[c]	10.0	20.5

[a]Data as of December.

[b]Includes estimated commercial, Medicare, and Medicaid enrollment; data as of January.

[c]This county had an intermediate AAPCC rate—between $375 and $464.

[d]Not applicable.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994); and InterStudy, Competitive Edge, 5.2 ed. (Minneapolis, Minn.: 1995).

Higher Enrollment in Risk HMOs in Other MSAs With Lower Payment Rates

Counties in MSAs in California, Florida, Hawaii, Minnesota, Oklahoma, Pennsylvania, and Texas had lower AAPCC rates but higher percentages of beneficiaries enrolled in risk HMOs. Minneapolis-St. Paul had a large number of Medicare beneficiaries enrolled in risk HMOs. Risk enrollment in several southern California and Florida MSAs was also higher despite lower AAPCC payment rates. Even parts of several MSAs in Pennsylvania had higher enrollments in risk HMOs despite lower payment rates.

Table II.5 shows the risk HMO enrollment rates for the counties in the Minneapolis-St. Paul MSA. Risk enrollment was higher—about 19 percent—compared with many areas of the country but not nearly as high as in several western MSAs even though total HMO enrollment in the Minneapolis-St. Paul MSA was close to 40 percent.

Table II.5: Risk HMO Enrollment for All Counties in the Minneapolis-St. Paul MSA, December 1995

County/state	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs
Anoka, MN	26.1
Ramsey, MN[a]	22.8
Hennepin, MN	20.0
Washington, MN	19.2
Dakota, MN	17.0
Scott, MN	9.3
Carver, MN	8.4
Sherburne, MN	6.9
Chisago, MN	6.4
Isanti, MN	3.6[b]
Wright, MN	3.2[b]
St. Croix, WI	1.1[b]
Pierce, WI	0.6[c]

[a]This county had an intermediate AAPCC rate—between $375 and $464.

[b]Intermediate risk enrollment.

[c]Lower risk enrollment.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA.

Risk enrollment patterns were less clear in the remaining six states. Table II.6 compares the total HMO enrollment and risk HMO enrollment where at least one county in an MSA had more than 5 percent of its Medicare beneficiaries enrolled in a risk HMO and where the AAPCC rate was in the lower payment category. These MSAs had varying degrees of risk enrollment ranging from being higher in Florida to lower in Pennsylvania.

Table II.6: 17 MSAs With One or More Counties That Received Lower or Intermediate AAPCC Rates and Had Higher Risk HMO Enrollment, 1995

MSA/state	Percentage of eligible Medicare beneficiaries enrolled in risk HMOs[a]	Percentage estimated total HMO enrollment in MSA[b]	Number of HMOs serving MSA[c]
Daytona Beach, FL	31.8	14.7	3
Santa Barbara-Santa Maria-Lompoc, CA	31.2	23.1	6
San Luis Obispo-Atascadero-Paso Robles, CA	28.6	2.9	2
San Antonio, TX	27.1[d]	12.5	7
Fort Worth-Arlington, TX	14.7[e]	14.1	8
Gainesville, FL	11.9	13.9	1
Tulsa, OK	11.2[f]	13.4	5
Williamsport, PA	11.2	7.9	2
Fresno, CA	9.9	22.0	8
State College, PA	9.4	11.3	3
Honolulu, HI	9.1	23.3	7
Ocala, FL	9.0	[g]	[g]
Yuba City, CA	7.5[h]	5.5	3
Scranton-Wilkes Barre-Hazleton, PA	5.9[i]	10.3	2
Oklahoma City, OK	5.1	11.4	5
Austin-San Marcos, TX	4.8[j]	26.3	4
Harrisburg-Lebanon-Carlisle, PA	3.1[k]	14.1	2

(Table notes on next page)

[a]Data as of December.

[b]Includes estimated commercial, Medicare, and Medicaid enrollment; data as of January.

[c]The same HMO can serve more than one MSA; data as of January.

[d]Includes Bexar County, which has higher risk HMO enrollment and an intermediate AAPCC rate.

[e]Includes Tarrant County, which has higher risk HMO enrollment and an intermediate AAPCC rate.

[f]Includes Tulsa and Wagoner counties, which have higher risk HMO enrollment and intermediate AAPCC rates.

[g]Data not available.

[h]Includes Yuba County, which had an intermediate AAPCC rate.

[i]Includes Lackawanna, Luzerne, and Wyoming counties, which all have higher risk HMO enrollment and intermediate AAPCC rates.

[j]Includes Travis County, which had a risk HMO enrollment rate of 6.7 percent.

[k]Lebanon County had a risk HMO enrollment rate of 5.2 percent. The three remaining counties in the MSA had the following risk enrollment and AAPCC rate combinations: Cumberland County, intermediate enrollment/lower AAPCC; Dauphin County, intermediate enrollment and AAPCC; and Perry County, lower enrollment/intermediate AAPCC.

Sources: Medicare Market Penetration Report File, AAPCC Rate File, and other selected files, Office of Managed Care, HCFA; U.S. Bureau of the Census, County and City Data Book: 1994 (Washington, D.C.: U.S. Government Printing Office, 1994); and InterStudy, Competitive Edge, 5.2 ed. (Minneapolis, Minn.: 1995).

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