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Report to Congressional Requesters

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MEDICARE+CHOICE

Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001

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Contents

Abbreviations

ACRP	adjusted community rate proposal
BBA	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare and Medicaid Services
FFS	fee-for-service
HCFA	Health Care Financing Administration
M+C	Medicare+Choice

MCO	managed care organization
PMPM	per member per month

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Congressional Requesters

Between 1998 and 2001, the total number of contracts under Medicare's managed care program, Medicare+Choice (M+C), fell from approximately 340 to 180. The reduction largely reflected the decisions of some managed care organizations (MCO) to terminate selected contracts or to discontinue service in certain covered areas. Although nearly all MCOs renewed at least some of their Medicare contracts over this period, many reduced the geographic areas served by one or more of their health plans.[1] As a consequence of both the contract terminations and the service area reductions, approximately 1.6 million beneficiaries have had to switch MCOs or return to Medicare's traditional fee-for-service (FFS) program. Recently, more MCOs have announced their intention to either terminate or reduce their participation in M+C at the end of 2001. These withdrawals are expected to affect approximately 536,000 of the 5.6 million beneficiaries currently enrolled in M+C plans.

Concerned about the potentially disruptive effect of MCO withdrawals from certain areas on Medicare beneficiaries and the overall reduction in their health plan choices, Congress has attempted to make participation in the M+C program more attractive to MCOs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) slowed the implementation of scheduled M+C payment reforms and established a new-entry bonus payment in areas where M+C plans were not being offered.[2] More recently, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000[3] (BIPA) increased M+C payments on March 1, 2001. For the typical M+C plan, Medicare monthly, per enrollee payments increased by an average of $16 per member per month

[1]The terms "MCO" and "plan" are frequently used interchangeably. In this report, we follow Medicare's definitions and make a distinction between the two terms. Medicare defines a plan as a specific package of benefits offered by an MCO in a particular geographic area. An MCO is a corporation or other business entity. It can have one or more Medicare contracts and offer one or more M+C plans under each contract. These plans may be offered in the same geographic area but have different benefits—for example a high option plan and a low option plan—or they may be offered in different geographic areas and may or may not have the same benefits.

[2]P.L. 106-113, App. F, Sec. 511 and 512, 113 Stat. 1501, 1501A-380, and 1501A-382.

[3]P.L. 106-554, App. F, Sec. 601, 114 Stat. 2763, 2763A-554.

(PMPM), although the increase was much higher for some plans and lower for others. As a result of BIPA, aggregate M+C payments in 2001 are estimated to have increased by nearly $1 billion.

When BIPA was enacted, M+C contracts for the 2001 benefit year had already been approved and the benefit package established for each plan. Therefore, the legislation required MCOs to submit a revised contract proposal for each plan that explained how the payment increase would be used. BIPA permitted three basic uses for the higher payment. MCOs could (1) improve their health plans' benefit packages, (2) set aside money for future years in a benefit stabilization fund, or (3) stabilize or enhance beneficiary access to providers.

To assist in further congressional deliberations on M+C participation and payment issues, you asked us to examine (1) how MCOs used the additional money authorized by BIPA in 2001 and (2) the extent to which the availability of M+C plans changed after BIPA. To conduct our study, we analyzed data maintained by the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare, and interviewed agency officials responsible for implementing BIPA's M+C payment provisions.[4] We reviewed all MCOs' initial (pre-BIPA) and revised (post-BIPA) 2001 contract proposals, which contained detailed information on their health plans' costs and covered benefits. We also consulted all seven MCOs that contracted to serve new areas following the passage of BIPA. Our work was done from July through October 2001 in accordance with generally accepted government auditing standards.

Results in Brief

For the majority of M+C plans, MCOs reported that additional money authorized under BIPA would be used to stabilize or enhance beneficiary access to providers; for a minority of M+C plans, MCOs reported that the money would go toward benefit improvements or be placed in a benefit stabilization fund. MCOs stated that some or all of the additional money would be used to stabilize or enhance beneficiary access in about 83 percent of M+C plans. Following guidance from the Health Care Financing Administration (HCFA)—the former name for CMS—MCOs could meet the beneficiary access option by increasing payment rates to providers,

[4]On June 14, 2001, the Secretary of HHS announced that the name of the Health Care Financing Administration (HCFA) had been changed to the Centers for Medicare and Medicaid Services (CMS). In this report we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

contracting with additional providers, or revising their original estimates of beneficiaries' use of health care services during 2001. In nearly 29 percent of M+C plans, MCOs used some or all of their additional money to improve benefits. These improvements, which affected about a quarter of all M+C enrollees, primarily consisted of reduced premiums or lowered cost-sharing requirements. MCOs added or enhanced coverage of pharmaceuticals and other services in a few of their plans. These improvements affected about 3 percent of all M+C enrollees.

The payment increase provided by BIPA had little effect on the availability of M+C plans during 2001. Following BIPA, three MCOs reentered counties they had dropped from their service areas, three MCOs expanded into counties that they previously had not served, and one MCO both reentered previously served counties and expanded into new ones. A total of 15 counties were affected by expanded plan availability. All but 21,000 of the approximately 750,000 beneficiaries living in those counties already had access to at least one M+C plan in 2001. In the 11 counties that MCOs reentered, payment rate increases ranged from $56 to $110 PMPM, reflecting a 13 to 27 percent payment increase. Two of these counties were also affected by MCO expansions. In the four counties where MCOs expanded their health plans' service areas but no MCO reentered, payment rate increases were generally smaller and ranged from $8 to $54 PMPM (or 1 to 11 percent higher). The payment rate increases in 13 of the 15 affected counties exceeded the national average increase of $16 among all counties served by MCOs. Representatives of the three MCOs that reentered counties stated that the higher payments authorized by BIPA were the reason their plans reentered. Representatives of the MCO that both reentered counties and expanded into new ones also stated that the higher payments motivated their decision to increase their plan's service area. However, representatives of the three MCOs that expanded their service areas stated that they would have done so without the increased payment. CMS generally agreed with our results.

Background

The M+C program, established by the Balanced Budget Act of 1997[5] (BBA), grew out of Medicare's previous managed care option known as the risk-contract program. BBA included provisions designed to expand the number and type of health plan choices available to Medicare beneficiaries. BBA also modified the method used to set payment rates,

[5]P.L. 105-33, Sec. 4001, 111 Stat. 251, 275 (classified at 42 U.S.C. 1395w-21 et seq.).

both to encourage MCOs to serve new geographic areas and to pay them more appropriately for the beneficiaries they enrolled. Since the first of BBA's payment reforms were implemented, MCOs have terminated some of their Medicare contracts and reduced the geographic areas served under other contracts. As a result, many beneficiaries previously enrolled in M+C plans have had to switch plans or return to the FFS program. In 1999, and again in 2000, Congress passed legislation that increased payment rates in an effort to make participation in the M+C program more attractive for MCOs.

As of September 2001, about 5.6 million people—or approximately 14 percent of Medicare's 40 million beneficiaries—were enrolled in M+C plans. Overall, approximately two-thirds of all beneficiaries lived in areas served by at least one MCO, but M+C plan availability varied among locations. Most beneficiaries living in urban areas, but less than one-quarter of beneficiaries living in rural areas, had access to one or more M+C plans.

Payments, Benefits, and the Contract Approval Process

MCOs receive a fixed monthly payment for each beneficiary enrolled in their health plans, regardless of the actual cost of an individual enrollee's care. Because Medicare establishes separate payment rates for each county, the amount that Medicare pays for a specific beneficiary depends, in part, on the beneficiary's county of residence.[6] The beneficiary's demographic characteristics and an indicator of his or her health status also affect the monthly payment. These adjustments are made to the county rate so that the payment amount better reflects the expected health care costs of the specific beneficiary.

Benefit packages—in terms of premiums, required cost sharing, and covered services—vary among M+C plans. All plans must cover the services available in the FFS program, with the exception of Medicare's hospice benefit. MCOs may include additional benefits in their health plans, such as coverage for routine physical examinations and outpatient prescription drugs. Every July, as part of the annual contracting process,

[6]Subject to CMS' approval, MCOs determine the geographic areas—typically a single county or group of contiguous counties—where they will provide services to Medicare beneficiaries. Under some circumstances, an MCO may receive approval to offer a plan that serves only part of a county. In general, a M+C plan must serve any Medicare beneficiary within its defined service area unless the plan has reached its membership capacity and has stopped enrolling new members.

MCOs must estimate how much it will cost them to provide Medicare-covered benefits during the next calendar year. These estimated costs, which may include the organization's normal profits, are supposed to reflect the premiums that the MCOs would charge to commercial and other customers, adjusted to reflect differences in Medicare's covered benefits and beneficiaries' expected use of services. For each M+C plan they intend to offer, MCOs submit a document, known as an adjusted community rate proposal (ACRP), that contains detailed estimates of the plan's expected costs and revenues associated with providing covered benefits, and a description of the plan benefit package. CMS reviews each ACRP and compares the estimated costs to the plan's projected Medicare revenues. If the estimated costs are less than the projected Medicare revenues, the MCO must either use the difference to cover additional benefits or contribute to a benefit stabilization fund that it can draw on to augment the plan's revenues in future years. The cost of any additional benefits or stabilization fund contributions must also be detailed in the ACRP.

BBA's Payment Rate Reforms

Before 1998, Medicare's managed care payment rate in each county was set equal to 95 percent of FFS per capita spending in that county, adjusted for certain demographic characteristics of the beneficiaries living in the county to account for differences in service use associated with those characteristics. These county payment rates—reflecting the underlying pattern of FFS spending—ranged from $221 to $767 PMPM in 1997. This variation in payment rates may have contributed, along with many other factors, to the uneven availability of Medicare managed care options across the country. Our work and research by others has found that the methodology used to adjust payments for the expected service use of enrolled beneficiaries did not adequately reflect the above average health status and below average expected health costs of typical M+C enrollees. Consequently, Medicare paid MCOs substantially more than it likely would have spent if beneficiaries enrolled in M+C plans had instead received services in the FFS program.[7]

[7]We estimated that these excess payments totaled about $3.2 billion in 1998, when some, but not all, of BBA's payment reforms had been implemented. See *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (GAO/HEHS-00-161, Aug. 23, 2000) and *Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (GAO/HEHS-97-16, Apr. 25, 1997).

Beginning in 1998, BBA substantially modified the method used to set county payment rates for M+C plans. Some of the modifications were designed to reduce excess payments, while others were designed for other purposes—such as increasing program participation of MCOs in geographic areas that historically had low payment rates. Specifically, the law required that each county's payment rate equal the highest of three rates: a minimum amount, or "floor" (set at $367 in 1998 and increased each year); a minimum increase (2 percent) over the previous year's payment rate; or a blend of historical FFS spending in a county and national average costs adjusted for local price levels. BBA required, for five years, that the annual payment rate updates to the floor and blend rates be lower than the increases in national FFS per capita spending. The law also mandated that by 2000, M+C payments be adjusted to reflect the health status of plans' enrollees.

MCO Withdrawals

In the years following the implementation of BBA's payment and other reforms, MCOs terminated approximately 160 Medicare contracts and reduced the size of the geographic areas served under many of the contracts they renewed. Approximately 1.6 million beneficiaries had to switch to a different M+C plan or return to the FFS program because of these withdrawals. CMS expects that an additional 536,000 beneficiaries will be affected by withdrawals that will occur at the end of 2001. Most of the affected beneficiaries live in areas where other M+C plans are available, but approximately 38,000 beneficiaries will no longer have access to a M+C plan and will have to return to the FFS program.[8]

Managed care industry representatives have attributed the withdrawals to BBA's payment reforms and new administrative requirements for MCOs. The representatives have stated that the payment reforms and the cost of meeting the new administrative requirements make it difficult for MCOs to offer benefit packages that are attractive to beneficiaries.

[8]Approximately 53,000 beneficiaries will continue to have access to a M+C plan, but not one offered by an MCO. These beneficiaries have the option of enrolling in a fee-for-service M+C plan. Beneficiaries enrolled in this type of M+C plan may obtain health care services from any provider willing to accept the plan's payments. Medicare's payment to the plan is calculated as it would be for any other M+C plan and beneficiaries may be required to contribute a monthly premium or cost sharing.

M+C Payment Increases Included in BBRA and BIPA

To help maintain and expand beneficiary access to M+C plans, Congress twice revised the M+C program and modified BBA's payment reforms. In 1999, Congress passed BBRA, which provided for new-entry bonus payments to MCOs that contracted with Medicare to serve areas where no M+C plans were being offered.[9] The law also affected payment rates by modifying implementation of certain BBA payment reforms.[10] In December 2000, Congress passed BIPA, which increased payment rates in all counties in March 2001. Before BIPA took effect, the floor rate was $415 PMPM in 2001. BIPA created a new rate category for counties located in metropolitan areas of at least 250,000 people and established $525 as the floor rate for those counties in 2001; for all other counties, the law increased the floor rate to $475.[11] BIPA also mandated that 2001 county payment rates exceed 2000 rates by at least 3 percent, a 1 percentage point increase in the minimum annual update specified in BBA.[12] The increases in county rates that resulted from these changes ranged from about $5 to $110 PMPM (or 1 to 27 percent). The legislation also extended BBRA's new-entry bonus payments to counties where all existing Medicare MCOs had indicated they would withdraw at the end of 2001.

Beginning in March 2001, as a result of BIPA, the average payment rate increase for M+C plans ranged from less than $1 to more than $100 PMPM.[13] The amount of the increase depended on the specific counties each plan served and its expected enrollment in each county. Half of the M+C plans received overall payment rate increases of less than $10 PMPM, while the other half received $10 PMPM or more. BIPA provided that

[9]BBRA set the new entry bonus at 5 percent of the M+C county payment rate for the first 12 months of operation and 3 percent of the M+C county payment rate for the subsequent 12 months (42 U.S.C. 1395w-23(i)).

[10]BBRA slowed the phase-in of payment adjustments based on beneficiary health status and increased the annual update for floor and blend rates in 2002 (42 U.S.C. 1395w-23(a)(3)(C)).

[11]42 U.S.C. 1395w-23(c)(1)(B)(iii).

[12]42 U.S.C. 1395w-23(c)(1)(C)(iii). In about half of the counties, the payment rate increased by $40, while in the other half the rate increased more. However, because many of the counties with large payment rate increases had few or no beneficiaries enrolled in M+C plans, the average county rate increase per enrollee was about $16.

[13]Although the payment rates increased in each county by a minimum of about $5 as a result of BIPA, some plans' projected average payment rate increased by less than $5. This occurred in some instances in which MCOs revised the enrollment projections for a plan and assumed that a larger proportion of the plan's membership would come from the lower-payment counties in the plan's service area.

MCOs could use the additional money for each plan toward any combination of the following options:

- Improve the benefit package by
  - Reducing beneficiary premiums,
  - Reducing beneficiary cost sharing,
  - Adding benefits,
  - Enhancing benefits;
- Contribute to a benefit stabilization fund; or
- Stabilize or enhance beneficiary access to providers.

BIPA required MCOs to submit revised contract proposals to cover that portion of the 2001 contract year—March through December—when the increased payment rates would be in effect and explain how they would use the additional money.[14] The schedule for the submission and approval of the revised contracts, however, was compressed compared to the typical schedule. HCFA had originally announced the 2001 payment rates in March 2000. MCOs were not required to submit their 2001 contract proposals until July 2000—four months after the rates were announced. HCFA then spent two months reviewing and approving the contracts. Under BIPA's time frames, the process—HCFA' development and announcement of the new county rates, MCOs' preparation and submission of contract proposals, and HCFA's review and approval of those proposals—happened within six weeks.

MCOs Used BIPA Payment Increase for Stabilizing Access More Frequently Than for Benefit Improvements

MCOs reported that some or all of the BIPA payment increase would be used to stabilize or enhance beneficiary access to providers for the majority of their M+C plans.[15] Some of these MCOs stated that they would increase provider payments or contract with additional providers, but others—consistent with HCFA guidelines—may have revised their cost projections and reported that the additional money would be used to help offset projected cost increases. MCOs used additional money to improve their benefit packages for one-fourth of their plans—primarily by reducing

[14]P.L. 106-554, Sec. 604(c), 114 Stat. 2763A-556.

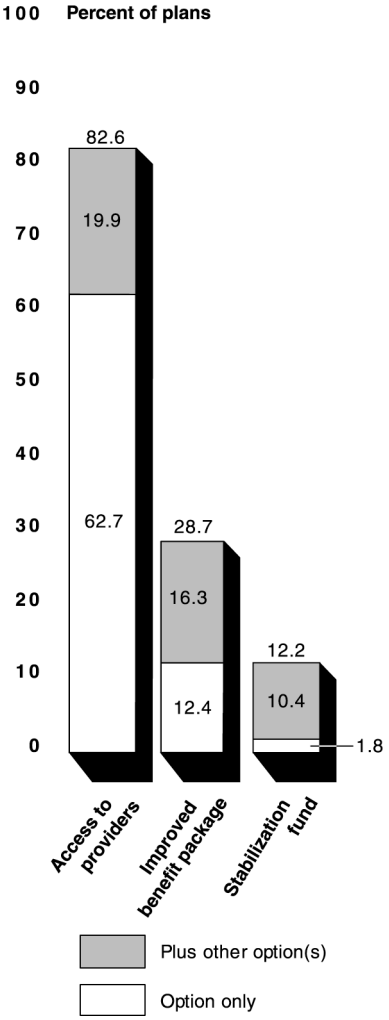
[15]We reviewed 543 M+C plans for which MCOs filed both initial and revised ACRPs. MCOs reported that they would devote the additional payments to one of BIPA's three options for about 77 percent of their plans. For the other plans, MCOs reported they would split the additional payments among two or three of the options.

the monthly premiums they charged to beneficiaries. MCOs put additional money into a benefit stabilization fund for a few of their plans.

For Most M+C Plans, Additional Money Used to Stabilize or Enhance Beneficiary Access to Providers

For about 83 percent of the 543 M+C plans, MCOs reported that some or all of the additional money authorized by BIPA would be used to stabilize or enhance beneficiary access to providers (see fig. 1). In about 63 percent of M+C plans, the entire BIPA payment increase was slated for this purpose. In about 20 percent of M+C plans, MCOs reported that they would also improve the benefit packages or contribute to a benefit stabilization fund.

Figure 1: Reported Use of Increased Payments by M+C Plans, 2001



Source: GAO analysis of plans' estimates of expected costs and revenues associated with providing covered benefits.

In HCFA's instructions for filing revised ACRPs, the agency stated that MCOs could increase provider payment rates to help stabilize beneficiary access to providers. Alternatively, MCOs could contract with additional providers to enhance beneficiary access to providers. HCFA also stated that MCOs could revise their previous cost projections—for example, by updating assumptions regarding enrollees' use of services, unit costs, or composition of enrollees—if the revisions would stabilize or enhance beneficiary access to providers. MCOs could then use any projected cost

increases to offset the BIPA payment increase and thus reduce the amount that they might otherwise spend on increases in provider payments, benefit improvements, or contributions to the stabilization fund.[16] MCOs were required to submit justifications of any projected changes in costs along with their revised ACRPs.[17] HCFA did not review these justifications, but they are potentially subject to audits.[18]

In some instances in which MCOs stated that the additional money would be used to improve access to providers, the ACRP justifications clearly stated that the MCO intended to contract with additional providers or increase provider payment rates. Some MCOs that increased provider payment rates explained that that they did so voluntarily to help retain existing providers or expand their provider networks. Other MCOs stated that contractual arrangements required them to increase provider payment rates because those rates were specified as a percentage of Medicare's payment.

For Some M+C Plans, Additional Money Used to Improve Benefit Packages

MCOs used some or all of the BIPA payment increase to improve the benefit packages in about 29 percent of plans. For these plans, MCOs reduced beneficiary premiums or cost sharing, added new benefits, or enhanced coverage for existing benefits. MCOs used the entire payment increase for benefit package improvements in approximately 12 percent of plans and used a portion of the payment increase for this purpose in another 16 percent of plans.[19]

[16]According to HCFA's instructions regarding the submission of revised ACRPs, increases to plans' administrative costs were prohibited unless the increase significantly and directly stabilized or enhanced beneficiary access to providers or directly enhanced benefits. MCOs could also revise revenue projections for their plans and use any decreases to offset increased payments resulting from BIPA.

[17]Because the justifications submitted by MCOs did not follow a standard format and varied widely in the extent of information each contained, we could determine the number of plans that reported they would stabilize or enhance beneficiary access to providers, but we could not always identify the specific approach they used. Thus, we could not specify the number of plans that increased provider payment rates, increased the number of providers, or increased underlying cost assumptions.

[18]BBA required the Secretary of Health and Human Services to provide for an annual audit of the ACRPs from one-third of the MCOs participating in M+C. (42 U.S.C. 1395w-27(d)).

[19]If plans used the additional money to improve the benefit package, HCFA allowed MCOs to devote some of the BIPA payment increase to administrative expenses or to the expense category that includes profit and other additional revenues.

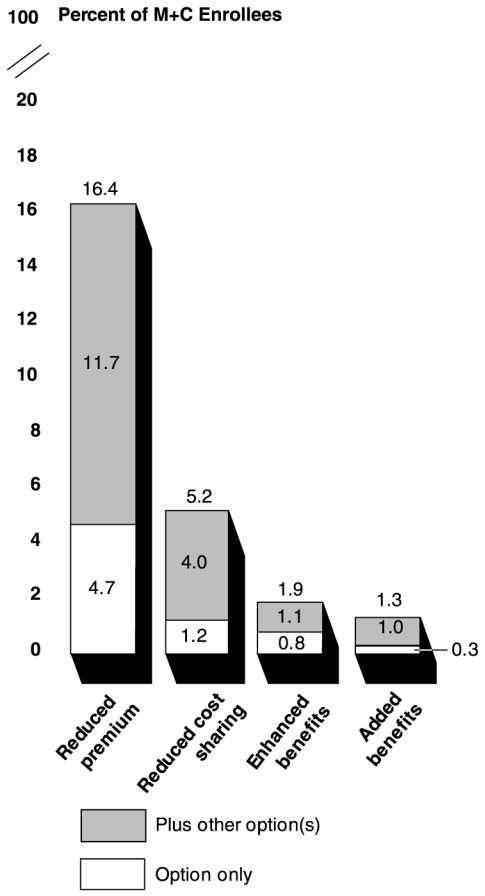
Most plans (86 percent) did not have any changes in their premiums as a result of BIPA.[20] Premiums were reduced in 12 percent of plans and eliminated entirely in 2 percent. The maximum premium fell from $250 to $200 PMPM while the lowest premium required remained unchanged at $4 PMPM among plans that charged a premium. The average premium fell by $2 overall from $25 to $23 PMPM.

Approximately 1.4 million beneficiaries (25 percent) enrolled in M+C plans received improved benefits as a result of BIPA. The typical improvement, affecting more than 900,000 beneficiaries (16.4 percent), was a premium reduction (see fig. 2). For these beneficiaries, the median premium reduction was $10 per month, although some premiums dropped by as much as $59 while others fell by only $2. More than 100,000 of these beneficiaries—about 2 percent of total M+C enrollment—were enrolled in plans in which premiums were eliminated. Previously, these beneficiaries had paid premiums that ranged from $10 to $59 per month. The second most frequent benefit package improvement was a reduction in required cost sharing, which affected about 290,000 beneficiaries (5.2 percent of total M+C enrollment).[21]

[20]Prior to BIPA, roughly two-thirds of all plans required a beneficiary premium.

[21]Cost sharing increased for some beneficiaries. CMS allowed MCOs to increase cost sharing required by their plans in conjunction with the addition of new benefits or the expansion of existing benefits.

Figure 2: M+C Enrollees Affected by Benefits Improvements Due to Increased Plan Payments, 2001



Source: GAO analysis of plans' estimates of expected costs and revenues associated with providing covered benefits.

Relatively few M+C enrollees received enhanced service benefits (105,000 or 1.9 percent) or additional service benefits (72,000 or 1.3 percent) as a result of BIPA. Many beneficiaries who received enhanced or additional service benefits saw improvements in their coverage for prescription drugs. Approximately 50,000 beneficiaries were enrolled in M+C plans in which MCOs enhanced existing drug coverage. Another 53,000 beneficiaries were enrolled in M+C plans in which the MCO added drug coverage as a new benefit. Some MCOs also added or improved coverage for hearing aids, preventive dental services, and a variety of other services.

For Few M+C Plans, Additional Money Contributed to a Benefit Stabilization Fund

MCOs put some or all of their additional money into an escrow-like account, known as a benefit stabilization fund, for about 12 percent of their plans (see fig. 1). An MCO that contributes a portion of a plan's Medicare payments to such a fund can draw on its accumulated contributions to help finance the cost of that plan's benefits in future years. By drawing on its stabilization fund, an MCO may avoid having to increase beneficiary premiums or reduce coverage for non-Medicare benefits in years when it expects to retain less of Medicare's payment after paying for Medicare-covered benefits.

For less than 2 percent of M+C plans, MCOs put all of the additional money into a benefit stabilization fund. These amounts ranged from about $5 to $37 PMPM. For approximately 10 percent of their plans, MCOs applied some (2 percent to 78 percent) of the payment increase to a benefit stabilization fund for the plan. Among these plans, the median contribution was 34 percent of the BIPA payment increase. The dollar contributions for these plans ranged from less than $1 PMPM to $55 PMPM with a median contribution of $9 PMPM.

MCOs have always had the option of placing a portion of a plan's Medicare payments into a benefit stabilization fund. Historically, however, MCOs have not used this option but instead used the full payment amount to cover costs in the current year. An industry trade association has suggested that some MCOs may have used the benefit stabilization funds in 2001 because of the short time frames associated with the implementation of the BIPA payment changes. According to the association, some MCOs may have decided they had too little time to renegotiate provider contracts or to change their health plans' benefit packages. However, short time frames may not have been the only factor because some MCOs that offer multiple health plans in the same geographic area used the stabilization funds for some of their health plans but not others.

BIPA Had Little Effect on Beneficiary Access to M+C Plans in 2001

BIPA had little effect on the number of beneficiaries with access to at least one M+C plan in 2001. Seven MCOs, offering a total of 12 M+C plans, either reentered counties they had previously dropped from their service areas or expanded into counties they had not previously served. However, all but 21,000 of the approximately 750,000 beneficiaries living in the affected counties already had access to a M+C plan. All of the counties that MCOs reentered, but only 2 of the counties into which MCOs expanded, received above average payment rate increases. Interviews with

MCO representatives suggest that BIPA influenced MCOs' reentry but not expansion decisions.

Following BIPA, Seven MCOs Increased Geographic Service Areas

Following BIPA's enactment, seven MCOs contracted to serve additional geographic areas (see table 1). Three of these MCOs reversed earlier decisions and reentered counties they had dropped from their 2001 service areas. Three others expanded their service areas into counties that they previously had not served. The seventh MCO both reentered previously served counties and expanded into new counties. In addition to these 7 MCOs, 15 other MCOs submitted applications to expand their geographic service areas or begin service in new areas, but these applications had not been approved as of October 2001.

Table 1: MCOs That Reentered M+C or Expanded Their Service Areas After BIPA, 2001

MCOs	Affected market (State and counties)	Medicare beneficiaries in market, September 1, 2001[a]	Market enrollment December 1, 2000	Market enrollment September 1, 2001	Month participation effective, 2001
Reentry					
Univera HealthCare Central New York	NY: Onondaga, Cortland, Cayuga,[b] Oswego,[b] and Madison[b]	124,000	2,131	0	March
United Health Care of the Midwest	IL: Monroe	4,000	484	200	March
St. Joseph Healthcare	NM: Bernalillo, Sandoval, Torrance, and Valencia	97,000	4,546	5,968	January[c]
Expansion					
Blue Cross and Blue Shield of Massachusetts	MA: Hampshire[b,d]	21,000	1,630	1,882	May
United Healthcare Insurance Co.	OH: Franklin and Hamilton	264,000	NA	731	June
Managed Health Inc.	NY: New York[b]	220,000	80	131	September
Reentry and expansion					
Lovelace Health Systems	NM: Santa Fe, Sandoval, and Torrance[b]	29,000	3,200	3,178	March and May

[a]Numbers rounded to the nearest thousand.

[b]MCO serves only a part of the county. Beneficiary counts are for whole counties and overstate the number of affected beneficiaries.

[c]St. Joseph Healthcare asked for and received permission to return effective January 1, 2001.

[d]Portion of county affected by expansion not previously served by an MCO.

Source: GAO analysis of CMS/HCFA data and GAO interviews with MCO officials.

The MCOs' reentry and expansion decisions did not substantially increase the number of beneficiaries who had access to a M+C plan. Nearly all (97 percent) of the approximately 750,000 beneficiaries living in affected counties already had access to at least one M+C plan in 2001. For these beneficiaries, the reentry and expansion decisions increased the number of M+C plans from which they could choose. Blue Cross and Blue Shield of Massachusetts expanded into additional portions of a county that it already partially served.[22] The expansion affected less than 21,000 beneficiaries.

As of September 2001, the seven MCOs that had contracted to serve additional geographic areas had enrolled a total of about 12,000 beneficiaries. About half of these beneficiaries (5,968) were enrolled in St. Joseph Healthcare. This MCO had intended to discontinue service in four counties in New Mexico as of January 2001. Following BIPA, the MCO reversed its earlier decision and proposed including the four counties in its service area. St. Joseph Healthcare obtained permission from HCFA to serve the four counties during January and February. Thus, St. Joseph Healthcare operated without a disruption in service. The other three MCOs that reentered previously served counties had to disenroll their members in those counties at the end of December 2000 and could not reenroll them until March 2001 when the BIPA payment increase went into effect. Many of the disenrolled beneficiaries did not return to their original plans. As of September 2001, these three MCOs had enrolled about 2,200 beneficiaries in the affected counties—substantially less than their combined enrollment level at the end of 2000.

The four MCOs that expanded their service areas had not enrolled many beneficiaries as of September 2001. However, one of the four MCOs had only begun service in its expansion area during September. The four MCOs' aggregate enrollment increased by approximately 460 beneficiaries in the counties affected by the expansions.[23]

[22]Blue Cross and Blue Shield did not qualify for the new-entry bonus because a portion of the county was already being served by an MCO.

[23]Includes enrollment increases that may have occurred in portions of the counties previously served by the MCOs.

BIPA Influenced MCOs That Reentered Counties, but Not MCOs That Expanded Into New Counties

BIPA payment rate increases were greater in all of the counties that MCOs reentered and in two of the counties where MCOs expanded, compared to the overall average payment rate increase of $16 PMPM (about 3 percent) in counties with M+C enrollment. In the nine counties that MCOs reentered but where no MCO expanded, the payment rate increases ranged from $56 PMPM (13 percent) to $110 PMPM (27 percent) (see table 2). Payment rate increases were generally lower in the four counties where MCOs expanded but no MCO reentered, and ranged from $8 (1 percent) to $54 (11 percent). The smallest payment increase occurred in New York County, NY where the pre-BIPA 2001 payment rate was $772—substantially above the national average county payment rate of $463. Two counties in New Mexico—Sandoval and Torrance—were affected by one MCO's reentry and another MCO's expansion. The payment rate increased by $110 (27 percent) in Sandoval County and $60 (15 percent) in Torrance County—increases similar to those in the reentered-only counties.

Table 2: Pre-BIPA and Post-BIPA Payment Rates in Counties That Medicare MCOs Reentered or Included in a Service Area Expansion, 2001

	Counties where MCOs reentered only (N = 9)	Counties where MCOs reentered and expanded (N = 2)	Counties where MCOs expanded only (N = 4)
County payment rates, 2001			
Pre-BIPA	$415–$443	$415	$471–$772
Post-BIPA	$475–$525	$475–$525	$525–$779
Payment rate increase	$56–$110	$60–$110	$8–$54
	13%–27%	15%–27%	1%–11%
Average county payment rate increase	$88	$85	$22
	21%	20%	4%

Source: GAO analysis of CMS data.

According to representatives of the MCOs that reentered previously served counties, the BIPA payment increase was primarily responsible for their decision to return to those counties. Representatives of the MCO that both reentered counties and expanded into new ones also stated that the higher payments motivated their decision to increase their plan's service area. In contrast, representatives of the three MCOs that expanded their service areas said that the additional payments authorized by BIPA did not influence their decisions at all. These representatives generally said that their MCOs had decided to expand before BIPA passed or that expansion was a good business decision regardless of the payment increase.

Concluding Observations

In the short run, BIPA has had a limited effect on M+C plans' benefit packages. For most M+C plans, MCOs reported that the additional money resulting from BIPA would be used to maintain or improve beneficiary access to providers. MCOs used the additional money to improve their plans' benefit packages—most often by reducing premiums—or to contribute to benefit stabilization funds for less than half of all their plans. BIPA increased the number of M+C plans available to some beneficiaries, but it largely did not extend choice to beneficiaries who were not previously served by MCOs. Although seven MCOs increased the size of their health plans' service areas, approximately 97 percent of the beneficiaries living in the 15 affected counties already had access to at least one M+C plan.

However, the longer-term effects of BIPA may differ from the effects in 2001. MCOs had only a few weeks to react to the legislation and decide how they would use the increased payments. Over time, new county payment rates established by BIPA may have a greater influence on the geographic areas that plans serve and the benefits they offer.

Agency Comments

In commenting on a draft of this report, CMS generally agreed with our results. CMS noted that MCOs may not have had sufficient time to react to the legislation and reconsider and reverse carefully considered financial decisions, or to rebuild provider networks. Technical comments were incorporated as appropriate. The full text of CMS' comments appears in appendix I.

As we agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies of this report to the Administrator of CMS and to interested parties upon request. If you or your staffs have any questions about this report, please call me at (202) 512-7119. This report was prepared under the direction of James Cosgrove, Assistant Director, by Zachary Gaumer, Jim Hahn, and Jennifer Podulka.

Laura A. Dummit
Director, Health Care—Medicare Payment Issues

List of Requesters

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

The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

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

The Honorable Benjamin L. Cardin
The Honorable William Coyne
The Honorable Lloyd Doggett
The Honorable William Jefferson
The Honorable John Lewis
The Honorable Michael McNulty
The Honorable Karen Thurman
House of Representatives

Appendix I: Comments From the Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE:

TO: Laura A. Dummit
Director, Health Care—Medicare Payment Issues
General Accounting Office

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, *MEDICARE+CHOICE: Recent Payment Increases Had Little Effect On Benefits, Plan Availability In 2001* (GAO-02-202)

We appreciate the opportunity to comment on the GAO report.

In general, the Centers for Medicare & Medicaid Services agree with the results of the analysis by GAO and its concluding observations. Specifically, CMS agrees with the general observation that the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2001 (BIPA) provided a relatively short time period to enable renewing Medicare+Choice (M+C) organizations to determine how to use additional payments. Likewise, non-renewing organizations had little time to reconsider and reverse their carefully determined financial decisions. In addition, we note that BIPA may not have allowed enough time for these M+C organizations to rebuild provider networks, which were dismantled once their decision not to renew had been made.

We look forward to working with GAO on this and other issues in the future.

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