NATIONAL AND LOCAL FACTORS DRIVING HEALTH PLAN WITHDRAWALS FROM MEDICARE+CHOICE

ANALYSES OF SEVEN MEDICARE+CHOICE MARKETS

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FIELD REPORT

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EXECUTIVE SUMMARY

The future of Medicare+Choice, Medicare's managed care program, is in question. In the last three years, beneficiary enrollment in Medicare+Choice has declined from a high of 6.3 million in 1999 to less than 5.7 million in 2001. Meanwhile, a total of 151 health plans terminated their Medicare+Choice contracts during this period, while another 165 health plans reduced their service areas. The result: nearly 1.7 million beneficiaries have been displaced by a Medicare+Choice plan in one of the last three years. In January 2001 alone, a total of 934,000 beneficiaries were affected, of whom 159,000 were left without any health plan choice.

An often-cited reason for large-scale health plan withdrawals from Medicare+Choice relates to health plan payment rates, particularly the limits Congress established for annual rate increases in the Balanced Budget of 1997. In recent years, most plans have been limited to 2 percent annual rate increases, at a time when medical cost inflation has run more than twice the amount of payment increases.

This report examines reasons for withdrawals in seven Medicare+Choice markets: Cleveland, Houston, Los Angeles, Minneapolis–St. Paul, New York, Tampa–St. Petersburg, and Tucson. The analysis reveals that local market dynamics strongly influenced health plans' decisions to withdraw from the Medicare+Choice program in 2000 and 2001. While payment rates, which the federal government sets on a county-by-county basis, were a factor in decisions by plans to terminate or reduce their Medicare+Choice contracts, interviews with plan, provider, and community sources reveal that rates cannot entirely explain plan withdrawals.

Scant evidence exists that Congress's efforts to increase payments to Medicare+Choice plans as a way of bolstering the program actually prevented plans from leaving Medicare+Choice. In Houston, where the local average payment rate for plans per member per month runs a generous $651, seven Medicare+Choice plans left the market. Although it is necessary to increase Medicare+Choice plan payment rates to help stabilize the program, the study of seven sites shows that a host of local factors influenced plans' decisions to withdraw. These include:

- increases in utilization and costs of medical care, such as prescription drugs;
- health care providers' unwillingness to accept capitated payment rates or even to contract with Medicare+Choice plans;

- lack of local decision-making with regard to plan viability (i.e., decisions are made by plans' national headquarters, not by local offices);

- fears of adverse selection; and

- low market share.

Medicare+Choice is not a single national program, but is made up of local markets around the nation. Although raising payment rates will help stabilize the floundering program, local factors need to be addressed as well. These, though, are more difficult to address than increasing payment rates across the board.

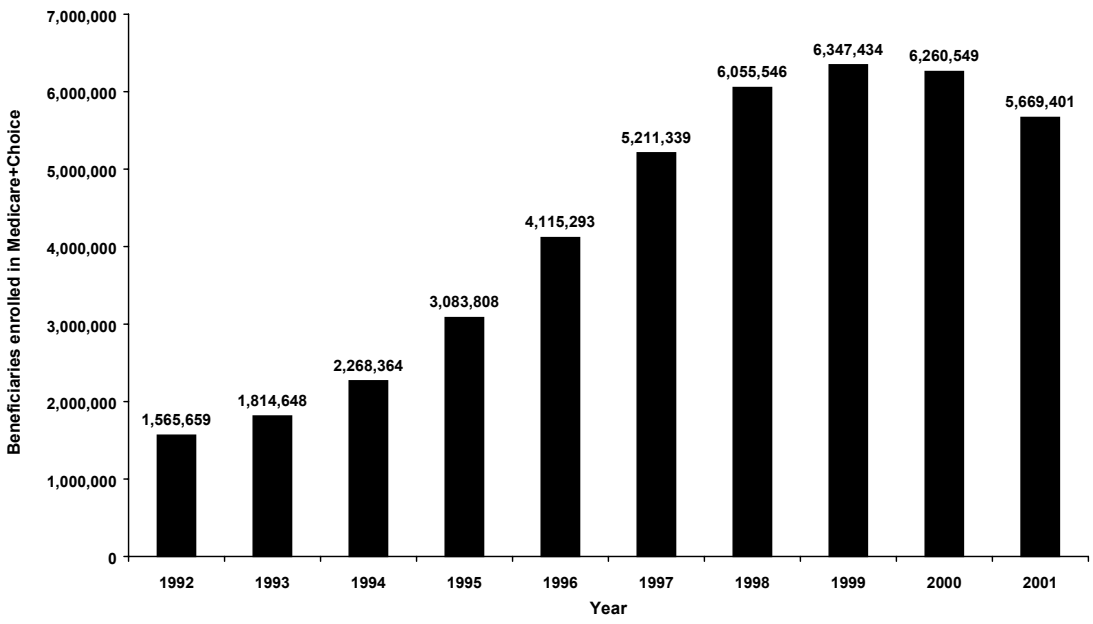
NATIONAL AND LOCAL FACTORS DRIVING HEALTH PLAN WITHDRAWALS FROM MEDICARE+CHOICE

ANALYSES OF SEVEN MEDICARE+CHOICE MARKETS

INTRODUCTION

A significant portion of Medicare beneficiaries, approximately 14 percent, have enrolled in managed care plans, principally to reduce their out-of-pocket health care costs and to obtain benefits, particularly prescription drugs, unavailable under traditional fee-for-service Medicare.[1] Nationally, the number of beneficiaries in Medicare health plans grew from nearly 1.6 million in 1992 to 6.3 million in 1999. By 2001, the number of Medicare health plan enrollees declined to 5.7 million.[2]

Figure 1. National Enrollment in Medicare+Choice, 1992–2001



Source: Health Care Financing Administration.

In an effort to expand Medicare beneficiaries' choice of private health plans, the Balanced Budget Act of 1997 (BBA) authorized Medicare+Choice, a new Part C, to Medicare.[3] Some policymakers also wanted to increase enrollment in Medicare+Choice plans to set the stage for possible future structural changes in Medicare. In practice, however, substantial numbers of health plans have withdrawn from the Medicare+Choice program over the past three years. Of the 261 so-called health plan "risk contracts" in effect in July 2000, 65 were terminated while 53 service areas were reduced, as of January 2001 (Table 1).

Table 1. Medicare+Choice Plan Withdrawals and Service Area Reductions, 1999–2001

	January 1999	January 2000	January 2001
Terminations	45	41	65
Service Area Reductions	54	58	53
Enrollees who could not stay in their plan	407,000	327,000	934,000
Enrollees in counties where all plans withdrew	50,000	79,000	159,000

* Withdrawals were announced in July and effective January of the following year.

Source: HCFA announcements July 15, 1999, HCFA fact sheet "Protecting Medicare Beneficiaries After Medicare+Choice Organizations Withdraw," June 2000, and HCFA Financial Report Fiscal Year 2001.

Plan withdrawals can be disruptive and costly for members. Beneficiaries need to find new coverage arrangements, may pay higher premiums, accept different and often diminished benefits, and/or switch health care providers. Plan withdrawals are the most disruptive for lower-income beneficiaries and for seniors with chronic illnesses, who often have high prescription drug costs. These beneficiaries have few alternatives from which to obtain prescription drugs.

Medicare HMO withdrawals in 2001 affected more than 900,000 seniors and disabled persons nationwide, nearly one-sixth of the 6.2 million Medicare beneficiaries enrolled in Medicare+Choice and more than 2 percent of the 39 million Americans receiving Medicare (Table 2). Of these beneficiaries, 159,000 (17%) no longer have the option to join another Medicare+Choice plan.

Table 2. Beneficiaries Affected by HMO Withdrawals Nationally, 1999–2001*

Year	Beneficiaries Affected	Percent of M+C Enrolled Population	Percent of Medicare Population
1999	407,000	6.3%	1.0%
2000	327,000	4.7%	0.8%
2001	934,000	13.6%	2.3%

* "Beneficiaries Affected" is the number enrolled in a plan at the deadline for plans to announce withdrawal. For example, the 1999 row refers to beneficiaries affected by withdrawals as of 6/99 in a plan that withdrew effective 1/00.

Source: HCFA announcement, July 15, 1999; HCFA fact sheet "Protecting Medicare Beneficiaries After Medicare+Choice Organizations Withdraw;" MedPAC's, "Medicare+Choice: Trends Since the Balanced Budget Act"; and HCFA quarterly state/county market penetration reports, June 1998, June 1999, June 2000.

This paper discusses the reasons for Medicare+Choice plan withdrawals based on site visits to seven Medicare+Choice markets in 1999 and 2000: Cleveland, Houston, Los Angeles, Minneapolis–St. Paul, New York City, Tampa–St. Petersburg, and Tucson.

The overall finding is that local market dynamics strongly influenced plans' decisions to withdraw from the Medicare+Choice program. Monthly payment rates by

Medicare to HMOs did not entirely explain Medicare+Choice plan withdrawals in 2000 and 2001, said plan, provider, and community representatives.

Major local factors that led to plan withdrawals included increases in utilization and costs and a growing unwillingness of providers to accept capitated payment rates or even to contract with Medicare plans. Other considerations included concerns about plan adverse selection (defined in this context as enrolling a disproportionate number of older and sicker beneficiaries) and low market share in certain locales.

In an effort to deal with plan withdrawals and benefit reductions, Congress in 2000 authorized $11 billion in extra Medicare+Choice funding over the next five years. Specifically, the Benefits Improvement and Protection Act (BIPA) increased the minimum monthly Medicare+Choice payment rate to $525 in any metropolitan statistical area with a population greater than 250,000 and to $475 in other areas. BIPA also increased payments by 1 percent to other counties and provided a new entry bonus in counties without plans, as of October 2000.

There is little evidence, however, that the additional funding BIPA provided to plans was enough incentive for withdrawing plans to return to the Medicare+Choice program in the short term.[4] Since BIPA does not address any of the local market factors identified in the seven cities, BIPA's provisions are unlikely to address the instability in the Medicare+Choice program.

MEDICARE PLAN WITHDRAWALS IN SEVEN CITIES

Throughout much of the 1990s, HMO enrollment grew steadily in all seven study sites except for Minneapolis–St. Paul. Growth was most dramatic in Cleveland and Houston, where HMO market penetration rates grew by more than 500 percent from December 1993 to December 1999[5] (See Figure 2 on page 13).

Significant Plan Withdrawals Affected Beneficiaries in Five of Seven Study Sites

Plan withdrawals at the end of 1998, 1999, and especially 2000, however, resulted in a substantial decline in Medicare+Choice enrollments in every site except New York City. Medicare HMO pullouts effective in January 2001 affected more than 144,000 Medicare+Choice enrollees, ranging from 11 to 85 percent of beneficiaries in the seven cities (Table 3).

Table 3. Percent of M+C Enrolled Population Affected by HMO Withdrawals, 1998–2000

Site	Percentage of M+C Enrolled Population		
	1998	1999	2000
Cleveland	0.0%	0.5%	33.0%
Houston	2.5%	0.1%	85.1%
Los Angeles	9.2%	0.0%	2.8%
Minneapolis–St. Paul	1.8%	0.0%	20.9%
New York City	1.8%	0.4%	1.6%
Tampa–St. Petersburg	3.0%	0.9%	11.2%
Tucson	0.0%	8.8%	25.9%

Source: Analysis of HCFA enrollment data and geographic service area reports.

For example, in 2001 the extent of plan withdrawals was substantial in five cities:

- In Houston, seven of eight plans left, affecting 66,135 (85%) Medicare beneficiaries enrolled in Medicare+Choice plans. More beneficiaries were impacted by withdrawals in Harris County than in any other county nationwide. Since the announcement of plan withdrawals in July 2000, two new plans have entered Houston's Medicare market as of March/April 2001.

- In Minneapolis–St. Paul, one of three plans quit the Medicare+Choice market, affecting 37,347 beneficiaries (35%) of those enrolled in plans.[6]

- In Cleveland, three of eight plans withdrew from the Medicare+Choice market, displacing 21,000 (33%) enrollees.

- In Tucson, two of four plans left the Medicare+Choice market, impacting approximately 16,000 (26%) enrolled beneficiaries.

- In Tampa–St. Petersburg, three of eight plans left the area at the end of 2000. These withdrawals affected over 13,000 (11%) of Medicare+Choice enrollees.

Number of Medicare+Choice Plans Decreased in All Study Sites from 2000 to 2001

The number of Medicare+Choice plans increased in all seven study cities from 1993 to 1998 (Table 4). The number of plans decreased, however, in all study cities from 1998 to 2001.

Table 4. Number of Medicare+Choice Plans in Seven Study Sites: December 1993–March 2001

	Number of Plans				
Site	**12/93**	**12/98**	**12/99**	**12/00**	**3/01**
Cleveland	1	9	9	8	5
Houston	2	11	9	8	3*
Los Angeles	11	14	11	11	10
Minneapolis–St. Paul	2	4	3	3	2
New York City	5	13	12	11	10
Tampa–St. Petersburg	2	9	8	8**	5
Tucson	3	8	7	4	2
TOTAL	26	68	59	53	37

* Although all but one plan left the Houston market at the end of 2000, two new plans (AmCare and SelectCare) entered the market.

** One plan (HIP) left the Tampa–St. Petersburg market and one plan (WellCare) entered the market in January 2000.

NATIONAL MEDICARE FACTORS CONTRIBUTED TO HMO WITHDRAWALS

Interviews with several plan, provider, and senior community sources revealed that both national Medicare factors and local market dynamics contributed to Medicare+Choice plan withdrawals. A number of national factors contributed to plan withdrawals, including payment rates and limited increases, early Medicare notification date requirements, and other regulatory burdens.[7]

Payment Rates

In the five sites with significant withdrawals, plan executives cited low base payment rates and a low rate of annual increase in payments as critical to their plans' decisions to withdraw from the program.

Table 5. Medicare+Choice Payment Rates in Seven Study Sites, 1998–2000

	Medicare+Choice Payment Rates		
Site	**1998**	**1999**	**2000**
Cleveland	$553.24	$564.30	$575.59
Houston*	$607.07	$619.21	$631.59
Los Angeles	$635.00	$647.70	$660.65
Minneapolis–St. Paul**	$422.30	$430.75	$464.16
New York City***	$728.88	$743.45	$758.32
Tampa–St. Petersburg****	$503.26	$513.33	$527.17
Tucson	$473.52	$482.99	$499.04

Note: 2000 figures represent Aged Part A + Part B payment rate not considering risk adjustment and rescaling factors.

* Harris County only.

** Average for Hennepin and Ramsey counties.

*** Average for New York, Kings, Queens, Bronx, and Richmond counties.

**** Average for Pinellas and Hillsborough counties.

The BBA effectively reduced payments to plans and locked in annual payment rate increases at 2 percent. Yet plan informants estimated medical care cost inflation rates of 7 to 10 percent per year with prescription drug cost increases from 12 to 20 percent. One executive summed up plans' concerns when he noted, "Continued efficiencies in managed care aren't going to negate increasing health care costs, including high-tech drugs, a rising medical inflation rate, and the availability of more complex and costly medical care."

HCFA's Early Notification Date

To allow time for adequate advance warning to Medicare enrollees of plan withdrawals, Medicare+Choice plans were required to notify HCFA on July 1 of each year of their intention to leave the Medicare+Choice market in the following year. Several plan representatives felt that this early notification date did not allow plans ample time to calculate current year expenditures, forcing them to make decisions without adequate financial information.

In addition, plan representatives felt that requiring all plans to make this decision "at once" created havoc because plans factor in the competitive environment when making withdrawal decisions. In Houston, the announcement by some plans that they were leaving the market created a domino effect. One Houston plan executive noted that because "so many plans pulled out unexpectedly," other plans, fearing they would be inundated with high-cost enrollees from withdrawing plans, panicked and pulled out too.

Regulatory Burden

Health plan compliance directors reported concerns about the administrative burden created by new BBA requirements. Plan representatives across study cities, consistent with other reports, echoed these concerns.[8] One plan executive noted, "M+C plans have administrative costs and issues that they just don't have on the commercial side. Getting into the Medicare business was much more expensive than any of the plans thought it would be."

Plan representatives were particularly concerned about the imposition of so many regulations at one time and the short time frame for implementing them. Payment issues and local market dynamics, however, were viewed as more important than regulatory requirements in influencing plan withdrawal decisions.

LOCAL FACTORS CONTRIBUTED TO HMO WITHDRAWALS

While Medicare payment rates are a factor for some exiting Medicare+Choice organizations, local market dynamics play an important role, according to plan and community representatives (Table 6). In Houston, for example, a relatively generous payment rate of $651 in 2001—third highest among the study cities—did not prevent seven of eight plans from leaving the Medicare+Choice program. Important local factors contributing to plan withdrawals include:

- provider pushback, or a growing unwillingness of providers to accept plan payment levels;
- increasing use and costs of care;
- national plans leaving local Medicare markets in favor of more lucrative employer-based enrollment;
- fear of adverse selection; and
- low market share.

Table 6. Local Market Dynamics Contributing to HMO Withdrawals

Site	Provider Pushback	Increasing Utilization Costs	National Plan Strategy	Fear of Adverse Selection	Plans with Low Market Share
Houston	√	√	√	√	√
Minneapolis–St. Paul	√	√		√	√
Tucson	√	√	√		√
Cleveland	√	√	√		√
Tampa–St. Petersburg	√	√	√		√

Source: Summary of project staff findings.

Provider Pushback on Plan Payments

Medicare+Choice plan officials described that providers and hospitals are less willing to accept payments and contracts, and in some cases were refusing altogether to contract with Medicare managed care plans. Across the seven cities, provider groups and hospitals were moving away from capitation and risk-based contracting and back to hospital per diem, diagnosis-related group (DRG), or physician fee-for-service payments.

"The days of providers accepting the risk for patient care are numbered," concluded one Cleveland HMO executive. "Risk-sharing is almost a dinosaur," agreed a consulting firm executive.[9]

Houston study respondents in particular stressed the importance of provider resistance to HMO contracting terms. Houston Medicare+Choice plans, especially the smaller ones, had less success at negotiating favorable contracts with provider groups and hospitals. Large provider groups were less willing to accept pharmacy risk and were moving away from accepting risk for hospital care. The city's hospitals were also threatening to cancel contracts if Medicare HMOs did not raise payment rates, and were negotiating fee-for-service contracts with plans.[10]

The strength of providers to define the terms of plan payment arrangements was fueled by the consolidation of providers into large organizations. Monopolistic entities in Tucson, Cleveland, and rural counties surrounding Tampa–St. Petersburg contributed to plan withdrawals, according to plan and community sources in those markets.

To remain competitive, Cleveland Medicare+Choice plans hold contracts with one of the two major health systems, University Hospitals Health System or the Cleveland Clinic Health System. These two hospital systems control nearly 70 percent of the area's inpatient bed capacity.[11] University Hospital system has its own Medicare HMO and no longer contracts with other Medicare HMOs. This gives the Cleveland Clinic tremendous "bargaining clout," noted one HMO executive. His HMO pulled out of Cleveland, in part because the Cleveland Clinic was "playing hardball," insisting on changing its contract in 2001 from a global cap to a per diem arrangement.[12]

Increasing Utilization and Costs of Services

Plans' inability to control utilization and costs of care, especially hospital days, was also an increasing problem for Medicare HMOs. The move away from risk-based contracting is eroding HMOs' ability to control utilization.[13]

One Minneapolis provider explained that although physicians in the city had learned how to manage utilization and to hold down costs, providers "seem weary" of this effort. He also noted that managing utilization is easier when plans have smaller and more defined provider networks because of the increased ability to monitor utilization and communicate with physicians about appropriate practice patterns. He was, therefore, not surprised when Medica, a plan with a broad network, decided to leave Minneapolis–St. Paul. The trend toward larger plan networks in several sites seems to have undermined plans' ability to reduce excess utilization, especially hospital bed days.

National Plan Decisions Regarding Local Medicare Markets

As part of a national strategy to increase profitability, some of the larger for-profit national HMOs withdrew from selected, or even many, local Medicare markets. The overall poor financial performance of some of these plans contributed to Medicare withdrawal decisions. Under financial pressure, national plans and insurers may choose to change the allocation of resources from city to city, from the Medicare market to the employer market, and for other competitive reasons.

The decision to withdraw from a market is made by executives located at plan headquarters, and not by those in the individual cities affected by such decisions. The plans often have little infrastructure in local cities and the actual investment in the local areas is relatively small.

In January 2001, CIGNA ended coverage for 104,000 Medicare beneficiaries in 11 states, while Aetna withdrew entirely from 11 states and 23 additional counties, dropping coverage for 355,000 Medicare enrollees.[14, 15] Prudential left 94 counties in 11 states, which affected 52,087 beneficiaries, and PacifiCare withdrew from 20 counties in 6 states, impacting 16,188 beneficiaries.[16]

Consumer advocates, beneficiaries, and plan executives felt that the for-profit status of these national HMOs could have been an important variable in some plans' decisions to leave local Medicare markets. For example, one Houston plan executive felt that Aetna's "bottom line" led to its withdrawal decision. She noted that "the plan will cut loose any product that isn't making its profit margin expectation." The nonprofit status of Twin City plans—even those with small operational margins—made them more committed to the community and less likely to desert the Medicare market, sources in Minneapolis–St. Paul said.

Adverse Selection

Controlling use of services and costs was difficult for some plans because their HMOs had a disproportionate number of older and sicker enrollees. The impact of adverse risk selection on their plans' ability to survive financially was of special concern to HMO representatives in Houston, Minneapolis, and Los Angeles.

With Minneapolis's long history of managed care, Medicare enrollees were older and, therefore, sicker compared to enrollees in other parts of the country. Medicare payment rates did not adequately adjust for the higher costs of caring for these aging enrolled populations, plan executives argued.

In Houston, the large exodus of plans from that market all at once caused one plan, which had a reputation for high-quality care, to leave the market when it was planning on remaining. According to plan representatives, concerns about attracting high-cost patients were instrumental in the plan's decision to withdraw from Houston.[17]

Low Market Share

Relative market share contributed to plan withdrawals in the study sites for two reasons. First, plans with small market share are more vulnerable to the effects of adverse risk selection because their enrolled population is not large enough to balance out the impact of a few very high-cost members. Second, smaller plans also have greater difficulty leveraging favorable contracts with providers. Small market share was a major factor in the decision to withdraw for plans in Cleveland and Houston.

Of the 35 plans that withdrew from the seven study sites from 1998 to 2000, 21 (60%) had less than 5 percent market share at the time of withdrawal. Meanwhile, 29 (83%) had less than a 10 percent market share (Table 7).

Table 7. Plan Characteristics of Withdrawing HMOs

Site/Plans	Date Entered Market	Tax Status	National or Local	Date of Withdrawal	Market Share at Time of Withdrawal
Cleveland					
CIGNA of Ohio	1997	For-Profit	National	1999	0.48%
Prudential of No. Ohio	1994	For-Profit	National	2000	16.88%
Aetna U.S. Healthcare	1994	For-Profit	National	2000	15.13%
SummaCare Health Plan	1996	For-Profit	Offered in Northeast Ohio	2000	0.95%
Houston					
Aetna	1997	For-Profit	National	1998	1.03%
HMO Blue	1998	For-Profit	National	1998	0.07%
PCA	1993	For-Profit	Offered in Florida and Texas	1998	8.86%
United HealthCare	1998	For-Profit	National	1999	0.07%
Humana	1988	For-Profit	National	2000	19.46%
NYLCare	1993 (as Sanus)	For-Profit	Offered in some Texas counties, owned by Aetna	2000	43.0%
Prudential	1995	For-Profit	National	2000	7.07%
Texas Health Choice	1996	For-Profit	Offered in Texas, owned by a Las Vegas-based company	2000	0.69%
CIGNA of Texas	1997	For-Profit	National	2000	1.34%
Mem. Sisters of Charity	1997	For-Profit	Offered in 33 Texas counties (bought by Humana)	2000	8.50%
MethodistCare	1999	For-Profit	Offered in 10 Texas counties	2000	5.04%
Los Angeles					
Care America	1990	For-Profit	Offered in 6 California counties	1998	8.68%
Prudential	1994	For-Profit	National	1998	0.46%
UnitedHealthcare of Calif.	1997	For-Profit	National	1998	0.05%
CIGNA of California	1994	For-Profit	National	2000	2.83%
Minneapolis–St. Paul					
Blue Plus	1995	Nonprofit	Offered in Minneapolis metro area	1998	1.77%
Medica Health Plan	1985	Nonprofit	Offered in Minneapolis metro area	2000	20.91%
New York City					
Prudential	1998	For-Profit	National	1998	0.34%
NYLCare	1992	For-Profit	National	1998	1.54%
Vytra Health Plans	1995	For-Profit	Offered in Queens only in 1999	1999	0.44%
CIGNA of New York	1996	For-Profit	National	2000	1.64%
Tampa–St. Petersburg					
PCA	1997	For-Profit	Offered in Florida and Texas	1998	2.95%
HIP	1995	Nonprofit	Offered in Florida and New York	1999	0.9%
Aetna U.S. Healthcare	1998	For-Profit	National	2000	0.82%
Prudential	1995	For-Profit	National	2000	4.97%
CIGNA of Florida	1995	For-Profit	National	2000	5.44%
Tucson					
Humana of Arizona	1988	For-Profit	National	1999	2.59%
BCBS of Arizona	1996	Nonprofit	Offered throughout Arizona	1999	6.0%
Premier*	1996	For-Profit	Offered in 15 Arizona counties	1999	0.17%
United Healthcare	1992	For-Profit	National	2000	19.2%
CIGNA of Arizona	1993	For-Profit	National	2000	6.69%

* Financial collapse, not voluntary withdrawal.

Source: HCFA enrollment reports, HCFA data on 2001 plan withdrawals, 1999 Medicare Compare database, geographic service area reports, and managed care reports.

DISCUSSION

The Medicare+Choice program is in turmoil in five of the seven cities studied. Plan withdrawals have left beneficiaries fearful that they can no longer rely on the Medicare+Choice program for the added benefits—especially prescription drugs—and the program stability they have come to expect from Medicare. In January 2001 alone, plan withdrawals from Cleveland, Houston, Minneapolis–St. Paul, Tampa–St. Petersburg, and Tucson affected from 11 to 85 percent of Medicare+Choice enrollees in each city, forcing 144,000 beneficiaries to join other HMOs or return to fee-for-service Medicare.

Both national and local market dynamics led plans to withdraw from Medicare. An analysis of local market dynamics in seven sites suggests that raising payment rates is not the only policy remedy needed to stabilize the Medicare+Choice program.

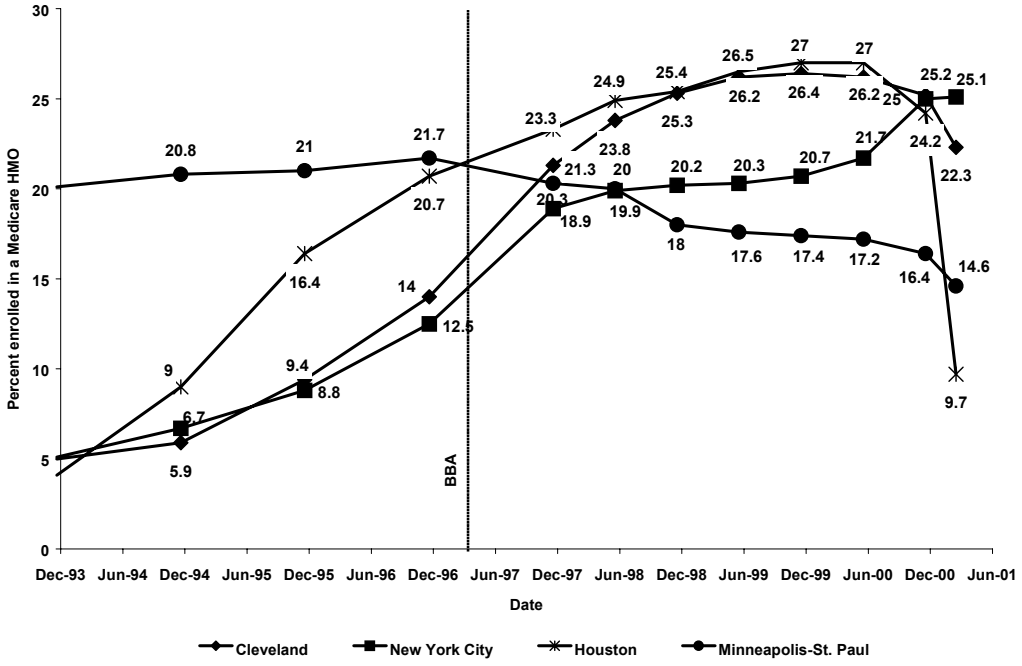
There is little evidence that added BIPA funds were enough of an incentive for withdrawing plans to return to the Medicare+Choice program or for existing plans to increase their benefit packages. BIPA funding resulted in just four plans nationwide reentering the market. The two new plans that entered Houston's Medicare+Choice market had decided to do so before BIPA was enacted, and few of the remaining plans in our study sites increased benefits or reduced premiums as a result of added BIPA funds. Nationwide, however, the majority of plans used BIPA funds to help stabilize their provider networks, addressing one element of program instability.[18] Increased BIPA funds have made further plan withdrawals unlikely, in the short term anyway, at least according to sources in Minneapolis–St. Paul.

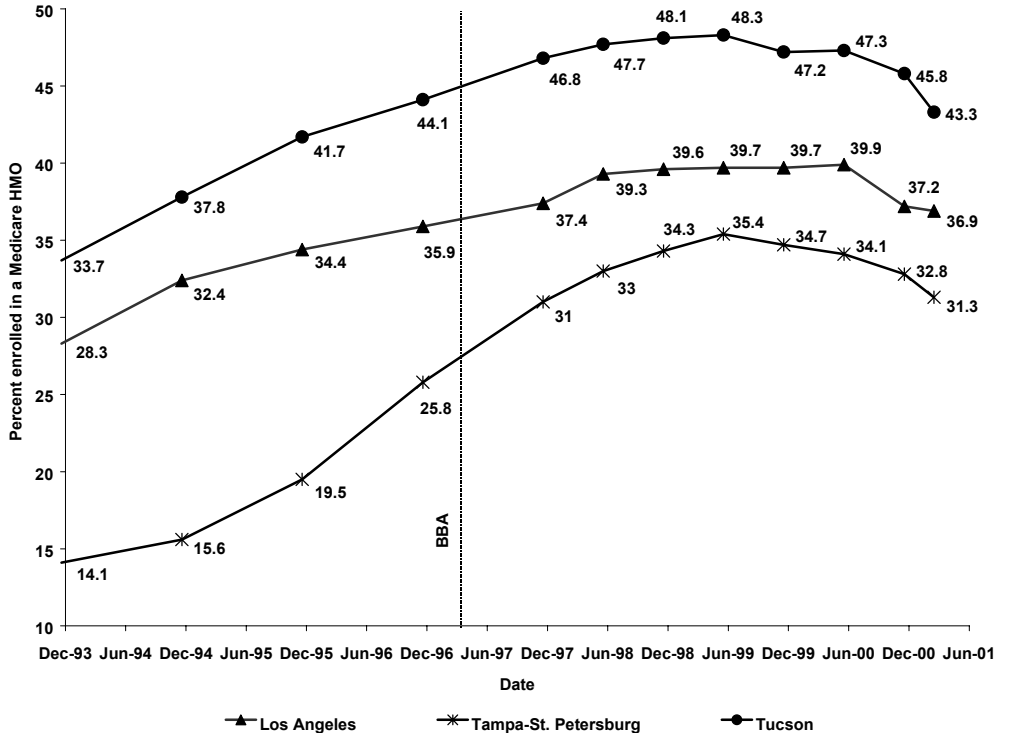
Even with BIPA funding, the local factors influencing plans' withdrawal decisions remain. These include:

- provider unwillingness to accept capitated payment arrangements with plans;
- increases in utilization and costs of care, including escalating prescription drug costs;
- decisions by national plan leaders about far-away local markets;
- fear of adverse selection; and
- low market share.

Medicare+Choice is not a single national program, but an aggregation of dozens of local markets in cities and counties across the nation. As a result, the problems with plan withdrawals at the local level are difficult to resolve with simple, or quick, national policies.

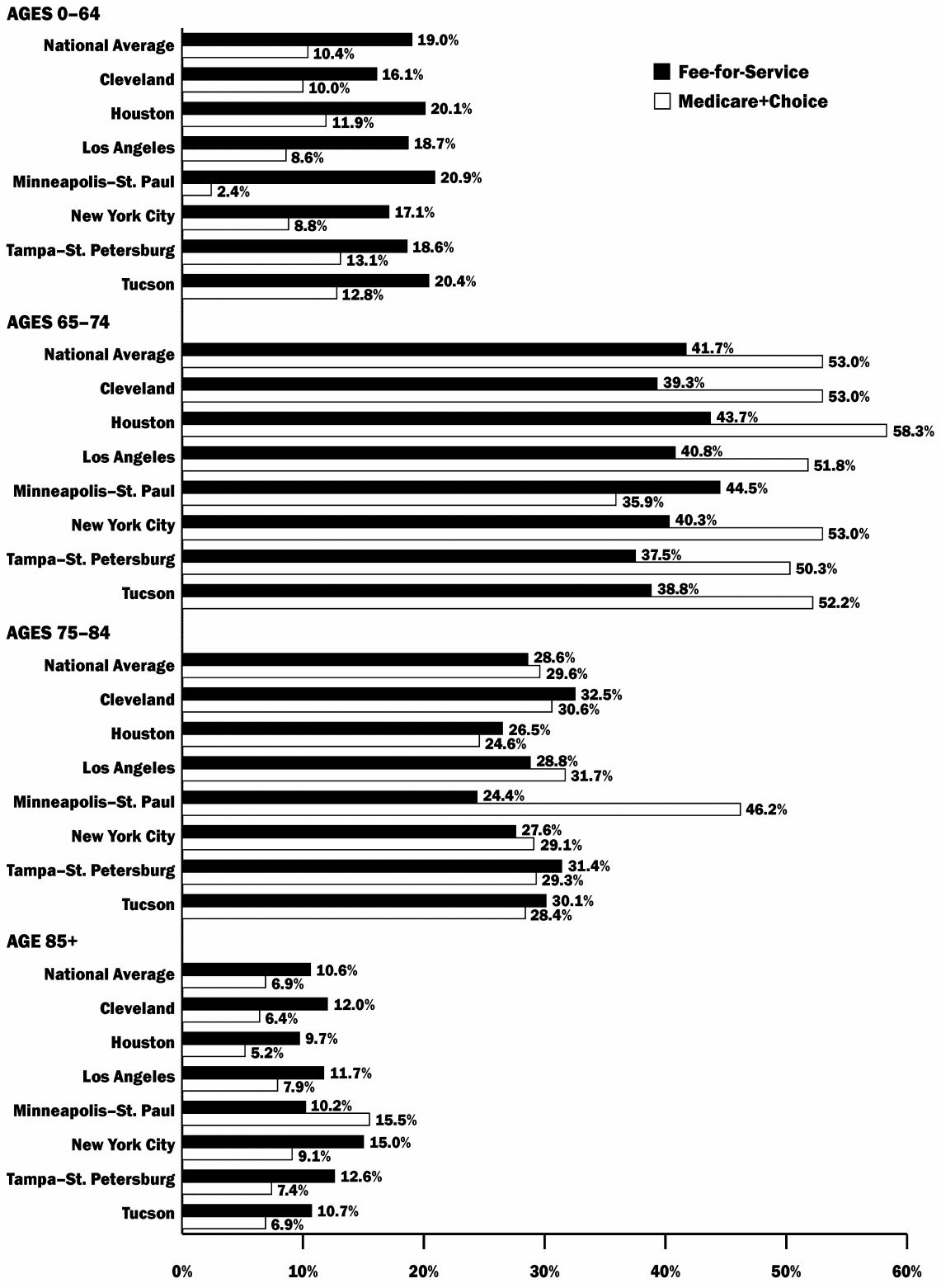
Figure 2. Medicare Managed Care Penetration Rates: Seven Study Sites, December 1993–March 2001





Source: HCFA state/county/plan managed care enrollment reports.

Figure 3. 1998 Differences by Age Between Fee-for-Service and Medicare+Choice Enrollees: Seven Study Sites



Source: Based on data provided by B. Gage from a related Commonwealth Fund project, *Who Changes Medicare+Choice Plans?* (forthcoming).

NOTES

[1] Medicare Payment Advisory Commission (MedPAC). "Medicare+Choice: A Program in Transition." In *Report to Congress: Medicare Payment Policy*. Washington, D.C.: MedPAC, March 2000.

[2] Health Care Financing Administration (HCFA). *Medicare+Choice: Changes for the Year 2000,* December 21, 1999.

[3] The BBA also required Medicare+Choice organizations to adhere to stronger managed care consumer protections, slowed the growth of plan payment rates relative to Medicare fee-for-service spending, and changed the enrollment and disenrollment rules, phasing in a lock-in requirement beginning in 2002.

[4] *HCFA Analysis of How Medicare+Choice Organizations Used BIPA Payment Increases,* available at: www.hcfa.gov/medicare/bipahome.htm.

[5] Analysis of HCFA quarterly state/county/plan managed care enrollment data.

[6] Only risk plans were considered in this analysis, although Minnesota has an unusually high enrollment in Cost and Select plans.

[7] U.S. General Accounting Office, *Many Factors Contribute to Recent Withdrawals; Plan Interest Continues,* GAO/ HEHS-99-91, April, 1999; U.S. General Accounting Office, *Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings,* GAO/ HEHS-00-183, September, 2000; Mary Laschober et al. "Medicare HMO Withdrawals: What Happens to Beneficiaries?" *Health Affairs* 18 (November–December 1999): 150–157.

[8] GAO, *Many Factors Contribute to Recent Withdrawals; Plan Interest Continues,* GAO/ HEHS-99-91, April, 1999.

[9] "M+C Plans Tap Experience to Prove Their Viability, Endurance," *Managed Medicare & Medicaid* 7 (February 19, 2001): 3. See also Center for Studying Health System Change, *Issue Brief: Back to the Future? New Cost and Access Challenges Emerge,* February 2000; and Jon Christianson, Cara Lesser et al., "Increased Consolidation Raises Concerns: Cleveland, Ohio, Community Report #2," Center for Studying Health System Change, Fall 2000.

[10] Mary Sit-DuVall, "Medical Power Struggle: Hospitals Outpunch HMOs," *The Houston Chronicle,* August 23, 2000, Business p.1.

[11] Center for Studying Health System Change, *Issue Brief: Back to the Future? New Cost and Access Challenges Emerge,* February 2000.

[12] Similarly, in New York, Anthem BC/BS severed its relationship with Long Island's predominant 13-hospital North Shore–Long Island Jewish Health System, forcing many enrollees to seek care from what is considered by many Long Island residents to be less prestigious hospitals or to travel to New York City for care.

[13] Under global capitation, hospitals are paid a flat fee for a package of clinically related services; under per diem, hospitals are paid for each day a beneficiary is in the hospital. See Leigh Page, "Doctors Find Bargaining Clout with HMO Contracts," *American Medical News* 43 (November 20, 2000): 12.

[14] Robert Pear, "More HMOs Quit Medicare, Stirring Turmoil." *New York Times,* June 3, 2000, p.1.

[15] "Managed Care Monitor—Medicare+Choice: 711,000 Seniors to Lose HMO Coverage," *American Health Line,* June 30, 2000.

[16] HCFA data, "Medicare+Choice (M+C) Enrollees Affected by Non-Renewals and Service Area Reductions for 2001," July 21, 2000.

[17] The fear of adverse selection was also a consideration in the design of plans' benefit packages. Medicare HMOs remaining in our sites in 2001 said they were worried that if their benefit packages were "too generous" compared to the benefits offered by their competitors, they would attract sicker patients.

[18] *HCFA Analysis of How Medicare+Choice Organizations Used BIPA Payment Increases,* available at: www.hcfa.gov/medicare/bipahome.htm.

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#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

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Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review,* vol. 2, no. 1. Reprinted from *New Jersey Medicine,* March 2000. Available online at http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

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A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

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Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the *Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries,* reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to President Clinton. It also examines possible reform opportunities following the November 2000 elections.

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#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

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