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TO: Interested Parties

FROM: Sandy Christensen SC

SUBJECT: Medicare+Choice Provisions in the Balanced Budget Act of 1997

In the Balanced Budget Act of 1997 (P.L. 105-33, hereafter called the BBA), the Congress made a number of changes to Medicare in an effort to limit growth in program costs. About half of the savings expected over a 10-year projection period come from provisions that would reduce payments to providers in Medicare's traditional fee-for-service sector. Another quarter of the savings come from keeping the premium paid by Medicare Part B enrollees at 25 percent of program costs, rather than letting it drop as a percentage of costs as it would have under prior law. The remaining savings come from provisions that would alter participation by and payments to risk-based plans that are available to enrollees as an alternative to Medicare's traditional fee-for-service sector.

This memorandum describes the changes enacted for Medicare's risk-based (or Medicare+Choice) sector and assesses the likely effects on beneficiaries and plans. Risk-based plans agree to provide all covered medical services to their Medicare enrollees for a predetermined per-capita payment—a "capitation" amount. Under both prior law and the BBA, the capitation amount is set by Medicare each year, and plans then determine whether they will serve Medicare enrollees for that amount. Currently, the payment rate is high enough in many areas that capitated plans provide enrollees with free supplemental benefits.

CHANGES IN MEDICARE'S RISK-BASED SECTOR

When the Medicare provisions of the BBA are fully in place, they will change Medicare's risk-based sector in four primary ways. They will expand the types of capitated plans available to beneficiaries, the conditions under which plans may participate, the way in which Medicare's payment rates to plans are calculated, and the process by which beneficiaries enroll. The BBA also imposes new requirements on medigap plans that are intended, in part, to facilitate movement between Medicare's traditional fee-for-service sector and the risk-based sector.

The five subsections below discuss each of these changes in turn. Each subsection begins with a summary overview of the change, followed by a section with additional details. It is not necessary to read the detailed descriptions to follow the discussion in the rest of this memorandum.

Beneficiaries' New Options

Under prior law, participation in Medicare's risk-based sector was effectively limited to health maintenance organizations. HMOs provide their enrollees with comprehensive health services through physicians who are either staff employees of the HMO, multispecialty groups who contract only with the HMO, or networks of independent practices (IPAs) for whom the HMO provides only part of their patient base. Most Medicare HMOs are closed-panel, meaning that only services from physicians on the HMO's panel of providers are covered, except for emergencies. However, in recent years some Medicare HMOs have offered an open-panel (or point-of-service) option, which covers services from non-panel providers—typically with higher cost-sharing requirements. Although HMOs receive capitated payments from Medicare, they pay their physicians under a variety of methods, including salary, capitation, and fee-for-service. HMOs also often have utilization-based bonuses or penalties.

Effective for 1999, the BBA will allow a broader range of plans to participate in Medicare on a capitated basis, comparable to the range now available through private insurance. The additional kinds of plans permitted include:

- Preferred provider organizations—PPOs are plans with an organized network of providers who have agreed to accept the plan's payment rates and utilization controls. PPOs will pay for covered services from non-network providers, but the cost-sharing requirements they impose are lower when enrollees are treated by providers in the plan's network. PPOs typically pay physicians on a fee-for-service basis, which may be modified by utilization-based bonuses or penalties. PPOs are similar to open-panel IPAs.

- Provider-sponsored organizations—the BBA defines PSOs as plans organized and operated by affiliated health care providers who provide a substantial portion of the services covered by the plan. The affiliated providers must have a majority financial interest in the PSO.

The BBA does not otherwise limit the organizational form or payment system for PSOs.[1]

- Private fee-for-service plans—the BBA defines PFFS plans as ones that cover services from any qualified provider and pay physicians on a fee-for-service basis. These plans may not have utilization-based bonuses or penalties or otherwise place providers at financial risk.

- High-deductible plans coupled with tax-favored medical savings accounts—Like PFFS plans, MSAs cover services from any qualified provider and pay physicians on a fee-for-service basis, with no utilization-based bonuses or penalties. They (like all Medicare+Choice plans) must cover at least all those services covered by Medicare's traditional fee-for-service plan, but only after the enrollee incurs countable expenses equal to the plan's annual deductible. Above that deductible, MSAs might cover all incurred expenses but need not do so—the BBA requires only that MSAs pay the lesser of all costs incurred or all costs that would have been allowable in Medicare's fee-for-service sector. Countable expenses must include what Medicare would have paid plus any cost-sharing amounts payable in the fee-for-service sector, and may include other expenses at the plan's option. Because the BBA specifies a maximum for the MSA deductible (equal to $6,000 in 1999) rather than a minimum, MSAs need not actually be high deductible plans. MSA enrollees are required to establish a medical savings account, into which is deposited any excess of Medicare's capitation payment over their plan's premium each year. MSA enrollees may use the funds in their accounts to pay their out-of-pocket medical expenses, although there is no guarantee that those funds will be sufficient.

In addition, the BBA permits physicians to contract privately with Medicare beneficiaries on any terms mutually acceptable (excluding involvement with Medicare) although this option is unlikely to be popular because physicians with any such contract would be prohibited from claiming Medicare reimbursement for any of their patients for the next two years.

Details. Under prior law, plan participation in Medicare's alternative sector was limited to open- or closed-panel HMOs, which could serve Medicare enrollees on either a risk or a cost basis. Risk-based plans receive a prospective per-capita

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1. This is not an entirely new option, since some HMOs now serving Medicare enrollees are provider-sponsored plans that qualify under their states' insurance regulations. What is new under the BBA is a temporary waiver from state licensing requirements for PSOs and a reduction in minimum enrollment requirements for them.

payment for each Medicare beneficiary they enroll, while cost-based plans are reimbursed for the costs of whatever services they provide to Medicare enrollees. There are two kinds of cost-based plans—comprehensive plans that provide all Medicare services, and health care prepayment plans (HCCPs) that provide only Part B services. As of September 1997, about 14 percent of Medicare beneficiaries were enrolled in HMOs. Of these, 90 percent were in risk-based plans.

Under the BBA, Medicare's risk program will be replaced by the Medicare+Choice program. Existing risk-based contracts may not be renewed beyond December 1998, when most are expected to shift to Medicare+Choice contracts. Effective immediately, no new cost contracts may be initiated. Most existing cost contracts may not be renewed beyond December 2002. The BBA will phase out Medicare's comprehensive cost-based option completely and permits only limited continuation of HCCPs after 1998, for existing plans sponsored by unions or employers.

The BBA eliminates the option of risk-based enrollment for people eligible only for Medicare's Part B, although all such beneficiaries who are enrolled in risk plans at the end of 1998 may continue indefinitely in those plans.

Under the BBA, the Secretary of the Department of Health and Human Services is instructed to develop a plan by 1999 to integrate social health maintenance organizations (SHMOs) as a permanent option in the risk-based sector. The SHMO program is a managed care demonstration project that combines traditional Medicare benefits with community-based long-term care services for the frail elderly.

Conditions Imposed on Medicare+Choice Plans

In most instances, the conditions imposed on all plans who choose to participate in Medicare's risk-based sector will be similar to those now imposed on HMOs. In general, qualified plan sponsors must be organized and licensed under state law as risk-bearing entities eligible to offer health insurance, including adequate provision for protection against insolvency. (The BBA provides for a temporary waiver of this condition for PSOs, described in the details section.) Plans must cover at least the same services covered in Medicare's fee-for-service sector, and enrollees' expected expenses for cost-sharing and plan premiums for required benefits may not exceed the cost-sharing expenses they would face in that sector. (There are exceptions for PFFS plans and MSAs, described in the details section.) Any premiums charged by Medicare+Choice plans must be community-rated (equal for all Medicare enrollees in a given service area and plan). Plan premiums, if any, are in addition to the Part B premium paid by all enrollees.

However, the BBA changes two important conditions now in effect for all plans. First, as of 1999 (with waivers available earlier), the current requirement that at least half of each plan's enrollment must be commercial (neither Medicare nor Medicaid) will no longer apply. This restriction was originally intended to ensure the quality of alternative plans serving Medicare enrollees. The BBA provides instead for a quality assurance program in each plan, periodic surveys of enrollees to assess their satisfaction with their plans, and distribution of information on plans' performance during an annual coordinated election period.

Second, for PSOs only, the BBA reduces the minimum enrollment requirements imposed on plans. The minimum allowable size for PSOs will be 500 enrollees in rural areas and 1500 in all other areas. For all other risk-based plans, the minimum allowable size is 1500 enrollees in rural areas and 5000 in all other areas, as it was under prior law. For all new plans, these minimum enrollment requirements may be waived for up to three years.

Details. Capitated plans must assume full financial risk for the health care needs of their enrollees on a prospective basis, although this risk can be shared with plan providers and reinsurers. The Secretary will extend and modify as necessary the conditions for certification now applied to HMOs serving enrollees in Medicare's risk-based sector. Federal standards established for Medicare+Choice plans will preempt state laws and regulations where they are inconsistent. In particular, state standards relating to plans' benefit requirements, inclusion of providers, and handling of coverage disputes will be preempted.

The BBA provides for a temporary non-renewable exception to the state licensing requirement for PSOs. Up until November 1, 2002, PSOs can seek a waiver of state law by filing an application with the Secretary. Plans may seek a waiver under three conditions—if a state has failed to act on their application within 90 days, if a state has denied licensing based on discriminatory requirements, or if a state has imposed solvency requirements that differ from federal solvency requirements to be established by the Secretary. If granted, the waiver would be effective for three years, would apply only in that state, and could not be renewed.

For all but PFFS plans and MSAs, enrollees' expected expenses for cost-sharing and plan premiums may not exceed the cost-sharing expenses they would face in Medicare's fee-for-service sector. (The BBA defines cost-sharing to include deductibles, coinsurance, and copayments, but not balance-billing.) For PFFS plans, enrollees' expected cost-sharing expenses for required benefits under the plan may not exceed their expected cost-sharing expenses in Medicare's traditional fee-for-service plan, but there is no constraint on plan premiums. There is no necessary limit on enrollees' expenses for MSAs under the BBA. While MSAs might provide catastrophic protection (eliminating all out-of-pocket costs for enrollees once they

exceed the deductible amount) they need not do so. MSAs could be designed to leave enrollees liable for balance-billing costs and for part of the costs of supplemental benefits not covered by Medicare (such as prescription drugs) after enrollees' countable expenses exceed the plan's deductible amount.

Rates Paid to Medicare+Choice Plans

Under prior law, Medicare's capitation rates were set at 95 percent of the program's expected costs in the fee-for-service sector for a similar enrollee living in the same county. This payment method was intended to reduce Medicare's costs by 5 percent for every fee-for-service enrollee who moved to a risk-based plan. However, there is good evidence that in fact Medicare has paid 6-8 percent more for enrollees in risk-based HMOs than it would have paid for them in the fee-for-service sector, because the categories used to adjust payments for risk did not adequately account for the favorable selection that Medicare's HMOs typically experience.[2]

Another reason Medicare's capitation rates may have been too high is because the costs of graduate medical education were included in the rates, whether or not the plans receiving the payments used teaching hospitals for their patients. Analysts have suggested that it would be better to exclude those costs from the capitation rate and, instead, pay those amounts directly to teaching hospitals based on the number of capitated patients they serve. Similar arguments have been made to exclude from the capitation rate the costs of extra payments Medicare makes to hospitals that serve a disproportionate share of low-income patients.

An additional problem with capitation rates under prior law was the extent of variation in rates across areas that could not be explained by differences in the price of medical inputs. By basing capitation rates on per capita fee-for-service costs in each enrollee's county of residence, payments under prior law were adjusted to reflect area-specific differences in both input prices and practice patterns. While input prices may reasonably differ across areas because of differences in the cost of living, there is little justification for large differences in practice patterns across areas for a patient with a given condition. For that reason, analysts have suggested setting capitation rates in a way that is closer to the way Medicare sets hospital payment rates for each diagnosis-related group under the prospective payment system—using

2. See the CBO Memorandum, *Predicting How Changes in Medicare's Payment Rates Would Affect Risk-Sector Enrollment and Costs* (March 1997); R.S. Brown and others, *The Medicare Risk Program for HMOs--Final Summary Report on Findings from the Evaluation* (Princeton, N.J.: Mathematica Policy Research, Inc., February 1993); and G. Riley and others, "Health Status of Medicare Enrollees in HMOs and the Fee-for-Service Sector in 1994," *Health Care Financing Review*, vol. 17, no. 4 (Summer 1996).

a standardized rate that reflects the resources used on average nationwide, adjusted only for local differences in input prices.

The BBA will change the way capitation rates are calculated in several ways, with modifications phased in between 1998 and 2003. The modifications will:

- Add a risk adjustment category for health status to better account for selection bias;
- Eliminate the costs of graduate medical education from the capitation rates and, instead, pay those amounts directly to facilities providing medical education based on the number of Medicare+Choice patients they serve;[3]
- Move from area-specific capitation rates to a 50-50 blend of area-specific and price-adjusted national rates; and
- Set floors on both the amount ($367 in 1998) and the annual percentage increase (2 percent) in each county's rate.

The method of setting capitation rates under prior law resulted in substantial variability in payment rates—from one year to the next for a given county and between neighboring counties. This variability was especially severe for counties with small Medicare populations, because in such counties average fee-for-service costs are strongly affected by just a few beneficiaries with extraordinary expenses. HMOs are reluctant to serve areas where Medicare's payment rates are highly variable from year to year because enrollment and profits are then so uncertain. The blended rates and the floors specified in the BBA will reduce year-to-year and geographic variation in county-level payment rates.[4] Those provisions are expected to encourage more risk-based plans to serve less populous counties, especially in concert with other provisions in the act—such as eliminating the requirement for 50 percent commercial enrollment and permitting more kinds of plans to participate.

The BBA will also update average capitation rates by less than the percentage increase in per-capita fee-for-service costs for each year from 1998 through 2002.

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3. Graduate medical education is training provided to new physicians through medical residencies in their specialty. Medicare makes two kinds of payments to teaching hospitals related to graduate medical education. Direct medical education payments are intended to cover some of the costs of faculty, graduate stipends, and other direct teaching costs. Indirect medical education payments are intended to compensate for the higher operating costs that have been noted in teaching hospitals.

4. The BBA also gives each state the option of consolidating current county-level payment areas into larger areas, such as a single statewide area or MSA-specific areas together with a rest-of-state area. This would also reduce variability in payment rates.

If this were the only payment change, the national average capitation rate would fall from 95 percent to a little over 92 percent of per capita fee-for-service costs by 2002, reflecting a cumulative reduction of about 2.8 percentage points in relative terms. Thereafter, annual updates to the average capitation rate will once again match the rate of change in costs per fee-for-service enrollee.

Details. Under the new system for setting capitation rates, county rates for 1997 are the starting point for calculating rates for 1998 and subsequent years. For each county, rates are set at the highest of three amounts: a blended rate which is a mix of the area-specific local rate and a price-adjusted national average rate; a floor ($367 in 1998); and a rate 2 percent higher than the previous year's rate in that county.[5] Each year, the two components of the blended rate and the floor rate will be updated by the national growth percentage, which is set based on projected growth in Medicare's spending per capita in the fee-for-service sector (minus a statutory reduction for 1998 through 2002). The mix for the blended rate starts at 90 percent local and 10 percent national in 1998 and shifts gradually to a 50-50 blend for 2003 and later years. An increasing portion of graduate medical education costs are excluded from the calculation of costs until they are entirely eliminated in 2002 and later years (see Table 1).

TABLE 1. PARAMETERS FOR CALCULATING MEDICARE'S CAPITATION RATES

Calendar Year	Percent of GME Removed	Percentage Mix in Blended Rates		Value of Floor[a]	National Growth Percentage[a]
		Local	National		
1998	20	90	10	367	2.6
1999	40	82	18	381	3.7
2000	60	74	26	398	4.1
2001	80	66	34	421	5.4
2002	100	58	42	446	5.7
2003	100	50	50	478	7.2

SOURCE: Congressional Budget Office.

a. The floor and national growth percentage for 1998 are the values used by the Health Care Financing Administration to set rates for 1998. Values for later years are CBO projections.

5. The price adjustment specified in the BBA uses a mix of the hospital wage index used in setting hospital payment rates under Medicare's prospective payment system and the geographic adjustment factor used in setting payment rates under Medicare's fee schedule for physicians' services.

Actual capitation payments to plans depend on the characteristics of their enrollees. County-level rates are adjusted by national risk factors to account for the demographic characteristics of each enrollee. The risk adjusters now used by Medicare are age, sex, disability status, institutional status, Medicaid enrollment, and whether the enrollee works and has employment-based insurance coverage (called the working aged adjuster). The BBA mandates the use of additional adjusters for health status by 2000.

New Enrollment Procedures

The BBA will significantly change the enrollment process for risk-based plans, in two ways. First, it will institute an annual coordinated election period, similar to the open enrollment period held each year by the Federal Employees Health Benefits Plan. Currently, there is no coordinated election period for Medicare's risk-based plans, and no single source of comparative information about the plans available to beneficiaries in a given area.

Second, the BBA will limit enrollees' freedom to switch plans or to return to Medicare's fee-for-service sector during the year. Under prior law, beneficiaries could disenroll from risk-based plans at any time (monthly) and either switch to another HMO, if it was open, or return to the fee-for-service sector. After 2002 under the BBA, enrollees electing a risk-based plan will be permitted to change plans only once (apart from the annual open enrollment period) and only during the first three months of the year.

Details. The BBA requires that all Medicare+Choice plans hold an open enrollment period during November of each year, beginning in 1999 for enrollment during 2000. Further, it requires that the Secretary mail to each Medicare beneficiary notice of each upcoming open enrollment period and comparative information about all Medicare plans available in the beneficiary's area. The notice is to include specific information about benefits, cost-sharing requirements, premiums, and performance under Medicare's original fee-for-service program and under each Medicare+Choice plan available in the area. In addition, the notice is to describe coverage election procedures and beneficiaries' procedural rights under each plan.

An unlimited option to change plans is continued through 2001 under the BBA (except for MSAs, as explained below). After that (apart from changes during the open enrollment period), beneficiaries may make one change only during the first six months of enrollment in 2002, and one change only during the first three months of enrollment in 2003 and subsequent years. For aged beneficiaries who elect a Medicare+Choice plan when they first enroll in Medicare, an additional option

exists—they may elect to return to the original fee-for-service sector at any time during their first 12 months of coverage.

Beneficiaries may elect MSAs only during their initial open enrollment period or the annual coordinated election period. MSA enrollees may discontinue those plans only during an annual coordinated election period or if their plan is terminated. Further, total enrollment in MSAs is limited to 390,000 people nationwide. No provision for new enrollment in MSAs exists beyond December 31, 2002, pending reports on the effects of this option.

New Requirements for Medigap Plans

Although medigap plans are not required to participate in the annual coordinated election period, the Secretary's notice is also to include general information about medigap (including Medicare Select) plans that supplement Medicare's fee-for-service coverage, so that beneficiaries are made aware of all options available to them. Further, the BBA contains provisions intended to encourage beneficiaries to try a risk-based plan by ensuring their access to medigap coverage (under specified conditions) if they subsequently return to the fee-for-service sector.

In addition, the medigap options available to Medicare beneficiaries will be expanded. Under prior law, medigap offerings were limited to 10 standard plans all of which provided full coverage for Medicare's coinsurance requirements on hospital and physicians' services, although coverage for Medicare's deductible amounts and for additional benefits (such as prescription drugs) varied among the plans. Under the BBA, medigap insurers may offer high deductible variants for two of the plans previously available (plans F and J). The high deductible amount would be $1,500 for 1998 and 1999, indexed thereafter to the consumer price index. Enrollees would be responsible for all covered expenses up to the deductible amount, and the plan would pay all covered costs once the deductible had been met.

Details. Beneficiaries' enrollment rights in medigap plans are expanded under the BBA. Under prior law, medigap plans were required to offer a 6-month open enrollment period for newly eligible aged beneficiaries. While plans were permitted to limit coverage of new enrollees for services relating to preexisting conditions, such exclusions could not last for more than six months. Further, enrollees who had met the preexisting condition limitation under one medigap policy could not be subjected to another exclusion period when switching plans, except for newly covered benefits.

The BBA further limits the application of coverage exclusions by prohibiting them even during beneficiaries' initial medigap enrollment at age 65, to the extent those beneficiaries had a continuous period of health insurance coverage prior to

Medicare/medigap enrollment. Also, the act enumerates additional circumstances in which medigap plans must offer open enrollment with no exclusion for preexisting conditions to continuously covered beneficiaries: 1) when the applicant's previous supplementary plan (whether employment-based, medigap, or Medicare+Choice) is terminated or breached by the insurer; 2) when the applicant moves out of the area served by the previous plan; or 3) when the applicant leaves a Medicare+Choice plan within the first 12 months of initial enrollment in the risk-based sector—a one-time only circumstance available only to those who were never in Medicare's original fee-for-service sector, or who had medigap coverage before choosing the risk-based sector.

EFFECTS ON PAYMENTS AND ENROLLMENT IN MEDICARE'S RISK-BASED SECTOR

Medicare's capitation rates for 1998 will be set at the $367 floor in more than a third of counties, affecting 2 percent of current risk-sector enrollees and 14 percent of total Medicare enrollment (Table 2). Rates will increase by the 2 percent floor in all other counties, affecting 98 percent of risk-sector enrollment and 86 percent of total Medicare enrollment (using enrollment data for 1997). Nearly all Medicare beneficiaries in large and mid-size metropolitan areas live in counties where capitation rates will increase by the minimum of 2 percent. More than a third of beneficiaries in smaller areas, however, live in counties where capitation rates will rise by significantly more than 2 percent because of the $367 floor.

Rates for 1998 were entirely determined by the floors specified in the BBA, with nothing left for blending area-specific and national rates. This occurred because the projected increase in nationwide per capita fee-for-service costs—which determines the increase in area-specific rates before allowance for the floors—was not much higher than the minimum 2 percent increase required in all areas.[6] Projections by the Physician Payment Review Commission indicate that a similar result is likely for 1999. Starting in 2000, however, growth in national per capita fee-for-service costs is expected to be high enough to generate rate increases in some counties that are higher than those set by the payment floors. By 2002, nearly three-

6. Medicare's actuaries project an increase of 3.4 percent in nationwide per capita fee-for-service costs between 1997 and 1998, after allowing for the provisions of the Balanced Budget Act. Under the BBA, that increase was reduced by 0.8 percentage points, so that the nationwide per capita rate used to determine area-specific rates increased by 2.6 percent between 1997 and 1998. Then, excluding 20 percent of the costs of graduate medical education from each county's rate further reduced the national average increase by 0.5 percentage points, for an overall average increase of 2.1 percent.

TABLE 2. EFFECTS OF THE BALANCED BUDGET ACT ON MEDICARE'S CAPITATION RATES FOR 1998

	Percentage Change In Rates for 1998 Relative to 1997	Percentage Distribution of Enrollment	
		All Medicare	Risk-Based
All Counties (n = 3130)			
Nationwide	2.1	100.0	100.0
By Metropolitan Size			
Large (1 million or more)	2.0	44.9	73.9
Mid-Size (250,000 to 1 million)	2.2	22.5	19.7
Small (Under 250,000)	2.7	8.9	3.0
Non-Metropolitan Areas	3.4	23.7	3.4
Counties Where Rates Increase to the Floor of $367 (n = 1101)			
Nationwide	9.3	13.8	1.8
By Metropolitan Size			
Large (1 million or more)	4.3	0.4	0.2
Mid-Size (250,000 to 1 million)	8.4	2.0	0.7
Small (Under 250,000)	12.2	2.4	0.3
Non-Metropolitan Areas	10.5	9.1	0.7
All Other Counties (Rates Increase by 2 Percent) (n = 2029)			
Nationwide	2.0	86.2	98.2
By Metropolitan Size			
Large (1 million or more)	2.0	44.5	73.7
Mid-Size (250,000 to 1 million)	2.0	20.5	19.0
Small (Under 250,000)	2.0	6.6	2.7
Non-Metropolitan Areas	2.0	14.6	2.7

SOURCE: Congressional Budget Office from county-level data on enrollment for June 1997, capitation rates for 1997 and 1998, and medical education costs, all provided by the Health Care Financing Administration.

NOTE: Results were calculated using only rates for aged enrollees, with 1997 enrollment unchanged.

fourths of all counties are expected to be at blended rates, with the rest of the counties at one of the floors specified in the BBA.[7]

Even without any blending of rates for 1998, most areas whose 1997 capitation rates were appreciably below the price-adjusted national average rate will move up relative to the average because of the $367 floor. Payments for 1998 will increase by 2.6 percent in counties whose 1997 rates were less than 90 percent of the price-adjusted national average rate, while payments will increase by only the minimum 2 percent in all other areas (see Table 3).

However, movement toward a standardized price-adjusted national rate will be much more pronounced in later years when capitation rates for most areas are set by the blend. For example, if capitation payments for 1998 had all been set using the 50-50 blend that will eventually prevail under the BBA, areas with below-average rates for 1997 would have seen their payments increase by 16 percent, while payments would have dropped by nearly 5 percent in areas with above-average rates for 1997. By contrast, eliminating GME costs from the capitation rates does little to move rates toward the price-adjusted national average. (See the effects of the hypothetical payment alternatives shown in Table 3, which are budget neutral for 1998 .)

When fully in place, the payment provisions in the BBA will reduce capitation rates relative to per-capita costs in Medicare's fee-for-service sector by at least 5 percent on average nationwide—the result of updating capitation rates by less than the percentage increase in per capita fee-for-service costs (a cumulative reduction of 2.8 percent) and eliminating GME costs from the rate (for an additional reduction of about 2.5 percent).[8] Adding a health status adjuster could further reduce capitation rates relative to per capita fee-for-service costs—the size of the additional reduction would depend on the extent of selection bias in the risk sector when the new adjuster is put in place and on how effectively the adjuster accounts for that selection.

The reduction in Medicare's capitation rates relative to per capita fee-for-service costs would slow the growth in risk-sector enrollment were it not for a number of other provisions in the BBA that are expected to accelerate growth in Medicare's risk-sector enrollment by more than enough to offset the effect of the relative rate reduction. More risk-based plans will participate because additional

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7. Physician Payment Review Commission, *Medicare+Choice: Payments to Plans*, PPRC Basics No. 3 (September 1997).

8. Plans that use teaching hospitals might compensate for the reduction due to excluding GME costs by negotiating lower prices from those hospitals, since the hospitals would receive a separate payment from Medicare for their GME costs based on the number of capitated patients they served.

TABLE 3. EFFECTS OF THE BALANCED BUDGET ACT ON STANDARDIZING MEDICARE'S CAPITATION RATES ACROSS COUNTIES

	Percentage Changes in 1998 Payments Relative to 1997 Payments				Percentage Distribution of Enrollment	
		Hypothetical Budget Neutral Alternatives				
	Actual 1998 Rates (Floors)	Blended Rates	GME Carveout	Blend and Carveout	All Medicare	Risk-Based
Counties with 1997 Rates Less Than 90 Percent of the Price-Adjusted National Average						
Nationwide	2.6	16.1	2.1	16.1	31.5	19.3
By Metropolitan Size						
Large (1 million or more)	2.0	15.8	1.4	15.0	7.7	10.9
Mid-Size (250,000 to 1 million)	2.6	15.8	3.0	16.8	7.8	5.7
Small (Under 250,000)	3.9	18.8	3.4	20.3	4.6	1.3
Non-Metropolitan Areas	5.8	18.0	3.3	19.5	11.4	1.4
Counties with 1997 Rates Between 90 Percent and 110 Percent of the Price-Adjusted National Average						
Nationwide	2.0	4.2	2.5	4.6	40.5	42.0
By Metropolitan Size						
Large (1 million or more)	2.0	4.1	2.4	4.3	17.5	30.2
Mid-Size (250,000 to 1 million)	2.0	4.3	3.0	5.2	10.7	9.3
Small (Under 250,000)	2.0	6.6	3.3	7.8	3.3	1.2
Non-Metropolitan Areas	2.0	5.5	2.7	6.2	9.0	1.3
Counties with 1997 Rates Greater Than 110 Percent of the Price-Adjusted National Average						
Nationwide	2.0	-4.7	1.7	-5.1	28.0	38.6
By Metropolitan Size						
Large (1 million or more)	2.0	-4.8	1.5	-5.4	19.7	32.7
Mid-Size (250,000 to 1 million)	2.0	-3.8	3.1	-2.8	3.9	4.7
Small (Under 250,000)	2.0	-4.2	1.7	-4.5	1.1	0.5
Non-Metropolitan Areas	2.0	-5.5	3.1	-4.5	3.3	0.7

SOURCE: Congressional Budget Office from county-level data on enrollment for June 1997, AAPCCs for 1997 and 1998, and medical education costs, all provided by the Health Care Financing Administration.

NOTES: Results were calculated using only rates for aged enrollees, with 1997 enrollment unchanged.

Payment levels under the budget neutral alternatives were set to achieve the same total payments as will occur using actual rates for 1998.

Blended rates are 50 percent area-specific and 50 percent price-adjusted national rates.

Carveout rates are 1997 rates reduced by county-specific factors for 100 percent of the costs of graduate medical education.

sponsors and organizational forms will be permitted, and also because plans will no longer be required to have commercial enrollment at least as large as their Medicare/Medicaid enrollment. In addition, all beneficiaries will have uniform, comprehensive, and timely comparative information about the Medicare options available to them each year, so that they will be more likely to try risk-based plans when the supplements offered are better or less expensive than those available through medigap plans. Those provisions relating to plan participation and program administration, in conjunction with more predictable payment rates, will tend to increase risk-sector enrollment above predictions based only on payment rate changes.[9]

Overall, the BBA is expected to accelerate the growth in enrollment in Medicare's risk-based sector, mostly due to enrollment in PPOs, MSAs, and in rural PSOs. CBO's cost estimate assumes that enrollment in capitated plans will be about 15 percent higher by 2005 than it would have been under prior law—nearly 34 percent of total Medicare enrollment instead of the 29 percent rate projected under prior law (see Table 4).

TABLE 4. CURRENT AND PROJECTED ENROLLMENT IN MEDICARE'S RISK SECTOR AS A PERCENTAGE OF MEDICARE PART A ENROLLMENT

	1997	2000	2003	2005	2007
Prior Law	11.7	19.4	24.8	29.2	34.2
Current Law	11.7	22.4	29.3	33.7	38.6

SOURCE: Congressional Budget Office.

9. T. McBride, J. Penrod, and K. Mueller, "Volatility in Medicare AAPCC Rates: 1990-1997," *Health Affairs*, vol. 16, no 5 (September/October 1997).

OTHER CONSIDERATIONS

The Medicare+Choice provisions of the BBA are expected to generate a number of benefits for the Medicare program and its enrollees. However, there are also some concerns associated with the new provisions.

Main Benefits

One of the motivations underlying the Medicare+Choice provisions of the BBA was the desire to give Medicare beneficiaries the same variety of insurance options now available in the private sector. Another important motivation was the desire to secure for Medicare the slower cost growth that has occurred recently in the private insurance market. The conventional view is that competition among insurers for enrollees in employment-based plans has forced insurers to focus on containing costs, and that various forms of managed care have enabled them to do so. In hopes of capturing similar benefits for Medicare, the BBA expands the kinds of plans permissible in Medicare's risk-based sector and improves the competitive process by instituting an annual open enrollment period during which the Secretary will provide all Medicare beneficiaries with comparative information about their options.

One benefit is that enrollees will have more alternatives to the original fee-for-service program. In areas already served by Medicare's HMOs, enrollees will have more kinds of plans from which to choose, so that they will be more likely to find one that suits them. In areas not well-served by HMOs now, it is more likely that alternatives to Medicare's fee-for-service sector will arise. Further, options will improve even for those who remain in the original fee-for-service sector because the act expands the permissible medigap options to include two high-deductible plans—which will protect enrollees from Medicare's potentially high cost-sharing expenses at a lower premium cost than do current medigap plans, which provide nearly first-dollar coverage.

A second benefit will arise from the coordinated annual election period to be established. This should provide enrollees with comparable information about the various alternative plans available to them, reducing their costs of getting information. Coordinating plans' open enrollment periods will also improve enrollees' ability to switch plans when that would be beneficial for them, thus fostering stronger competition (and hence better or less expensive benefits) among the alternative plans available in each area. Coordination should also reduce the costs of marketing to Medicare enrollees for the participating plans.

A third benefit will result when health status is added to the risk factors now used to adjust payment rates to risk-based plans. If the favorable selection that

Medicare's HMOs experience continues after the addition of other kinds of plans, even imperfect adjustment for health status will reduce the extent to which Medicare's costs increase for each enrollee who moves into a risk-based plan. It will also reduce plans' incentives to avoid or disenroll people whose health status is poor, thereby reducing the favorable selection plans experience.

Possible Concerns

The concerns discussed here about how well the Medicare market will function under the BBA fall into two main categories: 1) how well beneficiaries will cope with their new options; and 2) how troublesome selection bias will be. There is also a third area of concern not discussed here—whether the Health Care Financing Administration has the resources to handle on a timely basis the many new responsibilities assigned to it.

How Well Will Beneficiaries Deal With Their New Options? How well the new Medicare+Choice market will function depends in part on having prudent and knowledgeable consumers among the Medicare population who are willing to change plans when better alternatives are available. For the many Medicare enrollees who are impaired by disability, age, illness, poverty, or lack of education, making appropriate health plan choices may be beyond their ability without considerable help. Further, even when changing plans would be financially advantageous, it could be detrimental to good care if it also requires changing providers, or if lower quality of care or access accompany a plan's lower costs. The Secretary is to provide comparative information about both costs and quality during open enrollment periods, but quality is far more difficult to evaluate than cost.

One measure of plan quality is how well plans treat especially vulnerable groups of enrollees—those with chronic conditions, disabilities, or severe illness; low-income people; and those with little education. While there is evidence that relatively healthy beneficiaries generally do at least as well in Medicare's HMOs as they do in the fee-for-service sector, there is also evidence that those with chronic conditions or low income tend to fare significantly worse.[10] One reason for this may be that these vulnerable groups of enrollees are less adept at negotiating their way through the administrative barriers that are one way in which costs are controlled in HMOs and other managed care plans.

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10. See J.E. Ware and others, "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems," *Journal of the American Medical Association*, vol. 276, no. 13 (October 2, 1996). For a review of this and other recent studies, see R.H. Miller and H.S. Luft, "Does Managed Care Lead to Better or Worse Quality of Care?" *Health Affairs*, vol. 16, no. 5 (September/October 1997).

Currently, enrollees who are dissatisfied with the care they receive in a risk-based plan are locked into their HMO for no longer than a month, since they may switch plans or return to the fee-for-service sector at the end of any month. Under the Balanced Budget Act, this safeguard will continue through 2001, but will be limited thereafter. As of 2003, enrollees may change their plan election only one time (in addition to the annual open enrollment period) and only during the first three months of the year. This is more flexible than most employment-based plans are (where no changes are permitted except during the annual open enrollment period), but it is considerably less flexible than Medicare is currently. Enrollees might be locked into an unsatisfactory plan for up to nine months, increasing the importance of having effective and timely grievance resolution mechanisms in place.

An additional concern raised by some analysts is that providers in certain areas may become increasingly reluctant to serve any but the most costly beneficiaries in Medicare's traditional fee-for-service sector. Because of the floor on risk-based payment rates, in some areas risk-based payments per enrollee will be significantly higher than per-capita costs in Medicare's fee-for-service sector, permitting risk-based plans to pay higher rates to providers. In such areas, providers who had participated in Medicare's fee-for-service sector may instead choose to serve most Medicare enrollees only through a fee-for-service Medicare+Choice plan to get higher rates, and this could increase the costs that enrollees must pay out of pocket. Although the act prohibits PFFS plans from imposing aggregate cost-sharing amounts (deductibles, coinsurance, and copayments) in excess of what enrollees would have paid in Medicare's fee-for-service sector, balance-billing costs are limited to 15 percent of potentially higher payment rates and plan premiums are subject to no limit.

Experience under the FEHBP offers some assurance that the concerns discussed above can be addressed adequately, however. Enrollees are generally well-served by the FEHBP even though there is no public plan offered as a fallback to the participating private plans, and despite the fact that enrollees are locked into their selected plan for a year. Competitive pressures on plans are maintained even though only a small percentage of FEHBP enrollees change plans each year. For the Medicare population, though, it may be necessary to fund local agencies to provide the guidance about choosing plans that FEBHP enrollees get from their employers' personnel offices. Even with this assistance, it is likely that the most costly and impaired beneficiaries will remain in Medicare's traditional fee-for-service sector.

How Troublesome Will Selection Bias Be? Medicare's original fee-for-service sector is likely to continue to experience adverse selection compared with plans in the risk-based sector because it provides relatively unrestricted access to whatever providers and treatments beneficiaries want. This makes it particularly attractive to high-use beneficiaries who are not concerned about Medicare's high cost-sharing

requirements—either because they have sufficient income to purchase medigap coverage, or because they are eligible for Medicaid which covers their cost-sharing expenses. This adverse selection inappropriately increases Medicare's costs in the risk-based sector because risk payments are now (and will, under the BBA, continue to be) tied to per capita costs in the fee-for-service sector.

Some provisions in the BBA might reduce selection bias while others might increase it. With the new open enrollment procedures to be established, it will be more difficult for plans to market selectively to relatively healthy Medicare beneficiaries, tending to reduce favorable selection among new enrollees. Although plans might encourage disenrollment of costly enrollees by limiting access to services they need, the selection bias resulting from those efforts will be muted by the lock-in provisions that will be in place by 2003. However, the selection bias that now occurs because of enrollees' preferences will continue and might even increase because of the new options that will be available, especially MSAs. Most analysts believe that MSAs will attract only the healthiest Medicare beneficiaries, who will return to more comprehensive Medicare+Choice plans or to the fee-for-service sector as their health deteriorates.[11] However, these effects will be limited under the act because of two provisions—enrollment in MSAs is capped at 390,000 people, and MSA enrollees are prohibited from changing plans except during the annual open enrollment period.

Selection bias can be eliminated only by putting all Medicare beneficiaries into one risk pool—that is, into one plan. In a system with multiple plans, the potential for selection bias must be recognized, and payments to plans must be adjusted to compensate for it when it occurs. Without such compensation, efficient risk-based plans providing quality care may be unable to survive solely because they attract a disproportionate share of enrollees with above-average needs. Such plans will either leave the market, or reduce the quality of care they provide by withholding appropriate services.

The new risk adjuster for health status mandated by the BBA could reduce the adverse consequences of selection bias in the Medicare program, although it is unlikely to eliminate them altogether. (Exactly what the new health status adjuster will be has yet to be decided.) Although selection bias might still occur by enrolling or retaining only people who are relatively low-cost within any given health status category, favorable selection will be more difficult to achieve under such a grouping mechanism than it is when the goal is simply to enroll or retain healthy people. With a risk adjuster based on health status, some plans might even find it profitable to develop and advertise expertise in treating certain costly conditions, a marketing approach that would be financially risky at present.

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11. See the CBO Memorandum, *The High-Deductible/MSA Option Under Medicare: Exploring the Implications of the Balanced Budget Act of 1995* (March 1996).

But no risk adjuster will by itself entirely eliminate risk-based plans' financial incentives to skimp on care for their enrollees. It may be that grievance resolution mechanisms and providers' concerns about malpractice suits are sufficient to prevent skimping. However, some analysts believe that it would be better to modify the financial incentives for underprovision of care in capitated payment systems by using partial capitation payment methods—where payments to risk-based plans are based partially on risk-adjusted per-capita rates and partially on enrollees' actual use of services.[12]

12. J. P. Newhouse, M. B. Buntin, and J.D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs*, vol. 16, no. 5 (September/October 1997).