Report in Response to Legislative Request to the Maryland Department of Health and Mental Hygiene to Study the Cost of Providing Access to Managed Care for Medicare+Choice-Eligibles in Maryland

Maryland Senate Bill 855, Section 3, 2000 Legislative Session

January 11, 2001

Maryland Department of Health and Mental Hygiene

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Report in Response to Section 3, 2000 Maryland Senate Bill 855:
The Cost of Providing Access to Managed Care for
Medicare+Choice-Eligible Individuals in Maryland

I. Introduction to the Report

A. Charge from the Maryland Legislature to the Department of Health and Mental Hygiene

Maryland Senate Bill 855, Senior Assistance – Short-Term Prescription Drug Subsidy Plan, was signed by the Governor on May 18, 2000. The legislation mandated a temporary prescription drug subsidy program for up to 15,000 Medicare beneficiaries age 65 and over residing in seventeen Maryland counties. **Section 3 of Senate Bill 855 requires that the Department of Health and Mental Hygiene (the Department) shall study the cost of providing access to managed care for Medicare Plus Choice-eligible individuals in Maryland and report to the legislature by January 1, 2001.** This report responds to that request.

The charge in Senate Bill 855 envisioned a cost analysis that could provide the basis for recommending a financial subsidy for Medicare+Choice (M+C) plans. Upon implementing the research, it was quickly found that the costs of making Medicare managed care available throughout Maryland go well beyond fiscal considerations. Based on this finding, the research and study take a more comprehensive approach and describe the national and state context in which the M+C withdrawals are occurring and the impact of the withdrawals on consumers and health care programs.

Resolution of the fiscal issues is paramount to resolving Medicare managed care problems, however, it was not possible to answer the question of how much of a financial subsidy would be needed to make Medicare managed care available in all areas of Maryland. As the study documents, the resolution of additional issues including federal administrative burden, provider network development, and adequate numbers of enrollees are essential to making Medicare managed care viable. The report provides findings and conclusions regarding:

- The significant impact of the M+C withdrawals on Maryland Medicare beneficiaries and health care programs in partnership with M+Cs;
- The complex federal issues underlying M+C payment rates and regulation; and
- M+C administrators' descriptions of federal and state policies affecting their decisions to operate nationally and in Maryland.

B. Organization of the Report

The remainder of this report is organized to describe:

- The national historical background of Medicare managed care and the emergence of current issues related to M+C withdrawals including key federal legislation;
- The impact of M+C withdrawals on consumers and health care programs, especially in Maryland;
- Reasons for M+C withdrawals based on information drawn from private and federal national reports and interviews with Maryland M+C plan administrators;
- An analysis of federal capitation rates as applied to M+Cs; and
- Findings and conclusions drawn from the research.

C. Summary of Findings and Conclusions

The following findings and conclusions are described in more detail in Section V of the report.

1. The impact of Medicare+Choice (M+C) withdrawals on Maryland residents is significant.

2. Consumers affected by the M+C withdrawals have lost important benefits and will have increased out-of-pocket costs for health care.

3. The reasons for the M+C withdrawals are complex and primarily federal. Increasing payment rates may not solve the M+C withdrawal problem.

II. National Historical Background of Medicare Fee-for-Service and Medicare Managed Care

A. Traditional Medicare (fee-for-service)

The United States Congress enacted Medicare in 1965 under Title XVIII of the Social Security Act. It is the nation's largest health insurance program, administered by the Health Care Financing Administration (HCFA) in the United States Department of Health and Human Services. Medicare coverage is limited. Medicare primarily covers acute care services, rather than chronic or long-term care. Because Medicare coverage is limited, many beneficiaries purchase supplementary private policies or enroll in Medicaid to fill in the gaps of Medicare coverage.

Medicare has two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (SMI) (Part B). Part A covers institutional care such as inpatient care and some skilled nursing home. Part B pays for physician services, outpatient hospital care, durable medical equipment and supplies, home care and other medical services that Part A does not cover, such as services provided by physical or occupational therapists. (See Figure 3 on page 11 for details for Medicare fee-for-service coverage and gaps.)

B. Medicare Managed Care

The Medicare managed care program was established by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Under this program Medicare beneficiaries can choose to participate in the fee-for-service program or the managed care program if a Medicare managed care plan operates in the beneficiary's county of residence.

The monthly pre-paid per person (capitation) payment for Medicare managed care plans was initially based on 95 percent of the average adjusted per person per-capita costs (AAPCC) of historical fee-for-service payments for beneficiaries in each county, adjusted separately for persons age 65 and over and for persons with disabilities. The payment also was adjusted for age, gender, Medicaid status, nursing facility residence status in each county, and whether the beneficiary was working.

The assumption was that Medicare managed care would save money and, therefore, provide additional benefits. Medicare managed care plans frequently cover the copays and deductibles associated with Medicare fee-for-service and offer additional benefits such as prescription drugs and limited vision, dental, and hearing. Individuals participating in Medicare managed care plans must participate in Medicare Part A and B and thus pay the monthly premium associated with Part B. Medicare managed care plans may have an additional monthly premium, but a majority of plans do not charge additional premium. In fact, nationally, 77 percent of Medicare beneficiaries had access to zero premium plans in 2000 (Health Care Financing Administration, September 1999).[1] The availability of zero premium plans has been decreasing.

Of the four M+C plans operating in Maryland in 2000, two did not charge premiums. Premiums for the other two plans were $19 and $50 per month. All four M+C plans offered prescription drug benefits ranging from a cap of $300 to unlimited coverage annually for drugs approved by the plan.

In Maryland in 2000, among the four existing Medicare managed care plans, monthly premiums ranged from 0 to $50. In 2001, one newly licensed plan, Elder Health, will have no premium, but will have reduced benefits directed toward people who are eligible for Medicare and Medicaid. The other plan, Kaiser, will require a $69 or $79 monthly premium depending on the county.

C. Transitions in Medicare Managed Care and the Emergence of Current Issues Related to M+C Withdrawals

Many of the changes in Medicare managed care in the late 1990's have been attributed to federal legislation. This section of the report includes a discussion of key federal legislation and the impact it has had on the Medicare program.

Nationally, the number of Medicare managed care plans grew steadily from its establishment under Title XVIII of the Social Security Act in 1982 until 1987, when a four-year decline began. The decline reversed in 1991 and rapid growth occurred until 1998, when there were 346 plans. Medicare managed care enrollments increased steadily from 1982 until 1999, when there were 6.4 million beneficiaries enrolled in plans.

In the 1990's, during the same time that plans and enrollments were expanding, concern was mounting regarding the expanding costs of both Medicare fee-for-service and Medicare managed care. Other concerns with the managed care program included:

- The inability to make managed care available in all areas of the country creating equity issues among beneficiaries;
- Evidence that plans were being paid rates reflecting the health of the general beneficiary pool, but in most cases seemed to be enrolling a healthier membership; and
- A "national mood" that some plans were making members' access to care difficult.

1. The Balanced Budget Act of 1997 (1997 BBA)

The response to all of these concerns culminated in passage of the Balanced Budget Act of 1997 (1997 BBA). The 1997 BBA renamed the Medicare managed care option the Medicare+Choice Program. The primary purposes of the 1997 BBA were to:

- Provide beneficiaries with more choice of Medicare plan options, similar to that available in the private sector and the Federal Employees Health Benefits Program; and
- Help control the growth in Medicare spending.

Supporters of the 1997 BBA also hoped that the Act would make richer benefits available to beneficiaries through M+Cs and expand M+C participation to restructure Medicare (Medicare Payment Advisory Commission, March 2000).

The 1997 BBA contained provisions to slow the rate of Medicare spending by reducing payments to providers in Medicare fee-for-service and by creating new rate methods for Medicare managed care. The new Medicare managed care

rate methodology was intended to equalize rate payments among different counties and to better reflect the health status of M+C members. The 1997 BBA also increased M+C reporting requirements.

The 1997 BBA had an unexpected effect on the Medicare managed care market. Almost no new alternative types of M+C plans[2] have become available to beneficiaries (Medicare Payment Advisory Commission, March 2000). In addition, existing plans reduced their market areas, withdrawing from areas with lower census and lower capitation rates. In some areas, plans added or raised membership premiums and copayments or restricted specific benefits. Of the 346 plans that participated in Medicare+Choice in 1998, 45 terminated their contracts in 1999 and another 54 plans reduced the number of counties they served (GAO, September 2000).

The 1997 BBA resulted in savings to Medicare; it did not result in expansion of options for beneficiaries or of M+C plans. In fact, the Act is largely blamed for causing the rapid decline in M+C plans.

2. The Balanced Budget Refinement Act of 1999 (1999 BBRA)

In November 1999, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (1999 BBRA) was signed. The 1999 BBRA attempted to correct some of the impact of the 1997 BBA by easing regulatory requirements as well as increasing payments.

Changes to Medicare in the 1999 BBRA that were intended to expand choice for beneficiaries included:

- Creating a new entry bonus for M+C contracts in specific geographic areas[3];
- Increasing consumers' options for enrollment in other M+C plans or Medigap plans if the M+C plan is terminated;
- Reducing the M+C market reentry penalty;
- Extending the Social HMO (S/HMO) demonstration program authority; and
- Lifting S/HMO individual demonstration enrollment caps. [4]

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[2] Preferred Provider Organizations (PPO), Provider Service Organizations (PSO), and Medical Savings Accounts (MSA) were some of the contemplated new Medicare +Choice forms (Medicare Payment Advisory Commission, March 2000).

[3] The payment bonus consists of paying an additional five percent of the monthly Medicare+Choice payment rate in the first 12 months and three percent in the subsequent 12 months to organizations that offer a plan in a payment area without a Medicare+Choice plan since 1997, or in an area where all organizations had announced their withdrawal from the area as of October 13, 1999.

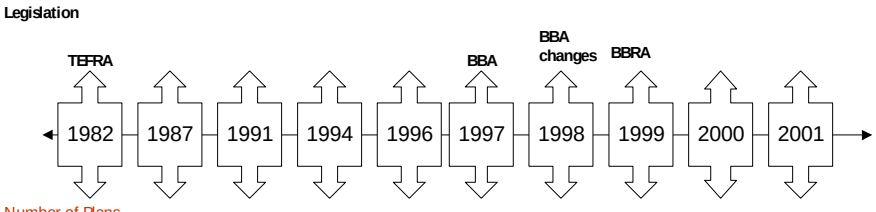
[4] The Social HMO is a managed care demonstration program that provides enhanced benefits to Medicare beneficiaries.

The 1999 BBRA also mandated changes to adjust payments to both fee-for-service and M+C providers in response to market reactions that followed the 1997 BBA. In addition to providing financial relief to providers under Medicare fee-for-service, the 1999 BBRA made a number of changes to the M+C payment methodology including:

- Easing the phase-in of the 1997 mandated risk adjustment methodology;
- Requiring the development of a new comprehensive risk adjustment method for M+Cs including methods for dealing with the frail, to be implemented by 2004;
- Reducing the beneficiary education assessment for graduate medical education (GME); and
- Easing the allowable growth rate cap in Medicare spending.

Despite these changes, in 2000 following passage of the 1999 BBRA, 41 of 309 plans across the country terminated their M+C contracts and an additional 58 plans reduced the number of counties served. This trend has continued in 2001 when another 65 plans have terminated their contracts and 53 plans have reduced their service areas. Together, these plan changes affect about 1.3 million M+C enrollees (GAO, September 2000). (See timeline below.)

Figure 1: Timeline Of Legislation, Number of M+C Plans, and Enrollments in the United States and in Maryland



	1982	1987	1991	1994	1996	1997	1998	1999	2000	2001
Number of Plans in US	160	90	150	250	325	346	309	261	196	
Number of Enrollees in US (in thousands, est.)	1.0	1.3	2.25	4.1	5.25	6.0	6.4	6.2	5	
Number of Plans in Maryland	1	1	5	5	7	7	4	4	2	
Number of Enrollees in Maryland (in thousands, est.)*	-	-	-	-	83	93	88	72	18.5	

*** HCFA data for Maryland enrollments was not available prior to 1997.**

3. The Benefits Improvement and Protection Act of 2000 (2000 BPA)

In December 2000, the 2000 BPA was passed and includes a number of provisions that attempt to ease payment restrictions and administration

requirements on M+Cs and provide incentives to M+Cs to stay in market areas or enter new under-served markets. Major M+C relief provisions include:

- Increasing the annual payment for 2001 from two percent to three percent and allowing plans that gave notice of termination in 2001 up to two weeks after the new rates are published to submit new filings to continue operating (effective March 1, 2001);
- Permitting M+C plans to offer reduced Medicare Part B premiums to their enrollees;
- Expanding the new entry bonus payments to include areas that were notified as of October 2000 that all M+C plans would terminate;
- Placing certain restrictions on administration requirements from HCFA and clarifying that state laws and regulations affecting marketing materials, benefit schedules, etc. would be preempted by Medicare law; and
- Delaying further implementation of the new risk adjustment methodology until 2004.

III. Impact of Medicare+Choice Withdrawals

The M+C pullout has had a significant impact on Maryland Medicare beneficiaries. Maryland is one of the hardest-hit states in terms of the actual number of beneficiaries and the proportion of M+C enrollees affected. Beneficiaries losing M+C coverage will have additional out-of-pocket costs in terms of copays and deductibles associated with Medicare fee-for-service, or they will have the additional cost associated with the purchase of Medicare supplemental insurance (Medigap).

A. Impact on Consumers

Consumers losing M+C benefits will have additional out-of-pocket expenses. Historically, Medicare managed care plans have offered more benefits and coverage than traditional Medicare fee-for-service. Benefits for prescription drugs, vision, and hearing are commonly provided by M+Cs, but are not covered under fee-for-service Medicare.

Monthly premiums charged by M+Cs in Maryland have ranged from $0 to $79. Copays and deductibles for services are generally between $5 and $35 for visits with primary care and specialist physicians, and $3 to $35 for prescriptions depending on whether the prescription is generic, preferred brand name, or non-preferred brand name. Medicare fee-for-service requires copays of 20% of the Medicare-approved cost for outpatient physician visits and does not cover outpatient prescriptions. The expanded benefits and coverage available in an M+C make it unnecessary to purchase Medicare Supplement (Medigap) insurance, which can cost several thousand dollars a year.

1. Statistics

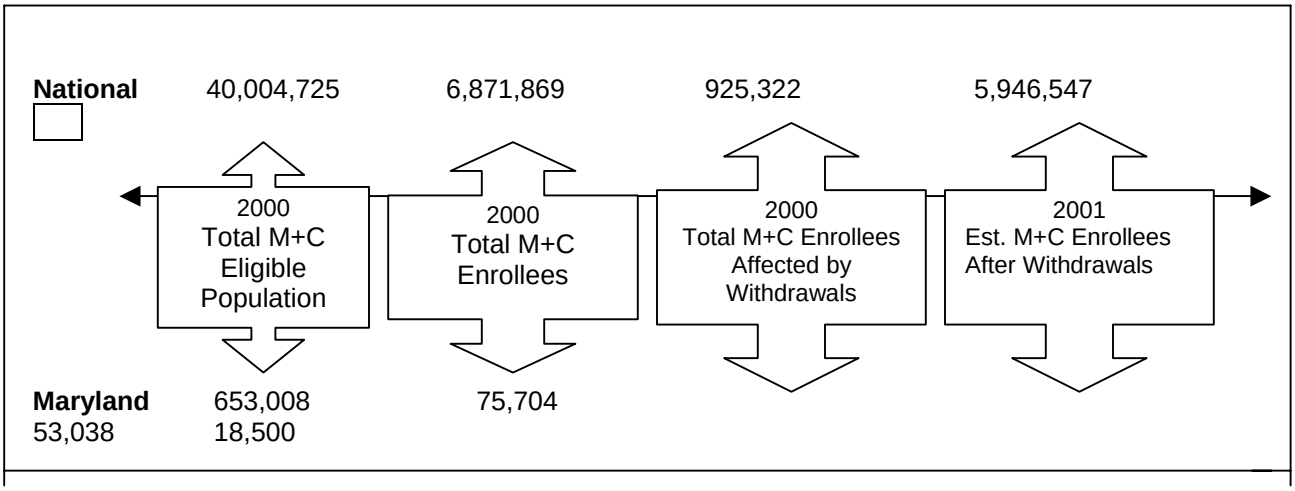
The withdrawal of M+Cs has had a major impact on beneficiaries in Maryland. In 2000, Maryland had approximately 653,008 Medicare beneficiaries. This includes individuals 65 years and over and individuals under 65 with disabilities representing approximately 11 percent of Maryland's Medicare beneficiaries (Mathmatica Policy Research, Inc. November 2000).

Enrollment in Maryland M+C plans peaked in 1998. At that time, about 93,000 Maryland Medicare beneficiaries were enrolled in M+Cs representing 14 percent of the eligible population. M+C enrollment began to decline in 1999 and 2000 concurrent with the withdrawal of a number of M+C plans.

- Over 15,000 Maryland residents were affected by the M+C withdrawals in 2000, and had to enroll in a different M+C or revert to Medicare fee-for-service.
- Thirteen thousand of the 15,000 people did not have another M+C option available in their county of residence.
- As of January 1, 2001, because of additional M+C withdrawals, another 53,000 Maryland Medicare beneficiaries have been affected by M+C withdrawals.
- Approximately 51,500 of 53,000 affected in 2001 will not have access to another M+C with comparable coverage to that offered by the withdrawing plans.
- About 1,500 will convert from FreeState to Elder Health, a newly licensed M+C targeting people dually eligible for Medicare and Medicaid.
- Approximately 17,000 beneficiaries enrolled in Kaiser will not be affected by the withdrawals.

Figure 2 below shows the number of Medicare beneficiaries affected nationally and in Maryland by the 2001 M+C withdrawals. The cumulative effect of the 2000 and 2001 M+C withdrawals in Maryland is that approximately 64,500 Maryland beneficiaries previously enrolled in M+Cs will have no viable M+C alternative.

Figure 2: M+C Enrollment 2000 to 2001 Nationally and in Maryland



Appendix A shows M+C activity in Maryland from 1997 to 2000 by county and M+C plan. Appendix B shows total Maryland Medicare beneficiaries eligible to enroll in M+Cs from 1997 to 2000. In 2001, only two M+C plans will be available in Maryland: Kaiser Permanente (Kaiser) and Elder Health. Appendix C is a map showing the growth and decline of M+C plans in Maryland since 1998.

Kaiser, a national medical plan, had approximately 17,000 Maryland members as of March 2000. Kaiser has obtained a Medicare waiver allowing it to cap enrollments next year, the result of which will keep the plan at essentially the same membership level of 17,000 in Maryland.

Elder Health, a program focusing on people who are dually eligible for Medicare and Medicaid or residents in nursing homes, had contracted with the Maryland BlueCross M+C, CareFirst, which terminated its M+C business in Maryland as of December 31, 2000. In response to CareFirst's termination, Elder Health applied to HCFA to become an M+C and became operative as an M+C on January 1, 2001. Elder Health has converted its 1,500 members to its M+C that will be available in Baltimore, Harford, Montgomery, Prince George's, Howard, and Anne Arundel Counties as well as Baltimore City. While the Elder Health M+C will be open to all eligible beneficiaries in the operating areas, the coverages offered by the plan are best suited to individuals who are dually eligible for Medicare and Medicaid or residents in nursing homes.

Maryland is the sixth hardest-hit state in total numbers of M+C enrollees affected by withdrawals. Among those state and territories with any significant M+C enrollment, Maryland is the hardest-hit in terms of the percentage of M+C enrollees affected (HCFA, July 21, 2000).

2. Financial Impact on the Individual Consumer

Medicare continues to cover beneficiaries who were enrolled in M+C plans that withdraw from the Maryland market. However, since no plan is currently available to most of the former M+C enrollees, they must revert to the original Medicare fee-for-service option. Medicare supplemental insurance (Medigap) can be purchased to cover the higher out-of-pocket deductibles and copays associated with Medicare fee-for-service.

One of the biggest challenges facing consumers whose M+C enrollment is terminating is the loss of benefits not covered by Medicare fee-for-service. The fee-for-service copays and deductibles, in combination with the loss of prescription benefits and other ancillary services, can represent thousands of dollars in annual out-of-pocket costs to the beneficiary.

Figure 3 below shows traditional Medicare benefits and what must be paid by the beneficiary either (1) out-of-pocket, (2) through the purchase of private Medigap insurance, or (3) under an M+C. The out-of-pocket cost of copays and deductibles can be significant. In addition, Medicare fee-for-service does not cover prescription, dental, hearing aids, or vision benefits, which have been covered to varying degrees by Maryland M+Cs. Prescription benefits in Maryland M+C plans ranged from a cap of $300 per year to unlimited for generic prescriptions, depending on the M+C plan.

Figure 3: Traditional Medicare Beneficiary Out-of-Pocket Expenses/M+C or Supplemental Insurance

Medicare Part A Benefits (2000)		
Service	**Covered**	**Beneficiary (Co-pay/ deductible)**
Hospital Inpatient Stays	Inpatient hospital 190 days inpatient psychiatric	• $776 one-time deductible for 1st 60 days • $194 for day 61-90 • $388 for day 91-150 • All for 151 days on
Skilled Nursing Facility	After 3 day hospital stay Rehabilitative	• $0 for1-20 days • $97for 21 to 100 days • All for 101 days on
Home Health Care	Therapies Home health aides Durable medical equipment	• 0–Home health • 20 percent - Equipment
Hospice Care	Drugs Care in Facility or Home	• $5 copay for outpatient drugs • 5 percent inpatient respite care
Blood	Inpatient infusions	• 1st 3 pints
Medicare Part B Benefits (2000)		
Service	**Covered**	**Beneficiary Co-pay/Deductible**
Outpatient Care	Doctors Visits Supplies Diagnostic Tests Durable Medical Equipment Therapies	• $100 deductible per benefit year • 20 percent of approved amount for all but mental health • 50 percent of approved amount for mental health
Home Health		• 0 For services • 20 percent approved for equipment
Clinical Laboratory		• 0
Blood	Inpatient	• 1st 3 pints
Preventive Care	Vaccinations (limited) Bone Mass Measurements Colorectal Cancer Screen Diabetes Monitoring Pap Smear Prostate Cancer Screening	• 20 percent of Medicare approved amounts except for PSA
General Prescriptions	Not Covered	Varying coverage available
Routine Dental, Vision, Hearing	Not Covered	May be available in M+C

Some of the Medicare fee-for-service out-of-pocket costs can be reduced with the purchase of Medigap insurance policies. Under federal law, beneficiaries in terminating M+Cs have the right to purchase one of four specified Medigap

policies, regardless of their health conditions. Medigap insurance premiums must be paid by the beneficiary out-of-pocket. None of the four guaranteed policies include prescription benefits.

Medigap policies are sold by private insurance companies. There are currently 25 insurers in Maryland offering Medigap policies. The policies can only be sold in ten standardized plans called "A" through "J," each with a different set of standard benefits. Each policy must cover basic benefits,[5] including most, if not all, of the original Medicare coinsurance amounts, and they may cover the deductibles. Some of the policies cover extra benefits like preventive care and prescription drugs. Medigap policies do not cover long-term care, vision or dental care, hearing aids, private-duty nursing, or unlimited prescription drugs, all of which can contribute to high out-of-pocket costs. Appendix D includes a listing of insurers offering Medigap plans in Maryland and a chart describing Medigap benefits under the ten form policies.

Annual premiums for Medigap policies in Maryland range from $407 to $4,788, depending on the richness of benefits and the age of the insured. Policies offering prescription benefits range from $1,275 to $4,788 a year, depending on the richness of the prescription benefit and the amount of deductible.

For those beneficiaries who are eligible for full Medicaid coverage or for partial coverage under the Maryland Pharmacy Assistance Program (MPAP), Qualified Medicare Beneficiary (QMB), or Specified Low-income Beneficiary (SLMB) programs, all or some of the costs of copayments, deductibles, and additional benefits such as prescriptions may be covered.

3. Characteristics of Involuntarily Disenrolled Medicare+Choice Members

No direct research has been conducted to determine the characteristics of Maryland beneficiaries affected by the M+C withdrawals. A number of national studies and reports provide insight into characteristics of the population enrolled in M+Cs, particularly those that have been involuntarily disenrolled due to M+C withdrawals.

A recent report from Mathematica Policy Research, Inc. studied Medicare beneficiaries, including M+C members in six market areas of the United State including the Baltimore Metropolitan Area (BMA) (Mathematica Policy Research, Inc., November 2000). The Mathematica study surveyed a total of 6,500 beneficiaries. The survey sampling included geographic areas representing 34,176,000 Medicare beneficiaries nationally including 303,000 in BMA. Figure 4

[5]Basic Medigap benefits are: Part A (inpatient hospital) coinsurance and the cost of 365 days of hospital care during the beneficiary's lifetime after Medicare coverage ends; Part B (medical costs) coinsurance (generally 20 percent of the Medicare-approved payment amount); and the first 3 pints of blood each year.

below shows some of the significant findings of the study on a national basis. The figure shows differences observed among all Medicare beneficiaries whether in an M+C or fee-for-service, and those enrolled in M+Cs, and those who had been enrolled in a terminating M+C.

Figure 4: Characteristics of Beneficiaries in Terminating Medicare+Choice Plans, Compared to All Beneficiaries in Medicare+Choice Plans

	M+C Terminated Beneficiaries Covered Now?[6]			All M+C Enrollees	All Beneficiaries In Counties With M+C
	All	Yes	No		
Education					
Less than high school	38%	33%	52%	22%	26%
High school graduate	30%	31%	27%	42%	38%
Other	32%	36%	21%	36%	36%
Income*					
Under 10,000	17%	13%	34%	16%	23%
$10,000-$20,000	56%	54%	60%	37%	32%
$20,000 or more	27%	33%	6%	47%	45%
Health Status					
Excellent	6%	4%	11%	15%	14%
Very good/good	55%	53%	60%	54%	54%
Fair/poor	39%	43%	29%	31%	32%

Source: Monitoring Medicare+Choice Fast Facts: Forced Exit: Beneficiaries in Plans Terminating in 2000, No. 3, Gold & Justh, September 2000. MPR Survey of Medicare Beneficiaries, 2000.
*Excludes data from about 13 percent of the sample that refused income questions or didn't know.

Minimal differences were observed in education, income, or health status between those enrolled in M+Cs and all Medicare beneficiaries including those in fee-for-service. Slight differences were observed between the general Medicare population and those that had been enrolled in a terminating M+C. A higher percentage of people who had been in terminating M+Cs had less than a high school education and a lower percentage of people in a terminating M+C regarded their health as excellent.

Significant differences existed between those people who had been in a terminating M+C and had obtained other supplemental coverage and those who had been in a terminating M+C, but who had not obtained other supplemental coverage. Supplemental coverage includes joining another M+C, obtaining Medigap insurance, or obtaining supplemental employer insurance. The supplemental coverage would cover most of the Medicare fee-for-service deductibles and copays and could have some prescription benefits.[7] Among those beneficiaries in terminating M+Cs that did not obtain alternative

[6]The term "covered now" means having obtained supplement coverage to Medicare fee-for-service either through another M+C, Medigap, or employee insurance.
[7]Beneficiaries were not asked if they were receiving any state subsidy like Medicaid.

supplemental coverage, 94 percent had incomes under $20,000 per year, and 52 percent had less than a high school education (Mathematica Policy Research, Inc., November 2000).

Other national studies show that the greatest disruption due to an M+C withdrawal occurs among enrollees who are poor or near poor, have a disability, are of racial or ethnic minorities, or are in fair or poor health (Laschober, M. A., et al, 1999). Of those people whose M+C plans terminated, 77 percent rejoined an M+C if one was available (Laschober, M. A., et al, 1999). Enrollees who could not join another M+C cited added costs and loss of prescription coverage as their greatest concerns (Laschober, M. A., et al, 1999). Among beneficiaries that lost prescription coverage, 15 percent stated that they had not filled prescriptions due to costs (Laschober, M. A., et. al., 1999).

B. Possible Impact on Programs in Maryland

Maryland will have almost no M+C options for beneficiaries whose plans have terminated in 2001. It is possible that a portion of the nearly 65,000 people losing prescription coverage and the added benefits associated with M+Cs will seek some form of financial assistance for health care needs. Since the M+C withdrawal announcement in 2000, the number of people calling the Maryland Pharmacy Assistance Program (MPAP) to inquire about enrollment has increased (November 15, 2000 Interview with MPAP Administrator). Other programs that may be affected over time are the Medicaid funded Qualified Medicare Beneficiary (QMB) and Specified, Low-income Medicare Beneficiary (SLMB).

Income qualifications for all three of these programs are low and it is unlikely that many M+C enrollees would qualify. Figure 5 shows income eligibility and benefits by program in 2000.

Figure 5: Summary of Maryland MPAP, QMB, and SLMB Programs

Programs	MPAP	QMB	SLMB
Maximum Eligible Income by Month:			
Single Household	$804.17	$716	$855
Couple Household	$870.84	$958	$1,145
Maximum Eligible Assets:			
Single Household	$3,750	$4,000	$4,000
Couple Household	$4,500	$6,000	$6,000
Covered Benefits	• Chronic maintenance drugs, anti-infective drugs, and insulin.	• Medicare hospital deductible • Medicare Part B medical insurance premium • Annual Part B deductible • May cover 20 percent coinsurance for Medicare covered services depending on the provider	• Medicare Part B premium

It would be helpful to monitor inquiries and enrollments in these programs to determine how many people who apply and qualify have been enrolled in a terminating M+C.

C. Maryland Medicare/Medicaid Managed Care Proposals

A number of existing and developing health care programs like the Second Generation Social Health Maintenance Organization (S/HMO II) and programs serving people who are dually eligible for Medicare and Medicaid have either partnered or anticipated partnering with a M+C plan. Programs like Elder Health and Erickson Retirement Services have provided services in partnership with M+Cs and are facing serious transition challenges as the M+Cs withdraw. Newly developing programs like the S/HMO II that anticipated working with Maryland M+Cs may need to find new forms of organizational partners.

IV. Reasons for Medicare+Choice Withdrawals

The primary factors affecting M+C withdrawals operate at the federal level. The issues are complex, having developed over time and in the context of changing and conflicting principles underlying the Medicare managed care program. Much of the conflict centers on the federal position that M+C plans are overpaid.

A. Federal Position

The position of most federal agencies is aptly described by chronologically reviewing a number of public statements made in testimony before Congressional Committees and in reports from the United States General Accounting Office (GAO). Appendix F provides chronological summaries of relevant federal reports, testimony, and letters.

Prior to enactment of the 1997 BBA, federal research had shown that Medicare managed care plans were overpaid compared to what was being spent on similar populations in the Medicare fee-for-service program. The 1997 BBA was seen as a sound strategy to correct the overpayments and unevenness of M+C payments among counties without creating too much stress on the plans.

The payment caps and risk adjustment proposed in the 1997 BBA were considered to be interim steps that would improve estimates of Medicare enrollees' medical costs. The risk adjuster was to be phased-in to reduce sharp payment changes that could affect plans' offerings and diminish the attractiveness of the M+C program (GAO, February 25, 1999).

In response to the withdrawal of 45 M+C plans following enactment of the 1997 BBA, a Government Accounting Office report described the major issues underlying the withdrawals as market dynamics, including:

- Recent entry into a county;
- Low enrollment ;
- Higher levels of competition; and
- Inability to compete effectively to attract enrollees and establish sufficient provider networks (GAO, April 1999).

Federal representatives and reports have continued to hold firmly to the view that plans are overpaid. More recently, federal representatives have acknowledged that the withdrawals may be somewhat related to administrative burden and the inability to provide prescription benefits within the capitation rates (GAO, August and September 2000; DeParle, August 2000). Federal reports do not recommend rate increases. However, congressional legislative proposals have included strategies to increase payments to M+Cs and to slow down the rate methodology changes contained in the 1997 BBA (1999 BBRA; 2000 BPA).

B. Analysis of Federal Capitation Rates

The adequacy of capitation rates is a pivotal issue underlying conflicts and issues surrounding the M+C industry. This section provides a description of how the rates have evolved over time and how federal rate setting policies have affected Maryland M+C plans.

Before 1998, base capitation rates to plans in each county were set at 95 percent of the estimated fee-for-service expenditures. Expenditures are established for two types of services: inpatient hospital services (Medicare Part A), and outpatient services (Medicare Part B). The wide variation in local fee-for-service costs, caused by local differences in both the prices of medical services and beneficiaries' use of services, led to corresponding variation in the base capitation rates. A number of concerns were raised by federal agencies, including:

- The unevenness of payment in different jurisdictions;
- Lack of the availability of M+C options to people in different areas of the country;
- Overpayment to plans that were enrolling beneficiaries in better-than-average health; and
- Expanding expenses in the Medicare program.

The 1997 BBA was enacted to address some of these concerns. Following the passage of the 1997 BBA, the method for setting M+C rates changed substantially. The new method involves paying the highest of the following three alternative rates:

- A minimum amount, or "floor" ($367[8] in 1998 and $402 in 2000);
- A minimum increase over the previous year's payment rate (capped at two percent decreased by .0008 in 1998 and by .005 from 1999 to 2002); or
- A blend of historical fee-for-service spending in a county and national average costs adjusted for local price levels.

All adjustments were limited by a budget neutrality provision, which essentially limited total spending to what it would have been if county payments were based strictly on local rates.

A primary goal of the 1997 M+C rate adjustments was to reduce the excess in Medicare's health plan payments, primarily by holding down per capita payment increases for five years and by mandating a new health-based risk adjustment system. In 2000, a new risk adjustment system was partially implemented. The risk adjustment system adjusts payment based on a beneficiary's health status, and accounts for 10 percent of the rate-setting method. The new risk adjustment system was scheduled to account for 100 percent of the rate adjustment by 2004. However, the 1999 BBRA and the 2000 BPA have delayed implementation of the risk adjustment method.

The Principal Inpatient Diagnosis Based (PIP) risk adjustment system uses inpatient (hospital diagnostic) information and has been widely criticized for (1)

[8]The only county in Maryland with less than a $367 average capitation rate in 1997 was Somerset. That rate was increased to $367 in 1998 after passage of the BBA.

understating costs associated with chronic conditions associated with the elderly, especially the frail elderly, and (2) creating incentives to hospitalize members. Federal agencies have recognized the shortcomings of the system and the implementation schedule has been delayed.
Figure 6 shows the combined Part A and B Medicare average monthly capitation payments by county in Maryland from 1995 through 2001. In 1997, only one county's payment was below the $367 floor that was established by the 1997 BBA.

Figure 6: Medicare Combined Part A and Part B Capitation Rates in Maryland, 1995 to 2001 in Dollars

County Name	1995	1996	1997	1998	1999	2000	2001
Allegany	463	514	552	563	574	586	598
Anne Arundel	492	548	563	574	586	597	609
Baltimore	469	520	541	552	563	574	586
Baltimore City	552	614	633	646	659	672	685
Calvert	416	451	477	486	495	517	528
Caroline	324	369	401	409	417	448	457
Carroll	398	451	481	491	501	520	530
Cecil	424	477	513	522	533	549	560
Charles	490	530	565	576	588	600	612
Dorchester	374	402	438	446	455	478	488
Frederick	368	409	425	433	441	478	488
Garrett	379	417	457	467	476	494	503
Harford	461	508	535	545	556	568	579
Howard	503	545	543	554	565	576	587
Kent	376	417	443	452	461	483	493
Montgomery	426	472	492	501	511	536	547
Prince George's	543	586	602	614	627	639	652
Queen Anne's	371	407	425	434	443	469	479
St Mary's	405	460	497	507	517	527	538
Somerset	308	345	357	367	380	413	421
Talbot	319	367	392	399	408	441	449
Washington	330	361	382	388	397	439	448
Wicomico	314	361	382	390	397	434	442
Worcester	298	342	369	376	384	424	432

At the same time that capitation rates have been held to a two percent increase, Maryland M+C plans have experienced actual cost increases of between six and ten percent.

Federal data show that since the 1997 BBA, Medicare fee-for-service spending has been increasing at a lower rate than the increases given to M+C plans. Cost comparisons between the fee-for-service and managed care Medicare programs is helpful, but do not represent precise comparisons for purposes of evaluation.

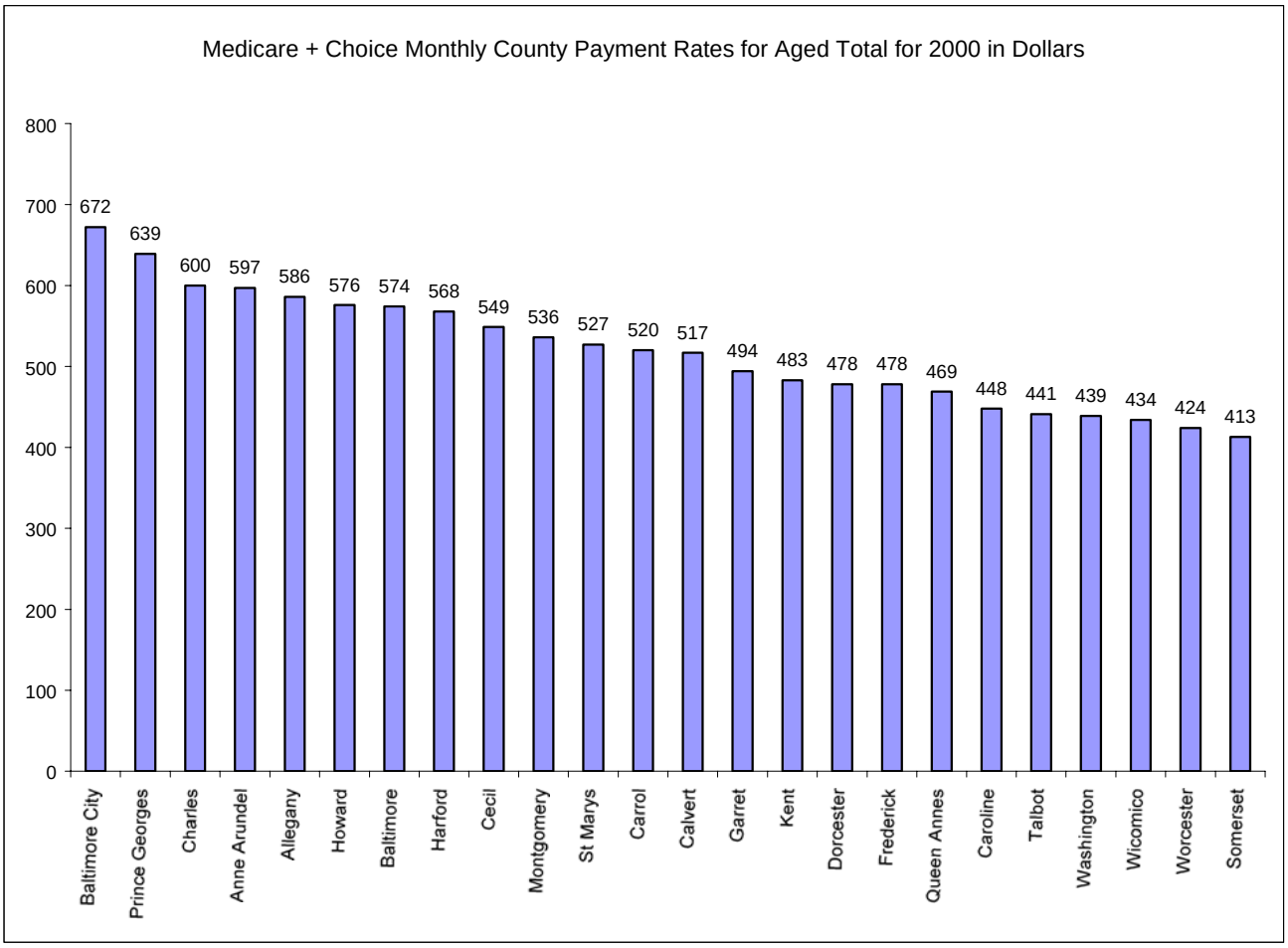
The creation of a managed care program changes a number of variables, including:

- Most plans offer expanded benefits for purposes of market attractiveness and for purposes of covering services deemed essential to quality managed care. The costs of these benefits are not included in the capitation rates because they are not covered under Medicare fee-for-service.
- The expanded benefits result in some "adverse selection." People who need the benefits are more likely to join; people who do not need the benefits stay in fee-for-service.
- Plans are required to establish a complete provider network that is accessible to members. The M+C network reduces some of the barriers to care, resulting in "induced demand," i.e., if the services are available and accessible financially and organizationally, they will be used by members and offered by providers.
- Preventive services and enrollment assessments are provided and may result in additional follow-up procedures.
- Plans reduce the out-of-pocket payments required for members to access services and may result in a higher utilization rate.
- Early evaluation of plans suggested that they were enrolling the healthier people who were not adverse to changing providers due to on-going health issues. More recently, plans believe they may be attracting the less healthy who do not have other subsidized insurance to cover services not covered by Medicare fee-for-service.
- Prescription benefits have become a major reason for people joining M+Cs, even if they have to keep moving from plan to plan as withdrawals occur. The M+C has become one of the few resources for prescription coverage, especially for lower income people without other subsidized coverage such as employer retirement benefits.

All these factors make the comparison of costs between M+Cs and Medicare fee-for-service difficult and possibly invalid unless the only concern is total spending on health care for the Medicare-eligible population.

The 1997 BBA goal of making M+C capitation payments more consistent among counties has not been met nationally or in Maryland. Payment rates still vary widely among Maryland counties and throughout the nation. The following bar graph shows the variation in the combined Part A and B payments by county in 2000. The rate adjustments introduced by the 1997 BBA were intended to make rates more consistent among urban and rural areas. The adjustment resulted in accelerating rate increases in lower paid predominately rural counties and slowing down rate increases in higher paid predominately urban counties. Despite the rate increases in rural areas, plans continued to withdraw from the rural areas, and the slow-down of rate increases in the urban areas is a major factor contributing to withdrawals in those areas.

Figure 7: Variation in Combined Part A and Part B Medicare Capitation Rates in Maryland Counties 2000



The M+C withdrawals in 2000 were largely in rural counties where both capitation rates and census are low. The withdrawals announced for 2001 suggest that the problem is broader than rates or the uneven distribution of rates among counties. This constitutes further evidence that the problem underlying the M+C withdrawals is not solely the result of inadequate capitation rates.

C. Summary of Interviews with Administrators of Maryland Medicare+Choice Plans and Affected Demonstrations and Programs

In 2000, there were four M+C plans operating in Maryland: Kaiser Permanente (Kaiser), CIGNA, BlueCross BlueShield (FreeState), and UnitedHealthcare (United). In July of 2000, CIGNA, FreeState, and United announced that they would exit the Maryland M+C market as of January 1, 2001. All four of Maryland's M+C plans were invited to participate in a structured interview to discuss the factors precipitating their decisions to withdraw, as well as actions that Maryland might take to encourage the development and operation of M+Cs

in the state. Kaiser, FreeState, and United agreed to be interviewed. CIGNA declined, stating that its comments were available through public announcements. In addition to the M+C plans, administrators from three provider programs that depend heavily on M+C contracts or Medicare capitation were interviewed to discuss similar questions to those addressed by the M+C plans.

The results of the interviews are presented in summary form. Particular issues or statements are not attributable to any one plan or program. Appendix E provides descriptions of all four Maryland M+C plans and the three Medicare programs whose administrators participated in the interviews.

Administrators from each of the M+C plans and programs listed the same three major factors affecting M+C decisions to withdraw:

- Inadequate Medicare capitation rates resulting in significant losses over several years;
- Administrative burdens placed on the plans by federal regulation; and
- Difficulty in maintaining adequate provider networks.

The plans also expressed concern about a specific state policy that contributes to the difficulty of operating in Maryland.

1. Inadequate Medicare Capitation Rates

The M+C rate changes introduced by the 1997 BBA are seen as problematic by all M+C administrators interviewed. The changes essentially cap the rate increases at two percent per year while the actual cost of care for M+C members has been increasing between six and ten percent annually. Other rate-setting options under the 1997 BBA, like the blended local and national rate, do not provide any additional relief.

One federal argument has been that if plans did not offer benefits beyond those offered by Medicare fee-for-service, plans would be able to operate efficiently. In response to this argument, plan administrators stated that without the additional benefits, it would not be possible to provide quality managed care and the M+ C program would be unattractive to members. One plan administrator stated that "the concepts of providing quality managed care and cutting back Medicare costs by reducing benefits are dramatically opposed philosophies."

Maryland M+C plan administrators stated that plans have been experiencing significant losses since 1998 and, in most cases, have never recovered start-up losses. One plan administrator described that their plan had been held responsible to pay downstream provider claims on behalf of insolvent providers that had been previously subcapitated to pay those downstream claims.

Administrators described the pharmacy benefit cost as contributing significantly to the overall six to ten percent increases in cost of care, with pharmacy costs trending upward as much as 20 percent in a year. Plans responded to increased costs and capped rates by reducing the pharmacy benefit and raising prescription copays. Some plans also introduced or raised premiums to offset costs. In most cases, members remained loyal even with increased out-of-pocket costs.

Plan administrators discussed the fact that Maryland's Medicare managed care population is relatively small in number and does not produce large enough enrollments to create what are considered stable groups to handle the actuarial risk. M+C administrators cited the following factors as possibly contributing to high medical costs in Maryland:

- Maryland members may be "sicker" than the national average or other areas of the country possibly due to the prevalence of blue-collar industries.
- Some plans enrolled their members through existing provider groups, thus possibly enrolling a disproportionate number of people who were sicker and already receiving services.
- When plans entered into areas of the state previously without M+Cs, there seemed to be some "pent-up" demand for health care, i.e., new enrollees wanted and needed services that they may have deferred prior to the plan's entry into the area.

Low payments to the M+C plans were also cited as contributing to the ability to maintain adequate provider networks. Low federal payments result in reduced or non-increased payments to contracted providers, further exacerbating the providers' financial difficulties and concerns, and contributing to the plans' difficulties in maintaining efficient partnerships with providers over the long-term.

When asked what additional monthly amount would need to be added to the capitation rates, M+C administrators were reluctant to provide a formal fiscal amount because the issues are more complex than cost alone. One plan did provide an analysis using information filed with the Adjusted Community Rate filing submitted to the Health Care Financing Administration (HCFA). Although the ACR filing was regional, the data was massaged to show losses specific to the Baltimore area. The per person per month loss for 1999 was $46.21 in the Baltimore area. The regional loss was $57.32. The estimated losses for 2000 were $42.52 using an eight-percent trend rate.

In addition to asking M+C administrators to estimate the additional amount needed to cover losses, 1999 financial filings with the Maryland Insurance Administration (MIA) were reviewed for three of the four M+C plans operating in Maryland. The plan filings showed per member medical expenses between $421 and $492 per month in the Medicare line of business. Net income among the plans ranged from a gain of $3 per member per month to a loss of $15 per

member per month. MIA data is limited in describing the losses experienced by M+C plans in Maryland. The data is filed on a regional basis and may not represent losses in Maryland. In addition, plans are required to use different accounting guidelines depending on the agency with which they are filing. Therefore, stated losses will differ between the federal and state filings.

Plan administrators stated that medical costs had been trending at between six and ten percent annually. This trend is consistent with state filings. The 1997 BBA essentially capped rate increases for M+Cs at two percent per year. Maryland capitation rates in all counties have been increasing approximately at the two-percent rate since 1998. The federal rate cap has created a growing discrepancy between the trend in costs and the increases in rates.

2. Administrative Burden

Plan administrators described how the 1997 BBA had increased what were already significant administrative requirements in terms of reporting and regulating the interaction of plans with members. One plan administrator stated that there are 132,000 pages of laws and regulations related to Medicare managed care. The administrative and compliance requirements necessitate the existence of a fairly large infrastructure and dedicated staff just to remain compliant. Failure to comply can result in heavy penalties.

New reporting requirements under the 1997 BBA include the submission of encounter data in similar form to that collected under the Medicare fee-for-service program. To produce this data, administrators stated that their plans must develop new infrastructures and work with providers to obtain compliance.

Administrators also believed that the newly introduced risk adjustment factors based on individual member health status acuity require plans and providers to produce and deliver new data to HCFA or to be penalized for not properly identifying and reporting diagnoses. The risk adjustment method introduced in 2000 is based on inpatient diagnosis and thus operates as a disincentive to keeping people out of the hospital because it penalizes plans for not having a hospital-based diagnosis.

Administrators described how regulations developed to protect patient rights could create costly financial burdens. For example, when a person is being discharged from a hospital, the plan is required to provide the member with a lengthy letter describing their discharge and appeal rights. While the member is considering the letter and deciding, he or she is held harmless for the costs of hospitalization. Other examples of administrative burdens cited include:

- Documentation tracking members' enrollment and exceptions to normal enrollment, e.g., "working aged" designations, which HCFA must document

and which are often incorrect, requiring the plan to cover the person without reimbursement while the error is corrected, sometimes taking up to two years;
- The tracking of enrollment terminations and reasons, changes in providers, services, and National Committee for Quality Assurance (NCQA) requirements;
- HCFA's review of all member communications; and
- Extensive and highly specified provider contract provisions.

Administrators recognized that HCFA is working to improve some of the problems arising from new administrative requirements.

3. Maintaining an Adequate Provider Network

Network Characteristics. There are differing approaches to developing provider networks among Maryland M+C plans. One plan traditionally has maintained a fairly tight network of providers, often working with physicians as employees rather than as capitated or reimbursed subcontractors. Other Maryland plans developed wider provider networks partly in response to market pressures but also based on different philosophies.

Providers' Lack of Data Systems and Infrastructure for Risk-Based Managed Care. Administrators described how, as M+Cs developed in Maryland, there was initial enthusiasm among new plans and providers to subcapitate most of the risk of care to large, vertically integrated provider systems. Providers agreed to accept risk, manage claims, and manage data requirements. However, in many cases, the providers did not have the infrastructures or experience to operate as risk-based managed care. Providers had difficulty managing the hospital days, one of the most important components of financial efficiency in managed care. Three of five large, vertically integrated systems that became major subcontractors with M+C plans no longer exist. One M+C plan stated that it had seventeen providers in its network initially, but has dropped to seven within the last two years. The exodus of large providers required plans to find new providers, possibly less integrated, and to re-orient the new providers. Provider exodus also causes disruption in services and membership relationships.

Rural Issues. M+C administrators described how provider network development can be exacerbated in rural areas that do not have large physician and provider networks. Residents of rural counties generally are loyal to their providers and there is little competition for patients. Thus, individual physician providers have minimal incentive to participate in managed care. These conditions tend to make network development difficult. Practice patterns that support managed care are particularly hard to change among providers in rural areas.

Hospital Practices. Administrators described Maryland hospitals as powerful and having few incentives to be responsive to M+Cs. For example, one hospital refused to notify the M+C if a member came to the emergency room.

4. State Policies Impacting Medicare+Choice Operations

In addition to the federal issues, there was a general sense that the state regulatory system could be more supportive of managed care plans. The primary state policy that was cited by administrators from all plans and programs was the Maryland system of setting hospital rates, the "all payer" system.

Most plan administrators described Maryland hospital rates as higher than what they are able to negotiate in other states. For example, it was stated that a medical-surgical bed in Maryland could cost up to $1,000 per day, but only $800 in D.C. Rates vary dramatically from hospital to hospital in Maryland based on the hospital's percentage of uncompensated care and other cost factors that do not seem to be related to the quality of care provided in the hospital.

V. Findings and Conclusions

The cost of providing access to Medicare managed care in Maryland cannot be measured solely in dollars. Primary factors underlying the withdrawal of Medicare + Choice plans involve federal administrative, financial, and regulatory issues. An analysis of the information led to the following findings and conclusions:

A. The impact of Medicare +Choice (M+C) withdrawals on Maryland residents is significant.

In 1997, Maryland had seven M+C plans. In 2001, only one of those plans remains. A new, specialized program, Elder Health, has been licensed as an M+C program beginning in 2001.[9] Maryland is one of the hardest-hit states in terms of the number of Medicare beneficiaries and the proportion of M+C beneficiaries affected by M+C withdrawals. Among those states and territories with any significant M+C enrollments, Maryland is the hardest-hit in terms of the percentage of M+C enrollees affected. Maryland is sixth hardest-hit in the actual number of Medicare beneficiaries affected by M+C withdrawals. Between 2000 and 2001, approximately 64,500 of Maryland Medicare beneficiaries will have been involuntarily disenrolled from M+Cs and will not have another M+C option available to them. (See Figure 2 at pg. 9 for details.)

[9] Elder Health is a specialized program focusing on about 1,500 people who are dually eligible for Medicare and Medicaid or in nursing homes. Elder Health has been licensed as an M+C and will be operating in Baltimore City and several metropolitan counties.

B. Consumers affected by the M+C withdrawals have lost important benefits and will have increased out-of-pocket costs for health care.

Medicare managed care plans cover all the benefits covered by Medicare Part A (specified inpatient services) and Part B (physician services and outpatient care). In addition, most Medicare managed care plans cover the copays and deductibles associated with Medicare fee-for-service and provide additional benefits not covered by Medicare fee-for-service. Most managed care plans cover prescription drugs. (See Figure 3 at pg. 11 for details.)

Beneficiaries involuntarily disenrolled from their M+C plans lose benefits for prescriptions, the covered Medicare copays and deductibles, and the ancillary vision, dental, and hearing services. Beneficiaries losing M+C coverage will have additional out-of-pocket costs in terms of copays and deductibles associated with Medicare fee-for-service, or they will have the additional costs associated with the purchase of Medicare supplemental insurance (Medigap), insurance policies that are purchased to fill in the gaps left by Medicare fee-for-service.

C. The reasons for the M+C withdrawals are complex and primarily federal.

Conflicting philosophies and strategies underlie the current issues facing Medicare managed care. Although Maryland is one of the hardest-hit states, the problem is national in scope.

Solely increasing capitation rates may not solve the problem. The major financial issue for M+C plans is the difference between cost trends for medical care and the federal statutory cap on rate increases. Plan administrators stated that their costs have been trending upward at between six and ten percent annually while Medicare has limited rate increases to two percent per year since 1997. In addition to the rate cap, plans have experienced increasing administrative costs and challenges as a result of increased federal reporting requirements. Finally, the ability and willingness of provider networks to participate in the M+Cs is a major contributing factor.

Control over M+C rates rests solely with the federal government and control over administrative requirements is almost exclusively federal. Direct state financial subsidies are not practical in light of the significant federal issues underlying current problems in Medicare.

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