

## **DISTRIBUTION OF INCREASED PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS UNDER THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000**

**Background:** *Of the 39 million people with Medicare, about 5.6 million are enrolled in a Medicare+Choice organization. The Medicare+Choice program was established under the Balanced Budget Act (BBA) of 1997 to permit contracts between HCFA and a variety of different managed care and fee-for-service entities. In addition, the program sets federal reimbursement rates for Medicare+Choice organizations (including HMOs and other private health plans). The BBA set the payment rate per enrollee per month. Payment is based on the rate in the county in which an enrolled beneficiary lives, adjusted for factors associated with health care costs, such as age. The county payment rate established by the BBA is the highest of three amounts:*

- *A minimum two percent increase over the prior year's rate;*
- *A minimum dollar amount called a "floor". This was \$402 in 2000;*
- *An amount derived from blending the local rate with a national rate based on historic spending under the "fee-for-service" Medicare program.*

*Floor payments and the blended rate were intended to reduce the variation in Medicare+Choice payment rates by raising payments in low-payment counties.*

*With The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), enacted in December, 2000, Congress increased both the minimum percentage increase for 2001 (from 2 percent to 3 percent) and the floor amount. In addition to the basic floor of \$475, the legislation established another, new floor of \$525 for counties in urban areas with populations over 250,000. The legislation also extended bonus payments set by the Balanced Budget Refinement Act of 1999. The bonus is for Medicare+Choice organizations that enter a county where no other plan has been offered since 1997, or where coverage was terminated as of January 1, 2001. That bonus increases payments by an additional 5 percent the first year a plan is offered, and by an additional 3 percent for the second year. The BIPA legislation invited Medicare+Choice organizations, which had given notice of their intent to terminate coverage for Medicare beneficiaries, to rescind that decision by January 18, 2000. Finally, the BIPA legislation contains a provision that phases in risk adjustment payments over the next seven years. Risk adjustment pays plans more for treating sicker, and therefore more costly, beneficiaries.*

*These changes to payment rates are expected to increase aggregate payments to Medicare+Choice organizations by about \$11 billion over the next five years (about \$1 billion for 2001). The new rates are effective March 1, 2001.*

### **Medicare+Choice organizations were required to submit new benefit information**

To qualify for the higher payments under BIPA, the legislation required Medicare+Choice organizations to submit revised Adjusted Community Rate Proposals

(ACRPs) by January 18, 2001. These proposals detail Medicare+Choice organizations' premiums, benefit packages, and the costs and payments associated with providing benefits. (The consumer oriented portions of each Medicare+Choice organization's premiums and benefit packages can be found on [www.medicare.gov](http://www.medicare.gov), under "Medicare Health Care Compare.")

Under BIPA, the new payments must be used by Medicare+Choice organizations in only four ways:

- Reduce beneficiary premiums or cost sharing (e.g. co-pays);
- Enhance benefits;
- Enhance the network of health care providers available to beneficiaries;
- Reserve funds to help offset premium increases or benefit reductions in the future through contributions to a benefit stabilization fund.

Because the BIPA was enacted late in the year -- it was signed December 21, 2000 -- the Health Care Financing Administration worked rapidly to implement its new provisions. New payment rates were published on January 4, 2001. Since Medicare+Choice organizations were required by BIPA to submit new ACRPs within two weeks of that date, HCFA consulted extensively with representatives of Medicare+Choice organizations to enable those organizations to understand the new legislation and submit their new benefit plans.

### **650 proposals from 177 Medicare+Choice organizations**

HCFA received about 650 revised ACRPs from 177 Medicare+Choice organizations. HCFA staff worked to review and approve all of them, and the many marketing and advertising materials that describe them, in time for any Medicare+Choice plans that wished to market to beneficiaries to enroll them by March 1, 2001, when the new payment rates begin.

### **Four organizations return to Medicare+Choice**

Five Medicare+Choice organizations that terminated participation or reduced their service areas in the Medicare+Choice program effective December 31, 2000, submitted a letter of intent to return as a result of BIPA. Of these, one decided not to go forward. HCFA has signed contracts with the remaining four organizations, which served about 13,000 beneficiaries in 2000:

- Univera HealthCare of Central New York, in five counties;
- United HealthCare of the MidWest, in Monroe County, Illinois;
- Lovelace Health Plan, in Santa Fe, and six zip codes in Tarrant County, New Mexico;
- St. Joseph Medicare Plus, in four counties in New Mexico.

These organizations' plans cover 11 counties in three states. In six of the 11 counties, BIPA increased their county payment rates by over 20 percent. In the five counties served by Univera, in central New York, no other Medicare+Choice options are offered. As promised under BIPA, Univera will also receive the extended bonus payment.

**The most common use of new funds was to enhance provider networks.**

Medicare+Choice organizations could apply funds to the four options outlined above in any way, or combination of ways, that they chose (see Chart 1). Overall:

- 65 percent of enrollees are in plans that used funds only to enhance provider networks
- 6 percent of enrollees are in plans that used funds only to reduce premiums or cost sharing (such as copays).
- 1 percent of enrollees are in plans that used funds only to add or enhance benefits. About one-quarter of these added or enhanced a prescription drug benefit.
- 11 percent of enrollees are in plans that only put funds into reserve for the future through the benefit stabilization fund.
- 17 percent of enrollees are in plans that used multiple options.<sup>1</sup>

**The largest payment rate increases (based on BIPA) went to floor counties; plans in these counties were less likely to use new funds exclusively for enhanced provider networks.**

The distribution of the new funds varies by whether or not the counties served by the Medicare+Choice organization are floor counties, and which type of floor applies (Chart 2).

- The highest increases in rates are in counties that receive the new \$525 floor for urban areas of 250,000 or more. Medicare+Choice organizations serving these counties will see, on average, increases of 9.7 percent above pre-BIPA rates for 2001. Nearly one-quarter of all Medicare+Choice enrollees live in these counties.
- The \$475 floor raises rates in these counties by 8.3 percent above pre-BIPA rates for 2001. A small proportion (less than 2 percent) of enrollees live in these counties.
- All other counties receive just 1 percent increases above pre-BIPA rates for 2001—rates rise 3 percent above the 2000 rate. However, these counties have had the highest payment rates historically. About 75 percent of Medicare+Choice organization enrollees live in these counties.

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<sup>1</sup> Of the 17 percent of beneficiaries who were in plans that used the BIPA money for multiple purposes: 86% were in plans that enhanced provider access; 63% had their premiums reduced; 49% were in plans that put monies into benefit stabilization funds; 26% had a reduction in cost-sharing; 8% had added benefits; 7% had enhanced benefits (note percentages do not add to 100% since monies were used for multiple purposes).

Medicare+Choice organizations' use of the new funds varies by the amount of the payment increases under BIPA (Chart 3).

- In counties with the \$525 and \$475 floor, Medicare+Choice organizations using all funds to enhance provider networks represent the largest share of enrollees, 44 and 49 percent, respectively. About 8-9 percent of enrollees in these counties will be in plans where the BIPA funds were used only to reduce cost sharing or premiums.
- In non-floor counties, about 72 percent of enrollees are in Medicare+Choice organizations that put all of the BIPA funds into enhancing provider networks. (Non-floor counties had the smallest percentage increase in their pre-BIPA 2001 rates, but have the highest historical payments).

### **Premiums dropped about \$2/month nationally as a result of the BIPA changes.**

Looking at national average, premiums for basic plans<sup>2</sup> will go down an average of \$2 per month relative to pre-BIPA 2001 premiums as a result of the choices made by Medicare+Choice organizations in using the BIPA funds (Chart 4). (Premiums have tended to be highest in counties where Medicare payment rates have been historically lowest, i.e., the floor counties.)

- Relative to pre-BIPA 2001 premiums, post-BIPA premiums are reduced more in the \$525 floor counties. There, premiums will fall an average of about \$6.
- In the \$475 floor counties, relative to pre-BIPA premiums, post-BIPA premiums will drop an average of about \$4, from about \$52 to \$48.
- Post-BIPA premiums will be about \$1 less than pre-BIPA 2001 premiums in non-floor counties.

Without BIPA, almost 21 percent of Medicare+Choice enrollees would have had premiums for basic plans greater than \$50 in 2001, compared with just 7 percent of Medicare+Choice enrollees the prior year (Chart 5). In counties with \$525 floor payments, premiums of more than \$50 per month will be less common than before BIPA--dropping from 40 percent of all enrollees to 24 percent. With BIPA, almost 16 percent of enrollees will see premiums beginning in March of 2001 above \$50 (a 5 percentage point decrease). There was almost no change in the share of enrollees in Medicare+Choice organizations with \$0 premium basic plans in 2001 as a result of BIPA (about 45 percent).

### **Adding drug coverage was rare.**

The proportion of enrollees with drug coverage in Medicare+Choice organizations' basic packages has declined over the past several years--from 84 percent in 1999 to 72 percent in 2000 (Chart 6). Drug coverage is most common in counties with the highest payment rates.

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<sup>2</sup> That is, the plan offered at the lowest premium. If more than one plan is offered at that premium, it is the plan at that premium level with the most generous benefits coverage.

Few Medicare+Choice organizations used the BIPA funds to add a drug benefit (Chart 6). Without BIPA, about 69 percent of beneficiaries would have had drug coverage in their basic plan in 2001. With BIPA, the percent of enrollees in Medicare+Choice plans with drug coverage in the basic packages beginning in March of 2001 rises one percentage point to 70 percent. That is, about 61,000 Medicare+Choice enrollees will have access to new drug coverage in basic packages beginning in March of 2001 (Chart 7).

- About three-fourths of enrollees with a new drug benefit who lacked drug coverage in 2001 pre-BIPA and will have drug coverage post-BIPA (i.e., effective March 1, 2001) live in counties with the \$525 floor.
- The largest increase in the percentage of enrollees who lacked drug coverage in 2001 pre-BIPA and will have drug coverage post-BIPA (i.e., effective March 1, 2001) is in counties with the \$475 floor, from 31 percent to 38 percent.
- Enrollees in non-floor counties will continue to be the most likely to have access to drug coverage in a basic Medicare+Choice package (77 percent).