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Medicare: Payments to HMOs and Other Private Plans Under the Medicare+Choice Program

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Summary

P.L 105-33, the Balanced Budget Act (BBA) of 1997, changed the method of calculating payments to health maintenance organizations (HMOs) and other private plans that contract with Medicare. This report describes how payments will be calculated under the Medicare+Choice program established under the new law.

Background

Prior to enactment of P.L. 105-33, payments for care of Medicare beneficiaries in risk HMOs[1] were based on the adjusted average per capita cost (AAPCC). The AAPCC represented a monthly payment to cover the costs of treatment in a Medicare risk HMO. It was calculated according to a complex formula, based on the costs of providing Medicare benefits to beneficiaries in the fee-for-service (FFS) (i.e., non-managed care) portion of the Medicare program. The capitated payment was set at 95% of the AAPCC, and was adjusted for demographic characteristics of HMO enrollees.[2]

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[1]Risk HMOs have risk-sharing contracts with Medicare. These HMOs are paid a pre-established per person amount (i.e., a capitated payment) by Medicare. They are fully at risk for providing the basic Medicare benefit package to beneficiaries who enroll in the HMO. Other HMOs, known as cost-contract HMOs, contract with Medicare to provide benefits, but are not at financial risk; Medicare pays the HMO the actual cost of providing care to beneficiaries. In addition, Medicare makes payments to health care prepayment plans that contract to provide Part B services only on a cost contract basis. The new payment method described in this report would apply to risk HMOs and other Medicare+Choice organizations including preferred provider organizations, provider sponsored organizations, private fee-for-service plans and Medicare+Choice medical savings account (MSA) plans.

[2]AAPCCs were adjusted for category of eligibility for Medicare (e.g., age, disability, or end-stage renal disease), age, gender, whether the beneficiary resided in an institution, working status, and coverage under Medicaid. Following common usage, the term *AAPCC* is used in the remainder of this report to represent the reduced payment amount (i.e., 95% of the AAPCC). The
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This procedure assumed that an HMO could deliver Medicare benefits at a lower cost than FFS providers, and that the "5% savings" captured these lower costs for the Medicare program. The accuracy of the AAPCC in representing the true costs of care for risk plan enrollees has been questioned repeatedly since the effective beginning of the current risk program in 1985. Most studies found that Medicare beneficiaries who enroll in risk HMOs use fewer services than beneficiaries who remain in the FFS program.[3] Differences in utilization suggest that many risk HMOs should be receiving less than 95% of FFS costs. Changes to the payment method included in the 1997 BBA were prompted, in part, by these findings.

Calculation of Payment Rates Under the BBA

Under the BBA, a county's[4] Medicare+Choice payment rate will be determined by taking the largest of three different rates:

- a "floor," or minimum payment rate;
- a "minimum update" rate; and
- a "blended" rate.

After each county's payment rate is determined, the total projected spending for Medicare+Choice will be compared to a budget neutral amount. If the projected spending is greater than the budget neutral amount, payment rates will be reduced until budget neutrality is met. This will be accomplished by lowering payments in counties with "blended" rates. However, no county will receive less than the floor rate or the minimum update rate, whichever is larger.

Floors. Under the BBA, the floor will be $367 for aged beneficiaries in 1998 in the 50 states and the District of Columbia. For Puerto Rico and the territories, the floor will be the minimum of either $367, or 150% of the 1997 total AAPCC, whichever is lower. In subsequent years, the floor will be updated using an annual update factor, estimated to be about 4-6% between 1999 and 2002.[5] Projected floors from 1999 through 2002 are shown in **Table 1**.

There were 1,213 counties in the 50 states and D.C. (39%) with 1997 AAPCC payments below $367. Under the BBA, payments in these counties will increase to at least $367 in 1998. For counties with very low 1997 AAPCCs, such as Arthur and

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[2](...continued)
Medicare+Choice payments will also be adjusted for demographic characteristics of enrollees.

[3]For example, see Physician Payment Review Commission. Risk Selection and Risk Adjustment in Medicare. *Annual Report to Congress 1996*, Chapter 15; Riley, Gerald, Cynthia Tudor, and Yen-pin Chaiang, et al. Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994. *Health Care Financing Review*, v. 17, no. 4, summer 1996. p . 65-76.

[4]Medicare+Choice payment areas are counties or equivalent areas specified by the Secretary of Health and Human Services. The Secretary may adjust payment areas if requested by a state.

[5]This factor will be based on projected per capita growth in Medicare expenditures (minus 0.8 percentage points in 1998, minus 0.5 percentage points in 1999-2002, and minus 0.0 in subsequent years). Note that this factor is not used to establish the floor in 1998.

Banner, Nebraska, the increase from the 1997 AAPCC to the floor will represent a 66% increase in payments, on average.

Table 1. Floors, or Minimum Payments to Medicare+Choice Plans Under the 1997 BBA

1998	$367
1999	$381[a]
2000	$398[a]
2001	$420[a]
2002	$445[a]

Source: Table prepared by Congressional Research Service (CRS).
[a] Projections based on prior year's floor payment and estimates of growth in Medicare expenditures per capita prepared by the Congressional Budget Office (CBO).

Minimum Update Rates. If a county's 1997 AAPCC is greater than $367, Medicare+Choice plans in the county will be guaranteed an increase of at least 2% in payment rates in 1998.[6] Specifically, in 1998, the minimum update, or hold-harmless rate will equal the 1997 AAPCC times 102%. In 1999, payment rates for Medicare+Choice plans in a county will be at least 2% higher than rates in 1998. Thus each county will be guaranteed that payment rates will increase by at least 2% each year.

Blended Rates. AAPCCs have been criticized for their wide variation across the U.S. In 1997, for example, AAPCCs for aged beneficiaries ranged from a low of $221 per month in Banner and Arthur, NE to a high of $767 in Richmond, NY. Many have argued that this wide variation cannot be explained by differences in costs of medical care or severity of illness among Medicare beneficiaries in different geographic locations.

To reduce variation in costs across the nation, the BBA will average, or blend, national and local rates. Blending will reduce payments in counties with AAPCCs that have traditionally been higher than the national average rate, and increase payments in counties with AAPCCs that have traditionally been lower than the national average rate. Over time, the blended rate will rely more heavily on the national rate, and less heavily on the local rate. This will reduce the variation in rates across counties over time. **Table 2** shows how the BBA will phase in blending of national and local rates between 1998 and 2003.

Both the national and local rates used to compute the blended amount will be "adjusted" rates. The national rate will not simply be the average of rates nationwide. Nor will the local rate simply be an update of the previous year's payment rate. For purposes of computing blended rates, the local rate is an *area-specific capitation rate*. To compute this area-specific rate, the share of the HMO payment that represents

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[6] Actual payments will depend on the demographic characteristics of Medicare beneficiaries enrolled in a Medicare+Choice plan.

graduate medical education (GME) payments will be removed, with a phase-out over 5 years. Beginning in 1998, local rates for blending purposes will remove 20% of GME spending. Thus, the local area-specific rate in 1998 will equal the county's 1997 AAPCC minus 20% of GME spending in 1997, multiplied by the annual update factor mentioned above to bring the rate to 1998. The reduction in GME payments will be increased by 20% each year, to 40% in 1999, 60% in 2000, 80% in 2001, and 100% from 2002 onward. In 1999, the local area-specific rate will be the 1998 local area-specific rate minus an additional 20% of GME spending in 1997, multiplied by the update factor to bring the estimates to 1999.[7]

Table 2. Weights Used for Blended Rates

	Weight for national rate	Weight for local rate
1998	10%	90%
1999	18%	82%
2000	26%	74%
2001	34%	66%
2002	42%	58%
2003+	50%	50%

National rates for blending purposes will be *input-price adjusted* to reflect differences in the costs of providing medical care across counties. Input prices are amounts charged for goods and services that are used to deliver medical care, such as nurses' wages and physician office rent. These are factors that generally do not reflect efficiency in the delivery of medical care, but instead are items over which the provider has little control. In 1998, input-price adjustments will be made to the national average rate using the hospital wage index and geographic adjustment factor (GAF), which are factors already used to adjust payments to FFS providers under Medicare.[8] Thus the input-price adjusted national rate will differ for each county, but will be based on the national average rate. If the national rate was not input-price adjusted, counties with very high input prices (e.g., high office rents) would be penalized when local and national rates are blended, while counties with low input prices (e.g., low office rents) would receive a bonus payment.

The national rate for 1998 will be the average of 1998 local area-specific payment rates, weighted by the number of Medicare beneficiaries in each county. The national rate for 1999 will be the average of 1999 local area-specific payment rates. Note that this is

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[7]Beginning in 1999, adjustments will be made to the previous year's local area-specific and national rates to correct for any differences in projected growth, before the next year's rates are determined. Note that the current year's local area-specific rate is calculated using a modification to the previous year's local area-specific rate, not the previous year's actual capitation rate.

[8]The hospital wage index is used to adjust payment rates for relative hospital wage levels under Part A (hospital insurance), while GAFs are used to adjust payments for physician services under Medicare's Part B (supplemental medical insurance).

not the average of projected payments, but instead the average of payments that would have been made if the AAPCC method had been continued (except for removal of GME spending).

Both the local area-specific and national rates used to compute the blended rate will be updated from year to year using an annual update factor. Finally, the blended rate will be subject to budget neutrality adjustments as discussed below. The rate provisions are summarized in **Table 3**.

Budget Neutrality

Payments to Medicare+Choice plans will be limited by the BBA's budget neutrality provisions, which means that no more money is to be spent as a result of policy changes under the BBA than would have been spent without the policy changes. The BBA requires that the Secretary determine a budget neutrality adjustment factor each year. This factor will be used to adjust payment rates so that total payments made for Medicare+Choice are equal to total payments that would have been made if county-level payments were based entirely on local area-specific capitation rates.[9]

If payments to counties at the calculated floor, minimum update, and blended rates produce total payments in excess of the budget neutral amount, rates in blended counties will be reduced. However, payments will not be reduced to levels that are lower than the floor or minimum update rates. In other words, no county will have payment rates that are lower than the floor, or the county's minimum update rate if it is higher, even if rates are reduced in blended rate counties to meet budget neutrality.

Some Sample Rates

A few examples illustrate how the computation works, using counties with the lowest, about average, and highest AAPCCs in 1997. **Table 4** reports the sample counties' 1997 AAPCC, the three rates from the initial calculation of an estimated 1998 rate, and the actual 1998 rate. For Arthur and Banner, NE, the 1998 floor of $367 is higher than the estimated minimum update or blended rates, so these counties will receive the floor payment in 1998. In Dade, FL and Richmond, NY, the minimum update rates of $763 and $783, respectively, are greater than the floor ($367) and estimated blended rates, so these counties will receive their minimum update rates. Sonoma, CA and Orange, NY have estimated blended rates that are greater than either their floor or minimum update rates. However, because blended rates were altered to meet budget neutrality, the final estimated payment rates in these counties are equal to their minimum update amounts. These estimates of blended rates were prepared using specific assumptions about HMO enrollment, annual update factors, and other programmatic data. These assumptions and data may differ from those used by the Health Care Financing

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[9]The budget neutral amount in 1998 will be the sum of each county's 1997 AAPCC minus 20% of GME payments (i.e., the local area-specific capitation rate), multiplied by the number of Medicare HMO enrollees, and by the annual update factor for 1998 (i.e., projected per capita growth in FFS costs minus 0.8 percentage points). The budget neutral amount in future years will equal each county's previous year's area-specific rate, adjusted for the phase-out of GME payments, times the number of HMO enrollees and the annual update factor.

Administration (HCFA) to prepare final payment rates for 1998, which were released on September 8, 1997; these rates will apply to existing risk contracts.

Table 3. Summary of Provisions

Base year	1997
Floor, or minimum payment	1998=$367 for states and DC; minimum of ($367 or 150% of 1997 AAPCC) for territories. Increased annually by update factor
Minimum update (hold-harmless)	1998 = 1997 AAPCC * 102% 1999+ = previous year's Medicare+Choice payment rate * 102%
Blend of local and national rate (national rate would be input-price adjusted)	1998: 90% local, 10% national 1999: 82% local, 18% national 2000: 74% local, 26% national 2001: 66% local, 34% national 2002: 58% local, 42% national 2003+: 50% local, 50% national
GME carve out	1998: minus 20% 1999: minus 40% 2000: minus 60% 2001: minus 80% 2002+: minus 100%
Annual update for blending and floors	1998 = Growth in Medicare expenditures per capita - 0.8 percentage points 1999 to 2002 = Growth in Medicare expenditures per capita - 0.5 percentage points 2003+ = Growth in Medicare expenditures per capita

Table 4. Sample Payment Rates Calculation for Aged Beneficiaries in 1998

		Estimated rates			
County	1997 AAPCC	Floor	Minimum update	Blend[a]	Payment[b]
Arthur, NE	$221	$367	$225	$249	$367
Banner, NE	$221	$367	$226	$252	$367
Orange, NY	$470	$367	$480	$486	$480
Sonoma, CA	$471	$367	$480	$489	$480
Dade, FL	$748	$367	$763	$745	$763
Richmond, NY	$767	$367	$783	$751	$783

Source: Table prepared by CRS.

[a]. Calculations by the Congressional Research Service, July 31, 1997. Note that different assumptions about enrollment in Medicare+Choice plans, per capita growth in Medicare expenditures, and other factors could produce different estimates.

[b] HCFA payment rates, September 8, 1997.