MONITORING MEDICARE+CHOICE

FAST Facts

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Raising Payment Rates: Initial Effects of BIPA 2000

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The Benefits Improvement and Protection Act (BIPA) of 2000 raised payment rates to Medicare+Choice plans in lower payment areas effective March 2001. Before BIPA, the minimum county payment under Medicare+Choice was $415 in 2001. BIPA raised the minimum payment in counties with metropolitan areas of at least 250,000 people to $525 and elsewhere to $475. For counties with rates already above these thresholds, the minimum payment increase was raised from 2 percent to 3 percent for 2001 only.

Few Re-Entrants or New Entrants Yet

BIPA was designed to generate more geographical equity in payment and to reverse some of the announced program withdrawals and reductions in benefits offered under Medicare+Choice. Because of the timing of congressional action, plans seeking to make changes effective March 2001 had to be positioned to make them quickly. Few re-entered, but those that did play important roles in their individual markets.

Of 60 plans withdrawing from the Medicare+Choice program in 2001, four plans with 13,000 enrollees re-entered the program after the enactment of BIPA:

- Lovelace Health Plan in Sante Fe/Torrance County, NM;
- St. Joseph Medicare Plus in four counties around Albuquerque, where the three Medicare HMOs offered enroll 46 percent of Medicare beneficiaries in the area;
- Univera HealthCare in five counties in central New York State, where there is no other Medicare health maintenance organization (HMO) alternative; and
- United HealthCare of the MidWest in Monroe County, IL.

Current Enrollee Distribution

BIPA provided substantial increases in counties eligible for floor payments, but only a 1 percent increase in payments in other counties (see Table 1). Seventy-five percent of Medicare HMO enrollees are in counties receiving the minimum payment increase, even though less than half of Medicare beneficiaries live in such counties. Most of the rest of Medicare HMO enrollees are in urban counties, where the floor payment was raised to $525. Though 23 percent of Medicare beneficiaries live in the mainly rural counties receiving $475, few Medicare HMOs operate in these areas. Only 13 percent of beneficiaries in such counties had a choice of Medicare HMOs in January 2001, and only 1 percent were enrolled in one.

How Payment Increases Were Used

Provider complaints of payment inadequacy were a factor behind some of the withdrawals from the Medicare+Choice program, and BIPA payment increases were largely used to respond to providers' concerns, according to a Health Care Financing Administration (HCFA) analysis of Medicare HMO filings (see Table 2). Sixty-five percent passed on the increase to providers exclusively. Only 6 percent used the increase exclusively to reduce premium or cost sharing, and 1 percent expanded benefits only. Those receiving floor payments were much more likely to use the additional funds for multiple purposes, including some change in premiums and benefits. Plans generally did not add a pharmacy benefit if they did not already offer one.

Plans did not have much time to restructure premium costs and benefits. BIPA was signed on December 21, 2000, and the associated rate increases were announced on January 4, 2001. Medicare HMOs were required to submit revised rate proposals and benefit packages within two

Table 1

Payment Changes under BIPA, 2001

	Nonfloor	$525 Floor	$475 Floor
Average payment increase	1 %	9.7 %	8.3 %
Share of Medicare HMO enrollees	75	23	2
Share of Medicare beneficiaries	44	32	24

Source: Health Care Financing Administration (www.hcfa.gov/medicare/bipafact.htm)
NOTE: Statistics are weighted by enrollment in plans.

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weeks, and they also had to notify enrollees about these changes. Complicating the issue, some HMOs base payment with providers on a percentage of premiums. These plans have little discretion over how to use the BIPA increases, because they are automatically passed on to providers. For plans receiving a small increase, the administrative costs of making changes in premiums or benefits were probably not worth it.

Moderate Declines in Premiums

Medicare HMOs were more likely to make adjustments in the premiums they charged than to introduce more complex changes in cost-sharing requirements or benefits (see Table 3). Average premiums declined 18 percent in plans whose largest county received a $525 premium, 4 percent in those whose largest county received $475, and 5 percent elsewhere.

Even with the BIPA increase, plans in floor counties have higher average premiums and are much less likely to offer a zero-premium product. Further, premium levels in March 2001 are still much higher than in earlier years.

Looking Ahead

HCFA is raising floor rates for 2001 to $533 in urban areas with 250,000 or more people and $503 elsewhere. Although the average increase will be 5.3 percent, most enrollees are still likely to be located in counties receiving only the 2 percent minimum increase. Plans are required to notify HCFA by July 1 about any changes in participation, service area definition, premium, and benefit/cost-sharing design.

Any effects of BIPA are likely to be seen most in urban counties eligible for the higher floor. Even though Medicare HMOs are viable in these markets, low payment rates historically have limited product design and, probably, negatively affected enrollment. A key question is whether the additional payments can stabilize and expand this component of the Medicare+Choice market by encouraging plans to remain in these areas.

BIPA is unlikely to have a major effect in rural and less urbanized areas. Though the payment increases are significant, it is not clear that they will be sufficient to encourage substantial new entry of Medicare HMOs, because managed care in these areas is limited by diseconomies of scale and provider resistance.

Sterling Life Insurance Company, the only private fee-for-service Medicare plan that operates in many of these counties, has begun to market its product more aggressively in response to BIPA. While enrollment remains limited, it has started to grow, reaching 11,472 in March 2001. How attractive this option is for beneficiaries remains to be seen.

Table 2

Use of Increased Payments under BIPA by County Payment Type

	All	Nonfloor	$525 Floor	$475 Floor
Enhanced provider access only	65%	72%	44%	49%
Stabilization fund only	11	14	3	0
Reduced premium or cost sharing only	6	5	9	8
Added or enhanced benefits only	1	1	0	1
Used multiple options	17	7	45	42

Source: Health Care Financing Administration (Table Medicare+Choice BIPA 3) (www.hcfa.gov/medicare/bipahome.htm)

NOTE: Statistics are weighted by enrollment in plans. Totals may not add to 100 percent due to rounding.

Table 3

Trends in Premiums and Pharmacy Coverage Pre-and Post-BIPA, Basic Plans by Payment Type, 1999-2001[1] (Enrollment Weighted)[2]

	All	Nonfloor	$525 Floor	$475 Floor[3]
Mean Premium (in dollars)				
1999	$6.37	$1.46	$13.19	$25.35
2000	14.43	9.63	27.57	38.55
2001, January	25.26	21.13	38.78	59.29
2001, March	22.94	20.09	31.81	56.73
Percent Zero Premium				
1999	80%	95%	63%	29%
2000	59	69	33	8
2001, January	44	49	29	20
2001, March	46	50	31	20
Percent Pharmacy Benefits				
1999	84%	91%	70%	34%
2000	78	87	55	26
2001, January	68	78	37	31
2001, March	70	78	43	33

Source: MPR Analysis of Medicare Compare

[1]Statistics refer to basic packages in plan-contract segments. Classification of payment rates based on the county with the largest plan enrollment.

[2]Enrollment is for March of each year.

[3]Trends are confounded by a large drop in enrollment in these Medicare+Choice contract segments. While 249,557 beneficiaries were in Medicare+Choice in 1999, this number decreased to 126,105 in 2000 and 51,896 in 2001.

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