CBO TESTIMONY

Statement of
Steven M. Lieberman
Executive Associate Director
Office of the Director
Congressional Budget Office

on
Medicare+Choice

before the
Committee on Finance
United States Senate

June 9, 1999

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Wednesday, June 9, 1999.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, Senator Moynihan, and Members of the Committee, it's a pleasure to appear before you today to discuss the enrollment and payment issues confronting the Medicare+Choice program. The growth in that program's enrollment is closely linked to the adequacy and appropriateness of Medicare's capitated payments. The recent withdrawal of plans from Medicare+Choice, coupled with reduced growth in payments, has prompted some observers to worry about the future of the Medicare+Choice program.

My testimony discusses the Congressional Budget Office's (CBO's) projection of enrollment in Medicare+Choice plans over the next 10 years and the factors influencing growth in that enrollment. Financial incentives play a critical role in determining whether plans participate in Medicare+Choice, whether beneficiaries enroll, and whether providers deliver appropriate services in an efficient manner.

For Medicare+Choice to be a viable program, beneficiaries must have incentives to relinquish traditional fee-for-service and enroll instead in competing health plans. The challenge is to have a system that yields greater returns when it efficiently provides necessary, high-quality services and smaller returns when it provides inefficient, low-quality, or unnecessary services. Meeting that challenge requires that plans, providers, and beneficiaries each bear some degree of financial risk. Serious problems can result if Medicare payments do not bear a reasonable relationship to the costs of care for each group of beneficiaries for which plans and

providers accept risk. Payments to providers must be fair and, ideally, give incentives to control costs while rewarding quality.

If consumers have a choice of health plans offering various combinations of benefits and premiums, they can select the plan that best meets their needs. Enrollment in Medicare+Choice plans would grow if those plans offered better benefits or lower costs than traditional Medicare. If consumers have no choice of plans or if those plans offer unattractive benefits, high costs, or poor quality, beneficiaries will remain in fee-for-service Medicare.

ENROLLMENT IN THE MEDICARE+CHOICE PROGRAM

CBO projects that growth in Medicare+Choice enrollment will average 9 percent annually between 1999 and 2009. Though quite rapid, that rate of increase represents a sharp reduction from earlier trends.

The Balanced Budget Act of 1997 (BBA) established Medicare+Choice and changed payment provisions for both health maintenance organizations (HMOs) and fee-for-service providers. CBO had assumed that Medicare+Choice enrollment would continue to grow at the dramatic rates of the program it replaced. The annual rate of growth in enrollment in Medicare's risk-based plans peaked at 36 percent in

fiscal year 1996, however, and slowed in subsequent years. CBO projects that 31 percent of all Medicare beneficiaries will join Medicare+Choice plans in 2009, up from 16 percent this year (see Table 1).

TABLE 1. ACTUAL AND PROJECTED ENROLLMENT IN RISK-BASED HMO PLANS AND MEDICARE+CHOICE

Fiscal Year	Enrollees		Annual Growth in (Enrollment Percent)
	Number (Millions)	Percentage of Medicare Beneficiaries	
	Actual		
1992	1.4	4.0	n.a.
1993	1.6	4.5	13.8
1994	1.9	5.2	18.9
1995	2.5	6.7	29.7
1996	3.4	8.9	36.0
1997	4.5	11.7	32.4
1998	5.5	14.1	22.2
1999	6.2	15.7	12.7
	Projected		
2000	6.6	16.6	6.5
2001	7.1	17.7	7.6
2002	7.6	18.7	7.0
2003	8.4	20.4	10.5
2004	9.2	22.0	9.5
2005	10.1	23.8	9.8
2006	11.0	25.6	8.9
2007	12.0	27.4	9.1
2008	13.1	29.3	9.2
2009	14.1	30.9	7.6

SOURCE: Congressional Budget Office.

NOTE: HMO = health maintenance organization; n.a. = not applicable.

HMO Withdrawals

Last year, 99 HMOs announced they were either terminating or, far more commonly, scaling back their Medicare+Choice operations in certain counties. The potential disruption involved 407,000 enrollees, accounting for 7 percent of all Medicare+Choice enrollment. Plan withdrawals occurred in 406 counties—42 percent of the counties covered by Medicare managed care. Nonetheless, the overwhelming majority of the affected beneficiaries had the option to switch to a competing Medicare+Choice plan.

The unanticipated withdrawal of plans from the Medicare market has heightened awareness that plans can leave the market. That perception is likely to reduce the willingness of some Medicare beneficiaries to enroll in plans in the next few years. Although the effects of plans' withdrawal on Medicare+Choice enrollment seem relatively clear, explaining why plans withdrew appears more controversial.

In a recent report, the General Accounting Office concluded that most likely more than one factor was responsible for the withdrawals.

> No one factor can explain why plans choose to participate in particular counties. Although plans obviously consider payment rates, many other factors also influence their business decisions.[1]

> The current movement of plans in and out of Medicare may be primarily the normal reaction of plans to market competition and conditions. . . . Other factors associated with plan withdrawals—recent entry in the county, low enrollment, and higher levels of competition—suggest that a number of Medicare plans withdrew from markets in which they had difficulty competing.[2]

By contrast, the HMO trade group, the American Association of Health Plans (AAHP), attributes the withdrawals to inadequate payment rates, exacerbated by the administrative burdens imposed by the Health Care Financing Administration's (HCFA's) "MegaReg" for implementing the BBA's provisions. AAHP believes that without substantial revisions to Medicare+Choice, additional plans will withdraw from the program.[3]

Adverse publicity associated with the health plans' withdrawal from Medicare+Choice is likely to temporarily slow growth in enrollment. But over the

---

1. General Accounting Office, *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues*, GAO/HEHS-99-91(April 1999), p. 22.
2. Ibid., p. 44.
3. Ibid., Appendix V.

longer term, that growth depends critically on the size of payment increases and the ability of plans to offer attractive additional benefits, such as prescription drugs.

Constraining Medicare+Choice Payments

Health plans, as businesses, will participate in Medicare+Choice markets only if they have an expectation of an adequate return—at a minimum, if they can reasonably expect at least to cover costs. If payments are perceived as being inadequate, health plans will tend not to participate in Medicare+Choice, especially if they foresee little prospect of Medicare payments becoming adequate.

A similar dynamic applies to providers. Regardless of mission or not-for-profit status, physicians and other providers cannot afford to participate indefinitely when their enterprises are losing money.

In addition to causing plans to withdraw, inadequate Medicare+Choice payments have another, compounding effect on enrollment growth. Reducing payment increases to Medicare+Choice plans will impede their ability to offer extra benefits or limit beneficiary cost sharing. Taking steps such as eliminating prescription drug benefits or requiring hefty monthly premiums instead of "zero premiums" will make Medicare+Choice plans less attractive to consumers. As a result, fewer beneficiaries will choose to join those plans.

Are Medicare+Choice payments inadequate? The adequacy of payments can be evaluated from five often-competing perspectives.

- Are plans able to provide appropriate services while remaining financially stable?

- Are payments fair, permitting (if not encouraging) plans and providers to serve sicker patients?

- Is there an adequate choice of health plans in both urban and rural parts of the country?

- Do the payments offered by Medicare+Choice plans attract physicians, hospitals, and other providers to participate in their networks?

- Do the payments help keep Medicare affordable for both beneficiaries and taxpayers?

Having well-established plans "vote with their feet" and withdraw from their key Medicare+Choice markets is an indication that payment and other conditions of participating in Medicare+Choice may be too stringent. But health plans have

powerful incentives to convince policymakers that Medicare+Choice payments need to be increased without having to withdraw from the program.

CHANGES TO MEDICARE+CHOICE PAYMENTS UNDER THE BALANCED BUDGET ACT

The BBA enacted six policies that affected Medicare+Choice payments.

- The BBA significantly reduces fee-for-service spending, which also slows the growth of payments to health plans because annual updates to Medicare+Choice payment rates are tied to the growth in per-enrollee spending in the traditional Medicare program.

- The BBA sets the annual increases in Medicare+Choice payment rates below the growth in fee-for-service spending from 1998 through 2002.

- The portion of Medicare+Choice payment rates that is attributable to fee-for-service spending for graduate medical education will be gradually eliminated.

- HCFA will withhold about 0.2 percent of payments to Medicare+Choice plans to pay for dissemination of information to beneficiaries about their coverage options.

- A blend of local and national payment rates will be phased in for Medicare+Choice plans. That blending provision redistributes money from areas with high payment rates to those with low payment rates.

- New payment risk adjusters will be implemented in two stages. Those adjusters are intended to more accurately reflect the expected costs of providing health care to enrollees in Medicare+Choice plans.

The first four policies were enacted with the expectation that they would slow the growth of Medicare spending. Those policies reduce the cumulative growth in Medicare+Choice payment rates relative to fee-for-service payments by 6 percent. The blending of local and national payment rates is purely redistributive, but particular counties will see substantial changes in payment rates. The new risk adjusters were not necessarily expected to lower average payments to Medicare+Choice plans but, as discussed below, they could yield substantial program savings when they are implemented.

Impact of the Payment Blend

Because of the blending of national and local payment rates, payment increases are projected to vary enormously from county to county. For example, some counties would experience such large increases in payment rates from 1997 to 2000 that the theoretically available Medicare+Choice payment rates—if any plans operated in the areas—would exceed 180 percent of the 1997 (pre-BBA) payment rates. In contrast, some counties with high payment rates would see only a 6.1 percent increase in their rates over the same period.

Historically, both the level of and increase in Medicare spending per beneficiary varied dramatically in different counties. HCFA, however, no longer produces those data on county-specific spending trends. If past trends continue, some Medicare+Choice plans will face payment rates that are projected to be substantially below both per capita fee-for-service spending and 1997 (pre-BBA) amounts.

Over half (52) of the 100 counties with the most Medicare+Choice enrollees are projected to have payment rates fall by 5 percent or more using as the standard of comparison the rates that Medicare would have paid if 1997 payments were increased by the national average growth in per capita fee-for-service spending and the BBA payment provisions were fully in effect. Using that methodology, the steepest reduction is estimated to be 12 percent. In the top 100 counties, 88—home

to 78 percent of the enrollees—would experience declines in payment rates, compared with 1997 rates. These estimates do not include the lower payments resulting from HCFA's implementation of risk adjustment.

Impact of Risk Adjustment

Until 1999, CBO had assumed that Medicare+Choice payments would be adjusted for risk without changing total outlays. In January, the Administration published plans to phase in risk adjustment in a manner that would reduce payment rates for enrollees in Medicare+Choice plans. The first stage of risk adjustment would be based on the use of inpatient hospital services by individual enrollees. That change would reduce payments for existing enrollees by 7.6 percent when fully phased in—by 2004. The Administration also announced a second stage of risk adjustment that would be based on use of services in all settings. The Administration expects that such an adjustment would reduce payments by another 7.5 percent, beginning in 2004. If both plans are implemented as announced, the combined effect could reduce payments by about 15 percent.

Payment reductions related to risk adjustment on the order of 15 percent would be likely to cause plans to drop out of the program and enrollment in Medicare+Choice to drop sharply. Because of the magnitude of the planned

reduction and the discretion retained by the Administration in implementing the adjusters, the CBO baseline does not assume the full savings from risk adjustment. For the same reason, the projections of Medicare+Choice enrollment discussed in my testimony today explicitly do not reflect the full savings. Instead, CBO assumes that risk adjustments will ultimately reduce payments by lesser amounts.

RISK SELECTION AND RISK ADJUSTMENT

Risk selection occurs when groups of beneficiaries, such as those who enroll in a Medicare+Choice plan, have average costs that are systematically different from the average costs of beneficiaries who are treated as similar by the risk adjuster. When monthly payments are made on a fixed, prospective (or capitated) basis, those groups of enrollees are referred to as "risk pools." If Medicare+Choice enrollees tend to have lower costs than comparable fee-for-service beneficiaries, the result is known as "favorable" risk selection. Conversely, "adverse" risk selection occurs when groups or risk pools have costs that are higher than those of comparable fee-for-service beneficiaries.

Risk selection is incompletely understood and imperfectly measured. It can arise from many different sources.[4] If unchecked, risk selection can destroy an

4. Biased selection can occur without a clear basis. For example, in the early 1990s, Mathematica Policy Research conducted evaluations for HCFA and concluded that Medicare HMOs benefited from favorable selection. Yet Mathematica also suggested that how selection occurred was not well understood—and might have been the result

insurance system. Systematically selecting people who are healthier than average pays off handsomely: the returns on favorable selection can overwhelm any potential savings from operating an efficient system for managing care. Health insurance systems in which biased selection segments the risk pool are said to enter a "death spiral" if the problem is not fixed.

One goal of risk adjustment is to pay more fairly. In a fair system, the amounts paid for different risk pools would closely approximate the average cost of providing services to their members. Under that framework, a good risk adjuster would pay groups with sicker, more expensive people proportionately more and groups with healthier, less expensive beneficiaries proportionately less.

Medicare+Choice Risk Adjuster

There are a wide variety of potential approaches to mitigating the effects of risk selection. HCFA has adopted a mechanism for risk adjustment that relies on inpatient hospital admissions for specific diagnoses to trigger higher capitated payments in the following year. That mechanism, which is known as the principal in-patient/diagnostic cost group (or PIP/DCG), attempts to adjust payments statistically

of enrollment decisions by beneficiaries. In one report, Mathematica concluded that a small underrepresentation of the most expensive group of beneficiaries in the HMO risk pools probably accounted for most of the favorable selection they identified.

to account for individuals with persistently high costs. On average, PIP/DCGs would reduce payments somewhat for most beneficiaries but increase them significantly for the minority of beneficiaries who were hospitalized in the prior year for specific conditions (such as congestive heart failure).

HCFA has had to overcome significant analytical and operational obstacles in setting up the PIP/DCG system. The agency appears to be successfully implementing that complex system, for which it deserves recognition. But it is important to understand the limitations of that system for adjusting payments.

Developing a Medicare Risk Adjuster

Although the PIP/DCG system is a significant improvement over demographic adjusters, it has had limited success in achieving the goal of "fair" payments—payments that are closely related to the costliness of beneficiaries (based on their health status). Two factors contribute to the difficulty of developing an adequate Medicare risk adjuster.

First, the health care costs for individuals are enormously difficult to predict. That difficulty is compounded when the predictions are based on the administrative data available from processing claims.

Second, Medicare spending is extremely skewed—that is, the sickest beneficiaries are extraordinarily costly. The most expensive 5 percent of Medicare beneficiaries cost almost as much as the remaining 95 percent of all Medicare beneficiaries. On average, those in the top 5 percent cost over $70,000 annually—more than 10 times the average annual cost for all Medicare beneficiaries.

The variation in cost per beneficiary has two critically important implications. On the one hand, it highlights the potential financial consequences associated with both risk selection and inadequate risk adjustment. On the other hand, assuming neutral risk selection—that a risk pool has an "average" population—the skewness of the distribution of costs may require relatively large numbers of participants for a risk pool to be stable. Very large risk pools are unlikely to be undermined by having one too many—or too few—million-dollar cases in a year. Small risk pools, however, could be seriously disrupted by having just one person who incurs catastrophic health care costs.

Large health plans may be able to assume full financial risk for their enrollees. Even without risk selection, small plans may not be well positioned to assume full financial risk. In many large Medicare+Choice markets, health plans base payments to physicians or other providers on a percentage of premiums, thereby passing risk on to the providers.

These compensation arrangements do not directly connect HCFA to provider payments. Yet HCFA remains vitally involved for two reasons. First, HCFA regulates the terms and conditions under which physicians may be placed at substantial financial risk, approving their contracts with Medicare+Choice plans. Second, HCFA has a vital interest in and regulatory responsibility for assuring that beneficiaries have adequate access to sufficient providers and receive high-quality care.

The numerous Medicare+Choice providers who are paid on a capitated, percentage-of-premium basis subdivide a health plan's risk pool. As a result, even relatively large risk pools at the health plan level may become too small at the provider level. PIP/DCGs may not be a desirable system for adjusting payments to small risk pools.

Problems with Using an Inpatient Risk Adjuster

The first phase of the PIP/DCG relies solely on inpatient hospital admissions and excludes care delivered in other settings. One can argue that the reliance on inpatient hospital admissions hurts managed care plans, many of which have reduced their use

of inpatient hospital services. Some plans have implemented effective disease management and other protocols that may alter the pattern of care, possibly minimizing the specific admissions that are rewarded by the PIP/DCG methodology.

What are the implications of the inpatient PIP/DCG payment system for a Medicare+Choice plan that has invested in developing sophisticated disease management systems for chronic conditions? Unlike acute episodes of care, chronic conditions, such as congestive heart failure, can frequently have high and recurring costs. Paradoxically, that makes such conditions ideal for both disease management interventions and for creating a PIP/DCG payment adjustment.

With chronic conditions, an HMO can identify who is at risk and develop intervention strategies to improve outcomes. Typically, successful interventions stress prevention, investing in patients' education, and gaining their compliance with protocols. Although such strategies do not "cure" chronic conditions, they improve patients' outcomes and frequently save money by avoiding hospitalizations. Success in avoiding hospitalizations, however, means that the Medicare+Choice payment rate is never increased to compensate for the beneficiary with high-cost, chronic conditions. Without a hospitalization for congestive heart failure, for example, the PIP/DCG system does not recognize that the beneficiary has the condition.

Is this "Catch 22" real? Preliminary findings from an analysis being conducted by John Bertko, a principal in the actuarial consulting firm of Redden & Anders, provide some guidance. A highly sophisticated Medicare+Choice plan appears to have implemented effective disease management protocols for several conditions, including congestive heart failure. By investing about $3,000 annually in each patient, that HMO has apparently managed to avoid about half the expected hospital inpatient admissions for congestive heart failure. Such an HMO could become the victim of its own success in managing care. In cases in which a beneficiary with congestive heart failure avoids hospitalization because of better medical management, for example, the HMO would forgo over $12,000 in higher PIP/DCG payments in the subsequent year if the system was fully phased in. Not only would the HMO's success in avoiding hospitalization preclude its receiving the higher revenues, but the plan would also have incurred higher expenses to finance the disease management program.

These findings are preliminary. But even if the completed analysis confirms the initial findings, it is unclear how many Medicare+Choice plans have the sophistication to implement comparable programs. It is also unclear how many conditions would be susceptible to disease management interventions that avoided hospitalizations that trigger higher PIP/DCG payments. However, sophisticated disease management programs for conditions such as diabetes with complications or chronic obstructive pulmonary disease might generate similar "Catch 22s."

Problems with Refining PIP/DCGs

The successful development of the second stage of PIP/DCG risk adjusters faces formidable obstacles. Relying on hospital inpatient data means that the data sets are, compared with the total volume of Medicare claims, relatively manageable. Expanding the adjustment system to include outpatient procedures markedly increases the number of claims to be analyzed. Including all Medicare services could further increase the number of claims by an order of magnitude. Simply manipulating the data will pose significant challenges.

Hospitals have long had strong incentives to precisely code inpatient admissions, making the claims and diagnostic information relatively reliable. HCFA may encounter significant problems with the reliability and validity of some of the data that would be used in the second stage of PIP/DCGs. The accuracy of hospital outpatient data, for example, might prove problematic for use in the more comprehensive risk-adjustment system.

ALTERNATIVE APPROACHES TO RISK ADJUSTMENT

The discussion earlier in my testimony highlighted some of the problems associated with devising and improving an adequate mechanism for adjusting payments for risk.

HCFA and others have funded extensive research in efforts to develop viable mechanisms. The inability to devise more effective tools underscores how difficult the challenge actually is.

An alternative to using a statistical approach to adjust payments is to alter the level of risk borne in the payment pool. Some payers, such as state Medicaid agencies, are using a variety of approaches that, in effect, adjust the risk pool, not the payments.

Under fee-for-service, physicians and other providers can be viewed as revenue centers: the more services they provide and bill, the more they get paid. That arrangement provides strong incentives to use more, rather than fewer, services. In stark contrast, under capitated payment arrangements, providers are cost centers: their revenue is fixed, so that providing services adds only to costs, not to payments. One explanation for the differing utilization patterns between fee-for-service and (capitated) managed care is that providers are converted from "revenue centers" to "cost centers."

In a *Health Affairs* article, Joseph Newhouse and colleagues have argued in favor of partial capitation.[5] They raise concerns about stinting on needed care when

5. Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs*, vol. 16, no. 5 (September/October 1997), pp. 26-43.

a provider must bear 100 percent of the marginal cost of providing services. That concern may be strongest where providers' risk pools are too small to be stable or where providers are thinly capitalized.

Payment systems that combine attributes of fee-for-service and capitation create incentives to avoid unnecessary services but not stint on needed care. Many such approaches are possible.

I will describe four generic types of hybrid payment systems that combine some capitation with additional payments as services or costs increase. Those approaches are currently used in commercial markets, Medicaid, or Medicare demonstrations. They all limit the amount of risk assumed by a risk pool by paying extra for high-cost cases; that permits smaller risk pools to be more stable, lessening their volatility and susceptibility to big financial swings. To keep such systems budget neutral, the average capitation payments must be reduced by the amount being "carved out" for separate payment.

First-Dollar Partial Capitation. HCFA is experimenting with partial capitation payments in a demonstration project with an academic health center at the University of California at San Diego (UCSD). For inpatient hospital services, HCFA pays the UCSD health plan half of the Medicare fee-for-service payment plus a capitated amount. In part because of the reduced risk associated with this payment system,

UCSD chose to offer a managed care plan that permitted direct access to the specialists on its medical school faculty.

Condition-Specific Carve-Outs. Pregnancy, acquired immunodeficiency syndrome (AIDS), solid organ transplants, and end-stage renal disease (ESRD) are all examples of disease or condition-specific carve-outs being employed by Medicaid agencies, HMOs, or Medicare. Some Medicaid agencies remove AIDS or other high-cost conditions from their capitation rates. Others exclude pregnancy-related costs from their normal capitated payments. Instead, special payments are made for each case or each delivery.

Such payment systems can easily be adjusted to promote specific objectives. For example, if a goal was to promote prenatal care and limit caesarian deliveries, a flat "bundled" payment could be made for all hospital and physician services. In contrast, paying separate, higher rates for C-sections and lower rates for vaginal deliveries would instill fewer incentives to avoid C-sections.

For decades, Medicare has separated individuals with ESRD into a distinct risk pool. Now, Medicare is experimenting with paying for ESRD beneficiaries on a capitated basis. Similarly, some HMOs carve out solid organ transplants from their capitation payments to providers, retaining the risk (and payment responsibility) at the plan level.

Individual (Specific) Stop-Loss Coverage. Many providers and health plans purchase private reinsurance to limit the costs of specific individuals or cases, which is often referred to as "specific stop-loss" coverage. Coverage thresholds, known as "attachment points," vary considerably. Some entities choose very high reinsurance thresholds, seeking to handle only catastrophically expensive cases. Others choose lower attachment points, seeking to reduce their financial exposure. The lower the attachment point, the higher the reinsurance premium— the amount carved out of the capitation rates—necessary to finance the costs.

Like the attachment points, the amount of excess costs reimbursed can also vary. In some cases, reinsurance pays 50 percent of costs in excess of the first threshold and 80 percent of costs above a second, higher threshold. Other policies pay 100 percent of costs in excess of a threshold. By varying both the attachment point(s) and the share of costs paid, specific stop-loss policies can significantly moderate risk. At the extreme, certain stop-loss policies approach first-dollar partial capitation. (That occurs if the initial payment threshold is the first dollar.)

Aggregate Stop-Loss Coverage. Aggregate stop-loss coverage is also a commercially available product. Typically, that coverage presupposes the existence of an underlying specific stop-loss policy. If the cost of services for all members of the risk pool exceeded a specific level, the aggregate reinsurance policy could reimburse those excessive costs.

For example, assume that a physician has 300 capitated Medicare beneficiaries in his or her risk pool and buys both specific and aggregate reinsurance. Any costs of physician services for an individual in excess of $7,500 would be paid by specific reinsurance. None of the amounts above the attachment point would be counted when calculating aggregate costs. However, all costs up to $7,500 would be included in calculating whether aggregate reinsurance payments would be triggered. In this example, two individuals might require extensive cardiac services and open-heart surgery, generating physician fees in excess of $10,000 each. The specific reinsurance policy would pay the costs over $7,500 in each case. Assume further that the average cost of physician services for each member of this physician's Medicare risk pool equals $1,800 (after excluding the catastrophic costs over the threshold) but that the physician only averaged a capitation payment of $1,440 per patient per year. Any costs averaging in excess of $1,728 per patient per year, which is 120 percent of the annual capitation payment, would qualify for aggregate reinsurance.

CONCLUSION

The success of Medicare+Choice is tied to how much, and how, Medicare pays. Low rates of increase in payments will tend to cause health plans to withdraw from or limit their presence in the Medicare+Choice market. Constrained payment rates will make benefit offerings less attractive to consumers, which will further slow growth

in enrollment. Even though it is an improvement over the prior demographic adjuster, the PIP/DCG is a flawed mechanism for adjusting for risk selection. HCFA is working to develop an improved method for implementing stage two that would take account of service use in all settings. Because of the difficulty in markedly improving mechanisms that adjust payments, however, the Congress may wish to consider other approaches that would limit the risk borne by a pool.