United States General Accounting Office

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Report to the Honorable
John F. Kerry, U.S. Senate

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MEDICARE HMOs

Rapid Enrollment Growth Concentrated in Selected States

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GAO

United States
General Accounting Office
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Health, Education, and
Human Services Division

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January 18, 1996

The Honorable John F. Kerry
United States Senate

Dear Senator Kerry:

Medicare, the nation's largest health care insurer, has traditionally provided health insurance coverage to its elderly and disabled beneficiaries on a fee-for-service basis. But the option of receiving managed health care through a health maintenance organization (HMO) has existed for more than 2 decades. To date, however, Medicare beneficiaries have enrolled in HMOs to a much lesser degree than persons with private-sector health insurance. Private-sector insurers cite extensive use of HMOs and other managed care approaches as a key factor in slowing the growth of their insurance premiums. As a result, part of the current attention to controlling rising Medicare costs has focused on how to bring about greater use of HMOs.

To help the Congress study this matter, you asked us to develop information on trends in the number of (1) Medicare beneficiaries enrolling in HMOs and (2) HMOs enrolling beneficiaries. You also asked us to analyze this and other available information for any indications of factors that might be influencing decisions by HMOs to enroll Medicare beneficiaries and decisions by beneficiaries to enroll in HMOs.

We based our analysis on data obtained primarily from two sources: the Health Care Financing Administration (HCFA)[1] and the Group Health Association of America (GHAA).[2] We focused our work on HMOs that had entered into risk contracts with HCFA.[3] Under such contracts, HMOs receive a fixed payment for each Medicare beneficiary enrolled. As a result, they assume a level of risk in managing the cost of providing care in that for

[1]HCFA, an agency of the Department of Health and Human Services, administers the Medicare program.

[2]GHAA is the national trade association representing most HMOs. As of November 1, 1995, GHAA merged with the American Managed Care and Review Association (AMCRA) to become GHAA/AMCRA.

[3]These contracts can also be awarded to a competitive medical plan, which is a provider that is subject to similar regulatory requirements as HMOs but has greater flexibility in setting its commercial premium rates and the services offered to commercial members. In this report, our use of the term HMO includes such plans.

any particular patient the cost of care may exceed the fixed payment.[4] We used this information to analyze trends in HMO usage and as a basis for identifying factors affecting the level of usage. In addition, we talked with officials at HCFA and GHAA and representatives of two management consulting firms and five HMOs to obtain more information on factors that are associated with usage. We performed our work between February and November 1995 in accordance with generally accepted auditing standards.

Results in Brief

About 2.8 million Medicare beneficiaries—about 7 percent of the total—were enrolled in risk-contract HMOs as of August 1995.[5] This was double the percentage enrolled in 1987. The growth has been particularly rapid in the past 4 years and has centered on certain states. California and Florida, for example, have more than half of all enrollees. The number of risk-contract HMOs offering care to Medicare beneficiaries, while decreasing between 1987 and 1991, has nearly doubled from 93 in 1991 to 171 in August 1995. Distribution of these HMOs across the country, however, is far from uniform; 4 states account for nearly half of them, and 19 states have none.

The available data show two key characteristics that are common to many locations where HMOs have decided to sign risk contracts with Medicare. One is that HMOs are relatively well-established as medical providers to the general population. The other is that the amount of money the government pays risk-contract HMOs for each enrollee, which varies from county to county throughout the nation, tends to be relatively high where enrollment is the highest.

In addition, two key factors may affect Medicare beneficiaries' decisions to enroll in HMOs. The first factor deals with costs and services: HMOs increase their attractiveness by not charging Medicare's normal deductibles and coinsurance and often providing services beyond basic Medicare coverage (such as outpatient drugs); and many HMOs offer coverage with no or low monthly premiums. The other factor is that some Medicare beneficiaries join HMOs to continue receiving medical benefits provided by their former employers.

[4]HCFA pays some HMOs on a cost-reimbursement basis. This approach is essentially similar to reimbursement on a fee-for-service basis in that the provider assumes no risk that fees will be insufficient to cover costs and therefore does not have the same incentive to reduce costs. We did not include cost-reimbursement HMOs in our analysis.

[5]Another 2 percent were enrolled in cost-reimbursement HMOs.

Background

HMOs have become a significant part of the nation's health care delivery system. By the end of 1994, more than 50 million people received their health care through an HMO. However, the importance of HMOs varied considerably from state to state. For example, five states (Arizona, California, Maryland, Massachusetts, and Oregon) had more than 30 percent of their population enrolled in HMOs, while three states (Alaska, West Virginia, and Wyoming) had no HMO enrollees.

Medicare beneficiaries cannot enroll in an HMO unless the HMO contracts with HCFA. Medicare's current approach for contracting with HMOs on a risk-contract basis has been in place for more than 10 years. Medicare pays the HMO a capitated (fixed) payment for each Medicare beneficiary enrolled. This payment, the adjusted average per capita cost (AAPCC) rate, differs from county to county.[6] In return, the HMO must provide or arrange for all the services covered under Medicare part A, Hospital Insurance, and Medicare part B, Supplemental Medical Insurance.[7] To the extent that the Medicare payment exceeds the HMO's cost to provide these services, the HMO must provide additional benefits of an actuarially equivalent value.

HMOs are generally the only form of managed care available to Medicare beneficiaries. Private purchasers and employer-sponsors of health insurance also use other forms of managed care, such as preferred provider organizations (PPO) and point-of-service (POS) health plans.[8] These other approaches may provide enrollees with a wider choice over their medical provider than the HMO approach.

In many cases, Medicare beneficiaries pay a monthly premium to the risk-contract HMO.[9] This premium covers the portion of costs not borne by Medicare under the capitated payment. For those HMOs charging premiums, the median monthly premium was $39 as of August 1995.

[6]For each Medicare beneficiary enrolled, the HMO is paid at a rate of 95 percent of the average amount HCFA would expect to spend on fee-for-service Medicare in the county where the beneficiary resides. The Senate and House have passed bills that, among other things, would change the way HMOs are paid.

[7]For fiscal year 1995, total risk-contract program payments were estimated to be $12.2 billion.

[8]Under PPOs, services are provided on a discounted basis to plan members by contracted service providers. Members can use other providers but have a financial incentive to use participating providers. Under a POS plan, members choose how to receive services when the service is needed, with different cost-sharing levels associated with the choice.

[9]This is in addition to the premium that all beneficiaries must pay to receive physician services under Medicare part B. Under fee-for-service Medicare, beneficiaries also have other cost-sharing responsibilities.

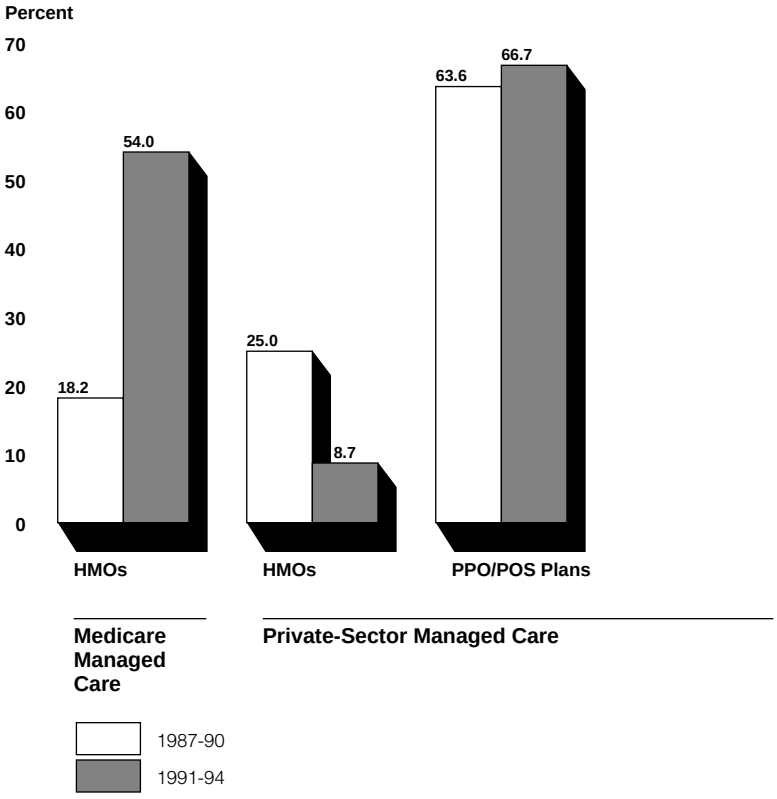
HMO Enrollment Growth Is Rapid but Concentrated in a Few States

Medicare's use of HMOs is considerably less than private-sector insurers, but it is growing. For private-sector insurers, HMOs and other forms of managed care now account for about 70 percent of their insurance, compared with just 5 percent in 1980. By contrast, Medicare's current use of HMOs is comparable to the level that private-sector insurers reached in the early 1980s. However, the 2.8 million Medicare beneficiaries enrolled in HMOs in August 1995 were more than double the number enrolled in 1987 and were increasing rapidly. Since 1993, for example, the annual growth rate for beneficiaries enrolled in risk-contract HMOs has been about 25 percent.

Medicare also differs from private-sector patterns in terms of the types of managed-care approaches that are growing. As figure 1 shows, the market-share growth rate of HMOs in the Medicare program more than doubled from 1991 to 1994 compared with 1987 to 1990, while the growth rate of HMOs in the private sector actually declined. However, private insurers continued to expand in other managed-care approaches such as PPOs and POS plans. These managed-care approaches are currently not available in the Medicare market.[10]

[10]While the PPO option is still not available to Medicare beneficiaries, the POS plan option may be available starting January 1, 1996.

Figure 1: Growth in Market Share of Managed Care Health Plans, 1987-90 and 1991-94



Source: Medicare data from monthly reports, Office of Managed Care, HCFA, and Medicare enrollment database files. Private sector data from KPMG Peat Marwick, Health Benefits in 1994, (1994), p. 25; and Elizabeth W. Hoy, Richard E. Curtis, and Thomas Rice, "Change and Growth in Managed Care," Health Affairs, Winter (1991), pp. 18-36.

While the number of Medicare beneficiaries choosing the risk-contract HMO option continues to grow each year, the vast majority (about 87 percent) live in 10 states. Since 1987, the number of Medicare enrollees has increased in 22 states (and the District of Columbia) and decreased in 14. As further evidence of how concentrated the Medicare risk-contract program is, about 44 percent of all enrollees are currently in 10 of the 171 HMOs with risk contracts. Appendix I contains additional information on HMO enrollment, including state-by-state information.

Resurgence of Growth in Participating HMOs

The number of risk-contract HMOs participating in Medicare dropped from 161 in 1987 to 93 in 1991, then reversed direction to 171 by August 1995. As with enrollees, HMOs offering their services to Medicare beneficiaries are concentrated in relatively few states. Forty-five percent of the HMOs enrolling Medicare beneficiaries were located in four states—California, Florida, Pennsylvania, and Texas. Five states saw declines in the number of HMOs offering services to Medicare beneficiaries between 1991 and 1995, and 19 states have no HMOs with Medicare risk contracts.[11] Appendix II contains additional information on the number of HMOs participating in the Medicare risk-contract program.

Some Relatively Consistent Factors Associated With HMO and Beneficiary Decisions Exist

Our data analysis shows a range of factors that could be influencing HMO decisions to offer services to Medicare beneficiaries. These factors vary considerably from location to location, but two factors emerged more consistently than any others. First, while exceptions exist, states with the highest concentration of HMOs offering services to Medicare beneficiaries tend to be the ones with the highest levels of HMO participation in the general population. For example, in 1994, the three states with the highest percentage—greater than 20 percent—of their Medicare population enrolled in HMOs (Arizona, California, and Oregon) were also among those states with the highest percentage of their total population enrolled in HMOs. Second, those counties with the highest monthly rates paid by the government for each Medicare beneficiary—over $500—also tend to have higher levels of HMO participation. About 40 percent of the counties with high payment rates also had a high percentage of Medicare beneficiaries enrolled in 1994. In contrast, only about 3 percent of the counties with low payment rates—under $375—had a high percentage of beneficiaries enrolled.

To attract Medicare beneficiaries, participating HMOs have increasingly turned to incentives for beneficiaries. One incentive is to offer coverage with no monthly premium or a low monthly premium that Medicare beneficiaries must pay. Over the past 3 years, the number of HMOs charging Medicare beneficiaries no premiums for the services provided increased from about 26 percent to about 49 percent. Another incentive is to provide services—such as outpatient drugs or dental benefits—beyond those required under Medicare. For example, while about 32 percent of the HMOs provided outpatient drugs in 1993, about 49 percent did so in August 1995.

[11]The 19 states with no HMOs with Medicare risk contracts in August 1995 were Alaska, Arkansas, Delaware, Georgia, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wyoming.

As retiree health benefit costs rise, HMOs appear to be a more attractive approach to major employers for providing retiree benefits. As more employers look to managed care to reduce their costs, Medicare beneficiaries and persons nearing 65 years old may have to enroll in HMOs to receive health care benefits. Appendix III contains more information on these factors. Also, appendix IV contains supplemental state data on Medicare risk-contract HMOs.

We provided copies of a draft of this report to officials of HCFA's Office of Managed Care and GHAA. These officials generally agreed with the information presented. They did offer some technical suggestions that we incorporated where appropriate. As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Secretary of the Department of Health and Human Services. We will make copies available to others on request. Please contact me on (202) 512-7119 if you have any questions. Major contributors to this report are listed in appendix V.

Sincerely yours,

Jonathan Ratner
Associate Director,
Health Financing Issues

Contents

Tables

Figures

Abbreviations

AAPCC	adjusted average per capita cost
AMCRA	American Managed Care and Review Association
GHAA	Group Health Association of America
HCFA	Health Care Financing Administration
HMO	health maintenance organization
POS	point of service
PPO	preferred provider organization
SFAS	statement of financial accounting standards

Rapid Growth in Medicare Risk-Contract HMO Enrollment Concentrated in a Few States

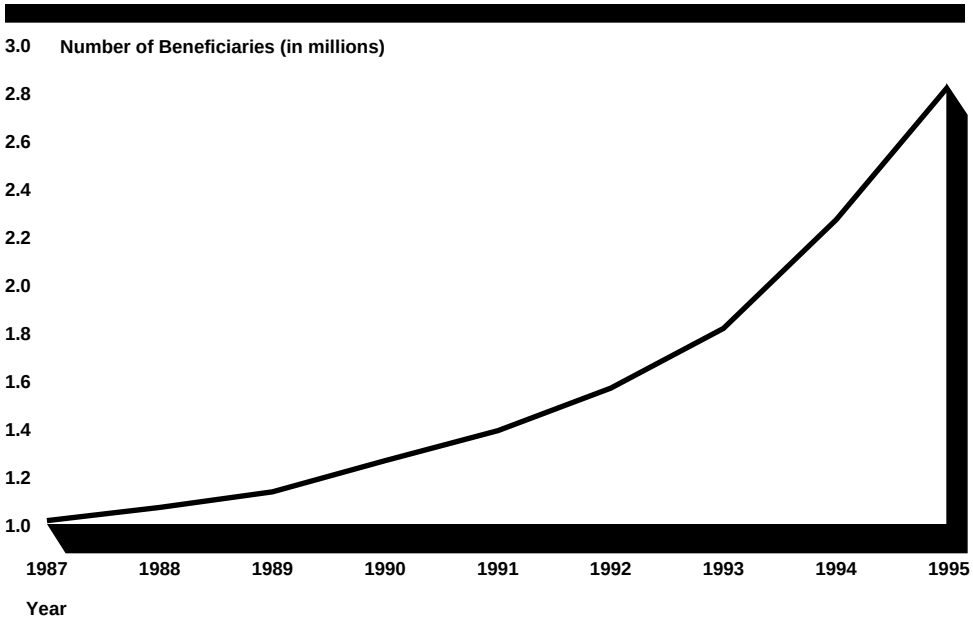
Medicare beneficiaries enrolled in risk-contract HMOs at a relatively slow rate during the first years of the program, but more recently, enrollment has taken off. As of August 1995, about 2.8 million beneficiaries—roughly 7 percent of the total—were enrolled in risk-contract HMOs. Although the percentage of Medicare beneficiaries enrolled remains small compared to the Medicare population, enrollment has been growing since 1987 when fewer than half that many beneficiaries—only about 3 percent—were in HMOs. Moreover, risk-contract HMO enrollment has been increasing at a double-digit rate in recent years—much faster than in the early years of the risk-contract HMO option.

Most Medicare beneficiaries in risk HMOs are concentrated in just a few states and a few large HMOs. About 55 percent live in two states—California and Florida. Similarly, 10 large HMOs enroll about 44 percent of all Medicare beneficiaries in the risk-contract program.

Beneficiary Enrollment Growing in Medicare's Risk-Contract Program

After existing for nearly a decade, the current Medicare risk-contract program now appears to be attracting more beneficiaries. Since 1987, the number of beneficiaries enrolled in a risk-contract HMO grew nationwide. Figure I.1 shows that enrollment more than doubled between 1987 and 1995; enrollment went from about 1.0 million to about 2.8 million. Furthermore, figure I.2 shows that enrollment has grown each year, with annual growth rates reaching about 25 percent between 1993 and 1994.

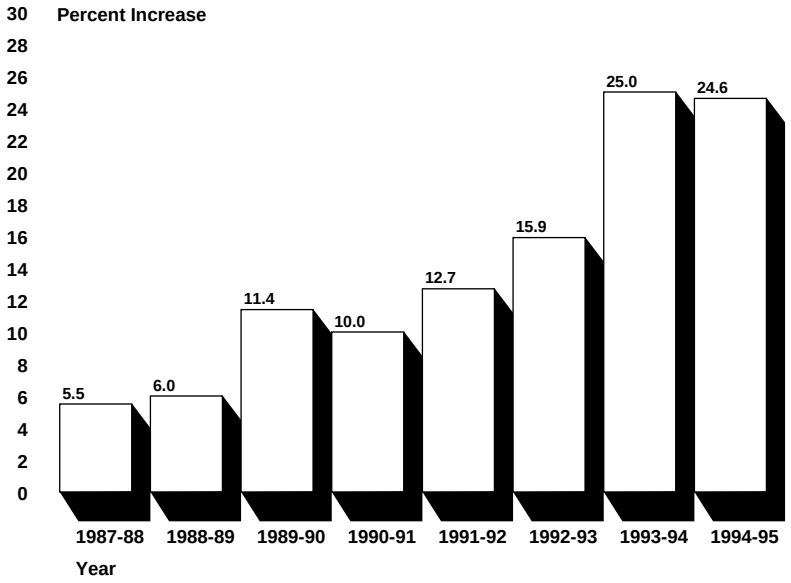
Figure I.1: Number of Medicare Beneficiaries Enrolled in a Risk-Contract HMO, 1987-95



Notes: Data as of December of each year from 1987 to 1994. Data as of August 1995.

Source: Monthly reports, Office of Managed Care, HCFA.

Figure I.2: Annual Growth Rates for Medicare Beneficiaries Enrolled in a Risk-Contract HMO, 1987-95



Notes: Data as of December of each year from 1987 to 1994. Data as of August 1995.

Source: GAO calculations based on data from monthly reports, Office of Managed Care, HCFA.

While enrollment in risk-contract HMOs grew throughout the more than 7-year period, the rate of growth continues to escalate with annual rates approaching 25 percent by 1994. However, even though recent growth has been rapid, the Medicare risk-contract program is still in its early stages of development. About 7 percent of the Medicare population is enrolled in such HMOs compared with about 25 percent of the population with private health insurance.

Beneficiary Enrollment Growing Faster in Recent Years

During the past few years, more Medicare beneficiaries have been enrolling in risk-contract HMOs. While beneficiary enrollment increased by about 6 percent between 1987 and 1988, it increased by about 16 percent between 1992 and 1993. In the following year—between 1993 and 1994—the number of beneficiaries choosing the HMO option grew by about 25 percent. Moreover, during the 8 months between December 1994 and August 1995, enrollment had already increased by 25 percent. Although about 2.8 million Medicare beneficiaries were enrolled in an HMO in

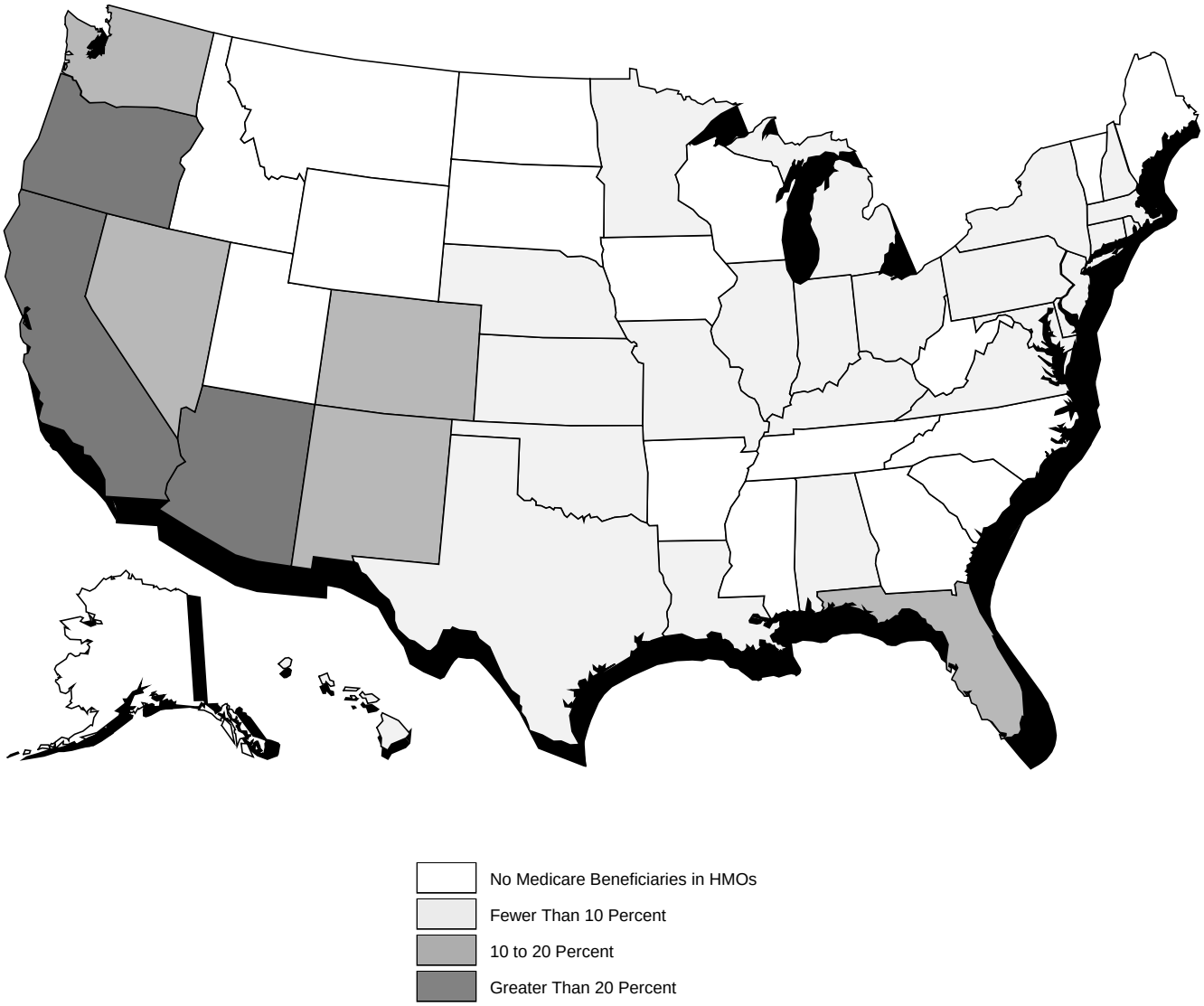
August 1995, this enrollment was not distributed consistently throughout the country.

19 States Have No Beneficiaries Enrolled in Risk-Contract HMOs

Medicare beneficiaries have not enrolled in risk-contract HMOs in all states. Enrollment by state splits into several different groups, including those states that have (1) no beneficiaries enrolled, (2) limited Medicare HMO penetration, and (3) the highest Medicare HMO penetration. Figure I.3 shows that in 1994, no Medicare beneficiary was enrolled in a risk-contract HMO in 19 states.[12] In 24 states, fewer than 10 percent of the Medicare beneficiaries were enrolled—more significantly, enrollment was less than 1 percent in half of these states. Therefore, 31 states had no or insignificant enrollment in Medicare risk-contract HMOs. In only three states in the west—Arizona, California, and Oregon—more than 20 percent of the Medicare beneficiaries were enrolled in a risk-contract HMO.

[12]Includes the District of Columbia.

Figure I.3: Percentage of Medicare Beneficiaries Enrolled in a Risk-Contract HMO, by State, 1994

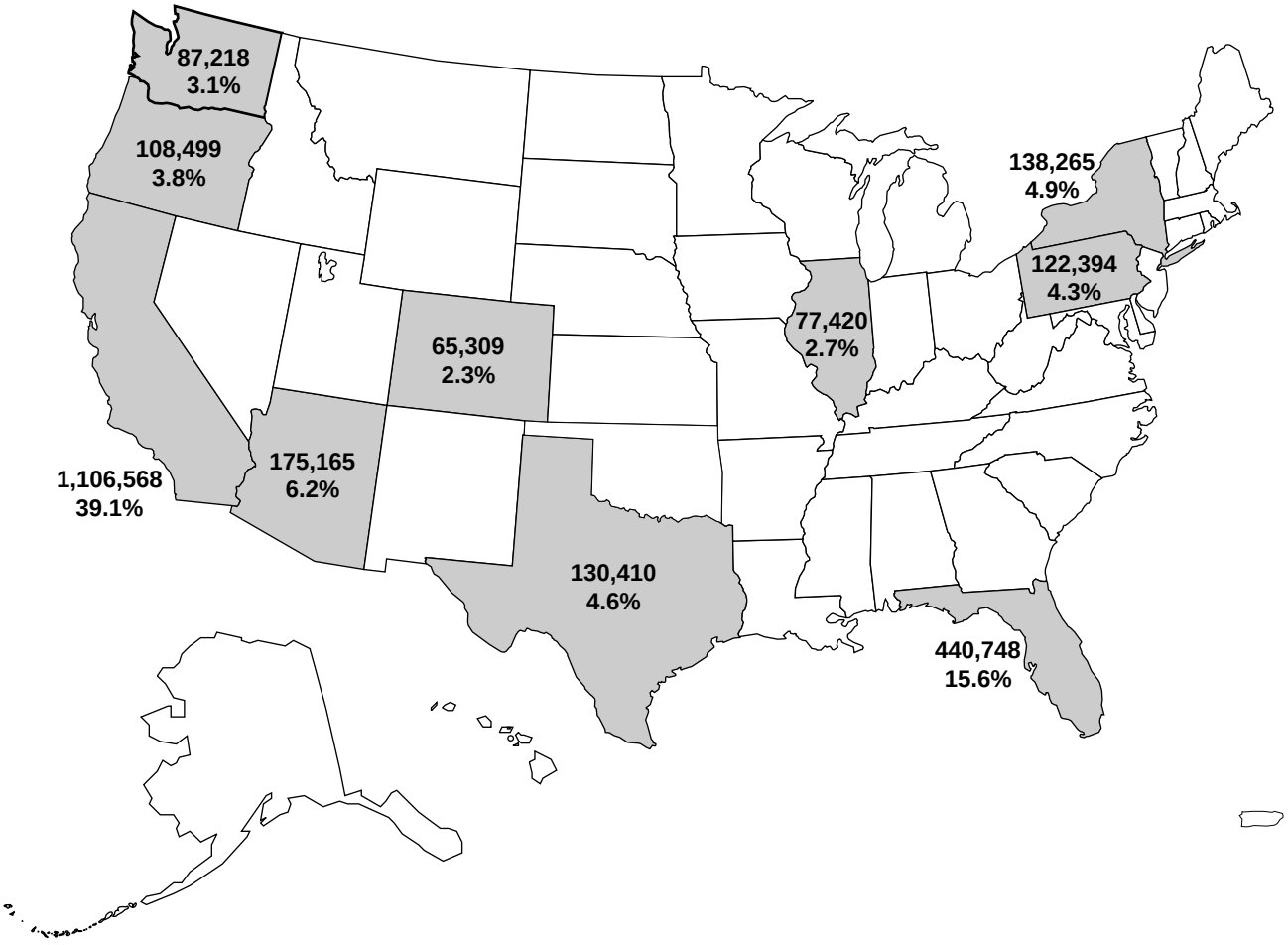


Note: Not shown is the District of Columbia with no Medicare beneficiaries enrolled in a risk-contract HMO.

Source: December 1994 monthly report, Office of Managed Care, HCFA. Number of Medicare beneficiaries as of July 1994 from 1995 Data Compendium, HCFA. Percent enrolled calculated by GAO.

The strong concentration of HMO Medicare beneficiaries in a handful of states can be clearly seen in figure I.4. About 2.4 million of the more than 2.8 million Medicare beneficiaries enrolled in August 1995—about 87 percent—lived in 10 states. These states were in different regions of the country. However, half of these states—Arizona, California, Colorado, Oregon, and Washington—were in the west. Furthermore, more than half of the beneficiaries lived in either California or Florida.

Figure I.4: Ten States With the Largest Number of Medicare Beneficiaries Enrolled in a Risk-Contract HMO, August 1995



Source: Monthly Report, Medicare Prepaid Health Plans, Office of Managed Care, HCFA, and GAO calculation.

Few States Show Large Increases in Beneficiary Enrollment

For the most part, states with the largest number of Medicare beneficiaries enrolled in a risk-contract HMO in August 1995 have also experienced the most growth since 1987. Even though beneficiary enrollment increased in 23 states[13] during that period, the number enrolled increased by more than 100,000 in only 6 states. Table I.1 shows that the increases in beneficiary enrollment varied significantly. For example:

- States like California and Florida, which already had significant penetration, still grew substantially.
- Some states, like Washington, initially had very limited penetration but grew to a relatively large program.
- A handful of states entered risk contracting and have fledgling programs.

[13]For this analysis, the District of Columbia is counted as a state.

Table I.1: Twenty-Three States With Increases in the Number of Medicare Beneficiaries Enrolled in a Risk-Contract HMO, 1987-95

States ranked in descending order of increase[a]	Beneficiaries		
	1987[b]	1995[c]	Increase 1987-95
California	225,884	1,106,568	880,684
Florida	184,146	440,748	256,602
Arizona	9,027	175,165	166,138
Texas	6,085	130,410	124,325
New York	34,617	138,265	103,648
Pennsylvania	20,886	122,394	101,508
Washington	101	87,218	87,117
Oregon	44,427	108,499	64,072
Colorado	26,740	65,309	38,569
Nevada	13,711	43,205	29,494
Illinois	48,705	77,420	28,715
Louisiana	0	26,619	26,619
Missouri	1,305	26,338	25,033
Ohio	7,191	27,759	20,568
New Mexico	14,258	30,933	16,675
Oklahoma	4,234	16,193	11,959
Massachusetts	55,029	65,079	10,050
Rhode Island	4,365	13,913	9,548
Alabama	0	8,103	8,103
Virginia	0	3,729	3,729
Kentucky	0	3,621	3,621
Maryland	3,404	6,487	3,083
District of Columbia	0	2,111	2,111
Total	**704,115**	**2,726,086**	**2,021,971**

[a]Includes the District of Columbia, which is counted as a state.

[b]Data as of December.

[c]Data as of August.

Source: Monthly reports, Office of Managed Care, HCFA, and GAO calculation.

Several States Show Decreases in Beneficiary Enrollment

While the number of Medicare beneficiaries enrolled in a risk-contract HMO grew in nearly half the states between 1987 and 1995, 14 states also lost enrollment. For example, table I.2 shows that

- some states, like Minnesota and Michigan, with a relatively large HMO penetration, lost a significant number of risk-contract enrollees;
- Hawaii's HMO risk-contract program shrank by about half; and
- the HMO risk-contract program disappeared in several states with small HMO concentrations.

Table I.2: Fourteen States With Decreases in the Number of Medicare Beneficiaries Enrolled in a Risk-Contract HMO, 1987-95

	Beneficiaries		
States ranked in descending order of decrease	1987[a]	1995[b]	Decrease 1987-95
Minnesota	161,300	58,716	102,584
Michigan	45,337	7,246	38,091
Indiana	19,070	3,056	16,014
Kansas	13,110	0	13,110
Hawaii	26,003	13,418	12,585
Connecticut	12,164	1,274	10,890
Tennessee	5,520	0	5,520
Wisconsin	3,709	0	3,709
Iowa	2,863	0	2,863
New Jersey	15,199	13,683	1,516
North Carolina	1,141	0	1,141
Nebraska	3,850	3,468	382
Georgia	153	0	153
Utah	1	0	1
Total	**309,420**	**100,861**	**208,559**

[a]Data as of December.

[b]Data as of August.

Source: Monthly reports, Office of Managed Care, HCFA.

Beneficiary Enrollment in Medicare's Risk-Contract Program Concentrated at 10 HMOs

While there are more than 570 HMOs in the United States and about 30 percent of them enrolled Medicare beneficiaries, a surprisingly small number of large HMOs commands a substantial share of total Medicare risk-contract HMO enrollment. Ten HMOs with individual risk contracts accounted for about 44 percent of the beneficiaries enrolled, as shown in table I.3. Half of the 10 largest individual HMOs enrolling Medicare beneficiaries in 1995 were in California.

Table I.3: Ten Medicare Risk-Contract HMOs That Have the Largest Number of Beneficiaries Enrolled, August 1995

HMOs ranked in descending order[a]	Beneficiaries[b]	Percentage of national total[c]
Pacificare—Los Angeles, Orange County, California	275,877	9.8
Humana—Florida	213,722	7.6
FHP—California	208,656	7.4
Kaiser—Los Angeles, California	149,531	5.3
Kaiser—Oakland, California	98,393	3.5
FHP—Arizona	84,818	3.0
Pacificare—Northern California	67,740	2.4
HIP—New York	48,313	1.7
Group Health Coop—Puget Sound, Washington	46,141	1.6
CAC-Ramsey Health Plans—Coral Gables, Florida	44,564	1.6
Total (top 10 HMOs)	**1,237,755**	**43.8**
Total (171 HMOs)	**2,826,947**	

[a]Enrollment figures are for unique risk contracts. HMOs must have a risk contract for each distinct geographic location in which they operate.

[b]Data are as of August.

[c]Detail does not add to total due to rounding.

Source: Monthly Report, Medicare Prepaid Health Plans, Office of Managed Care, HCFA.

Number of Medicare Risk-Contract HMOs Has Grown Rapidly in the Past Few Years

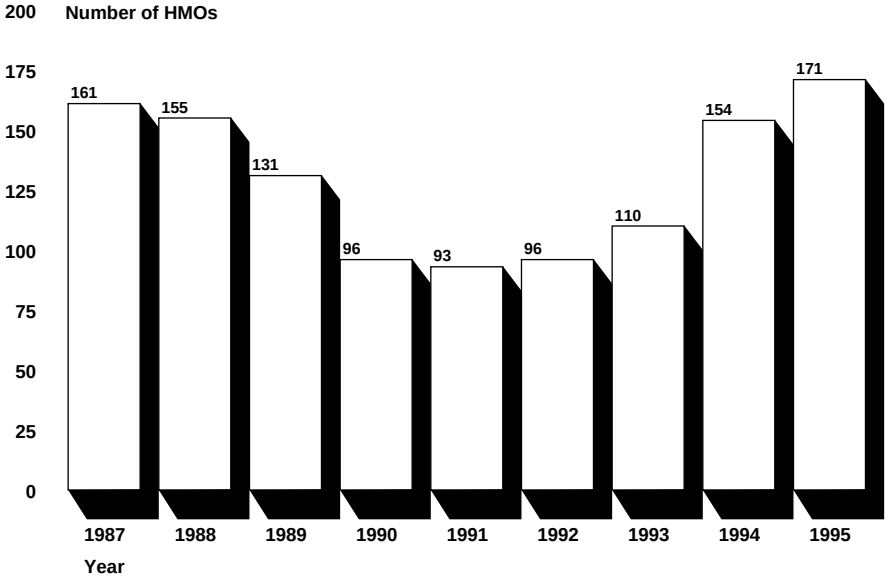
Medicare beneficiaries cannot enroll in an HMO unless the HMO contracts with HCFA to serve the beneficiaries. While the number of beneficiaries enrolling has increased, participation by HMOs has been considerably more erratic. The number of HMOs participating actually fell between 1987 and 1991 before reversing direction and increasing each year since then. The increase was especially rapid between 1993 and August 1995.

Moreover, patterns of HMO participation in the Medicare risk-contract program varied considerably by state. In 1995, about one-third of the HMOs that were enrolling Medicare beneficiaries were located in just two states, and 19 states had no HMO enrolling Medicare beneficiaries.

Number of HMOs Entering Into Medicare Risk Contracts Has Fluctuated Since 1987

Nationwide, significant changes occurred in the number of HMOs that had Medicare risk contracts in the years between 1987 and 1995. Figure II.1 shows that the number has changed over time, initially decreasing and then increasing more rapidly in recent years. By December 1991, risk-contract HMOs had dropped to 93. Since that time, the number has continued to grow. And in the past few years, growth has been especially rapid. In just 1 year, 1993 to 1994, the number of risk-contract HMOs grew from 110 to 154—about 40 percent. As of August 1995, the number had increased by another 17 to 171 risk-contract HMOs.

Figure II.1: Number of Medicare Risk-Contract HMOs, 1987-95



Notes: Data as of December of each year from 1987 to 1994. Data as of August 1995.

Source: Monthly reports, Office of Managed Care, HCFA.

When growth resurfaced in the Medicare risk-contract program, much of it occurred in a handful of states. Table II.1 shows that between December 1991 and August 1995 the number of risk-contract HMOs increased by 50 in just four states—a significant part of the overall total. In California alone, 23 more HMOs entered into Medicare risk contracts during that time.

Table II.1: Four States Where the Number of Medicare Risk-Contract HMOs Increased, 1991-95

	Number of HMOs	
State	**1991[a]**	**1995[b]**
California	12	35
Florida	7	21
Pennsylvania	2	11
Texas	6	10
Total	**27**	**77**

[a]Data as of December.

[b]Data as of August.

Source: Monthly reports, Office of Managed Care, HCFA.

In sharp contrast to the resurgence of growth in these four states, several states showed no growth or even declined. Indeed, five states had fewer HMOs with Medicare risk contracts in 1995 than in 1991. In fact, in two of these states—Georgia and Kansas—the Medicare HMO program disappeared as the number of HMOs with Medicare risk contracts dropped to zero.

Most States Have Few HMOs With Medicare Risk Contracts

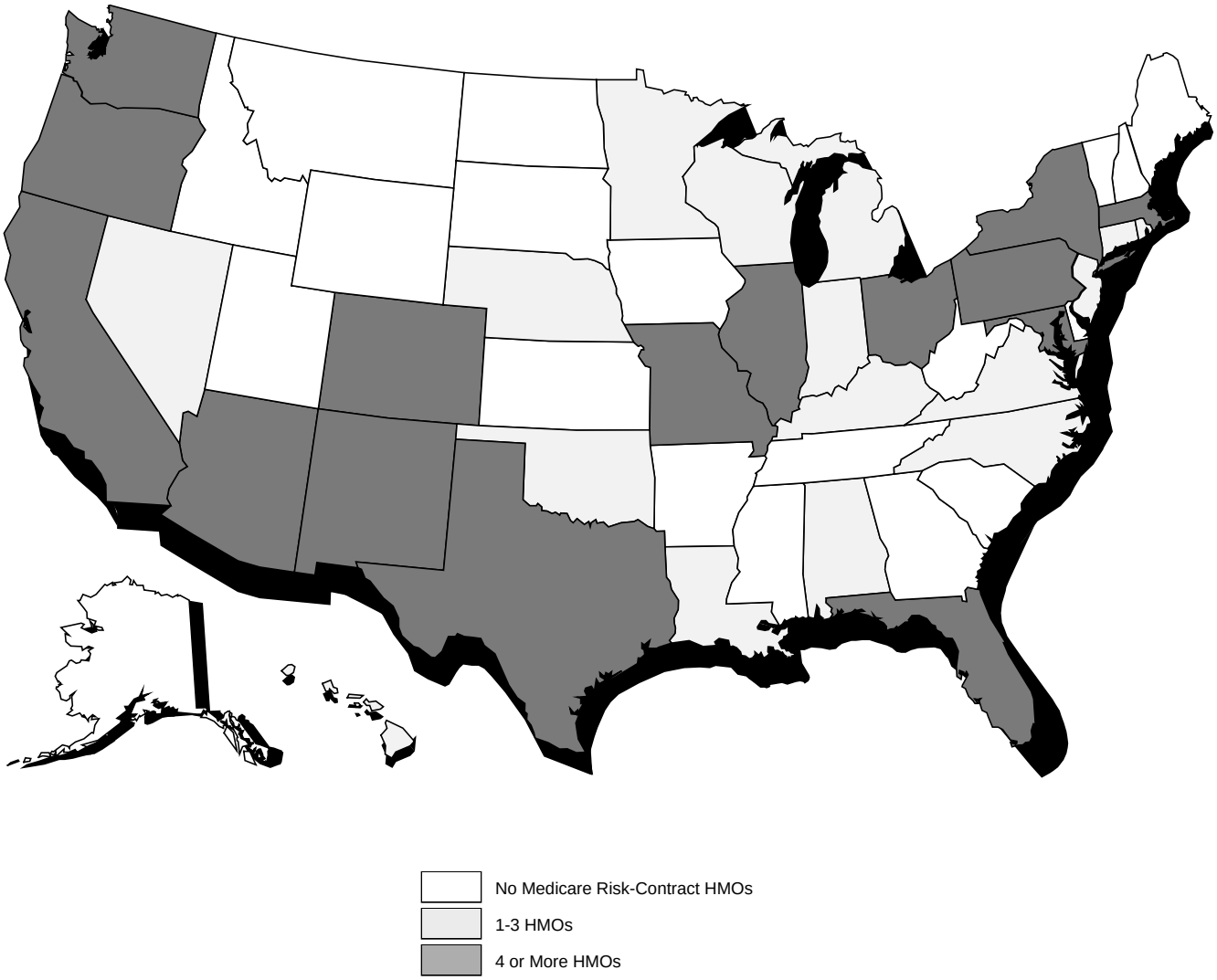
In most states, a small number of HMOs had Medicare risk contracts. Figure II.2 shows that in August 1995, 19 states[14] did not have a risk contract HMO and 17 states[15] had three or fewer—71 percent of all the states. More significantly, however, about 45 percent of all the risk-contract HMOs were located in just four states. These HMOs were distributed as follows:

- 35 in California,
- 21 in Florida,
- 11 in Pennsylvania, and
- 10 in Texas.

[14]The 19 states that had no HMO with a Medicare risk contract in August 1995 were Alaska, Arkansas, Delaware, Georgia, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wyoming.

[15]Includes the District of Columbia.

Figure II.2: Number of Medicare Risk-Contract HMOs, by State, August 1995



Note: Not shown is the District of Columbia with one risk-contract HMO.

Source: Monthly Report, Medicare Prepaid Health Plans, Office of Managed Care, HCFA.

Factors Associated With an HMO Entering Into a Medicare Risk Contract or a Medicare Beneficiary Enrolling in an HMO

During the past few years, the resurgence of HMOs entering into a Medicare risk contract and the continuing growth of beneficiaries enrolling in these HMOs have been influenced by a number of key factors. Entry or re-entry by HMOs into the market appears to be associated with HMO penetration of health care markets in general and with the growth in Medicare's AAPCC rates for HMOs relative to the HMOs' costs of providing care.

Risk-contract HMOs may appeal to Medicare beneficiaries because beneficiaries may obtain services in addition to those offered through the regular Medicare fee-for-service program. Moreover, these additional services may be available to beneficiaries at little or no cost. Employers who are trying to reduce retiree health care costs may continue to look to HMOs as a way to save money. As a result, more Medicare beneficiaries may have to enroll in a risk-contract HMO to obtain retiree benefits through their former employers.

Two Factors Associated With HMOs' Decisions to Enter Medicare's Risk-Contract Program

Before deciding to enter into a Medicare risk contract and to enroll beneficiaries, an HMO has to consider the many questions that can affect the profitability of entering a new market. In general, an HMO's market strategy—the type of patients that it wants to serve and how it wants to expand—plays a role in how it plans for the future. While many factors contribute to HMO decisions in any given location, two factors that appear to have influenced the decisions of HMOs that have entered the Medicare market are the size of the (1) existing market share and (2) AAPCC rate.

Extent of HMO Market Share May Play a Role in an HMO's Risk-Contract Decision

In general, states with higher total HMO enrollment among the states' populations also have a higher enrollment among the Medicare population. However, not all states with high non-Medicare HMO enrollment also have high Medicare enrollment. Several notable exceptions exist.

Before Medicare beneficiaries in each state can enroll in an HMO, HMOs must be operating in the state and must have entered into a Medicare risk contract. Table III.1 shows that, in the states with the largest number of HMOs, the number of HMOs that had Medicare risk contracts varied. In 1994, for example:

- 89 percent of the HMOs in California and 53 percent in Florida had Medicare risk contracts, and
- none of the HMOs in Wisconsin had a Medicare risk contract.

Table III.1: Seven States With the Largest Number of HMOs and HMOs With a Medicare Risk Contract, 1994

States ranked in descending order	HMOs[a]	HMOs with a Medicare risk contract[b]
California	36	32
Florida	36	19
New York	33	9
Ohio	31	6
Texas	31	7
Illinois	27	3
Wisconsin	27	0

[a]Data as of the end of 1994.

[b]Data as of December 1994.

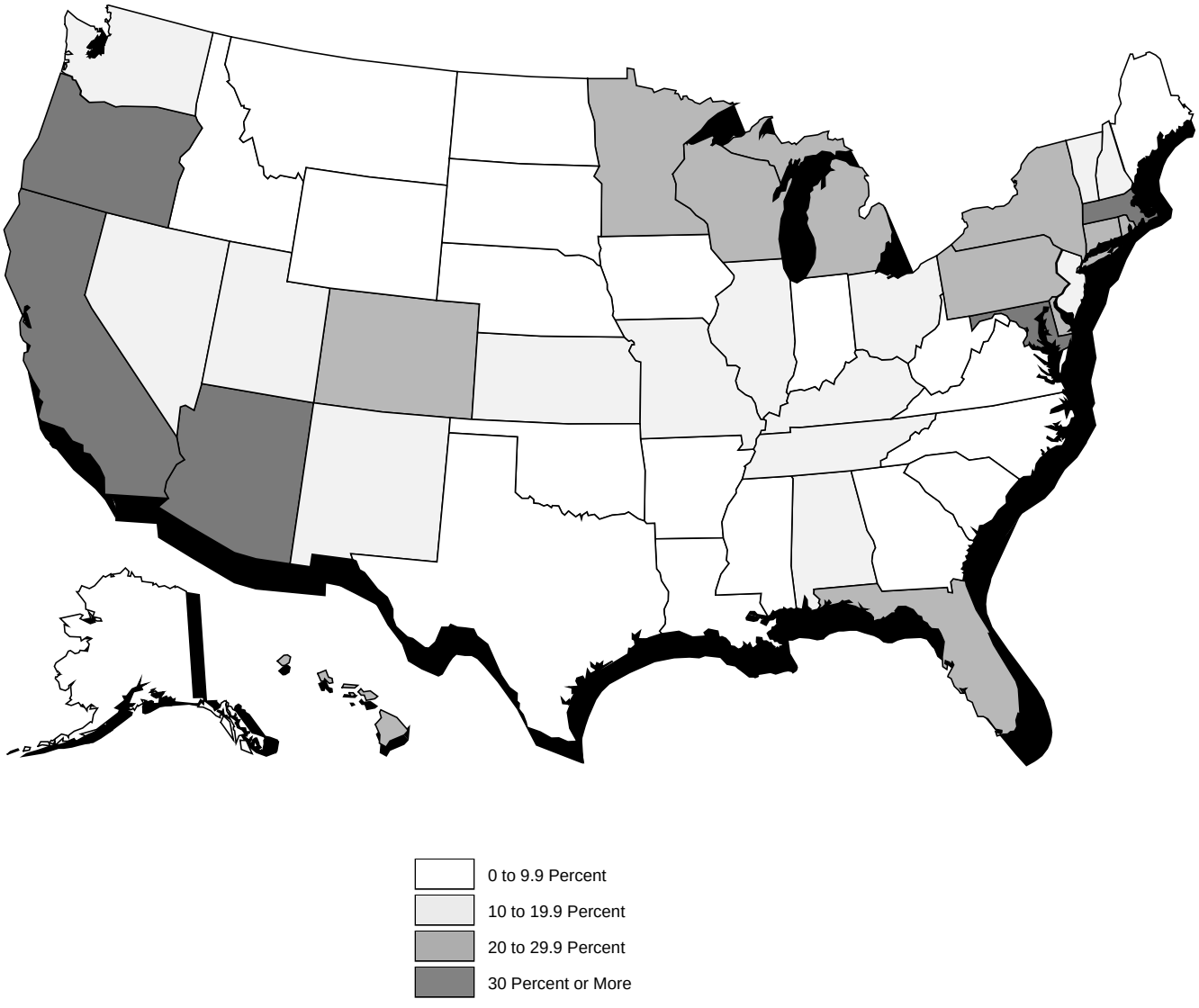
Source: Number of HMOs from Patterns in HMO Enrollment, GHAA. Number of HMOs with a Medicare risk contract from monthly report, Office of Managed Care, HCFA.

About 20 Percent of the Total Population Was Enrolled in an HMO at the End of 1994

At the end of 1994, about 51 million people were enrolled in 572 HMOs nationwide.[16] Overall, about 20 percent of the total population in the country—and about one-fourth of the population with private health insurance—received its health care through an HMO. More importantly, however, HMO enrollment varies by state. Figure III.1 shows that in five states—Arizona, California, Maryland, Massachusetts, and Oregon—more than 30 percent of the state population was enrolled in HMOs—the highest market share in the country. Conversely, three states—Alaska, West Virginia, and Wyoming—had no people enrolled in an HMO at the end of 1994. While these are the extremes, HMOs are just beginning to make their presence felt in many states throughout the country.

[16]Total HMO enrollees include, among others, members of employer groups, individuals, federal employees, Medicare beneficiaries, and Medicaid recipients. Data are for the 50 states and the District of Columbia; data from Guam are excluded.

Figure III.1: HMO Market Share, by State, 1994



Note: Not shown is the District of Columbia with a 25.6 percent market share.

Source: Patterns in HMO Enrollment, GHAA.

Medicare Risk-Contract HMO Enrollment Mirrors Non-Medicare Market Share in Some States

Each state's total HMO market share provides an overview of how heavily HMOs have penetrated the health care market. However, table III.2 shows the percentage of Medicare beneficiaries enrolled in an HMO and the percentage of non-Medicare HMO enrollees in each state.[17] Several states with a high percentage of Medicare enrollees in risk-contract HMOs also had high non-Medicare enrollment. For example, the three states with the highest Medicare risk-contract HMO enrollment in 1994—Arizona, California, and Oregon—also had high non-Medicare enrollment. Nevada is the only state that had a higher percentage of Medicare beneficiaries enrolled in risk-contract HMOs than non-Medicare HMO enrollees. However, high non-Medicare enrollment is no guarantee that HMOs will play a large role in the Medicare program. Several states with fairly high HMO activity have little or no activity in the Medicare risk-contract program. For example:

- in Maryland, non-Medicare enrollment was over 40 percent but Medicare risk-contract HMO enrollment was less than 1 percent,
- in Massachusetts, non-Medicare enrollment was over 40 percent but Medicare risk-contract HMO enrollment was about 4 percent,
- in Connecticut, non-Medicare enrollment was over 30 percent but Medicare risk-contract HMO enrollment was less than 1 percent, and
- in Wisconsin, non-Medicare enrollment was about 29 percent but no Medicare beneficiary was enrolled in an HMO with a risk contract.

[17]Each state's non-Medicare HMO enrollment provides an estimate for what is happening in the private sector. Non-Medicare HMO enrollees include all HMO enrollees in a state except Medicare beneficiaries enrolled in a risk-contract HMO.

Table III.2: Percent of Medicare Beneficiaries Enrolled in an HMO With a Risk Contract and Percent of Non-Medicare HMO Enrollees for All States, 1994

State	Percent of Medicare beneficiaries enrolled in HMOs	Percent of non-Medicare HMO enrollees	State	Percent of Medicare beneficiaries enrolled in HMOs	Percent of non-Medicare HMO enrollees
Arizona	27.0	37.9	Indiana	0.3	8.5
California	26.8	40.0	Alabama	0.3	11.6
Oregon	22.2	40.5	Virginia	0.2	9.6
Nevada	19.9	14.4	Delaware	0.1	23.9
Florida	14.9	21.5	Connecticut	0.04	32.3
New Mexico	13.8	18.1	New Hampshire	0.02	19.8
Colorado	12.2	26.3	Alaska	0.0	0.0
Washington	10.3	17.5	Arkansas	0.0	4.6
Minnesota	9.1	29.5	District of Columbia	0.0	29.4
Hawaii	9.1	25.3	Georgia	0.0	10.0
Rhode Island	6.9	33.1	Idaho	0.0	1.3
Illinois	4.3	19.0	Iowa	0.0	5.0
Massachusetts	4.3	40.8	Maine	0.0	7.3
Texas	4.1	10.5	Mississippi	0.0	0.3
New York	3.9	27.7	Montana	0.0	1.8
Pennsylvania	2.7	25.3	North Carolina	0.0	9.8
Oklahoma	2.6	8.1	North Dakota	0.0	1.4
Missouri	1.9	17.1	South Carolina	0.0	4.9
Nebraska	1.3	11.0	South Dakota	0.0	3.5
Ohio	1.2	22.4	Tennessee	0.0	19.1
Kansas	0.6	12.7	Utah	0.0	21.5
Kentucky	0.5	14.2	Vermont	0.0	14.7
Michigan	0.5	23.5	West Virginia	0.0	0.0
Louisiana	0.4	8.1	Wisconsin	0.0	28.5
New Jersey	0.4	19.8	Wyoming	0.0	0.0
Maryland	0.3	41.1			

Source: December 1994 Medicare HMO enrollment data from monthly report, Office of Managed Care, HCFA. Number of Medicare beneficiaries and state population estimates as of July 1994 from 1995 Data Compendium, HCFA. Year-end 1994 non-Medicare HMO enrollment data from Patterns in HMO Enrollment, GHAA. Percent enrolled calculated by GAO.

Higher Medicare HMO Penetration Appears to Be Linked to Higher Medicare Payment Rates

Among other factors considered, HMOs may weigh the financial pros and cons of enrolling Medicare beneficiaries. Medicare risk-contract HMOs are paid a monthly amount by the government for each beneficiary enrolled; this is the AAPCC rate. AAPCC rates, which are developed for each county in the country, vary considerably. For 1995, AAPCC rates range from a low of $177.32[18] to a high of $678.90. Over time, these payment rates have been increasing. In 1992, the lowest AAPCC rate in the 50 states and the District of Columbia was $139.30, while the highest was $507.88.

A relationship appears to exist between the amount of money paid to an HMO for each Medicare beneficiary enrolled and the Medicare enrollment in that county.[19] Of all the counties in the country that had low AAPCC rates in 1994, most of them also had low Medicare HMO penetration rates. Very few counties had low payment rates and high penetration. Interestingly, however, table III.3 shows that for counties with high AAPCC rates, an equal percentage had high Medicare risk-contract HMO penetration as did those with low penetration.

Table III.3: Percent of Counties With High and Low Medicare Risk-Contract HMO Penetration Rates by AAPCC Rates, 1994

		Penetration rates	
AAPCC rates	Counties	Low[a] (percent of counties)	High[b] (percent of counties)
Low (under $375)	2,788	93	3
Moderate ($375 to $500)	434	72	15
High (over $500)	25	40	40

[a]Penetration rate—percent of Medicare beneficiaries enrolled in risk-contract HMOs—less than or equal to 1 percent.

[b]Penetration rate—percent of Medicare beneficiaries enrolled in risk-contract HMOs—greater than 5 percent.

Source: AAPCC rates obtained from Office of Managed Care, HCFA. Enrollment information based on computer runs using the denominator file, Bureau of Data Management and Strategy, HCFA.

The same patterns shown in table III.3 also hold when only the 500 counties with the largest number of Medicare beneficiaries are included in the analysis. High AAPCC rates are more likely to be associated with higher

[18]Excludes payments for Guam, Puerto Rico, and the Virgin Islands.

[19]This plausible relationship is also supported by a statistical analysis of Medicare HMO enrollment that controls for several other factors in addition to payment rates. See: Physician Payment Review Commission, Annual Report to Congress, Physician Payment Review Commission, 1995 (Washington, D.C.: 1995), pp. 92-94.

Medicare HMO penetration, but high AAPCC rates alone are not sufficient to generate HMO risk-contract program participation.

Table III.4 identifies all 25 counties that had high AAPCC rates—rates over $500—and the degree of their Medicare risk-contract HMO penetration. As shown in the table, high AAPCC rates alone do not generate high penetration rates. In future work, we intend to examine the various factors that may affect Medicare risk-contract HMO penetration. For example, areas like Washington, D.C., and Detroit, Michigan, that have low penetration of Medicare risk-contract HMOs despite high AAPCC rates will be examined, especially the characteristics of the retired workforce and the health care market in these communities.

Table III.4: Counties With High AAPCC Rates and Medicare Risk-Contract HMO Penetration, 1994

Penetration rates		
Low[a]	**Moderate[b]**	**High[c]**
Washington, D.C.	Jefferson, La.	Los Angeles, Cal.
Plaquemines, La.	St. Charles, La.	Broward, Fla.
St. Bernard, La.	Suffolk, Mass.	Dade, Fla.
Baltimore City, Md.	New York, N.Y.	Bronx, N.Y.
Prince Georges, Md.	Rockland, N.Y.	Kings, N.Y.
Genesee, Mich.		Queens, N.Y.
Oakland, Mich.		Richmond, N.Y.
Wayne, Mich.		Philadelphia, Pa.
Chambers, Tex.		Liberty, Tex.
Norton City, Va.		Montgomery, Tex.

[a]Penetration rate less than or equal to 1 percent.

[b]Penetration rate greater than 1 percent and less than or equal to 5 percent.

[c]Penetration rate greater than 5 percent.

Source: AAPCC rates obtained from Office of Managed Care, HCFA. Enrollment information based on computer runs using the denominator file, Bureau of Data Management and Strategy, HCFA.

Most of the counties (2,778) had low AAPCC rates—rates under $375. For these counties, table III.5 shows a sample of 10 randomly selected counties with low Medicare risk-contract HMO penetration and a sample of 10 randomly selected counties with high penetration. As shown in the table, while most of the counties with low AAPCC rates also had low Medicare risk-contract HMO penetration, 78 counties, including some in California and Oregon, had high penetration despite low AAPCC rates; a situation we will examine further in future work.

Table III.5: Randomly Selected Counties With Low AAPCC Rates and Low and High Medicare Risk-Contract HMO Penetration, 1994

Penetration rates[a]	
Low[b] (N = 2,577)	**High[c] (N = 78)**
10 randomly selected counties:	10 randomly selected counties:
Mason, Ill.	Graham, Ariz.
Beaver, Okla.	Eldorado, Cal.
Fannin, Ga.	Santa Barbara, Cal.
Pike, Ga.	Honolulu, Hawaii
Union, Ky.	Cass, Mo.
Gallatin, Mont.	Bernalillo, N. Mex.
Darke, Ohio	Valencia, N. Mex.
Custer, Okla.	Lane, Ore.
Anasco, P.R.	Marion, Ore.
Jack, Tex.	Walla Walla, Wash.

[a]123 counties had moderate penetration rates—greater than 1 percent and less than or equal to 5 percent.

[b]Penetration rate less than or equal to 1 percent.

[c]Penetration rate greater than 5 percent.

Source: AAPCC rates obtained from Office of Managed Care, HCFA. Enrollment information based on computer runs using the denominator file, Bureau of Data Management and Strategy, HCFA.

Two Factors Associated With Medicare Beneficiary Decisions to Enroll in a Risk-Contract HMO

High Medicare penetration in risk-contract HMOs takes more than a decision by the HMO community to target the Medicare population. The Medicare beneficiary must make the choice, and this has typically required extensive marketing and expansion of benefits to attract the Medicare population. HMOs have increasingly turned to lower payments by the elderly in terms of reduced premiums to attract them. They also have expanded the benefits provided to Medicare beneficiaries by including such additional benefits as outpatient drugs and dental benefits. In addition, in an effort to save money, more employers are limiting the health care coverage choices of retirees. As a result, Medicare beneficiaries may have to consider receiving health benefits through a risk-contract HMO.

Many Risk-Contract HMOs Provide Additional Services to Beneficiaries

An attractive feature of the Medicare risk-contract program is the additional services that beneficiaries may receive if they enroll. In many cases, in addition to not having to pay Medicare's normal deductibles and coinsurance, Medicare beneficiaries enrolling in these HMOs may receive one or more services not covered by the regular fee-for-service Medicare

program. For example, routine physicals, eye examinations, and outpatient drugs may be provided by an HMO with a risk contract. Table III.6 shows the types of additional services provided to Medicare beneficiaries that enroll. While all services are not offered by all risk-contract HMOs, the percentage of HMOs offering these services has been changing since 1993. In particular, a higher percentage of HMOs offered outpatient drugs and dental benefits in 1995 than in 1993.

Table III.6: Number and Percent of HMOs With a Risk Contract Providing Additional Benefits to Medicare Beneficiaries, 1993 and 1995

	HMOs			
	1993[a]		1995[b]	
Additional benefit provided	Number	Percent	Number	Percent
Routine physicals	102	96.2	154	96.3
Immunizations	94	88.7	139	86.9
Eye exams	89	84.0	142	88.8
Ear exams	68	64.2	118	73.8
Health education	35	33.0	39	24.4
Outpatient drugs	34	32.1	78	48.8
Foot care	28	26.4	55	34.4
Dental care	26	24.5	56	35.0
Eyeglasses	5	4.7	8	5.0
Hearing aids	1	0.9	6	3.8

[a]Data as of December.

[b]Data as of August.

Source: Monthly Report, Medicare Prepaid Health Plans, Office of Prepaid Health Care Operations and Oversight, HCFA.

Medicare beneficiaries may have to pay monthly premiums when they enroll in an HMO. While Medicare beneficiaries' basic HMO premiums were as high as $111, the average was $22 and the median was $39 in August 1995. However, table III.7 shows that the percent of HMOs that did not charge any premiums increased between 1993 and 1995 from about 26 percent to nearly 50 percent. The lack of premiums can provide an incentive for more Medicare beneficiaries to consider this form of health care.

Table III.7: Range of Premiums Charged Medicare Beneficiaries by HMOs With a Risk Contract, 1993 and 1995

	HMOs			
	1993[a]		1995[b]	
Range of premiums charged	Number	Percent	Number	Percent
$0	27	25.5	79	49.4
$0.01 to $39.99	28	26.4	42	26.3
$40.00 to $79.99	45	42.5	33	20.6
$80.00 or more	6	5.7	6	3.8

[a]Data as of December.

[b]Data as of August.

Source: Monthly Report, Medicare Prepaid Health Plans, Office of Prepaid Health Care Operations and Oversight, HCFA.

Employer Decisions May Cause More Beneficiaries to Consider Risk-Contract HMOs

Although Medicare is the primary payer for medical care among people over 65, many Medicare beneficiaries rely on employer-based health benefits to cover deductibles, coinsurance, and non-Medicare-covered items such as prescription drugs. However, employer-provided retiree health benefit coverage has been eroding over the past decade due, primarily, to the rising cost of such coverage according to a recent study by KPMG.[20] The number of firms offering retiree health coverage has been dropping, while retirees are bearing an increasing share of this cost. This trend may increase the number of Medicare beneficiaries enrolling in HMOs, which deliver the same or broader coverage without deductibles or coinsurance.

In the mid-1980s, almost two-thirds of employees of large or mid-size firms were offered retiree health benefits by their employers. However, by 1993, the percentage of active workers slated to receive retiree health benefits had fallen to 45 percent. Retirees who received coverage from their employers paid only 15 percent of the cost of single coverage in 1988, 31 percent in 1992, and 42 percent in 1993. The rising cost of retiree health benefits is driving this trend. The average total monthly cost in 1993 for retirees over 65 was $118 per month for single coverage, up from about $40 per month in 1985.

Employers may be playing a role in driving the growth of Medicare risk-contract HMO enrollments according to HCFA and industry experts. HMOs look attractive to employers because of the rising cost of retiree

[20]KPMG Peat Marwick, "1994 Retiree Health Benefits: The Uncertainty Continues," (U.S.A.: 1994).

health benefits. The effect of retiree health benefits on companies' bottom lines was highlighted when the Financial Accounting Standards Board adopted the Statement of Financial Accounting Standards (SFAS) 106.

SFAS 106 requires private-sector employers with 500 or more plan participants to treat obligations for present and future years on an accrual instead of a pay-as-you-go basis. In 1992, SFAS 106 expenses cost Fortune 100 companies one-third of their operating income because most decided to write off the cost of retiree coverage immediately. According to one industry analyst, SFAS 106 liability is the number one motivation for employers to get retirees into managed care. The effect of these health care cost realities is for employers not only to encourage retirees to join HMOs, but to provide them financial incentives to do so.

Supplemental State Data on Medicare Risk-Contract HMOs

Table IV.1: Medicare Beneficiary Enrollment in HMOs With Medicare Risk Contracts and HMO Participation by State, 1994

State	Enrollment in Medicare HMOs as a percent of the total Medicare population 1994[a]	Number of Medicare beneficiaries enrolled in an HMO in 1994[b]	Number of HMOs in 1994[c]	Number of HMOs with a Medicare risk contract in 1994[b]
Arizona	27.0	154,939	20	6
California	26.8	946,668	36	32
Oregon	22.2	101,823	7[d]	9[d]
Nevada	19.9	35,873	7	2
Florida	14.9	377,966	36	19
New Mexico	13.8	27,939	6	4
Colorado	12.2	49,469	12	5
Washington	10.3	68,590	11	6
Minnesota	9.1	56,421	9	3
Hawaii	9.1	13,044	7	1
Rhode Island	6.9	11,437	3	1
Illinois	4.3	68,355	27	3
Massachusetts	4.3	39,129	16	5
Texas	4.1	82,685	31	7
New York	3.9	100,421	33	9
Pennsylvania	2.7	55,913	19	9
Oklahoma	2.6	12,590	6	2
Missouri	1.9	15,793	18	5
Nebraska	1.3	3,285	5	1
Ohio	1.2	19,678	31	6
Kansas	0.6	2,269	10	1
Kentucky	0.5	2,705	7	1
Michigan	0.5	6,964	17	2
Louisiana	0.4	2,344	11	2
New Jersey	0.4	4,449	14	1
Maryland	0.3	1,823	16	4
Indiana	0.3	2,549	12	2
Alabama	0.3	1,630	8	1
Virginia	0.2	1,306	13	1
Delaware	0.1	91	6	1
Connecticut	0.04	193	14	1
New Hampshire	0.02	23	3	1
Alaska	0.0	0	0	0

(continued)

State	Enrollment in Medicare HMOs as a percent of the total Medicare population 1994[a]	Number of Medicare beneficiaries enrolled in an HMO in 1994[b]	Number of HMOs in 1994[c]	Number of HMOs with a Medicare risk contract in 1994[b]
Arkansas	0.0	0	6	0
District of Columbia	0.0	0	2	1
Georgia	0.0	0	11	0
Idaho	0.0	0	2	0
Iowa	0.0	0	3	0
Maine	0.0	0	3	0
Mississippi	0.0	0	1	0
Montana	0.0	0	1	0
North Carolina	0.0	0	12	0
North Dakota	0.0	0	2	0
South Carolina	0.0	0	4	0
South Dakota	0.0	0	1	0
Tennessee	0.0	0	17	0
Utah	0.0	0	8	0
Vermont	0.0	0	1	0
West Virginia	0.0	0	0	0
Wisconsin	0.0	0	27	0
Wyoming	0.0	0	0	0
Total		**2,268,364**	**572**	**154**

[a]Enrollment data as of December. Number of Medicare beneficiaries as of July.

[b]Data as of December.

[c]Data as of the end of the year.

[d]Data as reported by HCFA and GHAA.

Source: Medicare HMO enrollment data and number of HMOs with a Medicare risk contract from December monthly report, HCFA. Number of Medicare beneficiaries from 1995 Data Compendium, HCFA. Number of HMOs from Patterns in HMO Enrollment, GHAA.

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