Section 4. Medicare Risk HMOs

Managed care encompasses a wide variety of arrangements, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Typically managed care plans control costs by restricting an enrollee's choice of provider or by giving enrollees strong financial incentives to choose particular providers. They also reduce costs by managing enrollees' use of services. In 1983, Congress authorized payment to qualified "risk-contract" HMOs or similar entities that enrolled Medicare beneficiaries. The intent was to give Medicare beneficiaries the opportunity to enroll in HMOs as a more cost efficient alternative to fee-for-service health care.

In December 1996, about 13% of Medicare beneficiaries were enrolled in HMOs, most of whom were in risk contract plans. (The remainder were in HMOs paid on a cost basis, or in demonstration HMOs.) An HMO accepts financial responsibility for a defined set of health care benefits in return for a capitation payment, or a fixed monthly per capita premium paid by or on behalf of each enrolled member. In return for the capitation payment, the HMO agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers. With certain exceptions, Medicare beneficiaries must obtain all covered services through the qualified HMO, except in emergencies.

Some in Congress believe that Medicare could achieve substantial savings by increasing the managed care options available to beneficiaries and changing the payment methodology to take greater advantage of the forces of market competition. This perspective is, in part, encouraged by the experiences of the private sector, where the rapid movement of large group health plans from fee-for-service into managed care has helped to slow the rate of medical care inflation. While these changes are not regarded by everyone as positive (concerns exist, for example, that the growth of managed care has reduced access to services for lower-income populations), substantial support exists for trying to restructure Medicare to make it work more like the large group private insurance market.

This section provides information on the number and location of Medicare risk HMOs and the number, geographic distribution, and characteristics of beneficiaries enrolled in HMOs. Comparisons are drawn between Medicare HMO enrollees and beneficiaries in Medicare fee-for-service. Information is also provided on Medicare payments to risk HMOs and geographic variation in these payments.

Figure 4.1.
Risk HMOs Participating in Medicare, 1987-1996

Risk contract HMOs (or risk HMOs) are HMOs that contract with the Medicare program to provide Medicare's package of benefits to enrolled beneficiaries. The risk HMOs receive a predetermined monthly payment from Medicare for each enrolled beneficiary, regardless of the actual medical care utilization of the enrollee. Risk HMOs were authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TERFA) and are sometimes called *TEFRA HMOs*.

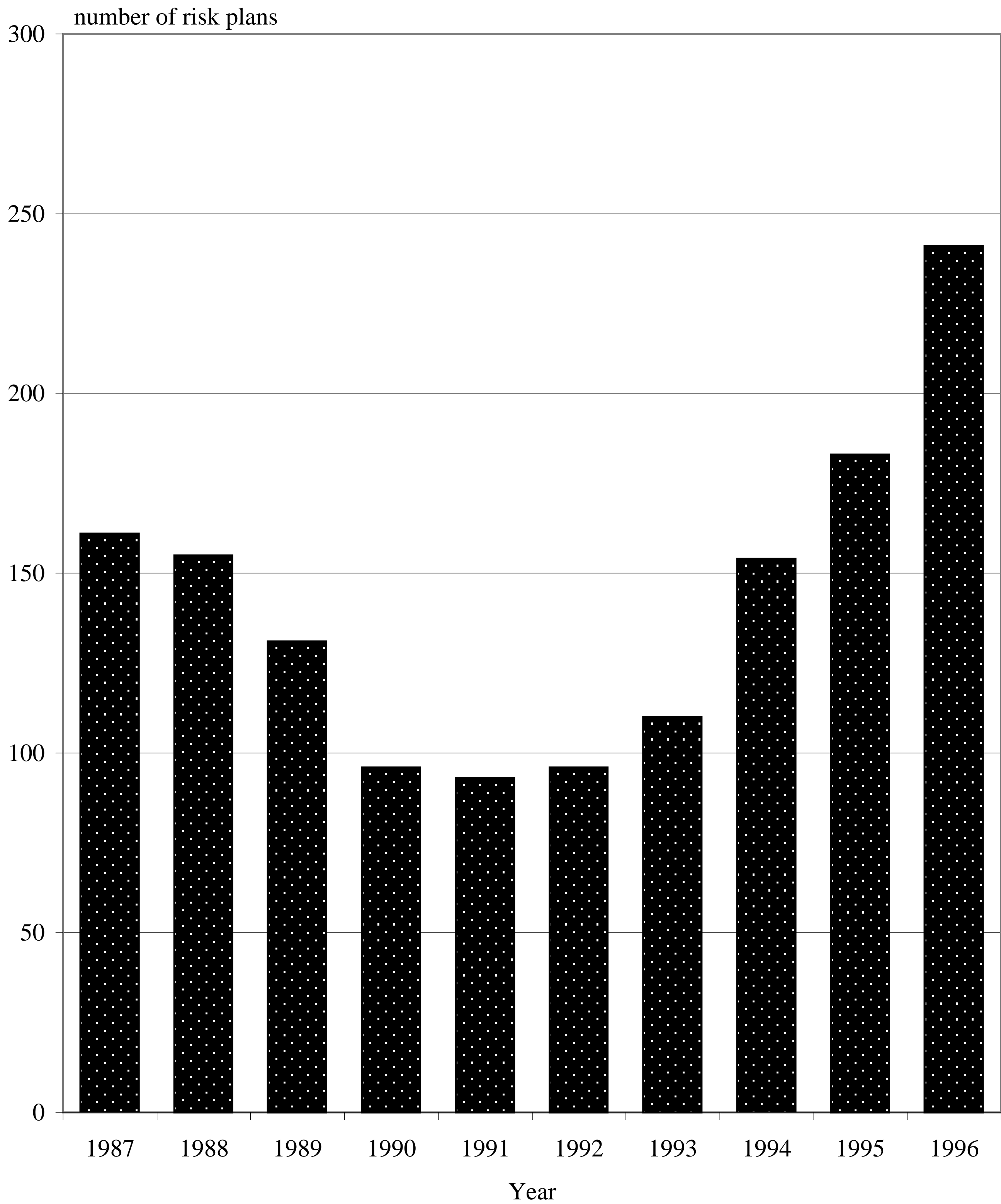
Participation of risk contract HMOs in Medicare declined from 1987 to the early 1990s when many plans terminated existing contracts. However, the total number of health plans signing risk contracts with the Medicare program more than doubled between 1993 and 1996. The rapid increase starting in 1993 shows no signs of abating. As of December 1996, another 67 risk plan applications were pending with the Health Care Financing Administration (HCFA).

TABLE 4.1.
Risk HMOs Participating in Medicare 1987-1996

Year	Number of Plans
1987	161
1988	155
1989	131
1990	96
1991	93
1992	96
1993	110
1994	154
1995	183
1996	241

NOTE: Table prepared by CRS.

Figure 4.1. Risk HMOs Participating in Medicare, 1987-1996



Source: Figure prepared by CRS based on Physician Payment Review Commission (PPRC), *Medicare Risk Plan Participation and Enrollment: A Chart Book*, December, 1996, Chart 1.

Figure 4.2.
Beneficiaries Enrolled in Medicare Risk HMOs, 1990-2000

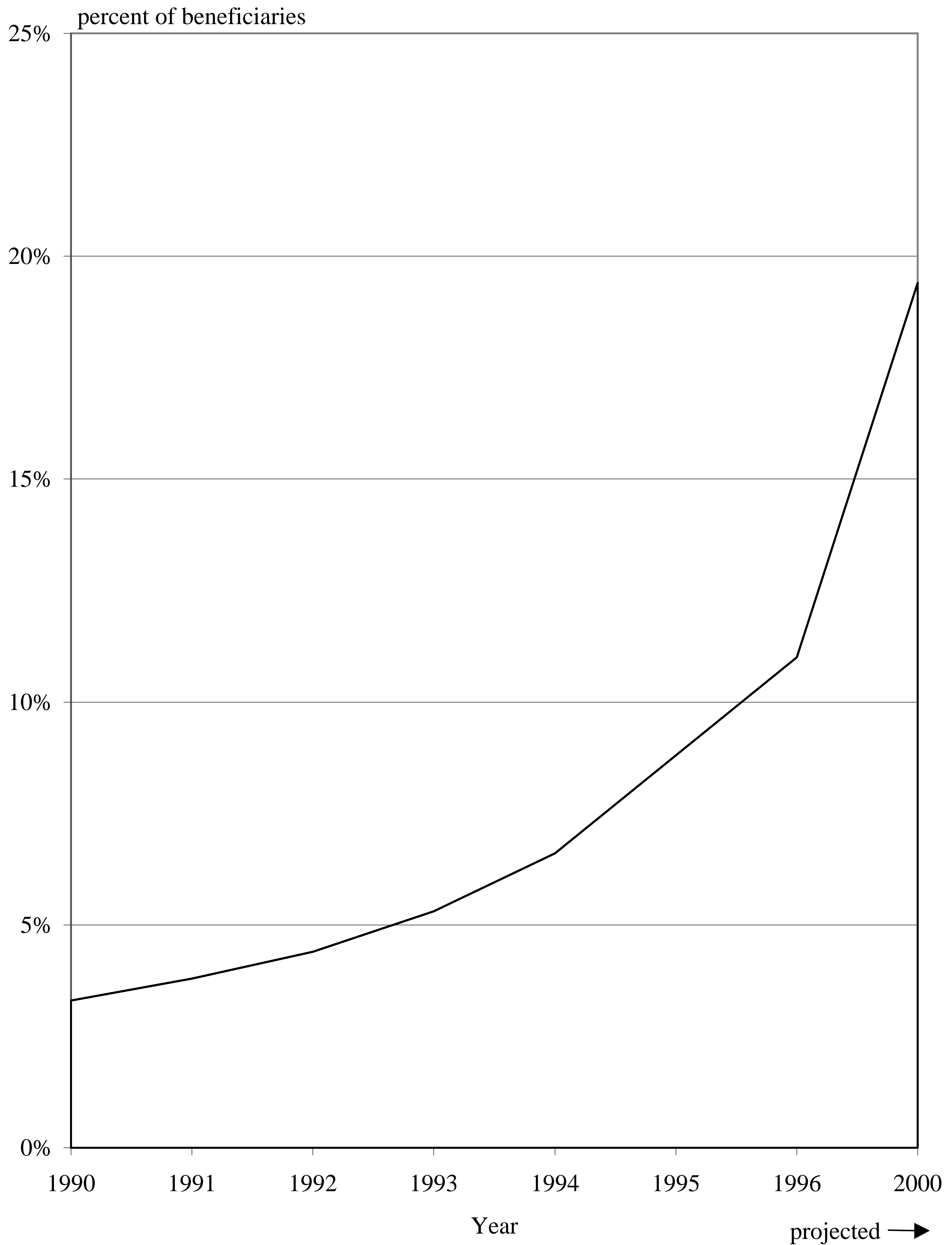
There has been a steady growth in enrollment in Medicare risk HMOs during the 1990s, reaching 11% of all beneficiaries in December 1996. Between 1993 and 1996, enrollment doubled. The annual rate of growth over the last several years has been in the range of 25% to 35%. The Congressional Budget Office (CBO) projects that enrollment in risk plans will reach about 19.4% of all beneficiaries by 2000, assuming no changes in policy.

TABLE 4.2.
Beneficiaries Enrolled in Medicare Risk HMOs, 1990-2000 (in percent)

Year	Risk HMO Enrollment
1990	3.30
1991	3.80
1992	4.40
1993	5.30
1994	6.60
1995	8.80
1996	11.00
2000	19.40

NOTE: Data for year 2000 are projected. Table prepared by CRS.

Figure 4.2. Beneficiaries Enrolled in Medicare Risk HMOs, 1990-2000



Source: Figure prepared by CRS based on *PPRC Chart Book*, Dec-96, chart 3; CBO, *Jan-97 Baseline Medicare,* Jan. 1, 1997.

Figure 4.3.
Distribution of Medicare Beneficiaries, by Number of Risk HMOs Available in Their Area, 1995-1996

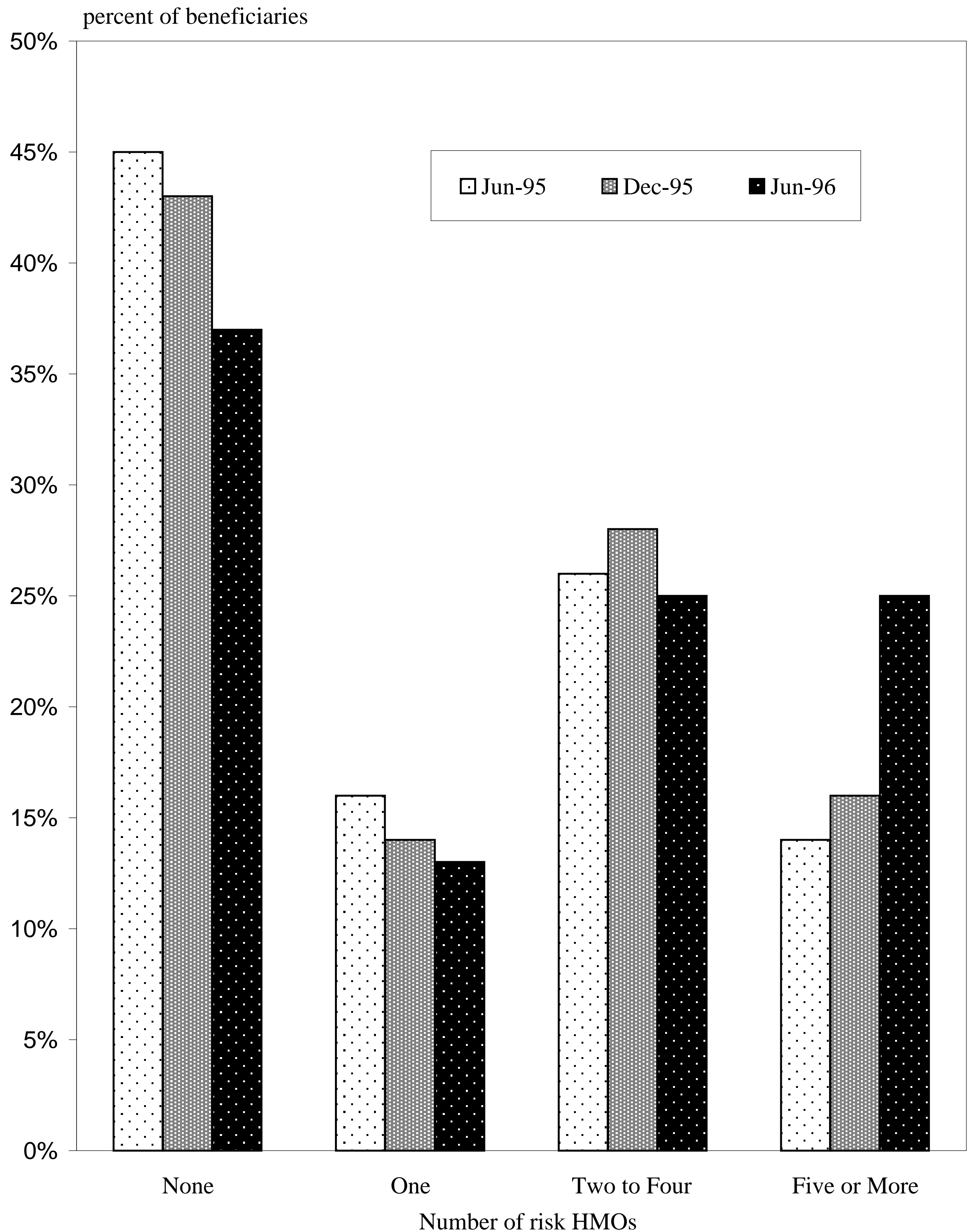
Although over 200 risk HMO plans participate in Medicare, each is available only to beneficiaries in a specific service area. Plans define a service area as a set of counties and county parts, itemized at the zip code level. In June 1996, 63% of all Medicare beneficiaries lived in a zip code that was served by at least one risk plan. About half of all beneficiaries had access to a choice of plans, and one-fourth had five or more plans available to them. Over the year from June 1995 to June 1996, the proportion of all beneficiaries with access to at least one risk plan rose 8 percentage points, while the proportion with access to at least five plans had risen 11 percentage points.

TABLE 4.3.
Distribution of Medicare Beneficiaries, by Number of Risk HMOs Available in Their Area, 1995-1996
(in percent)

Number of Risk HMOs Available	June 1995	December 1995	June 1996
None	45	43	37
One	16	14	13
Two to four	26	28	25
Five or more	14	16	25

NOTE: Table prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.3. Distribution of Medicare Beneficiaries, by Number of Risk HMOs Available in Their Area, 1995-1996



Source: Figure prepared by CRS based on *PPRC Chart Book,* Dec. 1996, Chart 2.

Figure 4.4.
Medicare Beneficiaries in Urban and Rural Locations Who Are Enrolled in Risk HMOs, June 1996

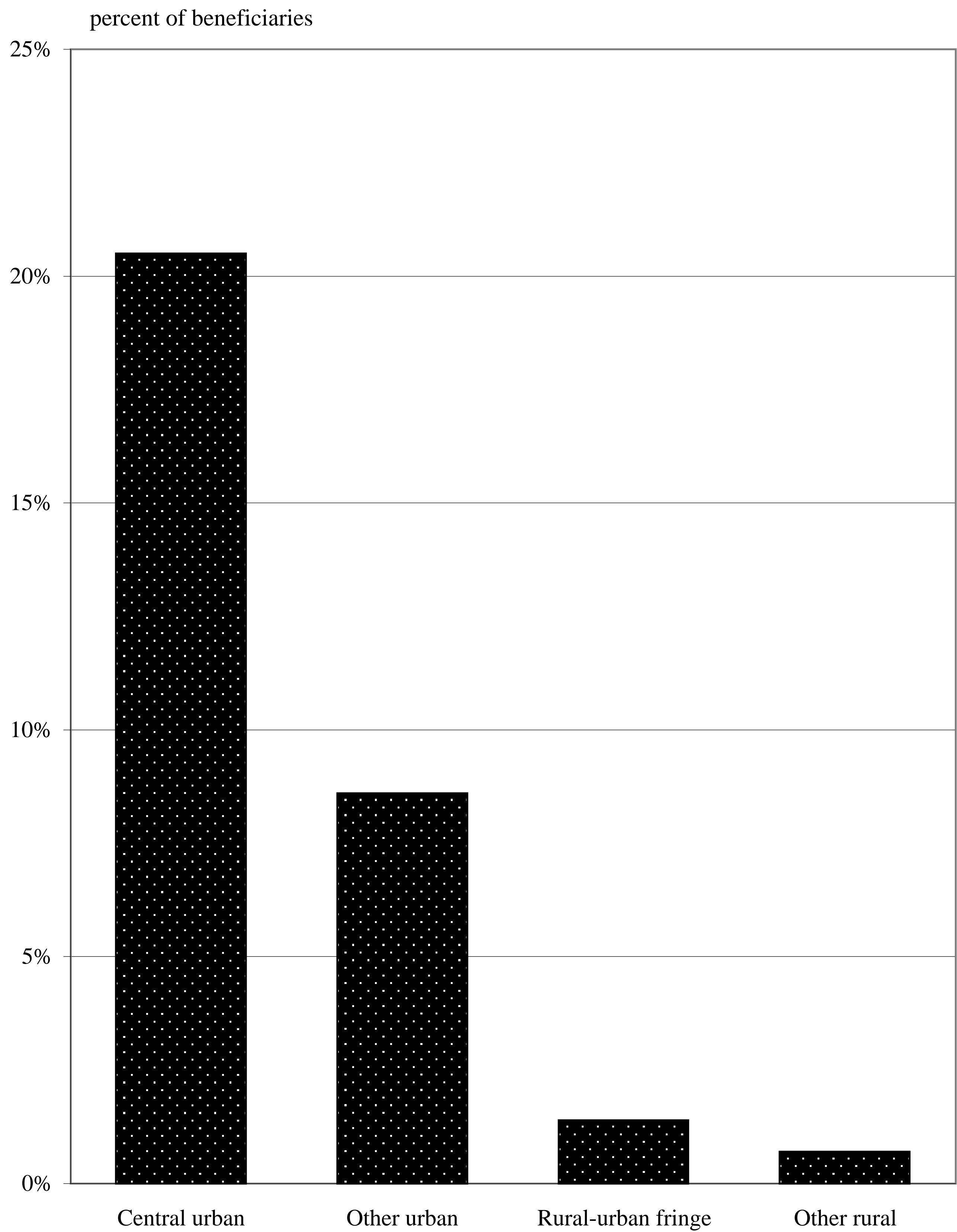
Patterns of enrollment in risk contract HMOs are not uniform across urban and rural locales. Risk plan enrollment in central urban areas (generally, the cities at the core of metropolitan areas) was about 20% in June 1996, about twice the level of enrollment in outlying urban areas. Risk HMO enrollment in rural areas is about 1%.

TABLE 4.4.
Medicare Beneficiaries in Urban and Rural Locations Who Are Enrolled in Risk HMOs, June 1996
(in percent)

	Risk-Contract Plans
Central urban	20.5
Other urban	8.6
Rural-urban fringe	1.4
Other rural	0.7

NOTE: Table prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.4. Medicare Beneficiaries in Urban and Rural Locations Who are Enrolled in Risk HMOs, June 1996



Source: Figure prepared by CRS based on *PPRC Chart Book*, Dec. 1996, Chart 2.

Figure 4.5.
Variation in Number of Risk HMOs Available to Medicare Beneficiaries in Urban and Rural Locations, June 1996

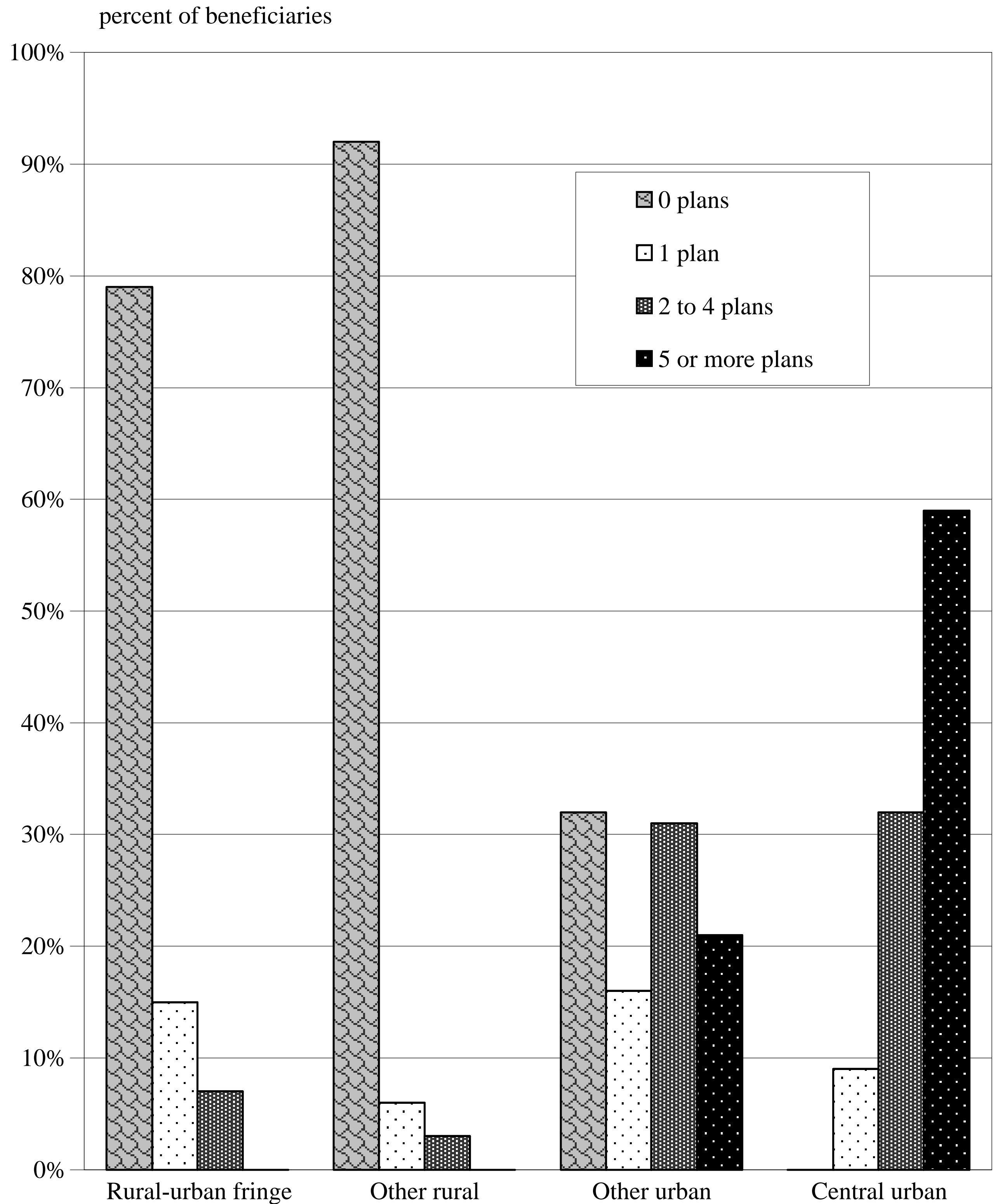
The availability to Medicare beneficiaries of risk contract plans is much greater in urban areas than in rural areas. A choice of risk plans is available to most residents of central urban areas. By contrast, rural beneficiaries rarely have even a single plan available to them.

TABLE 4.5.
Variation in Number of Risk HMOs Available to Medicare Beneficiaries in Urban and Rural Locations, June 1966
(in percent)

	0 Plans	1 Plan	2 to 4 Plans	5 or More Plans
Central urban	0	9	32	59
Other urban	32	16	31	21
Rural-urban fringe	79	15	7	0
Other rural	92	6	3	0

NOTE: Table prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.5. Variation in Number of Risk HMOs Available to Medicare Beneficiaries in Urban and Rural Locations, June 1996

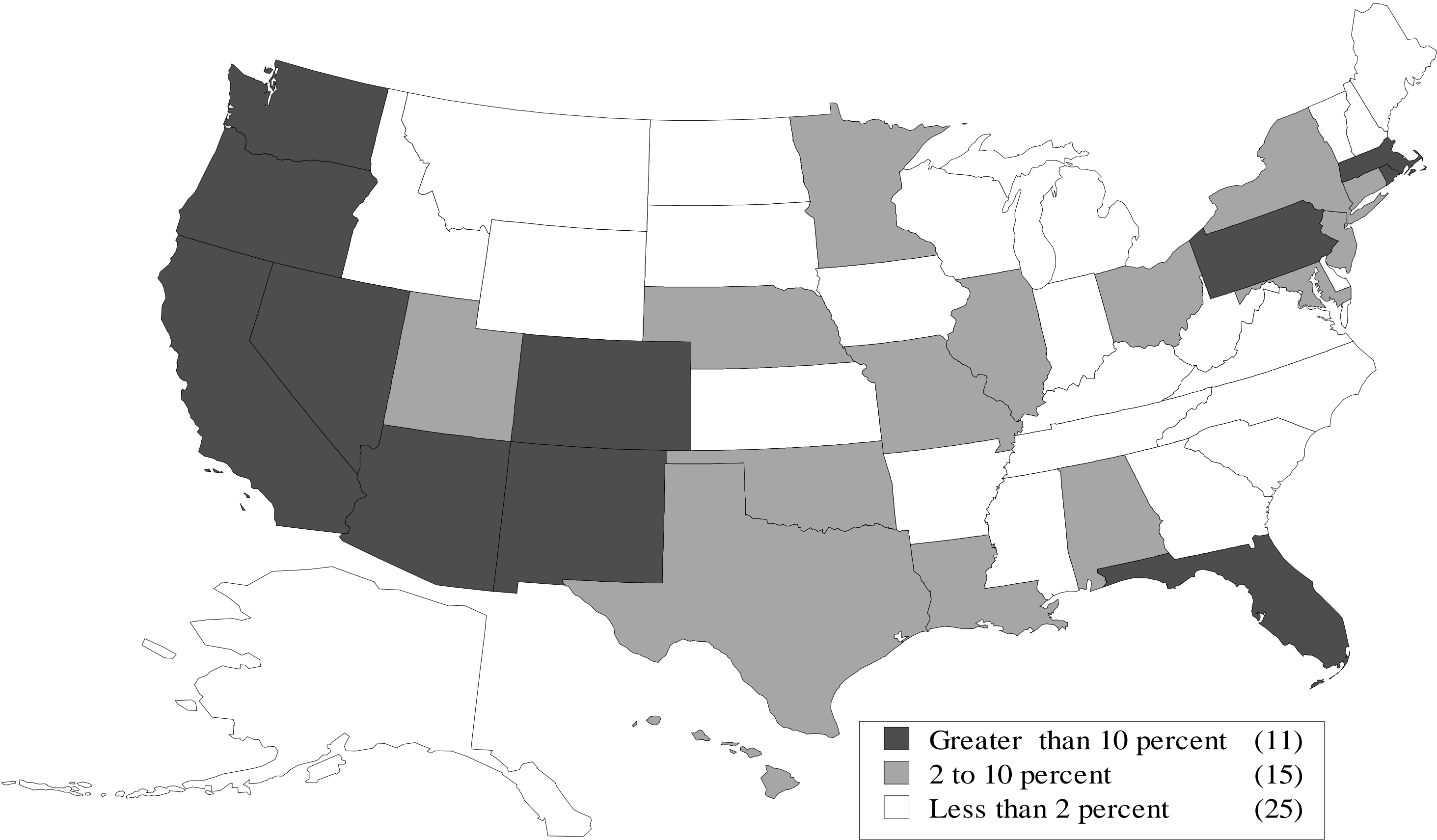


Source: Figure prepared by CRS based on *PPRC Chart Book*, Dec. 1996, Chart 4.

Figure 4.6.
Medicare Beneficiaries Enrolled in Risk HMOs, by State
December 1996

Enrollment patterns are not uniform on a regional basis, with Medicare risk HMO enrollment higher in western states. Over 25% of the total number of Medicare beneficiaries residing in three western states are in risk HMOs. In Arizona, 34% of its Medicare beneficiaries are enrolled in Medicare risk HMOs; California (35%); and Oregon (27%). The only eastern states where enrollment tops 10% of all Medicare beneficiaries living in those states are: Florida (22%); Massachusetts (14%); Pennsylvania (16%); and Rhode Island (12%).

Figure 4.6. Medicare Beneficiaries Enrolled in Risk HMOs, by State, December 1996



SOURCE: Map prepared by CRS based on PPRC analysis of *Medicare Managed Care Contract Reports,* December 1996.

Figure 4.7.
Distribution of Medicare Risk HMO Enrollees Among Selected States, 1994-1995

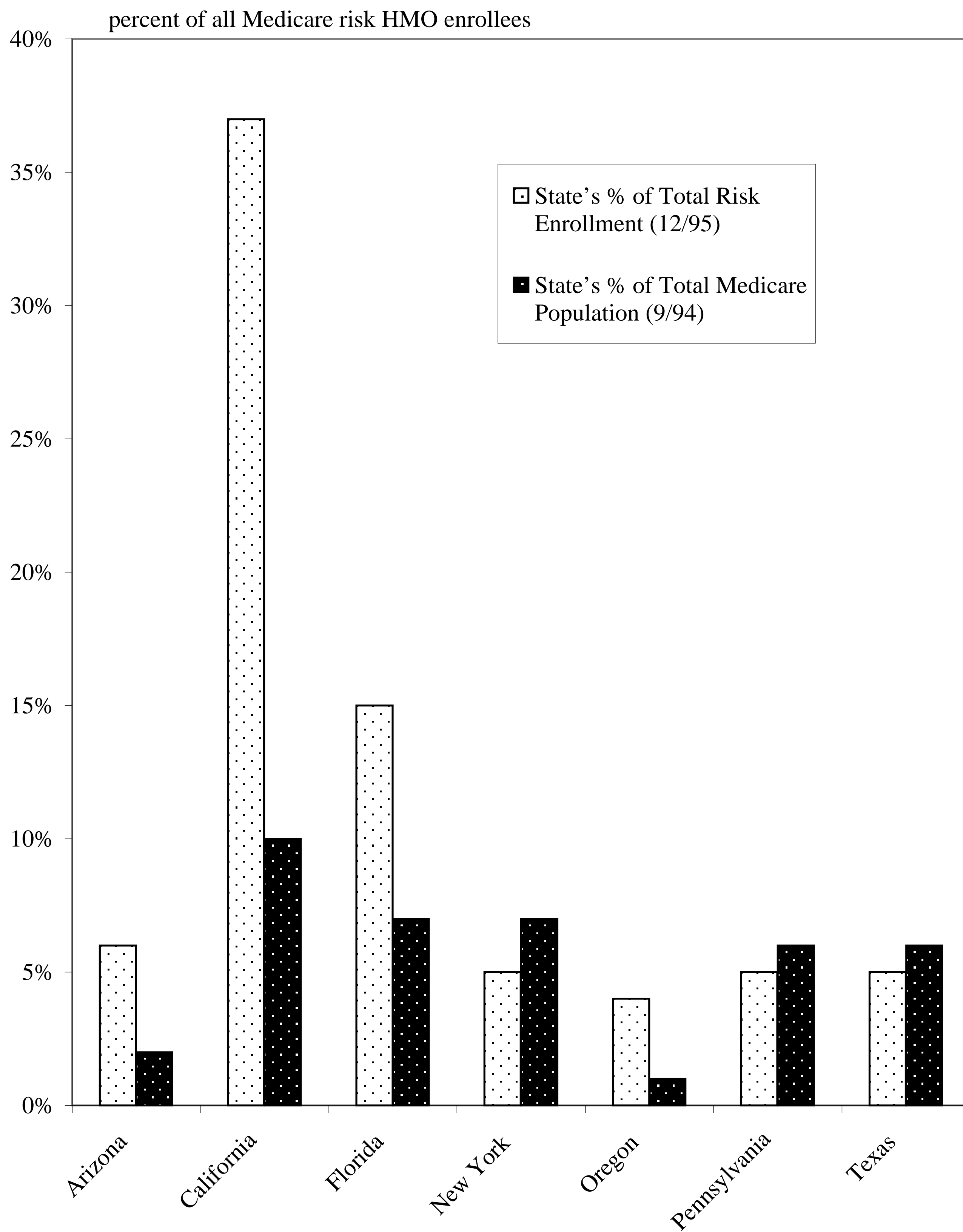
Medicare risk HMO enrollees are far more concentrated geographically than are Medicare beneficiaries as a whole. As of December 1995, 52% of all Medicare risk HMO enrollees lived in California and Florida, even though only 17% of all beneficiaries live in those two states.

TABLE 4.7.
Distribution of Medicare Risk HMO Enrollees Among Selected States 1994-1995 (in percent)

State	Total Risk Enrollment (12/95)	Total Medicare Population (9/94)
Arizona	6	2
California	37	10
Florida	15	7
New York	5	7
Oregon	4	1
Pennsylvania	5	6
Texas	5	6

NOTE: Table prepared by CRS.

Figure 4.7. Distribution of Medicare Risk HMO Enrollees Among Selected States, 1994-1995



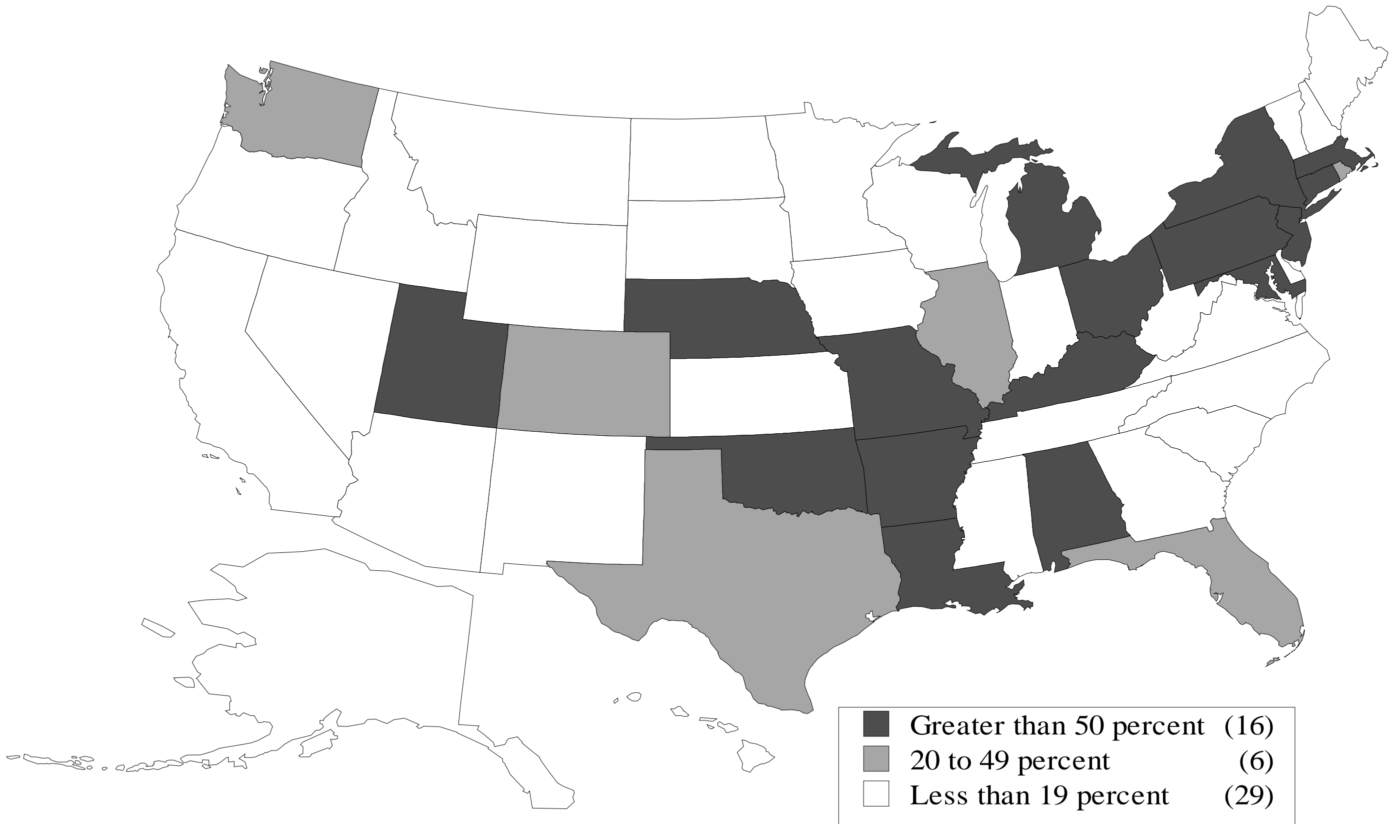
Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare,* Chart MC-5, p. 99.

Figure 4.8.
Growth in Medicare Risk HMO Enrollment
December 1995-December 1996
(New Enrollees as a Percent of Previous State Enrollment)

The traditional definition of growth in Medicare HMO enrollment is the change in enrollment from one time to the next. Using this definition, national growth was 34% during the period December 1995 to December 1996. Growth was highest in eastern states, where enrollment levels are typically low or moderate. Because the base enrollment is quite low in some of these states, even relatively few new enrollees lead to large growth rates.

Figure 4.8. Growth in Medicare Risk HMO Enrollment, December 1995-December 1996

New Enrollees as a Percent of Previous State Enrollment



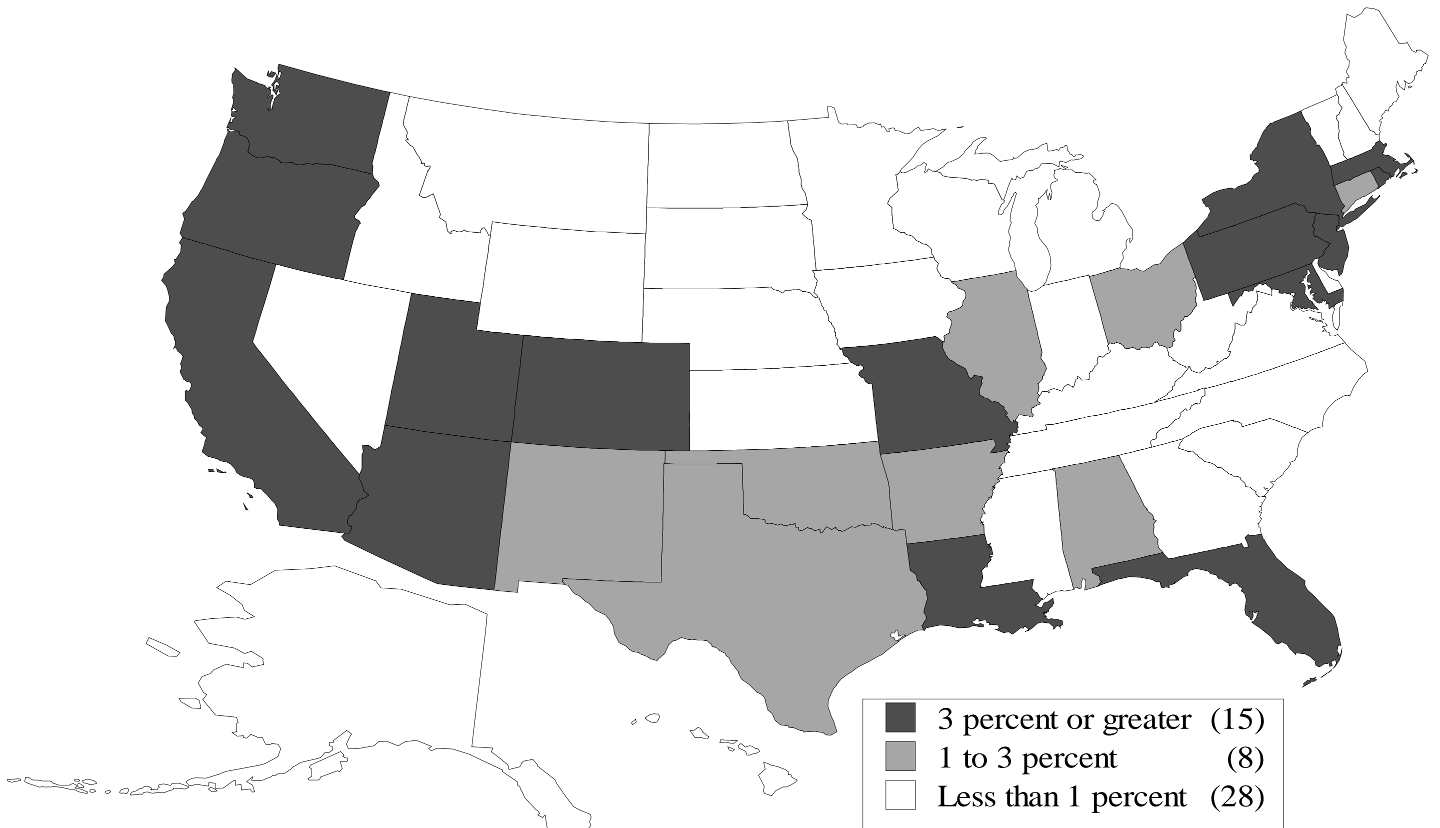
SOURCE: Map prepared by CRS based on PPRC analysis of *Medicare Managed Care Contract Reports.*

Figure 4.9.
Growth in Medicare Risk HMO Enrollment
December 1995-December 1996
(New Enrollees as a Percent of Total State Beneficiaries)

When measured as a percentage of all beneficiaries in the state, the highest growth has occurred mostly in states with moderate or high percentages of beneficiaries already enrolled in Medicare risk HMOs. This approach, however, highlights relatively high growth in certain states (e.g., Maryland and Missouri) not usually associated with a large managed-care presence. Nationally, a net total of 2.8% of all beneficiaries joined risk plans in this 1-year period.

Figure 4.9. Growth in Medicare Risk HMO Enrollment, December 1995-December 1996

New Enrollees as a Percent of Total State Beneficiaries

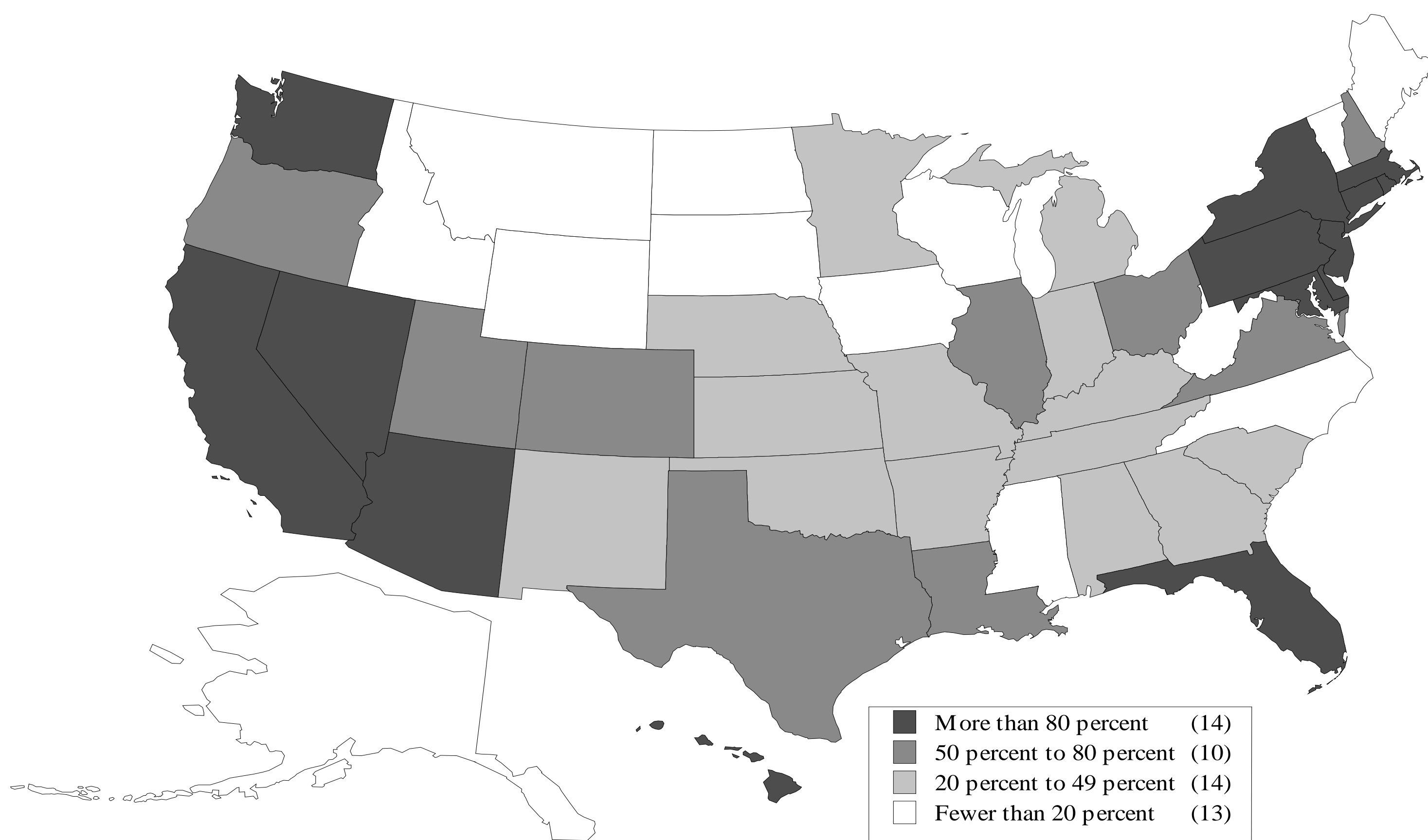


SOURCE: Map prepared by CRS based on PPRC analysis of *Medicare Managed Care Contract Reports, December 1996.*

Figure 4.10.
State Medicare Population with at Least One Medicare Risk HMO Available, June 1996

In only a few states are Medicare risk HMOs available to all or nearly all Medicare beneficiaries. In 14 states, 80% or more of the beneficiaries have access to at least one plan. However, risk HMO enrollment is not high in all of these states. By contrast, there are 13 states where fewer than 20% of all Medicare beneficiaries have plans available, including nine states where no plans at all are available.

Figure 4.10. State Medicare Population with at Least One Medicare Risk HMO Available, June 1996



SOURCE: Map prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.11.
Medicare Beneficiaries Enrolled in Risk HMOs by Number of Plans Available in Their Area June 1996

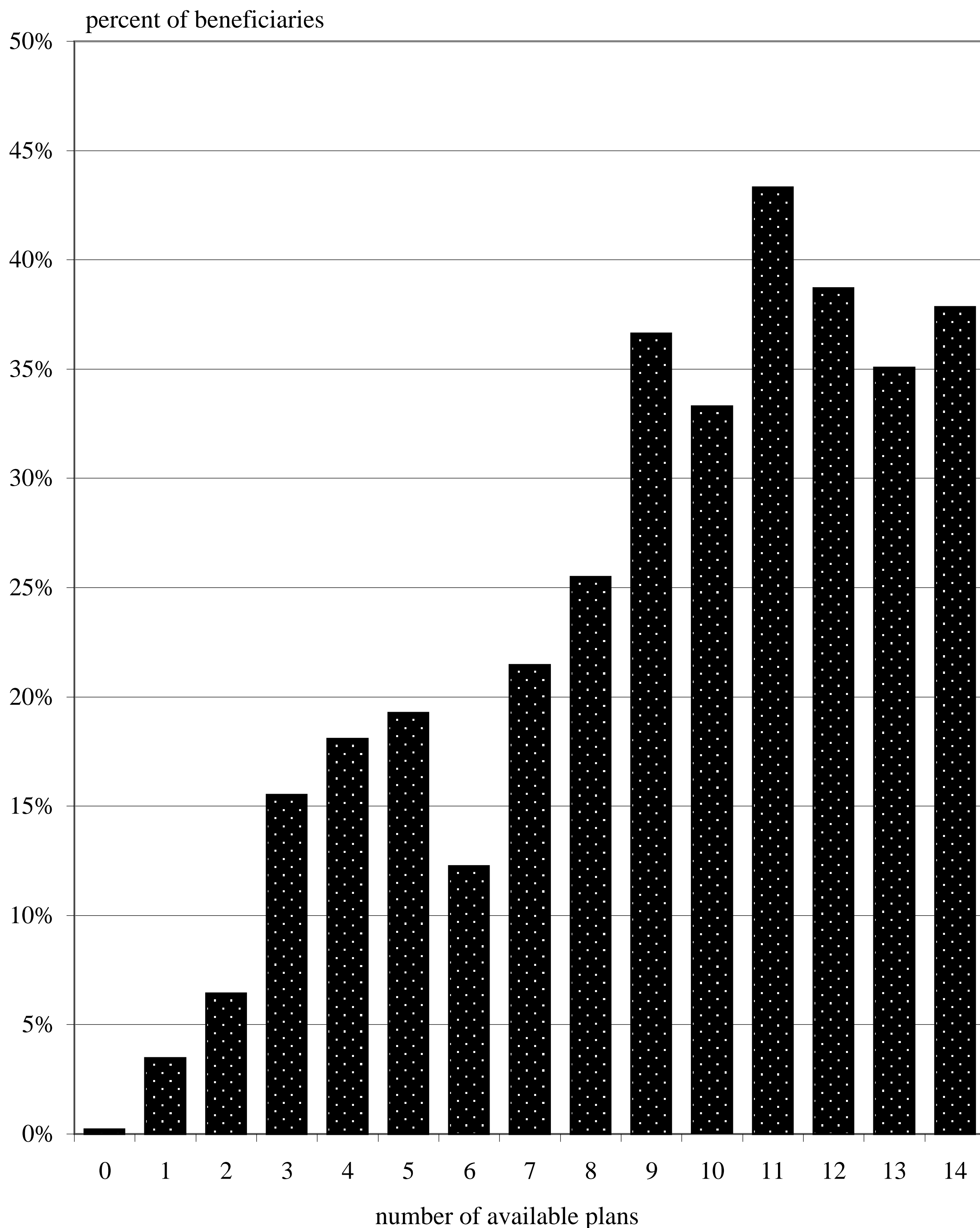
There is a correlation between the number of plans available to a beneficiary and the likelihood of being enrolled in a risk plan. Fewer than 10% of beneficiaries with two or fewer plans available have enrolled in a plan. At the same time, more than 30% of those beneficiaries in areas where nine or more risk contract plans are available are enrolled in one of those plans.

TABLE 4.11.
Medicare Beneficiaries Enrolled in Risk HMOs by Number of Plans Available in Their Area
June 1996

Number of Plans Available	Percent of Beneficiaries Enrolled
0	0.21
1	3.46
2	6.42
3	15.51
4	18.08
5	19.26
6	12.26
7	21.47
8	25.49
9	36.63
10	33.29
11	43.31
12	38.70
13	35.06
14	37.83

NOTE: Table prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.11. Percent of Medicare Beneficiaries Enrolled in Risk HMOs, by Number of Plans Available in Their Area, June 1996



Source: Figure prepared by CRS based on *PPRC Chart Book* , Dec. 1996, Chart 17.

Figure 4.12.
Medicare Risk Contract Plan Terminations, 1985-1995

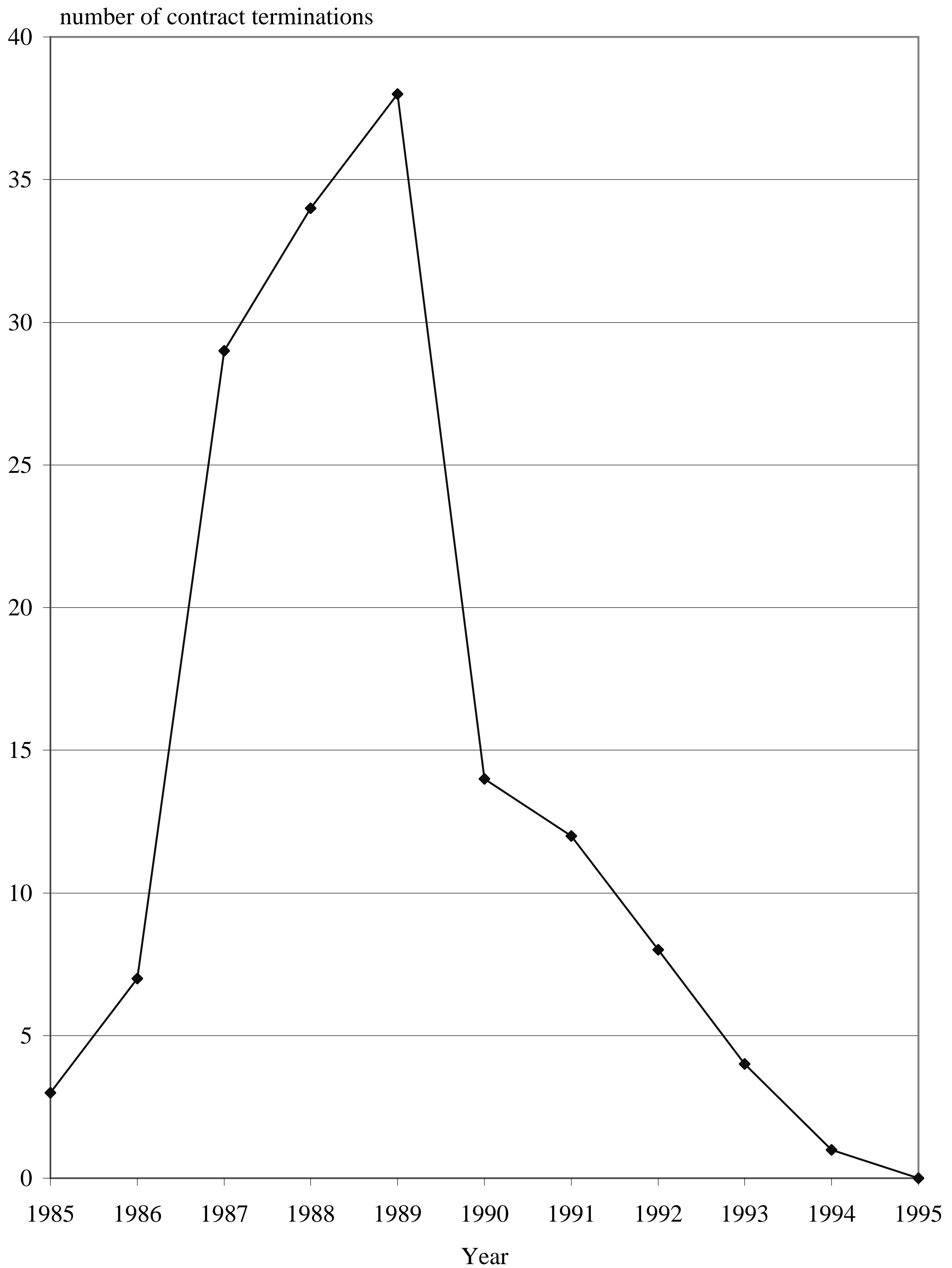
The early years of the Medicare risk program saw the quick entry and exit of a number of HMOs as Medicare contractors. In the past few years, more and more HMOs have entered the Medicare risk market whereas contract terminations have declined. Terminations reached a high of 38 plans in 1989, declining to zero in 1995.

TABLE 4.12.
Medicare Risk Contract Plan Terminations, 1985-1995

Year	Contract Terminations
1985	3
1986	7
1987	29
1988	34
1989	38
1990	14
1991	12
1992	8
1993	4
1994	1
1995	0

NOTE: Table prepared by CRS.

Figure 4.12. Medicare Risk Contract Plan Terminations, 1985-1995



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare,* Chart MC-4, p. 98.

Figure 4.13.
Enrollment Distribution by Duration of Medicare Risk HMO Contract, as of December 1995

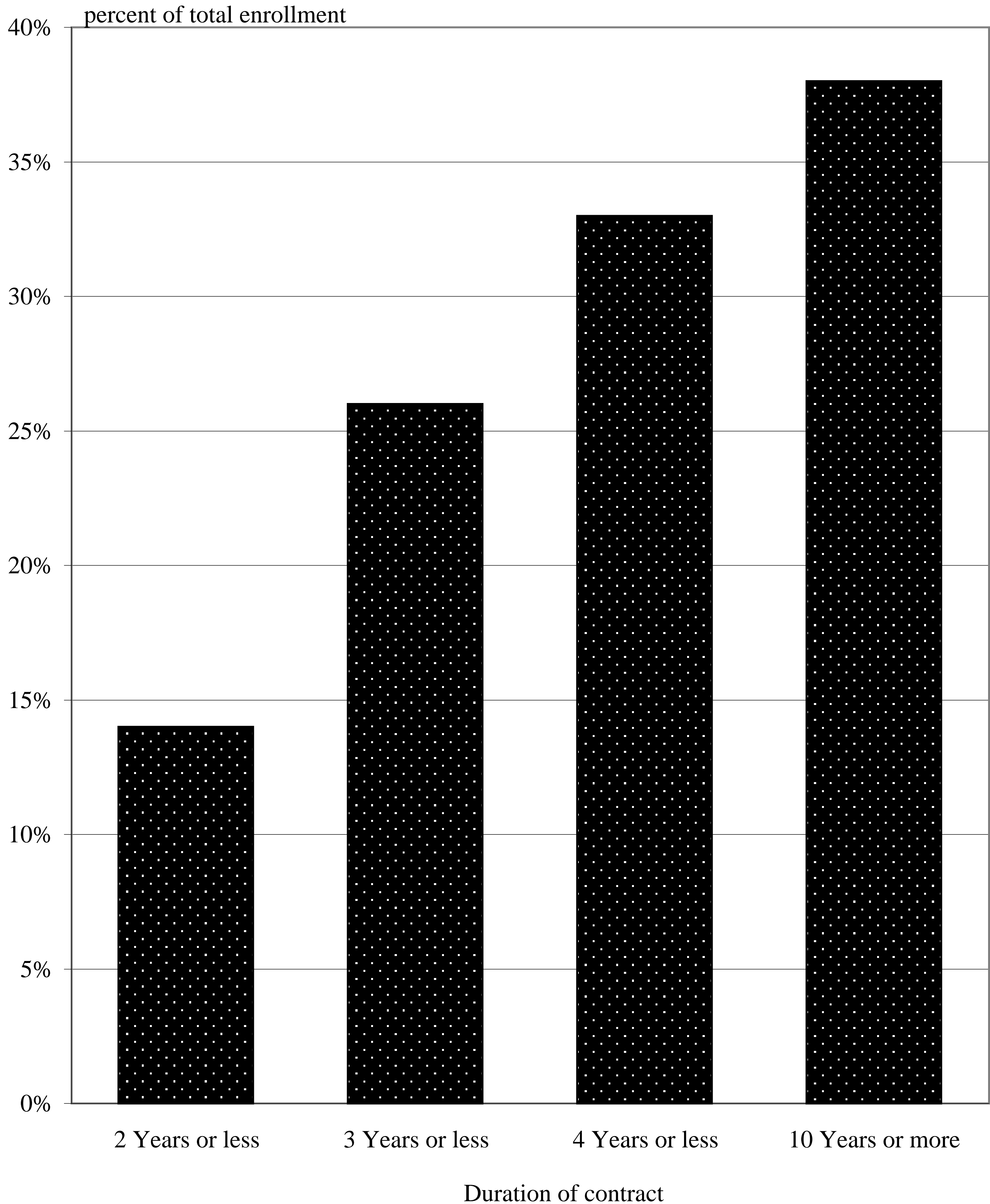
As of December 1995, 26% of all Medicare risk enrollment was in plans that had had Medicare risk contracts for 3 years or less, with 14% of enrollment in plans that were 2 years old or less. Almost 40% of Medicare risk enrollment was in plans that had Medicare risk contracts for 10 or more years.

TABLE 4.13.
Enrollment Distribution by Duration of Medicare Risk HMO Contract, as of December 1995

Duration of Contract	Percent of Total Enrollment
2 years or less	14
3 years or less	26
4 years or less	33
10 years or more	38

NOTE: Table prepared by CRS.

Figure 4.13. Enrollment Distribution by Duration of Medicare Risk HMO Contract, as of December 1995



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare,* Chart MC-18, p. 114.

Figure 4.14.
Medicare Risk HMO Contracts by Plan Model, January 1997

The vast majority of Medicare risk HMOs are independent practice associations (IPAs), totaling 62% of all Medicare enrollees. An IPA is an HMO that contracts with physicians in solo practice, or with associations of physicians which in turn contract with their member physicians, to provide health care services to enrollees. Many physicians in IPA HMOs have a significant number of patients who are not IPA enrollees. Group model HMOs contract with one or more group practices of physicians to provide health care services, and each group primarily treats the HMO's members. Staff model HMOs employ health providers, such as physicians and nurses, directly. The providers are employees of the HMO, and deal exclusively with HMO enrollees.

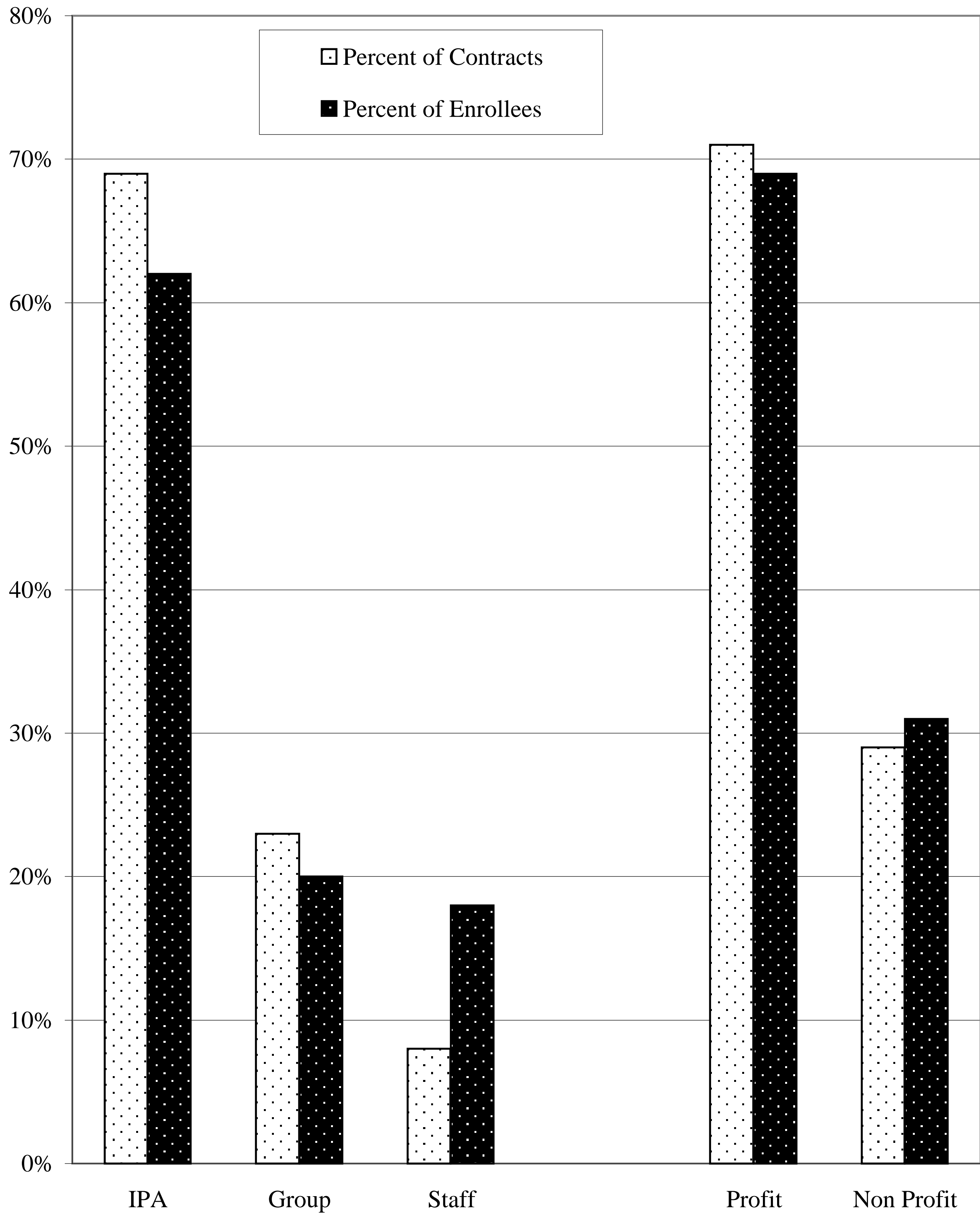
Most risk contract plans (71%) are owned by for-profit managed care organizations. These plans have 69% of Medicare risk plan enrollees.

TABLE 4.14.
Medicare Risk HMO Contracts by Plan Model, January 1997

		Number of Contracts	Percent of Contracts	Number of Enrollees	Percent of Enrollees
Model					
	IPA	172	69	2,628,481	62
	Group	56	23	843,198	20
	Staff	20	8	758,434	18
Ownership					
	Profit	175	71	2,919,981	69
	Non Profit	73	29	1,310,132	31

NOTE: Table prepared by CRS.

Figure 4.14. Medicare Risk HMO Contracts by Plan Model, January 1997



Source: Figure prepared by HCFA, *Medicare Managed Care Contract Report,* Jan. 1997.

Figure 4.15.
Spread of County Adjusted Average Per Capita Costs (AAPCCs) by Location, 1996

For each Medicare beneficiary enrolled in a Medicare risk HMO, Medicare pays the HMO 95% of the amount that it would have paid if the beneficiary had remained in Medicare fee for-service. This payment is known as the adjusted average per capita cost (AAPCC).

There is a range of adjusted average per capita costs (AAPCCs) that Medicare pays for enrollees in different counties across the United States. Nationally, this range is $552 per member per month. On average, AAPCCs are higher in urban areas than in rural areas. However, there is also a wide range of variation for AAPCCs even within urban and rural areas. For example, the lowest AAPCC per month for 1996 in "other rural" areas was $207, whereas the highest for such an area was $605, or almost three times as much.

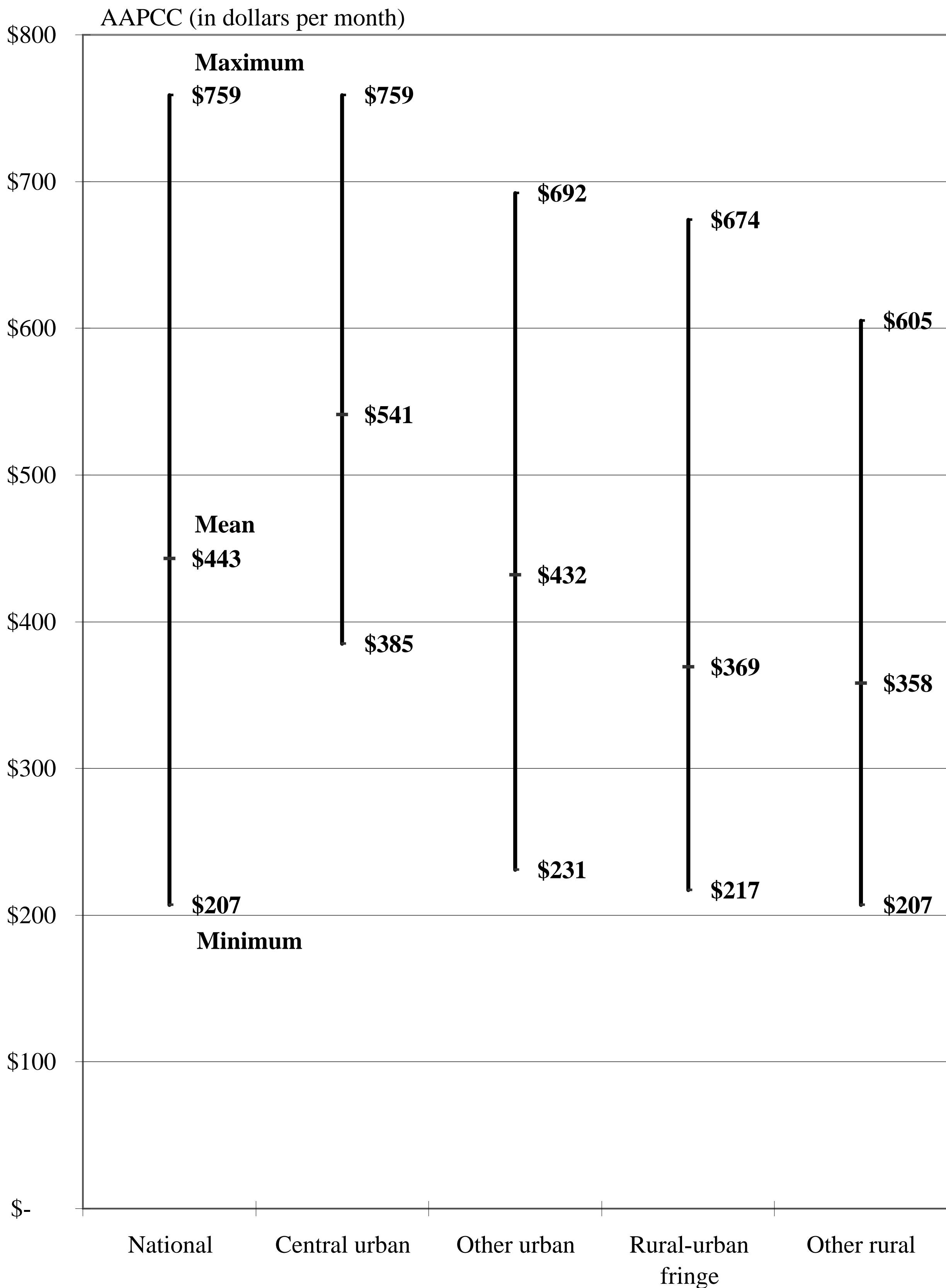
The AAPCCs reported here are the actual amounts received by the HMO for the average Medicare enrollee, which are 95% of the estimated fee-for-service expenditure for that enrollee in the area.

TABLE 4.15.
Spread of County AAPCCs by Location, 1996

	Minimum	Mean	Maximum
National	$207	$443	$759
Central urban	385	541	759
Other urban	231	432	692
Rural-urban fringe	217	369	674
Other rural	207	358	605

NOTE: Table prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.15. Spread of County AAPCCs by Location, 1996



Source: Figure prepared by CRS based on PPRC, *Medicare Risk Plan Participation and Enrollment: A Chart Book*, Chart 18, December 1996.

Figure 4.16.
Spread of County Adjusted Average Per Capita Costs (AAPCCs) Within Selected Primary Metropolitan Statistical Areas (PMSAs), 1996

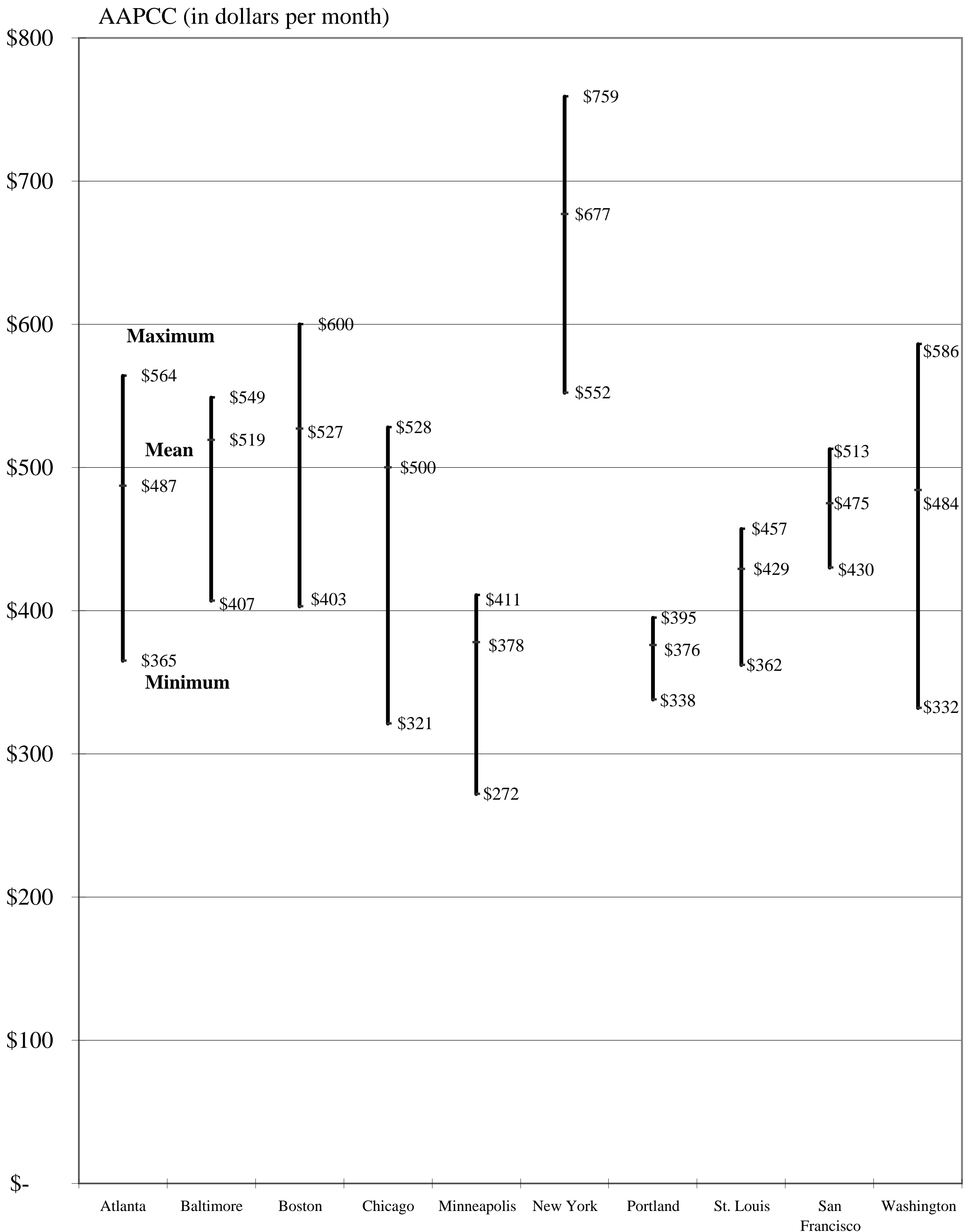
Within primary metropolitan statistical areas (PMSAs) that consist of more than a single county, there is a range of AAPCCs that Medicare pays for enrollees in those counties. In many PMSAs, the range of AAPCCs is $100 or greater per month. (The means shown in the figure are weighted by beneficiaries as opposed to enrollees.) In most PMSAs, enrollment in risk HMOs is disproportionately higher in counties where the AAPCC is higher.

TABLE 4.16.
Spread of County AAPCCs Within Selected PMSAs, 1996

	Minimum	Mean	Maximum
Atlanta	$365	$487	$564
Baltimore	407	519	549
Boston	403	527	600
Chicago	321	500	528
Minneapolis	272	378	411
New York	552	677	759
Portland	338	376	395
St. Louis	362	429	457
San Francisco	430	475	513
Washington	332	484	586

NOTE: Table prepared by CRS based on PPRC analysis of HCFA data.

Figure 4.16. Spread of County AAPCCs Within Selected PMSAs, 1996



Source: Figure prepared by CRS based on PPRC, *Medicare Risk Plan Participation and Enrollment: A Chart Book,* Chart 19, 1996.

Figure 4.17.
Medicare Risk HMOs Offering Additional Benefits in Their Basic Option Package, January 1997

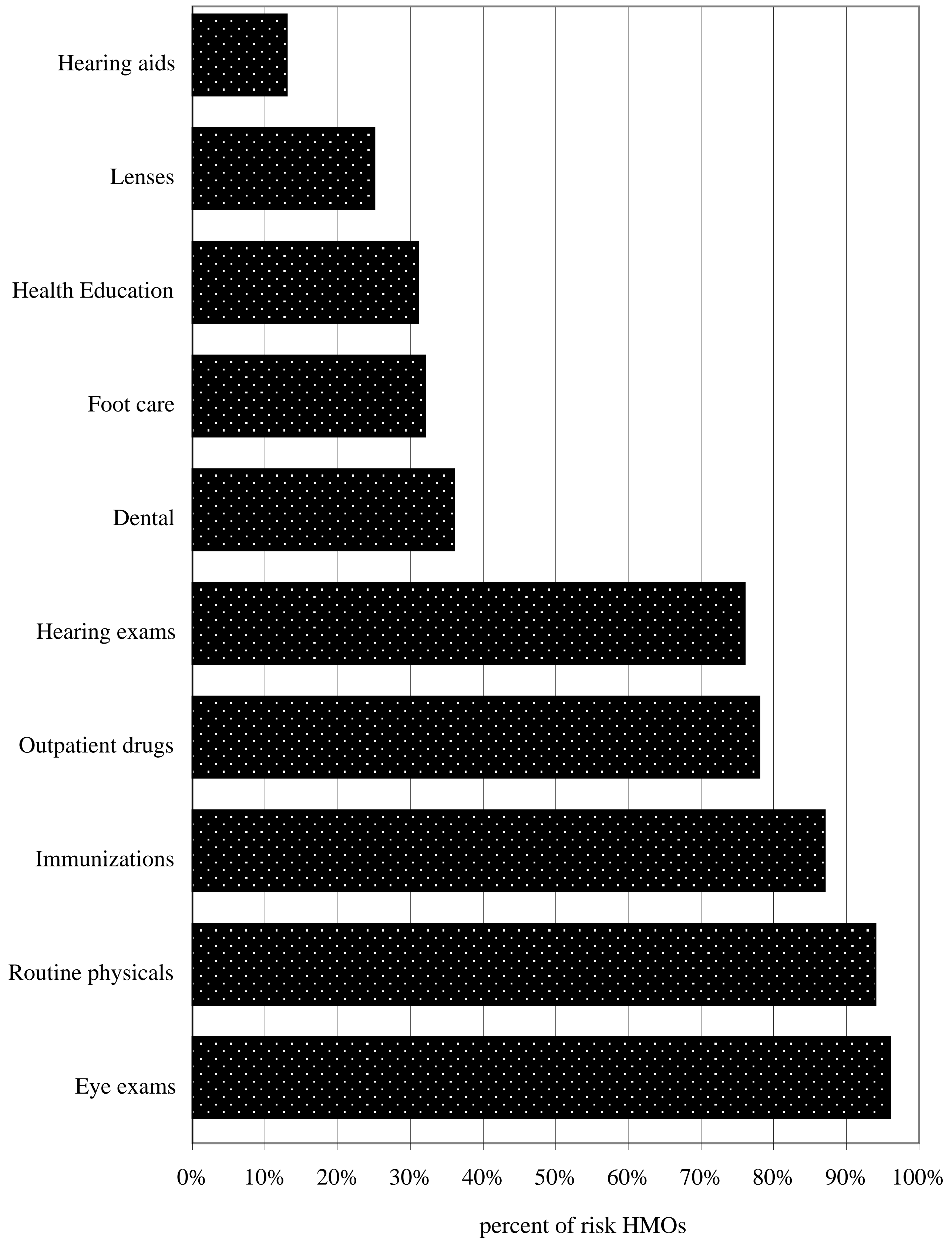
Most Medicare enrollees in risk HMOs are provided with a substantial level of additional services not covered by Medicare. For example, in 1997, 96% of Medicare risk plans offered eye exams as part of their basic benefit package; 94% offered routine physicals; and 78% offered some coverage of prescription (outpatient) drugs. The percentage of plans covering prescription drugs has been rising. In December 1995, only 50% of risk plans offered such coverage.

TABLE 4.17.
Medicare Risk HMOs Offering Additional Benefits in Their Basic Option Package
January 1997

Benefit	Percent
Eye exams	96
Routine physicals	94
Immunizations	87
Outpatient drugs	78
Hearing exams	76
Dental	36
Foot care	32
Health education	31
Lenses	25
Hearing aids	13

NOTE: Table prepared by CRS.

Figure 4.17. Medicare Risk HMOs Offering Additional Benefits in Their Basic Option Package, January 1997



Source: Figure prepared by CRS based on CRS analyses of HCFA data from *Medicare Managed Care Report* , Jan. 1997; Dec. 1995.

Figure 4.18.
Distribution of Medicare Risk HMOs by Premiums Charged 1995-1996

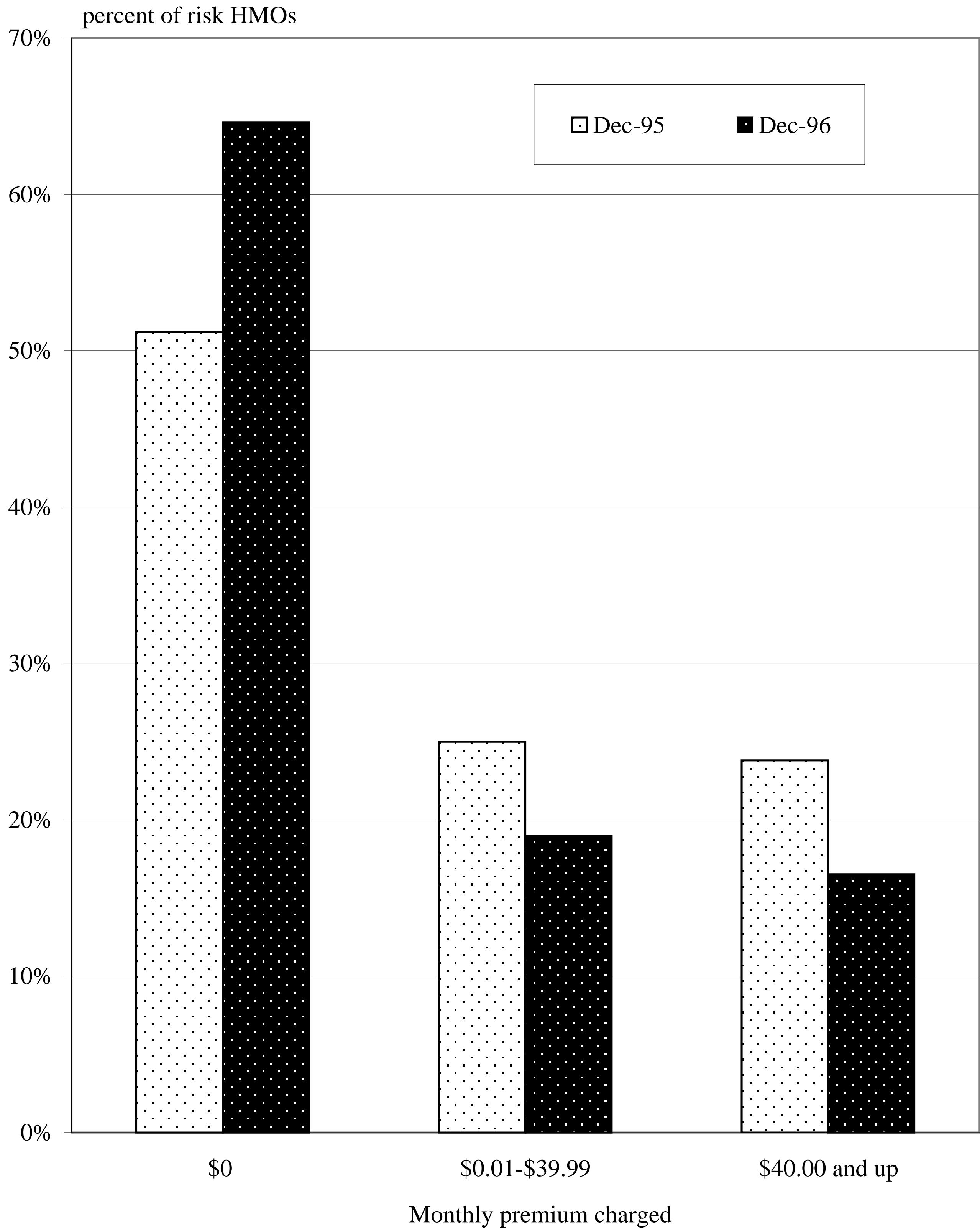
Medicare risk HMOs charge different premiums to enrollees. The majority of risk HMOs offer zero-premium plans for their basic package. This means that enrollees pay no premium above and beyond the Medicare Part B premium ($42.50 in 1996; $43.80 in 1997). In 1996, one in six plans charged a monthly premium of over $40 for their basic package. The proportion of zero-premium plans increased by over 25% from December 1995 to December 1996.

TABLE 4.18.
Distribution of Medicare Risk HMOs by Premiums Charged
1995-1996
(in percent)

In Addition to Medicare Monthly Premium	December 1995	December 1996
$0	51.2	64.6
$0.01-$39.99	25.0	19.0
$40.00 and up	23.8	16.5

NOTE: Table prepared by CRS.

Figure 4.18. Distribution of Medicare Risk HMOs by Premium Charged, 1995-1996



Source: Figure prepared by CRS based on CRS analysis of HCFA data from *Medicare Managed Care Contract Report*, Dec. 1995 and Dec. 1996.

Figure 4.19.
Age Distribution of Medicare HMO and Fee-for-Service Enrollees, 1995

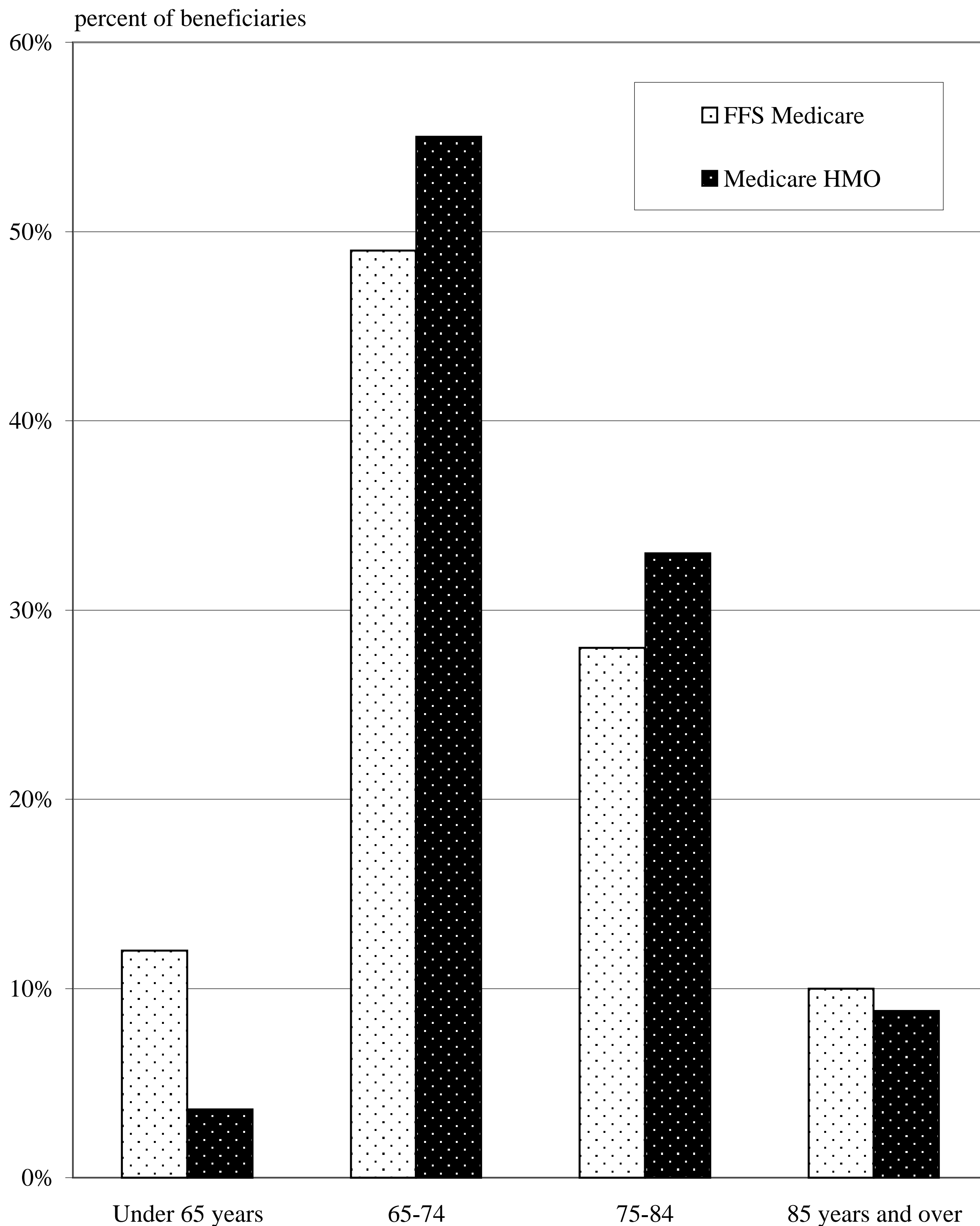
The very old (beneficiaries 85 and older) and individuals entitled to Medicare on the basis of disability (those under 65 years old) are less likely to be enrolled in Medicare in risk HMOs than in fee-for-service (FFS). The likelihood of being enrolled in a risk HMO is highest for beneficiaries ages 65 to 74. Payments to risk HMOs (the AAPCCs) are adjusted for such demographic factors as age and whether or not a plan's enrollee is disabled. For example, if the HMO has a smaller share of older enrollees as compared to the local Medicare population, the HMO's overall payment will be less than if the HMO's share of older enrollees was greater than the community's share of older enrollees.

TABLE 4.19.
Age Distribution of Medicare HMO and FFS Enrollees, 1995
(in percent)

Age	FFS Medicare	Medicare HMO
Under 65 years	12.0	3.6
65-74	49.0	55.0
75-84	28.0	33.0
85 years and over	10.0	8.8

NOTE: Table prepared by CRS.

Figure 4.19. Age Distribution of Medicare HMO and Fee-for-Service Enrollees, 1995



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , Chart MC-12, p. 108.

Figure 4.20.
Distribution of Medicare HMO Enrollees versus Medicare Fee-for-Service Enrollees, by Income, 1993

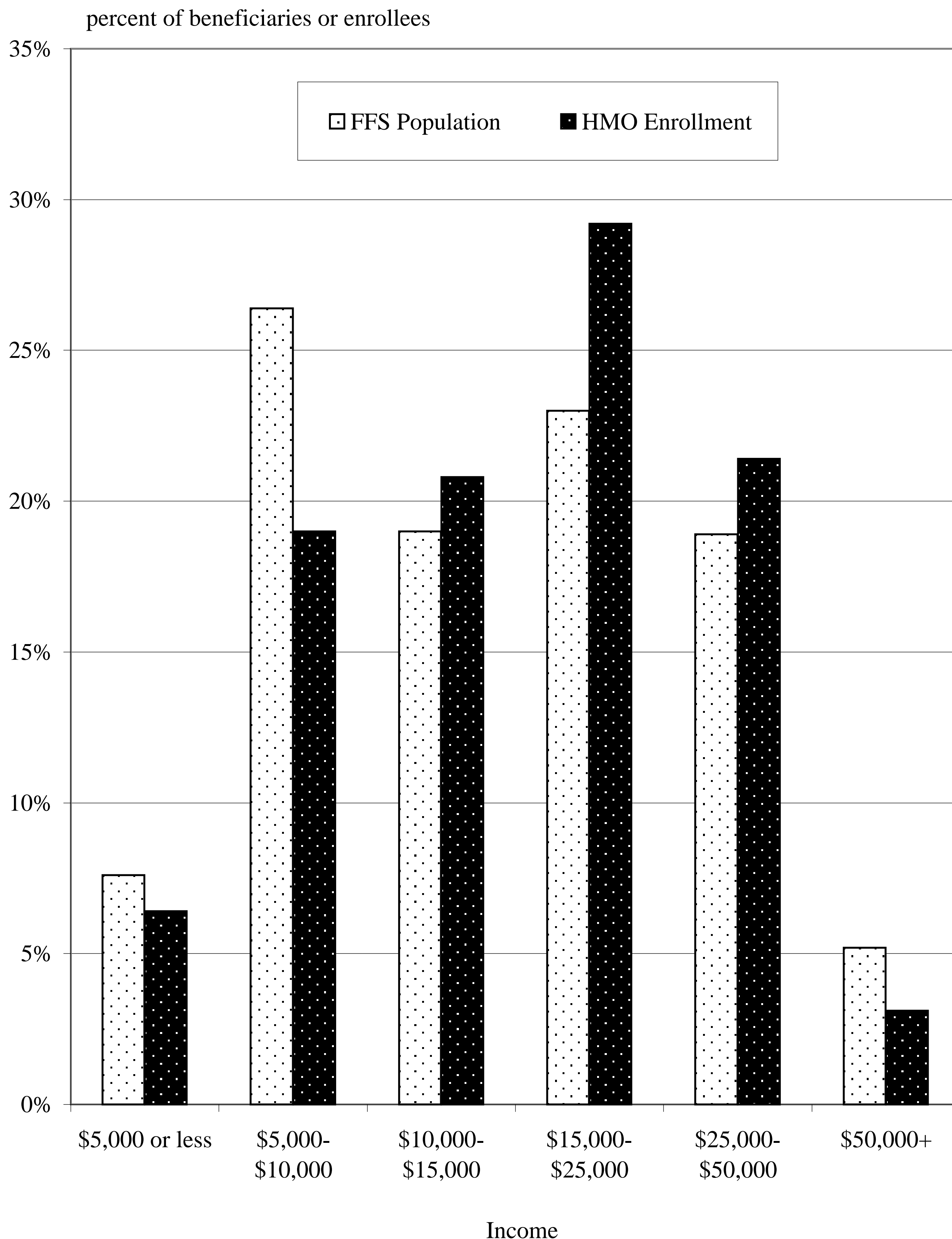
Within income groups, the least wealthy Medicare beneficiaries and most wealthy beneficiaries are least likely to be enrolled in a Medicare HMO. The most likely income group of beneficiaries to be in a Medicare HMO reports income of $15,000 to $25,000.

TABLE 4.20.
Distribution of Medicare HMO Enrollees versus Medicare FFS Enrollees, by Income, 1993

Income	Percent of FFS Population	Percent of HMO Enrollment
$5,000 or less	7.6	6.4
$5,000-$10,000	26.4	19.0
$10,000-$15,000	19.0	20.8
$15,000-$25,000	23.0	29.2
$25,000-$50,000	18.9	21.4
50,000+	5.2	3.1

NOTE: Table prepared by CRS.

Figure 4.20. Distribution of Medicare HMO Enrollees versus Medicare Fee-for-Service Enrollees, by Income, 1993

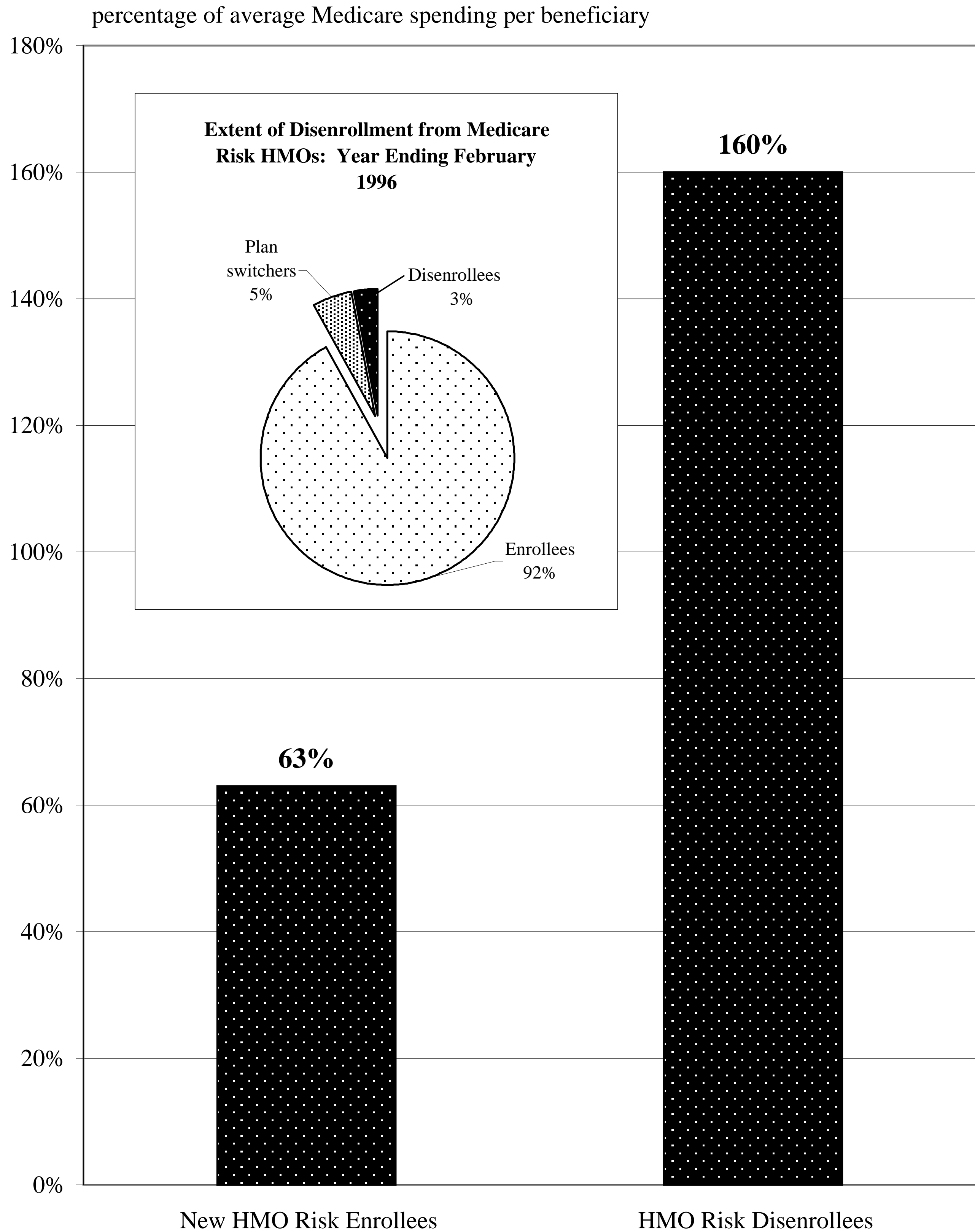


Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , Chart MC-14, p. 110.

Figure 4.21.
Medicare HMOs: Costs as a Percentage of Average Medicare Spending Per Beneficiary

Several studies have found that Medicare beneficiaries who enroll in HMOs use fewer Medicare-covered services than those who are in the fee-for-service program. Such differences are also reflected in studies that show that Medicare beneficiaries who enroll in HMOs have relatively low costs prior to enrollment. Using data through mid-1994, the Physician Payment Review Commission (PPRC) found that new HMO enrollees' costs were 37% below average Medicare spending per beneficiary during the 6 months prior to HMO enrollment. Moreover, as shown in the figure, beneficiaries who enrolled and then disenrolled from an HMO (and returned to fee-for-service) had costs that were 60% above the average expenditure for fee-for-service individuals. However, it should be noted that within the 1 year period ending February 1996, the vast majority (97%) of HMO enrollees did not disenroll. (As shown in the inset, 3% of beneficiaries disenrolled and 5% switched from one HMO to another.)

Figure 4.21. Medicare Risk HMOs: Costs as a Percentage of Average Medicare Spending Per Beneficiary



Source: Figure prepared by CRS based on PPRC, *Evidence of Risk Selection in Medicare HMOs* , No. 1, October 1996, Figure 1, p. 1; and Update No. 4, 1996.

Figure 4.22.
Relative Health Status of Medicare HMO Enrollees, 1993

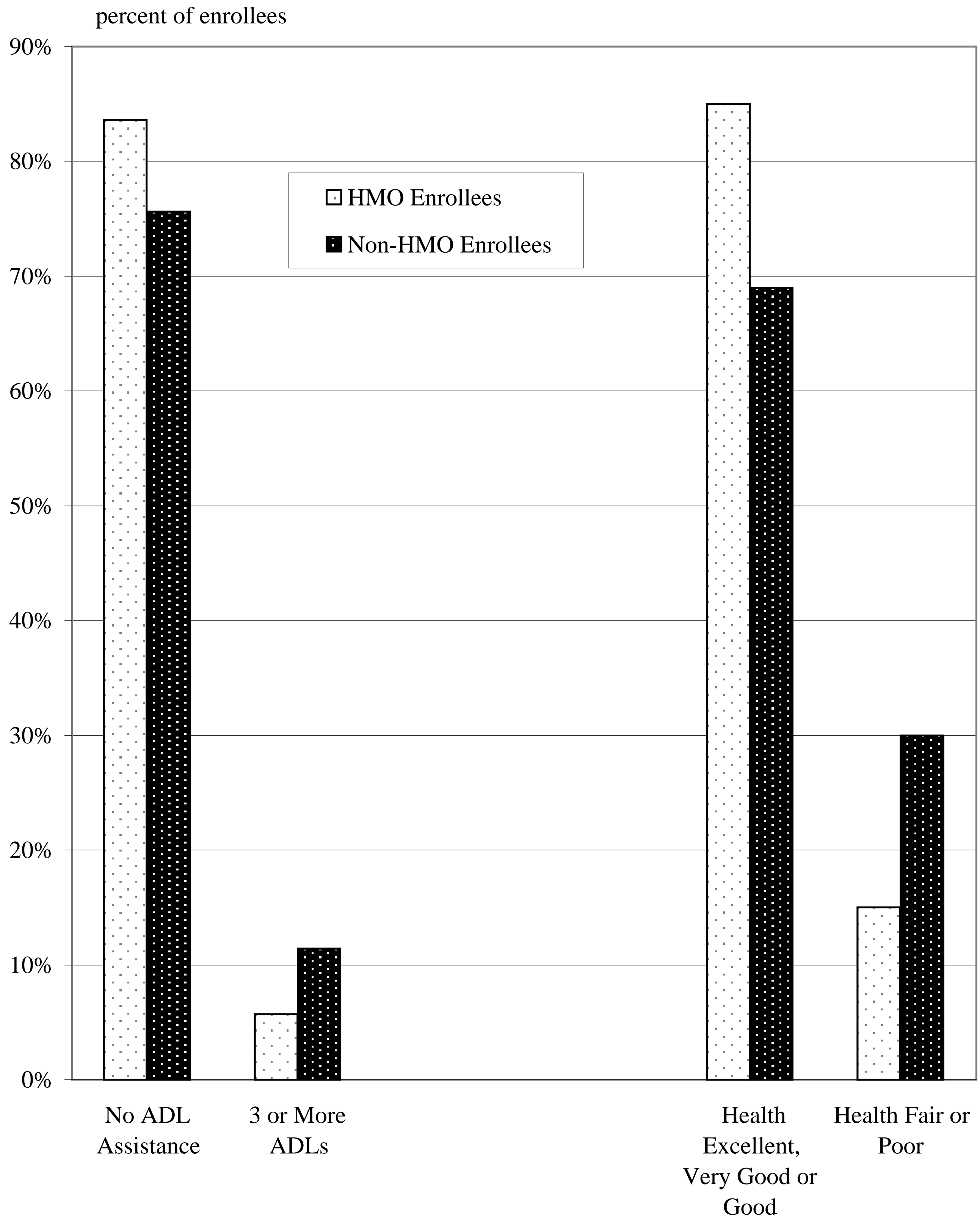
According to HCFA's analysis of the 1993 Medicare Current Beneficiary Survey, Medicare beneficiaries enrolled in risk HMOs were healthier than those in the fee-for-service program. For example, almost 84% of risk HMO enrollees needed no assistance with activities of daily living (ADLs) compared with about 76% of beneficiaries in Medicare fee-for-service. Twice as many fee-for-service beneficiaries reported that their health was fair or poor than risk HMO enrollees. This may reflect a variety of factors. Healthier beneficiaries may be more likely to enroll in risk HMOs. It is also possible that enrollees in risk HMOs might have relatively better access to care.

TABLE 4.22.
Relative Health Status of Medicare HMO Enrollees, 1993

	Non-HMO Enrollees	HMO Enrollees
No ADL assistance	75.6	83.6
Three or more ADLs	11.4	5.7
Health: excellent, very good or good	69.0	85.0
Health: fair or poor	30.0	15.0

NOTE: Table prepared by CRS.

Figure 4.22. Relative Health Status of Medicare HMO Enrollees, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles in Medicare* , Chart MC-15, p. 111.

Figure 4.23.
Beneficiary Satisfaction with Medicare HMOs and Fee-for-Service, 1993

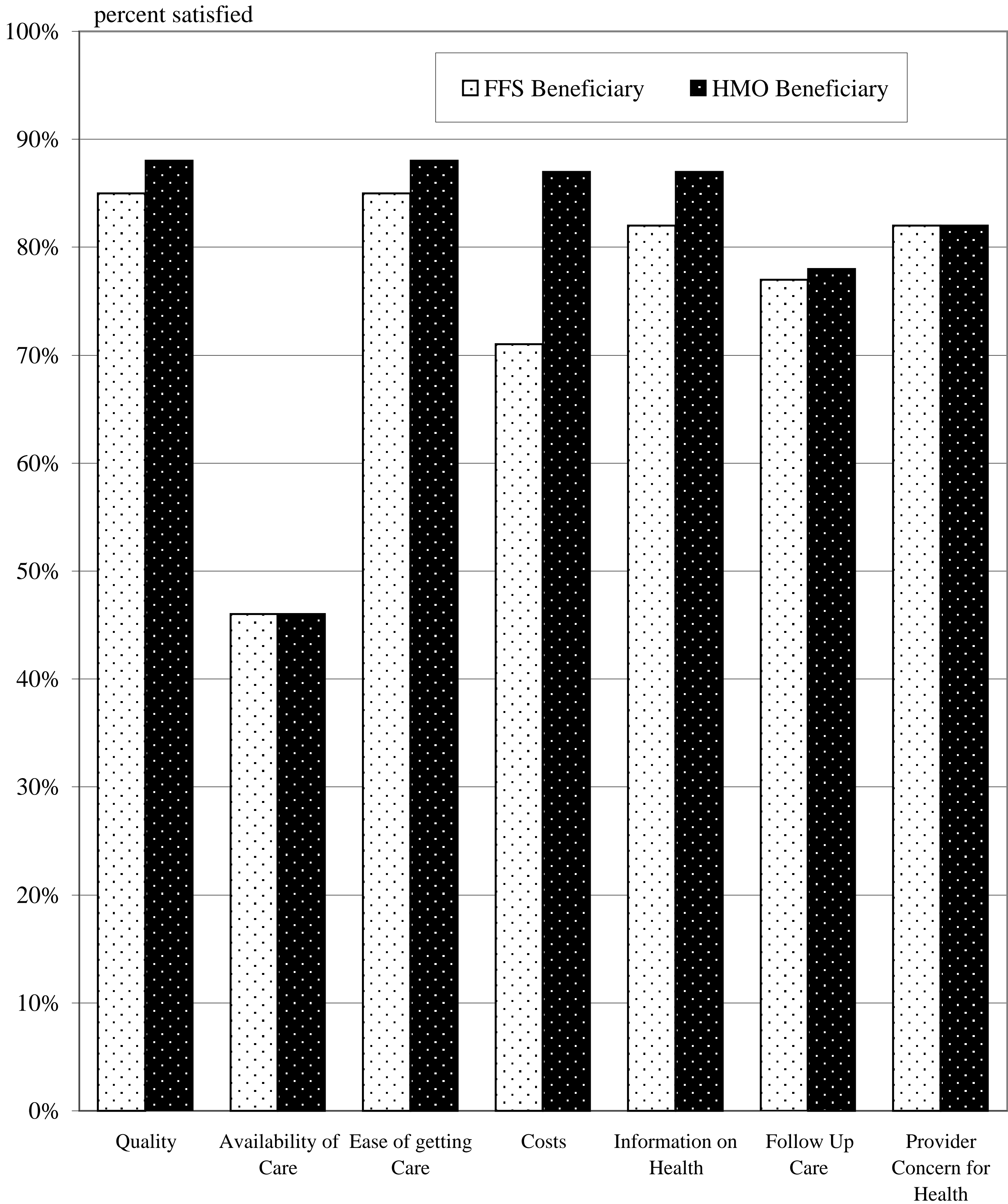
In 1993, Medicare beneficiaries enrolled in risk HMOs were more satisfied or very satisfied with the quality of and access to their care than those in Medicare FFS. While the differences in satisfaction rates are generally small, they are notable with respect to the issue of costs. Whereas 87% of risk HMO enrollees reported that they were satisfied with the costs of their care, only 71% of beneficiaries in FFS were satisfied.

TABLE 4.23.
Beneficiary Satisfaction with Medicare HMOs and FFS, 1993

Type of Service	Percent Satisfied FFS	Percent Satisfied HMO
Quality	85	88
Availability of care	46	46
Ease of getting care	85	88
Costs	71	87
Information on health	82	87
Follow-up care	77	78
Provider concern for health	82	82

NOTE: Table prepared by CRS.

Figure 4.23. Beneficiary Satisfaction with Medicare HMOs and Fee-for-Service, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , Chart MC-16, p. 112.

Figure 4.24.
Beneficiary Dissatisfaction with Medicare HMOs and Fee-for-Service, 1993

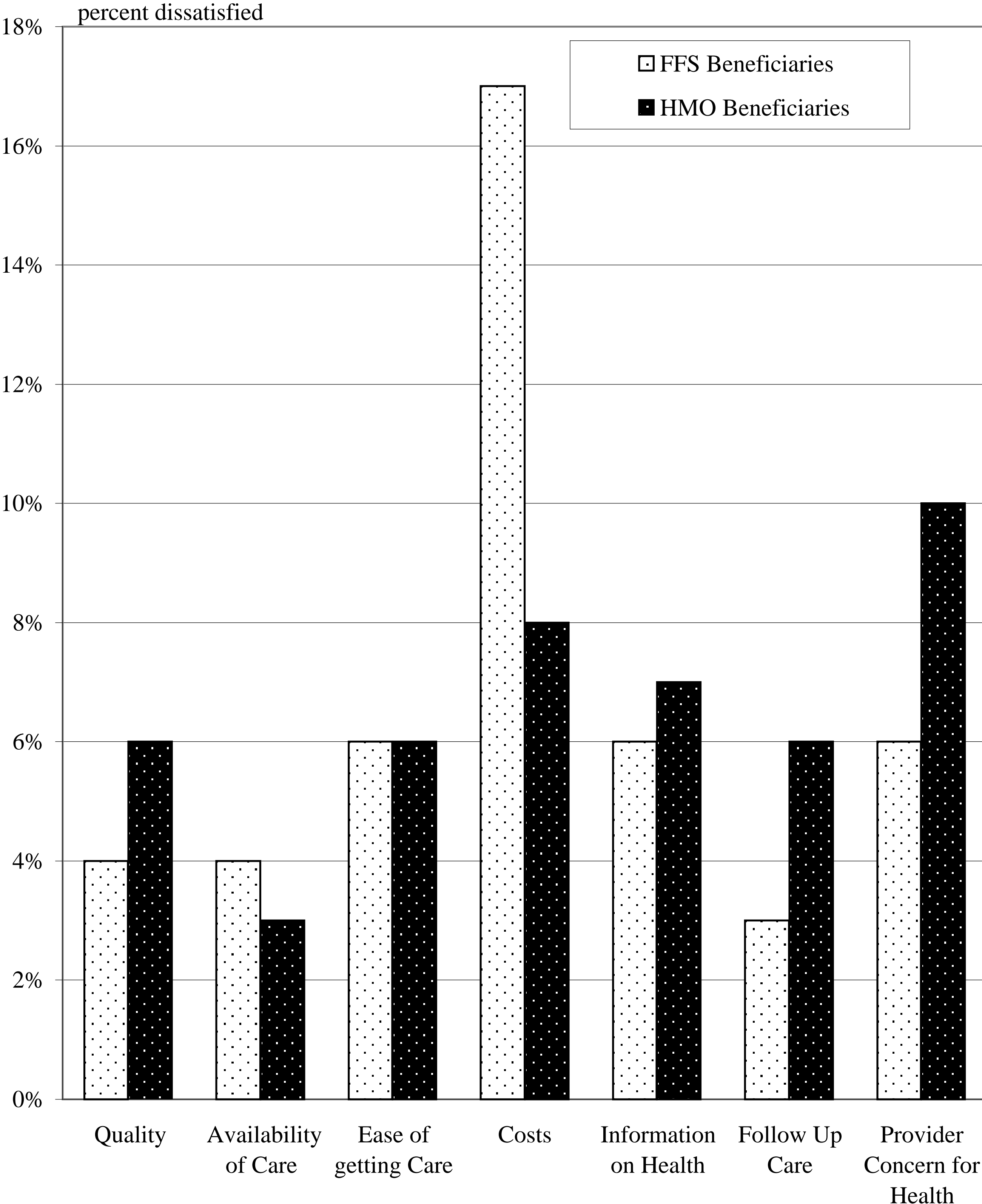
Only a small percentage of Medicare beneficiaries reported being dissatisfied or very dissatisfied with their Medicare coverage in 1993. However, risk contract enrollees were somewhat more likely to report being dissatisfied about quality, quality follow-up care, and their providers' concern for their health than beneficiaries with Medicare fee-for-service (FFS) coverage. The dissatisfaction rates are again notable for the differences on the issue of costs. More than twice as many fee-for-service enrollees were dissatisfied or very dissatisfied with the costs of their care than enrollees in risk HMOs.

TABLE 4.24.
Beneficiary Dissatisfaction with Medicare HMOs and FFS, 1993

Type of Service	Percent Dissatisfied FFS	Percent Dissatisfied HMO
Quality	4	6
Availability of care	4	3
Ease of getting care	6	6
Costs	17	8
Information on health	6	7
Follow-up care	3	6
Provider concern for health	6	10

NOTE: Table prepared by CRS.

Figure 4.24. Beneficiary Dissatisfaction with Medicare HMOs and Fee-for-Service, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , Chart MC-16, p. 112.

Figure 4.25.
Reasons for Disenrolling from Medicare Risk HMOs and Switching to Medicare Fee-for-Service, 1996

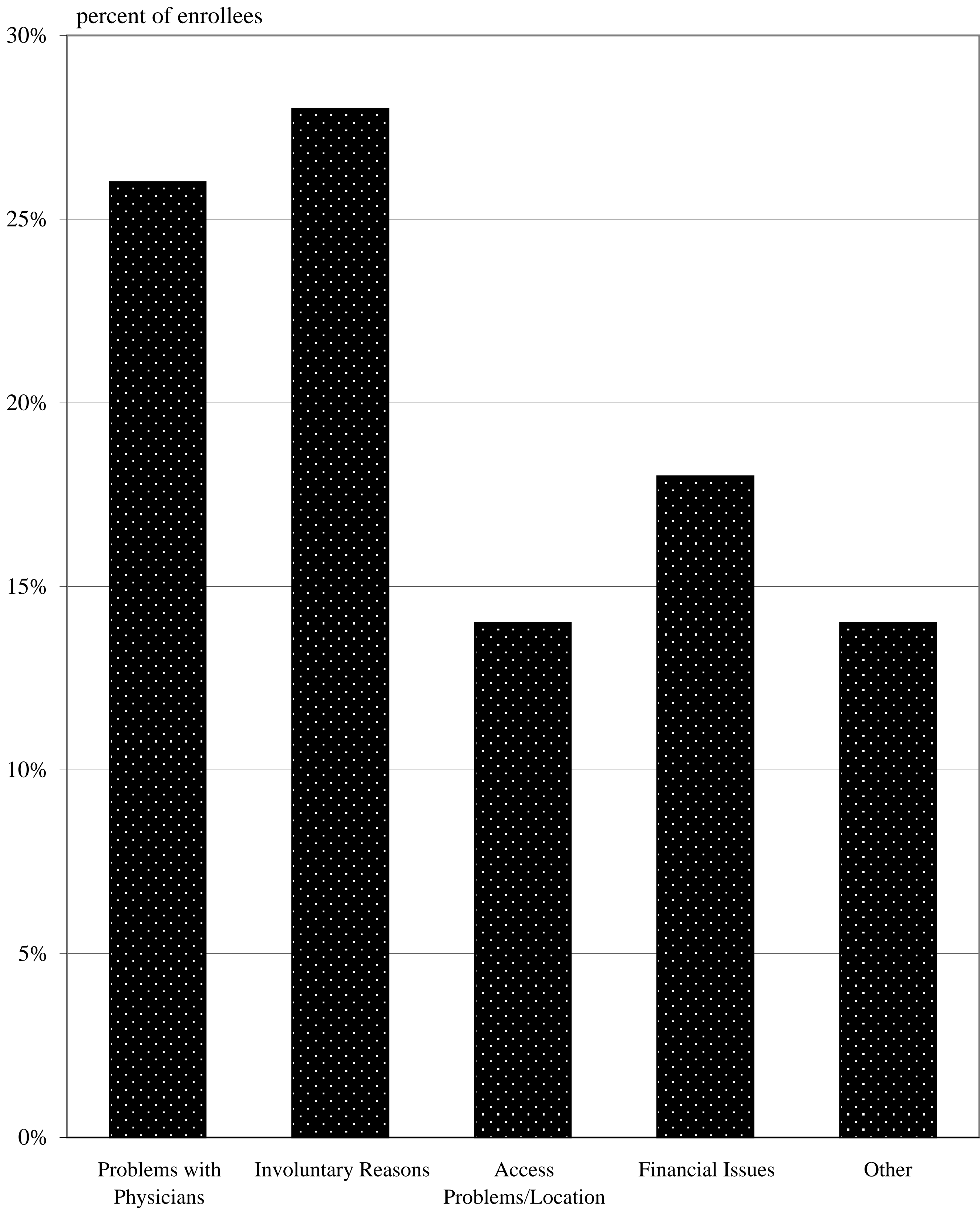
A telephone survey of Medicare beneficiaries enrolled in a risk HMO for at least 1 year during the year ending February 1996 revealed that those Medicare beneficiaries who disenrolled in favor of Medicare fee-for-service did so for a variety of reasons. Problems with physicians and access concerns motivated 40% of disenrollments to fee-for-service. More than 25% disenrolled because they moved or for other, involuntary reasons. Not shown in figure 4.25 is that beneficiaries who disenrolled from one risk HMO and enrolled in another risk HMO were more likely than those who switched back to fee-for-service to have left because their doctor left, died, or retired, and were less likely to have left because of access problems.

TABLE 4.25.
Reasons for Disenrolling from Medicare Risk HMOs and Switching to Medicare FFS
1996

	Percent of Enrollees
Problems with physicians	26
Involuntary reasons	28
Access problems/location	14
Financial issues	18
Other	14

NOTE: Table prepared by CRS based on PPRC survey. See source under figure 4.25.

Figure 4.25. Reasons for Disenrolling from Medicare Risk HMOs and Switching to Medicare Fee-for-Service, 1996



Source: PPRC: *How Do Medicare Beneficiaries Fare in HMOs? Preliminary Results from PPRC Access Survey*, Update No. 4, Oct. 1996.

Figure 4.26.
Trends in Relative Growth in HMO Enrollment: Medicare versus Non-Medicare Markets 1988-1994

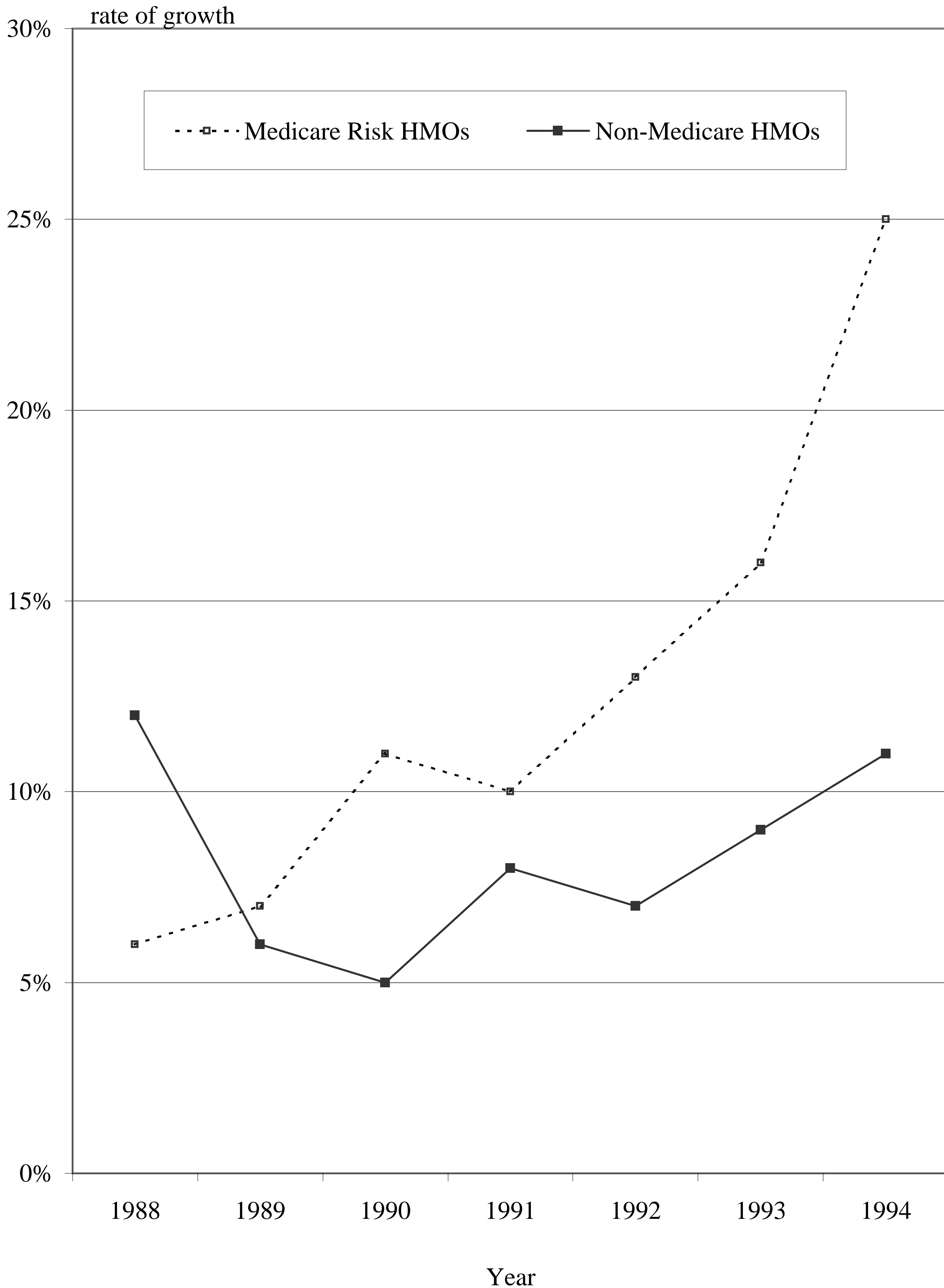
The rate of increased enrollment in Medicare risk HMOs has surpassed that for non-Medicare HMOs every year since 1990. In recent years, enrollment in Medicare risk HMOs has increased at an accelerated rate, reaching a 25% increase between 1993 and 1994, compared with 11% for non-Medicare HMOs.

TABLE 4.26.
Trends in Relative Growth in HMO Enrollment:
Medicare versus Non-Medicare Markets
1988-1994
(in percent)

Year	Medicare Risk HMOs	Non-Medicare HMOs
1988	6	12
1989	7	6
1990	11	5
1991	10	8
1992	13	7
1993	16	9
1994	25	11

NOTE: Table prepared by CRS. Other forms of managed care delivery stems, such as preferred provider organizations are not included in the *non-Medicare HMO* totals.

Figure 4.26. Trends in Relative Growth in HMO Enrollment: Medicare Versus Non-Medicare Markets, 1988-1994



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , Chart MC-2, p. 96.

Figure 4.27.
Non-Medicare and Medicare HMO Penetration in Selected States

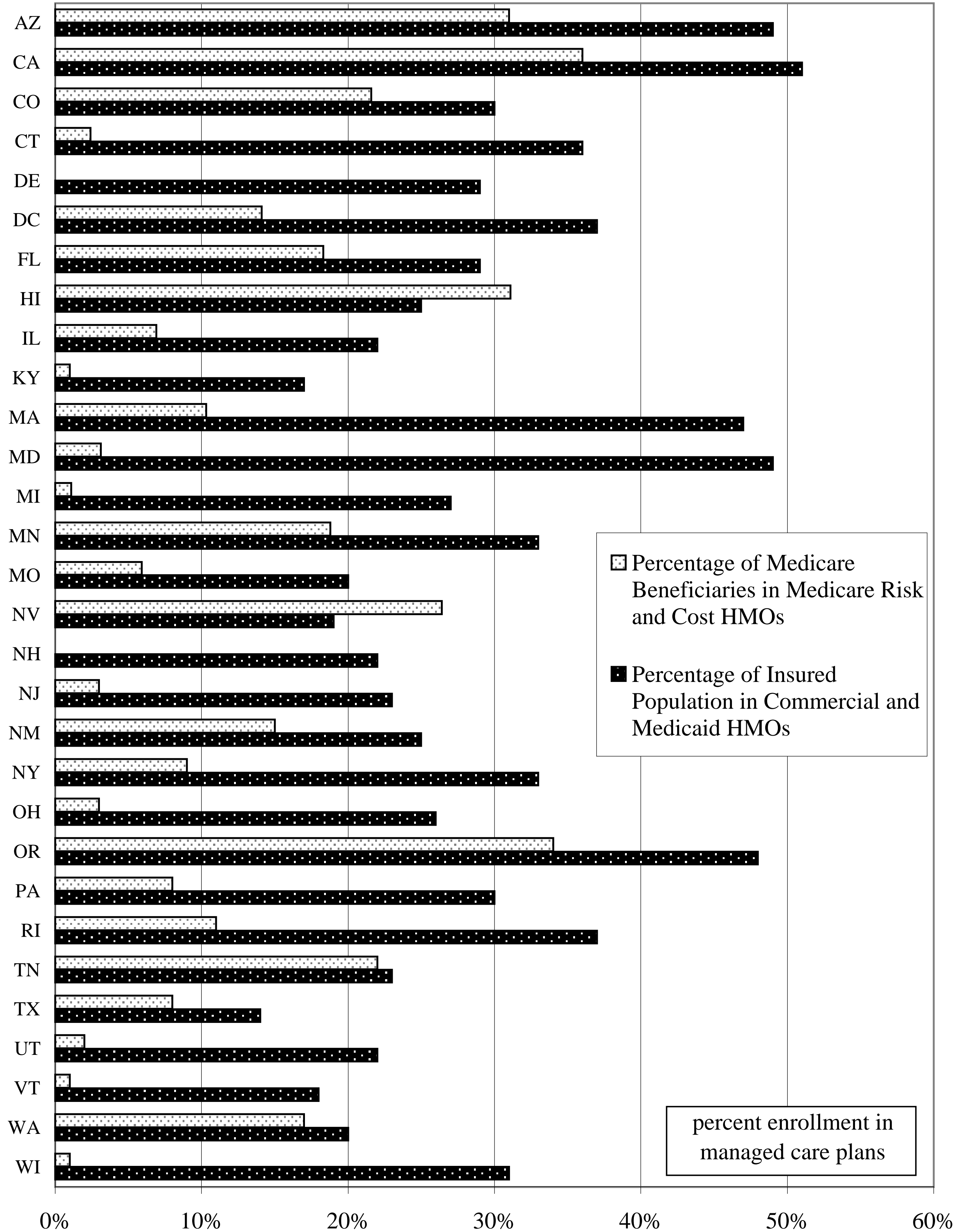
HMO penetration (the extent to which individuals enroll in managed care plans) varies across states, for both Medicare and non-Medicare enrollment. In many areas, managed care companies have only recently begun to market to Medicare beneficiaries.

TABLE 4.27.
Non-Medicare and Medicare HMO Penetration in Selected States
(in percent)

State	Insured Population in Commercial and Medicaid HMOs (1993-1994)	Medicare Beneficiaries in Medicare Risk and Cost HMOs (December 1995)
Arizona	49	31
California	51	36
Colorado	30	22
Connecticut	36	2
Delaware	29	0
District of Columbia	37	14
Florida	29	18
Hawaii	25	31
Illinois	22	7
Kentucky	17	1
Maryland	49	3
Maine	47	10
Michigan	27	1
Minnesota	33	19
Missouri	20	6
Nevada	19	26
New Hampshire	22	0
New Jersey	23	3
New Mexico	25	15
New York	33	9
Ohio	26	3
Oregon	48	34
Pennsylvania	30	8
Rhode Island	37	11
Tennessee	23	22
Texas	14	8
Utah	22	2
Vermont	18	1
Washington	20	17
Wisconsin	31	1

NOTE: Table prepared by CRS.

Figure 4.27. Non-Medicare and Medicare HMO Penetration in Selected States, 1993-1995



Source: Figure prepared by CRS based on HCFA, *Profiles in Medicare* , Chart MC-6a-b, pp.100-101.

Figure 4.28.
Estimated Medical Education and Disproportionate Share Payments as Components of Medicare Risk HMO Payment Rates, by Urban and Rural Location, 1995

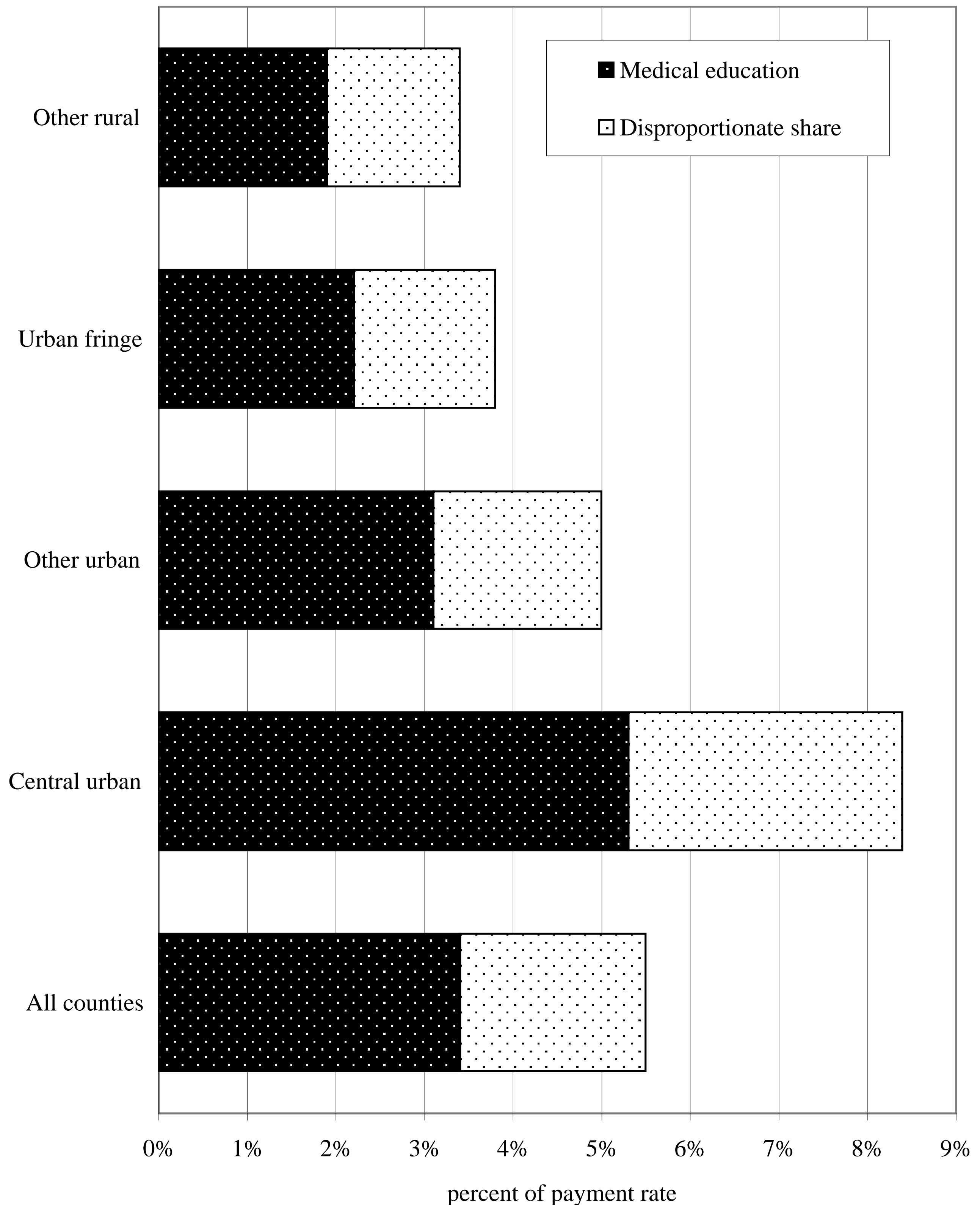
Medicare fee-for-service payments for inpatient hospital stays include payments for indirect and direct medical education costs incurred by teaching hospitals and extra payments to hospitals that serve a disproportionate share of low-income beneficiaries (or DSH payments). These payments are retained in the expenditures used to calculate the adjusted average per capita costs (AAPCCs) paid to risk HMOs. As a result, the AAPCC reflects a county's average monthly per capita cost for fee-for-service medical education and DSH. These amounts may not correspond with actual risk HMO costs, however, because not all such HMOs have medical education programs or use teaching or disproportionate share hospitals. In 1995, medical education and DSH payments were an estimated 5.5% of the AAPCC rates overall, but their share of total payment rates varies across the country, as shown in figure 4.28.

TABLE 4.28.
Estimated Medical Education and Disproportionate Share Payments as Components of Medicare Risk HMO Payment Rates, by Urban and Rural Location, 1995
(percent of payment rates)

	Medical Education	Disproportionate Share	Total Percentage
All counties	3.4	2.1	5.5
Urban counties	3.8	2.3	6.1
Central urban	5.3	3.1	8.4
Other urban	3.1	1.9	5.0
Rural counties	2.1	1.5	3.6
Urban fringe	2.2	1.6	3.8
Other rural	1.9	1.5	3.4

NOTE: Table prepared by CRS.

Figure 4.28. Estimated Medical Education and Disproportionate Share Payments as Components of Medicare Risk HMO Payment Rates, by Urban and Rural Location, 1995



Source: Figure prepared by CRS based on *House Ways and Means*, Green Book, p. 209.