

Medicare risk contracting: Determinants of market entry

by Frank W. Porell and Stanley S. Wallack

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 made it more attractive for health maintenance organizations (HMOs) and other competitive medical plans to enter into risk contracts with Medicare. Since the start of the TEFRA program in April 1983, more than 160 HMOs have had risk contracts with Medicare under

the program. An investigation of factors associated with TEFRA risk-market entry at the end of 1986 revealed that high adjusted average per capita cost payment levels, prior Medicare cost-contract experience, and prior Federal qualification were the most important factors distinguishing market entrants from nonentrants.

Introduction

Given the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, risk contracts with health maintenance organizations (HMOs) have been viewed as a promising approach for the efficient delivery of high-quality care to the Medicare population through competitive market forces. The future success of Medicare risk contracting will depend greatly on the eagerness of HMOs to enter into and maintain their risk contracts with Medicare. Whereas Medicare's significant buying power in hospital markets virtually ensures widespread hospital participation in the prospective payment system (PPS), Medicare does not possess the same market power in the HMO marketplace. The rapid expansion of the HMO industry over the past decade has occurred without significant Medicare risk enrollment. Significant expansion of Medicare HMO capitation will occur only if HMOs find it in their best interest to participate in the TEFRA program and to enroll large numbers of Medicare beneficiaries.

As of June 1, 1988, 138 plans had signed TEFRA risk contracts with the Health Care Financing Administration (HCFA) as federally qualified HMOs or competitive medical plans (CMPs). Forty-eight other plans also had pending TEFRA risk applications as of that date. Enrollment in Medicare at-risk HMOs has grown substantially since the inception of the program in April 1983. More than 1 million Medicare beneficiaries were enrolled in TEFRA risk plans in June 1988. Although this growth has been encouraging, the future of Medicare HMO capitation is uncertain. More than three-quarters of all HMOs currently do not serve the Medicare population under TEFRA risk contracts, and 68 TEFRA risk contractor HMOs have chosen not to renew their risk contracts with HCFA within the last 3 calendar years.

A significant fraction of the Medicare population will never be enrolled in Medicare HMOs unless large numbers of HMOs enter into Medicare risk contracts. Understanding what factors are associated with Medicare HMO market entry can help to shape policy that could potentially encourage broader HMO participation in the

TEFRA program. The study of market entry should also help in assessing the need for and/or the likely supply response to potential changes in capitation payment formulas in the future.

Previous research

Most of the earliest research on HMO growth was focused on identifying the impacts of market and regulatory conditions on the formation and growth of HMOs. Based on surveys of HMO administrators (McNeil and Schenkler, 1975) and econometric analyses (Goldberg and Greenberg, 1981; Morrissey and Ashby, 1982), it is suggested that HMO development was most prevalent in areas where high fee-for-service (FFS) utilization or expenditures reflect opportunity for competitive pricing by HMOs. Differential HMO market share was found to be more strongly associated with demand characteristics of the population, such as age composition and income levels.

The later work of Welch (1984) was also focused on factors affecting the establishment of HMOs and their subsequent enrollment growth. Welch found that HMO establishment and enrollment per capita were greater in markets with lower per capita incomes and those with more educated populations. In addition, HMO establishment was more likely to be found in the more populated geographic markets, and greater HMO enrollment per capita was found in markets with higher hospital per diem costs.

The recent work of Adamache and Rossiter (1986) is of particular relevance to this study because in it they addressed the determinants of HMO participation in the Medicare HMO Competition Demonstrations sponsored by HCFA. In their findings, they suggest that the most important factors associated with participation in the demonstrations were high Medicare capitation rates under HCFA's adjusted average per capita cost (AAPCC) formula in the HMO's main county of operation, prior HMO experience in serving the Medicare population on a cost basis, and previous Federal qualification of an HMO. These findings are an important contribution toward understanding the supply response of HMOs to Medicare capitation. However, it is not clear whether the response of HMOs to a Medicare demonstration program will accurately reflect their response to the actual TEFRA program. Because early demonstration participants might be viewed as pioneer entrants into the Medicare risk marketplace, factors leading a small set of 40 plans to become demonstration sites may differ from those

The research was originally conducted through the University Health Policy Consortium under Cooperative Agreement No. 18-C-98526/1-09 with the Health Care Financing Administration.

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Risk Contracting And Medicare Choice

Frank W. Musgrave



Risk Contracting And Medicare Choice:

Risk Contracting and Medicare+Choice Winfield Towles, Charlotte Collins, 2000 Risk Contracting and Medicare Plus Choice edited by Winfield Towles M D and Charlotte Collins J D is your all in one guide to understanding the details and implications of the Medicare Plus Choice program and accompanying provider sponsored organization PSO legislation It is a comprehensive reference that provides a framework for understanding how health delivery systems operate under Medicare risk contracts and describes the questions providers must answer before deciding to become a risk bearing contractor Risk Contracting and Medicare Plus Choice discusses Medicare managed care the role of the risk contractor in the health delivery system and the fundamental characteristics of the Medicare Plus Choice Program It also details the various financing mechanisms associated with Medicare Plus Choice and addresses issues pertaining to licensure solvency and the other legal regulatory requirements for establishing Medicare Plus Choice risk contracts The book concludes with a summary of the opportunities offered to PSOs through Medicare Plus Choice and a valuable appendix that contains Operational policy letters from the Health Care Finance Administration HCFA Sample applications for Medicare Plus Choice organizations Sample waivers from state licensure for PSOs and solvency requirements Excerpts from HCFA manuals and the National Marketing Guidelines Model work plans for setting up Medicare Plus Choice Plans and model provider contracts **Budget**

Reconciliation Recommendations of the Committee on Finance (spending Provisions) United States. Congress.

Senate. Committee on Finance, 1997 Federal Register, 2013-07 *Annual Report to Congress* United States. Physician Payment Review Commission, 1997 Health Care Financing Review, 1986 **The Rise and Fall of HMOs** Jan

Coombs, 2005 Drawing upon a wealth of research Coombs compares HMOs throughout the nation with the one in Marshfield which came as close as any HMO to realizing the ideal of early advocates This book is a resource for specialists in the fields of health policy research and analysis health care management health law and politics public health and social and organizational history of medicine It will also appeal to many readers who are disturbed by the current state of America's health care system and are curious about its future **BOOK JACKET** **The Economics of U.S. Health Care Policy: The**

Role of Market Forces Frank W. Musgrave, 2015-02-24 Designed as a primary text for courses in health care economics and policy analysis this comprehensive work places the issues and economic analysis of the health care industry in the context of market forces driving the industry including negotiated markets managed care and the growing influence of oligopolies Written in accessible prose without the aid of technical jargon and mathematical formulations the content is rich with applicable understandable economic concepts and analysis and examples of market failure and government involvement Some of the major policy issues covered are drug pricing Medicare and Medicaid reform the medically uninsured for profit hospital monopoly price power managed care competitive pricing and new negotiated markets The relevant economic concepts employed in the text include price elasticity of demand supply market structure from competitive to oligopolistic

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