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Options for Defining Medicare Advantage Regions: An Assessment of Tradeoffs

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EXECUTIVE SUMMARY

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) was designed to achieve five goals related to private Medicare Advantage (MA) health plans and the Medicare program: (1) maximize the number of beneficiaries with access to MA plans, (2) encourage MA plans to enter areas not served by MA plans today, especially rural areas, (3) promote vigorous competition among MA plans in all markets, (4) expand the range of private plan types in MA, and (5) reduce long-term growth in program outlays. A key policy decision that will affect the achievement of these goals involves selecting the number of market regions into which the nation will be divided and the geographic boundaries of those regions. While leaving this decision to the Secretary of the Department of Health and Human Services (HHS), the MMA limited the secretary's discretion somewhat by mandating that the number of regions be no less than 10 and no greater than 50.

To encourage health plans to serve Medicare beneficiaries with regional PPO products as opposed to as a local plan, the MMA included special and temporary incentives as well as a two-year moratorium on plans initiating new local PPOs. The legislation also requires competitive bidding by MA plans, and sets out three important rules to govern the bidding process: (1) regional MA plans must bid one price for the entire region (local plans are allowed to bid one price for each county); (2) the government payment will be set equal to a benchmark premium (adjusted for relative beneficiary risk), so beneficiaries will have to pay—in addition to their usual Part B premium—the difference between the bid and the benchmark if the bid exceeds the benchmark; (3) benchmarks are determined differently for regional and local plans, and will generally not be equal for the two types of plans even though they may compete against each other in some counties. These different benchmarks could very profoundly affect market dynamics and program outcomes.

To explore the implications of the secretary's decision in light of these rules and the central goals of the MMA, the Office of the Assistant Secretary of Planning and Evaluation (ASPE) of HHS contracted with the Center for Studying Health System Change (HSC) to conduct the analysis documented in this report. The purpose of the report, therefore, is not

to make specific recommendations to ASPE about which strategy it should use in drawing MA market regions. Rather, we sought to identify and analyze tradeoffs inherent in alternative strategies. In some sense, the valuations of these tradeoffs are not economic judgments, but political ones, which are best left to policymakers, not policy analysts. We can, however, inform the policy process by articulating what some of the key implications of these judgments are, relative to the very clear goals of the MMA.

This summary reviews HSC's approach to the analysis, the dynamics of plan competition that should be considered in drawing the MA market regions to achieve MMA goals, the scenarios that might come about as a result of these dynamics, and the pros and cons of some alternative numbers and types of market regions.

A. ANALYSIS

HSC's analysis of the implications of regional boundary choices comprises four tasks. We held discussions with a range of health plan and hospital executives who have experience with commercial insurance products and Medicare products. We read the MMA conference report and relevant statutory language in detail, along with some official commentary and analysis in the public domain. We analyzed the geographic variance in fee-for-service (FFS) Medicare costs and in Medicare+Choice (M+C) enrollment patterns, using the Centers for Medicare & Medicaid Services (CMS) and Dartmouth Atlas data and tools. And we explored how plans would be likely to behave in the face of different policy choices. That investigation was based on economic theory, policy analysis experience, and the findings from our discussions with market participants.

The economic framework we used to evaluate plan decisions and market dynamics centers on the decision to enter an MMA regional market in which local cost structures differ from one another. Two conditions are necessary (but not sufficient) for entry: (1) the plan must expect the long-run average bid price (P) to exceed long-run marginal operating costs (MC), and (2) the difference between P and the weighted average MC, however diverse MC might be within the region, must exceed the amortized expected cost of entry. The difference between P and MC will be determined by the extent of competition for beneficiaries, the bidding and payment rules established by Medicare, the provider contracts that a plan can negotiate, and the degree of adverse or favorable risk selection that is not accounted for in the risk adjuster for plan payments. For plans, entry costs are likely to be high and uncertainty about all of these factors is likely to be great under the conditions spelled out in the MMA. In discussions with market participants, we sought empirical evidence on how high these costs might be and why and on how much uncertainty exists.

B. REPORT FROM MARKET PARTICIPANTS

We held discussions with health plan executives who have launched managed care products and developed provider networks, as well as with hospital contracting executives, in a variety of geographic areas. We also spoke with national experts who are familiar with the MMA and with broader strategic calculations that health plans would have to make in deciding whether to enter a regional market. Key findings from these discussions follow.

- Most observers expect MA regional boundaries to strongly influence the number and types of plans that choose to participate as well as their prospects for success. In general, the individuals we spoke with believe that creating smaller and more numerous regions will increase the likelihood that more plans will participate.

- Plan executives believe that expanding networks beyond "natural markets" will reduce their negotiating leverage and diminish their ability to manage care. Expanded networks thus lead to higher costs of care and higher-priced insurance products. Plans would therefore be less likely to market aggressively in areas outside their natural boundaries.

- Plans have little experience selling products for uniform, blended rates/prices across broad geographic areas because commercial product prices typically reflect both regional differences in cost of care and group member experience.

- Precedents and models of plans serving members across multi-state markets exist, but each differs in important respects from the regional MA plan envisioned in the MMA.

- Competitive dynamics between local and regional MA plans are difficult to predict, in part because payment methods will be based on one benchmark rate for local plans and another for regional plans and because the mechanism by which varying local costs are incorporated into regional benchmarks has not yet been established. Local plans are concerned about maintaining a level playing field among all plans.

- The role that Part D and private drug plans will play in influencing the appeal of regional PPOs, particularly to Medicare supplemental policyholders, is unclear.

- Most observers are seriously concerned that the timetable for implementing the regional plan strategy is unrealistic given the time and degree of difficulty associated with assembling multi-state networks. Those we spoke with fear that an unreasonable schedule will result in only a few, and possibly ill-suited, bidders.

C. CONSIDERATIONS RELATED TO COMPETITIVE DYNAMICS

Competitive dynamics are driven by two differences between regional and local MA plans. First, regional plans must offer benefits at the same premium in a much larger geographic area. CMS will adjust payments for a regional plan to reflect variations in "local payment rates" within each region. At this point, CMS is considering a range of alternatives to do this. In one, only differences in input prices would be reflected; in another, differences in spending in Medicare fee for service (FFS) would be reflected. Second, the costs incurred by a regional plan to provide the benefits are likely to vary much more throughout this uniformly priced area than costs for local plans vary within a county.

Costs vary substantially within of a region because provider prices, enrollee service use patterns, and plan ability to manage care vary with both the market power held by local providers and historical patterns of care delivery. The greatest source of variation in Medicare FFS expenditures within regions appears to be use patterns, not the administered prices. But plans expect to face very different provider payment rates within MA regions as they develop provider networks. In areas where they have few enrollees or that have little provider competition, plans expect to pay high rates. For regional plans, creating a competitive network in rural areas may be particularly challenging, since the local providers' market power is virtually unchecked. Plans' lack of experience in either provider contracting or marketing to Medicare enrollees in sub-areas of a large region adds to their uncertainty by clouding their ability to predict costs and determine a bid.

No plan currently offers a single MA plan that covers a full region as envisioned in the MMA, so any plan would have to do some things differently to offer a regional product. Plans' experience will affect their ability and willingness to enter the regional market quickly. For example, Blue Cross Blue Shield plans, whose territories in most cases are statewide, typically have more extensive provider networks throughout a state than most commercial plans. If regions conform to 50 state boundaries, those commercial insurers that operate nationally or in many states might perceive themselves to be at a disadvantage in each state relative to the state's Blue plan and therefore be less likely to offer regional MA plans. On the other hand, if regional boundaries encompass a number of states or do not follow state boundaries at all, national or regional commercial insurers would have the advantage on the basis of their experience in operating in multiple states and since Blue plans would have to form joint ventures to cover a multi-state region.

The combination of a single premium bid and geographic variation in the costs of providing services to enrollees will create strong incentives for plans to attract enrollees from relatively lower-cost areas and to avoid enrollees from higher-cost areas. Plans have a number of tools at their disposal to draw enrollees disproportionately from lower-cost areas. One is to build their local MA products to serve the higher-cost areas that way. Another tool is selective marketing. Since marketing involves radio and television, newspapers, or appearances before local organizations, plans have several avenues to reach the sub-areas that they most value. Regulation could address this, but to be effective, it would probably have to be detailed and costly.

D. COMPETITIVE DYNAMICS SCENARIOS

Our economic analysis informed by the discussions with executives suggests that most of the competitive dynamics will be driven by the differences in benchmarks for local and regional plans. Under the MMA, the benchmark for local plans will be the MA payment rate in the county. But the benchmark for regional plans will be a blend of the average plan bids for the region and the average MA payment rate over the region.

The competitive dynamics will depend greatly on whether and how CMS adjusts for variation in local payment rates within a region. The MMA gives the secretary discretion on this issue. If the regional plan payment is uniform—corresponding to a single region-wide

bid (for example, the average of county-level MA payment rates, weighted by Medicare beneficiaries), or if the geographic adjustments are relatively small—such as adjusting only for input prices—regional MA plans will have incentives to market in the low-cost areas and avoid high-cost areas. In contrast, if adjusters reflect variation in FFS Medicare spending, MA plans will have the same incentives as M+C plans had to avoid the low-cost areas. This would mean that the Congress's goals of giving beneficiaries in rural areas more choices of health plans would not be realized.

We outline three scenarios to describe the range of competitive dynamics that could occur with different types of boundaries for regional MA products. Most of the discussion assumes that the plan payment rates are uniform throughout the region or that geographic adjustments for variation in local payment rates are turn out to be less extensive than full reflection of Medicare FFS spending.

Scenario A. Regional MA plans dominate throughout the region. The basis for this scenario is that local plans today are concentrated in markets with the highest Medicare FFS costs, such as Miami and Los Angeles. Regional plans will cover lower-cost areas as well and would be able to offer products at lower average cost. This would permit them to offer lower prices to beneficiaries in higher cost areas than those charged by local plans and undercut them. Regional plans would market aggressively in lower-cost areas but would still serve beneficiaries in the high-cost areas, and over time, their share of the high-cost markets would grow.

If this scenario came to pass, it would likely take considerable time to play out because local plans are not only already established, but they also have a substantial number of enrollees, many of whom are both happy with their coverage and unlikely to switch immediately to a regional plan even if it is offering a more attractive package.

This scenario would be more likely—at least early on—with smaller regions that conformed mostly to state boundaries. Smaller regions would make it easier for plans to offer MA regional products, especially Blue plans, so there would be more regional MA activity. It is possible that the initial advantages of the Blue plans would deter national and regional plans from offering regional MA products—especially since they can continue offering local MA products. To the extent that this is the case, over time, larger multi-state regions could result in more competitors in each region.

If adjustment for local payment rates followed variations in FFS spending, Scenario A would be very unlikely to come to pass. Regional plans would not have any advantages over local plans in high cost areas, so that local MA plans would dominate in the areas that they now are serving. Few regional plans would probably be formed because to do so would involve offering products in areas that they have to date chosen not to operate under the similar terms. Plans would be accepting a lower benchmark to serve those areas that have to date been neglected by local plans because the payment rates are too low. If regional MA plans did in fact form, they would not have the advantage over local plans in high-cost areas.

Scenario B. Local MA plans dominate throughout the region. Under this scenario, the problems with the potential regional boundaries not corresponding to what plan executives

refer to as "natural markets" would dissuade plans from offering regional MA products. The more geographic boundaries depart from natural markets, the more likely would be this scenario. Regions that have large metropolitan statistical areas (MSAs) at their core correspond most closely to natural markets and thus would attract the most regional MA activity. Regions that split MSAs or are vary large would be least attractive to regional MA plans.

Scenario C. Local MA plans and regional MA plans dominate in different parts of the region. Local MA plans would concentrate in the high-cost counties--like those areas they already serve. Regional plans would draw most of their enrollees from lower-cost areas, such as small metropolitan areas and rural areas. The MMA would, in a sense, be providing regional plans a subsidy to do this, since the contribution of the high-cost counties to the calculation of a benchmark for the region would provide an incentive to enroll beneficiaries living in lower-cost counties who are not currently being served by MA plans. If regional plans had an enrollee mix that drew more heavily from counties with low MA rates than from the overall Medicare population in the region, Medicare would be paying more than it does under current policies. But this overpayment would work toward another of the legislation's goals, which is to provide more of the Medicare beneficiary population with the option to choose a private plan.

E. PROS AND CONS OF ALTERNATIVE NUMBERS AND TYPES OF MARKET REGIONS

The overarching goals of the MA portions of the MMA are to promote vigorous private health plan competition and more choices for beneficiaries throughout the country, especially in rural areas. The geographic boundaries of the market regions ultimately chosen by the secretary of HHS will profoundly affect the extent to which these goals are achieved.

Markets form naturally in some areas and not others, and this fact led to elements in the MMA that were intended to promote development of viable markets for MA plans in areas that have historically been served only by the Medicare FFS program. Natural Medicare markets can be expected to form where rates of service use and provider prices are relatively uniform, where effective provider networks for non-Medicare products have already been constructed, where the density of population allows plans to realize important economies of scale, and over areas that are linked economically so that travel and referral patterns (for secondary and tertiary care) are already established. In other words, natural health plan market areas are those in which a single premium is expected to be appropriate throughout the area for any product with a given actuarial value and target enrollee population.

Trying to create a market out of contiguous "unnatural" areas will be costly in some form, since inducements would then have to be provided to plans to get them to offer products. This effort will require either taxpayer-financed incentives or mandatory service requirements, with the latter likely to produce compensating distortions in plan behavior. In particular, forcing regional plans to offer the Medicare statutory benefit package at one bid price across an entire region with heterogeneous cost patterns will necessarily force plans to offer a blended or average premium, a kind of "regional community rate." Thus, in the name of making a regional "market," the MMA, in some sense, actually promotes distortions

between prices and costs that do not exist in today's commercial markets and probably not at least to the same degree in today's MA markets either, since price and service decisions are still made at the county level. These distortions will most likely end up increasing Medicare outlays, but that may be a price worth paying in the minds of some policymakers if those beneficiaries living in areas not being served by MA today, such as rural areas, end up with more choices than they have today.

Distortions between price and cost send the wrong signals to plans about allocating their resources. For instance, if price is higher than average cost in an area, then plans will be overpaid and inclined to devote substantial resources to marketing and enrollment. If price is lower than cost, then plans will be underpaid and inclined to avoid enrolling beneficiaries where possible. Regional boundaries that minimize these distortions are therefore preferred to those that do not, all other things equal.

We assess three market boundary options that capture the range of feasible alternatives. Two options—10 multi-state regions and 50 state regions—have been discussed often. We developed an alternative designed to minimize the distortions discussed above. Regions would be built around large MSAs, with smaller MSAs and rural counties assigned to the most appropriate large MSA. Under this alternative, the number of regions could be limited to 50—which is specified in the MMA. In evaluating these options, we assessed the extent to which the varying approaches are likely to achieve the following goals: (1) minimizing price-cost distortions, (2) limiting the percentage of a region that is new and unfamiliar to current MA plans, and (3) minimizing the risk to plans when they expand their market to include rural areas.

MSA-Centered Regions. Price-cost distortions could be minimized by forming regions out of areas with homogeneous price and cost patterns, i.e., organized around metropolitan statistical area (MSA) markets that are largely already formed for commercial and current MA products. The second two goals could be reached by limiting the number of beneficiaries in counties outside of the "natural market" that are attached to each MSA core of the would-be regions. Rural counties would be included in the region built around each MSA, with each county assigned to the "nearest" MSA, which would reflect both travel distance and existing referral patterns.

Some MSAs (and surrounding rural counties) would be too small to be viable as regions for MA plans. They may not have enough Medicare beneficiaries to support viable regional plans, especially given the desirability of having more than one plan so as to have competition. Also, attention needs to be paid to the administrative burden for CMS of conducting bidding in a large number of areas.

There are 371 MSAs and over 360 Dartmouth Atlas Health Referral Regions (HRRs)With a threshold of 20,000 beneficiaries, 231 MSAs would qualify. With a threshold of 50,000 beneficiaries, 113 MSAs would qualify. Since the MMA limits the number of regions to 50, this could be the determining factor behind the threshold used to decide how large a Medicare population is required for CMS to decide that the MSA should be the core of a region that also includes smaller MSAs and rural counties.

A problem with having up to 50 MSA-centered regions is that many would include multiple states. This would imply regulation by multiple states. It would also pose difficulty for Blue plans, whose territories do not cross state boundaries. Joint ventures would have to be developed to offer MA regional products. We are told that with the exception of adjacent plans that have merged, these arrangements would not be easy to develop. Nevertheless, 50 MSA regions might conform more to the notion of a natural market than 50 states.

The number of commercial PPOs now operating in a potential region should not be a significant factor in deciding which areas are large enough to be an effective MA region because PPOs are so dominant in commercial markets. A measure of current competitors in the commercial market is not a proxy for the number of plans that will be willing to participate as regional PPOs in the MA program. If plans believe that there are opportunities for sustained profitability as a regional PPO in a given region, then both local commercial PPOs and new entrants may decide to participate. Conversely, if the business does not appear profitable, neither new entrants nor plans currently operating commercial PPOs in the market would be likely to participate. Indeed, in the mid-1990s, observers frequently reported to interviewers from the Community Tracking Study (CTS) that, in certain geographic areas, the Medicare risk contracting business was the most attractive of all health insurance products, drawing insurers into areas in which they had not previously operated on a commercial basis.

Ten CMS Regions. CMS has aggregated the states into 10 administrative regions. Having the MA regions conform to the CMS boundaries involves accepting a large degree of cost heterogeneity in exchange for bringing many rural counties and small MSAs into a region with large MSAs. This approach could engender many plan choices in areas that have not been served to date, such as rural areas, in the long –run, but would also most likely discourage the formation of regional plans in the early yearsbecause the short-term challenges of establishing effective provider networks over large areas are so formidable. The larger degree of heterogeneity in costs would also lead to larger increases in Medicare outlays than for regions that are smaller and more homogeneous.

Fifty State Regions. Administrative simplicity and fairly easy implementation support this option. Multi-state regulatory coordination would not be necessary and many Blue plans would find these regions familiar, although in states with multiple Blue plans, such as New York, joint ventures would likely be required. States vary considerably in the extent to which costs vary by county within their boundaries, but the variation is generally less than that within CMS multi-state regions. The process of creating statewide networks is not trivial, but it is much more feasible than a multi-state network, especially in the short run. The single greatest drawback to this option is that it would convey a large advantage to many Blue plans, which have statewide provider networks for at least some commercial products today. This advantage could deter other plans from trying to challenge the Blues as a regional plan. Thus, the greatest risk here is that long-run competition for rural beneficiaries may not be forthcoming as envisioned by some drafters of the MMA (unless local MA plans are enticed to enter the market because of the new higher payment rates).

In summary, drawing geographic boundaries involves difficult tradeoffs. Boundaries that will attract the most regional PPO products in the early years of the program may foster less competition down the road. But boundaries that look most promising in the long run pose risks that disappointment with the lack of participation could lead to abandonment of the regional MA plan concept in the short run and never getting to the long run. Adjusters for variations in local payment rates involve other tradeoffs. Regional plan payment rates that are uniform or that vary payment rates less than changes in FFS spending will encourage regional MA plans to operate in areas that local plans are not operating today. But with local MA plans in the high-cost areas, this will increase Medicare outlays. On the other hand, full adjustment for differences in FFS spending risks discouraging the development of regional MA plans and discouraging those that do form from investing to serve those areas that have not had Medicare private plan options.

CHAPTER I

INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) was designed to achieve five goals related to Medicare and to private Medicare Advantage (MA) health plans: (1) maximize the number of beneficiaries with access to MA plans; (2) encourage MA plans to enter rural areas; (3) promote vigorous competition among MA plans in all markets; (4) expand the types of private plans that participate in MA; and (5) reduce long-term growth in program outlays. One of the most important policy decisions that will affect the achievement of these goals, which will be made by the Secretary of the Department of Health and Human Services (HHS), involves the specification of the geographic areas to be covered by regional MA plans.

In April 2004, the Office of the Assistant Secretary of Planning and Evaluation (ASPE) of HHS, contracted with the Center for Studying Health System Change (HSC), an affiliate of Mathematica Policy Research, Inc., to help identify the tradeoffs and implications inherent in different strategies for selecting the number and boundaries of the MA market regions. This report, which presents HSC's findings on this issue, was not intended to make specific recommendations to ASPE about which strategy it should use in drawing MA market regions. Rather, we sought to identify and analyze tradeoffs inherent in various strategies. This introductory chapter discusses the policy context for the study, how we went about the study, and the organization of this report.

A. POLICY CONTEXT

The MMA gave the secretary substantial discretion in designing many implementation details, but it also defined a number of key parameters. These include requirements governing the number of regions and the bidding process.

Number of Regions. The MMA requires that there will be no less than 10 and no more than 50 market regions. Designating an area as a region is made important by the fact that the MMA allows plans to serve Medicare beneficiaries as *regional* PPOs or as *local* HMOs

or PPOs. To encourage plans to offer regional products, the MMA includes special, temporary incentives available only for such products, as well as a two-year moratorium on new local PPO products.

Bidding and Benchmarks. The MMA also sets out three rules that govern the bidding process:

- Regional MA plans must bid a single price that applies to beneficiaries throughout the entire region. In contrast, local plans are allowed to bid a single price for each county.

- The government payment will be set equal to a benchmark premium (adjusted for relative beneficiary risk), leaving beneficiaries to pay—in addition to their usual Part B premium—the difference between the bid and the benchmark if the bid exceeds the benchmark.

- Benchmarks for regional and local MA plans are determined by different formulas, even though the two types of plans may compete against each other in certain areas.

The benchmark for local plans (LB) is what the MA plan payment rate would be without bidding. That is, under the Balanced Budget Act of 1997 (BBA), MA plans are paid the greater of three county-specific amounts: a minimum payment, or "floor amount," set by law; an amount reflecting minimum growth (currently 2 percent) from last year's payment amount, or a blend of a local rate and a national rate. The MMA added a fourth payment formula: 100 percent of per capita fee-for-service (FFS) costs. Therefore, as of 2004, no MA plan will be paid less than 100 percent of FFS cost in the county in which it accepts enrollees, and it could be paid more if one of the amounts in the formula resulted in a higher payment in a given county. Formally, each local (i.e., county) benchmark is:

$$LB = \max(\text{floor, minimum growth amount, blend, or } 100\% \text{ of FFS cost}).$$

The benchmark for a regional plan (RB) is a combination of bids and MA payment rates. Specifically, it is the weighted average of the average regional premium bid and the average MA payment rate in the region. The weights applied to the two amounts in the benchmark formula are the national share of beneficiaries enrolled in any MA plan (currently about 13 percent) and one minus that share. The weighted average regional premium bid is computed by weighting each bid by expected enrollment shares. In the first year of the program, in which there is no history of regional plans or bidding, a reasonable way to weight each bid by expected enrollment shares would be to assume that the enrollment for all regional bidders is equal or, in other words, equal weights for each bid.[1] The MA

[1] In later years, the secretary could decide if actual enrollment amounts from the immediately prior year should be used as weights for the individual plan bids, or if competition, beneficiaries, and taxpayers would be better served by continuing the equal weight assumption.

payment amount of each county in the region would be weighted by its share of Medicare enrollees in that county. Thus, if α is the national share of beneficiaries enrolled in any MA plan, then formally, each regional benchmark is:

$$RB = \alpha * \text{average regional bid} + (1-\alpha) * \text{average MA payment.}$$

B. STUDY OVERVIEW

To analyze the implications of regional boundary choices in light of MMA goals and requirements, HSC performed four tasks:

- Held discussions with a range of health plan and hospital executives from 6 of the 12 communities we visit regularly as part of the Community Tracking Study (CTS) and with a small number of national experts;

- Reviewed in detail the MMA conference report and relevant statutory language as well as some commentary and analysis in the public domain from the Congressional Budget Office and CMS Office of the Actuary;

- Analyzed the geographic variance in FFS Medicare costs and geographic referral patterns by using CMS and Dartmouth Atlas data and tools; and,

- Analyzed how plans would be likely to behave in the face of alternative policy decisions on regional boundaries, basing the analysis on economic theory, policy analysis experience, and the findings from our conversations with current commercial and Medicare market participants.

Through these tasks, we developed scenarios that reflect possible outcomes of health plan competition—conditional on different types of regional boundary choices the secretary makes—and identified the "pros and cons" of three market boundary options that capture the range of feasible alternatives.

The economic framework we used to evaluate plan decisions and market dynamics was based on a plan's decision to enter an MA regional market with heterogeneous local cost structures. Two conditions are necessary, but not sufficient, for entry: first, the plan must expect the long-run average bid price (P) to exceed long-run marginal operating costs (MC), and second, the difference between P and the weighted average MC, however diverse MC might be within the region, must exceed the expected amortized cost of entry. The difference between P and MC will be determined by four factors: the degree of competition for beneficiaries, the Medicare bidding and payment rules, the provider contracts that the plan can negotiate, and the degree of adverse or favorable risk selection that is not accounted for in the risk adjuster for plan payments. Entry costs are likely to be high, and uncertainty about all four factors is likely to be great. Therefore, the goal of our discussions with market participants was to gather empirical evidence on just how high the entry costs would be and the reasons for this, and on why the uncertainty is so great.

C. ORGANIZATION OF THIS REPORT

Chapter II of this report presents findings from our discussions with plan and hospital executives. Chapter III describes the analytic criteria we used to evaluate alternative market boundary choices and describes three alternative scenarios that could result from different decisions on regional boundaries. Chapter IV reviews the pros and cons for choosing among the four different regional MA market boundary schemes.

CHAPTER II

REPORT FROM MARKET PARTICIPANTS

To investigate the issues relevant to defining MA regions, we held discussions with individuals in six local markets, including health plan executives who have launched managed care products and developed provider networks and hospital contracting executives. These six markets, part of the 12 that we routinely visit in the CTS, were selected on the basis of their local dynamics, past M+C activity, and our expectation that they would be home to authoritative observers with network development, product marketing, and Medicare experience. We also contacted nine national policy experts familiar with both the MMA and broader strategic and policy issues that may affect the successful development of regional MA plans. This chapter presents key findings from these discussions and a synthesis of the perspectives of the diverse group of individuals with whom we spoke.

A. DISCUSSION TOPICS

In discussions with provider contracting executives in the six local markets, we explored issues that influence the selection of and negotiations with providers for geographically broad networks. Similar matters were reviewed with plan marketing and sales executives to understand how plans make decisions about where they will and will not offer products. For plans with current or past Medicare experience (including Medicare supplemental products as well as Medicare managed care), we discussed provider contracting and product marketing with staff who have primary responsibility in that area. Many of these individuals were only vaguely familiar with the MMA and spoke primarily about their commercial or Medicare experience, although a few were able to extrapolate this experience to speculate about what MA regional plans may encounter.

Our discussions with the nine national Medicare managed care policy experts focused on what they see as the key considerations in defining regions and what they consider to be the relative advantages of larger and smaller regions (e.g., 10 versus 50). We also reviewed the competitive dynamics likely to be faced by regional MA plans; how successful such plans might be in establishing broad, inclusive provider networks; and how plans might be affected by forthcoming changes in free-standing drug plans and Medicare supplemental coverage.

B. KEY FINDINGS

- Most observers expect the final MA regional boundaries to strongly influence not only the number and types of plans that choose to participate but also their prospects for success. In general, the individuals we spoke with believe that the presence of smaller, more numerous regions will encourage more plans to participate.

- Plan executives believe that expanding networks beyond "natural markets" will reduce their negotiating leverage with providers and diminish their ability to manage care. The rationale for this view is that expanded networks will result in high costs of care, making products priced too high to be competitive and plans less likely to market aggressively in these areas.

- Plans have had little experience selling products for uniform, blended rates/prices across broad geographic areas. Commercial product prices typically reflect regional cost of care differences and group member experience.

- Despite the numerous precedents for and models of plans serving members across multi-state markets, the extent to which they correspond to the development of regional MA plans is debatable.

- It is difficult to predict what the competitive dynamics between local and regional MA plans will be—in part because payment methods will be based on different benchmark rates and because the mechanism by which varying local costs are incorporated into regional benchmarks has not yet been established. Local plans are concerned about maintaining a level playing field with regional plans.

- The role that Part D and private drug plans will play in influencing the appeal of regional PPOs, particularly to Medicare supplemental policyholders, is unclear.

- Most observers have serious concerns that the timetable for implementing the regional plan strategy is unrealistic given the time and degree of difficulty associated with assembling multi-state networks. Those we spoke with fear that an unreasonable schedule will result in only a few, and possibly ill-suited, bidders.

1. Findings from Discussions with Local Contacts

a. Interplay of Product Pricing and Provider Contracting

We asked network and marketing staff a basic question about the relationship between product pricing and provider contracting: when a new product that requires re-contracting with network providers is launched, is the price of the product predetermined, or is it established after contract negotiations with providers? Our contacts generally see this

interplay of product pricing and provider contracting as an iterative process that involves first setting a target price and then adjusting it on the basis of market conditions. They pointed out that prices for most private sector products are negotiable. Consequently, most plans do not commit to fixed prices before determining what the cost of medical care will be, as determined in contract negotiations with providers. Product pricing is also affected by broader strategic objectives. For example, one observer suggested that plans new to a market are more likely to commit to a price without firm contracts in place in order to establish a beachhead; on the other hand, longstanding plans that are launching a new product are more concerned with determining provider payments before setting a product price.

There is broad consensus among our contacts that plans have become more cautious about product pricing as providers have, in recent years, become more assertive in negotiations. This "new reality," as one commentator put it, means that plans are now more likely to forgo geographic expansion opportunities until they know they can sustain profitability, or, in other words, until they can negotiate acceptable provider payment rates. Plans have also had to communicate this reality more aggressively to their customers, who bear the brunt of higher provider payments. For products that compete with those in which prices are administered (such as Medicare or Medicaid or related coverage expansions), the ability to negotiate acceptable rates is seen as essential to determine whether a plan can participate in the product line.

b. Network Development and Contracting

Network executives understand the issue of leverage very well, and they are very aware of the factors that influence how much leverage they can bring to the table. They underscored the notion that plans have recently lost considerable leverage to providers, especially hospitals. Geography and referral patterns are key determinants of negotiating strategies and tactics, and network executives draw a sharp distinction between core and secondary, or peripheral, markets. In the former, the bulk of a plan's lives are concentrated, putting leverage at maximum strength. These markets are typically urban areas that have many providers, which serve as regional referral centers. Peripheral markets are more remote, so there is less provider competition, fewer lives per plan, and consequently, less leverage. In these markets, the falloff in leverage is quite steep for many plans, and instead of doing their own contracting, they may simply use a rental network to fill in coverage.

Less leverage is associated with higher prices and less-than-preferable payment methods. The resulting contracting challenge is compounded by the prevalence of a sole community hospital in many secondary markets, or a short supply of specialty physicians and perhaps even of all physicians—all of which shift the balance of power to providers. As a result, most plans find themselves making higher payments to providers in rural areas. However, other factors complicate the contracting challenge as well, including certain hospitals in urban areas that have achieved "must have" status by virtue of reputation or that, through consolidation, may control an entire geographic submarket of a local market. A similar phenomenon is evident in some physician specialties and subspecialties, where,

either by stature or structure, groups of physicians can mobilize a considerable amount of negotiating clout.

The "more lives, more leverage" dynamic clearly favors plans that have developed large concentrations of lives in a market over other plans that have a more limited foothold, perhaps existing only to serve national accounts. In fact, some of the national or large regional plans are willing to accept very limited provider discounts in some local markets because they feel they must have a presence in every major market. Savvy providers can exploit this leverage deficit to gain favorable terms with these firms. Conversely, Blue Cross and Blue Shield plans typically enjoy the best terms because of the scale of their local membership across their multiple products. These plans also have the broadest networks in terms of provider inclusiveness and geographic expanse. But even Blue plans note that, in rural areas, their ability to negotiate favorable prices for commercial business is greatly constrained by the sole community provider status of some hospitals.

c. Product Development and Distribution

Product development and distribution vary greatly across business segments, particularly because certain segments (individual and small group) are regulated, while others are not (many large and mid-sized groups are typically either partly or fully self-insured and subject to little regulatory oversight). In regulated market segments, constraints on product development and distribution limit design and marketing activities accordingly. Conversely, in the less regulated segments, plans have made a concerted effort in recent years to make their products more customized and flexible in response to demands from larger employers for a broader range of alternatives. For these groups, plans will develop benefits, cost sharing, delivery structures, medical management, decision support, and so on into a multitude of configurations.

Pricing practices also vary by market segment—again because of both the regulatory structure and the size of the group, which determines the extent to which plans can use pure experience rating (for large groups) instead of modified approaches that blend group experience and community-wide "book" rates (as is common for mid-size groups that are too large to fall under a state's small group regulations). Geography is also relevant to regulated products because rating regions are prescribed for insurers. Although geographic variation in cost of care is not as central to experience rating as the group's demographic profile and health status is, it clearly influences the prices experience-rated groups will have to pay. In some areas, plans use their own rating regions, which reflect cost (price and/or use) variation across multiple metropolitan areas. Other plans may create only two regions, urban and rural, to crudely reflect cost-of-care differences. At the same time, and despite these differences, multi-site employers have the option to equalize cost contributions to covered employees, or they can introduce cross-region cost sharing or premium differences.

Most plans do not attempt to offer their full product portfolio in all parts of a region—even when they define a region as their service area. Some products, HMOs for example, may not fit well in certain markets because of population density, customer interests, or provider attitudes. Or a plan may have a preferred method of compensation, such as risk

contracting with physician groups, which would not be feasible in a given market. In addition, when a competitor's product appears to dominate a market, plans may not want to launch a product there, effectively ceding the market. Blue plans are somewhat of an exception to this selective offering of products, as their licensing agreement with the Blue Cross and Blue Shield Association, which gives them exclusive branded product status, means they are required to make certain products and networks available across their entire service area. Conversely, licensing agreements also mean that Blue plans cannot offer branded products in a territory in which another Blue plan is licensed.

Marketing and distribution costs do not appear to vary much across geographic areas, particularly because the fees paid to brokers and agents—the primary distribution channel plans use for individuals, small, and mid-sized groups—are standardized within states. Differences between rural and urban areas in the typical size of employer groups may play a minor role in determining marketing costs, but that difference may be offset by the fact that there are fewer plans to compete against in rural areas. Advertising costs do vary by media market size, but this is not a major expense item.

Our plan contacts note that the ability to launch products in broad geographic areas is directly related to how successful a plan is in contracting a credible provider network. Failure to land a major provider or group of providers can mean the difference between a sellable and an un-sellable product, irrespective of how attractive the price is. Likewise, some plans acknowledge that in some markets, while they have networks in place, the cost of assembling the network has resulted in a prohibitively priced product. Thus, they make little effort to promote the product, often offering it simply to serve national accounts. These observations illustrate that the presence of a product in an area may not be a clear indication of either having an offering that appeals to local customers or the intent to actively market a product.

d. Experience with and Perceptions of Medicare

The six markets were selected partly because they have had different experiences with Medicare managed care offerings. Three of the markets have extensive and longstanding HMO participation with a high level of penetration in Medicare. Two of the markets have limited Medicare managed care experience, and one has no Medicare managed care products, though a small plan was once briefly offered there. At least one plan in each market offers Medicare supplemental policies, including some that had Medicare Select arrangements in several counties. There are also Medicare PPO demonstrations in two of the markets, and, in at least two other markets, new local MA PPOs are under development. All of the markets also have some history of complete plan withdrawals and of plan retreat from contiguous counties.

Network contracting for Medicare typically differs from contracting with commercial plans in a number of ways. Most Medicare HMO networks are a subset of commercial HMO networks, either by design or because of attrition, especially since the BBA was passed. While plans have retreated from using capitation as a way to pay providers in their commercial products, plans in several of the markets we looked at continue to employ some

kind of risk arrangements in Medicare networks, including percentage of premium payments, though these have become much more difficult to maintain. Hospital contracting has become very challenging insofar as most facilities will not accept payment of less than Medicare DRG levels. Attrition in networks has both adversely affected marketing and made it difficult to sustain, let alone expand, membership. Even recent favorable changes in benefits and cost sharing facilitated by large payment increases under the MMA are not yet affecting membership growth in any material way; nor are they inducing providers to return to networks, though plans believe it is still too early to judge the full impact of higher payments.

It is noteworthy that a number of M+C/MA HMO plans have been able to contract with providers (mainly physicians) at payment levels below what Medicare fee-for-service would pay them. In some cases, this is because risk payments create an opportunity for additional savings. In other cases, Medicare fee-for-service payments are viewed in some markets as being quite generous, making discounting for plans possible. In still other cases, plans can use high commercial market share as negotiating leverage to extract some discounts in Medicare. And in some markets, physicians have chosen to participate out of loyalty to their patients who find the benefits of the HMO financially appealing.

MA HMOs are upbeat about their future prospects, given payment increases, and some are considering expanding their local products beyond their current market areas. Long-term participants in the Medicare market see this as their strategy for success and typically indicated in our discussion that it would be very difficult for them to become regional MA plans. As noted, many of these plans once served much wider geographic areas but retreated to core markets, where payment rates and provider networks were more favorable. Some plans also noted that if they were to attempt to extend their products beyond markets where they have little or no commercial business, it would be a stretch for them to exert a meaningful influence on and thereby negotiate favorable terms with providers. In at least two of the markets, local plans that offer HMOs were in the process of applying for approval as local PPO plans in contiguous counties. They see this move as an opportunity, created by the new rates and clearing the way for them to launch both a more loosely managed product before the moratorium on new local PPOs takes effect.

The firms offering Medicare supplemental policies are particularly concerned about the interplay between these products and the new regional PPO plans. Some of the firms believe regional PPO plans represent an opportunity to make major improvements in coverage and beneficiary protection over the existing supplements. Others fear the loss of this product line and so may launch regional PPO plans in an attempt to maintain their customer base, which could be enticed away by new market entrants. Still others think the regional PPOs may appeal to newly eligible Medicare beneficiaries and this attractive segment will be enticed away from Medicare supplemental polices. Some supplement offerors have had experience negotiating with hospitals to make Medicare Select options available in the some of their Medigap policies, though they report that their efforts to contract with hospitals and make the products appealing to beneficiaries have been uneven.

Virtually every contact with whom we discussed Medicare supplemental policies acknowledged that uncertainty about the ultimate Part D plan design makes it difficult to anticipate change. In general, plans, like the regional PPOs, that integrate a drug benefit are expected to have some advantage over freestanding Prescription Drug Plans designed to augment supplemental policies. But our contacts expect the outcome to be affected by the number and types of drug plans that choose to participate. They also acknowledged that relatively little is known about geographic variation in drug expenditures for seniors, given the substantial variation in benefit design and relatively compact markets in the current MA program. And while all agree that the impact of the drug benefit on market segmentation and risk selection may be substantial, it is difficult to foresee the actual dynamics.

e. Regional Coverage Considerations and Challenges

Many of our local contacts have only limited knowledge about the particulars of MA regional plan regulatory requirements, so we held a general discussion about the challenges of serving broad regions. Our contacts consistently raised the theme that contracting and marketing are most successful when they are aligned with "natural markets." In the case of contracting, this typically means that geographic regions conform to patterns of patient care-seeking and clinician referrals—with an urban area typically functioning as the nexus. For marketing and distribution, urban centers are also a convenient focus, though product distribution may straddle multiple medical care markets—especially in large, sprawling metropolitan areas—and may encompass surrounding suburban and even rural regions.

Another general observation made by our contacts is that there are few plans that truly offer products statewide or, correspondingly, that have statewide networks from which they could launch managed care products on a border-to-border basis. The obvious exceptions are Blue plans. But even they have to pay a premium to gain rural provider participation despite their status as the largest volume private payer. Some other plans do arrange for statewide networks, but to do so, they typically have to rely on one or more rental networks, a strategy that was uniformly noted by contracting executives as being sub-optimal because of poor discounts and limited influence with rental network providers. Because of this experience, many of the contacts see even state-level regional PPOs as a serious reach for them, and they view multi-state regions as inconceivable if a plan were to receive a region-wide blended rate to pay for all beneficiary care across the entire region. When asked about the prospects for forming confederations or consortia with other plans, most contended such consortia are difficult to develop and troublesome to maintain.

A handful of plans—Blues, nationals, and large regional firms—have well-established mechanisms for handling multi-market and multi-state accounts. At a minimum, these plans can deal with border-crossing metropolitan areas more easily than single-state plans can, and most tout their ability to handle large national employer accounts. Administratively, this appears to be the case. What is less certain, however, is whether plans can achieve the discounting and medical management that will enable them to live with and within blended payment rates. Our contacts are highly cognizant of the differences in the cost of care across the diverse set of regions in their commercial business, and they know that these cost differences can be and are passed along to private payers. The fact that HMO payment rates

have varied so much from county to county (and have contributed to county withdrawals) makes plans skittish about overlooking variation throughout a region. Moreover, they believe that substantial subsidies will be needed to get rural hospital monopolies to participate in MA products, and they are concerned about the sustainability of such subsidies. Some noted that it would have been preferable to allow plans to invoke Medicare payment (DRG) rates as the ceiling for plan payments to hospital.

Several contacts wondered about how the competition between local and regional plans might play out, since they will be competing for the same beneficiaries, at least in urban areas. Most of the contacts are not familiar with the benchmarks used to develop rates for the two types of plans, but they were still vocal about the importance of maintaining a "level playing field." They are also concerned that PPOs and HMOs may not be held to the same standard, and they believe strongly that the (presumably) more limited capacity of PPOs to manage care ought not to justify high payments. In addition, our contacts are worried about how the selection dynamics of these multiple options will play out in terms of enrollment and disenrollment. Finally, the impact of the Medicare prescription drug plans under Part D represents a significant unknown for both local plans and the emergent regional plans.

2. National Contact Findings

The nine individuals with whom discussions were held represented a broad spectrum of the managed care industry as well as benefits and policy consultants. All were familiar with past Medicare managed care experience and well versed in the main provisions of the MMA. Each of the individuals contacted agreed that the decision about the number of regions is of critical importance in determining what types of plan will choose to participate, as discussed below.

a. General Observations

A general observation made by many of the national observers was that some of the multiple MMA goals may be in conflict and that choices will need to be made to reflect the relative priorities policymakers place on the goals. For example, achieving rapid implementation and maximum geographic coverage may discourage some key players from participating or, worse, promote instability in participation if eager but unproven plans seek and secure bids. Another example cited was that blended rates over broad geographic regions may encourage plans to engage in selective marketing efforts in which they attempt to grow in some sub-regions but not in others, and that, in turn, will drive up the monitoring and enforcement costs of program oversight.

Requiring plans to expand to regions that are beyond their "natural markets" for network development and product marketing could prove to be costly, in the views of these contacts. Few plans can muster even statewide networks and those that claim to be regional and national typically have unevenness in their networks and product offerings with strong positions only in selected markets where large accounts are clustered. They pointed to the experience with the relatively narrow geographic scope of M+C plans, most of which have retreated from contiguous counties where there were large or even modest falloffs in

payment rates, as indicative of the difficulty plans have in achieving product and cost of care uniformity across disparate areas. The availability of supplemental payments for providers that are difficult to negotiate with will help mitigate this problem up to a point, in the minds of some observers. Others suggested that despite higher costs contracting with selected providers, such as rural hospitals, the small number of beneficiaries in these areas is unlikely to affect overall financial performance of plans.

Nearly all of these individuals are concerned about the competitive interplay between local and regional MA plans, especially because the payment rates for each are based on different benchmarks. Even more than the few MMA-knowledgeable local contacts mentioned earlier, these commentators were very concerned about the maintenance of a level playing field. They worry that efforts to promote rapid growth in MA regional plans could adversely impact the competitive position of local plans and ignore the longstanding role that they have played for Medicare beneficiaries. Likewise, they believe the HMO to be a much more proven product for care and cost management that should fare well against PPOs in balanced direct competition. In addition, nearly every observer suggested that the uncertainty and speculation surrounding the Part D benefit and the private drug plans make it difficult to anticipate how this may affect the appeal of HMOs and PPOs, both of which will "integrate" the drug benefit compared to Medicare supplemental policies and free-standing drug plans.

The observers were asked whether there were precedents or models for regional MA plans that could be instructive to compare and contrast. Typically mentioned were FEHBP, TRICARE, and the Blue Card program. Most of the observers felt the FEHBP model differed on too many features to be a useful analog, seeing it more like a national employer account than a public program and with the major plans being national, rather than regional ones. TRICARE was noted to have some relevant commonalities including a regional structure, though one that has now consolidated down to just three regions for the entire country. Notably, one of the 3 regional plans is a consortium developed by primarily not-for-profit Blue plans that has proven to be a durable and apparently successful model. Major differences were noted, however, in terms of the availability of a fee-schedule as a ceiling on provider payments, the ability of contractors to identify a priori who their beneficiaries will be and where they obtain their care, the opportunity for the contractor for a region to negotiate exclusively on behalf of the program, and the relatively well-defined and limited risk exposure the plans have under TRICARE.

The Blue Card program is a mechanism developed by the Blue Cross and Blue Shield Association to make available to subscribers in local Blue plans access to the networks and discounts developed by the licensed (branded) plan in each market across the country. Administrative infrastructure has been put in place to engineer reciprocity among plans, and each provider contracting with a local Blue plan has to agree to honor the Blue Card, i.e. extend to the holder the discount negotiated with the local (host) Blue plan. The Blue Card program is governed by the Association members—the leaders of the 41 constituent Blue plans—and it currently applies only to the commercial PPO and traditional indemnity products offered by all of the Blue Cross Blue Shield licensees.

In order for the Blue Card arrangement to be extended to something like a MA regional PPO product, it would be necessary to obtain Association approval; new contracts would have to be executed with all providers for services to Medicare beneficiaries; and the necessary administrative system adjustments would need to be made. More significantly, the Blue Card program does not have risk-bearing capacity (risk is borne by the individual "control" plans where customer accounts are based). Consequently, Blue plans or subsets of Blue plans would have to form new organizations or joint ventures to engage in multi-state risk-bearing lines of business. In states containing multiple Blue plans, a joint venture of some type would have to be formed even to serve a MA region that is limited to one state. Perhaps most important, if one of the Blues licensees in a designated region chose not to participate in a Blues-sponsored joint venture, then that venture could not market itself as a Blues product.

b. Defining Regions

The national observers shared several specific ideas about the definition of regions. In most instances, they believed that the program would attract greater participation in the short term if the regions are more numerous and more closely approximate state boundaries. Consolidation to larger regions could come later, as it has, for example, in the TRICARE program. Most plans that are candidates to be regional plans are positioned or closely positioned to achieve state level networks, and thus are more comfortable with adding a new product to that base, particularly in the near term. State level regions are also consistent with the current regulatory context in which plans exist and even if state regulations are preempted for Medicare participation, plans will prefer greater uniformity in the compliance environment in which they operate. A few individuals also commented that professional and trade associations are typically state-based and plan relationships with them will continue to be important. One caution raised about single state regions is that it may be overly accommodating to Blue plans (all but six states have a single Blue plan) and this could discourage entry of other plans.

Having fewer, larger regions is seen as almost certainly a guarantee that there will be fewer players willing and able to mount the effort and mobilize the resources to enter these new, "unnatural" markets, at least in the first few years of the program. These plans are likely to be the small number of national managed care plans and some of the larger regional plans ("super regionals" as one observer called them) who have already assembled or cobbled together coverage across regions for commercial business. Because of the high cost of entry, these plans would have to be well capitalized and that could mean a more stable market since they would be expected to be slow to exit after making major investments. While smaller, single state plans could, in principle, join together to create joint ventures or consortia to achieve multi-state regional coverage, this is viewed as unlikely, especially because of the relatively short time period available in which to assemble such arrangements. For that reason, there were some doubts expressed that most Blue plans will participate if the regions cross state borders, at least in the short term. An important benefit of larger regions cited by a number of observers was that the large region approach is likely to have stronger appeal to large employers who sponsor retiree coverage because of ease of administration for them.

One other line of comments offered on regional definitions was that many metropolitan areas straddle state boundaries and the "natural" market for health care services in such areas is in fact multi-state. Local plans may serve the entire market and contract across state lines as needed. National plans normally assign such markets to a single local plan affiliate. Blue plans typically address this by having the licensee in each state contract with providers located within the state and handle border crossing with the Blue Card program, though they can make some exceptions in these cases. If a decision were to be made to have 50 regions, some observers indicated that these should not correspond exactly to state borders but should allow for assigning metropolitan areas to one particular region. Alternatively, multi-state regions could be developed in such a way to prevent splitting up border-straddling metropolitan areas.

c. Medicare Advantage Design/Implementation Issues

Several design and implementation issues were raised in discussion with the national contacts. One large concern is how much welcome or resistance these new products may encounter from beneficiaries, employers, and providers, given continuing fallout from plan withdrawals after the BBA. The fact that enrollment has not been spiking since benefits were enriched and cost sharing reduced after payment improvements earlier this year was a concern to some observers. Providers also have not shown much enthusiasm for returning to the program despite some payment improvements, particularly since it is not yet apparent that their Medicare fee-for-service patients are enthusiastic about joining private plans. Other comments focused on the fact that employers who still sponsor retiree coverage and had looked to M+C as a solution to controlling current and future retiree health care costs were badly burned by plan withdrawal after the BBA. Moreover, employers are concerned that the cost containing prospects for managed care products are not nearly as favorable as they once seemed to be, and the PPO option itself is viewed as having less promise than the HMO to control use and cost.

There was a general sense among these individuals that PPOs will not/cannot really engage in much care management and the discounts they can garner will be diluted by the need to stretch networks beyond their current coverage. That probably means PPOs will not be able to be cost competitive in urban areas against local plans, which will in most cases be HMOs with tighter networks and more medical management. Thus, what success they might experience could arise only because of the vagaries of the bidding process where PPOs could end up with a price advantage because of blending in rural market costs.

The use of blended rates in general is a concern to most observers though they fully appreciate the importance of trying to extend access to private plans to non-urban areas. It was noted by a couple of these contacts that while provider payments for services in rural areas may be higher, lower rates of utilization typically offset these effects. Historically, low population density and limited provider supply in rural areas, not cost of care, are the real disincentives to plans to enter rural markets so blended rates could prove a costly solution to this problem. And these rates may invite plans to engage in maneuvering to exploit anomalies of the rates, rather than legitimately manage care; which, in turn, will necessitate more aggressive and more costly administrative oversight. Another observation related to

non-urban areas was that the number of bids awarded in these areas should be limited to two or three to ensure that winning bidders have an opportunity to accumulate sufficient numbers of lives to be successful.

Finally, the national contacts expressed very practical concerns about the pressure to implement the regional plan expeditiously. The tight timetables from announcing regions to assembling networks to submitting bids to launching products will be a serious deterrent to plan participation. They anticipate most plans will be unwilling to submit bids without having fully contracted networks in place because of the uncertainties about cost of care. Others worry that plans may be granted waivers from network adequacy standards in order to maximize opportunities to submit bids. Further concerns arise around whether efforts to maximize participation will lead to contract awards to weak plans that may prove to be unstable. As with local contacts, the uncertainty surrounding the structure and participation of private drug plans is another factor that will impinge on the strategizing and planning of MA plans.

CHAPTER III

COMPETITIVE DYNAMICS OF ALTERNATIVE MARKET BOUNDARIES

Whatever boundaries are drawn for MA regions, the competitive dynamics of the resulting markets will be influenced by the heterogeneity of negotiated provider payment rates and beneficiary utilization rates and how the regions compare to the market areas that insurers have already established for their commercial business and their existing MA business. Heterogeneity in costs could lead to higher program outlays and less intensive efforts by regional plans to serve high-cost areas. Major divergences from health plans' "natural markets" could lead to low regional plan participation, at least in the early years.

The framework for assessing the competitive dynamics goes as such: For a health plan to continue serving an area, the price it receives for services must exceed operating costs. When the difference between price and operating costs varies across the geographic sub-areas within a region, plans will be selective in their marketing, avoiding areas where they lose money and marketing vigorously in areas where the margins are highest. When plans are deciding whether to offer a new regional PPO product in an area, price must be high enough to cover not only operating costs but also the amortized fixed costs of entering the market. These fixed costs include the costs of constructing a provider network and building a brand name to market to beneficiaries. To the degree that future prices or future costs are uncertain, this will make it less likely that plans will offer the product.

A. GEOGRAPHIC VARIATION IN PRICE AND COSTS

Regional MA plans are distinct from local MA plans in two ways. First, regional plans are committed to offering their product at a uniform premium in a much larger geographic area. The MMA gives the secretary discretion concerning whether to apply regional adjusters to the government payments within a region. The plan payment could be uniform, corresponding to a single region-wide bid, (for example, the average of county-level MA payment rates, weighted by Medicare beneficiaries) throughout the region, or CMS could adjust payments for a regional plan to reflect variations in "local payment rates" within each

region. At this point, CMS appears to favor the use of geographic adjusters for local payment rates and is considering a range of alternatives to do this. In one option, only differences in input prices would be reflected; in another, differences in spending in Medicare fee for service (FFS) would be reflected. Second, the costs incurred by a regional plan to provide benefits are likely to vary much more throughout this uniformly priced area than costs for local plans are likely to vary within their county boundaries.

Costs will vary throughout a region for two reasons: plans will have to pay different rates to persuade enough providers to participate in its network, and the patterns of beneficiary service use vary by geography. Chapter II showed that plans have much more success in negotiating favorable provider pricing in areas where they have large enrollments. As they expand into areas where they will, at least initially, have fewer enrollees, they will obtain less favorable rates. "Renting" a network to serve these areas is an alternative to building a network, but as explained in Chapter II, rental networks do not result in large discounts from providers. This situation reflects a combination of the limited leverage held by rental networks and the markup of an added intermediary.

Constructing provider networks involves fixed and variable costs. The former have to do with identifying providers, learning which ones are most important to attempt to include in a network, and negotiating prices. Plans typically negotiate prices with each hospital. For physicians, the health plan typically offers a price, often a percentage of Medicare payment rates, and physicians decide if they are willing to contract at that price. But in some areas, there are single-specialty physician groups with enough market power that negotiations are required. Additional resources and time devoted to building networks might result in lower prices.

Discussions with plan executives indicate that the degree of provider concentration in a market is a key factor in determining where prices will be higher or lower. Plans tend to pay higher prices in rural areas than in metropolitan areas because of the absence of competition. Another factor that probably contributes to geographic variation in prices is cost shifting. Rural providers often have a larger portion of their patients covered by Medicare and/or Medicaid or without any coverage and as a result, are motivated to shift more costs to privately insured patients.

Difficulties in constructing networks in areas in which plans do not have operating experience will affect not only prices but also plans' ability to manage care. The latter is especially relevant to the success of regional MA plans, since they are likely to pay higher rates than FFS Medicare. But to the degree that a plan's enrollees constitute only a small part of physicians' practices, their ability to effectively manage care will be reduced. New relationships between plans and providers will take time to develop, so potential losses that result from relatively limited ability to manage care will be another fixed cost of entering a new area.

Uncertainty about the results of plans' efforts to construct networks is an issue as well. At least for the regional PPO rollout in 2006, plans will have to set premiums without having had enough time to construct networks in areas in which they have not been operating. They will have to use estimates of what the negotiated rates will ultimately work out to be.

This uncertainty about provider prices will affect even plans that have a commercial insurance presence in areas because "all products" networks are rare. Negotiated prices for M+C plans have rarely been the same as negotiated prices for commercial networks. The calculus for providers is quite different. Whereas not participating in a commercial network means the likely loss of patients in that plan, providers realize that many of their Medicare patients might decide to remain in the traditional program rather than switch providers.

Creating networks in rural areas involves much more uncertainty. Unlike more densely populated areas, rural areas tend to have fewer providers, which reduces competition and makes it more difficult to predict what payment rates will be necessary to assemble an adequate network.

This challenge will change over time. Plans will initially be at a strong disadvantage *vis-a-vis* their would-be providers. They will also be facing a great deal of uncertainty in the parts of a region in which they have not operated at all or in which they have offered only commercial products. But over time, plans that decide to enter the market and are able to gain substantial market share could overcome this disadvantage. The decision to offer a regional plan will depend on estimates of losses in the early years and how they compare to potential profits later on. Unfortunately, the history of unpredictable changes in Medicare policy will make plans more cautious about pursuing strategies involving such investments.

Part of this calculation will involve a competitive analysis. For example, Blue Cross Blue Shield plans often have better coverage throughout a state than most commercial plans. If the regional boundary favors the Blues, as state boundaries would, non-Blue plans would be less likely to offer regional products. On the other hand, if regional boundaries involve a number of states or do not follow state boundaries at all, those commercial insurers that operate nationally or in many states will find it more attractive to take the risk of entering those parts of the region in which they do not have experience. In this case, the willingness of Blue plans to offer products in very broad areas will depend on the difficulty of negotiating joint ventures with the other Blue plans with territories that make up the region.

Although Blue plans have been enjoying substantial success with the Blue Card, which enables national purchasers to obtain the benefits of provider payment rates negotiated by each local Blue plan, our discussions with executives have discouraged us from assuming that the plans will develop the necessary joint ventures to offer MA regional plans. For one thing, the existing Blue Card program does not involve sharing of risk among plans (risk is borne by the individual "control" plans where customer accounts are based) and so Blue plans would need to develop new structures for sharing risk across plans within a region. For another, the MA regional plan business is not likely to be as important to many Blue plans as the Blue Card business is, diluting their motivation to undertake the necessary investment in joint ventures for MA.

In contrast to the uncertainty about geographic variation in negotiated prices with providers, variation in rates of service use are relatively well known.. For many years, CMS has published detailed data by county on spending per beneficiary in the traditional Medicare program, and variations in costs by county are very large. The coefficient of variation for the nation is estimated to be 18.69 percent for 2004 (see Appendix A, Table A.1. for

coefficients of variation by area).[2] Within the 10 Medicare regions, the coefficients of variation range from 9.48 percent for the Seattle region to 25.98 percent for the New York region. The coefficients of variation tend to be smaller for states, ranging from 2.38 percent in Delaware to 19.51 percent in New York. And they are smaller still for metropolitan statistical areas (MSA) that have more than one county; virtually all are less than 10 percent.

Since Medicare FFS uses prospective payment and fee schedules extensively, and since policy makers have sought to limit the degree of geographic variation in payment rates to providers, variation is relatively small and much less than the variation in spending per capita. Geographic adjustment factors (GAFs) applied to FFS payment rates do not vary widely across areas. For example, over the 10 Medicare regions, the mean GAF in 2004 ranges from 0.92 percent in the Kansas City region to 1.06 in the New York region (See Appendix A, Table A.2. for mean values). Overall, GAFs vary much less than spending per capita, with a coefficient of variation for the nation of 7.53 percent, compared with 18.69 percent for spending. This means that most of the variation in Medicare spending reflects variation in utilization rates.

Given the expectation that plans will pay higher rates to providers in rural areas, it is possible that the geographic variation in costs faced by MA regional plans might be somewhat less than the variation faced by FFS Medicare. Another factor that could reduce variation somewhat is the influence of managed care plans on provider practice patterns. To the extent that usage patterns in rural areas are particularly low because of a limited provider supply, plan initiatives to coordinate care for chronically ill populations or to make it easier for patients to travel to urban areas for some specialized services could also reduce the variation in patterns of use. However, it is likely that the variation will remain fairly large.

The combination of uniform price and geographic variation in the costs of providing services to enrollees within a region will lead to the dual impulse on the part of plans to attract an enrollee population that comes disproportionately from lower-cost areas and to avoid situations in which they draw a disproportionate number of enrollees from high-cost areas. To achieve these goals, plans have two primary tools at their disposal. One is to limit themselves to regions in which they already have a local presence in the high-cost areas. If plans seek to limit enrollment from areas in which costs are high, they can work to maintain the appeal of their local product in those areas so that enrollees do not switch to their regional product. Indeed, this is a reason for plans to maintain their local product as a separate entity rather than expanding it to cover a region. To the extent that plans find Medicare beneficiaries to be more interested in PPOs than in HMOs, they can contemplate transforming their local HMOs into local PPOs, either before or after the two-year period in which plans are not permitted to form new local PPOs.

Selective marketing is the other tool through which plans could seek to draw disproportionately from low-cost areas. To the degree that marketing involves radio,

[2] These data have been extrapolated from an earlier year to 2004 by the Medicare Actuary for use in 2004 rates for Medicare Advantage plans.

television and newspaper advertising or appearances before local organizations, plans have first-hand control over the regions in which most efforts are made. Regulation could address selective marketing, but to be effective, regulatory oversight would probably have to be extremely detailed and costly, for example, involving assessments of how marketing resources were directed among sub-areas within a region.

B. SCENARIOS OF LOCAL/REGIONAL COMPETITION

The following scenarios, which reflect the possible outcomes of local/regional plan competition, are based on the economic theory behind plan marketing and location decisions and the information from discussions with executives. Much of the dynamics of competition will be driven by the differences in benchmark prices for local and regional plans. As mentioned, the benchmark price for local plans will be the MA payment rate in the county. But the benchmark price for regional plans will be a blend of the average regional bid for the region and the average MA payment rate over the region.

The competitive dynamics will depend greatly on how whether and how CMS adjusts for variation in local payment rates within a region. If payment rates are uniform or the adjustments are relatively small—such as adjusting only for input prices—regional MA plans will have incentives to market in the low-cost areas and avoid high-cost areas. In contrast, if adjusters reflect variation in FFS Medicare spending, MA plans will have the same incentives as M+C plans had to avoid the low-cost areas. This would mean that the Congress's goals of giving beneficiaries in rural areas more choices of health plans would not be realized.

Another consideration in this dynamic is that local plans will be predominantly HMOs and regional plans will be exclusively PPOs. The Medicare HMO product is a proven one that in some areas has drawn a consistent share of beneficiaries away from traditional Medicare. The Medicare PPO is much less proven. In the commercial insurance market, PPOs are more attractive than HMOs to many because of having less restriction on provider choice and on care delivery but lower provider prices than traditional (indemnity) insurance. In contrast, Medicare PPOs must compete with a traditional program that has broad choice of providers *and* low provider payment rates. Discussions with observers (reported in Chapter II) suggested doubts about how Medicare PPOs would fare when competing with both Medicare HMOs and traditional Medicare.

Scenario A. Regional MA plans dominate throughout the region. The basis for this scenario is that local plans today are concentrated in markets with the highest Medicare FFS costs, such as Miami and Los Angeles. Regional plans will cover lower-cost areas as well and would be able to offer products at lower average cost. This would permit them to offer lower prices to beneficiaries in higher-cost areas than those charged by local plans and undercut them. Regional plans would market aggressively in lower-cost areas but would still serve beneficiaries in the higher-cost areas, and over time, their share of the higher-cost markets would grow. Nevertheless, regional plans may face competition in some lower-cost rural areas. Since local MA rates in lower-cost areas are now substantially higher than FFS costs because of the floor amount, rural hospitals may have an incentive to develop local MA products, which could underprice the regional plans.

This scenario would be more likely—at least early on—with smaller regions that conformed mostly to state boundaries. Smaller regions would make it easier for plans to offer MA regional products, especially Blue plans, so there would be more regional MA activity. It is possible that the initial advantages of the Blue plans would deter national and regional plans from offering regional MA products—especially since they can continue offering local MA products. To the extent that this is the case, over time, larger multi-state regions could result in more competitors in each region.

In any case, this scenario would take some time to evolve. Local plans are very well established, having developed brand names, customer loyalty, and effective provider networks. Even if the economics do not favor local plans, the advantages of incumbency could endure for a long time.

If adjustment for local payment rates followed variations in FFS spending, Scenario A would be very unlikely to come to pass. Regional plans would not have any advantages over local plans in high cost areas, so that local MA plans would dominate in the areas that they now are serving. Regional plans would probably not be formed because to do so would involve offering products in areas that they have to date chosen not to operate under the similar terms. Plans would be accepting a lower benchmark to serve those areas that have to date been neglected by local plans because the payment rates are too low. If regional plans did in fact form, they would not have the advantage over local plans in high-cost areas spelled out above.

Scenario B. Local MA plans dominate throughout the region. In this scenario, the problems with the potential regional boundaries not corresponding to what plan executives refer to as "natural markets" would dissuade plans from offering regional MA products. The more geographic boundaries depart from natural markets, the more likely would be this scenario.

Regions that have large metropolitan statistical areas (MSAs) at their core correspond most closely to natural markets and thus would attract the most regional MA activity. If regional markets were mostly defined as states, the departure from "natural markets" would be less significant for Blue plans, which might, in turn, offer regional plans. But there might be very limited competition in these regional markets, since Blue plans have exclusive territories and are not permitted to use the trademark should they compete with each other, and many non-Blue plans might perceive themselves to be at a significant disadvantage in regions that so closely track markets that Blues have operated in for a long time.

Regions that split MSAs or are vary large would be least attractive to regional plans. Since insurers have an option to offer local products only, all of the problems with the potential regional boundaries not corresponding to what plan executives refer to as "natural markets" would dissuade plans from attempting to compete as regional plans.

Another factor that would favor this scenario would be the HMO product type, which would only be available as local MA products. Many observers believe that it will prove to be the case that HMOs are more successful products in Medicare than PPOs (see Chapter

II). So despite their disadvantages in competing against regional PPOs in the counties with the highest FFS costs, local MA plans could prevail because most of them are HMOs.

To the degree that geographic adjustments are used (and do not depart much from FFS Medicare spending), this would make Scenario B all the more likely.

Scenario C. Local MA plans and regional MA plans dominate different parts of the region. The former would continue their long-term strategy of offering HMO products in markets with the highest FFS costs. With some counties having MA rates that exceed FFS costs (such as those benefiting from the floor), new local plans—particularly provider-sponsored plans—might develop in those areas as well. Regional plans would predominantly serve areas in which costs are lower. With uniform payments or with geographic adjusters that vary less than FFS costs, plans would be getting a subsidy to serve areas with lower FFS costs, such as rural areas. If regional plans had an enrollee mix that was more from counties with low MA rates than the overall Medicare population in the region, Medicare would be paying more than it does under current policies. But this overpayment would contribute to another goal of the MMA, which is to give more of the Medicare population the option to enroll in private plans.

A portion of this overpayment would be captured by providers in rural counties or small MSAs, since regional plans' eagerness to establish adequate networks in low-cost areas will lead them to be very willing to negotiate high payment rates. Another portion would go to the beneficiaries, but these benefits would be spread to all enrollees in the region.

Table 1. Simplified Hypothetical MMA Region

County	Number of Medicare Beneficiaries	MA Monthly Payment Amount
1	50,000	$900
2	30,000	$700
3	20,000	$500

Table 1 shows how Scenario C can evolve. It shows sample payment parameters in a simplified hypothetical region with three counties. For simplicity, it does not have any geographic adjustment. In this example, the average MA payment rate in the region is $760. Assume that the weighted (by plan enrollment) average regional bid is $800. If the national market share of MA plans is 15 percent, the benchmark for regional plans is $766 (0.15*800 + .085*760). This determines the government payment. So the regional benchmark is $766, but the local benchmarks vary from $500 to $900.

The separate regional and local benchmarks effectively "prop up" higher-cost local plans even though the regional plans underbid them by quite a margin. In fact, it may be less expensive for some beneficiaries—those in county 1, for example—to enroll in higher-cost local plans than in lower-cost regional plans. The benchmarks also provide a strong incentive for higher-cost local plans to enter.

Large versus Small Regions. To sum up these scenarios, the larger the regions established, the more likely Scenario B will be, where only local MA products will be available. However, if regional MA plans are, in fact, established in large regions, they might be more competitive in the future than if regions conformed largely to state boundaries. The competition could include some national plans, such as United Healthcare and Aetna, some "super-regional" plans, such as Humana and Pacificare, and possibly some joint ventures between neighboring Blue Cross Blue Shield plans. What is particularly uncertain is whether we would see this competitive outcome or one in which there would not be any significant regional plans.

Conversely, the smaller the regions, the more likely Scenario C will be. In this case, existing local plans would continue as such, and some Blue plans and larger regional or national plans would be more likely to compete as regional plans. We believe that Scenario A is unlikely no matter how the regional boundaries are drawn.

A better result than either of these two outcomes might be achieved by drawing small regions that do not conform to state boundaries. For example, if regions were built around the 50 largest MSAs, with smaller MSAs and rural counties added into the nearest of the large MSAs ("nearest" would mean either the shortest distance or the large MSA that had most of the referrals from the county in question), the regions would be a lot closer to "natural markets" and could induce more local plans to broaden their market from a group of local counties to the region. Although this outcome would be less attractive to the preponderance of Blue plans that are statewide, the loss of their participation might be more than offset by more participation from existing local plans.

CHAPTER IV

PROS AND CONS OF ALTERNATIVE MARKET REGIONS

The overarching goals of the Medicare Advantage portions of the MMA are to promote vigorous competition among private health plans and to create a broader range of choices for beneficiaries throughout the country, especially in rural areas. The geographic boundaries of the market regions ultimately chosen by the Secretary of Health and Human Services will profoundly affect the feasibility of these goals. The MMA reflects the drafters' expressed preference to base the regions on the geographic boundaries formed by states or groups of states but also clearly gave the secretary discretion to analyze potential markets and to choose other boundaries for good reasons. This chapter develops criteria for ideal regional boundaries and analyzes three alternative boundary options on the basis of these criteria.

A. IDEAL REGIONAL BOUNDARIES

Markets form naturally in some areas and not others, a fact that spawned elements in the MMA that were intended to promote health plan market development in areas that have historically been served only by FFS Medicare. Natural Medicare health plan markets can be expected to form where health service use and provider prices are similar, where provider networks for other products have already been constructed, where the density of population allows plans to realize important economies of scale, and over geographic areas that are linked economically so that travel and referral patterns (for secondary and tertiary care) are already established. In other words, natural health plan market areas are those in which one premium price is expected to be appropriate throughout the area for any product with a given actuarial value and target enrollee population.

Trying to make a market out of contiguous but "unnatural" areas will be costly in some form, since it involves changing the way plans make decisions about where to locate. This behavioral change will require either costly taxpayer-financed incentives or mandatory service requirements, which are likely to produce compensating distortions in plan behavior. In particular, forcing regional plans to offer the statutory Medicare benefit package at one bid price across an entire region with heterogeneous cost patterns will necessarily force a blending or average price, a kind of "regional community rate." But unlike today's

commercial insurance market, in which plans are free to set prices according to expected costs in each sub-region, prices set by a regional MA plan would, by construction, be higher than expected costs in low-cost areas and lower than expected costs in high-cost areas. As a result, in the name of making a regional "market," the MMA, in some sense, actually promotes distortions between prices and costs that do not exist in commercial markets today—and probably do not exist at least to the same degree in today's MA market either, since price and service decisions are made at the county level.[3] This distortion will most likely end up costing the Medicare program more money, but that may be a price worth paying in the minds of some policymakers if, for example, rural beneficiaries end up with more choices than they now have.

Differences by sub-region between price and cost are undesirable because they send the wrong signals to market participants about resource allocation. If price is higher than average cost in a particular area, then plans will be overpaid, and too much activity might be devoted to marketing and enrollment rather than service delivery in that area. If price is lower than cost, then plans will be underpaid and will avoid seeking enrollees if at all possible. Ideal regional boundaries are therefore ones that minimize these distortions.

B. ALTERNATIVE REGIONAL SOLUTIONS

In evaluating alternative boundaries for regions, we assessed the extent to which the varying approaches are likely to achieve the following goals:

- Minimizing price-cost distortions;
- Limiting the percentage of a region that is new and unfamiliar to current MA plans; and,
- Minimizing the risk incurred by plans that expand their market to rural areas and other areas not served by MA plans today.

1. MSA-Centered Regions

Progress towards all three goals could be achieved by forming regions out of areas with homogeneous price and cost patterns—regions organized around MSA markets that are largely already formed for commercial and current local MA products. Rural counties would be included in the region built around each MSA, with each county assigned to the "nearest" MSA, which would reflect both travel times and existing referral patterns. But limiting the area that is outside of the "natural market" that would be attached to each MSA core would achieve the most. MSA-centered regions would be consistent with the Conference report's priority to include multi-state MSAs in a single region but at odds with priorities that regions should include at least one state and that states should not be divided.

[3] Of course, the administered M+C pricing system has had its own serious problems, some of which the MMA is designed to fix, partly by introducing plan bidding into the payment formulas.

Some MSAs (and surrounding rural counties) would be too small to be viable as regions for MA plans. They may not have enough Medicare beneficiaries to support a choice of regional MA products. Also, having a large number of regions would increase the administrative burden for CMS of conducting bidding in a large number of areas.

There are 371 MSAs and over 360 Dartmouth Atlas Health Referral Regions (HRRs). With a threshold of 20,000 beneficiaries, 231 MSAs would qualify. With a threshold of 50,000 beneficiaries, 113 MSAs would qualify. Since the MMA limits the number of regions to 50, this could be the determining factor behind the threshold used to decide how large a Medicare population is required for CMS to decide that the MSA should be the core of a region that also includes smaller MSAs and rural counties.

Looking at one state can illustrate some of the issues involved in constructing regions based on core MSAs. Figure 1 (at the end of this chapter) centers on Ohio and was adapted from the Dartmouth Atlas mapping tools. The black boundaries delineate the borders of the HRRs located in Ohio and on the boundaries of neighboring states. Cleveland and Cincinnati each have well-established regional medical centers and are the centers of HRRs today. Each of these MSAs has over 200,000 Medicare beneficiaries. But Columbus, with an academic medical center of its own, has over 150,000 Medicare beneficiaries in its MSA and draws from a much larger geographic area than do Cleveland or Cincinnati. Note also that Dayton, Toledo, Canton, and Akron—all of which have at least 60,000 beneficiaries—each form the cores of distinct and viable HRRs. Finally, note how Pittsburgh, Pennsylvania; Lexington, Kentucky; and Fort Wayne, Indiana naturally draw patients from Ohio, thus illustrating the point that arbitrarily forming market regions along state boundary lines would do a poor job of reflecting existing travel and referral patterns.

Examining coefficients of variation for the different geographic areas in Ohio shows the potential of this type of region to reduce heterogeneity in costs. The coefficient of variation in FFS costs in CMS Region 5 (including Ohio) is 16; in Ohio as a whole, it is 8.72; and in Cleveland alone it is 3.36 (Appendix A).

Since the MMA limits regions to 50, this would mean assigning MSAa like Dayton, Toledo, Canton and Akron—and perhaps even Columbus and Cincinnati—to the nearest of the 50 largest MSAs. This would affect all three goals. A particular problem with having only 50 MSA-centered regions is that many would include multiple states. For example, counties in Missouri, Tennessee, Illinois, and Kansas would likely be divided among the St. Louis, Kansas City, and Memphis MSAs; and counties in Ohio, Indiana, Kentucky and western Pennsylvania between the Cleveland, Cincinnati, Pittsburgh, and Indianapolis MSAs. This would imply regulation by multiple states.

It would also pose difficulty for Blue plans, whose territories do not cross state boundaries. Joint ventures would have to be developed to offer MA regional products. We are told that with the exception of adjacent plans that have merged, these arrangements would not be easy to develop (Chapter II). Nevertheless, 50 MSA regions might conform more to the notion of a natural market than either 10 CMS regions or 50 states.

2. Ten CMS Regions

CMS has long aggregated the states into 10 administrative regions. Having the MA regions conform to the CMS boundaries would create large multi-state regions in the simplest possible way. This approach trades off homogeneity of costs in exchange for bringing many small MSA and rural counties into the same region as some large MSAs. As explained in Chapter III, this alternative could encourage competition in rural areas in the long run, especially with either uniform payment or if geographic adjusters left strong incentives for plans to enroll rural beneficiaries. However, the barriers involved in setting up networks in such large regions would make it difficult for plans to enter as regional entities and, in particular, very unlikely that they would do so in the first year—and perhaps even in the first few years.

The incentives to remain a local MA plan and bid county by county appear to be very strong under this alternative. This is especially true because one of the plan payment guarantees for local MA plans is *no less than 100 percent of FFS in that county.*

3. 50 State Regions

The primary advantage of this approach is to achieve administrative simplicity. By making regions congruent with state boundaries (the District of Columbia would presumably be joined with Maryland), the solvency of all insurers in a given "region state" would be similarly regulated, and CMS administrative functions for all such insurers would be uniform as well. Many Blue plans would find these regions familiar, although in states with multiple Blue plans, such as New York, joint ventures would likely be required. States vary considerably in their cost heterogeneity (see Appendix A), but there is generally much less variation within a state than within a CMS multi-state region.

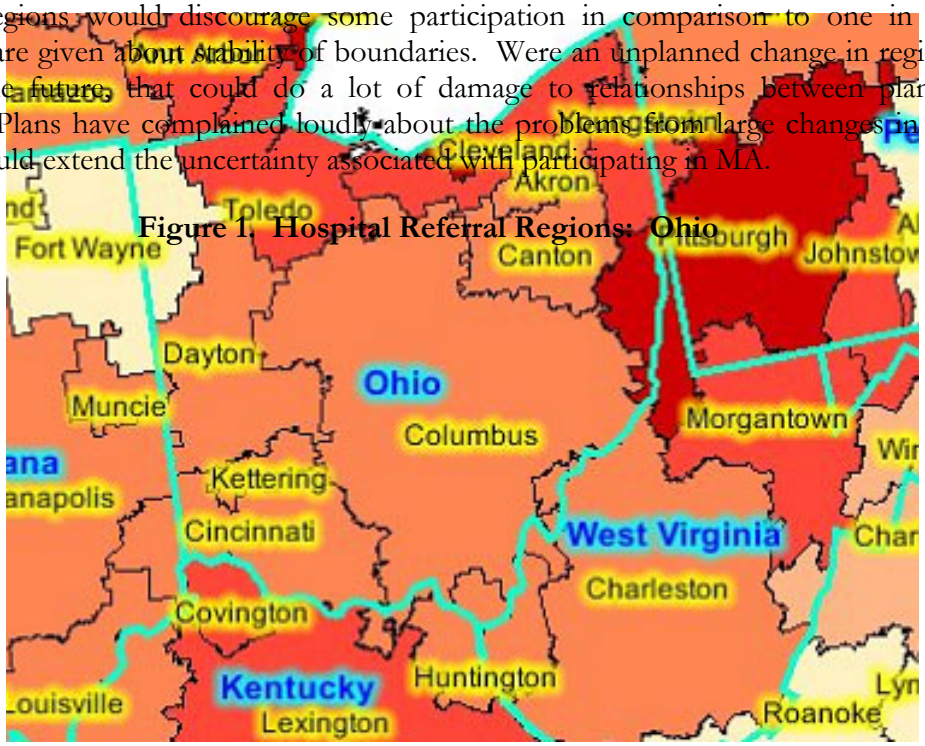
Since states are smaller than multi-state regions, fewer rural counties would need to be aggregated with the urban areas in the state. The process of creating statewide networks is not trivial, but it is much more feasible than a multi-state network, especially in the short run. A drawback to this option is that it would convey a large advantage to many Blue plans, which have statewide provider networks for at least some commercial products today. This advantage could deter other plans from trying to challenge the Blues as a regional plan. The result could be a sacrifice of competition down the road for a higher probability that currently unserved areas will be served by an MA plan in the early years.

In summary, drawing geographic boundaries involves difficult tradeoffs. Boundaries that will attract the most regional PPO products in the early years of the program may foster less competition down the road. But boundaries that look most promising in the long run pose risks that disappointment with the lack of participation could lead to abandonment of the regional MA plan concept in the short run and never getting to the long run. Adjusters for variations in local payment rates involve other tradeoffs. Uniform payments, or geographic adjusters that vary payment rates less than changes in FFS spending, will

encourage regional MA plans to operate in areas that local plans are not operating today. But with local MA plans in the high-cost areas, this will increase Medicare outlays. On the other hand, full adjustment for differences in FFS spending risks discouraging the development of regional MA plans and discouraging those that do form from investing to serve those areas that have not had Medicare private plan options.

Given the contrast between the short run and the long run, consideration could be given to changes in regional definitions over time. For example, in the initial years, regions could be defined as states, but over time states could be combined. This could either be planned from the beginning or decided later on. But the prospects of changing boundaries would add a great deal of uncertainty to what regional MA plans already face. A plan might be of the opinion that operating in one state is attractive but then find itself having to establish networks in an adjacent state that it might not have any presence in. So a plan for changing regions would discourage some participation in comparison to one in which assurances are given about stability of boundaries. Were an unplanned change in regions to occur in the future, that could do a lot of damage to relationships between plans and Medicare. Plans have complained loudly about the problems from large changes in policy and this would extend the uncertainty associated with participating in MA.

Figure 1. Hospital Referral Regions: Ohio



Source: Dartmouth Atlas of Health Care (mapping tool)