Trends in Medicare Health Maintenance Organization Enrollment: 1986-93

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This study examines Medicare health maintenance organization (HMO) enrollment under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248) from 1986 to 1993. It shows that there was moderate growth in the number of Medicare beneficiaries participating in the TEFRA risk program, reaching 1 in 20 beneficiaries in 1993. Medicare HMO enrollment is heavily concentrated in a few large plans, resulting in heavy concentrations geographically. California and Florida accounted for over one-third of Medicare HMO enrollees. One-half of the States have no Medicare HMO enrollment and one-fifth of the States have fewer than 15,000 Medicare HMO enrollees.

INTRODUCTION

A major goal of the Health Care Financing Administration (HCFA) has been to increase enrollment of Medicare beneficiaries in HMOs. It is believed that care provided through HMOs can be more cost effective than that provided in the fee-for-service (FFS) market and that enrollees have greater continuity of care.

TEFRA made a major change from the way HMOs were paid under the 1972 Amendments to the Social Security Act (Public Law 92-603). Under the 1972 Amendments, Medicare payments were subject to retrospective adjustments under both cost and risk contracts; under TEFRA risk contracts, Medicare pays HMOs a prospectively-set amount. For risk enrollees, HMOs receive 95 percent of the adjusted average per capita cost (AAPCC), which is defined as the estimated per capita amount that would be payable if Medicare-covered services for HMO members were furnished in the local FFS market. HMOs must use any difference between 95 percent of the AAPCC and their adjusted community rate (ACR) to provide additional benefits or to lower premiums. The ACR is defined as the premium the HMO would have charged Medicare enrollees for the Medicare benefit package. For enrollees under cost contracts, HMOs are paid for reasonable costs.

This article updates an earlier report on HMO enrollees (McMillan et al., 1987) and focuses on trends in HMO enrollment in risk contracts under TEFRA. (This article does not contain data on persons enrolled in cost contracts or those enrolled in health care prepayment plans.) Data are presented on national HMO enrollment and Medicare HMO enrollment by State. Also presented is information on the characteristics of the HMO: type of HMO (independent practice association [IPA], group, staff, network); profit status; whether or not the HMO is part of a chain

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organization; if the HMO offers benefits in addition to Medicare, such as outpatient prescription drugs; and the premium for the extra benefits.

DATA SOURCES

Data on Medicare HMO enrollees are maintained by the Office of Prepaid Health Care Operations and Oversight, Division of Contract Administration, HCFA. From these data, monthly reports are produced providing information on enrollment and type of contract. Information on plans offering additional benefits to Medicare and on premium rates is also tabulated.

The national data on all HMO enrollees are compiled and published by InterStudy, a non-profit health care policy research organization. Through biannual surveys, InterStudy collects and maintains information about the HMO industry, including enrollment, plan characteristics, membership growth trends, and additional information such as HMO premiums and profitability.

TRENDS

Since 1986, there has been considerable growth in HMO enrollment, both nationally and under Medicare. Nationally, in 1986 there were 23.7 million HMO enrollees; in 1993 there were 38.5 million HMO enrollees, an increase of nearly 63 percent (Table 1). The 38.5 million HMO enrollees comprised 15 percent of the total U.S. population. The nearly 1.7 million enrollees under Medicare risk contracts in 1993 were more than three times greater than the 467,000 enrollees in January 1986.

The proportion of Medicare beneficiaries enrolled under TEFRA risk contracts in January 1986 was 1.6 percent; by January 1993, 4.8 percent of Medicare beneficiaries were enrolled under an HMO plan. This increase occurred in spite of the decline in the number of TEFRA risk contracts, from 105 to 98, during this period.

Table 2 shows the trend in HMO enrollment for all persons and for Medicare beneficiaries from 1986 to 1993. Nationally, HMO enrollment increased each

Table 1

Comparison of Total U.S. and Medicare At-Risk Health Maintenance Organization (HMO) Enrollment: 1986 and 1992-93

Item Measured	1986	1992-93	Percent Change
U.S. Population in Thousands	241,077	[1]255,081	5.8
HMO Enrollees in Thousands	23,664	[2]38,467	62.6
HMO Enrollees as Percent of U.S. Population	9.8	15.1	54.1
Medicare Enrollees in Thousands	29,421	[1]35,579	20.9
Medicare Risk HMO Enrollees in Thousands	467	[3]1,691	262.1
Medicare Risk Enrollees as Percent of Total Medicare	1.6	4.8	199.4
Number of TEFRA Risk Contracts	105	[3]98	−6.7

[1]July 1992.
[2]January 1993.
[3]July 1993.

NOTE: TEFRA is Tax Equity and Fiscal Responsibility Act of 1982.

SOURCES: InterStudy Reports; Health Care Financing Administration: Data from the Office of Prepaid Health Care and the Bureau of Data Management and Strategy.

Table 2

Total National and Total Medicare Health Maintenance Organization (HMO) Enrollees and Percent Growth: January 1986-January 1993

Year	National HMO Enrollment	Percent Growth	Medicare HMO Enrollment	Percent Growth
1986	21,051,657	—	467,375	—
1987	25,777,130	22.4	836,713	79.0
1988	30,313,198	17.6	981,145	17.3
1989	31,940,494	5.4	1,039,901	6.0
1990	33,092,954	3.6	1,091,635	5.0
1991	34,071,646	3.0	1,240,474	13.6
1992	37,636,754	10.5	1,379,667	11.2
1993	40,839,134	8.5	1,554,879	12.7

SOURCES: InterStudy Reports; Health Care Financing Administration: Data from the Office of Prepaid Health Care.

year, with the greatest rates of growth in 1987 and 1988. The rate of growth for Medicare HMO enrollees was also greatest during the 1987-88 period, rising from 467,375 in 1986 to 981,145 in 1988. For Medicare, the rate of growth in HMO enrollment slowed in 1989 and 1990, increasing only 5-6 percent each year, but during the period 1991-93, the rate of growth averaged more than 12 percent.

Enrollee Characteristics

The distributions by age and gender of the general Medicare population and the Medicare HMO enrollment population are compared in Table 3. Ten percent of Medicare beneficiaries (disabled persons) are 64 years of age or under; in 1992 about 4 percent of Medicare HMO enrollees were in this age group. For most of those 65 years of age or over, the proportions in the general Medicare population were not very different from the proportions shown for the Medicare HMO enrollment. Those 65-69 years of age and those 85 years of age or over, however, had smaller proportions among the HMO enrollees than in the general Medicare population. Those 70-74 years of age had a relatively larger proportion of HMO enrollees than the proportion in this age group in the general Medicare population (28.8 percent versus 23.5 percent). The distribution of males and females enrolled in Medicare HMOs was similar to that of the general Medicare population.

Enrollment by State

Table 4 presents data on national and Medicare HMO enrollment by State. Ten States (California, New York, Massachusetts, Florida, Pennsylvania, Illinois, Michigan, Ohio, Texas, and Wisconsin) each had at least 1 million HMO enrollees, accounting for more than two-thirds of all HMO enrollees.

Table 3

Number and Percent Distribution of Medicare Beneficiaries and Medicare TEFRA HMO Risk Enrollees, by Age and Gender: 1992

Age and Gender	Total Medicare Beneficiaries July 1992	Medicare HMO Enrollees December 1992
Total	[1]35,579,149	1,555,653
	Percent Distribution	
64 Years or Under	10.0	4.4
65-69 Years	27.2	24.9
70-74 Years	23.5	28.8
75-79 Years	17.6	20.7
80-84 Years	11.7	12.9
85 Years or Over	9.9	8.3
Males	42.4	43.4
Females	57.6	56.6

[1]Includes aged, disabled, and end stage renal disease populations, enrolled in Part A and/or Part B of Medicare.

NOTES: TEFRA is Tax Equity and Fiscal Responsibility Act of 1982. HMO is health maintenance organization.

SOURCE: Health Care Financing Administration: Data from the Office of Prepaid Health Care and the Bureau of Data Management and Strategy.

Table 4

Total U.S. Health Maintenance Organization (HMO) Enrollment and Medicare HMO Enrollment, by State

State	U.S. Population in Thousands July 1992	HMO Enrollees		Medicare Population	Medicare HMO Enrollees	
		In Thousands January 1993	As Percent of Population	In Thousands July 1992	July 1993	As Percent of Medicare Population
United States	255,081	[1]38,391	15.1	[2]34,853	1,691,385	4.9
Alabama	4,136	216	5.2	606	0	0.0
Alaska	587	0	0.0	28	0	0.0
Arizona	3,832	753	19.7	538	118,379	22.0
Arkansas	2,399	91	3.8	404	0	0.0
California	30,867	9,800	31.7	3,421	671,318	19.6
Colorado	3,470	744	21.4	382	37,550	9.8
Connecticut	3,281	606	18.5	483	0	0.0
Delaware	689	130	18.9	93	0	0.0
District of Columbia	589	497	84.4	78	0	0.0
Florida	13,488	1,895	14.0	2,455	317,658	12.9
Georgia	6,751	368	5.5	771	0	0.0
Hawaii	1,160	261	22.5	136	12,501	9.2
Idaho	1,067	13	1.2	139	0	0.0
Illinois	11,631	1,745	15.0	1,574	57,776	3.7
Indiana	5,662	377	6.7	789	2,562	0.3
Iowa	2,812	110	3.9	465	0	0.0
Kansas	2,523	147	5.8	373	2,418	0.6
Kentucky	3,755	351	9.3	554	2,795	0.5
Louisiana	4,287	251	5.9	551	0	0.0
Maine	1,235	49	4.0	190	0	0.0
Maryland	4,908	919	18.7	567	713	0.1
Massachusetts	5,998	2,090	34.8	895	28,408	3.2
Michigan	9,437	1,580	16.7	1,282	6,918	0.5
Minnesota	4,480	810	18.1	606	55,721	9.2
Mississippi	2,614	([3])	0.0	378	0	0.0
Missouri	5,193	594	11.4	804	14,159	1.8
Montana	824	11	1.3	123	0	0.0
Nebraska	1,606	111	6.9	242	3,273	1.4
Nevada	1,327	149	11.2	161	22,933	14.2
New Hampshire	1,111	133	12.0	145	0	0.0
New Jersey	7,789	855	11.0	1,126	0	0.0
New Mexico	1,581	240	15.2	192	17,552	9.1
New York	18,119	3,293	18.2	2,556	71,092	2.8
North Carolina	6,843	407	5.9	944	0	0.0
North Dakota	636	3	0.5	101	0	0.0
Ohio	11,016	1,506	13.7	1,598	16,335	1.0
Oklahoma	3,212	173	5.4	466	8,383	1.8
Oregon	2,977	759	25.5	445	85,681	19.3
Pennsylvania	12,009	1,997	16.6	2,014	26,102	1.3
Rhode Island	1,005	101	10.0	163	11,719	7.2
South Carolina	3,603	90	2.5	468	0	0.0
South Dakota	711	0	0.0	113	0	0.0
Tennessee	5,024	204	4.1	722	0	0.0
Texas	17,656	1,388	7.9	1,923	41,817	2.2
Utah	1,813	287	15.8	171	0	0.0
Vermont	570	60	10.5	77	0	0.0
Virginia	6,377	323	5.1	760	300	0.0
Washington	5,136	818	15.9	645	57,322	8.9
West Virginia	1,812	74	4.1	317	0	0.0
Wisconsin	5,007	1,013	20.2	734	0	0.0
Wyoming	466	0	0.0	55	0	0.0

[1]Excludes Guam.
[2]Includes residence unknown.
[3]Less than 500.

SOURCES: U.S. Bureau of the Census; InterStudy Reports; Health Care Financing Administration: Data from the Office of Prepaid Health Care and the Bureau of Data Management and Strategy.

California had nearly 10 million persons enrolled in HMOs—nearly one-third of the State's population. New York ranked second in HMO enrollees with over 3 million persons—18 percent of the State's population.

Twenty-five States (including the District of Columbia) had no Medicare HMO enrollees. Ten States accounted for nearly 90 percent of all Medicare HMO enrollees, with California accounting for 40 percent and Florida accounting for 19 percent. Medicare HMO enrollees in 3 States represented about one-fifth of the State's total Medicare population: Arizona with 22 percent; Oregon with about 19 percent; and California, with about 20 percent.

Enrollment by HMO

In January 1993 there were 554 HMOs with 38.5 million enrollees. The 20 largest HMOs accounted for 13.6 million, or 35 percent, of total HMO enrollees (Table 5). Seven of the largest plans were in California, three of which had substantial numbers of Medicare enrollees, and three of the largest HMOs were in Massachusetts. Nine of the top 20 HMOs had no Medicare HMO enrollees. The four top ranking plans in 1993 were also the four top ranking plans in 1986.

Table 5

Enrollment in the 20 Largest Health Maintenance Organizations (HMOs), by All Persons and Medicare Enrollees: 1993

Name of HMO	Number of Enrollees Nationally	Percent Distribution	Medicare	
			HMO Enrollees	As Percent of HMO Enrollment
Total	[1]38,467,240	100.0	1,691,385	4.4
Top 20 Nationally	13,555,513	35.1	669,577	4.9
Kaiser Foundation Health Plan, Inc. Northern California Region	2,433,028	6.3	1,859	0.1
Kaiser Foundation Health Plan, Inc. Southern California Region	2,265,319	5.9	120,672	5.3
Health Insurance Plan of Greater New York	903,652	2.3	45,866	5.1
Health Net—California	870,033	2.3	8,786	1.0
PacifiCare, Inc.—California	741,082	1.9	209,607	28.3
HMO of Pennsylvania	607,914	1.6	0	0.0
Harvard Community Health Plan—Massachusetts	527,832	1.4	8,975	1.7
CaliforniaCare	470,223	1.2	0	0.0
Group Health Cooperative of Puget Sound—Washington	467,615	1.2	43,932	9.4
HealthPartners—Minnesota[2]	437,595	1.1	0	0.0
Blue Choice—New York	435,219	1.1	0	0.0
Family Health Plan, Inc.—California	427,058	1.1	192,940	45.2
HMO of New Jersey/U.S. Healthcare	415,341	1.1	0	0.0
Keystone Health Plan East—Pennsylvania	403,813	1.0	753	0.2
Health Alliance Plan of Michigan	381,054	1.0	2,836	0.7
Kaiser Foundation Health Plan of the Northwest—Oregon	377,844	1.0	33,351	8.8
HMO Illinois	371,851	1.0	0	0.0
HMO BLUE—Massachusetts	360,208	0.9	0	0.0
TakeCare Health Plan, Inc.—California	334,039	0.9	0	0.0
Bay State Health Care—Massachusetts	324,793	0.8	0	0.0

[1]Includes enrollees in Guam.
[2]Merger of Group Health and MedCenters.

SOURCES: Porter, M.J. and Hamer, R.L., 1993; Health Care Financing Administration: Data from the Office of Prepaid Health Care and the Bureau of Data Management and Strategy.

The 20 largest Medicare HMOs as of July 1993 are shown in Table 6. These HMOs had nearly 1.3 million enrollees, or 74.3 percent of total risk enrollees, with the top 5 HMOs accounting for nearly one-half of all Medicare HMO enrollment. Humana Medical Plan, Inc. of Florida (formerly International Medical Centers) had the largest number of Medicare enrollees with 212,231 (12.5 percent of the total), followed by Pacificare of California with 209,607 enrollees (12.4 percent), and Family Health Plan, Inc. of California with 192,940 enrollees (11.4 percent). Four of the top ranking plans are in California, with a combined enrollment of 567,416, or one-third of all Medicare HMO enrollees. Florida also had four of the top 20 plans: Humana Medical Plan, CAC-Ramsay, CareFlorida, and Health Options, with a combined enrollment of 283,886, or about 17 percent of Medicare enrollees.

Eleven Medicare HMOs that ranked among the top 20 in 1986 were not among the top 20 in 1993. Four of these plans no longer had risk contracts—Physicians Health Plan of Minnesota, Medcenters Health Plan-Minnesota, Inland Health Plan-California, and HMO-New Jersey—and one plan, International Medical Centers-Florida, was purchased by Humana Medical Plan, Inc.

One-half of Medicare HMOs are part of chain organizations; i.e., linked by common ownership or management. Table 7 shows the 5 HMO chains that had the most Medicare HMO enrollees. These 5 multi-State organizations operated under 27 different contracts and accounted for 65.2 percent of Medicare HMO enrollees

Table 6

Number of Medicare Health Maintenance Organization (HMO) Enrollees in the Top 20 Medicare HMOs: July 1993

Name of HMO	Medicare HMO Enrollees		Rank in 1986
	Number	Percent	
Total Medicare HMOs	1,691,385	100.0	
Top 20 Medicare HMOs	1,256,662	74.3	
Humana Medical Plan, Inc.—Florida[1]	212,231	12.5	1
Pacificare of California, Inc.	209,607	12.4	3
Family Health Plan, Inc.—California	192,940	11.4	2
Kaiser Foundation Health Plan, Inc.—California	120,672	7.1	—
Family Health Plan, Inc.—Arizona	78,870	4.7	17
HIP of Greater New York	45,866	2.7	—
Aetna Health Plan of Southern California	44,197	2.6	—
Group Health Cooperative of Puget Sound—Washington	43,932	2.6	—
Medica—Minnesota[2]	39,330	2.3	5
Kaiser Foundation Health Plan of the Northwest—Oregon	33,351	2.0	9
Share Health Plan of Illinois, Inc.	31,645	1.9	7
CAC-Ramsay, Inc.—Florida	28,764	1.7	6
Kaiser Foundation Health Plan of Colorado	25,961	1.5	—
Pacificare of Oregon II	22,994	1.4	—
Humana Health Plan, Inc.—Illinois	21,849	1.3	—
CareFlorida, Inc.	21,671	1.3	—
US Health Care Systems of Pennsylvania	21,289	1.3	—
Health Options, Inc.—Florida	21,220	1.3	—
Pacificare of Texas, Inc.	20,899	1.2	—
Fallon Community Health Plan, Inc.—Massachusetts	19,374	1.1	14

[1]Formerly International Medical Centers—Florida.
[2]Formerly Share Health Plan—Minnesota.

SOURCE: Health Care Financing Administration: Data from the Bureau of Data Management and Strategy.

in July 1993. Family Health Plan, operating in 4 States, had a total combined enrollment of 297,204, or 17.6 percent of Medicare HMO enrollees; Pacificare ranked second in combined enrollment of 262,014, or 15.5 percent, operating 5 plans in 4 States. Three of the largest five chains in 1993—United Health Care, Family Health Plan, and Pacificare, ranked first, second, and third, respectively, in risk enrollees in 1986.

Figure 1 shows the heavy concentration of HMO enrollees in a relatively small number of plans, both in total and among Medicare HMOs. Among the 543 HMO plans in July 1992, the top 10 percent accounted for more than one-half of all enrollees. About 50 percent of plans accounted for 90 percent of enrollees. Enrollment in the 98 Medicare plans was even more concentrated, with the top 10 percent accounting for about 60 percent of Medicare HMO enrollment. Fifty percent of Medicare HMO plans accounted for about 94 percent of enrollees.

HMO Characteristics

HMOs may use one or more organizational models to deliver services to enrollees. The types of models, the percent of plans, and the percent of enrollees are shown in Table 8, nationally and under Medicare risk contracts. IPAs continue to be the most predominant model among all HMOs. Under an IPA arrangement, an HMO contracts directly with physicians in solo or group practice. This model allows the enrollee whose physician contracts with an HMO to keep his or her physician in the HMO arrangement, a characteristic which perhaps contributes to the prevalence of this model. Total enrollment in IPAs represented about 36 percent of total HMO enrollment in July 1986 and about 40 percent in January 1993. Medicare enrollment under IPA models was about 42 percent of all Medicare HMO enrollment in December 1986 and 47 percent in July 1993.

Network models (those HMOs that contract predominately with two or more in-

Table 7

Number of Medicare Enrollees in the 5 Health Maintenance Organization Chains with the Most Medicare Enrollees: July 1993

Chain and State Location	Number of Plans	Number of Enrollees	Percent of Enrollees	Rank in 1986
Total TEFRA risk	98	1,691,385	100.0	—
Top 5 Risk Chains	27	1,103,165	65.2	—
Family Health Plan, Inc. (Arizona, California, New Mexico, Nevada)	4	297,204	17.6	2
Pacificare, Inc. (California, Oklahoma, Oregon, Texas)	5	262,014	15.5	3
Humana Health Plan, Inc. (Arizona, Florida, Kentucky, Texas)	5	242,235	14.3	—
Kaiser Foundation Health Plan (California, Colorado, Hawaii, Ohio, Oregon, Texas)	8	215,159	12.7	—
United Health Care, Inc. (Illinois, Minnesota, Missouri, Nebraska, Rhode Island)	5	86,553	5.1	1

NOTE: TEFRA is Tax Equity and Fiscal Responsibility Act of 1982.

SOURCE: Health Care Financing Administration: Data from the Bureau of Data Management and Strategy.

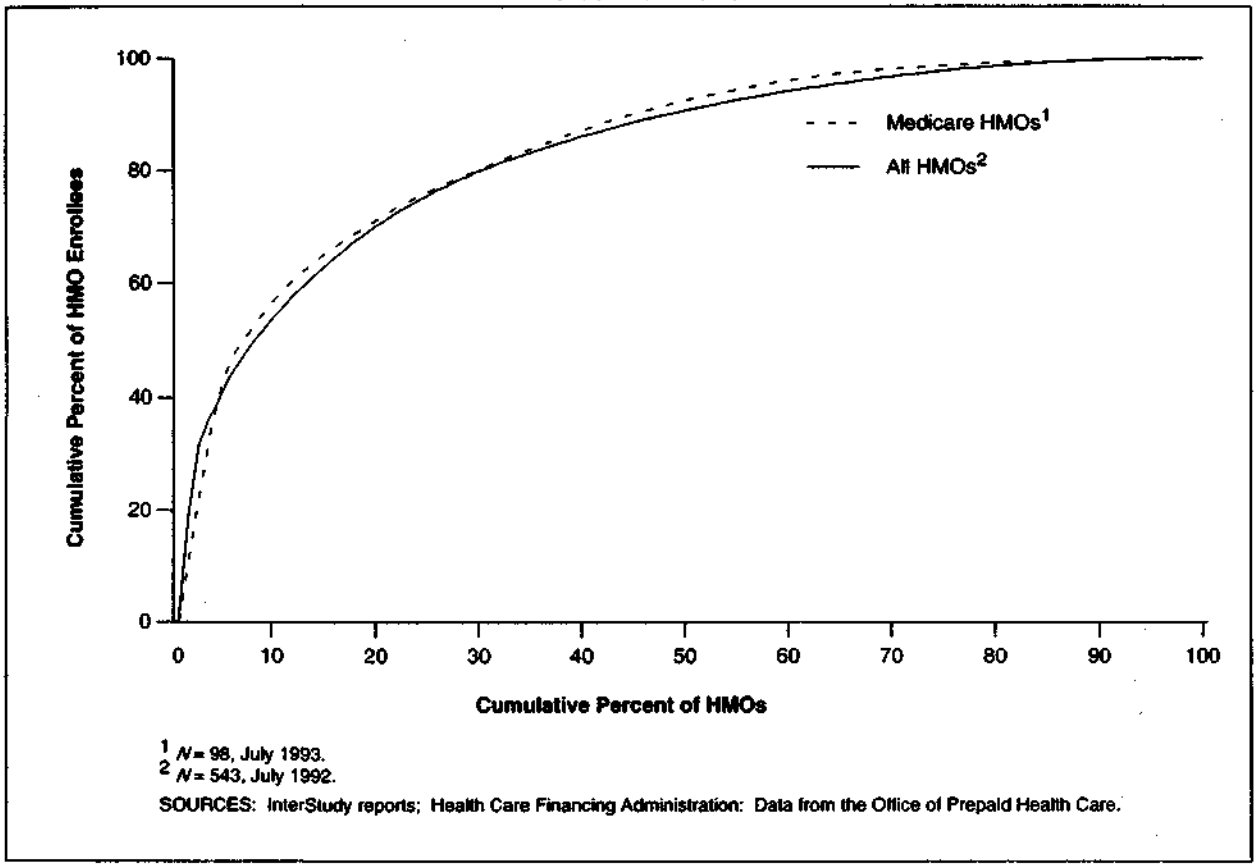
dependent practices) accounted for about 10 percent of HMOs nationwide, and mixed models (those HMOs using a combination of IPA, staff, group, or network models) for 13 percent in January 1993. The mixed models accounted for 20 percent of total enrollees and network models accounted for only 9 percent of enrollees. There were no network or mixed plans with Medicare participation in January 1993.

The proportion of group models nationwide (HMOs that contract predominately with one independent group practice) declined between 1986 and 1993 from about 15 percent to 10 percent of plans. The percentage of enrollees in group models also declined from 30 percent to 25 percent during that period. In comparison, the proportion of group models under Medicare contracts showed little change between 1986 and 1993, accounting for 22 to 21 percent of plans and 28 to 20 percent of enrollees.

Nationwide in January 1993, HMOs operating under staff models (those that deliver health services through a physician group that is controlled by the HMO) accounted for about 8 percent of plans, down from about 12 percent in 1986; enrollees under staff models were 6 percent of all HMO enrollees, down from 13 percent in 1986. Although the proportion of staff model plans under Medicare con-

Figure 1

Cumulative Percent of Health Maintenance Organization (HMO) Enrollees, by Cumulative Percent of Plans



[1] *N* = 98, July 1993.
[2] *N* = 543, July 1992.

SOURCES: InterStudy reports; Health Care Financing Administration: Data from the Office of Prepaid Health Care.

tracts declined slightly from 1986 to 1993 (16 versus 13 percent), the percent of enrollees increased considerably, rising from 13 percent in 1986 to 34 percent in 1993. Five of the 20 largest Medicare HMOs shown in Table 6, ranking numbers, 1, 3, 7, 12, and 15, were staff models. These 5 plans accounted for nearly one-third of all Medicare risk enrollees.

Table 8 also shows that nationwide, between 1986 and 1993, the proportion of for-profit plans increased from 59 percent to 67 percent; the proportion of enrollees in such plans rose from 38 percent to 50 percent during that period. The proportion of for-profit plans under Medicare HMO contracts also increased, rising from 42 percent in 1986 to 66 percent in 1993; the proportion of enrollees in Medicare for-profit plans increased from 47 percent in 1986 to 70 percent in 1993.

Extra Benefits Above Medicare

By law, all Medicare HMOs cover Medicare deductibles and coinsurance. However, the basic package of some HMOs may also cover some services above Medicare benefits. Most HMOs offered beneficiaries one or more services in addition to the benefits covered by Medicare, such as routine physical examinations, certain immunizations, eye and ear examinations, outpatient drugs, and dental services. Some services require a copayment amount for their basic package. For example, those HMOs that offer outpatient drugs may require a copayment for each drug prescription.

Table 8

Number of Health Maintenance Organizations (HMOs) and Medicare HMOs, by Type of Model and Profit Status: 1986 and 1993

Type of Model and Profit Status	Plans		Enrollees	
	1986	1993	1986	1993
National HMOs				
Total	595	554	[1]23,663,626	[1]38,467,240
		Percent Distribution		
IPA	58.0	60.3	35.7	39.8
Group	14.5	10.1	30.1	25.1
Staff	11.9	7.6	13.3	5.7
Network	15.6	9.6	20.9	9.3
Mixed	0.0	12.5	0.0	20.0
For-Profit	58.5	67.0	38.2	50.1
Non-Profit	39.8	33.0	61.5	49.9
Medicare HMOs				
Total	149	[2]98	813,712	[2]1,691,385
		Percent Distribution		
IPA	56.4	65.3	42.3	46.7
Group	22.1	21.4	27.5	19.8
Staff	16.1	13.3	13.3	33.5
Network	5.4	0.0	16.9	0.0
Mixed	0.0	0.0	0.0	0.0
For-Profit	42.3	66.3	47.2	69.7
Non-Profit	57.7	33.7	52.8	30.3

[1]Includes enrollees in Guam.
[2]July 1993.

NOTE: IPA is independent practice association.

SOURCES: InterStudy reports; Health Care Financing Administration: Data from the Office of Prepaid Health Care.

Table 9 shows that in 1986 extended hospital days (i.e., days beyond the first 90 days of a benefit period) were offered by 80 percent of Medicare HMOs. In addition, more than one-third of the plans offered extended skilled nursing facility (SNF) days and extended mental health coverage. In July 1993 none of the HMOs offered extended mental health coverage. Similar data on extended hospital days and extended SNF days have not been available since December 1988, just before the implementation of the Medicare Catastrophic Coverage Act (MCCA) of 1988. In December 1988, 94 percent of HMOs offered unlimited hospital days and 24 percent offered extended SNF days. With the implementation of MCCA, which provided for unlimited hospital days and broadened the SNF benefit by removing the 3-day prior hospitalization requirement and reducing the number of SNF days requiring coinsurance payments, HMOs dropped these two benefits from their extra benefits package. Although complete data are currently not available, it is known that some plans are again offering these two benefits in their extra benefits package.

More than 80 percent of Medicare-participating HMOs offered preventive care in 1986, although the types of preventive services were not identified. In 1993 the overall total for the preventive category was not provided; however, two preventive care measures were offered by a large proportion of plans: routine physical examinations were offered by 97 percent of plans and immunizations were offered by 90 percent of plans. In addition, health education was also offered by more than one-third of the plans.

Premium Charges

Since 1986, the range in the average premium charge under Medicare HMOs widened considerably, from a high of $49.99 in 1986 to a high of $80.00 or more per month in 1993 (Table 10). (The widened range in premium charges is due, in part, to inflation in the costs of medical

Table 9

Number and Percent of Medicare Health Maintenance Organizations (HMOs) Providing Benefits in Addition to Basic Medicare, by Type of Benefit: 1986 and 1993

Type of Benefit	1986		1993	
	Number of HMOs	Percent	Number of HMOs	Percent
Total	[1]149	100.0	98	100.0
Extended Hospital Days	120	80.5	NA	NA
Extended SNF Days	56	37.6	NA	NA
Preventive Care	123	82.6	NA	NA
Routine Physicals	NA	NA	95	96.9
Immunizations	NA	NA	88	89.8
Health Education	NA	NA	34	34.7
Outpatient Drugs	105	70.5	30	30.6
Eye Care (Examinations)	103	69.1	83	84.7
Lenses	NA	NA	5	5.1
Ear Care (Examinations)	55	36.9	65	66.3
Hearing Aids	NA	NA	1	1.0
Dental Care	23	15.4	25	25.5
Foot Care	NA	NA	23	23.5
Extended Mental Health	52	34.9	0	0.0

[1]Number of plans in December 1986.

NOTES: NA is not available. SNF is skilled nursing facility.

SOURCE: Health Care Financing Administration: Data from the Office of Prepaid Health Care.

care during that period. The consumer price index increased more than 50 percent from 1986 to 1992, the latest available data.) The premium charge covers Medicare cost-sharing and any additional services offered by the HMO. Fifteen percent of plans required no premium payment in 1986 compared with 26 percent in 1993. The average basic premium was $38.45 and the highest basic premium was $104.00 in 1993. In 1986, the premiums for 90 percent of the plans were under $40; in 1993, only one-half of the plans had premiums under $40 per month.

DISCUSSION

The number of Medicare beneficiaries participating in the risk program has continued to show moderate growth, to the point where 1 in 20 beneficiaries are in a risk HMO. Following a high growth rate in the early years of the program, rates of enrollment growth in Medicare moderated but were still higher than rates of enrollment growth in all HMOs.

Brown et al. (1993), in an evaluation of the Medicare risk program, note that HMOs would enhance their profitability if their Medicare enrollment were increased: Greater enrollment of Medicare beneficiaries, first of all "would help HMOs reduce their costs per member month by spreading the large fixed portion of administrative costs over more members" and secondly, more Medicare members would "reduce the risk that a few seriously ill members would create overall losses for a risk plan." These authors also suggest that HMO enrollment would be more attractive to Medicare beneficiaries, including those in poor health: if more area physicians were affiliated with a Medicare risk plan; and if more employers offer option of Medicare HMO to their retirees. Consideration of these suggestions could impact on future Medicare HMO growth.

Medicare HMO enrollment continues to be heavily concentrated in a few large plans, which also results in heavy concentrations geographically. The three top plans located in two States (California and Florida) accounted for more than one-third of Medicare HMO enrollees. In addition, Medicare enrollees are heavily concentrated in a few large chain organizations. This is unique to HMOs in Medicare, for no other Medicare providers, such as hospitals, have such a large market share. These concentrations of enrollees by plan, ownership, and location may effect expansion of HMO enrollment in

Table 10

Number and Percent of Medicare Health Maintenance Organizations, by Amount of Monthly Premium: January 1986 and July 1993

	1986		1993	
Amount of Premium	Number of Plans	Cumulative Percent	Number of Plans	Cumulative Percent
Total	105	—	98	—
$0	16	15.2	25	25.5
$.01-$19.99	28	41.9	6	31.6
$20.00-$39.99	51	90.5	18	50.0
$40.00-$49.99	10	100.0	9	59.2
$50.00-$59.99	0	100.0	14	73.5
$60.00-$69.99	0	100.0	10	83.7
$70.00-$79.99	0	100.0	9	92.9
$80.00 or More	0	100.0	7	100.0

SOURCE: Health Care Financing Administration: Data from the Office of Prepaid Health Care.

these areas by discouraging entry of potential new plans that may find it difficult to compete with the large plans.

All Medicare HMOs offered at least one extra benefit and more than one-fourth of the plans had no premium charge. There was, however, a shifting in the types of extra benefits offered in 1986 compared to those offered in 1993. The proportion of plans offering outpatient drugs is considerably less in 1993 than in 1986 (32 percent versus 70 percent), suggesting that plans may have perceived that this benefit contributed to reduced profitability and unfavorable selection.

Among the 20 largest Medicare HMOs, all but one offered routine physical examinations and all but two offered additional immunizations and eye care, while about one-half offered outpatient drugs. Extra benefits such as these, often paid for out-of-pocket in fee-for-service, provide incentives for beneficiaries to enroll in HMOs.

A final point on Medicare HMO enrollment is that one-half of the States have no Medicare HMO enrollment and about one-fifth of the States have fewer than 15,000 Medicare HMO enrollees. In all but three States with no Medicare HMO enrollees, there was some private sector HMO enrollment, indicating the potential for HMOs there to expand to Medicare. Providers of health care need to be encouraged to participate in the Medicare TEFRA risk program to achieve greater enrollment of Medicare beneficiaries.

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