Memorandum

Date DEC 16 1999

From June Gibbs Brown
Inspector General

Subject Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates (A-05-99-00025)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates." The objective of our review was to determine the effect of using the 1997 standardized county rates[1] as the basis for calculating Medicare payments to managed care organizations (MCO).

The Balanced Budget Act (BBA) of 1997 established the Medicare+Choice (M+C) Program. Under this legislation, the Health Care Financing Administration (HCFA) was directed to use 1997 standardized county rates as the basis for all future capitation payments to MCOs. Information provided by HCFA showed that the 1997 standardized county rates were based on actuarial estimates and, when compared with actual costs incurred, were overstated by 4.2 percent. Because the BBA established the 1997 standardized county rates as the base year amounts for the M+C Program, all future managed care payments will include a 4.2 percent overstatement.

Applying the overstatement percent of 4.2 percent to Congressional Budget Office projections of future Medicare payments to MCOs, we estimate that the inflated payment rates will result in Medicare overpayments totaling $11.3 billion over the next 5 years and $34.3 billion over the next 10 years. We recommended that HCFA seek legislation to correct the overstated base year rates, or at a minimum, use this information to suppress or eliminate any future increases in managed care capitation rates until this wide discrepancy is corrected.

We made a similar recommendation in a September 1998 audit report entitled, "Capitation Rates For Medicare Managed Care Plans Are Inflated Due To Improper Payments Included in Rate Calculations" (CIN A-14-97-00206). We reported that MCO capitation rates were overstated because improper Medicare FFS payments were included in the rate calculations. Audits of HCFA's financial statements found that the Medicare FFS program incorrectly

[1]Standardized county rates essentially represent HCFA's estimate of anticipated Medicare expenditures for an average beneficiary in a specific geographic county in the nation, modified by various actuarial adjustments.

paid providers $23.2 billion[2], or 14 percent of total expenditures, in Fiscal Year (FY) 1996 and $20.3 billion[3], or 11 percent of total expenditures, in FY 1997. The payment errors identified in the financial statement audits related mostly to instances of incorrect documentation, lack of medical necessity, incorrect coding, and noncovered or unallowable services.

The results of the audit noted in the preceding paragraph and the analysis contained in this report provide policy makers with compelling information that managed care companies are financially benefitting from the present process used to calculate the Medicare monthly capitation payments. The results from these two audits are mutually exclusive. Therefore, if a given year such as 2002 is viewed in light of these two audit results, one must conclude that the Medicare program may be needlessly paying as much as $5.38 billion too much in 2002 for Medicare managed care services.

In a written response to our draft report, officials from HCFA stated that the President's Medicare reform package included a proposal to change the methodology used to set payment rates for MCOs. Because this new methodology will not use the overstated base year rates enacted under the BBA of 1997, HCFA officials believe the legislation we have recommended, correcting the base year rates, is unnecessary. The Medicare reform legislation discussed in HCFA's response, though promising, has not yet been passed. Current legislation continues the payment methodology with an increase in payments as well as a delay in any competitive bidding demonstration projects. As a result, we continue to recommend that HCFA seek legislation to correct the overstated payment rates. We have also modified the final report to reflect HCFA's technical comments. The full text of HCFA's response is included with this report as Appendix A.

Please advise us within 60 days on the status of any further action taken or planned on our recommendations. If you have any questions or need clarification on the report, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-05-99-00025 in all correspondence relating to this report.

Attachments

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[2]The estimated range of the improper payments at the 95 percent confidence level is $17.8 billion to $28.6 billion, or about 11 percent to 17 percent.

[3]The estimated range of the improper payments at the 95 percent confidence level is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OVERPAYMENTS TO MANAGED CARE ORGANIZATIONS DUE TO OVERSTATED CAPITATION RATES

JUNE GIBBS BROWN
Inspector General

DECEMBER 1999
A-05-99-00025

Memorandum

Date DEC 16 1999

From June Gibbs Brown
Inspector General

Subject Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates (A-05-99-00025)

To Nancy-Ann Min DeParle
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This final report provides the results of our audit entitled, "Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates." The objective of our review was to determine the effect of using the 1997 standardized county rates[1] as the basis for calculating Medicare payments to managed care organizations (MCO).

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Applying the overstatement percent of 4.2 percent to Congressional Budget Office (CBO) projections of future Medicare payments to MCOs, we estimate that the inflated payment rates will result in Medicare overpayments totaling $11.3 billion over the next 5 years and $34.3 billion over the next 10 years. We recommended that HCFA seek legislation to correct the overstated base year rates, or at a minimum, use this information to suppress or eliminate any future increases in managed care capitation rates until this wide discrepancy is corrected.

In a written response to our draft report, officials from HCFA stated that the President's Medicare reform package included a proposal to change the methodology used to set payment rates for MCOs. Because this new methodology will not use the overstated base year rates enacted under the BBA of 1997, HCFA officials believe the legislation we have recommended, correcting the base year rates, is unnecessary. The Medicare reform legislation discussed in HCFA's response, though promising, has not yet been passed.

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[1]Standardized county rates essentially represent HCFA's estimate of anticipated Medicare expenditures for an average beneficiary in a specific geographic county in the nation, modified by various actuarial adjustments.

Current legislation continues the payment methodology with an increase in payments as well as a delay in any competitive bidding demonstration projects. As a result, we continue to recommend that HCFA seek legislation to correct the overstated payment rates. We have also modified the final report to reflect HCFA's technical comments. The full text of HCFA's response is included with this report as Appendix A.

INTRODUCTION

BACKGROUND

The BBA of 1997, Public Law 105-33, added sections 1851-1859 to the Social Security Act, establishing the M+C Program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The managed care options available to beneficiaries under the program include coordinated care plans like health maintenance organizations, medical savings account plans, and private fee-for-service (FFS) plans.

Under the managed care option, the Medicare program pays predetermined monthly per capita payments to MCOs that contract with HCFA. Prior to BBA of 1997, most MCOs contracted with HCFA on a risk basis to provide the full range of Medicare services. The payments to MCOs that contracted with HCFA on a risk basis were established on a county by county basis. The reimbursement rates for risk MCOs were set at 95 percent of the average cost of treating the beneficiary in Medicare's FFS program.

The BBA of 1997 revised the payment calculation methodology for MCOs effective January 1998. The BBA required that the 1997 standardized county rates for risk-based organizations be used as the basis for future capitation payments to MCOs. The 1997 rates were calculated in 1996 from actuarial estimates of per capita FFS costs in each county.

The process used to calculate standardized county rates began with HCFA projecting Medicare's national average per capita costs for the future year (1997). The national costs were, through an adjustment process, converted into the standardized county rates. The steps included adjusting the national per capita rate for county cost levels, removing managed care costs, and adjusting the rate for the demographic average of the beneficiary population in the county.

The BBA does not allow any adjustments to the 1997 base, other than a reduction for a small portion of the rates applicable to medical education expenses. The 1997 rates are updated each year by the national average per capita increase in Medicare expenditures minus a percentage specified in the law. The resulting capitation rate is the basis for Medicare payments to MCOs.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The objective was to determine the effect of using the 1997 standardized county rates as the basis for calculating Medicare payments to

MCOs. Our field work was conducted from January through March 1999, at HCFA offices located in Baltimore, Maryland and at our office in Columbus, Ohio.

We reviewed the new payment process implemented by the BBA of 1997 for Medicare managed care providers through discussions with HCFA officials and review of the applicable laws and regulations. To calculate the effect of using the 1997 standardized county rates as the basis for payments to MCOs, we used data provided by HCFA's Office of the Actuary and information available from the CBO.

The 1997 standardized county rates were calculated by HCFA in 1996 based on estimates of Medicare's national average per capita costs for 1997. To accomplish our objective, we obtained HCFA's most current determination of the overstatement made when estimating 1997 national per capita costs. We then applied the percentage to the amount of expected future payments to MCOs, as calculated by the CBO, to estimate the amount of overpayments that will occur over a 10 year period. This limited scope review did not entail audit steps to validate the accuracy of the data supplied by HCFA. The source of the data, however, is used consistently by HCFA in interacting with various Government agencies and the managed care industry in determining medical financial effects of policy changes.

RESULTS OF AUDIT

OVERSTATED CAPITATION RATES

Information provided to us by HCFA shows that the 1997 standardized county rates were overstated by 4.2 percent. We estimate that the inflated payment rates will result in Medicare overpayments to MCOs totaling $11.3 billion over the next 5 years and $34.3 billion over the next 10 years.

The BBA of 1997 directed HCFA to use the 1997 standardized county rates as the basis for all future capitation payments to MCOs. The standardized county rates for 1997 were calculated in 1996 based on ***estimates*** of Medicare's national average per capita costs for the next year. Each year HCFA updates the past cost estimates using more accurate data. Based on updated information at the time, officials from HCFA, testifying before Congress in 1998, stated that the national cost estimates used in the calculation of the 1997 county rates were overstated by three percent. The testimony before the House Subcommittee on Health, Committee on Commerce on Medicare+Choice Implementation stated in part:

> *"The BBA also did not allow us to adjust 1998 rates for errors in projections upon which 1997 plan rates were based. Since the 1997 rates were overstated by nearly 3 percent, the base for all future M+C rates will be permanently overstated by 3 percent. The Congressional Budget Office says that, because of this, Medicare will overpay plans about $8.7 billion over the next five years,*

> *and $31 billion over the next 10 years. Given such extensive evidence of overpayment, there can be no doubt that what we are paying plans is adequate."*

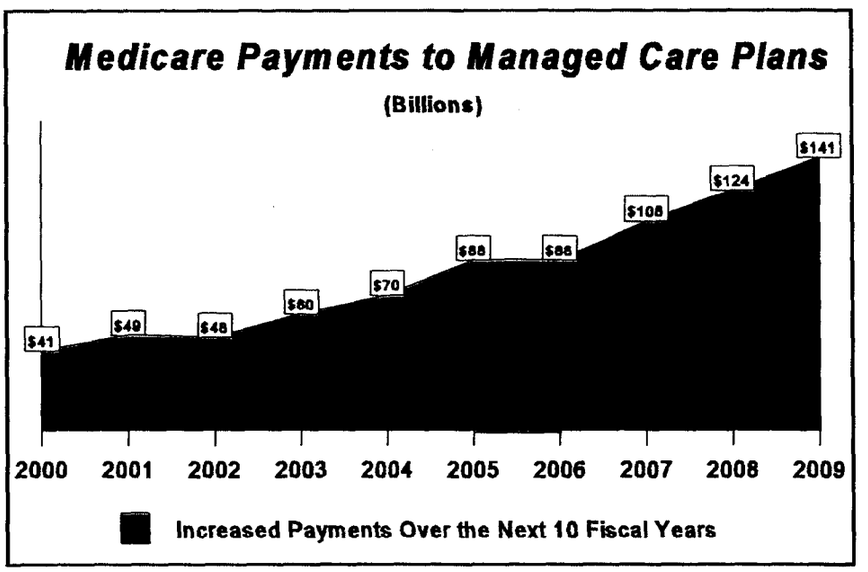
Updated information provided to us by HCFA, as part of this audit, shows that the overstatement is actually 4.2 percent--40 percent greater than discussed as a part of the previous Congressional testimony. Because the BBA established the 1997 standardized county rates as the base year amounts for the M+C Program, all future managed care capitation rates will include the 4.2 percent overstatement.

The 1997 standardized county rates were calculated using an estimate of the monthly average per capita costs. The following chart shows a comparison of the costs initially estimated for aged beneficiaries, with the costs as recalculated for 1999 and 2000.

MEDICARE MONTHLY AVERAGE PER CAPITA COSTS FOR 1997					
	Initial Estimate	1999 Revision	Percent Overstated	2000 Revision	Percent Overstated
Part A	$297.81	$292.09		$292.23	
Part B	169.14	161.12		155.81	
Total	$466.95	$453.21	3.0	$448.04	4.2

Projections by the CBO indicate that enrollment in Medicare managed care will grow steadily over the next 10 years. In the year 2000, the CBO anticipates that 17 percent of Medicare beneficiaries will be enrolled in managed care plans, and by the year 2009, the percentage will reach 31 percent.

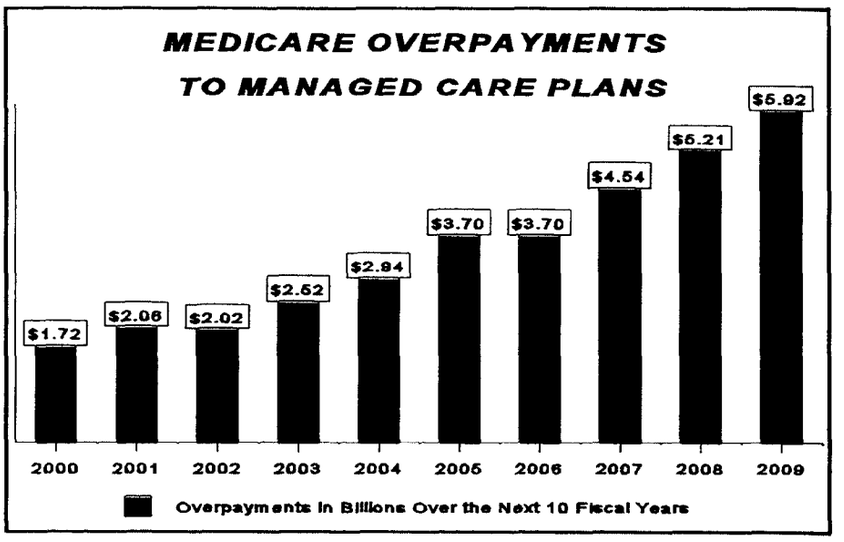
The increased enrollment projected by the CBO over the next 10 years will cause payments to MCOs to grow substantially. The CBO estimates that in the period from 2000 to 2004, payments will increase from $41 billion to $70 billion. Five years later in 2009, the CBO projects that Medicare payments to MCOs will reach $141 billion.



Using the CBO data, we calculated the effect of the overstated capitation rates on Medicare payments to managed care plans. We estimate that the inflated payment rates will result in Medicare overpayments totaling $11.3 billion over 5 years and $34.3 billion over the next 10 years. This is considerably greater than the estimated overpayments of $8.7 billion (over 5 years) and $31 billion (over 10 years) presented in the 1998 Congressional testimony.

The following chart shows how the estimated Medicare overpayments, resulting from the 4.2 percent rate variance, will increase as enrollment in managed care grows over the next 10 years[2]. The overpayment each year is mutually exclusive of the previous year(s).

[2]In our draft audit report we projected Medicare overpayments for the period 1999 through 2008. Per HCFA's response to our draft report, we have updated our audit results using more recent CBO estimates of future Medicare expenditures, and are now projecting overpayments for the period 2000 through 2009.



OTHER PERSPECTIVES

MCO INDUSTRY: Over recent months, various organizations representing managed care providers have made public statements to the effect that the BBA of 1997 has gone too far in limiting the growth of Medicare capitation rates. The industry representatives claim that because the BBA legislation has decreased the profitability of MCOs, some providers have been forced to leave the Medicare program.

PREVIOUS OIG REVIEWS: Contrary to this position, audits completed by the Office of Inspector General (OIG) have concluded that managed care payment rates are overstated or improperly inflated. In a September 1998 audit report (CIN A-14-97-00206), we reported that Medicare capitation rates for managed care providers were inflated because improper Medicare FFS payments were included in the rate calculations. Audits of HCFA's financial statements found that the Medicare FFS program improperly paid providers $23.2 billion[3], or 14 percent of total expenditures, in Fiscal Year (FY) 1996 and $20.3 billion[4], or 11 percent of total expenditures, in FY 1997. The payment errors identified in the financial statement audits related mostly to instances of incorrect documentation, lack of medical necessity, incorrect coding, and noncovered or unallowable services.

[3]The estimated range of the improper payments at the 95 percent confidence level is $17.8 billion to $28.6 billion, or about 11 percent to 17 percent.

[4]The estimated range of the improper payments at the 95 percent confidence level is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent.

Because the BBA of 1997 based managed care payment rates on historical FFS data, we concluded that all future managed care rates would be overstated. Based on the lowest point of the estimation range (seven percent), the Medicare program could save $3.4 billion in the year 2002 and $7.6 billion in 2007 if the unallowable FFS payments were removed from the calculation of payment rates for managed care providers. We recommended that HCFA seek legislation to adjust the 1997 base year HMO rates for payment errors. While HCFA agreed that Medicare payments to MCOs have been overstated and that they should be reduced, they did not agree to seek legislation as we recommended.

The results of the audit noted in the preceding paragraphs and the analysis contained in this report provide policy makers with compelling information that managed care companies are financially benefitting from the present process used to calculate the Medicare monthly capitation payments. The results from these two audits are mutually exclusive. Therefore, if a given year such as 2002 is viewed in light of these two audit results, one must conclude that the Medicare program may be needlessly paying as much as $5.38 billion too much in 2002 for Medicare managed care services.

YEAR 2002 OVERPAYMENTS (in billions)

Total Estimated Medicare Payment to MCOs (from page 4):	$48
Error Rate From CFO Report (1997):	x 7%
	3.36
MCO Overpayment Amount (as shown on page 5):	+ 2.02
Total Overpayments:	$5.38

NEW INITIATIVES: The findings contained in this report and in the above cited prior review do not include a study of individual providers' management competence nor do they address the reasonableness of providers' expectations or definition of a reasonable profit. One of the provisions of the BBA provided for a competitive pricing demonstration allowing MCOs to bid on contracts to provide healthcare services to Medicare beneficiaries in a given area. Pilot projects were to begin January 2001 in two urban areas but current legislation has delayed their implementation. However, we believe these pilots are a positive step which will provide HCFA with new data regarding marketplace prices based on negotiation; this type information may better enable evaluation of whether the current system enables Medicare to provide services at the best possible price.

CONCLUSION AND RECOMMENDATIONS

Our reviews of the MCO payment rates established under BBA of 1997 indicate that the base year 1997 standardized county rates are overstated. In our earlier audit (CIN A-14-97-00206), we found that FFS payment errors were included in the base rate calculations. In our current review, we have presented HCFA data showing that the 1997 standardized county rates were overstated 4.2 percent due to an over estimate in 1996, of 1997

Medicare expenditures. Because the BBA established the 1997 standardized county rates as the base year amounts for the M+C Program, all future managed care payments will include the 4.2 percent overstatement.

We recommended that HCFA seek legislation to correct the overstated payment rates which we estimate, if not adjusted, will cost the Medicare program an additional $11.3 billion over the next 5 years, and $34.3 billion over the next 10 years. At a minimum, we recommended that HCFA use this information to suppress or eliminate any future increases in managed care capitation rates until this wide discrepancy is corrected.

HCFA'S COMMENTS

The HCFA does not concur with our recommendation that legislation is needed to correct the overstated M+C payment rates. In a written response to our draft report, officials from HCFA stated that the President's Medicare reform package includes a proposal to change the methodology used to set payment rates for MCOs. Because this new methodology will not use the overstated base year rates enacted under the BBA of 1997, HCFA officials believe the legislation we have recommended, correcting the base year rates, is unnecessary. For this same reason, HCFA officials do not agree with our secondary recommendation, that future rate increases be halted until the 4.2 percent overage is offset.

In addition to responding to our recommendations, HCFA staff also provided a number of technical comments concerning specific language and figures in our report. The most important of these comments involve our use of HCFA's actuarial estimates of 1997 per capita Medicare costs, and the CBO projections of future Medicare spending. The comments from HCFA staff indicated that when calculating future Medicare overpayments, we should have used HCFA's estimate of 1997 per capita cost for aged beneficiaries, rather than the combined per capita cost estimate for aged and disabled beneficiaries. The HCFA comments also stated that CBO estimates of future Medicare spending for managed care, more recent than those used in our calculations, were available. The full text of HCFA's response is included with this report as Appendix A.

OIG RESPONSE

We are encouraged that HCFA is endorsing changes to the MCO payment system that will eliminate the overstated base year rates enacted under the BBA of 1997. We estimate that the overstated rates, if left in place, will cost the Medicare program $11.3 billion over the next 5 years, and $34.3 billion over the next 10 years. Given these estimated overpayments, we believe it is important that legislation adjusting the MCO payment rates be pursued aggressively. The overstated rates have cost the Medicare program billions of dollars over the past 2 years, and unless changes are made quickly, another $4 billion will be lost over the next 2 years. Because the Medicare reform legislation discussed in HCFA's response has not yet been passed, we continue to recommend that HCFA seek legislation to correct the overstated payment rates.

The technical comments provided in HCFA's response, concerning specific language and figures in our report were reviewed, and found to be reasonable. The comments from HCFA staff indicated that when calculating future Medicare overpayments, we should have used HCFA's estimate of 1997 per capita cost for aged beneficiaries, rather than the combined per capita cost estimate for aged and disabled beneficiaries. The HCFA Office of the Actuary was contacted to determine the basis for this comment. The actuary explained that the number of disabled beneficiaries enrolled in Medicare's managed care plans is disproportionately low compared to the FFS population. As a result, our estimates of future Medicare overpayments would be more accurate if the per capita cost for aged beneficiaries was used in our calculations. We have adjusted our calculations accordingly.

Officials from HCFA also suggested that we update our estimates of Medicare overpayments using the most recent CBO projections of future Medicare spending for managed care. We agree that the most recent CBO projections should be used in our report. Other minor comments included in the response were also concluded to be reasonable, and our final report was revised to reflect HCFA's suggested changes. We appreciate the input provided by HCFA officials in this matter.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 12 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates," (A-05-99-00025)

We share the concerns expressed in the above-referenced report and appreciate the opportunity to comment on the issues raised. Seniors and Americans with disabilities deserve a strong Medicare program. We are committed to making sure they have quality health care, whether they choose managed care or traditional fee-for-service.

The OIG findings are timely since some managed care companies assert that they are not paid enough to treat Medicare beneficiaries. As a result, they claim they are being forced to leave the program. These findings underscore why the country needs President Clinton's plan to strengthen and modernize Medicare, including the way that Medicare pays managed care plans. Unlike today's system of flat payments based on a standard formula, all managed care plans would be paid their full price through a combination of government and beneficiary payments.

In this report, the OIG's objective was to determine the effect of using the 1997 standardized county rates, as specified by the Balanced Budget Act of 1997 (BBA), on the calculation of Medicare payments to managed care organizations. The OIG found that the 1997 Medicare+Choice (M+C) payment rates are overstated by 4.3 percent and will result in excessive Medicare payments to managed health care organizations. The report reiterates an earlier report finding that the rate is inflated because improper Medicare fee-for-service payments were included in the rate calculation.

Although the BBA did not provide authority to reduce capitation rates for any overprojection, it did reduce payment rates by a total of 2.8 percent over a 5-year period. Both the overprojection in the 1997 base, now estimated to be 4.2 percent, and the 2.8 percent reduction in M+C capitation rates in the BBA are incorporated in the Administration's proposal to set the benchmark amount at 96 percent of the projected cost for fee-for-service benefits in the plan's service area. However, it is

important to note that plans have incentives to bid below the benchmark. The benchmark establishes the maximum Medicare payment.

We disagree with the OIG report that the 1997 base rate should be adjusted because of the OIG's previous finding of errors in fee-for-service payments. The base rates are based on 95 percent of fee-for-service spending. The five percent discount was a recognition that managed care can reduce spending through utilization review and other techniques which help reduce overutilization as well as excess spending as a result of incorrect coding and other sources of errors.

The OIG report recommends that the Health Care Financing Administration (HCFA) seek legislation to correct the overstated payment rates and/or at a minimum, HCFA should use this information to suppress or eliminate any future increases in managed care capitation rates until the wide discrepancy is corrected.

We do not agree with the recommendation to pursue legislation. Under the President's Medicare reform package, the current administered pricing system would no longer be used to determine plan payments. The proposed changes in how payment levels are determined would base plan payments on bids submitted by the plans. It would provide incentives for beneficiaries to choose plans that bid below a Medicare "benchmark" amount. The lower the plan bid, the greater the savings (in the form of a reduced Part B premium) or reduced cost-sharing the enrollee would receive. Since the Medicare payment as well as beneficiary costs or savings would be tied to a plan's bid, it is expected that competition between plans should bring Medicare payments down. The report recommendation that the Administration propose a modification to the current payment system is, therefore, not consistent with the current set of legislative proposals submitted by the Administration to the Congress.

Technical Comments

The second paragraph on page 2 would have been appropriate in 1998, but now that, as directed in the BBA, section 1876 risk-contracting managed care organizations have been converted to Medicare+Choice contracts, it seems out-of-date.

The report mentions receiving information from HCFA on the capitation rates. However, we note that the figures in the chart on page 4 of the report do not agree with our estimates. We have provided the Actuary's estimates in an attached chart.

Pages 4 and 5 of the report refers to Congressional Budget Office (CBO) projections of managed care enrollment and Medicare payments to managed care plans. In recent testimony (June 9, 1999 - Senate Finance Committee) the CBO indicated that its current projection for 2002 is 18.7 percent of beneficiaries enrolled in managed care plans; the figure for 2008 is 29.3 percent. These figures (and presumably the corresponding Medicare outlays) are lower than those in the draft report.

On page 6, in the last section, the report indicates that the demonstrations of competitive pricing "will begin shortly in two urban areas." Since the OIG draft report was written, the Competitive Pricing Advisory Committee has voted to allow the demonstrations to begin in January of 2001.

On page 7 use of the term "found" implies that HCFA did not know about the overstatement of the 1997 base and instead that this overstatement was discovered by the OIG. This is not correct. Additionally use of the term "errors" implies that the actuaries made a mistake rather than the overpayments being the result of inevitable differences between projected spending and actual spending. We ask that these references be corrected.

Attachment

Attachment

county rates as the base year amounts for the M+C Program, all future managed care capitation rates will include the 4.3 percent overstatement.

The 1997 standardized county rates were calculated using an estimate of the monthly average per capita costs. The chart below shows a comparison of the costs initially estimated with the costs as recalculated in 1998 and 1999.

MEDICARE MONTHLY AVERAGE PER CAPITA COSTS FOR 1997						2000 REVISION
	Initial Estimate	1998 Revision	Percent Overstated	1999 Revision	Percent Overstated	
Part A	~~297.81~~ $292.02	~~297.06~~ $285.95		~~292.09~~ $284.51		292.23
Part B	~~169.14~~ 166.82	~~159.39~~ 159.12		~~161.12~~ 155.50		155.81
Total	~~466.95~~ $458.84	~~456.45~~ $445.07	~~2.3~~ ~~3.1~~	~~453.21~~ $440.01	~~3.1~~ ~~4.3~~	448.04 4.2

Projections by the CBO indicate that enrollment in Medicare managed care will grow steadily over the next 10 years. In the year 2002, the CBO anticipates that 25 percent of Medicare beneficiaries will be enrolled in managed care plans, and by the year 2008, the percentage will reach 38 percent.

The increased enrollment projected by the CBO over the next 10 years will cause payments to MCOs to grow substantially. The CBO estimates that in the 5 years from 1999 to 2003, payments will increase from $38 billion to $83 billion. Five years later in 2008, the CBO projects that Medicare payments to MCOs will reach $166 billion.