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Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage

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MPR, one of the nation's leading independent research firms, conducts policy research and surveys for federal and state governments as well as foundations and other clients in the private sector. The employee-owned firm, with offices in Princeton, N.J., Washington, D.C., and Cambridge, Mass., has conducted some of the most important studies of health care, education, welfare, employment, nutrition, and early childhood policies and programs in the United States. MPR strives to improve public well-being by bringing the highest standards of quality, objectivity, and excellence to bear on the provision of information collection and analysis to its clients.

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OVERVIEW

With the support of The Robert Wood Johnson Foundation and others, Mathematica Policy Research, Inc. (MPR) monitored the Medicare+Choice (M+C) program since its inception with the passage of the Balanced Budget Act (BBA) of 1997. Under the Medicare Modernization Act (MMA) of 2003, M+C became Medicare Advantage (MA), and Congress embarked on a series of changes to create a larger role for competition and private plans as Medicare is expanded to cover drugs. MPR continues to monitor the MA program.

This report summarizes key findings of our experience monitoring M+C, from its beginning through December 2003. While individual findings have been released and widely cited, this report synthesizes the major findings for policymakers and researchers. It also discusses operational policy implications for the program's successor, Medicare Advantage.

The findings document the transition of M+C from a program that sponsors hoped would substantially expand the role of private plans in Medicare to one that, instead, is widely viewed as a failure, with plans leaving the program and fewer, less attractive choices for beneficiaries. The findings illustrate the challenges that programs like M+C face in encouraging beneficiaries to consider plan choices when many do not find such choice salient, when basic understanding of Medicare often is lacking, and when beneficiary characteristics complicate beneficiary education and choice. The findings also highlight key features of the plan and provider environment that constrain the effective reach of congressional policy and create challenges in seeking effective choice across diverse areas of the country.

It is unclear whether Congress will succeed where it has failed before in pursing the changes in private plan participation called for under the MMA. However, history suggests that failure is inevitable unless (1) Medicare is viewed as a reliable business partner; (2) beneficiaries are educated through programs that are well financed and focused on their needs; and (3) realistic expectations are formed about how much change to expect as a result of the MMA. Thus, the findings and lessons from M+C are very relevant to MA and its ultimate potential for success.

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CHAPTER I

MEDICARE+CHOICE IN PERSPECTIVE

Medicare began offering beneficiaries the option of enrolling in a private health maintenance organization (HMO) in the mid-1980s as part of the Medicare risk-contracting program. Under the Balanced Budget Act (BBA) of 1997, the risk program was absorbed into Medicare+Choice, which also called for a broader set of potential choices for beneficiaries (see the time line on page 2). In addition to HMOs, M+C authorized preferred provider organizations (PPOs), provider-sponsored organizations, and other looser forms of managed care. Together, HMOs and the new options comprised the coordinated care plans the Act authorized. M+C also included a private fee-for-service option and a time-limited medical savings account demonstration for Medicare beneficiaries. The BBA called for more beneficiary education and encouraging beneficiaries to make annual elections among plan options. However, this lock-in was delayed and implemented by the time the program ended. Similarly, the medical savings account demonstration was not implemented. Both of these policies remain of interest to policymakers, however, and are included in the Medicare Modernization Act of 2003.

In addition to promoting expanded choice of private plans through M+C, the BBA sought to address the geographical variation in rates that historically characterized the program. By statute, when M+C's predecessor, the Medicare risk contracting program, was authorized, payments were set to equal 95 percent of the expected local fee-for-service experience in each county. The intent was to tie payment to Medicare's existing payment levels in the traditional program while capturing a 5 percent savings for the government.[1]

[1] This savings assumes that rates are adjusted appropriately for patient mix. Earlier research indicates that the demographic adjuster used in the program provided only a very partial adjustment for patient mix. Given patterns of enrollment, this meant that, rather than saving 5 percent, the government actually paid 5.7 percent more (see Brown et al. "Do Health Maintenance Organizations Work for Medicare?" *Health* Care *Financing Review* 15(1): 7-23, Fall 1993). Because plans were able to provide Medicare benefits for 10.5 percent less than the traditional program could, this, combined with the overpayment, meant that plans had considerable funds to expand benefits for enrollees at limited additional expense. Such expansions were what made HMOs attractive to enrollees in the mid-1990s. While the BBA called for transition to greater use of diagnostic codes

Time Line of Key Events in Medicare+Choice

Medicare enacted	1965
Limited private plan offerings using cost reimbursement to group practice prepayment plans and demonstration authority.	1966-1985
Medicare risk (HMO) plans authorized under the Tax Equity and Fiscal Responsibility Act of 1982.	1982
Medicare HMO program becomes operational.	1985
M+C program adopted as part of the BBA of 1997, absorbing the Medicare HMO program.	1997
M+C changes in methods used to set the capitation payment rate take effect.	1998
Most other components of the M+C program take effect, including authority for new kinds of plans and expanded beneficiary education.	1999
Balanced Budget Refinement Act relaxes quality requirements for PPOs, authorizes new entry bonuses, and expands authority for cost based plans (scheduled to expire in 2002) to 2004.	1999
Benefits Improvement and Protection Act creates a separate and higher urban floor effective March 2001, raises the existing floor, and grants a temporary 1 percent increase in the minimum payment update.	2000
First private fee-for-service plan (Sterling) offered under M+C.	2001
M+C authority through 2002 for a Medical Savings Account demonstration with up to 390,000 enrollees. Expires with no applications received.	2002
M+C provisions limiting ability to switch plans monthly (lock-in) due to become effective but implementation delayed by Congress (HR 3448) until 2005.	2002
Medicare Modernization Act of 2003 enacted authorizing, among other things, the MA program that absorbs M+C as local plans. Medicare drug benefits and regional MA plans authorized beginning in 2006. Authority for cost plans extended beyond 2004 expiration date. Medical Savings Account authority made permanent with fewer restrictions. Lock in delayed from 2005 to 2006.	2003
Payment changes authorized under the MA for local plans take effect in March.	2004
Drug benefit, MA regional plan options, and revised capitation payment methods due to take effect.	2006

Source: Authors' analysis.

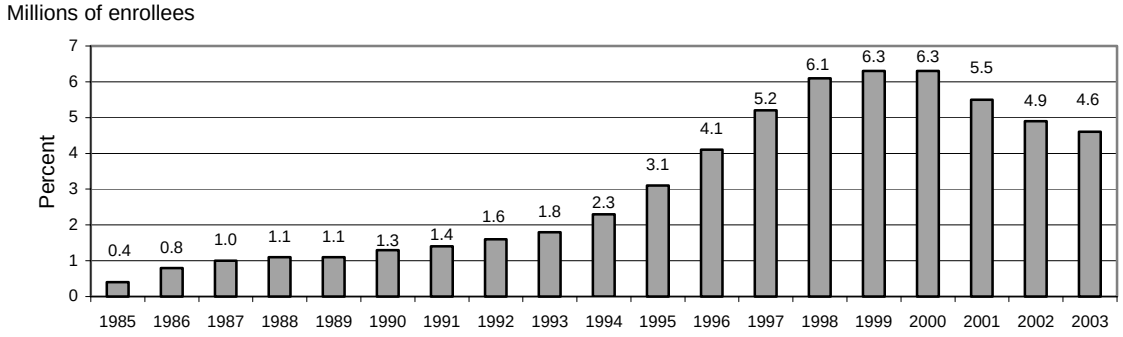
(*continued*)
and risk adjustment to achieve goals for parity in payment, the transition was slower than anticipated. Hence any plan with a healthier than average mix of enrollees still received higher payments over the history of M+C than they would have had full risk adjustment been in effect.

The plans were required to estimate what it would cost them to provide Medicare benefits and return any savings to beneficiaries in the form of additional benefits or lower supplemental premiums.[2] Because Medicare's spending in the traditional program varies widely across counties, Medicare risk payments also did.

To reduce this geographic variation, the annual increases for plans under M+C were to be calculated using a formula that blended national rates with local rates, with each plan guaranteed a minimum two percent increase annually. The blend was only applied when its net impact on Medicare costs was neutral (which occurred only in 2000). This meant that the two percent minimum increase annually became the de facto total increase for most plans. Exceptions to this were plans in the lowest-paid counties. To encourage plans to locate in areas (especially rural ones) where they had not been before and where payments were low, the BBA set a minimum floor of $367 in 1998 that would be adjusted annually and would reach $415 in January 2001, when the BBA changed its calculation further.

When the BBA was passed in 1997, the number of Medicare beneficiaries in private plans (particularly Medicare HMOs) was growing rapidly. Enrollment continued to grow through 1999 but at a slower rate. By 2000 it began to decline and continued to do so through 2003 (see Figure 1). The number of coordinated care contracts shrank dramatically over this period, from 309 in 1999 to 151 in 2003. (The reductions also reflect industry consolidation and market trends, not just the influence of the BBA.) Concerned that plan choice was not diversifying sufficiently, the Center for Medicare & Medicaid Services (CMS) developed a PPO demonstration in 2003; by February of that year, 31 PPOs were available to more than 10 million beneficiaries.

Figure 1. Enrollment in Medicare Risk/Medicare+Choice Plans, 1985-2003



Source: Gold, 2003 updated.

Note: Date for 1999-2002 are for enrollees in M+C coordinated care plans. Data for prior years are for enrollees in Medicare risk contracts. All data are for December of the given year. As of June 2004, 4.6 million were enrolled.

[2] Plans had the option to return savings to the government or to maintain them in a stabilization account to offset future years, but these options were used much less extensively.

In 1999, plans began withdrawing from M+C or reducing their service areas. More than two million beneficiaries were in plans affected by plan withdrawals between 1999 and 2003 (see Table 1). While most had alternative choices of plans, the withdrawals had a destabilizing effect on the market (see Young, 2003) and led beneficiaries and providers to have less confidence in the program.

Table 1. Medicare+Choice Enrollees Affected by Withdrawals, 1999-2003

	Enrollees		Enrollees with No Other Medicare+Choice Plan[a]	
Year	Number	Percent[b]	Number	Percent[c]
1999	407,000	6.7	47,000	12
2000	327,000	5.2	79,000	24
2001	934,000	14.7	159,000	17
2002	536,000	9.6	92,400	17
2003	193,313	3.6	35,793	18

Sources: Gold and McCoy, September 2002; CMS Reports, various years in *Fast Facts No. 8* updated.

Note: In 2004, 40,766 or 0.8 percent of all enrollees were affected by withdrawals; 1,430 had no other choice.

[a]Excludes private fee-for-service option.
[b]Percent of total Medicare+Choice enrollment in December of the prior year.
[c]Percent of affected enrollees.

In an effort to counter falling enrollments and address program shortcomings, Congress made various incremental changes in the program (Gold, July/August 2001 Interim Report; Appendix, Gold, Achman, and Verdier, 2003). In 1999, the Balanced Budget Refinement Act (BBRA) modified the earlier intent to phase out cost contracts by 2002 and extended the contracts' authority until 2004. Re-entry barriers for exiting plans were relaxed (from five to two years), and bonuses were authorized for plans entering counties where M+C did not already exist. The BBRA also eliminated some of the requirements that plans said were burdensome, including relaxing PPOs quality reporting requirements and temporarily pushing back the date by which health plans had to report plans for the upcoming year to allow them more time to track recent cost trends.

In 2000, the Benefits Improvement and Protection Act (BIPA) of 2000 made the filing date change permanent and raised the minimum annual payment increase from 2 percent to 3 percent from March through December 2001. BIPA created the minimum floor payment in large urban counties (250,000 people or more) and raised the existing floor in others, leading to an annually adjusted minimum of $525 in urban counties and $475 elsewhere in 2001.

CHAPTER II

TRENDS IN PLAN AVAILABILITY, DIVERSITY, AND ENROLLMENT

EXTENT AND TYPE OF PLANS AVAILABLE

Contrary to its goals, M+C did not result in a substantially more varied mix of health plan types (see Table 2). By mid-2003, HMOs still dominated the M+C program, with only five PPOs and three provider sponsored organization plans. Aside from the PPO demonstration, coordinated care options remained largely in the same form as they had been pre-BBA. A few private fee-for-service plans also have entered the program.[3]

Table 2. Medicare Contracts and Enrollment in Private Plans by Type, 1999-2003

	Enrollment					
Contracts	1999	2003	1999 (N)	1999 (%)	2003 (N)	2003 (%)
Total contracts	407	285	7,020,196	17.3	5,324,101	12.6%
Coordinated care plans (HMOs, PPOs, PSOs)	309	151	6,347,434	15.9	4,622,031	11.0
Cost plan	46	30	341,022	0.9	334,378	0.8
PPO demonstration	--	33	--	--	79,223	0.2
Other demonstration	37	23	205,309	0.5	152,722	0.4
Private FFS	--	3+1 demo	--	--	25,897	0.1

Source: Gold and Achman, *Fast Facts No. 8* updated, December 2003. Figures are for December of each year.

[3] Some HMOs offered a point-of-service option, which allowed beneficiaries to self-refer to at least some kinds of providers not in the plan network if the beneficiary was willing to pay more out of pocket.

Between 1999 and 2003, enrollment in M+C plans declined, with overall enrollment in any private plan option decreasing from 17.3 percent in 1999 to 12.6 percent in 2003. Most of this represents enrollment in the types of plans offered before the M+C program began. Only about 2,000 of 2003 enrollees were in PPOs under the BBA, and another 75,000 were in a PPO demonstration plan. Private fee-for-service plans accounted for only about 0.1 percent of all Medicare beneficiaries (Gold and Achman, December 2003).

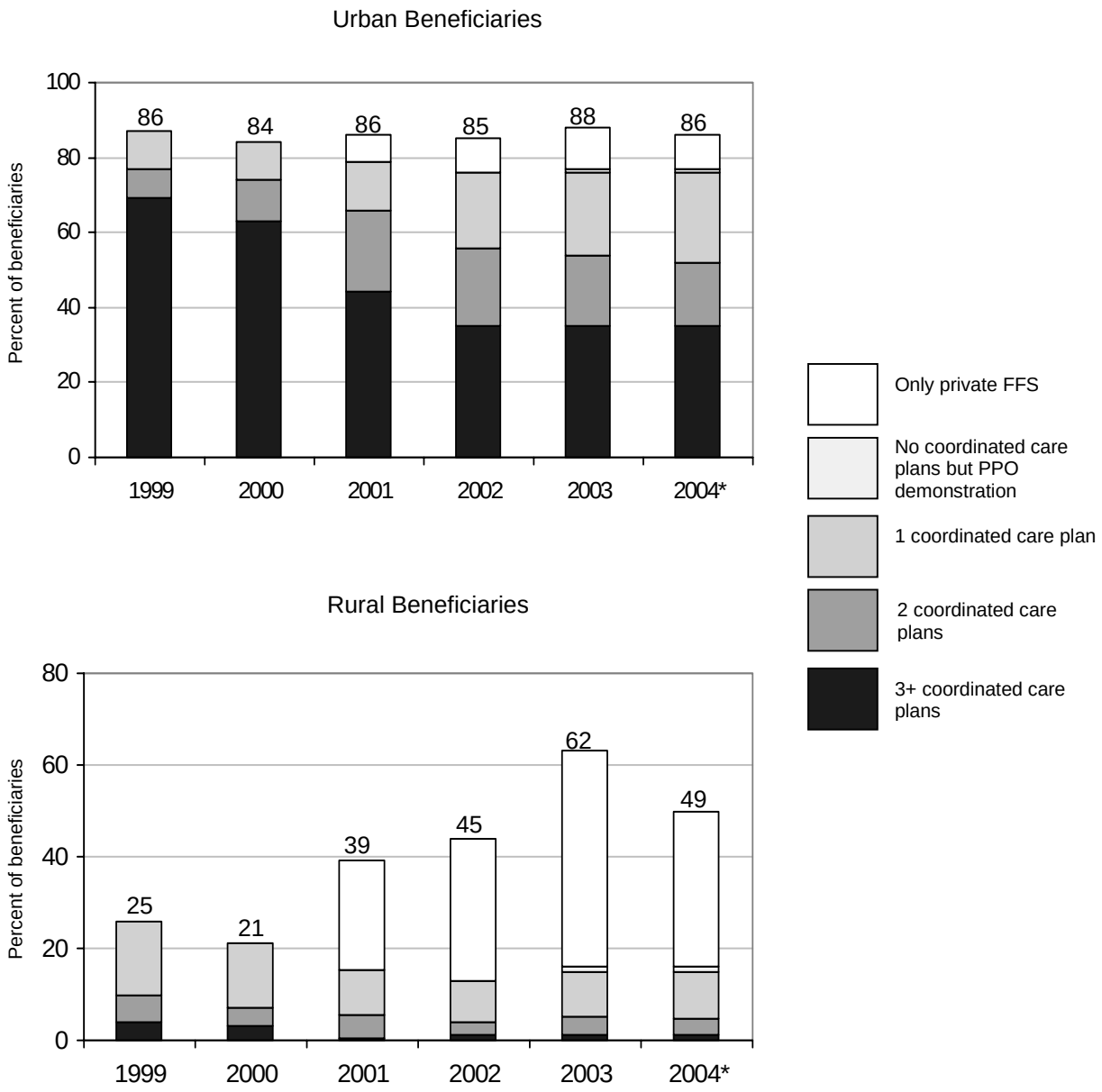
Beneficiaries had fewer managed care choices in 2003 when the program ended than they did in 1999, when it began. While the share of beneficiaries with any choice of private plan increased from 72 percent to 82 percent over this period, this increase is due entirely to the availability of a few private fee-for-service plans in some areas of the country with no previous choice. Over the same period (1999-2003), the share of beneficiaries with a coordinated care plan choice declined from 72 percent to 62 percent, and—most notably—the share with three or more such choices declined by half, from 53 percent to 27 percent.

GEOGRAPHIC VARIATION IN AVAILABILITY

Urban and Rural Areas. The availability of private plan choices varies markedly in urban and rural areas, and this remained the case despite the inclusion of floor payments in the BBA in an effort to expand choice in rural areas (see Figure 2). In urban areas, the share of beneficiaries with a choice of any form of private plan remained at around 86 percent over the period, but fewer had any form of coordinated care plan choice (86 percent in 1999 versus 76 percent projected based on 2003 plan filings for 2004). The share with three or more choices in urban areas decreased by about half, from 69 percent to 35 percent. The PPO demonstration offered choice to few additional beneficiaries in urban areas without a choice of coordinated care plan. Eleven percent had choice through the private fee-for-service (FFS) plan only in 2003. The availability of this option explains why the share of beneficiaries remained constant in urban areas despite the decline in coordinated care options.

Coordinated care plans are not widely available in rural areas. In 1999, 25 percent of rural beneficiaries had such a choice, but only 15 percent had one at the beginning of 2004. As in urban areas, the PPO demonstration did little to increase availability of such choice in rural areas. Private FFS plans are available in many rural areas, however. Because FFS plans do not require a network or local presence, they are easier to start up and operate in rural areas than are the managed care products in Medicare. The FFS option raised the share of rural beneficiaries with a choice of any private plan from a low of 21 percent in 2000 to a high of 62 percent in 2003. Ease of entry for FFS plans, however, may make it equally easy for them to exit. Sterling's announcement that it would leave 502 counties in 13 states in January 1, 2004, affected only 2,543 enrollees directly (because Sterling had limited enrollment), but it meant that the share of rural beneficiaries with a choice of private plans declined from 62 percent to 49 percent.

Figure 2. Trends in Availability of Medicare Private Plans, Urban vs. Rural, 1999-2004



Source: MPR Analysis of CMS geographical service areas file and contract withdrawal reports in Gold and Achman, *Fast Facts No. 8* updated, December 2003.

*Projected based on 2004 withdrawal reports and 2003 plan offerings.

Penetration by State and Metropolitan Area. Coordinated care enrollment has largely been in areas of the country where market conditions support such arrangements. Only 10 states have 15 percent or more of their beneficiaries enrolled in coordinated care (see Table 3). Penetration in the remaining states combined is only 4 percent, down from 8 percent in 1999.

Table 3. Percentage of Medicare Beneficiaries Enrolled in Coordinated Care Plans in the 10 Most Highly Penetrated States, June 2003

State	CCP Enrollees	Penetration (percent)
Rhode Island	57,203	32
California	1,266,466	30
Arizona	200,682	27
Oregon	121,779	23
Pennsylvania	491,068	23
Colorado	109,945	22
Florida	524,545	18
Massachusetts	164,229	17
Washington	125,537	16
New York	424,700	15
All other states	1,053,655	4

Source: MPR Analysis of CMS data.

Penetration varies greatly even within urban areas of similar size for reasons (see Brown and Gold, 1999). Among metropolitan statistical areas (MSAs) of 1.5 million or more, for example, M+C enrollment (excluding cost plans and non-PPO demonstrations) varied in September 2003 from 45 percent in Miami to only about 1 percent in greater Washington, D.C. (see Table 4). Further, markets were not all affected in the same way by BBA changes. In Rochester, penetration increased from 15 percent to 28 percent between 1999 and 2002, and new plans entered the market; in Dallas, seven of the eight plans departed, and penetration went from 21 percent to less than 7 percent.

PPO DEMONSTRATION AND MARKET EVOLUTION

In an effort to expand the availability of PPO products, CMS sponsored a PPO demonstration that began in January 2003 (Gold, Achman, and Verdier, 2003). To encourage firms to participate, CMS authorized payment levels of 99 percent of FFS spending if this was greater than the regular payment under M+C. CMS also agreed to share financial risk

Table 4. Medicare+Choice Market Penetration Rates, MSA with 1.5 million people or more, 1999 and 2003

	Number of Contracts		Penetration Rate (%)	
MSA Name	1999	2003	1999	2003
Atlanta, GA	5	3	11	8
Baltimore, MD	4	1	15	2
Boston, MA	6	4	23	15
Chicago, IL	5	1	14	4
Cincinnati, OH	7	5	22	14
Cleveland, OH	11	6	23	11
Dallas, TX	8	1	21	6
Denver, CO	6	2	45	37
Detroit, MI	7	4	7	3
Fort Lauderdale, FL	11	8	32	43
Fort Worth, TX	7	1	47	14
Houston, TX	8	3	25	7
Kansas City, MO-KS	7	2	24	13
Las Vegas, NV	4	2	26	11
Los Angeles, CA	11	10	36	32
Miami, FL	10	11	43	45
Minneapolis, MN	3	2	15	12
Nassau-Suffolk, NY	9	3	22	11
New York, NY	12	9	17	19
Newark, NJ	8	3	10	6
Oakland, CA	7	3	41	36
Orange County, CA	11	9	39	33
Philadelphia, PA-NJ	12	9	32	29
Phoenix, AZ	9	6	44	36
Pittsburgh, PA	4	4	30	37
Portland-Vancouver, OR-WA	7	6	47	40
Riverside, CA	10	8	52	40
Rochester, NY	3	4	15	27
Sacramento, CA	6	4	42	38
San Antonio, TX	4	2	30	22
San Diego, CA	6	4	48	40
San Francisco, CA	8	4	38	30
San Jose, CA	6	4	40	35
Seattle, WA	7	2	34	24
St. Louis, MO-IL	4		24	29
Tampa, FL	8	4	35	22
Washington, DC	4	1	7	0
West Palm, FL	11	8	36	26

Source: MPR analysis of CMS September 2003 Geographic Service Area File. MSA definitions based on 1999 OMB definitions.

Note: Market penetration based on enrollment in coordinated care, private FFS, and PPO demonstration plans. Does not include enrollment in cost plans or other demonstrations.

with plans as long as the risk was symmetric (equal sharing of gains and losses) and the plan assumed full risk for gains and losses within +2 percent of the target medical loss ratio. CMS also waived certain quality reporting and administrative requirements related to submission of adjusted community rates and limits on cost sharing. Though CMS still oversees this, the changes authorized under the demonstration give plans more flexibility to structure benefits and premiums in PPOs.

The PPO demonstration changes have proved popular with industry. At the outset of the demonstration, 31 plans were offered in areas available to nine million Medicare beneficiaries. Now there are 35 plans, and a number of firms have expanded their service areas so that more beneficiaries have access to a plan. Most participants, however, were participating already in M+C, with only one new firm (Group Health Inc.) entering the market in New York. Typically, the PPO demonstration operated in areas that already had an HMO option (Gold and Achman, October 2003). The short time frame over which products had to be developed made it substantially easier for existing firms to participate in areas where they already were based.

The PPO demonstration products have not been very popular with enrollees. In August 2003, only 69,471 people were enrolled, 46,000 of them in a New Jersey plan, which essentially substituted the PPO demonstration for its most popular Medicare HMO.[4] The PPOs vary substantially in their benefit design, but on average the premiums are more than double those of HMOs in the same markets ($92 versus $41 in 2003). Though the products offer out-of-network coverage, access to such providers often comes with extensive cost sharing. And while drug coverage is more likely to be offered, few PPOs covered brand-name drugs in 2003. Evidently, beneficiaries did not view the added-access PPOs a good enough reason to switch from their current HMO nor were the savings sufficient to drop their Medigap coverage given the benefit structure.

ROLE OF NATIONAL FIRMS

Though many organizations sponsor M+C plans, a few dominate the market and account for a large share of enrollees (see Figure 3). In 2003, 50 percent of M+C enrollment was in plans owned by six national firms: Kaiser-Permanente (17 percent), PacifiCare (15 percent); Humana (7 percent), United Healthcare (5 percent), Health Net (4 percent), and Aetna (2 percent). Another 17 percent are enrolled in firms affiliated with Blue Cross-Blue Shield. While each Blue Cross-Blue Shield organization is a separate entity, those affiliated with the brand have historically shared certain characteristics.[5] This concentration is

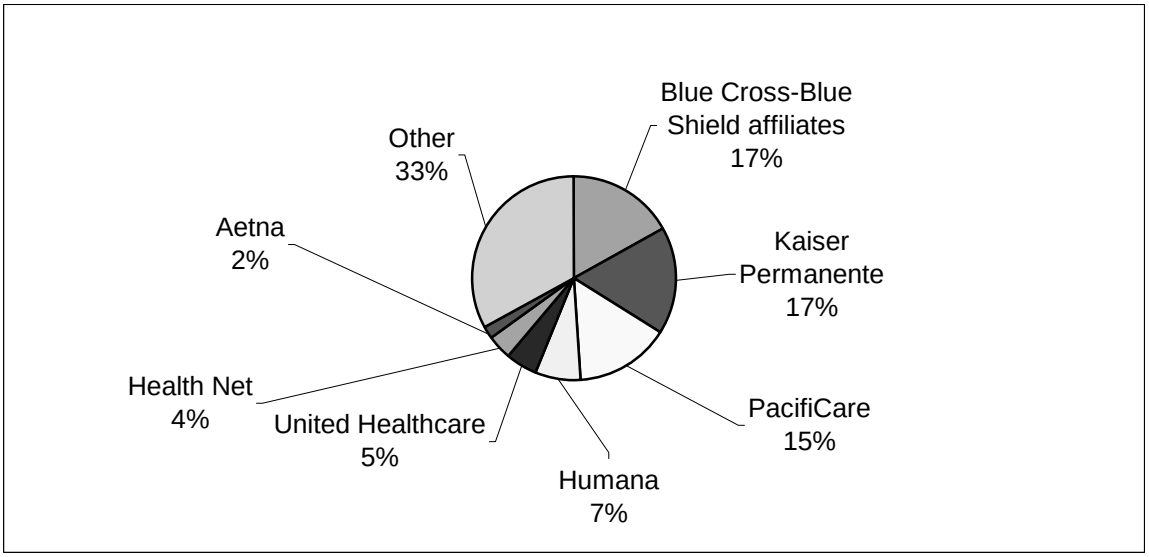
[4] Since then, enrollment has continued to grow slowly, reaching just under 100,000 in June 2004.

[5] For insight on the structure of these firms see, for example, Robert Cunningham and Douglas B. Sherlock. "Bounceback: Blues Thrive as Markets Cool Toward HMOs." *Health Affairs* 21(1):24-37, January/February 2002; Joy Grossman and Bradley C. Strunk. "Blues Plans: Playing the Blues No More." In Paul Ginsburg and Cara Lesser (eds.), *Understanding Health System Change; Local Markets, National Trends.* Chicago: Health Administration Press, 2001; Joy Grossman and Bradley Strunk. "For Profit Conversion and Merger Trends among Blue Cross Blue Shield Health Plans," Issue Brief No. 76, Washington DC: Center for Health Systems Change, January 2004.

important to keep in mind as it means that only a few firms have both the scale and the experience with Medicare that make them logical first candidates to participate in Medicare Advantage.

The PPO demonstration has provided what appears to be a useful laboratory for firms to test Medicare PPO products. With the exception of Kaiser-Permanente, all of the other major national firms in Medicare are participating in the demonstration—PacifiCare, United Healthcare, Humana, Health Net, and Aetna—as are many local firms. The extent of their involvement varies, however, as does the structure of the products they offer (Gold, Achman, and Verdier, 2003).

Figure 3. Coordinated Care Plan Enrollment by Firm or Affiliation, 2003



Source: MPR Analysis of CMS data.

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CHAPTER III

UNDERSTANDING MARKET VARIATION AND LOCAL MARKETS

While the monitoring project did not primarily study markets, we conducted (with the support of the Kaiser Family Foundation and others) a number of studies that provide insight into the market for Medicare managed care products and the way in which local factors influence the growth and development of private plans.

FACTORS THAT EXPLAIN MARKET VARIATION

Medicare managed care plans tend to be locally based, with a service area defined by county boundaries. Based on interviews conducted with a wide variety of stakeholders in Los Angeles, New York City, Portland, and Tampa, we identified eight factors that promote or impede the growth of Medicare managed care (Brown and Gold, 1999).

- ***Capitation level.*** Higher capitation payments make it easier for plans to earn profits, charge low premiums, and provide enhanced benefits that attract Medicare beneficiaries to the plan. Medicare sets payment rates by county, and plans define eligibility for enrollment based on county of residence. In metropolitan areas, plans may limit enrollment to higher-paid counties, which often means that residents in fringe counties with lower payment rates are excluded.

- ***Historical presence of managed care.*** In areas where non-Medicare managed care has a long history, provider networks are more likely to exist, and plans generally find it easier to develop successful Medicare products. In these markets, choice is likely to be more extensive and penetration is likely to be higher because beneficiaries are more familiar with the product and respond to choice by enrolling.

- ***Practice patterns and beneficiaries' care expectations.*** In markets where the practice style is resource intensive and patients see a lot of specialists, plans are likely to find it more expensive to deliver benefits, and they have less ability

to offer a generous benefit package or to restrict the provider network. As a result, penetration rates are likely to be lower in these areas.

- ***Beneficiary characteristics and patterns of supplemental coverage.*** Medicare managed care is likely to have more potential for growth in price-sensitive markets where beneficiaries lack employer coverage and incomes are limited. Conversely, where Medicaid or employer-subsidized coverage dominates, the incentive for growth of managed care is lowered because there is little financial incentive for beneficiaries to join plans.

- ***Extent and form of provider organization.*** Areas with large physician groups make it easier for plans to quickly develop a broad network that will attract large numbers of beneficiaries. In contrast, in markets where hospitals or academic medical centers dominate, plans may find it harder to thrive because it is harder to control costs (e.g., by shortening hospital stays or reducing use of expensive equipment).

- ***Concurrent goals and trends in other lines of business.*** If there are efforts to expand managed care from other lines of business, including Medicaid, plan interest in the Medicare market may be higher because the fixed costs of Medicare expansion are less.

- ***State regulatory factors.*** More extensive regulation generally impedes the growth of managed care because such regulation may limit what plans can do to control costs, or it may add to the costs of operation.

- ***Geographic location.*** Close location to markets where Medicare managed care is successful can encourage expansion by reducing the fixed costs of entry.

While payment is important, it is only one of a number of factors that influence the development of managed care. As a result, it is unlikely that managed care will develop at the same rate and intensity across the country, and policymakers interested in the growth of Medicare managed care will need to take into account how local market variation influences growth (Gold and McCoy, 2002).

CALIFORNIA VERSUS THE NATION: THE ROLE OF MATURITY

To understand the influence of market maturity on the M+C program, we compared the program and its trends in California to that of the nation generally. California has a long history with managed care and accounts for about 10 percent of Medicare beneficiaries nationwide and one in four beneficiaries in Medicare+Choice (Gold and Lake, 2002). Because of the maturity of the market, we assumed that if California managed care plans had a specific problem, plans elsewhere were not likely to be more successful in dealing with that same problem. The study was conducted through a statistical analysis of trends in M+C, with comparisons both to the nation and within parts of California using data from 1997 to

2001. The analysis highlighted similarities and distinctions between California and the nation, with a focus on four broad insights or lessons.

Market maturity. Market maturity appears to contribute to stability, but it does not immunize the market from destabilizing influences. Maturity meant that California's M+C enrollment was less volatile than elsewhere in the nation—with growth slower when it was rising rapidly nationally (1997-1999) and more limited declines when that was the case nationally (1999-2001). While California experienced fewer withdrawals from the program, withdrawals did increase over time.

Market domination. When a few firms dominate the market, the characteristics of these firms and the products they offer influence the future of Medicare managed care in the area. In California, Kaiser Permanente and PacifiCare each had more than a third of the market and Health Net had 8 percent. While Kaiser Permanente was not immune from marketplace pressures, its long history in California and integrated delivery structure resulted in some advantages and appeared to contribute a stabilizing presence for California's M+C program.

Provider infrastructure and contracting. Even within a state, provider organization varies, which influences the market. Providers are organized in different ways across California that make it more difficult to contract with providers in northern than in southern California. Integrated systems built around hospitals are common in the north, and large physician groups are common in the south. These differences and higher federal capitation payment rates for M+C in the south helped explain why both plan choice and benefits were greater there than they were in northern California. Across the state, however, providers were becoming less willing to accept risk, which created challenges for plans and stress on the system.

M+C as an urban product. Even in California, M+C was almost exclusively an urban product. Only about one percent of California's Medicare beneficiaries living outside metropolitan areas were in Medicare managed care in 2001, a decline from three percent in 1997. Firms attributed the difficulties of developing managed care in rural areas to the limited number of providers, providers' inexperience with and resistance to managed care, and the strong negotiating position that comes with being the only provider in the area.

PROGRAM WITHDRAWALS AND INSTABILITY UNDER MEDICARE+ CHOICE

Analyses carried out in several projects provide insight on M+C withdrawals and Congress's efforts to reverse this situation through legislation, which increased premium rates.

Withdrawals in 1999-2001. In multivariate work analyzing the factors associated with health plan withdrawals between 1999 and 2001, Lake and Brown (2002) examined the factors that appear to contribute to plan withdrawals over this period. Of the 298 M+C contracts in 1998, 59 percent withdrew between 1999 and 2001, with 39 percent canceling their contracts and 20 percent reducing their service areas. Plan pullouts were common

across all types of plans and markets, but the probability of pullout varied among plans and markets with diverse characteristics.

Payment effects were consistent across the three years (1999, 2000, and 2001). Among plans getting the minimum 2 percent update, withdrawals were less likely in plans with high previous (1997) payment rates, with each $100 monthly increase in capitation rate reducing the odds of a subsequent withdrawal by 25 percent. Rural plans receiving floor payments also were less likely to withdraw if they experienced higher payment updates as a result of the floor. Less competitive plans (and those in more competitive markets) were more likely to withdraw.

Though many factors influenced withdrawals, the most significant predictors of withdrawal were plan ownership and profit status, with for-profit and nationally owned plans about two and a half times as likely to withdraw as others. In contrast, those with large M+C enrollment were less likely to enroll, with the odds of plan termination reduced by nearly 50 percent with an increase in 10,000 enrollees. The earliest withdrawals (1999) were more likely to be in markets with more M+C plans. However, national firm effects were not significant in 1999; they emerged later, with differing patterns by firm. Thus, analysts may want to consider the role individual firm strategy plays, as well as plan and market factors, in predicting entry and exit.

In another study, we compared M+C benefits offered by plans departing in 2001 to those staying in the program. The findings showed that the departing plans' benefits were smaller, had less generous benefits in 2000, and had a history of benefit reductions dating from at least 1999 (Achman and Gold, February 2002). These findings signal that instability and poor market performance were part of the reason for plan withdrawals, at least in the earlier years of M+C. The multivariate analysis suggests that both low payment rates and inability to compete with others in the market help to explain the withdrawals in these earlier years of M+C. Because less competitive plans left earlier, the reasons for later withdrawals from the program could reflect a different balance of factors.

Effects of Rate Increases under BIPA. In an effort to respond to withdrawals, BIPA raised payment rates to health plans. From March to December 2001, all M+C plans received a temporary minimum payment increase of 3 percent (versus the standard 2 percent). BIPA also created a new floor payment of $525 (increased annually) for counties in metropolitan areas with 250,000 or more people and raised the previously existing floor for less populated counties from $415 to $475. Our analysis of the increases in 2001 showed that the immediate effects of the bill were minimal (Gold and Achman, October 2003). Because of where M+C enrollees were located, most plans got only the temporary 1 percent rate increase (from 2 percent to 3 percent). Perhaps because the increase was so small and temporary, few used the additional funds to expand benefits or lower premiums. According to CMS, almost three-quarters (72 percent) of those getting the additional percentage increase applied it to provider payments (allowable as a means of expanding provider access), and another 14 percent put the increase in a rate stabilization fund for later use. Among plans receiving the 3 percent, premiums declined slightly from January to March 2001 (from $21.13 to $20.09), with few changes in benefits.

BIPA's effects were more noticeable on floor counties where the increases were more substantial. BIPA resulted in a 9.7 percent increase for the new urban floor counties and an 8.3 percent increase for other floor counties. In floor counties, the increase was substantially more likely to be used to reduce premiums or expand benefits—only 44 percent of urban floor counties and 49 percent of other floor counties used it only to increase provider payments.

BIPA's effects were most meaningful in the urban floor counties since 23 percent of M+C enrollees were in counties where plans received these payments, in contrast to the low enrollment in rural areas helped by the previous floor. In urban floor counties, average premiums declined from $39 per month to $32 per month between January and March 2001, with a small increase in the proportion of beneficiaries in zero-premium plans (29 percent to 31 percent) and those with pharmacy benefits (37 percent to 43 percent). By 2003, urban floor payments had risen to $564 per month, and the share of M+C enrollees in plans in these counties increased from 23 percent to 26 percent. Analysis of payment rates in 2004 (after the MMA) indicated that, on average, urban floor payments were substantially higher than if plans were paid 100 percent of fee-for-service, giving plans in urban floor counties more flexibility to expand benefits or reduce premiums to offer an attractive product (Achman and Gold, 2004).

MARKET VARIATION AND SUPPLEMENTAL INSURANCE

Medicare+Choice plans integrate Medicare benefits with supplemental coverage. As such, the extent to which this is attractive to beneficiaries varies with the other supplemental options available both in that market and to the particular beneficiary. We conducted case studies in Atlanta, Long Island (New York), Minneapolis/St Paul, Nebraska, and San Diego in mid-2003 to learn more about Medicare supplemental coverage and the reasons why coverage varies across markets (Hurley, Gold, Black, and Achman, 2004).

The markets were selected for their variety. Atlanta has one of the lowest rates of supplemental insurance in the nation, and San Diego has among the highest, including a very high rate of M+C penetration and an extensive military presence that affects supplemental choices. Long Island has a high level of employer-sponsored group retiree supplements and an M+C history of withdrawals that contrasts dramatically with neighboring New York City.[6] Nebraska has some of the highest rates of Medigap coverage in the nation and includes extensive rural areas. Minneapolis/St Paul has a mature managed care market characterized by highly integrated delivery systems. The states in which these markets were located also have unique features. Minnesota is one of three states with a waiver from the OBRA-90 Medigap standardization requirements, and New York has a heavily regulated Medigap market. Through interviews with a diverse variety of stakeholders in these markets

[6] Since then, the MMA changed the way payment methods were set, resulting in a large increase in payment for Long Island, especially Nassau County. The increase was due to setting 100 percent of FFS as the minimum payment.

(health plans, providers, purchasers, state program officials, beneficiary advocates and counselors, etc.), we learned more about how the markets functioned and why.

At the time of our interviews, the MMA was under debate and Medicare+Choice was about to be transformed into Medicare Advantage. There were tensions in each of the markets as beneficiaries sought supplemental coverage with varied options. Participants' greatest single concern with the Medicare supplemental market was the absence of affordable drug coverage, and their search for such coverage drove their decisions on supplemental insurance in many ways. We found the following emerging problems:

- ***Medigap.*** Standardization appears to have led to stable options for beneficiaries, but the rising costs are pricing low- and some moderate-income seniors out of the market. Coverage for the under-age-65 Medicare disabled is a significant problem, especially in states that do not expand federal mandates for coverage.

- ***Employer-sponsored coverage.*** This option appears to be falling at an accelerating rate among employers, especially for new hires. Costs are sharply rising for existing retirees.

- ***Medicaid supplementation.*** This form of dual coverage varies across states and is focused on very poor beneficiaries whose health care needs and costs are great enough to overcome concerns about the stigma and other impediments to enrollment. State investment in these programs is substantial, but there are significant barriers for Medicare beneficiaries who want to enroll in them.[7]

- ***State-sponsored drug assistance programs.*** The availability and reach of these programs was highly uneven across states.

- ***M+C options.*** Enrollment in M+C remains high in markets with a long history of it, but it has disappeared in some markets, with severe erosion in benefits—especially drug coverage—across all markets. Beneficiaries were largely unaware of new M+C options, such as private FFS plans or Medicare PPOs. In addition, the recent history with M+C had strongly shaped beneficiaries' perceptions and had led to serious doubts in some quarters about relying on private plans to deliver sustainable alternatives to traditional Medicare.

[7] For an analysis of these barriers and how they might be addressed, see S. Felt-Lisk, *Operational Insights No. 9*, which analyzes the lessons from similar challenges faced by the State Child Health Insurance Program (SCHIP). Specifically, effectively enrolling Medicare beneficiaries who are dually eligible for Medicaid requires having partnerships to develop an appealing image for the program, use the media effectively, pursue innovative efforts to enroll, and provide in-depth information to beneficiaries and their families. Success also requires simplifying enrollment, reaching adult caregivers, and building on national initiatives that expand awareness of and support for the program.

While Medicare is a standardized national program, the need for supplemental insurance has led to substantial and growing diversity in options, costs, and benefits across beneficiaries and markets. What an individual can access, even within a given state, will depend on his or her employment history, income level, and the M+C and publicly subsidized options available where the individual lives. This results in inherent tension and complexity in the way Medicare supplemental coverage is obtained.

STRATEGIES OF DIVERSE NATIONAL FIRMS

In late 2001, we interviewed executives from the major M+C firms and analyzed data on trends in their products to understand better the role each firm plays in the market and how each positions itself (Draper, Gold, and McCoy, 2002). The findings generate insights about a number of issues relating to the operation of M+C products and the similarities and distinctions across firms.

Position of the M+C product. M+C does not represent a major line of business for most of the firms. Only two companies—Humana and PacifiCare—reported that the Medicare plans account for more than 20 percent of the firm's total HMO enrollment. However, because Medicare beneficiaries tend to need more care, the financial risk they generate for firms is understated by their share of enrollment. At the time of the interviews, plans were reducing their financial exposure by retreating from markets they deemed to be less supportive of the M+C product.

Firm's M+C decision processes. While the firms we interviewed served many markets, they made their M+C participation decisions on a county-by-county basis. The main determinant of participation was the M+C payment rate, followed by the number and intensity of program administrative requirements. However, firms' ability to develop and maintain an adequate provider network is also very important in influencing participation. Other factors include the competitive landscape, implications for other lines of business and/or products, and, in the case of publicly traded firms, pressure from Wall Street.

Views on the M+C product. Our interviews spanned the period of major withdrawals from the program. Firms we talked with appeared to be pursuing strategies that keep their "foot in the program door," and at the same time allow them to seek new business opportunities such as the introduction of Medicare supplemental and other products to reduce their dependence on M+C. Most thought that the program had a remaining shelf life of two to five years, barring any significant reforms. Though some were pursuing diversification strategies, most reported that they were engaged in watchful waiting.

Variation across national firms. Each of the firms interviewed had a distinct culture. While each is commonly referred to as a national firm, in fact most of them are geographically concentrated (at least for Medicare) in a few regions, and this concentration has increased in the since 2000 as firms strategically withdraw from markets.

- ***Aetna.*** The mainstay of this company is large national accounts. Aetna's role in the M+C market grew when it merged with U.S. Healthcare in 1996, NYLCare

in 1998, and Prudential in 1999. Still, M+C has always represented less than 10 percent of the firm's total HMO enrollment, and this proportion has decreased as a result of withdrawals from the program since 2000. In late 2001, the main focus of Aetna's M+C business was in selected markets in five states—Arizona, California, New Jersey, New York, and Pennsylvania. With extensive national accounts, 15 percent to 25 percent of the M+C enrollment was from employer groups.

- ***Blue Cross-Blue Shield.*** The 43 independent and locally operated Blue Cross-Blue Shield plans (at the time of the interviews) operated in all 50 states and the District of Columbia with a diversified product base that includes commercial, small-group, and individual products as well as participation in many government-sponsored products. In recent years, there has been substantial merger activity. The plans vary in their M+C participation, but generally they have been involved with the program for some time and account for a substantial share of national enrollment. Collectively, this sector has had more stable participation and enrollment in M+C than have other national firms. Blue Cross-Blue Shield organizations also tend to be a major source of Medigap and Medicare supplemental coverage, which means that their decisions on the M+C product may take into account the crossover effects on other product lines.

- ***Health Net.*** Health Net has evolved through mergers of three companies: Foundation Health Corporation, Health Net, and Qual Med. Commercial accounts are the firm's core business, with coverage provided in 13 states. Health Net also has a role in TriCare and Medicaid managed care in some states. The firm's participation in M+C has become more geographically concentrated in Arizona, California, and the Northeast (Connecticut, New York, and Pennsylvania). In 2001, the firm introduced Medicare supplements (as alternatives to M+C) in California and was considering expanding them elsewhere.

- ***Humana.*** Executives at Humana describe their firm as a "super-regional player" that focuses on serving 32 distinct markets. While it has extensive business in the commercial sector and TriCare especially, Medicare accounted for 21 percent of the firm's HMO enrollment in 2001. Until the mid-1990s, Humana was the largest Medicare risk contractor, and it remains a major player. In late 2001, enrollment was concentrated in a few states—Arizona, Florida, Illinois, Kansas/Missouri, and Texas. More recently, the firm has begun to offer a private FFS product. Humana says that it operates its M+C product uniformly across the markets it serves, making decisions centrally, based on local market information. To keep products affordable, it has introduced "benefit buydowns" based on what it views as a member preference for low-premium products.

- ***Kaiser Permanente (KP).*** Kaiser's emphasis on HMOs in integrated delivery systems makes it unique among national M+C firms. KP has a long history of growth in California, which still accounts for 75 percent of its total enrollment. KP also operates in Colorado, Georgia, Hawaii, the mid-Atlantic, Ohio, and Oregon. Because of its history and unique delivery system, the firm attracts a significant portion (43 percent) of its M+C enrollment from employer groups, many of whom "age in" to the product. M+C accounted for about 10 percent of KP HMO enrollment in 2001. Since then, the firm has converted its M+C contracts to cost contracts in Cleveland and Washington, D.C.

- ***PacifiCare.*** One of the largest M+C contractors, PacifiCare operates in eight predominantly Western states. M+C enrollment is concentrated in Arizona, California, and Texas, but the firm has a considerable presence in Colorado, Nevada, Oklahoma, Oregon, and Washington state. In late 2001, M+C accounted for 49 percent of PacifiCare's revenues, and the firm was seeking to decrease its dependence on that line of business by introducing a commercial PPO product as well as a Medicare supplement product.

- ***United Healthcare.*** Although United Healthcare operates 44 market-based HMOs, it has no significant West Coast presence today because it withdrew from many of those states. In contrast to some other national firms, the commercial business tends to be from medium and small groups and from Medicaid. In late 2001, M+C enrollment was concentrated in Florida, Illinois, Missouri, and Ohio. United says it is very committed to the senior market, but M+C is only one way to serve this group. The firm administers the AARP Medicare supplemental product and the Evercare demonstration aimed at the frail elderly. Recently, the firm entered the Medicare PPO demonstration in many markets and has begun to market a private fee-for-service plan.

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CHAPTER IV

TRENDS IN BENEFIT DESIGN, PREMIUMS, AND OUT-OF-POCKET COSTS

OVERVIEW OF TRENDS

Over Medicare+Choice's history, premiums for M+C plans increased while enrollees saw a drop in benefits, including less coverage for outpatient prescription drugs (see Table 5). These changes meant that Medicare beneficiaries, on average, had to spend substantially more out-of-pocket for health care, with those in poorer health who used more services affected the most. This section reviews these trends, focusing on trends in basic package, weighted by plan enrollment.[8] Tables are based on HMOs and other network-paid products authorized under M+C. Such plans include almost all the private plan enrollment in Medicare, with only M+C's private FFS plans and Medicare cost and demonstration plans (including the PPO demonstration) excluded.

MANAGED CARE BEFORE MEDICARE+CHOICE

Medicare beneficiaries are accustomed to the traditional Medicare program, its unrestricted choice of providers, and what historically has been an unmanaged product. While there are a few markets where HMO alternatives have a long history that makes them a mainstream rather than alternative option, this is rare, especially outside of California, Minneapolis, and a few parts of the Northwest.

What this means is that the main way managed care plans have to attract Medicare beneficiaries is to offer them expanded benefits at a lower premium than the competition offers (e.g., Medigap, employer-subsidized coverage). The ability to do so depends on how high the capitation rate for Medicare is set, and how well plans are able to manage the costs of the Medicare benefit against that premium so there are savings that can be used to subsidize the cost of supplemental benefits at a reduced premium.

[8] Plans may offer more than one benefit package. The basic package is defined as the one with the lowest monthly premium or—if more than one package is offered at the same low premium—the one with the best pharmacy benefits is used.

Table 5. Trends in Premiums and Benefits in Medicare+Choice Plans, 1999-2003*

	1999	2000	2001	2002	2003
Percent zero-premium plan[a]	80%	59%	46%	41%	38%
Average monthly premium	$6	$14	$23	$32	$37
Percent of enrollees with any drug coverage	84%	78%	70%	72%	69%
Percent of enrollees with drug coverage, including brand-name drugs	NA	NA	62%	43%	41%
Estimated annual average out-of-pocket spending	$976	$1,185	$1,438	$1,786	$1,964

Source: MPR Analysis for The Commonwealth Fund.

Note: Basic plans only; includes coordinated care plans only (HMOs, PPOs, point-of-service plans, and provider service organizations, excluding demonstration plans).

[a]Includes a few plans that also have rebates that apply to the Part B premium.

The benefit package that was offered at the start of the Medicare risk program was relatively limited (see Table 6). In 1987, 90 percent of plans required a premium for their basic package. While most provided routine physicals and eye exams to complement Medicare benefits and covered most of Medicare's cost sharing, less than half provided any drug coverage. In the mid-1990s, zero-premium products became more common and drug coverage began to rise markedly. The mid-1990s was also the period of the largest growth in the Medicare risk program and relatively hefty increases in rates for managed care plans (see Figure 4). By the time the Medicare risk program was folded into Medicare+Choice, 70 percent of plans charged no premium for their basic product and 67 percent covered drugs. Half also offered a higher-option package.

CHANGES IN BENEFITS AND PREMIUMS UNDER MEDICARE+CHOICE

Between 1997 and 1999, few changes were made in M+C benefits and premiums (Gold, Smith, Cook, and Defilippes, 1999). In light of this, and because data are better for 1999 than they are for preceding years, our analysis of changes in benefits and premiums tracks trends since 1999, the first full year of the program.

Premium Trends. Between 1999 and 2003, M+C premiums increased substantially, with the average monthly premium (weighted by plan enrollment) increasing from $6 in

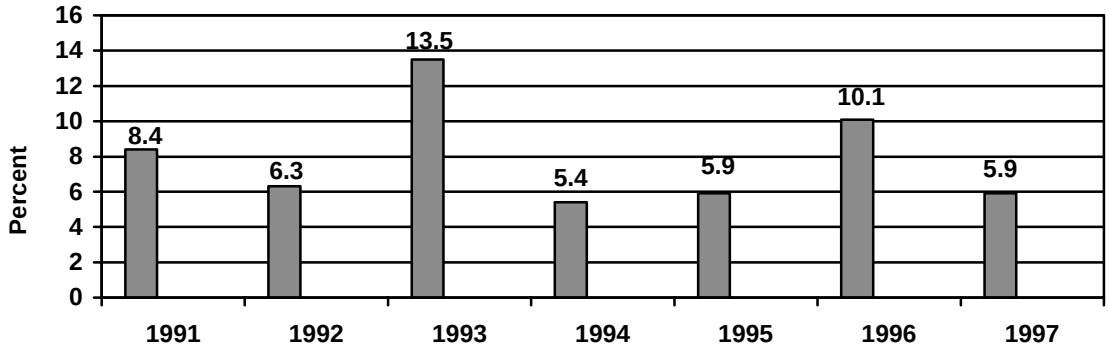
Table 6. Trends in Supplemental Benefits and Premiums Medicare Risk Plans, 1987-1998 (Basic Options for Selected Years)

	1987	1990	1994	1995	1996	1997	1998
Number of contracts	161	96	154	183	241	307	346
Enrollment (millions)	1.0	1.3	2.3	3.1	4.1	5.2	6.1
Percent offering							
Zero premium	10[a]	18	33	51	65	69	70
Outpatient drugs	43[a]	35	38	50	61	68	67
Routine physicals	80[a]	87	97	97	97	97	97
Immunizations	--	77	90	86	88	89	89
Health education	--	31	30	24	24	37	38
Foot care	--	28	31	33	37	30	30
Eye exams	60[a]	83	83	90	90	92	83
Lenses	--	12	20	5	7	15	1
Ear exams	35[a]	54	68	71	76	78	72
Hearing aids	--	1	6	3	4	10	1
Dental	11	22	28	36	37	39	37
Visit copayment in basic package	--	80	95	95	97	96	93
Offer high-option package	--	4	33	40	42	47	51

Source: MPR Analysis of December 1 Medicare Managed Care Report for indicated years.

[a]Data for 1987 come from Brown et al., 1993. The data are for April 1, 1987. The reference benefits vary from later years for eye, ear, and preventive care.

Figure 4. Trends in Medicare USPCC (Aged, Part A&B Combined), 1991-1997



Source: MPR Calculation from HCFA (now CMS) 3/2/98 Tables.

Note: The figure reflects the change in the prospective U.S. per capita cost (USPCC) for the given year.

1999 to $37 in 2003 (see Table 7).[9] The proportion of enrollees in a plan whose basic option required no premium declined by more than half, from 80 percent in 1999 to 38 percent in 2003. While only about 3 percent had a premium of $50 per month in 1999, 35 percent had such a premium in 2003. Premiums for M+C are not easy to compare to those for Medigap because Medigap data are limited and premiums vary by firm, market, and individual. An analysis of Medigap premiums in 2002 for the most common products, however, showed that M+C premiums were lower than Medigap premiums (Gold and Achman, November 2002).

Table 7. Monthly Premiums Medicare+Choice Plans, 1999-2003* (Weighted by Plan Enrollment)

	1999	2000	2001	2002	2003
None/reduced Part B premium	79.6	59.0	46.0	40.7	38.3[a]
Less than $20	3.1	8.7	8.2	4.8	1.3
$20-$49.99	13.5	19.3	27.1	22.8	25.2
$50 or more	3.2	11.1	18.6	31.8	35.1
Unknown	0.6	1.8	0.1	0.0	0.0
Mean	$6.37	$14.43	$22.94	$32.08	$37.35
Mean if premium not zero	$32.11	$36.19	$45.52	$54.05	$60.45

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund in Achman and Gold, December 2003.

Note: Enrollment is from March of each year. Reduced Part B premium plans only became available in January 2003.

*Based on the basic package in coordinated care plans; excludes demonstrations and private FFS plans.

[a]Reduced Part B plans accounted for 0.2 percent of enrollment in 2003.

Coverage for Medicare's Cost Sharing. Medicare benefits include substantial cost sharing. Under Part A, for example, beneficiaries pay a deductible for each hospital admission ($840 in 2003), coinsurance is required after 60 days of service, and there is a lifetime limit on the amount of the benefit. Under Part B, in addition to a deductible ($100 in 2003), beneficiaries typically pay 20 percent of the Medicare-approved amount for services. Like Medigap supplements, M+C plans usually cover all or some of these costs, but the amount of protection M+C provides diminishes over time (see Table 8).

[9] Some plans offer additional products in that same area in addition to the basic option. CMS data do not allow enrollment to be identified by product for this period, so we weight the basic plan by the total enrollment.

Table 8. Copayments for Medical and Hospital Services in Medicare+Choice Plans, 1999-2003* (Percentage of Plans, Weighted by Enrollment)

	1999	2000	2001	2002	2003
Primary Care Physician					
None	18.0	10.0	5.3	5.7	7.1
$5 or less	44.5	34.1	21.7	12.4	5.5
$5.01-$10.00	32.1	47.8	43.6	57.0	45.7
$10.01-$15.00	5.1	7.2	26.7	21.1	17.8
$15.01 or more	0.3	0.8	2.8	3.8	23.9
Specialist					
None	15.9	8.0	5.7	3.4	4.1
$5.00 or less	39.6	28.0	16.4	6.4	1.7
$ 5.01-$10.00	26.8	35.8	37.1	34.6	12.0
$10.01-$15.00	9.9	19.3	19.3	14.5	18.9
$15.01 or more	1.2	6.5	21.5	41.1	63.4
Varies	6.6	2.3	0.0	0.0	0.0
Emergency Room					
None	6.5	3.4	3.4	2.6	3.0
$20.00 or less	24.5	14.0	11.9	0.5	0.0
$20.01-$40.00	30.5	33.9	30.9	12.6	5.9
$40.01-$50.00	38.2	48.7	53.8	84.3	91.0
Over $50.00	0.2	0.0	0.0	0.0	0.0
Any Copayment					
Hospital admission	4.3	12.8	32.7	78.4[b]	81.9
Hospital outpatient[a]	30.7	28.6	43.7	69.9	58.1
X-ray[a]	7.5	11.3	17.2	17.0	16.2
Lab[a]	3.9	6.4	16.4	12.3	12.8

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund in Achman and Gold, Decmeber 2003.

Note: Enrollment from March of each year.

*Based on the basic package in coordinated care plans; excludes demonstration plans and private FFS plans.

[a]For 2002-03, many plans have provided dollar ranges for the copayment amounts for these services. For instance, a plan may report that enrollees are responsible for a $0-$150 copayment for outpatient hospital services. The percentages reported here use the lowest payment.

[b]Thirteen contract segments, representing 96,976 enrollees, were excluded from this analysis because the plans were missing Medicare Compare information about inpatient hospital benefits. Together, these basic plans represented 3.8 percent of all contracts.

In 1999, less than 10 percent of M+C plans required any copayment for inpatient hospital services. Fixed-dollar copayments were common for outpatient care, physician visits, and emergency room use, but not for ancillary care, laboratory, and x-rays. By 2003, 82 percent of basic plans required some cost sharing for inpatient services, and copayments for physician services were higher, with many plans requiring more cost sharing for specialty care than for primary care. Also, more plans were requiring copayments on ancillary services.

The amount and form of cost sharing varies substantially across plans. In 2002, the most common form of cost sharing was copayments per stay, followed by copayments per admission (Achman and Gold, November 2002). There were generally no upper limits on how high cost sharing could reach, but 29 percent of plans with hospital cost sharing limited the amount per year, and 7 percent limited the amount per stay. We estimated the average and maximum amount of cost sharing for beneficiaries under five use scenarios and found that the maximum amount of payment for inpatient services was relatively low for most health plans. However, the highest-cost scenario resulted in 2 percent of M+C enrollees paying $3,540 for a 12-day hospital stay.

Supplemental Benefits. Between 1999 and 2003, the number of supplemental services covered in M+C declined in some areas (see Table 9). Hardest hit was coverage of preventive dental services, which declined from 70 percent in 1999 to 19 percent in 2003. The physical exam, always a key part of the benefit package, remained covered; however, an initial comprehensive physical and selected other preventive services become regular Medicare benefits under the MMA, effective 2005.

Table 9. Supplemental Benefits in Medicare+Choice Plans, 1999-2003* (Percentage of Plans, Weighted by Enrollment)

	1999	2000	2001	2002	2003
Prescription drugs	83.9	78.0	70.2	71.7	68.9
Preventive dental	69.9	39.0	28.6	15.5	19.4
Vision benefits	97.8	96.2	94.7	86.7	88.2
Hearing benefits	91.3	92.0	77.7	54.3	57.1
Physical exam	100.0	100.00	100.0	100.0	99.6
Podiatry benefits	26.9	28.20	29.4	26.2	26.9
Chiropractic benefits	20.9	6.8	6.0	3.7	4.8
Number of enrollees	6,254,616	6,094,767	5,577,787	4,964,007	4,557,142

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

*Based on the basic package in coordinated care plans; excludes demonstration plans and private FFS plans.

Pharmacy services, one of the most sought-after supplemental benefits, declined from 84 percent in 1999 to 69 percent in 2003 (see Table 10). More notable was the change in the extent of the benefit. In 1999, the distinction between generic and brand-name coverage was typically not made, with both covered, though sometimes with variation in cost-sharing requirements. By 2003, more than half of enrollees with drug coverage were in plans covering only generics. Among those with brand-name coverage, 33 percent had coverage limited to less than $750 a year, in contrast to 21 percent that did so in 1999. Copayment also increased greatly over this period.

Table 10. Medicare+Choice Prescription Drug Coverage by Type of Coverage Offered, 2001-2003 (Percent of Plans, Weighted by Enrollment)

	2001	2002	2003
Prescription Drug Coverage by Type			
No drug coverage	29.9	28.3	31.1
Percent covering generic only	8.0	28.9	28.4
Percentage covering generic and brand-name drugs	62.1	42.8	40.5
Generic and Brand-Name Coverage[a]			
$500 or less	19.7	16.1	20.5
$501-$750	12.1	12.2	12.9
$751-$1,000	11.9	32.1	29.9
$1,001-$1,500	14.3	4.9	10.0
$1,501-$2,000	24.6	26.2	18.6
$2,001 or more	5.8	4.9	5.8
No cap	11.6	3.6	2.4
Generic Copayments			
None	8.8	10.1	9.7
$10 or less	83.6	80.2	82.4
$10.01 or more	7.6	9.7	8.0
Brand-Name Copayments			
None	2.4	0.0	0.8
$10 or less	21.7	4.6	5.9
$10.01-$20	43.6	14.8	18.6
$20.01 or more	32.3	80.6	74.7

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund in Achman and Gold, December 2003.

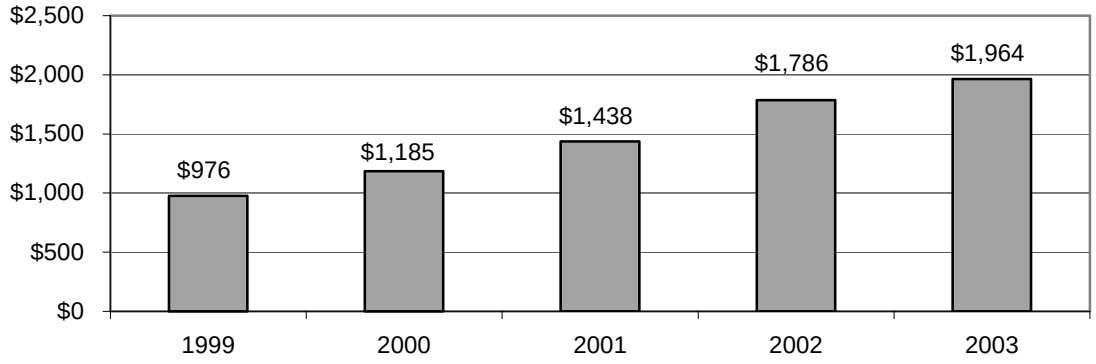
Note: Enrollment is from March of each year; based on basic plans offered under coordinated care contracts; excludes cost contracts, demonstrations, and private FFS plans.

[a]The basic plan limit that applies to brand-name drugs was used for this analysis. Some plans that cover both brand-name and generic drugs have differing limits for each class of drug.

Dynamics of Change. In an effort to assess changes in plan strategy over time, we analyzed the patterns of changes between 1999 and 2002 (Achman and Gold, November 2002). In 2000, plans' first response to the slowdown in payment rate increases was to cut premiums. That year, the proportion of plans with a zero-premium product declined from 65 percent to 40 percent. While benefits were cut somewhat in 2000, cuts were more dramatic in subsequent years. Particularly notable were an increase in the use of hospital cost sharing in 2001 and a reduction in pharmacy benefits in 2002. Required physician copayments increased in both years, and plans covered fewer supplemental services.

The cumulative effects of all these changes meant that the annual out-of-pocket cost for the average Medicare+Choice enrollee more than doubled between 1999 and 2003, from $976 in 1999 to $1,964 in 2003 (see Figure 5). These costs include the Medicare Part B premium, the premium for the M+C product, and cost sharing for hospital and physician services and for uncovered pharmaceuticals.[10] M+C enrollees in fair or poor health were particularly affected by the increased out-of-pocket costs (see Figure 6).

Figure 5. Estimated Average Annual Out-of-Pocket Health Costs for Medicare+Choice Enrollees, 1999-2003

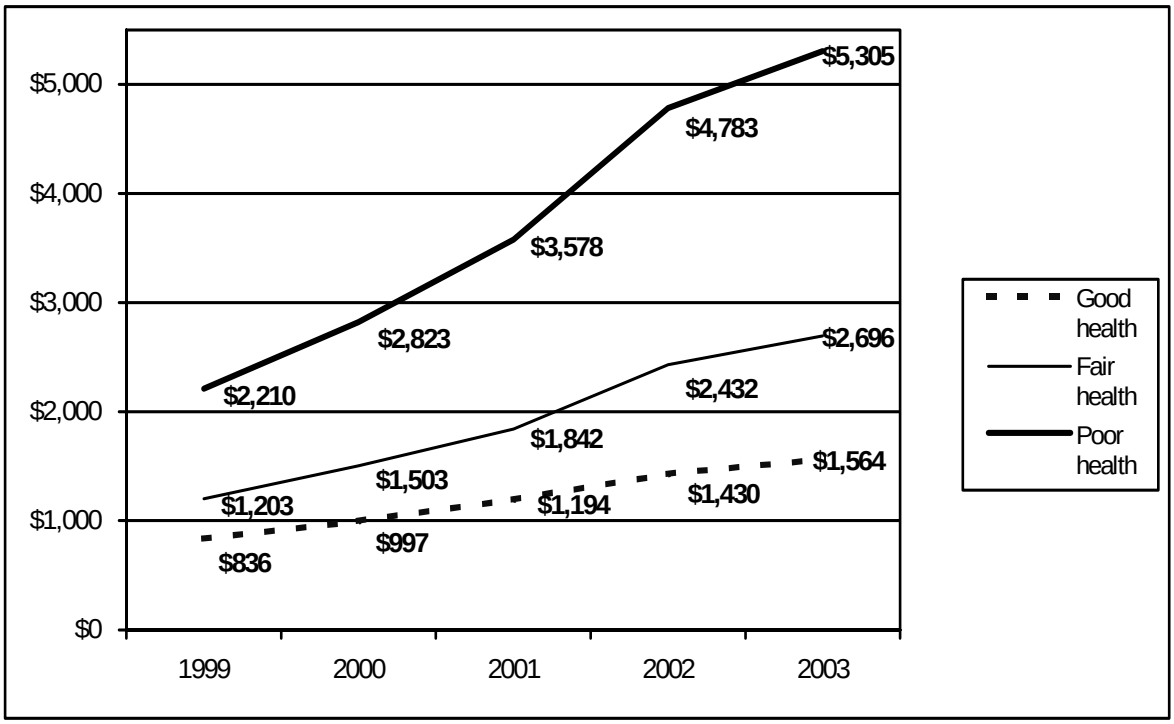


Source: MPR analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology in Gold and Achman, August 2003.

Note: Results are weighted by M+C plan enrollment. Includes only coordinated care plans. Costs include the Medicare Part B premium, the M+C plan premium and estimated out-of-pocket spending for pharmaceuticals, and selected acute care services (hospitalization, physician visits).

[10] The estimates exclude costs for some benefits (e.g., mental health, long-term care, laboratory services) so they underestimate total out-of-pocket costs.

Figure 6. Estimated Total Annual Out-of-Pocket Spending for Medicare+Choice Enrollees by Health Status, 1999–2002



Source: MPR analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology in Gold and Achman, August 2003.

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CHAPTER V

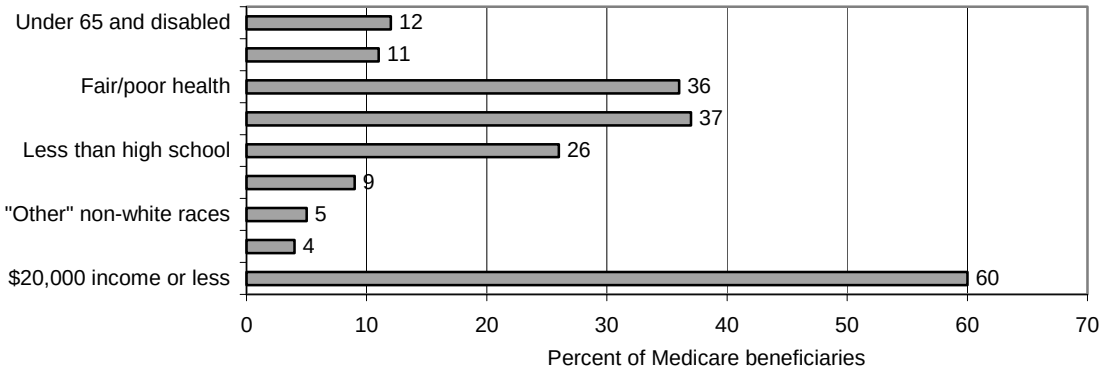
MEDICARE BENEFICIARIES AND CHOICE

We examined the experience of beneficiaries with choice in 2000 through a national-level survey and in-depth case studies in six communities.[11] We continued to track these community experiences by telephone annually through 2004. The communities were Albuquerque, Baltimore, Detroit, New Orleans, Orange County (CA), and Orlando (FL).

CHARACTERISTICS OF MEDICARE BENEFICIARIES

Medicare beneficiaries have many characteristics that make them vulnerable in a choice environment, including chronic illness and disability, limited incomes (which makes price an important issue), and racial and ethnic diversity (see Figure 7).

Figure 7. Selected Vulnerable Subgroups of Medicare Beneficiaries, 2000



Source: MPR Survey for RWJF in Gold et al., 2001.

[11] See Gold et al., 2001 and other targeted publications listed in the appendix: Gold et al., various months 2001; Stevens and Mittler, 2000; Stevens and Young, 2001; Young and Mittler, 2002; Young, 2003; and Black and Gold, 2004.

Beneficiaries surveyed in 2000 had the following important characteristics that are relevant to their ability to access information in a choice environment (see Table 11).

Table 11. Specific Situations That Affect Information Gathering or Processing by Age, 2000

Percent Answering "Yes" to Specified Item	All Beneficiaries	Under 65	65-84	85+
Blind or vision poor with glasses	11.5	18.8	8.9	21.7
Deaf or poor hearing with hearing aid	8.9	7.8	7.3	21.6
Difficulty reading[a]				
Newspaper	15.8	47.4	9.3	17.9
Directions for taking medicine	12.4	22.3	9.2	20.7
Health provider notes	37.2	68.6	27.3	59.5
Food package labels	17.8	39.3	11.3	31.1
Recipes	16.9	43.6	10.6	23.4
Books	18.0	50.1	11.4	20.1
At least one of above	40.8	71.6	31.6	58.4
Three or more of above	17.4	45.3	10.9	23.8
Needs proxy to answer all or most of survey	14.8	16.3	11.7	35.1
Language other than English spoken at home most of the time	2.3	3.2	2.2	1.9
Spanish	0.5	0.8	0.4	0.7
English/Spanish equally	1.0	0.8	1.1	0.4
Other non-English				
Ever used the Internet	18.5	23.3	18.1	15.5
Number of beneficiaries (in millions)	34.2	4.2	26.3	3.7

Source: MPR Survey of Medicare Beneficiaries for RWJF in Gold et al., 2001.

[a]Asked only of those who had not graduated from high school or had some college; excludes those with visual impairments

- Twenty-six percent had less than a high school education. Among those who had not graduated from college, 41 percent said they had trouble reading at least one of six kinds of materials (e.g., books, recipes).

- Twelve percent were blind or said their vision was poor with glasses, 9 percent were deaf or said they had poor hearing with a hearing aid, and almost 5 percent spoke a language other than English at home most of the time.

- In 2000, only 19 percent said they ever used the Internet for anything. While that figure undoubtedly has grown, on average the elderly use the Internet much less than younger people.

- Fifteen percent of those surveyed needed a proxy to answer all or most of the questions, and the most common reason was that the beneficiary was too cognitively impaired or ill to answer the questions. Such impairments were substantially more likely for those 85 and older.

In addition, both the survey and site-visit interviews indicate that most beneficiaries did not understand the basics of Medicare, including how the traditional program works and the differences between that and managed care and other private alternatives (Gold et al., 2001; Stevens and Mittler, 2000).

Collectively, these characteristics put Medicare beneficiaries in a difficult position because not only are they vulnerable but they also are asked to make more complex choices than those privately insured people must make (see Table 12). While most privately insured people must chose only one health insurance plan, those on Medicare historically had two—Medicare plus a supplement to fill in the gaps. The choices available for supplemental coverage vary substantially based on beneficiary locality, income, and prior enrollment history. As a result, at a minimum Medicare beneficiaries face a choice of Medigap, M+C, or "going bare" for coverage, and more than half have other options as well, such as an employer-sponsored plan.

Table 12. Sources of Supplemental Coverage by Type, 2000

	All Beneficiaries (percent)	All Beneficiaries in Counties with Medicare+Choice (percent)
Any group coverage	38	40
Employer	34	37
Self	24	27
Spouse	15	16
Military	6	6
Any Medicaid	14	13
Any Medigap	21	22
Any Medicare HMO	16	24
Any other	14	13
None	17	13

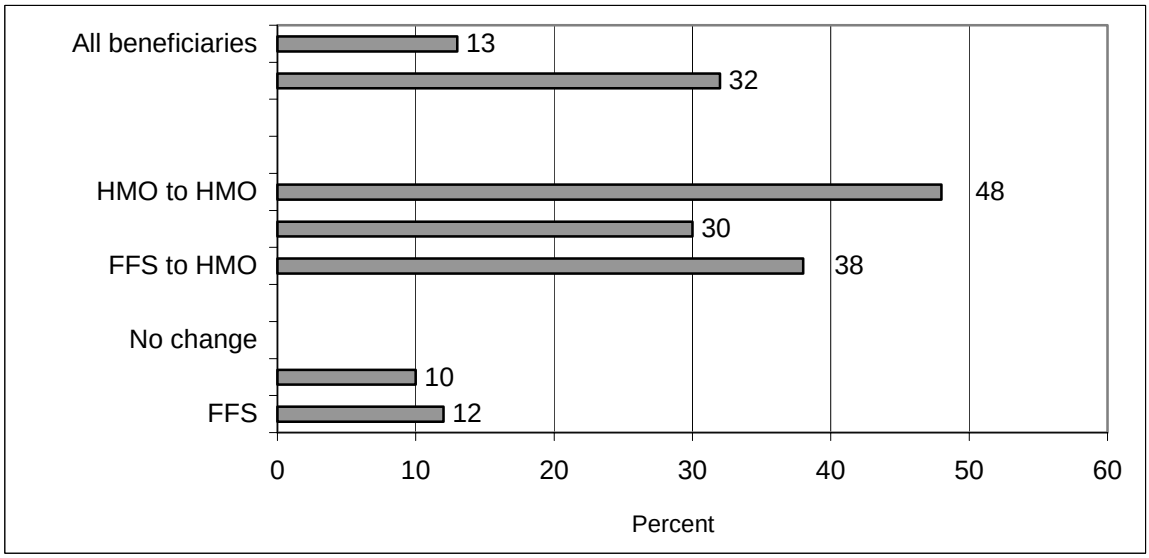
Source: MPR Survey Medicare Beneficiaries in Gold et al., 2001.

Note: Individuals may have more than one form of coverage. Data are self-reported except for Medicare HMO status, which comes from CMS records.

SALIENCE OF CHOICE

Despite the array of potential choices, more than half of Medicare beneficiaries either never thought about Medicare HMO or other supplemental coverage (44 percent) or said they did so only when they first became eligible for Medicare (14 percent). Only 15 percent of those surveyed said they thought seriously about their choices during the fall 1999 open-enrollment period, and only 11 percent said such thought involved very or somewhat serious consideration. Consideration of choice varies with an individual's circumstances (see Figure 8).

Figure 8. Extent to Which Beneficiaries Thought Seriously About Choice Since September 15, 1999, by Circumstance and Whether They Switched Plan



Source: MPR Survey of Medicare Beneficiaries for RWJF in Gold et al., 2001.

Note: Ninety-five percent of Medicare beneficiaries made no change; 2.5 percent were voluntary switchers; 0.9 percent was forced switchers; and 1.3 percent were new beneficiaries.

Some beneficiaries are forced to make choices whether they think about them or not—particularly those new to Medicare or those who are forced to switch because their plan withdrew from the program. Including these two groups with those giving serious consideration to change brings the estimate of Medicare beneficiaries who found choice salient in 2000 to 14 percent.

Switching health plans for whatever reason is not very common in Medicare even when it is considered. Less than 5 percent switch between the traditional Medicare program and a Medicare HMO or among plans in a year. Most typically, those switching say it was to improve benefits and premiums, because of plan withdrawals, or because they move.

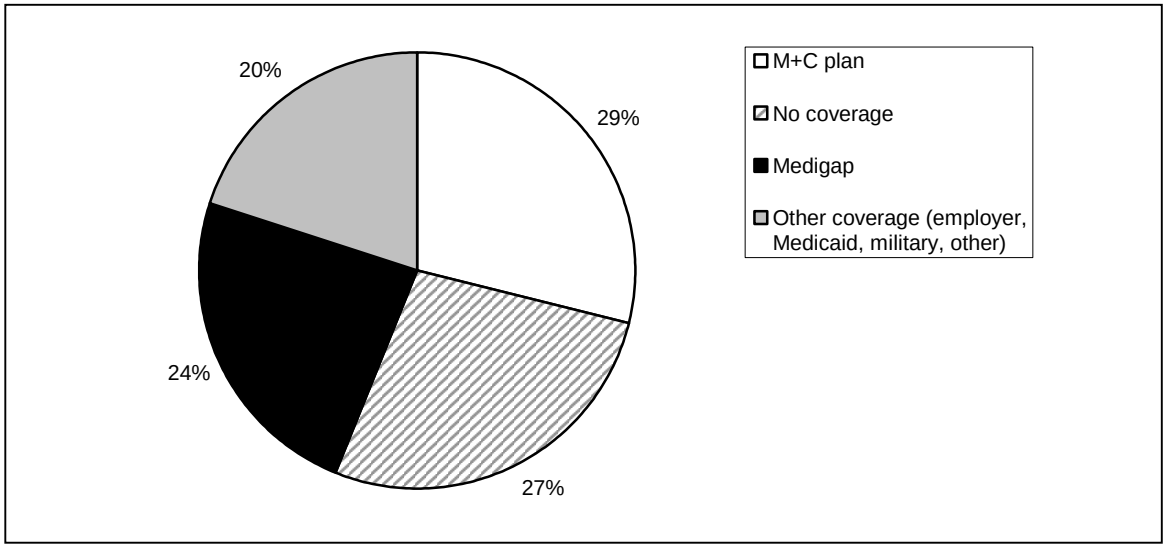
Among beneficiaries who want to switch but cannot, the most common reason is that they think they cannot afford it.

BENEFICIARIES IN TERMINATING PLANS IN 2000

In 2000, 327,000 beneficiaries were in plans that terminated their participation in Medicare, and beneficiaries in our survey who were enrolled in them were confused by the withdrawals (Gold and Justh, 2000). CMS (which was named the Health Care Financing Administration at the time) required plans to notify beneficiaries by letter about such terminations. Seventy percent of affected beneficiaries confirmed they received such a letter (the rest were evenly split between those saying they had not and those who did not know). Those saying they got a letter were about 1.5 times more likely to say they knew what their choices were (57 percent versus 38 percent) than were those not getting a letter. Even so, a third who received letters still said they did not know what to do.

Finding an alternative source of coverage on disenrollment was challenging, and 27 percent found no alternative. Among those terminated, 73 percent maintained supplemental coverage: 29 percent from another plan and 44 percent from Medigap (see Figure 9). Those who did not keep their supplemental coverage were disproportionately least educated and had lower incomes. While a lower proportion reported fair or poor health than among those who kept their coverage, 29 percent of those without coverage reported fair or poor health. In the later years of M+C, the task of maintaining coverage in the face of withdrawals probably grew harder as beneficiaries had fewer choices remaining in the market.

Figure 9. Current Coverage, Enrollees in Medicare+Chice Plans Terminating in 2000

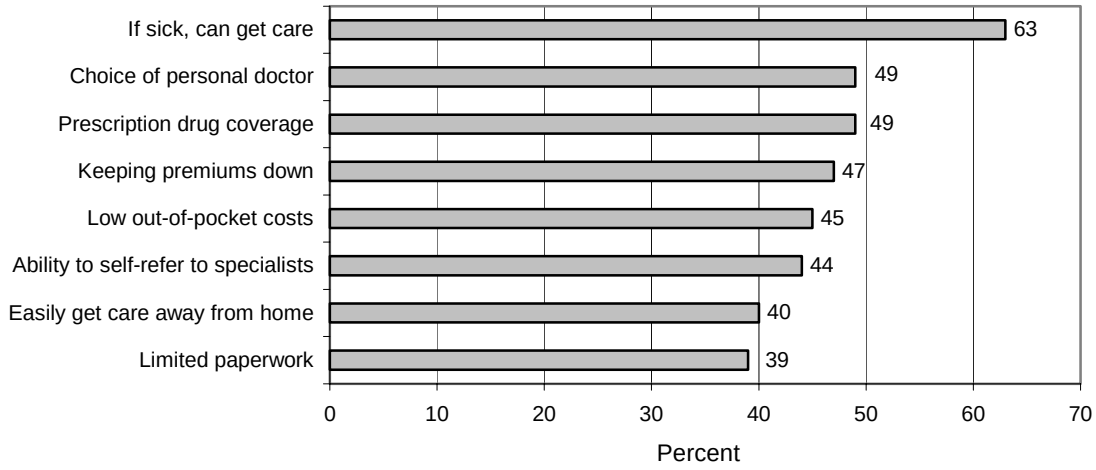


Source: MPR Survey of Medicare Beneficiaries in Gold and Justh, 2000, *Fast Facts No. 1* .

BENEFICIARIES' PRIORITIES IN CHOOSING A PLAN

Regardless of their consideration of choice, all beneficiaries responded to a hypothetical question about what would be most important if they were considering choice today. The dominant factor cited was the ability to get care when they are sick (63 percent said this was extremely important) (see Figure 10). Otherwise, beneficiaries appeared to be about equally concerned with benefits and costs (prescription drugs, keeping premiums down, low out-of-pocket costs) and their ability to access the providers they wish (choice of personal doctor, ability to self-refer to specialists). Getting care away from home and limiting paperwork were also important.

Figure 10. Percent of Beneficiaries Saying Various Factors Would Be Extremely Important If Choosing a Health Plan Today



Source: MPR Survey of Medicare Beneficiaries for RWJF in Gold et al., 2001.

Those in M+C plans and the traditional program were about equally likely to say getting care was especially important when they were sick. As one might expect, those in HMOs placed somewhat more weight on benefits and premiums, although differences were not large (Gold et al., 2001. Survey data for 2000 showed that beneficiaries were relatively satisfied with their coverage but were becoming more concerned with its cost. Those reporting rising costs and being more worried were substantially more likely than were those less concerned to make a change or consider one.

When asked to assess the information available to them to support health coverage choices in 2000, only 15 percent of those for whom choice was salient that year said it was excellent, and 23 percent said it was very good. Beneficiaries were about equally divided between those saying the choice was hard and those who said it was easy. Typically, beneficiaries spend either no time or only a few hours considering their choices (51 percent), though some spend much more time (e.g., 24 percent say they spend "many days").

Based on a review of the information infrastructure in the six communities, MPR researchers concluded that getting information to consumers is hard and takes time and

money, and that national-level policymakers need to be more sensitive to the many ways that nationally authorized plan options play out at the local level (Stevens and Mittler, 2000). They also concluded that education can only take beneficiaries so far, and policymakers needed to have realistic expectations about conveying information on very complex programs to people with the kinds of characteristics common in Medicare.

INFORMATION FOR CHOICE

When beneficiaries do consider their choices, they typically rely on informal sources of information (Gold et al., 2001). Of those making choices or seriously considering them for 2000, 36 percent said their most important source of information was their physician, and 18 percent relied on a spouse, family member, or, less common, a friend (see Table 13). Only 12 percent said they relied on health plan information as their most important source of information, though almost half (49 percent) said they make some use of information provided by their plan. Only 25 percent of all Medicare beneficiaries reported receiving no information of this type.

Among more formal sources of information in 2000, Medicare is the most commonly used source. While only 14 percent of beneficiaries for whom choice was salient in 2000 said that Medicare/Social Security was the most important source of information, 47 percent said they made some use of this information, about the same percentage that made some use of information from their current health plan (49 percent). Medicare is a particularly important source of information for new beneficiaries. Two-thirds of new beneficiaries surveyed who actively considered choice in 2000 said they made some use of this information, and almost a third said it was their most important source.

In contrast, though choices vary locally, and CMS supports local beneficiary counseling, only 10 percent of those for whom choice was salient said they used AARP or another senior group as a source of information in considering choice, and even fewer used any of these groups as their major source. Of those for whom choice was salient in 2000, only 11 percent said they attended any in-person meeting on Medicare plans. The most typical sponsor cited for such feelings was by a Medicare HMO. The data suggest that the formal infrastructure of organizations for seniors reached at most 5 to 10 percent of those who were actively considering choice in 2000.

Based on interviews, information intermediaries confirmed that their resources were limited (Stevens and Mittler, 2000). Most state organizations received only $5,000 to $10,000 per year in external federal funds to support Medicare education. Sometimes support came from other sources, but most of the time it did not, so the organizations were forced to stretch available funds. For many organizations at the local level, Medicare education was just one of their many activities.

VARIATION BY VULNERABLE SUBGROUP

Choice and educational needs vary with the characteristics of Medicare beneficiaries. Yet, while vulnerable subgroups often have more, not less, need for information to support choice, the vehicles available for doing so often are not well targeted to their needs. Key findings about the needs of several subgroups of beneficiaries are as follows (Gold and Stevens, September 2001) (see Table 14).

Disabled Under Age 65. This is a diverse subgroup whose needs are not very well met by an information infrastructure developed around the aged. Thirteen percent of Medicare beneficiaries are under 65 years of age and qualify because they have a disability (Gold and Stevens, May 2001). The disabled are likely to be in poor health (62 percent said their health is fair or poor), and 68 percent have a chronic condition lasting at least six months, requiring a prescription drug for three months or more, and seeing a doctor at least twice a year. Almost a third (31 percent) lack supplemental coverage, a rate twice as high as for beneficiaries overall.

Not surprising, almost twice as many disabled or aged beneficiaries found choice salient in 2000 (26 percent versus 14 percent). But finding information to support choice is particularly difficult for the disabled, who are a diverse group that cannot be reached easily by any single strategy. For example, those with mobility problems have trouble attending in-person sessions for information, whereas those with mental illness may have trouble processing information. Because 45 percent of the disabled are divorced, separated, or never married, a spouse is less available to help make decisions. Compared to the aged, disabled beneficiaries are much more likely to rely on a local hospital or clinic, and friends are more important than family. They also rely more on the Internet, TV, radio, the library, and newspapers for information than do the elderly. Community interviews found that even the formal infrastructure for educating Medicare beneficiaries is not well targeted to them. As a result, disabled beneficiaries often use sources of Medicare information geared to seniors, and almost two-thirds make some use of information from Medicare/Social Security.

The Oldest Old. These beneficiaries often face limitations in considering choice and need to rely on others to help them. Eleven percent of Medicare beneficiaries are 85 years old or older, and the proportion of oldest old is rising. Those 85 years old and older are more likely to have low incomes (39 percent had incomes of $10,000 or less in 2000 versus 22 percent of those ages 65-84). Only 56 percent of the oldest old completed high school, and 22 percent of this group has vision or hearing problems. Processing information is more of a challenge, with only 65 percent able to complete our survey without a proxy.

With less mobility, the oldest old are more likely to use the telephone or radio to get information; few used the Internet at the time of our survey. Many in this subgroup require help from friends and family to make choices. This task can be demanding, with surveyed caregivers who provided such help saying they spent 7 hours in person or on the phone with a beneficiary explaining his or her choice in 2000 and another 12 hours reading or considering other options. To do this, 44 percent said they had to drop or not attend to other matters.

Table 14. Sources of Information Used in Making Choices for Beneficiaries for Whom Choices Are Salient,* Selected Vulnerable Subgroups, 2000 (In Percentage)

	Any Use of Source								Most Important Source							
	All Beneficiaries[a]	Disabled under age 65	5+	Fair/Poor Health	Less than High School	African American	Other Races	Hispanic	All Beneficiaries[a]	Disabled under age 65	5+	Fair/Poor Health	Less than High School	African American	"Other" Races	Hispanic
Current health plan	49	49	51	59	64	52	51	43	12	19	4	15	14	8	7	12
Medicare/ Social Security	47	62	52	51	54	51	49	51	14	13	23	16	22	46	12	28
Former employer/ union	21	16	16	22	7	41	33	14	5	11	4	2	1	0	5	8
Local hospital/clinic	21	35	23	25	29	30	29	20	5	1	0	7	1	3	1	1
Doctor/other medical	47	51	40	45	61	53	37	37	36	38	27	43	42	17	15	13
AARP/senior group	10	14	26	8	11	9	12	8	2	4	1	2	2	1	2	0
Spouse	24	17	11	28	29	10	59	35	15	3	5	2	2	5	35	27
Other family	26	25	38	25	33	19	33	30		6	22	4	8	16	10	5
Friends	22	35	27	27	19	12	23	19	3	1	8	2	3	2	4	3
Library/news-paper	20	29	26	22	16	10	28	16	1	0	2	0	1	0	2	1
Television/ radio	21	32	28	22	11	17	21	14	2	1	4	1	1	3	1	1
Internet	2	5	3	3	3	3	8	3	1	3	0	2	3	0	5	0
Attended in-person meeting	11	9	11	6	3	34	10	6	NA	NA	NA	NA	NA	NA	NA	NA
Used Medicare handbook	33	31	20	43	29	14	20	15	NA	NA	NA	NA	NA	NA	NA	NA

Source: MPR Survey of Medicare Beneficiaries in Gold and Stevens, 2000.

NA: Not applicable; not included in the list used for most important source.

*Includes new beneficiaries; those switching to, from, or between HMOs; and other beneficiaries who say they seriously considered making a change.

[a]Figures shown include entire sample, not just vulnerable subgroups.

Fair or Poor Health Status. Health plan choice is particularly relevant to those with health conditions or disabilities which lead them to depend more than others on the timely receipt of needed services. Among beneficiaries ages 65-84, 32 percent said there were in fair or poor health, and 27 percent needed help with at least one activity of daily living. Like the under-age-65 disabled group, doctors and other medical providers are a very important source of information for this group. However, medical professionals receive little training or support in performing this function.

Racial and Ethnic Minorities. While Medicare beneficiaries are less diverse than the general population, diversity exists, and it is growing. Further, racial and ethnic subgroups, which tend to be geographically concentrated, account for a significant number of people in some communities. For example, Hispanics account for 28 percent of Medicare beneficiaries in Albuquerque, and African Americans are 28 percent and 19 percent of beneficiaries in New Orleans and Baltimore, respectively. In Orange County, where 15 percent of beneficiaries report their race as "other," Asian Americans are an important subgroup.

Both race and ethnicity influence how beneficiaries seek and interpret information and the kinds of sources they trust (Stevens and Mittler, 2000). In the six communities studied, minorities did not actively seek information about public programs until a trusted acquaintance or family member had a successful experience in learning about these programs or had actually received benefits from them. In communities with a history of discrimination, distrust may be high, and minorities primarily use word of mouth or informal channels of communication for information. Each subgroup and each community likely has its own pattern of communication. African Americans surveyed, for example, tended to rely less on family and more on Medicare, whereas the opposite is true for Hispanics.

THE INFORMATION INFRASTRUCTURE IN SIX COMMUNITIES

In general, the local information infrastructure has two tiers (Stevens and Mittler, 2000):

- The first tier usually consists of the local State Health Insurance Assistance Program (SHIP), the local Area Agency on Aging (AAA), the M+C organizations, the regional CMS office, Part B carriers, and the state Department of Aging. These organizations actively develop and present materials.

- The second tier comprises senior centers, ethnic churches, advocacy groups for immigrants, fraternal organizations, and other organizations that serve the elderly and disabled such as Meals on Wheels. These organizations often host first-tier groups.

The specific groups involved vary by community, as observed in the six communities we studied. For example, in California, Florida, and Louisiana, the department of insurance took an active role. In Detroit, New Orleans, and Orlando, the local peer review organization (PRO) was important. Particular organizations are active in individual

communities (e.g., the United Auto Workers and the "big three" automakers in Detroit). Cooperation between the community-based organizations and health plans is relatively rare, with most education occurring along parallel, not intersecting, paths. Health plan efforts to educate beneficiaries are viewed with some suspicion by public and nonprofit intermediaries, whereas many health plans are unaware of any activities (or sometimes even the existence) of the SHIPs or other nonprofit educational efforts. Typically, health plans devote substantially more resources to marketing and enrollment than do the public and nonprofit sectors, so they are likely to reach more people.

Many organizations thought to be likely Medicare educators did not actually provide much education. For example, few consumer or patient organizations are involved in Medicare education in the six communities studied (with limited exceptions in New Orleans and Orange County), and of traditional health care providers, hospitals and physicians are only minimally involved in any organized way.

CHANGES IN INFORMATION SOUGHT OVER TIME WITHIN SIX COMMUNITIES

As markets evolve, the need for information to support beneficiaries in markets has changed over time. Each of the six communities studied had a relatively well-developed M+C market when we selected them, yet by 2004 M+C had diminished in all of the communities and had virtually disappeared in Baltimore and Detroit (see Black and Gold, 2004). Even in markets with a substantial number of remaining plans, such as Orange County, benefits were lower.

As a result of these changes, beneficiaries wanted different kinds of information. For example, demand for information increased when there were plan withdrawals or major benefit cuts, particularly information about alternative sources of drug coverage if that benefit was no longer available. With withdrawals, plan instability became a more prominent beneficiary concern, and interest in new enrollment in M+C choices diminished. In markets with limited choice, demand for information was also low, and beneficiaries focused on alternative sources of coverage. With enactment of the MMA, information demands are shifting again, with high demand now for information to make sense of the new drug discount card choices and later, we expect, for information on the changes in 2006 in drug benefits and new kinds of private plans.

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CHAPTER VI

POLICY IMPLICATIONS OF PLAN OPERATIONS

Medicare HMOs are complex products that involve contractual relationships between plans and providers as well as features that influence the delivery of care. Two policy-relevant aspects of plan operations that we studied are the way M+C plans deliver drug benefits (pre-MMA) and how they structure their provider networks.

PHARMACEUTICAL BENEFITS

To understand better how pharmacy benefits are currently provided in M+C plans, we conducted interviews in February and March 2002 with six national managed care firms (Aetna, Health Net, Humana, Kaiser Permanente, PacifiCare and United Healthcare) and eight independent, geographically dispersed plans (three of which were affiliated with Blue Cross-Blue Shield) (Draper, Cook, and Gold, 2003).

Structure of the M+C Pharmacy Benefit. When M+C plans cover pharmacy benefits, they generally use a network of contracted retail pharmacies, often supplemented by a mail-order option. Both national and local M+C plans typically contract with a pharmacy benefits management (PBM) company to assist in managing the benefit. A few national firms do the all PBM functions in-house, but most do not. PBMs typically are used for claims adjudication and data collection. They also often use electronic communication technology to handle drug utilization review at the point of sale, prior authorization, copayment assessment, and expenditure tracking. HMOs typically retain responsibility for benefit design, maintenance of the formulary, and negotiating rebates with drug manufacturers.

Cost Management of the Pharmacy Benefit. Plans frequently impose formularies, tiered copayment structures, and physician and enrollee education programs to help manage the drug mix. Formularies play a central role in benefit management, underpinning all other cost-containment features. In Medicare, plans have commonly limited the drug benefit to a fixed-dollar amount to control the volume of prescription drugs and to discourage adverse

selection. The primary tools for lowering the price of individual drugs are rebates from drug manufacturers and negotiated retail pharmacy prices.

Integrating the Pharmacy Benefit with Care Management. M+C plans say that pharmacy benefits are an integral part of care management. Pharmacy benefits are especially relevant to implementing disease management programs, predictive modeling of catastrophic medical conditions, and condition-specific quality improvement initiatives, each of which typically relies heavily on pharmacy data. Case managers may be employed to coordinate various aspects of care, including pharmaceuticals. Enrollee education encourages appropriate care patterns and minimizes drug interactions, and physician education and benchmarking encourage improved prescribing practices.

The way M+C plans structure pharmacy benefits could give them an advantage in providing the benefit in MMA over a freestanding drug benefit plan. By providing an integrated benefit, plans are likely to have an easier time gaining access to pharmacy data they can use to manage care for particular conditions or circumstances. Because they are at risk for all Medicare benefits, plans are able to offset expenses in one area with savings in another if these occur. In contrast, those operating a freestanding drug plan would not have this advantage. In addition, the interviews show that PBMs generally do not assume risk, even when they work with an HMO. When employers use them for non-HMOs, the typical structure is for the employer (especially if it is large) to self-insure more loosely managed products (e.g., PPOs), carving out the pharmacy benefit and retaining risks for its costs. In effect, employers are serving the same role as HMOs in doing so. The freestanding drug benefit in the MMA is not set up this way.

PROVIDER NETWORKS

Historically, HMOs participating in Medicare were required to have 50 percent of their enrollment from private insurers (i.e., not Medicare or Medicaid). While this requirement no longer exists, the vast majority of HMOs have a mix of public and private enrollees, with the latter dominating enrollment in numbers.

To assist the Medicare Payment Advisory Commission in understanding how provider networks are structured in managed care plans, we surveyed a multistage random sample of HMOs operating in 20 metropolitan areas nationwide in 1999. The 116 responding plans represented 82 percent of those surveyed and enrolled nearly 28 million people at the time of the survey. All plans were asked about their commercial networks; the 85 of the 116 plans that reported having a Medicare contract were also asked about that arrangement and how it differed from that under Medicare (Lake, Gold, and Hurley, 2001).

Provider Networks in M+C. In general, M+C plans in 1999 tended to use the same provider networks for their Medicare and commercial product**s**. Seventy-three percent had the same physician network, 75 percent the same hospital network, and 85 percent the same skilled nursing facility network. When there were differences, the Medicare network almost always was smaller. The reason for this has to do with lower Medicare payment levels and greater provider unwillingness to participate in Medicare. (Skilled nursing facility network

differences were more idiosyncratic.) The survey was conducted at a time when M+C was under stress, with federal capitation rates rising slowly and plans starting to withdraw from the market. About three-quarters of the plans said that they had at least some problems renegotiating their provider contracts in 1998 and 1999. An inability to maintain an adequate network was one reason plans gave for withdrawing from the Medicare program.

Provider Payment in M+C. M+C plans tended to use similar basic payment methods for providers in their Medicare and commercial products. In 1999, risk sharing with intermediate organizations, including large medical groups, independent practice associations, and physician hospital organizations, was common in both Medicare and commercial products. Among plans with both types of products, 66 percent had at least one global capitation contract—with risk sharing for both hospital and professional services, 53 percent had professional risk-sharing contracts, and 11 percent had risk shared for hospital services. Among those with global risk-sharing products, about half used the same arrangement for both the Medicare and commercial product. While the risk-sharing arrangements differed, more risk was typically transferred in the Medicare product. Results provided evidence that instability was beginning to surface within M+C and highlighted the importance of risk sharing between plans and groups of providers as a way to manage the benefit. While such arrangements are reported to have diminished, they were important to plans and may still be more prevalent than commonly believed, particularly in terms of partnering between plans and large medical groups or integrated delivery systems in markets where they are dominant and managed care has a long history.

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CHAPTER VII

INSIGHTS FROM THE MEDICARE+CHOICE EXPERIENCE

DYNAMICS THAT NEED TO BE UNDERSTOOD

The Monitoring Medicare+Choice project highlights the important interconnections between public policy and market behavior. When there is a well-functioning partnership between government and industry, this can work well. When there is a mismatch between public priorities and business interests, there can be risks and strains. Our work highlights three fundamental features of the market for public plans in Medicare that need to be understood in creating an expanded role for private plans in Medicare.

- ***Plan availability.*** Plans treat decisions on entry and exit from the Medicare market as important strategic business decisions. Firms differ in how they view their overall position in the market, which influences their overall product lines and decisions on Medicare. Plans do not develop products they do not think will be viable. Many factors influence plan calculation of viability, including the structure of the population and the economics of markets that make some more hospitable to managed care than others. Public policy can influence the viability of products through the way they affect the cost of doing business, including the way payment rates are established, the kinds of requirements in place, and the restrictions placed on plan enrollment. Stable and predictable payments and requirements are greatly valued by plans. Congressional processes and budgetary pressures constrain how well public policymakers are able to meet these requirements. The potential cost impact of addressing industry concerns are factors policymakers may face and need to consider.

- ***Incentives to enroll.*** From a beneficiary perspective, good benefits at a competitive premium are the major incentive to enroll in a plan. Beneficiaries typically trade off provider choice for cost savings; their incentive to do so depends on how price-sensitive they are. Beneficiaries with alternative access to low-priced supplemental coverage from previous employment or from the state have less incentive to enroll in an M+C plan. This is because those employers

or the states subsidize the cost of Medicare supplemental benefits and subsidies typically are not structured in ways that provide strong financial incentive to join a Medicare managed care plan. Since private health plans probably will be voluntary for some time, the likely "reach" of managed care in Medicare will be limited. Looking ahead, it is possible that the Medicare Advantage program structure will result in new incentives to enroll, such as the ability to get a single integrated insurance plan that combines Medicare, Medigap, and prescription drug coverage.

- ***Effects of market instability.*** Plan entry and exit are integral features of markets. A number of the early withdrawals from M+C can be viewed as a normal response to the rapid expansion of the market in the late 1990s, with inevitable failures as plans misjudged the receptivity of particular markets to their products and the firm's ability to manage those products. However, the extent of instability under M+C far exceeds what one might have expected. Both public policy (limited annual payment increases) and changing market conditions (the managed care backlash and provider consolidation) appear to be important reasons why instability on the scale experienced by M+C occurred. Under these conditions, the dynamics created a downward spiral that made it increasingly difficult for plans to maintain their provider networks and attractive benefits. The instability associated with M+C created an environment in which plans, providers, and beneficiaries all felt "burned." Stakeholders' initial reaction to Medicare Advantage will be colored by these perceptions, and the program will only succeed to the extent that stakeholders believe it provides the opportunity for stable, long-term offerings.

LESSONS FOR MA FROM THE MEDICARE+CHOICE EXPERIENCE

The Medicare+Choice experience is relevant to Medicare Advantage and can provide policymakers with insights into what it will take to succeed. Based on our analysis, the following three challenges need to be addressed for successful development of private plans under MA:

- ***CMS as a reliable business partner.*** Advance notice and predictable processes and policies on changes in rates and requirements are essential to private plans so they can plan on a multiyear basis. CMS's early work in issuing regulations and following through on the MMA mandates will provide critical information to industry about how reliable it is likely to be as a business partner. Ultimately, however, predictability is bound by the limitations of the congressional process. In addition, many of the new options under MMA are being rolled out in 2006. The November 2004 election inevitably generates uncertainty about the government's long-term commitment. If there is change in leadership of the executive or legislative branch, the way new leaders interact with industry could affect the way plans react to the MMA.

- ***Beneficiary education.*** Beneficiary education needs to be well financed and to focus on the needs of vulnerable populations if these populations are to be encouraged to consider choice. Though the BBA recognized the importance of beneficiary education and added funds for it, our findings suggest that the amount of work needed to support choice fully far exceeds the capacity of the current system. Products that vary by market or a beneficiary's circumstance, as MA products do, make education substantially harder and the need for local information much greater. In addition, Medicare has many subgroups with distinct needs that require tailored efforts. These include under-age-65 disabled beneficiaries, those who are very old or need special help to overcome cognitive or physical limitations and limited education, and those with special needs—such as people with ethnic and racial preferences or who speak different languages. Unfortunately, support that is targeted to the most vulnerable subgroups of the population tends not to be very developed, thus magnifying the challenges in implementing the MMA.

- ***Realistic expectations are essential.*** Though MMA's goals are ambitious, there are many barriers to change. Given the current structure of supplemental coverage, private plans are likely to be most relevant to beneficiaries in the individual market. Ultimately, they may become attractive to employers or public purchasers, but given their experience, it is likely the plans will need to prove their viability and sustainability first. That will lower likely enrollment targets. Stand-alone drug plans that bear risk and regional plans that can cover large geographic areas, including isolated rural areas, at a single uniform rate will present challenges for business and may be hard to develop, especially rapidly. Expecting private plans to save substantial money for Medicare is unrealistic given the current marketplace and M+C experience.

While the MMA mandates extensive change, it is likely to evolve relatively slowly. How change is implemented and at what pace depends on how well government and industry understand each other's concerns, whether the concerns of each party are compatible, and how well they reflect beneficiary needs. The change of scale envisioned in the MMA for private plans in Medicare also will not occur unless beneficiaries see its value and support it. The risk in moving quickly is that the beneficiary protections in place may be insufficient, leading to confusion that will damage the overall enterprise and long-term goals of creating a stable and viable Medicare program.

While Congress set ambitious goals with the MMA, there are many challenges to translating these goals into realities. Successful translation is more likely if expectations are realistic, policymakers are able to understand and adapt to the business realities of the private plans they seek to involve, and sufficient budgetary and other resources are put in place to support and protect Medicare beneficiaries making the transitions called for under the MMA.

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APPENDIX A

MONITORING MEDICARE+CHOICE PUBLICATIONS

The Robert Wood Johnson Foundation funded most of the publications of the Monitoring Medicare+Choice project. The Commonwealth Fund provided support for the analyses of benefits and premium trends, and additional targeted analyses were funded by The Kaiser Family Foundation, the Medicare Payment Advisory Commission, and AARP. Publications generally are available through the MPR website (www.mathematica-mpr.com). Publications funded by entities other than RWJF also may be obtained from those organizations' web sites.

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** Funded by The Kaiser Family Foundation.
*** Funded by AARP.
**** Funded by the Medicare Payment Advisory Commission.

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APPENDIX B

MMA CHANGES AND THE MEDICARE ADVANTAGE PROGRAM

While the private plan features of the MMA are focused on a 2006 implementation date, the law authorizes immediate changes in MMA to stabilize the market. In January 2004, M+C ceased to exist and was absorbed into MA and what ultimately will be a more complex set of choices. In an effort to put more money into the system to help stabilize the market, payment rates were modified. All plans, regardless of what payment rules they otherwise would fall under, will receive at least 100 percent of the FFS payment rate in that county. The minimum annual increase, 2 percent in most years, is modified in ways that lead to higher minimum payment increases in 2004 and 2005.[12] In 2004, the minimum increase was 6.3 percent, with the average plan (weighted by enrollment) getting 10.9 percent (Achman and Gold, 2004). In 2005, the minimum increase is scheduled to be 6.6 percent, with 41 percent of enrollees in plans getting more because they are in counties where 100 percent of FFS leads to higher payments. Table B-1 shows the impact of these changes on plans for 2004. Analysis of the impact of these changes on plan benefits in 2004 is forthcoming (Achman and Gold, forthcoming).

Policymakers seeking to assess the return from such investments may want to focus on the ability of the added payments to stabilize or even reenergize the market through expanded options rather than diminished choices, offerings that are more attractive to beneficiaries, and enrollments that grow rather than shrink. Ultimately, it may be less important that MA becomes a larger program from 2004 to 2006 than that the changes give plans, beneficiaries, and providers more confidence that private plans will be a stable Medicare option so that beneficiaries are willing to consider enrolling, providers participating, and plans willing again to partner with the government.

[12] In 2004, the blend, authorized by the BBA originally, is allowed even if it adds to costs (i.e., exceeds budget neutrality). However, only 7 percent of enrollees are in plans helped by the blend because many get more by either the floors or 100 percent of FFS.

Table B-1. Medicare Advantage Enrollees, U.S. Counties, and Payment Increases by Type of MA Payment Rate, March-December 2004

Rate Category	Percent of Medicare Beneficiaries	Percent of M+C Enrollees	Number of Counties	Average Payment Rate Relative to FFS*	Average Increase 2003-2004[a]	Average Percent Change 2003-2004[a]
Overall	100	100	3,223	107.3%	$67.50	10.9
Increase blend	4.1	7.3	93	111.3%	$59.38	9.8
Rural floor	18.8	4.1	1,614	121.0%	$44.07	8.8
Urban floor	27.6	26.0	538	116.6%	$50.05	8.9
Minimum update	12.4	21.8	141	105.4%	$45.22	6.3
100% FFS	37.3	40.7	837	102.3%	$94.42	15.3

Source: MPR analysis of CMS Medicare Advantage 2004 Rate Files; see Achman and Gold, 2004 for methods.

Note: Excludes counties in Guam and the Virgin Islands, but includes Puerto Rico. Data reflect demographic payment rates, which account for 70 percent of plan payments in 2004. FFS rates were adjusted to account for double-counting of indirect medical expenditures (IME) in MA payment rates.

[a]Data weighted by M+C enrollees in September 2003.

In 2006, all beneficiaries who want Medicare-financed drug benefits will have to join a private plan. Those wishing to stay in traditional Medicare can, but they will be required to choose a freestanding drug benefit plan where they live to get such benefits. The alternative is to join a local MA plan or a new regional plan and receive drug coverage through that. CMS is still developing operational requirements for the regional plans. The country will be divided into 10 to 50 regions (still to be determined), with plans available in all counties. Regional plans will bid to participate in the program. Beneficiaries who do not choose a drug plan when the benefit becomes operational but choose to do so later will pay a 1 percent additional charge per month for each month they are not covered.

Regional PPOs will be modeled as loosely managed products. These products, which will include Medicare drug benefits, are required to address current Medicare benefit limitations by structuring themselves to include a single deductible and an out-of-pocket limit on cost sharing that may vary for in- and out-of-network services. To encourage development of regional plans, the government is authorized to share risk with plans in the short term and to use money from a regional stabilization fund to encourage participation of national plans, attract plans to underserved regions, and to prevent withdrawals. Regional plans are required to offer the same benefit package across all counties in the region, and their payments will reflect plan bids and regional/national benchmarks.