MEDICARE+CHOICE AFTER FIVE YEARS: LESSONS FOR MEDICARE'S FUTURE

FINDINGS FROM SEVEN MAJOR CITIES

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FIELD REPORT

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CONTENTS

LIST OF TABLES AND FIGURES

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EXECUTIVE SUMMARY

Policymakers had great ambitions for the Medicare+Choice program, established by the Balanced Budget Act of 1997. At its inception, the program seemed to be a promising way to solve two of Medicare's most pressing problems: its ever-increasing expense to the federal government, and its inadequate and outdated benefit package, which exposed many beneficiaries to high out-of-pocket costs.

Proponents also envisioned that the Medicare+Choice program would create a competitive marketplace, offering Medicare beneficiaries a meaningful choice among private health plans as an alternative to the original fee-for-service program. Medicare would provide beneficiaries with timely and accurate information about managed care options in this new market, and elderly and disabled consumers would respond by making informed choices. As enrollment in Medicare+Choice plans grew, private health plans would gradually relieve the federal government of its responsibility to regulate provider payment policies to hold down overall costs in the Medicare program.

Five years later, it is clear that Medicare+Choice has not become what program proponents had envisioned. While the Congressional Budget Office had originally forecast that program enrollment would rise to 34 percent of total Medicare enrollment by 2005,[1] the enrollment has now fallen from its 1997 level of 14 percent to just 13 percent. The number of Medicare+Choice contracts that Medicare holds with private health plans dropped by more than half from 1998 to 2002; these four years of highly publicized plan withdrawals affected more than 2.2 million beneficiaries. The program has also failed to restrain federal spending on Medicare.[2]

Growing Dissatisfaction with Medicare+Choice: Plans, Providers, and Beneficiaries

The decline in Medicare+Choice is partially attributable to the fact that the program has become increasingly unattractive to each of its three voluntary participant groups: private health plans; providers, including physicians and hospitals; and beneficiaries. This report, based on a review of the program in seven metropolitan areas with varying Medicare payment rates and local health care market structures (Cleveland, OH; Houston, TX; Long Island, NY; Los Angeles, CA; New York, NY; Seattle, WA; and Tucson, AZ), examines the reasons why each of these three parties has become disenchanted with Medicare+Choice. Understanding the dissatisfaction of participants is crucial to determining how to stabilize the program and assess its strengths and weaknesses when considering broader Medicare reform.

Plans' perspective. Medicare+Choice is an increasingly unappealing business venture for health plans for two reasons: the tight restrictions placed on federal annual payment increases for Medicare and the growing provider demands for larger payments. Most Medicare+Choice plans operate in large urban or suburban counties, where Medicare has been making only 2 to 3 percent payment increases per year over the past four years. Overall health care inflation has been running at 8 to 10 percent per year. National for-profit health plans, especially publicly traded firms, have fled the program in response to this policy's impact on future profitability.

Providers' perspective. In local health care markets across the country, hospital and medical groups have consolidated and used their newfound leverage to negotiate large payment increases and relaxed utilization review policies from their contracting Medicare managed care plans. This "provider pushback" against managed care has weakened the ability of Medicare+Choice plans to control either the price or the volume of health services that their members consume. Furthermore, terminations of provider–plan contracts have led to high provider turnover rates and disrupted care for many program enrollees.

Beneficiaries' perspective. Medicare+Choice has become an unstable program, characterized by annual announcements of health plan withdrawals, physician turnover, benefit reductions, particularly for prescription drug coverage, and premium increases. Clearly, the value of the plan to beneficiaries is declining. In some markets, Medicare+Choice plans are now only marginally less expensive than Medicare supplemental policies. In 2002, new cost-sharing requirements were added that are especially burdensome for beneficiaries with low incomes and chronic diseases.

Beneficiaries' confidence in the program is also waning. Elderly and disabled enrollees cannot be sure that their Medicare+Choice plan or a trusted provider in their plan's network will be there for them in the future. Growing geographic disparities in plan benefits are also leading to confusion and anger among beneficiaries.

Medicare+Choice: Options for the Future

Medicare+Choice is at a crossroads, and there are at least two different approaches to program reform. Unless policymakers make program reforms in 2002, they can expect to witness a fifth consecutive year of plan withdrawals and benefit reductions.

Medicare+Choice growth leading to private plan-based Medicare reform. This approach to program reform would require that substantial new resources be invested

in Medicare+Choice. Program proponents hope that new funds would allow private insurers to keep up with providers' demands for payment increases and consumers' demands for less restrictive plans, such as preferred provider organizations and private fee-for-service plans. This approach would place benefit expansion before cost containment, but the original conception of Medicare+Choice as a well-functioning market-based alternative to the fee-for-service program would remain.

This strategy is preferred by the Bush Administration, which has proposed major new policies to strengthen the Medicare+Choice program, including increasing payments to program plans by $3.7 billion over three years.[3] In March 2002, Secretary Tommy Thompson of the Department of Health and Human Services indicated that competition-based Medicare reform that relies on private plans should take precedence this year over other pending Medicare issues, such as revising provider payment systems in the fee-for-service program.[4] The Bush proposals build on an earlier effort, made in 2001, that modestly increased payments to Medicare+Choice plans in urban areas as part of the Benefits Improvement and Protection Act.

The Bush Administration hopes to further the role of private health insurance plans in Medicare with a proposal to replace, by 2005, the current Medicare+Choice payment structure with a "premium support" model along the lines of the Federal Employees Health Benefits Program (FEHBP).[5] This would, proponents hope, achieve two goals: strengthening Medicare's long-term financial security through private-sector competition and improving coverage by encouraging private plans to provide beneficiaries with additional benefits. Both goals are strikingly similar to those that policymakers had originally hoped to accomplish in 1997 with Medicare+Choice.

Stabilization of the Medicare+Choice program. A second approach to Medicare+Choice would be more modest, with the main goal being to preserve the program as a viable option for as many Medicare beneficiaries as possible. It would not, however, attempt to rebuild the program into what many proponents had hoped it would become—a platform for broad Medicare reform that relies almost exclusively on private managed care plans.

This approach, suggested by many policy analysts, would make some changes to Medicare+Choice policies to protect vulnerable beneficiaries from both high out-of-pocket expenses and the continuing instability of the program. It might, for example, provide modest additional funds to Medicare+Choice plans, especially those in areas previously held to 2 percent annual increases, and it might also call for streamlining

administrative policies and developing a new risk-adjustment payment system that would be phased-in without increasing the overall program budget. To strengthen beneficiaries' security in the program, it might standardize the Medicare+Choice benefit packages in a manner similar to Medigap guaranteed-issue provisions, expand beneficiaries' rights to purchase Medigap insurance, and prohibit Medicare+Choice cost-sharing on any Medicare-covered benefit or service in excess of what the costs would have been under the original fee-for-service program.

In addition, limited Medicare funds could be focused on improvements in the fee-for-service program rather than on major expansion of Medicare+Choice program. Funds could be used to increase provider payments for hospitals, physicians, home health agencies, and nursing homes. A major prescription drug benefit could be added to the fee-for-service program with appropriate provision for coverage through Medicare+Choice for beneficiaries enrolled in plans.

Lessons for Medicare Reform

As they consider Medicare reform, policymakers should carefully examine the recent experience of Medicare+Choice and its lessons for competition-based approaches. The program's track record offers the following insights for Medicare reform:

- Large national for-profit plans may be hesitant to participate in any FEHBP-type Medicare program.
- Managed care plans have demonstrated limited ability over time to control increases in payments to local health care providers.
- Without a risk-adjusted payment mechanism, chronically ill beneficiaries will pay high out-of-pocket expenses in many plans.
- Large disparities in benefits across different geographic areas of the nation can be expected in a market-based system.
- Beneficiaries need guarantees that plan withdrawals, provider turnover, and steep increases in cost-sharing and benefit cuts would not constantly disrupt their medical care in any reformed Medicare program.

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INTRODUCTION

The Balanced Budget Act of 1997 established the Medicare+Choice program with a number of ambitious goals. Policymakers hoped the new program would: (1) expand beneficiaries' health care choices; (2) provide additional benefits; (3) restrain the growth of federal Medicare spending by encouraging competition among private health plans; and (4) reduce the need for direct government regulation of provider payment policies.

Five years later, Medicare+Choice has largely failed to meet these goals. Substantial numbers of health plans have withdrawn from the program, beneficiaries are paying higher premiums and receiving fewer benefits, and there have been considerable disruptions in plan provider networks.[6] The program has become increasingly unstable in spite of administrative and legislative efforts in 2000 and 2001 to increase payments and reduce regulations.[7] The number of program beneficiaries, which peaked in 1999, has since declined by over 1.3 million and is now at 13 percent of total Medicare enrollment—far from the 34 percent policymakers had envisioned (Appendix A).

In spite of these problems and the program's decline, the Bush Administration hopes to use the Medicare+Choice framework of expanding the role of private health insurance plans as a way to reform Medicare, envisioning a program along the lines of the Federal Employees Health Benefits Program (FEHBP).[8] The FEHBP provides coverage to nearly 9 million current and former federal employees and family members, offering fee-for-service plans, managed care plans, and point of service products.[9] Reliance on a similar model for Medicare's future puts the Medicare+Choice program at the heart of considerations of both the short- and long-term future of Medicare.

This report, based on interviews with Medicare+Choice stakeholders in seven major metropolitan areas, assesses the Medicare+Choice program after five years. It analyzes why participating in the program has become less attractive to three key groups: health plans, providers, and Medicare beneficiaries. The authors conclude that the program is not a stable foundation upon which to base broader Medicare reform, and make suggestions about how to stabilize the program for the 5 million beneficiaries still enrolled in Medicare+Choice plans.

MEDICARE+CHOICE IN SEVEN CITIES

To study the ongoing implementation of Medicare+Choice and its effect on beneficiaries, project staff of the George Washington University Medical Center's Center for Health Services Research and Policy made site visits to four major metropolitan areas: Houston, TX; Long Island, NY; New York, NY; and Seattle, WA. Staff also updated information from three previously visited sites: Cleveland, OH; Los Angeles, CA; and Tucson, AZ (Appendix B).[10]

Project staff conducted structured interviews with senior representatives of the key program stakeholders in each city, including: Medicare+Choice plan officials; physicians, hospital executives, and provider organization officials; community leaders and advocacy groups; and relevant state and federal government agency staff. From October through December of 2001, staff members held focus groups with Medicare beneficiaries in Houston, Long Island, and Seattle.[11] During the same period, they performed telephone interviews to update information about the program's implementation in Cleveland, Los Angeles, New York, and Tucson. They complemented these interviews with an analysis of Centers for Medicare and Medicaid Services (CMS) data, extensive background material, and local media articles from each of the sites.[12]

WITHDRAWALS AND BENEFIT REDUCTIONS CONTINUE

Private health plans are the foundation of both the Medicare+Choice program and current proposals to reform Medicare on the FEHBP model. However, both nationally and in this report's seven study sites, private plans are withdrawing from Medicare+Choice, capping enrollment, and cutting benefits. Understanding the reasons for these trends is critical for policymakers looking to stabilize the program in the short term, and for those considering whether private plans are a reliable foundation upon which to reform Medicare as a whole. The Medicare+Choice program's struggles suggest that, as long as Medicare relies on private plans to offer additional benefits and, at the same time, reduce government spending, instability will be difficult to avoid.

Plan Withdrawals and Enrollment Limits

The number of plans participating in Medicare+Choice fell from 346 in January 1999 to 149 in January 2002, a decline of 57 percent. The complete or partial withdrawal of plans from 374 market areas in these years affected some 2.2 million Medicare beneficiaries.

Five of the seven study sites—Cleveland, Houston, Long Island, Seattle, and Tucson—followed the national trends in plan withdrawals. Adding to the problem, many of the plans that remained in these sites either obtained capacity waivers or froze

enrollments in 2001 and 2002.[13] In four study sites, the largest or the second-largest plan closed enrollment during the year to new members (Table 1).

Table 1. Number of Medicare Managed Care Plans in Seven Sites, 1998–2002

	1998	2001		April 2002	
Site	Number of plans	Number of plans	Plans with enrollment caps/freeze	Number of plans	Plans with enrollment caps/freeze
Cleveland	9	5	3	5*	—
Houston	11	3	1	3	—
Long Island	11	5	2	5	2
Seattle	5	2**	1	2**	—
Tucson	8	2**	1	2**	1
Los Angeles	14	10	1	10***	2
New York City	13	10	—	10	—

* One plan, Renaissance, left Cleveland effective January 2002 and a new demonstration plan, Evercare, entered.

** Does not include Sterling Option I, a private fee-for-service plan, which, as of December 31, 2001, had less than 250 enrollees in Seattle and Tucson.

*** One plan partially reduced its service area in Los Angeles County effective January 2002, while a new plan, Universal Care, entered the market in 2002.

Benefit Reductions

In 2001 and 2002, benefit reductions were also an increasing trend. Design changes emerged in three areas: significant reductions in prescription drug coverage both in the dollar amount and the type of prescription drugs covered; increased premiums for beneficiaries; and significant new cost-sharing requirements, many of which especially affect beneficiaries with chronic and life-threatening illnesses.

Reductions in prescription drug benefits. In 2002, plans across the country reduced prescription drug benefits, especially for brand-name medications.[14] Only 17 of the 33 plans (52%)[15,16] now provide any brand coverage, and many of those plans have significantly reduced what coverage they have. Many Medicare+Choice beneficiaries in the study sites have now experienced a decline in prescription drug benefits four years in a row (Table 2).

Table 2. PacifiCare's Prescription Drug Benefit in Tucson, 1999–2002

Year	Premium	Prescription Drug Benefit
1999	$0	$5 generic/$10 brand; unlimited generic/$3000 annual brand coverage
2000	$0	$7 generic/$15 brand; unlimited generic/$2500 annual brand coverage
2001	$25	$10 generic/$25 brand; unlimited generic/$1000 annual brand coverage
2002	$0	$15 generic; unlimited generic; no brand coverage

Premium increases. According to CMS estimates, the enrollment-weighted average basic premium for Medicare+Choice beneficiaries nationally rose by 53 percent between 2001 and 2002.[17] Plans in two of the study areas (Seattle and Nassau County, Long Island) increased premiums substantially more than that. Empire Blue Cross Blue Shield, in Nassau County, increased its premiums by 113 percent, from $75 to $116. In Seattle, PacifiCare increased premiums by 97 percent, from $30 to $59. In the other study sites, there was no consistent pattern of premium increase.

Increases in beneficiary cost-sharing. In 2000, most plans increased cost-sharing on such commonly used services as physician visits as well as costly items, including inpatient hospital care, injectable drugs, chemotherapy treatment, radiation therapy, and insulin. CMS estimates that these changes increased the national enrollment-weighted average monthly value of cost-sharing for Medicare-covered services from $14.88 in 2001 to $26.60 in 2002, a 79 percent increase.[18]

For example, three plans in the seven study sites increased copayments for an office visit to a specialty physician to $30. Some plans increased hospital copayments well above Medicare's $812 first-day deductible. In particular, plans increased cost-sharing on some services that beneficiaries with life-threatening illnesses require, such as durable medical equipment (including oxygen), dialysis treatment, self-administered outpatient injectable medications, oral chemotherapy drugs, and radiation treatments. (In response to patient complaints, one large plan, PacifiCare, later reduced its copayments for cancer treatment).[19]

Significant New Hospital Cost-Sharing for 2002

- **Manhattan:** United Healthcare charges $175 per day.
- **Los Angeles:** Blue Cross charges $50 per day; $2,000 maximum.
- **Cleveland:** United Healthcare charges $295 per day; $4,800 maximum.

These benefit reductions, combined with plan withdrawals and enrollment limits, have resulted in a sharp decline in the number of beneficiaries in the program in all study sites (Appendix C). In Houston, for example, enrollment in the program declined 62 percent from its peak in 2000; on Long Island, enrollment declined 46 percent from its peak in 1999; and in Seattle, enrollment declined 26 percent from its peak in 1999. Furthermore, across all seven study sites, the changes in benefit packages have created a growing geographic disparity in the benefits offered by Medicare+Choice plans. For example, in New York City and Los Angeles, only three plans (18%) provide no drug coverage or generic drug coverage only, compared with 83 percent of plans in the other five study sites.

Reasons for Plan Withdrawals and Benefit Reductions

Four major factors have led to plan withdrawals and benefit reductions. First, local medical providers over the last five years have grown more assertive in their demands for large payment increases from plans. Second, Medicare+Choice plans must deal with the tight limits on increases in Medicare payments. These two problems alone, rising costs and limited revenues, have caused plan executives to view Medicare+Choice as an unprofitable venture.[20] Third, adding to these concerns, Wall Street analysts have begun to increase pressure on the large publicly traded managed care firms that have traditionally carried the bulk of the program enrollment—Aetna, PacifiCare, and United Healthcare—to abandon public programs with highly questionable prospects for profit, such as Medicare+Choice. Together, these three factors have caused what some call a "death spiral." As large plans begin to flee the program, or cut benefits and raise premiums, those plans still in the program begin to follow suit out of concern about adverse risk selection in the dwindling pool of Medicare+Choice enrollees in their service area.

Increases in payments to local medical providers. Medicare managed care plans have traditionally limited total physician costs in three ways: passing the total risk of the cost of care to contracting provider groups as "global capitation"; paying providers substantially discounted fees; and reviewing the utilization of expensive services including hospitalization. Individual physicians and physician groups have successfully fought back against all of these techniques in most local markets across the country.[21] With the notable exception of Los Angeles, Medicare managed care plans in the seven study sites no longer pay most of their contracting physician groups on the basis of capitation.

Hospitals have also renegotiated payments away from capitated rates toward diagnosis related group payments, thereby increasing plan costs.[22] In many cities, Medicare+Choice plans now pay hospitals rates that equal or exceed the traditional fee-for-service Medicare rates, becoming "price takers" rather than "price setters" in the hospital market, as one Houston plan executive observed.

In addition to rising prices, plans are also finding it more difficult to control the volume of hospital services consumed. In the study cities with low hospital utilization, plan and provider representatives expressed concern that hospital days per 1,000 of the population were again increasing.[23] In high utilization sites, such as Houston and the New York area, while hospital days decreased from 1993 to 2000, they still remain well above the national average (Table 3).

Table 3. Hospital Utilization, New York City and Houston vs. National Average

	Inpatient Days Per 1,000 Population					
Region	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**
Greater New York Region*	—	1282.6	1195.2	1154.3	1129.2	1105.2
Houston	1400.6	1162.4	1141.3	1082.4	1085.7	1084.0
United States	905.9	760.7	730.6	727.7	708.4	703.7

* Includes New York City, Nassau, Suffolk, and Westchester counties.

Source: American Hospital Association, Annual Survey of Hospitals. Courtesy Greater New York Hospital Association.

Cost increases in other areas of health care, especially the price and volume of brand-name prescription drugs, often fueled by direct-to-consumer advertising, led plans to rethink their participation in Medicare+Choice.[24]

Limits on increases in Medicare payments to plans. The Balanced Budget Act effectively limited the annual increase in Medicare payments to 2 percent per year in most cities. However, according to recent analyses, the absolute level of Medicare plan payments is not a major factor in plans' decision to withdraw from a given county.[25] The past rate of payment increases as well as those projected for the future influence plan decisions on Medicare+Choice participation.

In most urban counties across the country, and in five of the seven study sites (Cleveland, Houston, Long Island, Los Angeles, and New York City), Medicare+Choice plans since 1997 have received just the 2 percent minimum annual payment updates. The year 2001 was an exception; that year the Benefits Improvement and Protection Act (BIPA) authorized an additional one-time 1 percent increase in payments. Payments in "mezzanine" counties (with population greater than 250,000) were increased to $525, which amounted to a 14.5 percent increase in Seattle and a 10.8 percent increase in Tucson between 1999 and 2002.

Nonetheless, the 2001 increases were not sufficient to offset the costs of provider demands and higher utilization. Even in Houston, where Medicare payment rates are well above the national average, plans were "losing their shirts" on Medicare+Choice, as one managed care plan executive put it. Nor were additional BIPA monies enough to attract managed care plans back to Seattle or Tucson.[26] The slow growth of Medicare payments to plans is also an issue in Los Angeles and New York City, where managed care and provider executives predicted that continued payment increases of 2 percent a year would prove inadequate to meet provider demands and that, within two to three years, this would lead to plan withdrawals.

Concern about adverse selection. In communities experiencing significant program withdrawals, remaining plans and their contracting provider groups were increasingly concerned about adverse risk selection—the fear that high-risk beneficiaries, described by one plan executive as the "walking wounded," would move into the remaining plans that offered the most generous benefits. This concern influenced plans' decision about both withdrawals and benefit decisions.

In 2001, for example, Anthem Blue Cross Blue Shield in Cleveland, which offered the most generous value in its prescription drug benefit, closed enrollment to new members. Similarly, PacifiCare's Secure Horizons plan in Tucson closed enrollment in February 2001 for the entire year after it became the only plan remaining in the city to offer brand-name prescription drug coverage. Surviving medical groups in the Medicare+Choice markets face an "Ellis Island syndrome," attracting only "the poor and the sick," one Los Angeles provider group executive noted.

Fear of adverse risk selection may also have influenced plans' benefit design strategies. Although some managed care plan executives argued that benefit cuts and increased cost-sharing were simply a "reflection of costs," other executives posited that plans designed the new charges specifically to, as one executive noted, "decrease adverse selection." Another executive added that Medicare+Choice competition is no longer about offering the best benefits: "It's about not sinking your plan—at this point in the game, it's all about adverse selection."

Plan structure. Most Medicare+Choice plans are nationally owned, follow the Individual Practice Association model, and are for-profit managed care plans.[27] Medicare+Choice plans account for a disproportionately large share of withdrawals, both nationally and in the seven study sites.[28] In particular, publicly traded managed care plans face pressure to maintain profitability; if they do not, Wall Street analysts may downgrade their firm's stock recommendation, which would negatively affect the stock's price. As one health care consulting firm executive observed, the managed care industry is under "tremendous pressure from Wall Street to perform."[29] Indeed, industry analysts have recently given firms with the most Medicare+Choice exposure the lowest stock recommendations (Table 4).

Table 4. Wall Street Stock Recommendations on Plans in Medicare+Choice

Organization	Medicare+Choice as % of Premium Revenue	Medicare+Choice Enrollees	Average Wall Street Recommendation
PacifiCare	59%	1,002,100	3.17
Humana	31%	418,000	2.71
Health Net	16%	224,000	2.29
Oxford	16%	85,200	2.17
United Healthcare	15%	365,000	1.57
Aetna	10%	279,000	2.83
WellPoint	4%	63,000	1.29

Notes: Wall Street recommendations: 1 = Strong Buy, 2 = Buy, 3 = Hold, 4 = Sell.
Revenues and enrollment as of June 30, 2001.
Source: CMS, *Health Care Industry Market Update,* November 28, 2001.

Both nationally and in the seven study sites, many observers believe that large national managed care plans will abandon Medicare+Choice in their own cities. Health care leaders in Seattle, Tucson, and Houston, for example, noted that without substantial increases in federal payments to the program's plans, PacifiCare would soon withdraw from Medicare+Choice in their cities. (PacifiCare remains one of the few large national managed care plans heavily invested in the program.) These executives cite three reasons they believe this to be the case. First, PacifiCare assumed financial risk in most markets in 2002; because it has long been passing along risk to providers through global capitation, according to these executives, it does not have the infrastructure and know-how to hold down costs and manage care in the changed context. (One provider group executive called PacifiCare's assumption of risk a "recipe for disaster.") The second reason is that PacifiCare is diversifying: in 2001, it introduced a new Medigap insurance product that is in competition with its Medicare managed care plans.[30] Finally, PacifiCare has financial and legal troubles that might further undermine the insurer's commitment to the Medicare+Choice program.[31]

In contrast to national, for-profit plans, locally owned and managed non-profit health plans will most likely remain in the Medicare+Choice program in their cities. A number of observers on Long Island, Seattle, and Cleveland anticipated that only the staff/group–model, locally based, not-for-profit plans—the Health Insurance Plan in Long Island, Group Health in Seattle, and Kaiser in Cleveland—would remain in their Medicare+Choice markets. Although these plans have withdrawn from some small markets,[32] they remain committed to these core communities through their historic ties and the large number of beneficiaries who have aged into their Medicare+Choice plan after years of previous membership through their employer-sponsored coverage.

While the continued presence of some local plans will most likely preserve Medicare managed care as an option for beneficiaries in a few select cities, Medicare+ Choice must have participation of the large national for-profit plans to meet the ambitious goals set out for it in 1997. Given the experience of the largest national managed care plans in the program over the last five years, their willingness to participate in a FEHBP-type Medicare program is now an open question. Without their reliable participation, it is hard to project the future success of such a program.

MEDICARE+CHOICE PROVIDERS: PUSHBACK BATTLES CONTINUE

Just as the viability of Medicare+Choice rests on the continued participation of private managed care plans, these plans in turn rely on the continued participation of physicians, hospitals, and other provider groups in their networks. Increasingly, however, plans have been unable to negotiate provider agreements for participation in the program's managed care networks. This is an important, if often overlooked, factor in Medicare+ Choice's recent decline.

In response to their negative experiences with rapidly expanding managed care plans in the 1990s—stringent utilization review limits, administrative hassles, payment delays, and a general loss of professional autonomy[33]—local hospitals and physician groups began to aggressively "push back" against managed care plans in the last five years. Previously, providers were willing to assume the financial risk of caring for Medicare+ Choice members because they feared being left out of the growing managed care market.[34] Today, providers are often unwilling to accept potentially unfavorable financial arrangements.

Hospital Consolidation

Long Island (Nassau & Suffolk Counties)
Long Island Health Network–11 hospitals
North Shore-Long Island Jewish–14 hospitals
(81 percent of certified beds)

Cleveland Area
Cleveland Clinic Health System–11 hospitals
University Hospitals Health System–12 hospitals
(68 percent of beds)

Seattle (King County)
Swedish Hospital–3 hospitals
University Hospital–2 hospitals
(40 percent of beds)

Houston Area
HCA–11 hospitals
Memorial Herman–9 hospitals
Methodist–4 hospitals
Tenant–5 hospitals
(72 percent of staffed beds)

Sources: Communications with the Nassau-Suffolk Hospital Council; Jon Christianson, Cara S. Lesser et al., *Increased Consolidation Raises Concerns* (Center for Studying Health System Change, Community Report No. 02, Fall; 2000); Washington State Hospital Association, "Hospital County Listing," www.wsha.org; Alan Baumgarten, *Texas Managed Care Review,* 2001.

Physician and Hospital Actions

By 2002, in all of the study sites, providers were "in revolt," as one observer noted.[35] Other than in Los Angeles, most providers in the study sites were in full retreat from risk-based contracts, which had proved financially disastrous for many medical groups, individual practice associations, and hospitals.[36] In five of the seven study cities—Cleveland, Houston, Los Angeles, Tucson, and Seattle—risk-based contracts were a major contributor to the insolvency, bankruptcy, or both of large provider groups in the area.[37]

As a rule, provider groups now insist on fee-for-service payment, with the exception of a few groups in Tucson, Houston, New York, and Seattle that continue to accept managed care capitation payments.[38] In some cases, physicians are now demanding and receiving from Medicare+Choice plans payments equal to or greater than Medicare fee-for-service rates.

At the same time, hospitals, too, were able to negotiate Medicare+Choice contracts away from capitated rate payments toward diagnosis related group reimbursement.[39] In many cities, Medicare+Choice payments now equal or exceed the amount Medicare pays hospitals. The hospitals' success in dealing with plans is due in part to their consolidation into multifacility systems; this has changed the balance of power between plans and hospitals in many of the study sites, especially in Long Island,[40] Cleveland, Houston, and Seattle. Hospital consolidation has eliminated the opportunity for plans to play one hospital against the other; plans are now forced to choose between contracting with all of a hospital system's facilities and associated physicians or none. Even in sites less dramatically affected by consolidation, Medicare managed care plans have had difficulty obtaining preferential rates from the largest and most prestigious hospitals and medical groups.[41]

Provider–Plan Contract Terminations and Provider Turnover

Yet another important trend among providers and hospitals has been their willingness to terminate contracts with Medicare+Choice plans if plans did not meet their demands. In the seven study sites, some physician groups and hospitals with "evergreen" contracts—contracts that may be terminated at any time—did so. Some who were forced to wait for their multiyear contracts to expire went bankrupt,[42] or, as in the notable case of Long Island's North Shore–Long Island Jewish Health System, bought out their contracts before they expired.[43]

Contentious plan–provider relations, as well as bankruptcies of several large medical groups, resulted in substantial provider turnover in a number of

Medicare+Choice markets.[44] Indeed, CMS data on primary care provider turnover rates in the program indicate that provider disaffection is a major cause of program instability. This was demonstrated in three of the study sites—Houston, Seattle, and Tucson. In each of these cities, the highest turnover provider rate occurred in the largest or the second largest Medicare+Choice plan; in Seattle and Houston, PacifiCare had a 37 percent and 34 percent turnover rate, respectively.

In retrospect, Medicare+Choice has failed to meet its goals in part because policymakers overestimated how effectively Medicare managed care plans could hold down annual increases in payments to local providers. Prior to 1997, due mostly to the growing power of managed care plans, annual increases in employer health insurance premiums had steadily fallen from a peak of 18 percent in 1990 to 0.8 percent in 1997.[45] Similarly, plans were able to hold down Medicare+Choice provider payment rates. At the time of the Balanced Budget Act enactment, in 1997, policymakers had little reason to believe that managed care plans would be unable to continue the same disciplined cost containment strategy. Had managed care plans been able to hold provider payment increases to their low 1997 levels, they could more easily have dealt with the new law's tight restrictions on annual Medicare payment updates.

As the recent experience of Medicare+Choice in the seven study sites demonstrates, the managed care plans' ability to control both the price and volume of health services consumed is in fact limited. The lesson for future Medicare reform is that Medicare should not overestimate private plans' ability to restrain the growth of health care expenditures and utilization if their contracting physicians and other providers are not willing to cooperate on the local level.

MEDICARE BENEFICIARIES: FEWER BENEFITS, LESS SATISFACTION

Primarily, Medicare beneficiaries join Medicare+Choice plans for the increased benefits offered. With the dramatic reduction in benefits over the past five years, many enrollees have lost interest in the program, feeling that, as one beneficiary representative commented, "The rug has been pulled out from under them." In a voluntary program such as Medicare+Choice, as benefits decline, many elderly and disabled beneficiaries opt to leave the program and purchase Medigap policies instead. Moreover, without generous benefit packages, the Medicare+Choice program will be unable to attract new, younger members, resulting in a further decline in enrollment and adverse risk selection.

Impact of Benefit Reductions

A source of great concern for beneficiaries is the continuing cutback in prescription drug coverage. Medicare+Choice benefit changes for 2002 made prescription drugs still less affordable to Medicare beneficiaries. In Cleveland, Houston, Tucson, and Long Island, most large plans in the program no longer cover brand-name medications, a particularly significant problem because generic drugs represent only a relatively small share of total beneficiary drug costs.[46] Because of the high costs of brand-name prescription drugs, provider, managed care plan, and beneficiary representatives reported that it was "very common" for beneficiaries to skip their medications or to take half doses.

Beneficiaries' Reasons for Voluntarily Disenrolling from Their Medicare+Choice Plan

In a 2001 survey of Medicare beneficiaries who voluntarily left their plans, 45 percent stated that their primary reason for doing so was because premiums or copayments were too high, 9 percent because of problems getting or paying for prescription medicines, and 18 percent because of problems with seeing particular doctors or other providers.

Source: CMS, Medicare Health Plan Compare Disenrollment data.

In response to prescription drug cuts, community organizations, politicians, news media, and at least one Medicare+Choice plan in the study sites sponsored bus trips to Canada to purchase medications or provided information on how to order prescription drugs over the Internet from Canada or fill prescriptions in Mexico.[47] The loss of drug coverage from Medicare managed care plans led to increased public pressure to create state pharmacy assistance programs; however, only New York's Elderly Pharmaceutical Insurance Coverage Program, arguably the most generous in the nation, provides much assistance to Medicare beneficiaries in the seven study sites.[48]

Limits on Medicare+Choice Cost-Sharing

Medicare+Choice plans are by law permitted to impose cost-sharing up to the average amount Medicare beneficiaries would pay in original fee-for-service Medicare (assuming they had no Medigap insurance coverage)—or $105/month in 2002. Although this actuarial limit protects Medicare+Choice enrollees in the aggregate, it does not help plan members with high-cost medical conditions. In many cases, beneficiaries affected by PacifiCare cost-sharing increases pay more in the Medicare+Choice plan than they would in original Medicare, even without Medigap coverage.

Beneficiaries with chronic or life-threatening illness were especially affected by higher cost-sharing for durable medical equipment, dialysis, and chemotherapy and radiation therapy. Enrollees who had paid little or nothing for treatments for cancer, emphysema, and dialysis faced new out-of-pocket costs of hundreds of dollars.[49]

The Decreasing Value of Medicare+Choice Compared with Medigap

Increases in Medicare+Choice plan premiums and out-of-pocket costs have substantially narrowed the value differential between Medicare managed care plans and Medicare supplemental insurance policies. For several of the plans in the study sites, premiums combined with cost-sharing for one five-day hospitalization, 10 primary care visits, and seven specialist visits put the cost of the managed care plan close to or above that of a Medigap Plan C (Table 5).[50] Add additional hospital stays, ambulatory surgery, durable medical equipment, rehabilitation services, or cancer treatment, and the costs of several of the Medicare+Choice plans are well above those of Medigap. These trends make the program an even less attractive option for beneficiaries.

Table 5. Out-of-Pocket Expenses for Hypothetical Frail Beneficiary in Four Sites: Medicare Managed Care Plan vs. Medigap Policy C, 2002

Site	Annual 2002 premiums	Physician copays (10 primary care + 7 specialist visits)	5-day hospital stay	Total costs
Houston				
Secure Horizons	$0	$150 + $210	$550	$ 910
AARP Plan C	$1,452	$0	$0	$1,452
Nassau County, L.I.				
Empire BC/BS	$1,920	$100 + $140	$250	$2,410
AARP Plan C	$1,932	$0	$0	$1,932
Cleveland				
United Healthcare	$0	$150 + $210	$1,875	$2,235
AARP Plan C	$1,608	$0	$0	$1,608
Tucson				
Health Net	$312	$150 + $175	$500	$1,137
AARP Plan C	$1,590	$0	$0	$1,590

Source: Medicare Health Plan Compare, http://www.aarphealthcare.com, accessed January 2002.

Impact of Plan Withdrawals and Provider Turnover on Beneficiaries

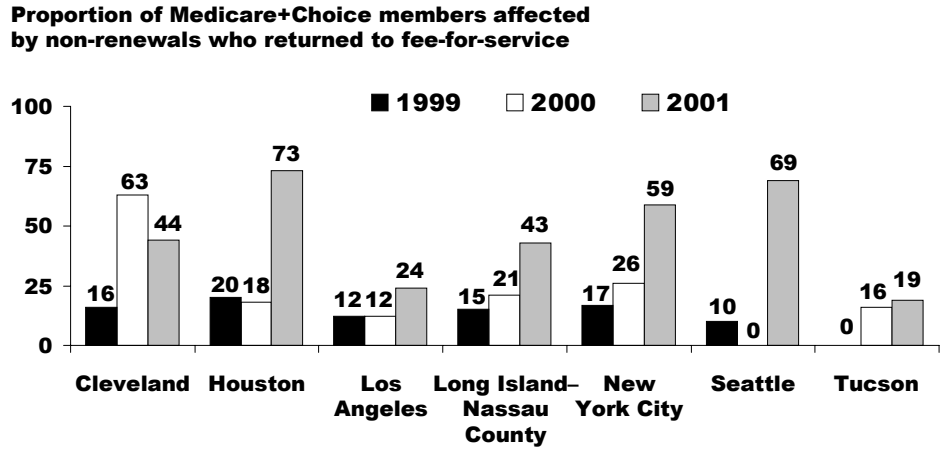
In addition to benefit cuts, Medicare+Choice enrollees were further troubled when plan closures, provider contract turmoil, and provider group bankruptcies left many of them without access to long-standing providers. In Cleveland, some enrollees lost access to the Cleveland Clinic; in Tucson, to the city's only teaching hospital; on Long Island, to its largest hospital network; in New York City, to one of the nation's premier cancer treatment centers; and in all sites, to primary care physicians and specialists.[51]

Increasing Disenrollment from Medicare+Choice Plans

An important indication of beneficiary dissatisfaction with Medicare+Choice is the number of beneficiaries affected by withdrawals who opt to rejoin original fee-for-service

Medicare rather than enroll in another program plan. In all study sites except Houston, beneficiaries in withdrawing plans had at least one Medicare+Choice plan they could sign up for at the time of their plan's withdrawal; however, members were increasingly less willing to reenroll in the program (Figure 1).

Figure 1. Percentage of Beneficiaries Affected by Medicare+Choice Plan Withdrawals Returning to Fee-for-Service Medicare, 1999, 2000, 2001



Source: Anna Cook, Tim Lake, and Bob Schmitz, *Early Experience Under Medicare+Choice: Early Summary Report* (Washington, D.C.: Mathematica Policy Research, December 2001, pp. 20–21).

Medicare+Choice: More Confusing for Beneficiaries

Decreased program benefits and provider network stability have also led to increased confusion about the program among beneficiaries, thus impeding their ability to make informed choices among Medicare options.

According to representatives of senior groups, beneficiaries often find plan materials difficult to understand. For example, CMS required plans that were withdrawing from the program to send affected enrollees a 14-page letter explaining their new health care options. "When you tell everything, you tell nothing," one representative said about the confusion caused by this lengthy letter. Basic information is difficult for plan enrollees to obtain. Plan enrollees report that they were taken unaware of the changes in plan benefits,[52] and, in cities where plans still cover brand-name drugs, that they had no knowledge of which drugs were on a plan's formulary before they joined. Managed care plan provider directories are often out-of-date, leaving beneficiaries surprised to learn that listed providers have left a plan or closed their practices to new members. In one site, inaccurate provider directories led local advocates to obtain a cease-and-desist order against a Medicare+Choice plan for false advertising.

Acute Problems for Beneficiaries

The experience of Medicare+Choice in the seven study sites suggests that the 5 million beneficiaries currently enrolled in plans are facing the following three acute problems, which need to be addressed in the near future.

High out-of-pocket expenses for chronically ill beneficiaries. Recent benefit reductions have particularly affected those with chronic illnesses, as measured by the increasing disparity between out-of-pocket expenses for those in good health compared with those in poor health.[53] While Medicare+Choice continues to provide most beneficiaries value over Medicare and Medigap policies, a few plans now expose members in poor health to cost-sharing that exceeds that under the fee-for-service program. Healthier beneficiaries will not feel the impact of their plans' benefit changes unless or until a major health event occurs, forcing them to begin using expensive services.

Beneficiary confusion. The Medicare+Choice program is also confusing to many beneficiaries. There is little evidence that beneficiaries want a choice of health plans simply for the sake of choice. What they do want is a stable program with reliable providers and good benefits, especially a prescription drug benefit. In addition to providing additional benefits including prescription drugs, any future Medicare program should be less confusing and more transparent to beneficiaries.

Geographic inequities in Medicare+Choice plan benefits. Increasingly, Medicare+Choice undermines Medicare's promise that all beneficiaries will receive the same benefits no matter where they live. There are almost no Medicare+Choice plans in rural areas, and some entire states now lack Medicare+Choice managed care plans. Even with large increases in Medicare payments targeted to counties with low Medicare+ Choice reimbursement rates, the program has been unable to attract managed care plans to rural areas.

In cities where the program does exist, the premiums required and cost-sharing and benefits offered vary dramatically. The beneficiary in Los Angeles or New York City who enjoys a zero-premium Medicare+Choice product with $2,000 worth of prescription drug coverage effectively experiences an entirely different program than her counterpart on Long Island or in Cleveland, where Medicare+Choice is barely more affordable than Medigap. In the long run, these inequities undermine geographically broad-based beneficiary support for the Medicare program.

LESSONS FOR MEDICARE REFORM

The recent history of Medicare+Choice in seven study sites clearly has important policy implications for future efforts to reform and modernize the Medicare program. The reform initiatives proposed to model Medicare on the FEHBP model vary in name—defined contribution, voucher, premium support, benefit support—and in some significant details. However, all of these initiatives would incorporate expanded dependence on private health insurance plans operating in a competitive rather than regulatory marketplace.

States Lacking Medicare+Choice Plans

Alaska	Montana
Arkansas	North Carolina
Delaware	South Carolina
Indiana	Utah
Iowa	Vermont
Kansas	Virginia
Kentucky	West Virginia
Maine	Wyoming
Mississippi	Washington, D.C.

* Medicare+Choice enrollees are 0% of total state Medicare Beneficiaries.
Source: The Henry J. Kaiser Family Foundation State Facts Online, Accessed 8/9/02.

The causes of the current dissatisfaction among Medicare+Choice's plans, providers, and beneficiaries can inform the broader debate about Medicare reform:

- Large national for-profit plans may be hesitant to participate in any FEHBP-type Medicare program that has the same mix of limited revenues and unlimited costs as Medicare+Choice because of increased pressure to enhance corporate profitability. If a Medicare reform model that expands the role of private plans is adopted, beneficiaries may well face large premium and cost-sharing increases, such as FEHBP members have had to bear,[54] or unreliable plan participation that disrupts continuity of care.

- When local medical providers are opposed to managed care and are able to gain an upper hand in payment negotiations, managed care plans will be limited in their ability to control increases in provider payments. Medicare cannot reasonably expect managed care plans to bring disciplined cost containment to health care markets that are rapidly restructuring to accommodate less restrictive health insurance products, such as preferred provider organizations and fee-for-service plans.

- The more leeway plans have to design their own benefit packages, the greater the chance that vulnerable beneficiaries will pay high out-of-pocket expenses. Without a risk-adjusted payment mechanism and standardized benefit packages, Medicare+Choice or a private plan system will undermine Medicare's social insurance function.

- Large geographic disparities in benefits offered are to be expected in a system that builds on Medicare+Choice because of the wide variation in Medicare payment rates across the country. This is of concern not only for those seeking to preserve equity in Medicare, but also for those working to give both urban and rural beneficiaries a stake in making such a program work.

- Medicare+Choice's instability has made beneficiaries wary. In any new reform program, beneficiaries will need guarantees that plan withdrawals, provider turnover, steep increases in premiums and cost-sharing, and cuts in benefits would not constantly disrupt their medical care. These concerns are especially acute among the chronically ill and low-income beneficiaries who are most in need of a stable Medicare program.

OPTIONS FOR THE FUTURE

The year 2002 will be important for the Medicare+Choice program. Large, national, for-profit plans may continue to leave the program in metropolitan areas across the nation. If firms such as Aetna, United Healthcare, and especially PacifiCare choose not to increase their participation in the program, Medicare+Choice seems unlikely to grow much beyond its current 13 percent share of Medicare enrollment. While other plans, among them Kaiser Permanente, the Health Insurance Plan of New York, and Group Health Cooperative of Puget Sound, will most likely continue as managed care options in their home cities, the continued presence of these locally owned non-profit plans alone cannot deliver the large increases in Medicare+Choice enrollment that would allow the program to meet its original goals.

The current trends in the Medicare+Choice program are almost certain to lead to consideration of important new funding initiatives in 2002 and 2003. In deciding how to reshape the program, Medicare policymakers will need to once again determine the purpose of Medicare+Choice. Is it a platform upon which to build a broader reform that expands the role of private plans in Medicare? Or should it be a less ambitious program that offers additional benefits to several million beneficiaries, particularly those in traditionally strong managed care markets, as a complement to a stable, reliable, fee-for-service Medicare program?

Medicare+Choice Growth Leading to Private Plan-Based Medicare Reform

The first approach to expand and build upon Medicare+Choice would start with additional funds for Medicare managed care plans for 2003. The Bush Administration has proposed a 6.5 percent payment increase to Medicare+Choice plans operating in counties

that have received only 2 to 3 percent minimum updates since 1998. The White House projects this to cost $3.7 billion over three years and increase program enrollment by an additional 7 percent of Medicare beneficiaries.[55] In addition, the proposal would provide bonus payments for new types of Medicare+Choice plans, such as preferred provider organizations, that enter the market. It would also modify regulatory requirements to "give managed care plans more flexibility in designing their plans."[56]

These measures are designed to "make it possible for more private plans to remain in Medicare until the new payment system is phased in."[57] Under that new payment system, which the Administration hopes to implement in 2005, Medicare+Choice would move towards a "premium support" model based on FEHBP. Plans would "be allowed to bid to provide Medicare's required benefits at a competitive price, and beneficiaries who elect a less costly option should be able to keep most of the savings so that a beneficiary may pay no premium at all."[58] The Administration also hopes to expand upon Medicare+Choice's current efforts to provide beneficiaries with comparative information on the quality and costs of their Medicare private plan options.

Stabilization of the Medicare+Choice Program

A second approach to the Medicare+Choice program would be less ambitious. It would seek to stabilize the program over the next several years by attempting to stop plan withdrawals and benefit cuts, but it would not significantly expand the program to meet the original 1997 projection of 34 percent of Medicare beneficiaries in managed care plans by 2005.

This approach would provide modest additional funds to Medicare+Choice plans and possibly streamline some administrative policies in response to industry concerns about the financial burden of CMS regulations. Modest consumer-oriented changes to the program could protect vulnerable beneficiaries from high out-of-pocket expenses and program instability. A new risk-adjusted payment system would also be developed and phased-in on a budget neutral basis.

Specific policies that could make a useful contribution to stabilizing the program might include:

- Increase payments to plans by more than the 2 percent now provided in most metropolitan areas. Additional funds would be targeted for plans in areas that have received the most limited increases since 1997 (e.g., generally higher payment level areas) rather than to plans in areas that have lower payment levels.

- Implement an effective plan payment risk-adjustment system. The lack of an effective new risk-adjustment system, after five years, makes it impossible for Medicare+Choice to generate overall savings for Medicare. It also contributes to plans' withdrawal from the program. CMS's new approach to risk-adjustment using ambulatory data is now scheduled for implementation in January 2004. Payments to Medicare+Choice plans could be set at 100 percent of local Medicare adjusted average per capita cost, rather than 95 percent, after development of an effective risk-adjustment system.

- Allow plans to continue to be paid on an optional cost basis. Plans have long been able to have Medicare pay them on a cost basis, but this option is scheduled to be phased out in 2004. The extension of cost contracts would be particularly useful to a number of locally based staff- and group-model plans with large numbers of beneficiaries aging into their Medicare+Choice plans after years of membership through their employer-sponsored coverage.

- Simplify Medicare administrative requirements of plans consistent with efforts to protect benefits and to assure quality of care. Specifically, there should be an effort to implement most new policy requirements on January 1, at the beginning of the Medicare plan contract year. Requirements that are based on patient protection policies adopted by many state governments should not be changed.

This approach would provide a portion of the additional new Medicare funds to stabilize the Medicare+Choice program. Significant sums would go toward improving the traditional fee-for-service Medicare program, especially addressing issues in payments to physicians, home health agencies, nursing homes, and other providers. A major prescription drug benefit could be added to the Medicare fee-for-service program with an equitable role for Medicare+Choice managed care plans.

Medicare+Choice Policies to Assist Beneficiaries

In addition to these new payment and administrative policies, specific policies to protect beneficiaries and encourage their participation in plans should be considered. These might include:

- Eliminate the lock-in provision. In a period of Medicare+Choice instability, the lock-in provision further undermines the program's attractiveness to beneficiaries. Medicare+Choice plans now support elimination of the lock-in requirement for this reason.[59] The lock-in provision has been delayed to 2005 and could be

repealed as part of a broad set of Medicare+Choice changes, including extending plans' filing deadlines and beneficiary enrollment periods.[60]

- Standardize Medicare+Choice benefit packages to address the confusion arising from the differing benefits among plans and even within the same plan from one year to the next. This confusion undermines beneficiaries' ability to make an informed choice about their health care options. The ability of Medicare beneficiaries to understand the cost implications of their choices in health coverage is critical to the success of Medicare+Choice, as well as any Medicare reform that depends on a competitive marketplace.[61]

- Expanded Medigap guaranteed-issue provisions could also extend to cover Medicare+Choice enrollees whose primary care physician withdraws from their plan or whose plan significantly increases premiums or cost-sharing.

- Prohibit Medicare+Choice cost-sharing on any Medicare-covered benefit or service that exceeds what the costs would have been under the original fee-for-service program.

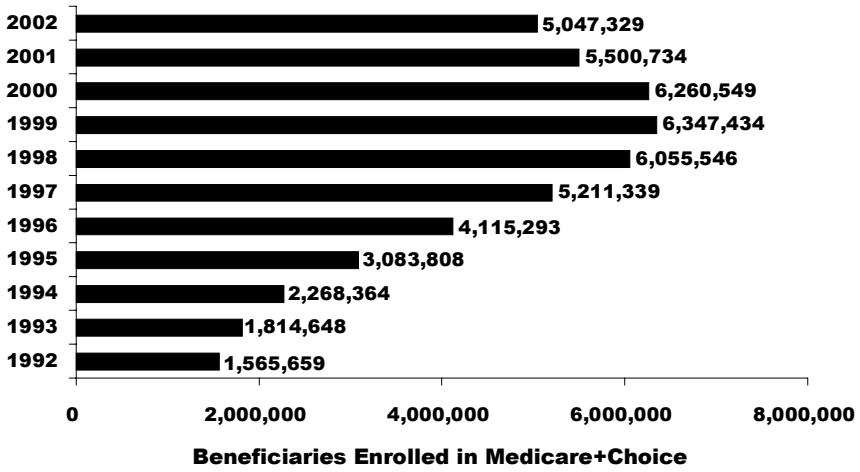
Medicare+Choice and Medicare's Future

Perhaps the main lesson from the Medicare+Choice program's five-year track record is that the law of unintended consequences applies to any effort to change a $240 billion program serving 40 million Americans. Medicare+Choice has failed to meet its major goals and in the process has disrupted care to millions of beneficiaries. Before making further major changes to Medicare+Choice or Medicare, policymakers should first consider the lessons learned from the Medicare+Choice program.

Policymakers should carefully review Medicare reform proposals that build upon the current Medicare+Choice program. A stable, modest managed care program, together with a strong fee-for-service program with a prescription drug benefit, may be the most realistic way to ensure Medicare's goals: to serve the nation's current elderly and disabled beneficiaries and the large Baby Boom generation that will begin to enter the program in 2011.

APPENDIX A

Appendix Figure A-1. National Enrollment in Medicare+Choice, 1992–2002



Source: Centers for Medicare and Medicaid Services, Medicare Managed Care Contract (MMCC) Plans Monthly Report, www.hcfa.gov/stats. Data are December enrollments. 2001–02 data include PFFS enrollment. 2002 represents March enrollment.

APPENDIX B

Appendix Table B-1. Medicare+Choice Site Characteristics

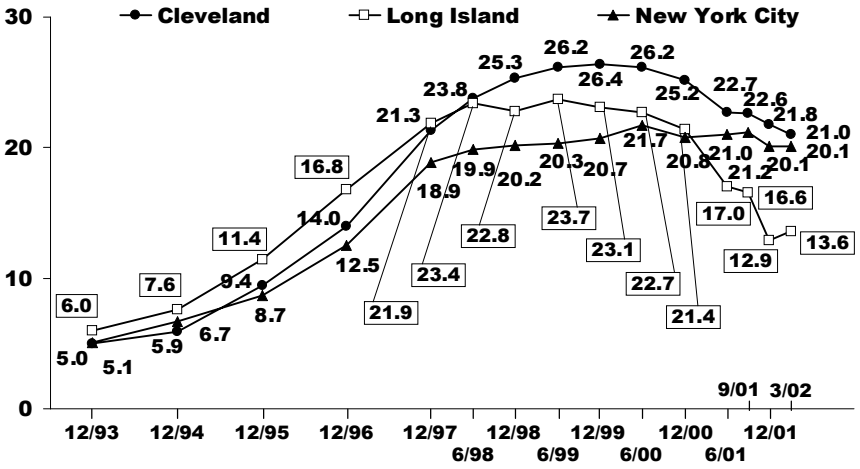
Site	Medicare Eligibles, March 2002	Medicare+ Choice Enrollees, March 2002	Medicare+ Choice Market Penetration Rate, March 2002	AAPCC Rate		
				2000	2001 Post-BIPA	2002
Cleveland						
Cuyahoga County	238,862	50,220	21.0%	$576	$593	$605
Houston						
Harris County	298,572	31,825	10.1%	$632	$651	$664
Long Island						
Nassau County	435,505		13.3%	$663	$641	$654
Suffolk County		59,050	13.9%	$592	$610	$622
Los Angeles						
Los Angeles County	1,041,786	372,360	35.7%	$661	$680	$694
New York City	1,030,480	206,913				
Bronx County			20.7%	$773	$796	$812
Kings County			19.6%	$749	$771	$786
New York County			12.2%	$757	$779	$795
Queens County			23.6%	$699	$720	$735
Richmond County			32.7%	$814	$839	$856
Seattle						
King County	205,829	48,479	23.6%	$483	$525	$553
Tucson						
Pima County	134,854	48,626	36.1%	$499	$525	$553

Source: CMS State/County/Plan market penetration report, March 2002.

APPENDIX C

Appendix Figure C-1. Medicare+Choice Market Penetration Rates: Cleveland, Long Island, and New York City, 1993–2002

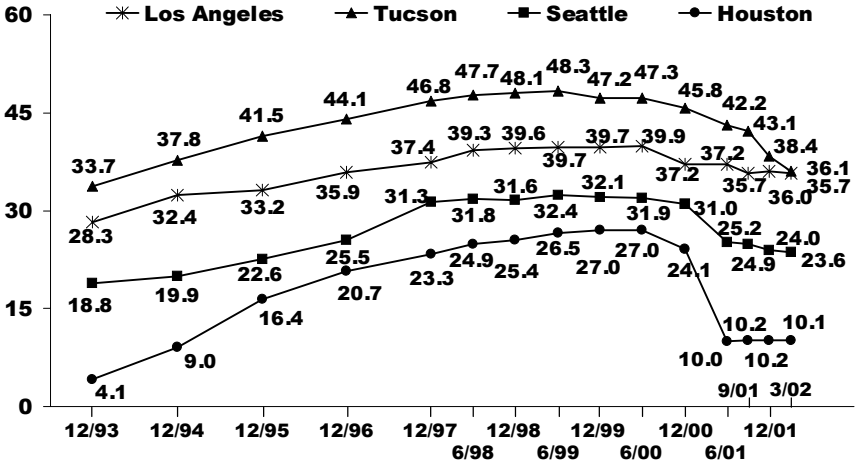
Percent of Medicare beneficiaries enrolled in the M+C plan



Source: CMS State/County/Plan managed care enrollment reports. 2001 figures include private fee-for-service enrollment.

Appendix Figure C-2. Medicare+Choice Market Penetration Rates: Houston, Los Angeles, Seattle, and Tucson, 1993–2002

Percent of Medicare beneficiaries enrolled in the M+C plan



Source: CMS State/County/Plan managed care enrollment reports. 2001 figures include private fee-for-service enrollment.

NOTES

[1] Robert A. Berenson, "Medicare+Choice: Doubling or Disappearing?," *Health Affairs* web exclusive (November 28, 2001): W65.

[2] General Accounting Office, "Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings" (Letter Report, September 7, 2000, GAO/HEHS-00-183); Department of Health and Human Services, Office of the Inspector General, "Review of the Administrative Cost Component of the Adjusted Community Rate Proposal at Nine Medicare Managed Care Organizations for the 1997 Contract Year" (A-03-98-00046), January 18, 2000.

[3] The White House, "Fact Sheet: Strengthening Medicare," January 28, 2002, press release. Available at: http://www.whitehouse.gov/infocus/medicare/.

[4] "HHS, OMB Officials Favor Major Changes to Medicare, Not Fixing Provider Payments," *BNA's Health Care Policy Report* 10 (March 18, 2002): 389–90.

[5] Office of Management and Budget (OMB), *Budget of the United States Government, Fiscal Year 2003,* pp. 150–55.

[6] Barbara S. Cooper and Bruce C. Vladeck, "Perspective: Bringing Competitive Pricing to Medicare; Theory Meets Reality, and Reality Wins," *Health Affairs* 19 (September/October 2000): 49–54.

[7] Congress authorized $11 billion in extra Medicare+Choice funding over five years in the Benefits Improvement and Protection Act (BIPA) of 2000. This provided a one-time 1 percent additional increase in payments to plans in most metropolitan areas, effective March 1, 2001. BIPA also increased the minimum "floor" payment rate in 2001 for plans operating in Metropolitan Statistical Areas with a population greater than 250,000. In 2001, the Centers for Medicare and Medicaid Services (CMS) made regulatory changes designed to make Medicare+Choice participation more attractive to private managed care plans, including delaying plans' annual deadline to announce withdrawals and benefit changes from July to September; postponing implementation of reporting ambulatory data for risk adjustment; and streamlining the review process for plans' marketing materials.

[8] OMB 2002, pp. 150–155; The White House, January 28, 2002, press release.

[9] OPM 2000, "FEHB Facts." Available at http://opm.gov/insure/health/fehb_facts/index.htm.

[10] These cities were chosen based on four primary factors: (1) a substantial presence of Medicare+Choice risk plans in 1997; (2) geographic diversity across the nation; (3) variation in Medicare+Choice plan payment rates; and (4) variation in the extent of plan withdrawals. In particular, payment rates varied dramatically among the sites in 2001, from a low of $525 in Seattle and Tucson to a high of $839 in Richmond Co. (Staten Island), New York. For the purposes of this study, a market is defined as one or more urban counties. The counties in the site visit cities included: Cuyahoga County, Ohio (Cleveland); Harris County, Texas (Houston); King County (Seattle), Washington; Los Angeles County, California; Nassau and Suffolk (Long Island), New York; the five boroughs of New York City, New York; and Pima County (Tucson), Arizona.

[11] Beneficiaries were predominantly enrolled in Medicare+Choice plans and living in mid- to low-income communities.

[12] CMS data collected includes information on plan withdrawals and plan benefits for three consecutive years as well as information on provider turnover, enrollee enrollment and withdrawal, and plan quality.

[13] CMS provides capacity waivers to plans that can prove they lack the capacity in their provider networks to accept new enrollees beyond a specified number. With proper notice, plans

may also freeze enrollments at their discretion, as long as they are open during the November open-enrollment period.

[14] Nationally, 855,695 beneficiaries lost brand coverage in their basic plan from 2001 to 2002. CMS, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002,* December 2001. Available at http://cms.hhs.gov/healthplans/.

[15] Because the plans in the five boroughs offer largely the same benefits, only plans in one of the boroughs (Manhattan) were included in the analysis.

[16] Staff counted each plan's most generous, high-option drug benefit in calculations. Sterling Option I, a private fee-for-service plan available in Seattle and Tucson, is counted as an option in each site.

[17] CMS, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002,* December 2001. Available at http://cms.hhs.gov/healthplans/. This applies to enrollees unaffected by non-renewals in 2001 compared with the same enrollees if they choose to remain in their current organization in 2002.

[18] Ibid. This applies to enrollees unaffected by non-renewals in 2001 compared with the same enrollees if they choose to remain in their current organization in 2002.

[19] PacifiCare began charging up to $550 per chemotherapy drug and up to $250 per radiation treatment in some counties effective January 1, 2002, but later reduced most of those copayments after complaints from patients. Julie Appleby, "PacifiCare Reduces Co-Fees for Cancer Care," *USA Today,* April 4, 2002: 2B.

[20] See Jennifer Stuber, Geraldine Dallek, and Brian Biles, *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (New York: The Commonwealth Fund, October 2001).

[21] For a national discussion of this topic, see transcripts from Center for Studying Health Systems Change conference, "Emerging Health Care Market Trends: Insights from Communities," (Washington, D.C.: December 19, 2001), available at http://www.hschange.org.

[22] R Levine, "Managed Care Fades, Fee-for-Service Returns," *Puget Sound Business Journal,* October 27, 2000.

[23] American Hospital Association, Annual Survey of Hospitals, 1993–2000.

[24] Ceci Connolly, "Pharmaceutical Spending Continues Steady Increase; A Few Heavily Advertised and High-Priced 'Blockbuster' Medications Drive 17 Percent Increase," *Washington Post,* March 29, 2002: A09.

[25] Anna Cook, Tim Lake, and Bob Schmitz, *Early Experience Under Medicare+Choice: Early Summary Report* (Washington, D.C.: Mathematica Policy Research, December 2001).

[26] Nationally, only three Medicare HMOs responded to BIPA payment increases by reentering counties that they had previously dropped. General Accounting Office, *Medicare+Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001,* November 2001.

[27] In February 2002, 60 percent of Medicare+Choice enrollees were in Individual Practice Association model plans, 30 in group-model plans, and 10 percent in staff-model plans. Fifty-nine percent of Medicare+Choice enrollees were in for-profit plans; 41 percent in non-profit plans. CMS, Medicare Managed Care Contract Monthly Summary Report, February 2002.

[28] At the end of 2000, Cigna dropped coverage for 104,000 Medicare beneficiaries in 11 states, Aetna dropped coverage for 355,000 Medicare enrollees from 11 states and 23 counties, Prudential withdrew from 94 counties in 11 states, affecting 52,087 beneficiaries, while PacifiCare withdrew from 20 counties in six states, impacting 16,188 beneficiaries. At the end of 2001, the biggest

contributors to withdrawals were Aetna, PacifiCare, and United Health Care, affecting 104,000 beneficiaries, 68,144 beneficiaries and 57,365 beneficiaries, respectively.

[29] Ronald White, "PacifiCare to Cut 1,300 Jobs in 'Profit Improvement' Plan," *Los Angeles Times,* January 3, 2002.

[30] "PacifiCare Offers New Medicare Plan," *Houston Business Journal,* October 10, 2001.

[31] Rhonda L. Rundle, "Legal Battle with Texas Raises Uncertainty for PacifiCare—An Unfavorable Outcome Could Hamper the Managed-Care Concern's Turnaround Efforts," *The Wall Street Journal,* February 28, 2002: B4.

[32] Health Insurance Plan withdrew from all of Florida at the end of 1999 and only political pressure kept it in Long Island in 2001. Group Health withdrew from most suburban and rural Washington counties at the end of 2000.

[33] Sharon Bernstein and Davan Maharaj, "Calif. Medical Assn. Filed Lawsuit Against Blue Cross of California, PacifiCare and Foundation Health System," *Los Angeles Times,* May 26, 2000: C1; "Health Net: Fined $100,000 for Late Payment to Providers," *American Health Line,* September 27, 2001; "New York Physicians Group Sues Six HMOs for Care Denials, Contract Breaches," *Kaiser Daily Health Policy Report,* August 16, 2001.

[34] Peter Neurath, "Hospitals in Shock over Regence Cuts," *Puget Sound Business Journal,* January 16, 1998.

[35] See generally, CMS, *Medicare Fact Sheet: The Medicare+Choice Program in 2001 and 2002,* August 29, 2001; Mark Williams, "Report: Ohio HMOs Losing Patients, Money," *The Associated Press State & Local Wire,* January 4, 2002.

[36] For a national discussion of this topic, see transcripts from Center for Studying Health Systems Change conference, "Emerging Health Care Market Trends: Insights from Communities" (Washington: December 19, 2001), available at www.hschange.org. See also, Peter Neurath, "Hospitals on the Critical List," *Puget Sound Business Journal,* December 15, 2000; Peter Neurath, "PacifiCare Is Out of the Red, but Still in the Fray," *Puget Sound Business Journal,* March 9, 2001; Carol Eisenberg, "Hospitals to Halt the Hemorrhaging; LIJ Ends Money-Losing Oxford Medicare Deal," *Newsday,* August 12, 2001: A6; Roni Rabin, "Blue Cross, Stony Brook Make a Deal," *Newsday,* August 14, 2001: A27.

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[38] Peter Neurath, "For Health Care, Prognosis Is Not Getting Better," *Puget Sound Business Journal,* January 4, 2002; Ruth Levine, "Managed Care Fades, Fee-for-Service Returns," *Puget Sound Business Journal,* October 27, 2000.

[39] Levine, 2000.

[40] Steward Ain, "Islands' Hospitals: Corporate vs. Community," *The New York Times,* April 8, 2001: Sec. 14, LI12.

[41] On August 14, 2001, Empire Blue Cross Blue Shield signed a contact with the University Hospital and Medical Center at Stony Brook, Suffolk County's only academic medical center and premier tertiary facility, after a seven-month contract hiatus. Roni Rabin, "Blue Cross, Stony Brook Make a Deal," *Newsday,* August 14, 2001: A27.

[42] Levine, 2000.

[43] Eisenberg, 2001.

[44] See generally, Dallek and Dennington, January 2002; Ashley C. Short, Glen P. Mays, and Timothy K. Lake, *Provider Network Instability: Implications for Choice, Costs and Continuity of Care,* Issue Brief 39, Center for Studying Health System Change, June 2001; Bradley C. Strunk, Kelly Devers, and Robert E. Hurley, *Health Plan–Provider Showdowns on the Rise,* Issue Brief 40, Center for Studying Health System Change, June 2001.

[45] Courtesy The Henry J. Kaiser Family Foundation. Compilation of figures from HIAA Employer-Sponsored Health Insurance Survey (1989–92), unpublished Bureau of Labor statistics (1992, 1994, 1997–98), KPMG Survey of Employer-Sponsored Health Benefits (1988, 1993, 1995–96) and Kaiser Family Foundation/HRET Survey of Employer-Sponsored Health Benefits (1999–2001).

[46] For example, in New York State's Elderly Pharmaceutical Insurance Coverage prescription drug benefit program, generic drugs account for 39 percent of claims, but only 14 percent of costs. One HMO executive estimated that generics cover only about 20 percent of medication costs for his plan's members.

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[48] For a national discussion of state pharmacy assistance programs, see AARP/Public Policy Institute, Issue Brief No. 50, *State Pharmacy Assistance Programs 2001: An Array of Approaches* (Washington: AARP, 2001). For problems with current programs, see Joy H. Lewis et al, "Compliance Among Pharmacies in California with a Prescription-Drug Discount Program for Medicare Beneficiaries," 346 *New England Journal of Medicine* (March 14, 2002): 830–835.

[49] Karin Kelly, "Cancer Patients Stop Treatment Due to Rising HMO Costs," WFAA-TV News, January 23, 2002; Video Monitoring Services of America, Inc. 11 News at Six, KTVT-TV (CBS), January 22, 2002; Julie Appleby, "Patients Drop Treatment Due to Costs: Co-payments Too Steep for Some Medicare HMO Clients," *USA Today,* January 28, 2002: B1; "Stark Introduces Bill to Improve M+C Plans," *California Health Advocates,* Vol. III, No. 1, Winter 2002; Susan Jaffe, "Seniors Pay to Breathe Pure Oxygen," *Cleveland Plain Dealer,* March 9, 2001.

[50] Medigap Plan C, the most popular Medigap policy, covers the 20 percent physician and other Part B coinsurance and the Part B $100 outpatient and $812 hospital deductibles.

[51] Saul Friedman, "Empire May Profit But Patients Won't," *Newsday,* July 17, 2001; Dallek and Dennington, 2002.

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[53] Lori Achman and Marsha Gold, *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (New York: The Commonwealth Fund, February 2002).

[54] According to the Office of Personal Management, average FEHBP premiums rose 13.3 percent from 2001 to 2002. Stephen Barr, "Health Plan Open Season Brings Higher Premiums and a Chance to Weigh Benefits, Cost," *Washington Post,* November 12, 2001: B02.

[55] The White House, January 28, 2002, press release.

[56] OMB, 2002.

[57] The White House, January 28, 2002, press release.

[58] The White House, "The President's Framework to Strengthen Medicare," July 2001. Available at: http://www.whitehouse.gov/infocus/medicare/.

[59] American Association of Health Plans, *Enrollment Lock-In Is Destabilizing to Both Beneficiaries and Medicare+Choice Plans* (Washington, D.C.: AAHP, June 2001).

[60] Geraldine Dallek and Andrew Dennington, *The 2002 Medicare+Choice Lock-In: Should It Be Delayed?* (New York: The Commonwealth Fund, December 2001).

[61] Dallek and Edwards, 2001.

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#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

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#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

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future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

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#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

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