FACT SHEET

MEDICARE

MEDICARE+CHOICE

April 2003

OVERVIEW

Medicare provides health benefits to 41 million elderly and disabled Americans. Most (89%) have their health bills paid directly by the traditional fee-for-service program. The remaining 11% are covered by Medicare+Choice (M+C) plans.

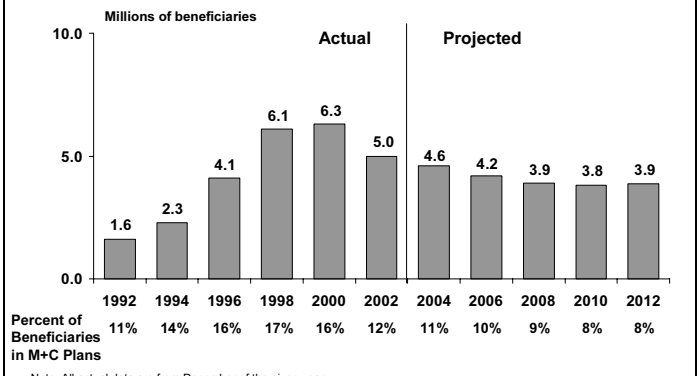
M+C was established by the Balanced Budget Act of 1997 to give beneficiaries the option of enrolling in a variety of private plans including health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans.

ENROLLMENT

- Medicare HMO enrollment grew rapidly between 1992 and 2000, climbing from 1.6 million to 6.3 million beneficiaries, or 16% of the total Medicare population (Figure 1).
- Since 2000, M+C enrollment has declined by 27% to 4.6 million beneficiaries, or 11% of the Medicare population.
- By 2010, CBO projects enrollment to shrink to 8% of the total Medicare population.
- More than 1 in 4 M+C enrollees nationwide live in California.

Figure 1

Enrollment in Medicare+Choice Plans



Note: All actual data are from December of the given year.
SOURCE: Actual: HCFA/Center for Health Plans and Providers, 2002; Projections: CBO, Medicare Baseline, March 2003.

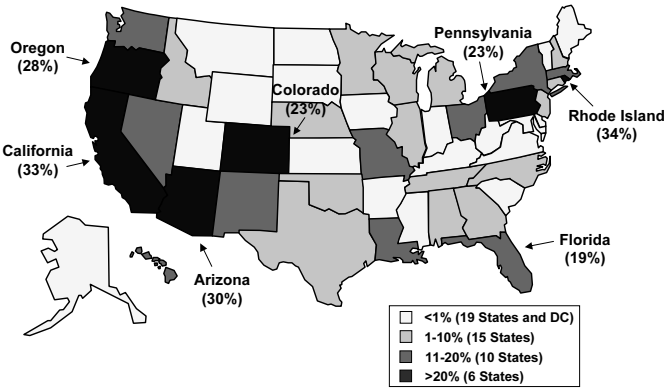
Although most have M+C options available in their area, the share of beneficiaries with such an alternative has declined from 72% in 1999 to 61% in 2002. Only 13% of those living in rural areas have the option of enrolling in an M+C plan today.

M+C penetration varies widely across states (Figure 2). At least 30% of beneficiaries living in CA, AZ, and RI are enrolled in M+C plans, but 10% or fewer are enrolled in M+C plans in 34 states. In 19 states plus D.C., less than 1% of Medicare beneficiaries are enrolled in an M+C plan.

M+C beneficiaries are permitted to enroll (provided the plan is accepting new enrollees) and disenroll from a plan at any time during the year. Phase-in of a "lock-in" was to begin in 2002, but has been delayed until 2005 to give the M+C program time to stabilize before imposing new restrictions.

Figure 2

Medicare+Choice Enrollees as a Percent of Medicare Beneficiaries, by State, 2003



SOURCE: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report, March 2003.

PLAN PARTICIPATION

- The number of M+C plans available in the 1990s grew rapidly, rising from 96 in 1990 to 346 plans in 1998.
- Between 1998 and 2003, the number of plans dropped by more than half to 148.

A number of changes have been adopted since 1997 to encourage plans to stay in the Medicare market. Both the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) increased payments to M+C plans. In addition, Congress eased administrative requirements, such as the deadline for plans to submit information on benefits and premiums.

While, to date, HMOs remain the primary alternative to traditional Medicare, two companies now offer PFFS plans in select markets. The Centers for Medicare & Medicaid Services (CMS) has also implemented a PPO demonstration that will offer 35 plans in 23 states. The demonstration is intended to expand M+C participation and assess the impact of enhanced payment and risk-sharing arrangements between CMS and participating plans. PPO plans will be paid the higher of the M+C capitation rate or 99% of the average fee-for-service payment in each county.

BENEFITS AND PREMIUMS

M+C plans are generally required to provide benefits covered under traditional Medicare without imposing additional out-of-pocket costs. Plans with costs below the Medicare payment level must distribute savings to beneficiaries in the form of lower plan premiums and copayments, or additional benefits.

The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 (650) 854-9400 Facsimile: (650) 854-4800
Washington, D.C. Office: 1330 G Street, N.W., Washington, DC 20005 (202) 347-5270 Facsimile: (202) 347-5274 **Publications:** (800) 656-4533 **Website:** www.kff.org

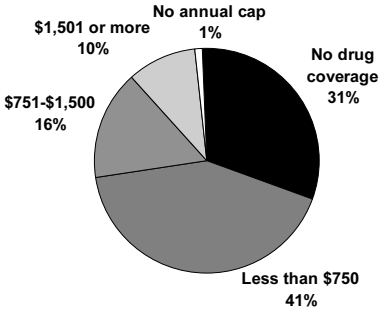
As of 2003, M+C plans are permitted to offer reduced Part B premiums as an extra benefit. Currently, 3 plans offer a partial rebate for Part B premiums, while 2 offer a full rebate.

Most M+C plans offer supplemental benefits. However, there has been a decline in availability and breadth of key benefits, particularly prescription drugs (Achman and Gold, 2003).

- The share of M+C enrollees in basic plans with drug coverage declined from 84% in 1999 to 69% in 2003.
- More than half (60%) of plans that offered drug benefits in 2003 covered only generics, compared with 19% in 2001.
- More than 4 in 10 enrollees had an annual prescription drug benefit cap of $750 or less in 2003 (Figure 3).

Exhibit 3

Prescription Drug Coverage and Annual Benefit Caps for Medicare+Choice Enrollees, 2003



Total = 4.6 million M+C enrollees

Note: Benefit caps apply to prescription drug benefits for basic plans in M+C contract segments. Includes plans with generic-only benefits. Data are weighted by enrollment.
SOURCE: Mathematica Policy Research, Inc. analysis of Medicare Compare database for the Commonwealth Fund, April 2003.

Until recently, the majority of M+C enrollees were offered additional benefits without being charged a premium (other than the monthly Part B premium). Between 1999 and 2002:

- The share of M+C enrollees in basic plans with no premium declined from 80% to 38%.
- The share of enrollees with a monthly premium of $50 or more rose from 3% to 35%.
- Average monthly premiums (among plans with a premium) increased from $32.11 to $60.50 (Figure 4).

PAYMENTS TO PLANS

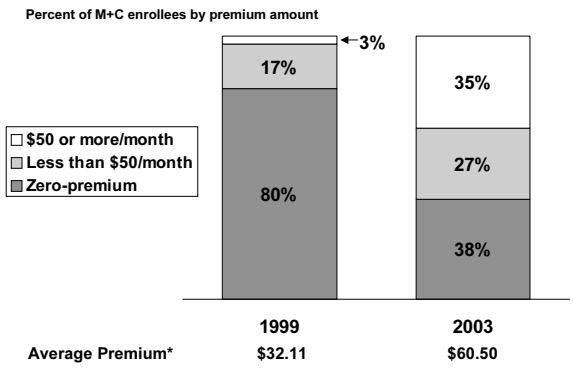
Medicare pays M+C plans a fixed monthly amount (adjusted for age, sex, Medicaid enrollment, and institutional status) to cover benefits for each enrollee. However, payments vary widely throughout the country. Regional payment variation is expected to decrease as Medicare phases in a system blending national average costs with county-level costs and raising payments to plans in rural and low-cost counties.

Minimum monthly payment rates in 2003 are $495 for plans serving areas with fewer than 250,000 people and $547 for plans in more populated areas. The minimum payment update is 2% in 2003.

Medicare payments to plans have been an ongoing issue for some time. Plans cite insufficient funding and payment increases as a major concern. Medicare's M+C payment methodology has also been criticized for inadequate adjustment for the health status of enrollees. A number of studies have found that managed care has resulted in increased Medicare spending, rather than savings, because enrollees are reportedly in better health and have lower than average medical costs than those in the traditional program.

Exhibit 4

Monthly Premiums for Medicare+Choice Enrollees, 1999 and 2003



*Average premium charged by basic plans that impose premiums.
SOURCE: Mathematica Policy Research, Inc. analysis of Medicare Compare database for the Commonwealth Fund, April 2003.

According to a 2000 GAO report, in 1998, Medicare paid plans an average of 13.2% more than Medicare would have spent if plan enrollees had received care under traditional Medicare.

In 2000, Medicare began to phase in a new risk-adjustment system based on inpatient hospital stays in the previous year. By 2007, a more comprehensive risk adjuster using both inpatient and ambulatory data is expected to be in place.

QUALITY OF CARE

The evidence on quality of care and satisfaction in M+C is mixed (Miller and Luft, 2001; Wholey, et al., 1998; Tudor, et al., 1998). A study of elderly cancer patients found managed care enrollees more likely to be diagnosed at an early stage than those in FFS (Riley, et al., 1994), while others report disparate access to specialists, home health, and rehabilitation services (Shaughnessy, et al., 1994; Retchin, et al., 1994; Clement, et al., 1994). A recent study found seniors in poor health or with low incomes had poorer outcomes in managed care than in FFS (Safran, 2002). While the majority of M+C enrollees report being satisfied with their care, those with health problems and the under-65 disabled are more likely to report difficulties accessing specialists and other covered services (Cox, et al., 2001; HHS OIG, 1998; PPRC, 1997).

FUTURE ISSUES

Managed care is likely to continue to have an important role in Medicare, but the future of the M+C program seems uncertain. Withdrawals and service area reductions by some plans and decreases in prescription drug and other benefits by others may make M+C a less attractive option for Medicare beneficiaries. Striking the right balance between the goals of controlling spending growth, setting payments to plans fairly, providing greater stability for plans and beneficiaries, and meeting beneficiaries' health-care needs will be an ongoing challenge for Medicare+Choice.