

# Report

## **Medicare+Choice in Phoenix, Arizona: So Far So Good?**

**Maricopa County Site Visit Report, May 7-9, 2003**

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### **Introduction**

Policymakers created the Medicare+Choice (M+C) program as part of the 1997 Balanced Budget Act in an effort to expand enrollment of Medicare beneficiaries in managed care plans. Health plans were expected to use managed care cost containment strategies to help control overall Medicare cost increases. At the same time, plans were expected to offer beneficiaries additional benefits such as lower deductibles and coinsurance and drug coverage. In 1997, M+C was originally projected to enroll a third of beneficiaries by 2005.<sup>1</sup>

However, M+C has not been as successful as its creators had hoped. The national experience with M+C has been characterized by plan withdrawals, reductions in benefits, and provider instability.<sup>2</sup> Consequently, program enrollment never reached projected levels and has been decreasing from a high of 16% in 1999 to a current level of 11% of eligible beneficiaries.<sup>3</sup>

There is significant variation in experiences with M+C across the United States. In some areas of the country, beneficiaries have a choice of multiple managed care plans and M+C market penetration rates remain well above the national average.

Phoenix, Arizona is one of the markets where M+C appears to be successful. Thirty-seven percent of eligible beneficiaries are enrolled in a managed care plan and beneficiaries can choose from eight plans offered by six firms.<sup>4,5</sup> Success of M+C in Phoenix has been partially attributed to a long history of managed care in Maricopa county, especially in the Medicaid program.<sup>6</sup>

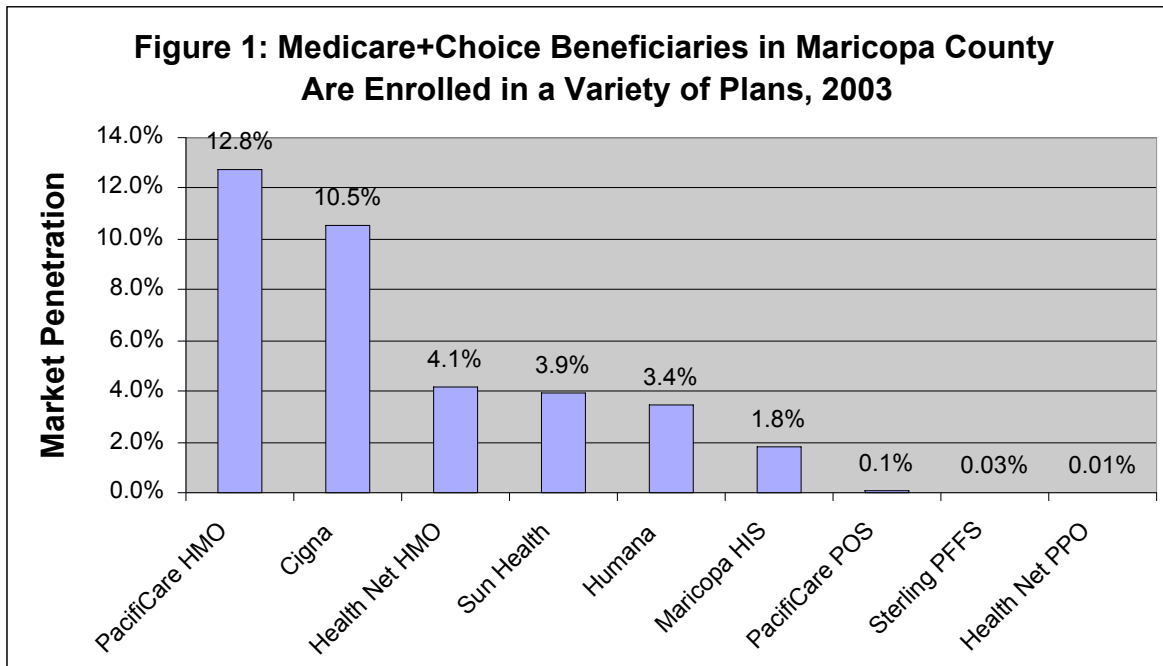
The new Medicare reform legislation envisions a large role for private plans in Medicare's future, which makes it important to understand the factors that have made Medicare+Choice successful in certain cities.<sup>7</sup>

### **Medicare+Choice in Phoenix**

Medicare+Choice is faring better in Phoenix than in most other areas of the country, but it is starting to show many of the same problems that have affected the program elsewhere. Plans have reduced benefits and introduced monthly premiums for beneficiaries. They have increased physician payments in response to provider pushback. Beneficiaries are confused about changing benefit packages and charges for services which were previously covered by their plans. Limited provider availability and plan enrollment caps reduce options available to beneficiaries. While M+C enrollment at thirty-eight percent remains well above the eleven percent national penetration rate, enrollment in Phoenix has fallen by twenty percent from the 1999 high of forty-four percent.<sup>8</sup>

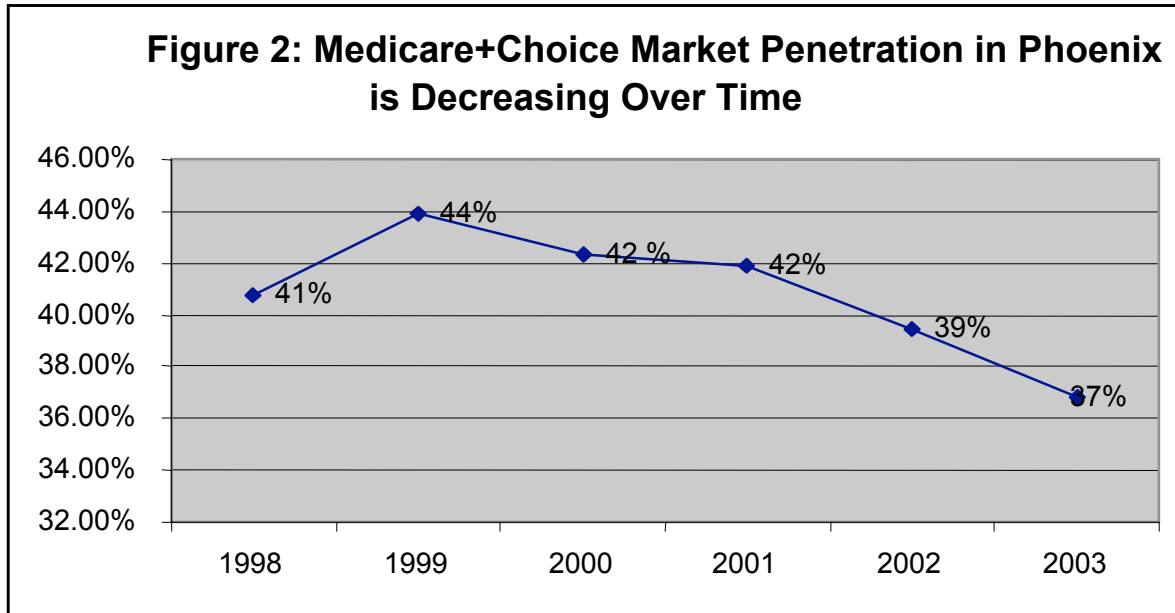
Many experts familiar with the local market now speculate that the Phoenix market may follow the patterns of enrollment decline seen in other cities over the next three to five years. Health plan administrators, providers, beneficiaries and senior counselors question whether M+C will continue to be characterized by many plans and current 30% enrollment levels.

Medicare+Choice beneficiaries in Phoenix currently have access to a variety of plans including six Medicare HMOs, a Point of Service (POS) plan, a PPO and a Private Fee for Service (PFFS) plan. PacifiCare and Cigna, large national plans which both offered \$0 premium plans through 2002, have traditionally dominated the Phoenix M+C market. Local and regional plans including Sun Health, Humana, Health Net and Maricopa County Integrated Health System have attracted beneficiaries as well. Figure 1 shows 2003 enrollment figures for the participating plans including PacifiCare's POS plan and the Health Net PPO, that were new additions to the market for 2003. A market history is attached as Appendix 1.



Source: CMS Medicare Managed Care State, County Plan Data Files, June 2003.

Despite the selection of plans, M+C enrollment in Phoenix is declining. Figure 2 shows the change in enrollment over time.



Source: GWU analysis of CMS Medicare Managed Care State, County Plan Data Files, 1998-2003.

### Changing Benefit Packages

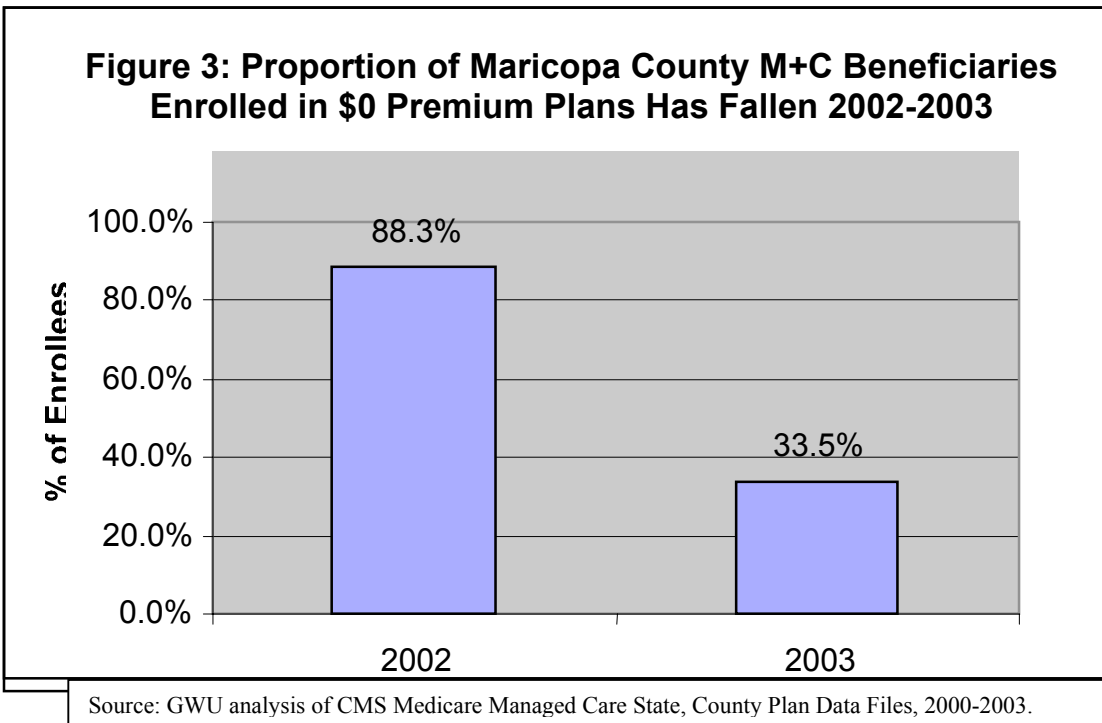
Much of the decline in Medicare+Choice enrollment in Phoenix may be attributed to the changing benefit packages, which are becoming less generous and less attractive to beneficiaries.

The Medicare+Choice market in Phoenix was extremely competitive through 2000, with plans competing for beneficiaries by offering generous benefit packages and zero-premium plans. Recently, health plans have been making changes to benefit packages including increasing premiums, reducing benefits and increasing cost-sharing for services as they try to remain in the market. Appendix 2 details many of the plan-specific changes made between 2002 and 2003.

#### *Fewer \$0 Premium Plans*

Through 2002, beneficiaries could access at least four \$0 plans which offered brand and generic drug coverage.<sup>9</sup> In 2003, only Cigna and Maricopa Integrated Health Systems continued to offer such plans. However, new Cigna members could only receive care at the Sun City facility and

the Maricopa plan is closed to new members. The enrollment-weighted average premium paid by Maricopa county M+C beneficiaries has increased significantly in the past year from \$5.50 in 2002 to \$16.27 in 2003.<sup>10</sup> Nearly three times as many beneficiaries were enrolled in a \$0 premium plan in 2002 than continue to be in such a plan in 2003. M+C plans that recently introduced monthly premiums reported “steady leaks” of their healthiest beneficiaries to the \$0 plans.



### *Reduced Prescription Drug Coverage*

As plan premiums have increased over time, benefit packages have eroded compared to plans' initial offerings.

Cigna, for example, entered the Medicare risk market in 1993 with a \$400 pharmacy maximum in its benefit package. In order to remain competitive with other plans in the market, Cigna first increased this to a \$2,500 brand name drug maximum in 1998 in response to the other

plans available to beneficiaries. Recently, Cigna has steadily reduced the brand pharmacy cap to a 2003 benefit of \$500/year.<sup>11</sup>

Sun Health’s MediSun has a policy of computing the drug benefit cap as the sum of the average wholesale price of a drug, not the actual pharmacy cost the beneficiary incurs.

Beneficiaries feel that this causes them to max out their benefit prematurely and discourages them from finding the best price for their drugs. One focus group member explained that the same prescription that had cost \$400 out-of-pocket through MediSun last year had already cost the beneficiary \$1,600 for the first five months of 2003.

*Increased Cost Sharing*

Recent changes in benefit packages appear to be designed to improve plan risk selection by offering packages that are more attractive to healthier beneficiaries. Since most M+C plan members have been aging with the plan, heightening the disease profile over time, plans structure benefits to appeal to younger, healthy beneficiaries in order to balance the increasing costs of sicker members.

For 2003, many plans increased cost-sharing for hospitalization. Sick plan members will face significant out-of-pocket expenses at the time of hospitalization, while those who remain healthy during the year will see less change in their annual expenditures. Table 1 illustrates some of the changes associated with hospital costs for 2003.

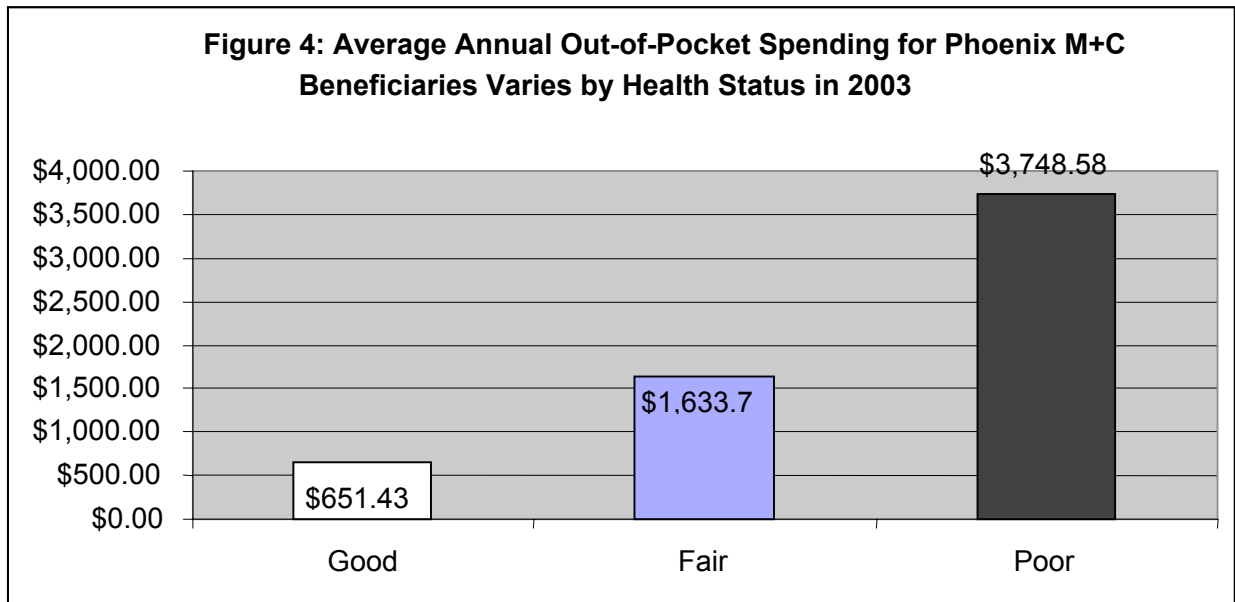
**Table 1: Selected Changes in Cost-Sharing for Hospital Care, Maricopa County M+C Plans 2002-2003**

Plan	Benefit Change 2002-2003
Cigna	Inpatient Hospital Stay- Copay increased from \$0 to \$300/stay
Health Net	Inpatient Hospital Stay- Copay increased from \$250/stay to \$100/stay +\$100/day days 1-5
Humana Gold Plus	Inpatient Hospital Stay- Copay increased from \$150/day for days 1-5 to \$300/day for days 1-5
Cigna	Outpatient Hospital Visit- Copay increased from \$12 to \$100
Humana Gold	Outpatient Hospital Visit- Copay increased from \$100 to \$250

Plus	
Sun Health MediSun	Outpatient Hospital Visit- Copay increased from \$25 to \$150

Source: GWU analysis of CMS Medicare Health Plan Compare Data 2002-2003.

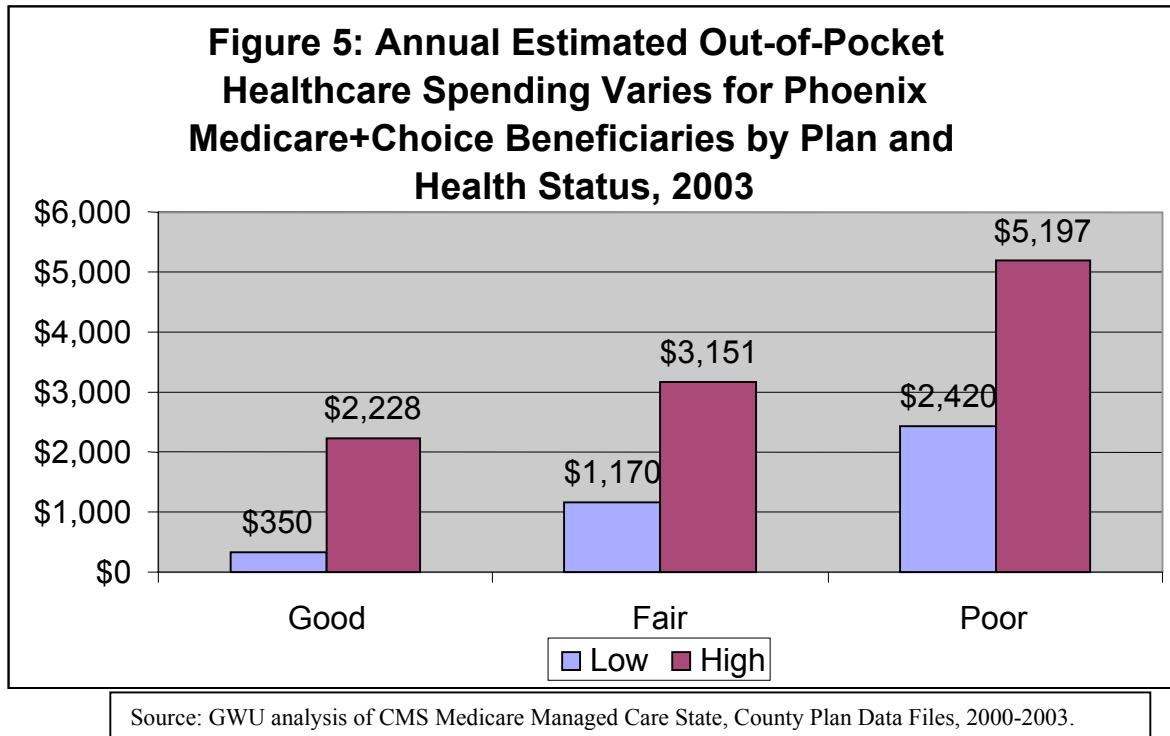
These changes lead to large discrepancies in annual out-of-pocket medical expenditures by health status for M+C beneficiaries in Phoenix. A healthy beneficiary is estimated to spend between \$350 in 2003 in out-of-pocket health care costs with the Cigna plan and \$2,228 for the Health Net Senior Care Options Plus PPO plan. A beneficiary in poor health is projected to spend much more in 2003- estimates of out of pocket spending range from \$2,420 for Sun Health beneficiaries to \$5,197 to those enrolled in the Health Net PPO.<sup>12</sup> Figure 4 presents the differences in enrollment-weighted average out-of-pocket costs for M+C beneficiaries by health status.



Source: GWU analysis of HealthMetrix Research 2003 HMO Cost Share Report, CMS Medicare Health Plan Compare Data 2003 and CMS Medicare Managed Care State, County Plan Data Files, 2003.

Since each plan offers a different benefit package, there is also significant variation in beneficiary out-of-pocket spending by M+C plan. Figure 5 shows the average annual out-of-

pocket spending estimates for beneficiaries enrolled in the plans with highest and lowest expected costs by health status.

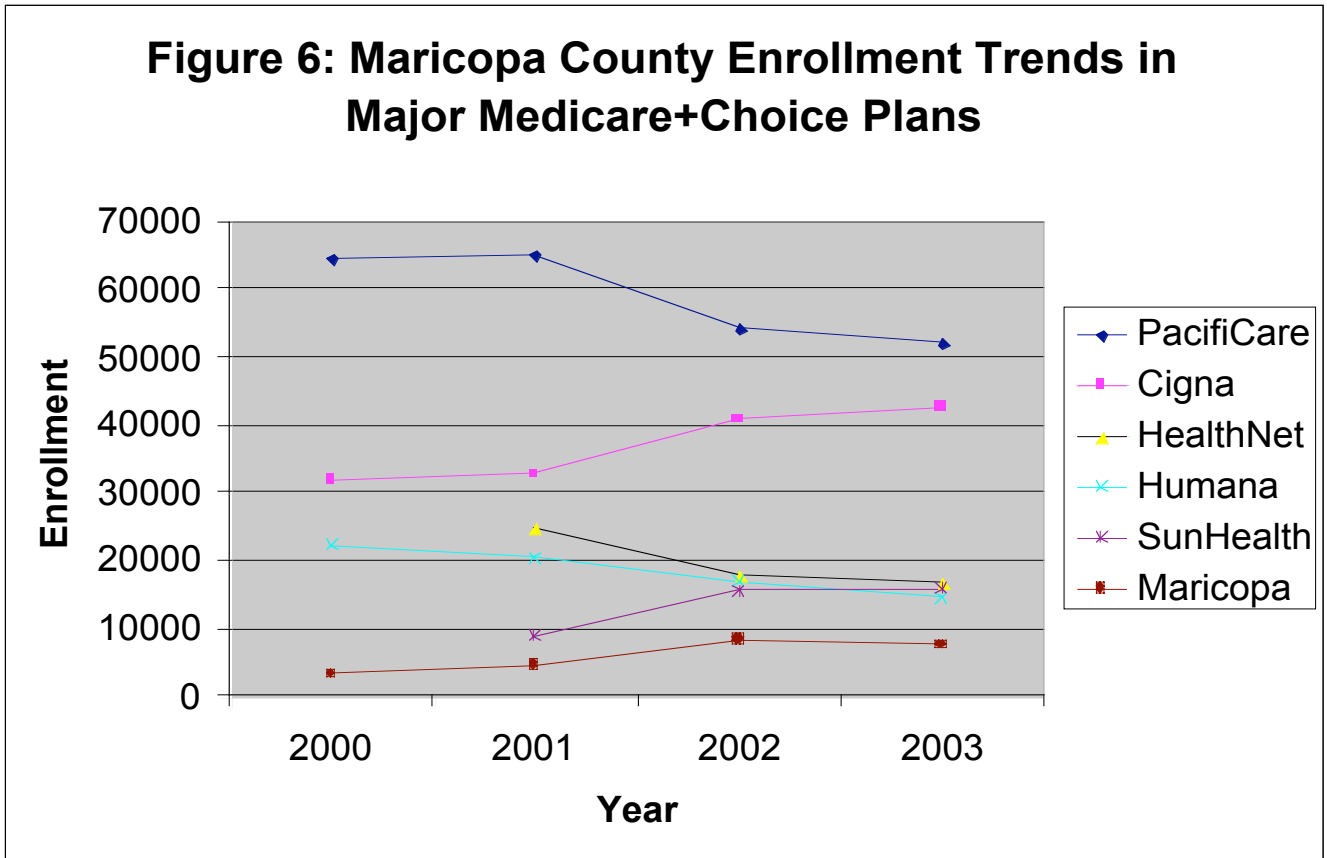


PacifiCare has consistently commanded the largest share of the Phoenix Medicare+Choice market, enrolling thirty-five percent of M+C beneficiaries in 2003. In 2001, the company’s national strategic plan called for actions to “reduce our dependency on Medicare+Choice. To maximize the cash flow from our Medicare+Choice business, we exited unprofitable markets, froze enrollment in many other markets, and announced the most significant benefit reductions in the company’s history.”<sup>13</sup>

In Phoenix, PacifiCare actions included increased cost-sharing for radiation therapy (up to \$150/treatment<sup>14</sup>), a move that discouraged cancer patients from enrolling or remaining in the plan, according to those familiar with the local market. Some of PacifiCare’s sicker patients shifted to other M+C plans for 2002. Overall M+C enrollment declined by 3% for 2002.



Other plans were affected by the unexpected increase in their patient disease profile. Most followed PacifiCare’s lead and increased co-payments for radiation therapy in 2003.<sup>15</sup> Figure 6 shows beneficiary movement from 2002 to 2003. Cigna, which was still offering a \$0 plan with some drug coverage, a \$12/treatment radiation co-pay and no co-pay for inpatient hospital care enrolled many of the former PacifiCare members. Maricopa Senior Select, the county plan, also saw an influx in enrollees since it maintained a generous benefit package and a \$0 premium.



Other plans reportedly introduced facility charges, which are not regulated by CMS, instead of copays for common procedures. Humana, for example, continues to cover mammograms with a \$0 copayment for in-network services, but recently assessed a local patient

a \$150 facility charge for having the procedure performed. Counselors report that an uninsured patient would pay \$125 out-of-pocket for a mammogram at the same facility, suggesting that for some procedures, M+C beneficiaries may pay more than those without coverage.

The Phoenix experience with generous benefit packages that have deteriorated over time has been similar to that of many other markets. Large national firms have scaled back benefits after limited increases in Medicare fee-for-service costs led to small annual increases to M+C plans across the nation. This has created a negative competitive strategy- as one plan executive explained, plans now ask “what benefits will we have to strip this year to work with our cost structure,” not “what else can we offer?”

Some plans are starting to increase their advertising and other recruitment efforts again in order to bring younger, healthier members into the plans to balance the cost of aging beneficiaries who are getting sicker. In Particular, PacifiCare and Sun Health appear to be actively marketing their M+C products in 2003. In the past, firms aggressively marketed plans to seniors through print and television ads as well as in-person presentations. In the late 1990s, firms would recruit at golf courses and other areas frequented by active seniors, which had encouraged favorable risk selection.

#### *Access to Plans and Providers:*

Although a relatively large number of firms and plans are offered in the Phoenix market, many of them are not attractive options for individual M+C beneficiaries. Cigna serves virtually all of its M+C members through seventeen staff-operated clinics. Beneficiaries can only enroll in clinics with adequate capacity. In May 2003, only the Sun City facility (which is part of the Sun Health campus but staffed with Cigna providers) was accepting new members. Seniors

living in other parts of the county who have doctors at Sun City clinics often rely on local Call-a-Ride services for transportation.

Cigna has recently discontinued its contract as a county Medicaid HMO, a move which may lead to more openings for M+C beneficiaries in local clinics. Cigna is the only \$0 premium plan in the market that is still accepting new members, which makes signing up with its Sun City clinic more attractive than otherwise to beneficiaries who do live in other parts of the county.

Maricopa Senior Select, a local plan run by Maricopa county's integrated health system and the only other \$0 premium plan in the market is also currently closed to new members. The county system, which continues to offer drug coverage with a \$0 premium, had a large influx of new members when Aetna left the market and other plans sharply reduced benefits effective January 2002. The plan was unprepared for such a large increase in membership and developed problems with access to care. Consequently, the Centers for Medicare and Medicaid Services (CMS) placed a cap on enrollment and precluded the plan from enrolling new members until performance improved. The county now has a new computer system and better administrative functionality, which should result in the lifting of the cap.

Sun Health was permitted to serve a partial-county area for its MediSun M+C product, an exception to Centers for Medicare and Medicaid Services (CMS) policy, which typically requires participating plans to serve an entire county. Sun Health is based in Sun City, a large retirement area in the western part of Maricopa county.

Sun City, the MediSun catchment area, boasts the state's oldest population, with a median resident age of 75.<sup>16</sup> Sun Health targets patients who reside near their facilities, which are thoroughly integrated into the community through a combination of planning and design factors and volunteer and foundation involvement. MediSun minimizes out-of-network

utilization costs (less than 2%) by attracting beneficiaries who will find it convenient to use their facilities and providing a full continuum of services in order to avoid having to negotiate with other providers or facilities.

Some beneficiaries living in the outer reaches of the MediSun service area encounter high out-of-network charges when they use more convenient providers. Senior counselors indicated that this is particular problem for MediSun beneficiaries in the Peoria-Glendale area of the county who live closer to an out-of-network hospital. In an emergency, ambulances transport them to the closest facility. Since it is not a Sun Health facility, seniors face a \$500 out-of-network charge and also have to be transported to a network hospital after being stabilized.

**PPO, POS and Private Fee-For-Service Plans: New Options in the Market**

Recent additions to the M+C plan choices for 2003 included a demonstration PPO offered by HealthNet, a Point-of-Service plan from PacifiCare (also part of the PPO demonstration), and the Sterling Private Fee for Service plan. These plans place fewer restrictions on access to providers than traditional Medicare HMOs do, typically allowing wider provider network and the ability to see a specialist without a referral.

These plans are also more expensive than the HMOs; monthly premiums range from \$75 for the PacifiCare POS plan to \$99 for the Health Net PPO. In comparison, HMOs in Phoenix charge monthly premiums of \$0 to \$39. The new plans are designed to compete with FFS Medicare with a Medigap supplement, rather than attract members away from the HMOs.<sup>17</sup>

Table 2 compares the monthly premiums for the new plans to those for Medicare HMOs and Medigap policies available to beneficiaries in Maricopa county.

**Table 2: Less Restrictive M+C Plans have Higher Monthly Premiums, 2003**

Plan	Monthly Premium
Cigna HMO (lowest premium Medicare HMO)	\$0
Health Net Senior Care (highest premium Medicare HMO)	\$39

PacifiCare POS	\$75
Health Net PPO	\$99
AARP Medigap Plan C	\$137
AARP Medigap Plan F	\$140

Source: Medicare Compare, 2003 and AARP Health Care Options Medicare Supplemental Insurance Rates, 2003. Monthly premiums are in addition to Medicare Part B premium.

PPOs and POS plans may face adverse selection since the plans are community-rated (a single monthly premium is charged to all enrollees regardless of age or health status) and offer easier access to specialists. These features may attract the older, sicker patients who would pay higher premiums for Medigap policies that have attained age or issue age premium rating practices.

Thus far, there has been little interest in the new plans and HMOs do not view them as competition. The new PPOs and POS plans have only enrolled 760 beneficiaries in total as of September 2003, despite county Medicare-eligible population of more than 40,000.<sup>18</sup> Low enrollment may be attributed to a lack of awareness by beneficiaries, as there is little advertising by these plans. It may also be due to confusion about the features of the PPOs that justify the additional premium. Senior counselors report that when potential enrollees call Sterling to ask about the PFFS plan, marketing representatives encourage them to enroll in more expensive supplement policies instead.

### **Local Providers and M+C**

Plans have seen annual Medicare payment increases of 2% to 3%, while providers have insisted on cost increases of 9% to 10% annually.<sup>19</sup>

### ***Hospitals***

Hospitals have regained considerable bargaining power with managed care companies and now practice “smarter contracting” and refuse to accept capitation payments. Most of the hospitals in Maricopa County have consolidated under local or national chains. Banner owns six

hospitals in the county and another four are Vanguard facilities. Network affiliations also give hospitals greater bargaining power by reducing the number of negotiating alternatives available to health plans.

PacifiCare is the only M+C plan that still requires hospitals to accept capitation payments. Area hospitals are often at capacity, especially during the winter when seasonal residents arrive and the population swells, and therefore not very dependent on members of M+C plans. This gives hospitals leverage to contract under more favorable terms, typically per diem payments with carve-outs (additional payments) for expensive procedures such as heart valve replacements and spinal fusion. Hospitals are also demanding higher rates for trauma care.

### ***Physicians***

Physicians are dependent on their Medicare patient base and consider Medicare to be their best payer. In the early days of Medicare+Choice, physicians were willing to accept M+C plan contracts paying them 60%-80% of FFS, which left plans with money to spend on additional benefits that lured beneficiaries to M+C. Physicians found that they could not sustain their practices with payments this low and demanded higher payments from M+C plans. Most doctors now contract with plans for 100% of FFS.

Humana still requires doctors to sign capitation contracts, which pay a single sum to cover a member's care during a contract period, thus shifting risk to the physicians. In some cases, M+C networks appear to be shrinking as physicians refuse to sign M+C contracts. Many of them avoid Sterling, which has a reputation for being very slow to reimburse physicians for services.

Cigna is one of the few remaining staff model HMOs in the Phoenix market. Its doctors are salaried and paid annual bonuses, so they do not contract separately for Medicare+Choice patients.

SunHealth physicians also accept capitation agreements, although they have a voice in plan decisions through the company's unique structure. Senior management proposed plans to scale back the drug benefit or eliminate brand-name coverage for 2003, but doctors said that they would be unwilling to continue to assume risk if they couldn't prescribe the drugs that their patients need. Use of some expensive brand name drugs is a key component of MediSun's disease management models.

Competition for physicians in Phoenix is intense. The heavy rate of managed care penetration (36.7% in 2001)<sup>20</sup> in Phoenix manifests itself in universally low payment rates, making it very difficult to attract new doctors to the area. Local experts predict that doctors will no longer contract with plans that are difficult to deal with by the end of 2003. Consequently, plans have been reducing their "hassle factors" and performing fewer utilization reviews. Twenty-five years of managed care in Phoenix have trained physicians to be cost-effective practitioners, so plans find little value in conducting most reviews.

Senior counselors questioned physicians' overall satisfaction with M+C because they have heard many stories about network instability, physician churning and doctors refusing to take M+C patients.

### ***Maricopa County System***

M+C beneficiaries in Phoenix may lose the Maricopa Senior Select plan option, as well as access to the county medical center, health clinics and a burn center if the Maricopa Integrated Health System is unable to remain financially solvent. County residents voted to create a

healthcare district to support the system through property taxes and bonds in the November 2003 elections, which should improve fiscal viability in the future.<sup>21</sup> Like many states, Arizona is facing budget shortfalls that force difficult decisions about healthcare spending. Recent budget cuts eliminated safety net health insurance for 2,500 in the state.<sup>22</sup> The county system is the major safety net provider for the community. Other local hospitals fear that they will have to provide significantly more uncompensated care in the future if the funds generated by the new tax district are insufficient to support the county system.

Phoenix has a high proportion of uninsured immigrants using local emergency rooms in addition to the county system. Local physicians are increasingly unwilling to practice in hospitals because they do not want to treat large numbers of uninsured, low-income patients. Doctors are increasingly shifting practices away from hospitals to outpatient centers where they have more control over patient populations. This is particularly prevalent among ophthalmologic surgeons.

### ***Beneficiaries***

Counselors from the local Benefit Assistance Program (BAP), Arizona's State Health Insurance Assistance Program help Medicare beneficiaries understand the plan choices available to them and often hear about problems beneficiaries have with their plans. Counselors report that in Phoenix, beneficiaries became accustomed to receiving additional benefits and developed unrealistic perceptions of what the basic Medicare benefits entails.

Beneficiaries in our focus groups expressed frustration about deteriorating benefit packages. They explained that they were more confused by the changes and sometimes do not learn about service and coverage changes until they need care and find that it is no longer covered.



## Prescription Drugs

Phoenix seniors appear to be very sensitive to health care and drug costs. Beneficiaries report aggressively seeking out the best drug prices and take bus trips to Mexico where prescriptions can be filled more inexpensively.

Arizona's governor, Janet Napolitano, made prescription drug affordability a major priority of her program by issuing an executive order in January 2003 to establish a drug discount program.<sup>23</sup> She invited pharmacy benefit managers to compete to provide a drug discount card for seniors.

RxAmerica was chosen to provide the benefit to all Medicare-eligible Arizonians. For \$9.95 per year, participants receive a card which on average provides them discounts of 15% or more off average wholesale price.<sup>24</sup> Participants can use the cards at a variety of participating pharmacies throughout the state.<sup>25</sup> The discount program is has no cost to the state but its impact on seniors remains to be seen. Some seniors felt that it would not be very helpful to low income seniors who would have as much trouble affording 85% of the cost of a drug as they do with the full price.

All of the Medicare HMOs also have their own drug discount cards which are issued to members regardless of additional drug coverage. HMOs negotiate volume discounts of 15%-30% for all subscribers and are able to pass these savings on to M+C beneficiaries. CMS does not allow plans to advertise the benefit because it costs them nothing to provide, but plan administrators point out that they can offer deeper discounts than those available through the RxAmerica plan.

Medicare+Choice plans now take a different approach to their decision to offer drug benefits. While generous benefits were once offered to attract beneficiaries to the plans,

administrators now focus on the short-term cost-effectiveness of covering prescriptions. Since members can switch plans at any time and plans can leave the market each year, there is considerable uncertainty surrounding the return on investment for drugs, even those that may be cost-effective in the long term.

## **Conclusion**

Medicare+Choice in the Phoenix market is viable at this time. National trends have been influenced by the decisions of three major players- health plans, providers and beneficiaries. Future actions by these groups in Phoenix will determine the sustainability of the local M+C program.<sup>26</sup>

Factors unique to the Phoenix market such as the large senior population, its long-time history of managed care in Medicaid, Cigna's reliance on staff-based models and Sun Health's community integration seem to make M+C more viable than it is in many cities. However, with plans limiting payments to providers and geographic limitations on facility availability, M+C beneficiaries may find that they are having increasing difficulty accessing services and leave the program.

The future of Medicare+Choice in Phoenix depends on the outcomes of three decisions.

1. *Will doctors, hospitals and health plans be able to negotiate rates that make program participation profitable for both providers and health plans?* Physicians in Phoenix increasingly view fee-for-service Medicare as their best payer and hospitals have large patient bases, making neither group heavily reliant on Medicare+Choice patients. At the same time, costs of care are increasing at a much higher rate than M+C plan payment rates, leaving plans with fewer resources to attract providers.

2. *Will plans like Cigna and Sun Health be able to retain their strong local infrastructure?*

Local plans are one of the strengths of Medicare+Choice in Phoenix. Cigna and Sun Health, in particular, continue to be able to provide additional benefits because of their integrated delivery system and knowledge of the local market. If local market factors change, models that have been successful in Phoenix may be forced out of the market.

3. *How will Medicare reform and the availability of the Governor's drug discount card affect beneficiaries' decisions to remain in Medicare+Choice?* As beneficiaries face diminishing benefit packages and alternative ways to access prescription drug benefits, they may be unwilling to accept the constraints imposed by managed care as the tradeoff for additional benefits and return to FFS Medicare with an additional drug benefit.

Phoenix is one of the few local markets nationwide where experiences with Medicare + Choice resemble the initial vision that program creators had for M+C- a large proportion of eligible beneficiaries enrolled in a variety of private plans which offer additional benefits. However, if recent trends, including diminishing benefit packages and declining enrollment continue, Phoenix may no longer be a model for M+C in the not too distant future.

**Appendix 1: Maricopa County Medicare+Choice Market History**

PLAN	1998		1999		2000		2001		2002		2003	
Total Eligibles	363012		370181		378496		385955		393246		405003	
Pacificare HMO	57426	15.82%	63433	17.14%	64729	17.10%	65268	16.91%	54056	13.75%	50820	12.55%
Pacificare POS											278	0.07%
Humana	18029	4.97%	19078	5.15%	22289	5.89%	20363	5.28%	17011	4.33%	13808	3.41%
Maricopa County	2358	0.65%	2770	0.75%	3169	0.84%	4516	1.17%	8329	2.12%	7004	1.73%
Intergroup	25566	7.04%	27124	7.33%	26641	7.04%						
Health Partners	4496	1.24%	47	0.01%					24	0.01%		
CIGNA	37223	10.25%	37675	10.18%	31824	8.41%	32648	8.46%	40640	10.33%	42116	10.40%
Premier	614	0.17%		0.00%		0.00%						
Evercare	89	0.02%		0.00%	123	0.03%	88	0.02%	1179	0.30%	1296	0.32%
Aetna <sup>1</sup>	1845	0.51%	7360	1.99%	11145	2.94%	4893	1.27%				
Sun Health			4542	1.23%			8833	2.29%	15503	3.94%	15866	3.92%
Health Net HMO							24837	6.44%	18031	4.59%	16516	4.08%
Health Net PPO											464	0.11%
M+C Penetration	147646	40.67%	162029	43.77%	159920	42.25%	161446	41.83%	154773	39.36%	148168	36.58%

Source: Centers for Medicare and Medicaid Services (2003). Medicare Managed Care State, County, Plan Data Files, December 1998 - December 2002, September 2003

<sup>1</sup> In 2002, Aetna's corporate strategy called for "significant price increases [and] withdrawals from certain unprofitable Commercial HMO and Medicare products within markets."<sup>27</sup>

<b>Appendix 2</b>								
<b>2002-2003 Premium and Selected Benefit Co-Pays: Maricopa County Medicare+Choice Plans</b>								
	<b>CIGNA</b>		<b>Health Net - SeniorCare</b>		<b>Humana Gold Plus</b>		<b>Maricopa Senior Select Plan</b>	
<b>Year</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>
Enrollment Limit	No	No	Yes	No	Yes	Yes	Yes - closed	Yes-closed
Premium	\$0	\$0	\$28	\$39	\$0	\$19	\$0	\$0
Doctor visits								
Primary Care	\$12	\$15	\$15	\$15	\$15	\$20	\$5	\$15
Specialist	\$12	\$25	\$25	\$40	\$25	\$40	\$5	\$25
<b>Outpatient visits</b>								
Ambulatory surgery	\$12	\$100	20% copay	20% copay	\$100	\$150	\$5	\$50
Hospital visit	\$12	\$100	20% copay	20% copay	\$100	\$250	\$5	\$25
Durable medical equipment	No copay	\$0-100	No copay	No copay	20% copay	20% copay	No copay	\$25
<b>Diagnostic Tests</b>								
Clinical lab	\$0	\$0	\$0	No copay	\$0-50	\$20-150	No copay	No copay
X-rays/ Diagnostic lab	\$0	\$0-100	\$15-100	\$15-150	\$0-50	\$20-250	No copay	No copay
Radiation Therapy	\$12	\$25	\$15	20% copay	\$0-50	\$20-150	No copay	No copay
Outpatient rehabilitation services	\$12	\$25	\$25	\$40	\$0-50	\$40-150	\$5	\$25
Inpatient hospital care	No copay	\$300/stay	\$250/stay \$500 cap	\$100/stay, \$100/day for days 1-5	\$150/day for days 1-5 \$0/ day thereafter	\$300/day for days 1-5	No copay	No copay
<b>Skilled nursing facility</b>								
Days 1-20	No copay	\$0	No copay	\$0	\$75	\$0 for d.1-6	No copay	No copay
Days 21-100	No copay	\$0	No copay	\$75	\$0	\$125 for >d.7	No copay	No copay
Home health care	No copay	\$0	No copay	\$0	\$15	\$0	No copay	\$20
Bone Mass Meas.	No copay	\$0	No copay	\$0	\$0-50	No copay	No copay	No copay

Diabetes Monitoring <sup>2</sup>	No copay	\$0-15	No copay	0-20% copay	0-20% copay	20% copay	\$5	No copay
<u>Prescription Drugs</u>								
<u>Formulary</u>								
30-day supply								
Generic co-pay	\$10	\$10	\$10	\$12.50	\$15	\$15-30	\$2	\$10
Brand co-pay	\$30	\$30					\$5	\$30
90-day Mail order								
Generic co-pay	\$25	\$25	\$30	\$31.50	\$45	\$90		
Brand co-pay	\$84	\$85						
Cap								
Generic	None	None	None	None	None	None	None	\$100/mth
Brand	\$800/year	\$500/year					\$200 monthly	combined
<b>Non-formulary</b>	Medically necessary	Medically necessary	Not covered	Not covered			\$10 - generic \$15 - brand	

<sup>2</sup> Glucose monitors, test strips, lancets, and self-management training.

<b>TABLE 2</b>									
<b>2001-2002 Premium and Selected Benefit Co-Pays: Maricopa County Medicare+Choice Plans</b>									
	<b>Secure Horizons Classic Plan</b>		<b>Sterling Option I</b>		<b>SunHealth MedisunOne Plus</b>		<b>SunHealth MedisunOne</b>		
<b>Year</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>	
Enrollment Limit	No	No	No	No	No	Plan Discontinued	No	\$29.50	
Premium	\$0	\$20	\$78	\$88	\$45		\$0		
Doctor visits									
Primary Care	\$10	\$10	\$20	\$15	\$10		\$10		\$5-\$10
Specialist	\$30	\$30	\$20	\$30	\$10		\$10		\$20-\$30
<b>Outpatient visits</b>									
Ambulatory surgery	\$150	\$150	No copay	15% copay	\$25		\$25		\$75 or 20%
Hospital visit	\$150	\$150	No copay	15% copay	\$25		\$25		\$150
Durable medical equipment	\$0-\$150	20% copay	50% copay with notice	40% copay with notice	0-10% copay		0-10%		0-10%
<b>Diagnostic Tests</b>									
Clinical lab	\$0	\$15	No copay	No copay	No copay		\$0		\$0-\$75
X-rays/ Diagnostic lab	\$10-150	\$15 (20%)	No copay	No copay	\$0-25		\$0-25		\$0-\$75
Radiation Therapy	\$10-150	20%	No copay	15%	\$10		\$10		\$10
Outpatient rehabilitation services	\$10	\$10	\$20	15% copay	\$10		\$10		\$10
Inpatient hospital care	\$300/stay	\$300/stay	\$350/stay	\$100/day for days 1-5	\$100/stay	\$150/stay	\$150/stay		
<b>Skilled nursing facility</b>									
Days 1-20	\$0	\$0	\$25	\$0 d.1-10	\$0	\$0	\$0		
Days 21-100	\$99	\$101.50	\$25	\$25 >d.11	\$0	\$0	\$50		
Home health care	No copay	\$0	35% copay	25% copay	No copay	No copay	no copay		
Bone Mass Meas.	No copay	\$0	No copay	No copay	\$10	\$10	\$25		

Diabetes Monitoring <sup>3</sup>	\$10-\$15	\$15 (20%)	No copay	0-40%	No copay		No copay	No copay for training, \$0-\$12 for supplies
<u>Prescription Drugs Formulary</u>								
deductible								\$250
30-day supply	\$15	\$15	No Rx coverage	No Rx benefits	\$10		\$10	\$12
Generic co-pay					\$20/\$30		\$20/\$30	\$20
Brand co-pay								
90-day Mail order	\$30	\$30			\$25		\$25	\$30
Generic co-pay					\$50/\$75		\$50/\$75	\$50 preferred brand, \$75 brand
Brand co-pay								brand
Cap	None	None			None		None	none
Generic					\$3250/yr		\$1500/yr	\$2000/yr
Brand								
<b>Non-formulary</b>	Not covered	Not covered			Not covered.		Not covered	not covered

<sup>3</sup> Glucose monitors, test strips, lancets, and self-management training.



<b>TABLE 2</b>				
<b>2001-2002 Premium and Selected Benefit Co-Pays: Maricopa County Medicare+Choice Plans</b>				
	<b>Secure Horizons</b>		<b>Health Net Options Plus</b>	
<b>Year</b>	<b>2002</b>	<b>2003</b>	<b>2002</b>	<b>2003</b>
Enrollment Limit	New Plan	No	New Plan	No
Premium		\$75		\$144
Doctor visits Primary Care		\$10		\$10
Specialist		\$10		\$20
<b>Outpatient visits</b>				
Ambulatory surgery		10%		10% copay
Hospital visit		10%		10% copay
Durable medical equipment		10% copay		\$0
<b>Diagnostic Tests</b>				
Clinical lab		No copay		\$0
X-rays/ Diagnostic lab		\$10 (10%)		\$10-100
Radiation Therapy		10%		\$350
Outpatient rehabilitation services		10% copay		\$20
Inpatient hospital care		No copay		\$50/stay, \$50/day for days 1-5
<b>Skilled nursing facility</b>				
Days 1-20	\$0	\$0		
Days 21-100	\$101.50	\$25		
Home health care	\$0	\$0		
Bone Mass Meas.	10% copay	\$0		

Diabetes Monitoring <sup>4</sup>		10% copay		\$0-10
<u>Prescription Drugs</u>				
<u>Formulary</u>				
30-day supply				
Generic co-pay		\$10		\$10
Brand co-pay				
90-day Mail order				
Generic co-pay		\$20		\$24
Brand co-pay				
Cap				
Generic		None		None
Brand				
<b>Non-formulary</b>		Not covered		Not covered

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<sup>4</sup> Glucose monitors, test strips, lancets, and self-management training.

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