

Medicare Advantage: Déjà Vu All Over Again?

Experiences with Medicare+Choice suggest major challenges that will affect both beneficiaries and the Medicare program.

by **Brian Biles, Geraldine Dallek, and Lauren Hersch Nicholas**

ABSTRACT: The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 expands the role of private health plans in Medicare through prescription drug plans and a revised Medicare+Choice (M+C), renamed Medicare Advantage, program. This paper discusses the factors responsible for the failure of M+C to develop as intended in 1997 and analyzes the challenges for MMA implementation in light of these factors. They include making a complex program understandable to beneficiaries; addressing plans' efforts to avoid enrolling high-cost beneficiaries; ensuring stability of benefits, providers, and plans; dealing with beneficiaries enrolled in unsuitable plans; providing equity of health benefits throughout the country; and controlling overall Medicare costs.

IN NOVEMBER 2003 CONGRESS ADOPTED the most far-reaching changes in the Medicare program since its enactment in 1965. This legislation—the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003—establishes a new Medicare Part D prescription drug benefit for the elderly and disabled, which will provide much help to millions of beneficiaries, especially those with low incomes and high drug costs. The legislation also greatly expands the role of private health plans in Medicare.

MMA is designed so that all forty-two million Medicare beneficiaries will receive drug coverage through private plans—Prescription Drug Plans (PDPs) or Medicare Advantage (MA), the new name for Medicare+Choice (M+C). The legislation also provides new incentives, including sizable payment increases, to expand the role of private MA plans in covering acute care services.

This paper discusses the factors responsible for the failure of M+C to grow as intended in 1997 and analyzes the challenges posed by the new legislation for beneficiaries and the Medicare program in light of these factors. MMA's emphasis on private plans is in many ways similar to, and builds upon, policies of the Balanced Budget Act (BBA) of 1997, which established M+C. MMA's goals are similar to those for M+C: to increase the number of beneficiaries enrolled in private plans; to

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expand the types of plans available to beneficiaries; and to foster competition among private plans.

The MMA legislation envisions that beginning in January 2006, all beneficiaries must enroll in a private plan to receive drug benefits. Drug coverage will be provided by stand-alone PDPs or by MA-prescription drug (MA-PD) plans. The legislation provides that beneficiaries should have a choice of at least two plans, at least one of which must be a stand-alone PDP.¹ It also authorizes new regional preferred provider organizations (PPOs). These plans contract with providers, but enrollees can obtain care outside the provider network, generally for higher out-of-pocket costs. The Centers for Medicare and Medicaid Services (CMS) will designate ten to fifty PDP and PPO regions, and all PDPs and PPOs must serve at least one full region. The new legislation also seeks to promote the provision of traditional Medicare benefits through private health plans by greatly increasing Medicare payments to MA private plans.

Challenges For Medicare Advantage

The history of M+C indicates that it has not been able to meet the expectations that many held for it in 1997. Plans' inability to control payments to providers coupled with modest increases in Medicare plan payments led many plans to leave the program and the remaining plans to increase premiums and reduce benefits.

The six-year experience with the M+C program suggests six major challenges for the new legislation affecting both beneficiaries and the Medicare program. If these challenges are not successfully addressed, the future judgment may well be Yogi Berra's oft-cited observation: "It's déjà vu all over again."²

■ **Challenge 1: health plan choices are complicated.** Support for expanded use of private plans is often premised on the goal of increasing choice for Medicare beneficiaries. The first lesson from the M+C program is that private plans offer subtle and multiple variations in benefits and cost sharing, which makes it difficult for anyone, particularly the elderly, to make a prudent plan choice following an evaluation of the value of individual plan benefits.³ The new prescription drug benefit adds to the complexity of the Medicare program in four ways.

First, the MMA standard prescription drug benefit package is complex. The standard drug benefit in 2006 will entail a monthly premium of \$35, which may vary among plans, and a \$250 deductible. Beneficiaries will then pay 25 percent of the cost of drugs until they reach an "initial coverage limit" of \$2,250. After this point comes the now-famous "doughnut hole," where drug coverage stops after outlays of \$2,250 and does not begin again until outlays of \$5,100 (the "stop-loss threshold"), after a beneficiary has exceeded \$3,600 in out-of-pocket costs. Above this stop-loss threshold is a copayment of 5 percent of costs or two dollars per generic and five dollars per brand-name prescription, whichever is greater.⁴

Second, by providing drug coverage only through private plans, MMA ensures that beneficiaries will inevitably see variations in drugs that are covered, out-of-

pocket costs of covered drugs, and pharmacies included in networks.

Third, MMA's "actuarially equivalent" policy allows plans to offer a seemingly limitless number of benefit packages. Unlike Medicare supplemental (Medigap) coverage, with ten standardized benefit packages, PDPs and MA-PDs can offer beneficiaries variations of the MMA prescription drug benefit if they are "actuarially equivalent." The MMA standard drug benefit is only illustrative. Plans can offer one or more benefit packages with different deductibles of \$250 or less and varying copayments in lieu of the 25 percent coinsurance. The lack of standardized benefit packages will make it very difficult for beneficiaries to compare the value of the benefits offered by different plans.

Fourth, individual MA-PD plan sponsors may offer up to four different prescription drug benefit packages: (1) a standard drug benefit package; (2) an "actuarially equivalent" benefit package; (3) a "supplemental" benefit package if no additional premiums are required; and if one of these three packages is offered, (4) an "enhanced" benefit package for an additional premium.

The number of plan and benefit package options will likely be very confusing for elderly and disabled beneficiaries, especially in urban areas with multiple plan options available.⁵ Research finds that half of the Medicare population does not have the consumer skills to compare basic information on health plans.⁶ Studies also indicate that the elderly are vulnerable to making poor purchasing decisions when insurance options are confusing and are reluctant to change insurers, even when it is in their economic self-interest to do so.⁷ Having too many choices can be immobilizing and result in consumer dissatisfaction.⁸ The decision-making process will be especially difficult for older beneficiaries, those with low educational levels, or those with poor English skills. One-third of Medicare beneficiaries have serious cognitive or physical impairments.⁹

The CMS will establish a drug price comparison database to help beneficiaries compare drug packages offered by plans, including drug prices, cost sharing, and network pharmacies. The initial database prepared for the drug discount card program at www.medicare.gov is a positive first step in educating beneficiaries. However, only 19 percent of seniors have access to the Internet.¹⁰ Given the complexity of plan comparisons, many will need individual assistance to make an informed decision.

MMA specifically requires the CMS to educate "disadvantaged and hard-to-reach" populations and to coordinate its education campaigns with those of state and local organizations, including the state Health Insurance Counseling and Assistance Programs (HICAPs). However, the funding for these community-based organizations is clearly inadequate to provide needed information to forty-two million beneficiaries.¹¹ Given the number of plans with multiple and complex benefit packages, the challenge of a plan-based program will be to provide easy-to-understand information and education so that all elderly and disabled beneficiaries can choose a plan that meets their individual needs.

■ Challenge 2: plan efforts to avoid enrollment of high-cost beneficiaries.

Historically, Medicare private plans have enrolled healthier, lower-cost beneficiaries than traditional fee-for-service (FFS) Medicare has done. The enrollment of healthier people is financially attractive to Medicare health plans, since the most costly 5 percent of beneficiaries incur 47 percent of the costs.¹² Similarly, in prescription drug benefits, 11 percent of Medicare beneficiaries account for 42 percent of total drug spending, while 41 percent account for only 18 percent of drug spending.¹³

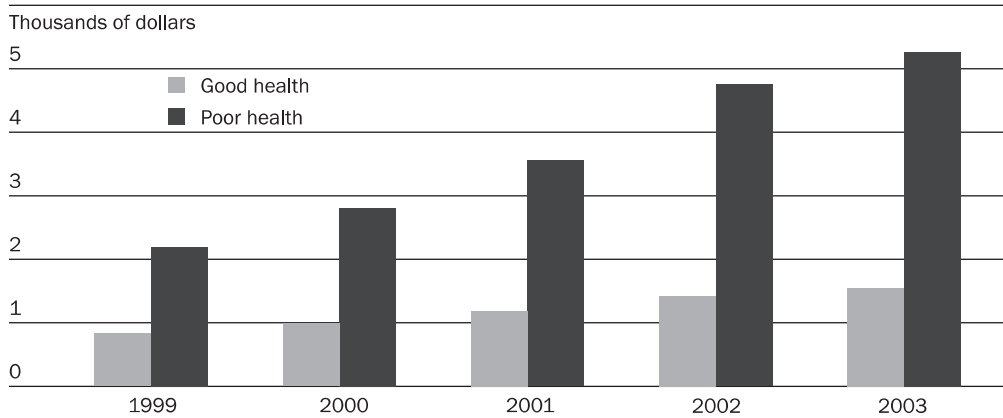
The initial attempt to adjust payments to M+C plans for enrollees' health status was rudimentary. Because of the failure to fully adjust for health status, the CMS estimates that Medicare spent approximately 8 percent more in 2003 for M+C plan enrollees than if those enrollees had remained in FFS Medicare.¹⁴ During the past decade Medicare has developed an improved risk-adjustment system that is now being phased in through 2007, but even this improved system will account for only half of the difference of the costs of plan enrollees in 2005.¹⁵

In recent years, M+C private plans have increasingly designed benefit packages to attract fewer high-cost enrollees.¹⁶ Plans around the country have raised the costs of specific services most likely to be used by enrollees with high-cost chronic conditions, such as hospital care, chemotherapy and radiation therapy, oxygen, and dialysis.¹⁷

In 2003, as a result of the design of M+C plan benefits, the average M+C enrollee in good health spent \$1,564 out of pocket on health care, compared with \$5,305 by an enrollee in poor health (Exhibit 1).¹⁸ Differences in out-of-pocket costs for M+C enrollees between those in poor health and good health are even more dramatic in some communities.¹⁹ Between 1999 and 2003, estimated out-of-pocket health care spending on average increased 87 percent for M+C beneficiaries in good health

EXHIBIT 1

Growth In Estimated Average Annual Out-Of-Pocket Spending For Medicare+Choice Enrollees, By Health Status, 1999–2003



SOURCE: M. Gold and L. Achman, "Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase 10 Percent in 2003," Issue Brief (New York: Commonwealth Fund, August 2003).

and 140 percent for those in poor health.²⁰

The new legislation allows PDP and MA-PD plans to control costs by limiting the number of drugs provided in each “therapeutic class” or disease category. Plans also have great latitude in deciding how to structure their formularies and may require higher cost sharing for all covered brand-name drugs that treat specific chronic diseases, even those without a generic equivalent.

MMA permits the secretary of health and human services (HHS) to approve PDPs only if their benefits, including any tiered formulary structure, are “not likely to substantially discourage enrollment” by “certain” beneficiaries.²¹

A major challenge to the new prescription drug program will be to address the risk selection issues similar to those in M+C by ensuring that individual plans do not design drug and other benefits in a way that discourages high-cost, sicker beneficiaries from enrolling. Strong regulatory and administrative oversight will be necessary to prevent plans from using flexibility to avoid high-cost enrollees.

■ **Challenge 3: benefits and provider and plan stability.** For thirty-eight years traditional Medicare has been a remarkably stable insurance program. More than forty-two million elderly and disabled Americans have the security of knowing from year to year the benefits that are covered and the out-of-pocket costs of those benefits. Moreover, because almost all U.S. providers participate in Medicare, beneficiaries know that a hospital or physician will be available to them at home or when they travel. In contrast, there have been considerable changes in M+C. From 1997 to 2003, sharp premium increases and benefit reductions, provider turnover, and plan withdrawals resulted in much program instability.

Premium and benefit instability. During 1997–2003, private M+C plans raised premiums, reduced prescription drug benefits, and increased beneficiary cost sharing, leading to much higher out-of-pocket costs for enrollees.²² Many M+C enrollees who paid little or no premium for benefits that included extensive prescription drug coverage in 1999 were paying high premiums for benefits with limited or no drug coverage by 2003. Cost sharing for hospital care and other benefits also rose, creating a special burden for beneficiaries with chronic illnesses.²³

Changes in benefit and cost-sharing levels may similarly affect the elderly and disabled enrolled in PDPs and MA plans. PDPs and MA-PDs are allowed to raise out-of-pocket charges or drop drugs from their formularies during the year as long as “adequate” notice is provided to beneficiaries, network pharmacies, and physicians through posting on a Web site. PDPs may also increase costs for beneficiaries from one year to the next by changing drugs from one formulary tier to another or by changing the drugs that are included on a formulary.

Sizable increases in out-of-pocket costs for beneficiaries are also built into the program, as MMA ties future benefit levels directly to the rate of increase in overall Medicare costs for prescription drugs. Congressional Budget Office (CBO) and CMS analysts predict an average increase in drug program costs of 10 percent per year from 2006 to 2013.²⁴ If this occurs, premiums and other out-of-pocket costs

will also increase at this rate (Exhibit 2).²⁵

Whatever the exact rate of increase, it is bound to be much higher than the increase in Social Security cash or private pension payments, which will ensure that drug costs will gradually become more difficult for beneficiaries—especially chronically ill beneficiaries—to afford.

Provider instability. A second factor contributing to M+C program instability has been high provider turnover rates in many plans. In 2002, six of thirty-six states that reported data had M+C primary care turnover rates of 20 percent or more.²⁶ M+C primary care provider turnover rates were as high as 43 percent in Illinois. In some individual plans, they have been even higher.²⁷ Contract disputes between plans and hospitals also disrupt care to M+C enrollees.²⁸ MMA increases in payments to MA plans of greater than 10 percent in 2004 should enable these plans to increase provider payment rates and thus reduce the level of dissatisfaction among providers.²⁹ Whether Medicare payment rates will be enough to permit PDPs and MA-PDs to cover costly prescription drugs and pay pharmacies enough to remain in their networks will be evident only in 2007 and subsequent years.

Plan instability. M+C has also been plagued by plan withdrawals. From 1997 to 2003 the number of private M+C plans decreased by more than half, from 346 plans in 1998 to 155 plans in November 2003. Private plan enrollment dropped from 6.2 million beneficiaries in 1998 to 4.6 million in November 2003, a reduction of 26 percent. This market turmoil is not a one-time phenomenon.³⁰

Limited plan participation could also become an aspect of the PDP program. The employer insurance market has no history with risk-based stand-alone prescription drug plans; thus, the degree of stability of PDPs in Medicare cannot be predicted. Whether extra funds and limits on financial risk will be enough to attract and retain PDPs, regional PPOs, and new MA-PD plans in the new program is also uncertain.

Private plans' interest in participating in Medicare may be tempered by the prospect of future efforts to reduce federal deficits, which now exceed \$300 billion a year. The last major effort to reduce the federal deficit, the Balanced Budget

EXHIBIT 2
Projected Increases In Beneficiaries' Annual Prescription Drug Costs, 2006–2013

	2006 (\$)	2013 (\$)	Increase (%)
Premium	35	58	66
Deductible	250	445	78
Initial coverage limit	2,250	4,000	78
Out-of-pocket spending	3,600	6,400	78
Total prescription spending before catastrophic coverage begins	5,100	9,066	78

SOURCE: Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (Washington: CBO, July 2004).

Act (BBA) of 1997, achieved 73 percent of its total savings from reductions in future Medicare costs.³¹ These reductions were a major factor that led to the modest rate of increase in payments to M+C plans in the late 1990s.

■ **Challenge 4: plan lock-in.** The BBA proposed to lock M+C enrollees into their health plan for the calendar year beginning in 2002. M+C instability in benefits, providers, and plans led to legislation that deferred the implementation of the lock-in provision through the enactment of MMA.³² MMA provides for an annual lock-in to private plan enrollment beginning in 2006, with a limited option to change plans once during the first three months of the year for MA enrollees. MA-PD and PDP enrollees can drop their plan enrollment during the year but will have to pay a penalty for the months in which they had no equivalent drug coverage.³³

The challenges posed by lock-in focuses on specific groups of enrollees who may be harmed by their inability to leave an MA-PD or PDP plan during the year. These include enrollees whose physician or hospital leaves an MA-PD plan during the year; whose plan drops a key prescription drug from its formulary; who were misinformed or confused about their choices—especially the cognitively impaired; and who find themselves enrolled in a plan that does not suit their needs.

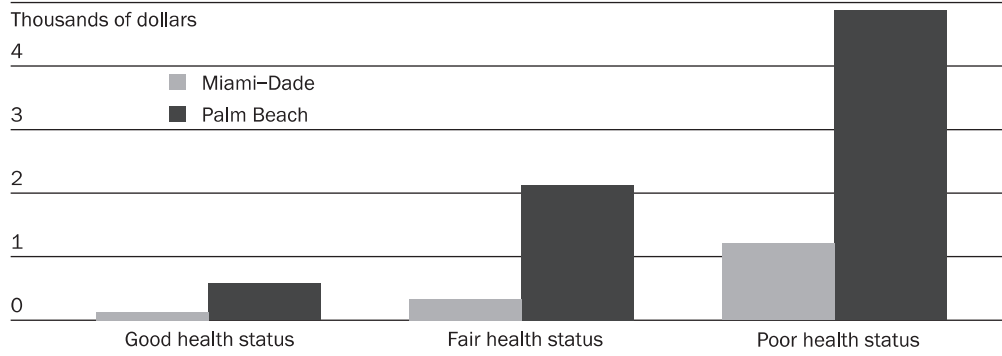
Medicare cannot protect everyone from poor judgment. However, given the vulnerability of many Medicare beneficiaries, a policy to allow beneficiaries to change plans for good cause during a year would reduce concerns about plan lock-in. Provision could be made for coordination of benefits between plans regarding out-of-pocket spending during portions of the year.

■ **Challenge 5: geographic inequity in plan choice and benefits.** As a national program, Medicare provides all beneficiaries with identical premiums and health care benefits no matter where they live. In contrast, M+C plans provided different premiums and benefits to beneficiaries in different areas. Large portions of the country, including the vast majority of rural areas, have never attracted Medicare health maintenance organizations (HMOs) and other managed care plans. Even though MA plan payment rates in rural counties average 16.4 percent more than average FFS costs in the same counties, many rural areas have no M+C plans. In 2003 nineteen states had less than 1 percent of Medicare beneficiaries enrolled in M+C private plans.³⁴ Even in areas served by private M+C plans, premiums, cost sharing, and benefits vary greatly among U.S. cities. These differences have resulted in wide geographical variations in total out-of-pocket costs for plan enrollees.³⁵

Exhibit 3 illustrates the variation in 2003 plan benefit packages as reflected by out-of-pocket costs in the Palm Beach and Miami-Dade markets in South Florida. Beneficiaries there are served by many of the same private health insurance firms but face different benefit packages.

MMA raised payments to MA plans by an average of 10.6 percent in 2004. These additional funds especially increased payments in counties where plans have been paid less than Medicare FFS costs (Exhibit 4).

MMA's additional funding to MA plans has not eliminated the geographic dif-

EXHIBIT 3**Variation In Average Out-Of-Pocket Health Care Costs Among Medicare+Choice Beneficiaries In Neighboring Florida Counties, 2003**

SOURCE: Authors' computations based on enrollment-weighted average annual out-of-pocket spending using estimates prepared by HealthMetrix, www.hmos4seniors.com.

NOTE: Spending estimates exclude the monthly Part B premiums paid by all beneficiaries.

ferences in plan payments. Medicare payments to MA plans in 2004 varied nationwide, from \$904 per beneficiary per month or \$10,848 per year in Miami, Florida, to \$555 and \$6,665, respectively, in the rural floor counties.³⁶ Similarly, the average extra funding to MA plans above FFS costs in 2004 varied from \$1,257 per MA enrollee per year in counties paid at the rural floor rate to \$189 in the counties paid at 100 percent of FFS.³⁷ MMA's higher payment rates and extra payments greater than FFS costs may encourage new MA plans to participate in Medicare. Additional financial incentives for the establishment of regional PPOs may also increase the number of plans in areas that were not attractive to M+C plans.

The challenges posed by efforts to assure the availability of private plans with broad benefits all across the country may persist, however. The experience with

EXHIBIT 4**Monthly Per Beneficiary Payment Rates To Medicare Advantage Plans In Neighboring Counties, New York And Florida, 2003-2004**

County	Payment rate (\$)		Increase (%)
	2003	2004	
Long Island region			
Nassau, Long Island	667	831	24.5
Suffolk, Long Island	635	755	19.0
Queens, New York City	749	804	7.3
South Florida region			
West Palm Beach	644	804	24.9
Broward	740	850	14.9
Miami-Dade	851	904	6.2

SOURCE: Authors' analysis of data from Centers for Medicare and Medicaid Services (CMS) 2004 Medicare Advantage Ratebook and 2003 Medicare+Choice Ratebook.

“Reliance on private plans can undermine Medicare’s ability to provide the same benefits to all beneficiaries.”

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M+C plans over six years suggests that there may not be local MA plans in many cities and most rural areas. Regionwide PPOs in the Medicare program have not been tried, and Blue Cross plans and large, for-profit insurance companies have undetermined interest in establishing plans to serve the Medicare population regionally.

The establishment of risk-bearing PDPs that join the skills of insurers and pharmacy benefit managers (PBMs) in all U.S. regions is uncertain. The experience from M+C suggests that premiums and cost sharing in private PDPs may well vary, perhaps greatly, by region.

■ **Challenge 6: private plans and savings to Medicare.** MMA provisions raise two concerns about overall Medicare costs. The first relates to increased Medicare spending for MA plans; the second, to lack of limits on prescription drug costs.

Increased Medicare spending. The overall goal of a private plan-based approach to Medicare is to use competition to control the growth in total Medicare costs. The experience from M+C suggests that private plans do not reduce Medicare costs but that, to the contrary, they increase Medicare spending.

In 2003, Medicare paid M+C HMOs an average of 4 percent more than average FFS costs.³⁸ With added payments provided by specific MMA policies, in 2004 Medicare has paid MA plans 8.4 percent more on average than the program would have spent if MA enrollees had remained in FFS Medicare. This averages to \$552 more per MA enrollee. MA plans are now paid more than average FFS costs in every U.S. county.³⁹

Medicare costs for MA plan enrollees were estimated by the CMS in 2004 to cost an additional 8 percent above FFS costs because of risk differences between MA plan enrollees and FFS beneficiaries.⁴⁰ MA plans are expected to continue to receive added amounts in future years because of a CMS decision to phase in the new risk adjustment system for MA payments on a budget-neutral basis.

Lack of limits on drug costs. The second question relates to the total cost of the prescription drug benefit. MMA authorizes PDPs to use techniques used by PBMs in employment-based health insurance to manage drug benefits, such as bargaining with drug companies and passing on drug discounts to enrollees. The record of these techniques in controlling total costs is limited, because the increase in drug costs in employment-based health insurance has exceeded 10 percent for many years. MMA relies on private PDPs to limit cost increases and explicitly prohibits the federal government from negotiating prescription drug prices on behalf of Medicare as it does for the Department of Veterans Affairs (VA) health system.

A major challenge for a private plan-based Medicare drug program is both to restrain the increase in costs for prescription drugs so that the Medicare drug benefit remains affordable and to provide the wide range of drugs needed by

forty-two million beneficiaries. Medicare might also reduce total costs by providing a level playing field for payments for benefits between MA plans and FFS Medicare through payment to MA plans of 100 percent of local FFS per capita costs, adjusted for health status as recommended by the Medicare Payment Advisory Commission (MedPAC).⁴¹

Concluding Comments

MMA establishes a program that relies on private plans to provide prescription drug benefits, by building on the Medicare private plan policies adopted in 1997 for M+C. In 1997 it was predicted that 34 percent of Medicare beneficiaries would be enrolled in an M+C private plans by 2005.⁴² It was also projected that educated beneficiaries would begin to make informed choices based on costs and quality, that M+C plans would expand to all parts of the country, and that competition among plans would reduce overall costs to the Medicare program and to beneficiaries. None of these predicted results has come about. Instead, M+C has experienced broad difficulties with private plans and dissatisfaction by beneficiaries. Only 12 percent of the Medicare population was enrolled in M+C plans in 2003.⁴³

The lessons from the M+C program suggest that MMA may face major challenges reaching its goal of making needed prescription drugs affordable and available to all Medicare beneficiaries. First, the exclusive dependence on private plans to provide drug benefits could lead to many of the same problems that have plagued the M+C program. Program instability is a possible feature of any program based on voluntary participation by private plans. Reliance on private plans can undermine Medicare's ability to provide the same benefits to all beneficiaries, no matter where they live. Private plans may design benefits and other plan features to avoid enrolling high-cost beneficiaries. Beneficiaries may be locked into plans that fail to provide promised benefits.

Second, the legislation establishes a program that is extremely complex and may be too intricate for many beneficiaries to understand. The standard benefit with a deductible followed by coverage followed by a doughnut hole with true out-of-pocket costs followed by catastrophic coverage is complicated. The lack of Medigap-type standardized benefits increases the complexity of these choices, and the explicit allowance of "actuarially equivalent" benefit packages by plans further adds to the difficulty of understanding benefits. MMA requires all of its forty-two million elderly and disabled beneficiaries to choose a private plan from completing choices; in comparison, only five million beneficiaries now choose MA plans. Competition cannot work if people are unable to understand their choices.

Third, private plans do not have a history of reducing overall Medicare costs. Private M+C plans have not been able to limit payments to hospitals and physicians. Private M+C plans have not reduced total Medicare costs. MMA now explicitly provides extra payments to MA plans that exceed average Medicare FFS costs by more than \$2.5 billion a year.

THE DESIGN OF A NEW MEDICARE prescription drug program offered a chance to draw on six years' experience with M+C. If MMA policies lead to experiences with private plans that are similar to what M+C experienced, observers six years from now may conclude that the problems facing MMA's prescription drug and MA programs are a classic case of "déjà vu all over again."

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This work was supported by a grant from the Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the Commonwealth Fund or its directors, officers, or staff.

NOTES

1. If two full-risk plans are not available in a region, the HHS secretary may contract with a "limited risk plan" or, if none is available, a "fallback" plan to manage the prescription drug benefit.
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