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Policy Brief

Lessons from Medicare+Choice for Medicare Reform

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Current discussions of the future of Medicare include proposals to increase the enrollment of beneficiaries in private health insurance plans.[1] These proposals would provide incentives for beneficiaries to join private plans, rely on more loosely structured health plans such as preferred provider organizations (PPOs), change the way health plans are paid, and in some cases create competition between private plans and traditional fee-for-service Medicare.

Today's proposals follow upon Medicare's long history with private health plans. The most significant effort to expand the enrollment in private plans occurred with the passage of the Balanced Budget Act of 1997 (BBA), which created the Medicare+Choice (M+C) program. The objectives of M+C included expanding the types of plans available to Medicare beneficiaries, increasing payments to plans in low-cost areas, and fostering competition among private plans.[2]

M+C has not met proponents' expectations. Tied to the low increases in Medicare's fee-for-service program and buffeted by provider pushback and an inability to control costs of care, HMOs have left the M+C program in large numbers. Although many private M+C plans perform well compared with fee-for-service (FFS) Medicare on selected preventive health measures, on other measures—including access to care, stability of providers, simplicity of benefit structure, and costs to the Medicare program—the history of M+C is less positive.[3,4] Turbulence in the program and beneficiary dissatisfaction have contributed to a decline in M+C enrollment, from 16 percent in 1998 to 11 percent in 2003 (Figure 1).[5] It had originally been projected that enrollment would reach 34 percent by 2005.

The six-year history of M+C provides seven lessons to help inform the policy debate on Medicare reform proposals.

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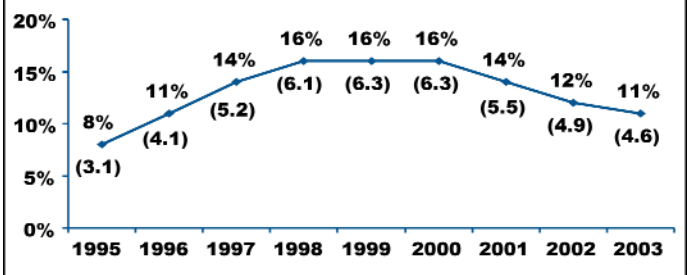
Figure 1
Enrollment in Medicare Managed Care/ Medicare+Choice Plans by Beneficiaries, 1995–2003

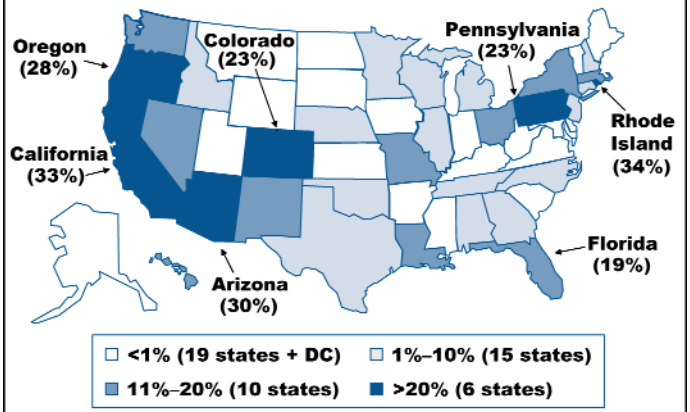


Sources: Gold and Achman, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums,* The Commonwealth Fund, February 2002; Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Contract Report; CMS 2002 Data Compendium, 2003; and CMS Medicare Enrollment: National Trends, 1966–2001, 2002. 2003 data are for May.

Lesson 1. Private Plans Do Not Participate in Many States and Geographic Areas

Large portions of the nation, including the vast majority of rural areas, have never been attractive to Medicare HMOs and other managed care plans. Even with payment rates in rural areas that are higher than fee-for-service costs in the same areas, rural areas have not attracted M+C plans. Nineteen states and the District of Columbia have less than 1 percent of Medicare beneficiaries enrolled in M+C private plans. These include rural states such as Iowa, Maine, Mississippi, Montana, North Dakota, South Dakota, Vermont, West Virginia, and Wyoming. An additional 15 states have from 1 to 10 percent in M+C plans (Figure 2).

Figure 2
Medicare+Choice Enrollees as a Percent of Medicare Beneficiaries, by State, 2003



Source: Henry J. Kaiser Family Foundation, *Medicare+Choice Fact Sheet,* April 2003. Data from Centers for Medicare and Medicaid Services, Medicare Managed Care Contract Plans Monthly Summary Report, March 2003.

Only 13 percent of rural beneficiaries even have the option of joining a M+C managed care plan today.[6]

Nor have other, more loosely organized private plans made significant inroads into rural America.

- Two private fee-for-service (PFFS) plans participate in M+C. PFFS plans must pay contracting providers on a fee-for-service basis and may not require beneficiaries to use network providers. The first PFFS plan, Sterling, began operations in 2000 and is available in 19 complete states and parts of six others. Humana began operations in six states in January 2003.[7] Despite the plans' geographic breadth, to date only 22,285 Medicare beneficiaries have enrolled in a PFFS.[8]

- Thirty-one PPOs operated by 17 insurers in 23 states have been established under a demonstration initiated by the Centers for Medicare and Medicaid Services (CMS). All but one of these insurers also has a M+C contract.[9] The PPO demonstration, which began in January 2003, has not expanded choice to areas where there are no M+C plans. Of 10.7 million beneficiaries who can enroll in a PPO demonstration, only 3 percent do not currently have the option of joining an M+C managed care plan.[10] Enrollment in PPOs has been limited; only 63,040 beneficiaries have enrolled in one of the new plans during the first five months of the demonstration.[11]

The lesson from M+C is that any new effort by Medicare to rely on private plans to serve the elderly and disabled in rural parts of the country will face major difficulties. The same barriers that have led to the absence of M+C plans in many rural states—a small number of hospitals and physicians combined with the reluctance of these providers to contract with managed care plans—will confront new efforts to attract private plans to rural areas. Rural America has demonstrated that it is not fertile ground for private Medicare plans.

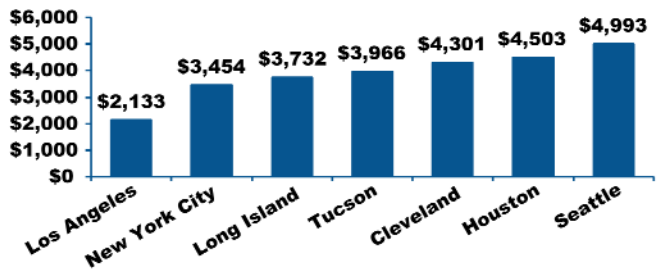
Lesson 2. Premiums and Benefits Vary Greatly by Geographic Area

As a national program, Medicare is built on the premise that all beneficiaries receive the same health care benefits no matter where they live. The M+C program undermines that promise. Premiums and benefits vary substantially among M+C private plans in cities and communities across the nation.

For example, the 2002 enrollment-weighted average monthly premiums ranged from $3 in the five boroughs of New York City to $87 in neighboring Long Island. In 2002, 92 percent of M+C enrollees in Los Angeles and New York City were in plans that provided some brand name prescription drug coverage, while no M+C enrollees in Seattle, Houston, and Tucson had such coverage. Cost-sharing for hospital and physician services also varies by community by hundreds of dollars a year.

Taken together, the differences in premiums, benefits, and cost-sharing result in wide geographical variation in total out-of-pocket costs. For example, Seattle M+C enrollees in good health would expect to pay 2.7 times as much in out-of-pocket costs as do enrollees in Los Angeles. Seattle M+C enrollees in poor health spend more than 2.3 times as much in out-of-pocket costs as do Los Angeles enrollees in poor health (Figure 3).[12]

Figure 3
Average Estimated Out-of-Pocket Spending for Medicare+Choice Beneficiaries in Poor Health Varies Considerably, 2002: Seven Sites



Note: Out-of-pocket expenses include M+C plan premiums, copayments, and deductibles for Medicare-covered services and prescription drugs; they do not include Medicare Part B premiums. Figures computed using "basic plans."
Source: George Washington University analysis of HealthMetrix Medicare HMO CostShare Reports, available at http://www.hmos4seniors.com. Weighted averages computed using March 2002 enrollment figures.

The lesson from M+C is that the causes of benefit inequality—differences in Medicare payment rates to HMOs that reflect local medical practice patterns, the inability of private plans to control costs and utilization, and plans' fear of adverse risk selection (see Lesson 6 below)—will confront any new Medicare program that depends on private plans.[13]

Lesson 3. Participation by Private Plans in M+C Has Been Unstable

For 38 years, traditional Medicare has been a remarkably stable insurance program. Over 40 million elderly and disabled Americans have the security of knowing from year to year the benefits covered and the out-of-pocket costs of those benefits.

Over the past six years, private plan withdrawals and sharp premium increases and benefit reductions have resulted in significant M+C program instability. Between 1999 and 2003, more than 2.4 million beneficiaries were affected by plan withdrawals or service area reductions and overall enrollment in M+C managed care plans dropped by 1.4 million beneficiaries (Table 1).[14] In addition to withdrawals, plans increasingly capped or froze enrollment in M+C, thus further limiting choice.[15] This market turmoil is not a one-time phenomenon. Between 1985 and 1991, 68 private plans withdrew from Medicare, a 42 percent decline in plan participation.[16]

Private plans withdrew from Medicare for specific reasons: hospital and physician pushback, including resistance to utilization review; demand for higher payments and refusal to accept risk contracts; increasing costs of prescription drugs; fear of adverse risk selection; low market share; and plan characteristics, including their national and for-profit status.[17]

Private plans have found it difficult to operate in an era in which overall costs in traditional Medicare have slowed. Medicare HMO payment rate increases during the late 1990s have been limited, generally to 2 percent a year.[18] This is signifi-

cantly lower than rate increases in employer health insurance, making continued participation in M+C less attractive to plans than expanded enrollment in the commercial market.[19]

Even when private plans have remained in M+C, they have raised premiums, reduced prescription drug benefits, and increased beneficiary cost-sharing in each of the past four years, leading to financial difficulties for plan enrollees.[20]

Many beneficiaries who paid low or no premiums for extensive prescription drug coverage in 1999 were paying high premiums for limited or no drug coverage by 2003 (Table 2). Cost-sharing for hospital care and other benefits has been increased, creating a special burden for beneficiaries with chronic and life-threatening illnesses.[21]

The lesson from M+C is that a Medicare program based on private plans is highly dependent on annual judgments by plans on the financial profitability of participating in Medicare. These decisions are made metro area by metro area. In many cases these decisions reflect judgments by national for-profit plans. A recent study found that 42 percent of M+C beneficiaries are enrolled in plans managed by one of six national for-profit health insurers.[22]

Instability is likely to be a feature of any Medicare program that relies upon private plans and a competitive marketplace to limit the increase in health care costs.[23] The same factors that have led M+C private plans to withdraw from Medicare over the past six years will confront any new Medicare program that depends on private plans.[24]

Lesson 4. Physician and Hospital Participation in M+C Private Plans Has Been Unstable

Because nearly every hospital and physician in the country participates in traditional Medicare, beneficiaries have the security of knowing that their medical providers will continue to serve them from year to year. M+C enrollees do not have that same measure of security.

Statewide M+C primary care provider turnover rates ran as high as 33 percent in New Mexico in 2001. Nine of 36 states with reported data had M+C primary care turnover rates of 20 percent or more.[25] These included plans in large states such as Illinois, Texas, and Florida (Table 3).

A review of M+C plan provider directories in selected cities found that primary care physician turnover rates during the two-year period 1999–2001 ranged from 23 to 61 percent among M+C plans in St. Petersburg, Florida, and from 17 to 25 percent among plans in the Cleveland area. Cardiologist turnover rates in St. Petersburg M+C plans were also high, ranging from 17 to 25 percent in the two-year period.[26]

Contract disputes between plans and hospitals also disrupt care to M+C enrollees. For example, during 2001–2002, M+C enrollees in Cleveland lost access to the Cleveland Clinic; in Tucson, to the city's only teaching hospital; on Long Island, to the largest hospital network; and in New York City, to one of the nation's premier cancer treatment centers.[27]

Elderly and disabled Medicare beneficiaries are more affected by provider turnover than are younger, employer-insured populations. High levels of disability and increasing age tie beneficiaries to their physicians and other health providers, making disruptions in continuity of care more serious.[28]

The lesson from M+C is that instability of physicians and providers is likely to be an issue with any Medicare program that depends on private plans. As the M+C experience demonstrates, the continuing availability of providers depends on the policies of individual plans across a wide range of payment and administrative matters. Once plans are placed between Medicare and providers, there is little that Medicare can do to prevent high provider turnover rates.

Lesson 5. M+C Options Are Too Complicated for Many Beneficiaries to Make an Informed Choice

Support for expanded use of private plans often is premised on the goal of increasing choice for

Medicare beneficiaries. Subtle and multiple variations in benefits and cost-sharing make it difficult for anyone, but especially the elderly and those who are cognitively impaired, to evaluate choices among plans.

Making a choice of M+C plans is very complicated. Because M+C does not require standardized benefit packages (as Medigap plans are required to do), different plans have varying cost-sharing requirements for drugs and other benefits (see Appendix). Drug benefits, for example, can vary by prescription drug limits and the way these limits are calculated (monthly, quarterly, or yearly); whether brand or only generic drugs are covered; copayment levels; whether a formulary is used, and if so, which drugs are on it; whether the plan provides a discount mail-order pharmacy benefit; and how each plan determines drug costs that count toward benefit limits.

Hospital costs can also vary dramatically. The M+C 2003 plan benefits available to Cleveland beneficiaries have hospital costs for a five-day stay of: $0, $250, $375, $750, $875, $1,000, and $1,325.

In Cleveland (and elsewhere), differences among M+C plans in the out-of-pocket costs for radiation services are as dramatic, ranging for $0 copayments to $35 to 20 percent of the cost of each visit. For a woman undergoing radiation therapy for breast cancer, which can require as many as 35 radiation therapy visits, out-of-pocket costs would be more than $1,000.

With additional cost-sharing on a myriad of other benefits, beneficiaries must now make complicated calculations based on premiums, drug benefits, and cost-sharing to assess which plan might make the most economic sense.[29]

Studies suggest that the elderly are vulnerable to making poor purchasing decisions when insurance options are too confusing and are reluctant to change insurer, even when in their economic self-interest.[30] Choosing an appropriate health plan is especially critical for beneficiaries in poor health, and 82 percent of the Medicare elderly population have one or more chronic conditions.[31]

The lesson from M+C is that—in the absence of a standardized benefit package—multiple private plans in a market area will offer very different and complex packages of benefits, cost-sharing, and premiums. These packages are confusing to elderly and disabled Medicare beneficiaries attempting to choose a personal health plan.[32] Until Medicare establishes standardized benefit packages limited to specific options, as is the case for Medigap policies, variations in benefits are likely to proliferate, making informed choice all the more difficult.

Lesson 6. M+C Plan Design Can Discourage Enrollment by High-Risk Beneficiaries

Historically, Medicare private plans have enrolled healthier, lower-cost individuals than has traditional Medicare. A General Accounting Office study found that, because of the failure to fully adjust for health status, in 1998 Medicare spent $3.2 billion, or 13.2 percent more, on health plan enrollees than they would have spent if those enrollees had received services in FFS Medicare.[33] These differences may be reduced as CMS increases use of risk adjustment.

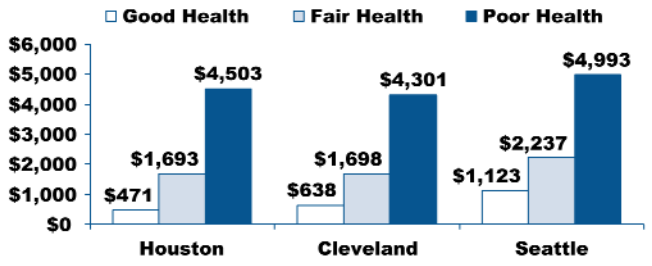
Private insurers remaining in the M+C market increasingly show an interest in risk selection. In particular, increases in cost-sharing for some services by some plans seem to be directly related to the fear of enrolling high-cost beneficiaries.[34] Across the nation, plans have increased costs on specific services most likely to be used by enrollees with high-cost chronic conditions, such as hospital care, oxygen, dialysis, chemotherapy, and radiation therapy.[35]

In 2002, the design of M+C plan benefits resulted in the average M+C enrollee in good health spending $1,429 out-of-pocket on health care, compared with $4,783 spent by an enrollee in poor health. Since 1999, plans' benefit changes have focused on increasing out-of-pocket costs

for those in poor health: costs for those in poor health have increased by 116 percent, compared with 71 percent for those in good health.[36]

Differences between out-of-pocket costs paid by M+C enrollees in poor health and those paid by enrollees in good health are even more dramatic in some communities. In Houston in 2002, M+C enrollees in poor health spent $4,503, while those in good health spent $471—nearly a tenfold difference. In Cleveland and Seattle, M+C enrollees in poor health spent over 6.7 and 4.4 times more out-of-pocket, respectively, than enrollees in good health (Figure 4).[37]

Figure 4
Medicare+Choice Beneficiaries Face Significant Variation in Out-of-Pocket Health Care Expenses by Health Status



Note: Out-of-pocket expenses include M+C plan premiums, copayments, and deductibles for Medicare-covered services and prescription drugs; they do not include Medicare Part B premiums. Figures computed using "basic plans."
Source: George Washington University analysis of HealthMetrix Medicare HMO CostShare Reports, available at http://www.hmos4seniors.com. Weighted averages computed using March 2002 enrollment figures.

The lesson from M+C suggests that private plans design their benefit packages to avoid attracting higher-cost enrollees. Beneficiaries most in need of care who enroll in a private plan may pay higher out-of-pocket costs than they would in fee-for-service Medicare. To the extent that private plans discourage beneficiaries in poor health from enrolling, and without an adequate risk adjustment methodology, the Medicare program will also face higher costs for beneficiaries who remain in traditional fee-for-service Medicare.

Lesson 7. Private Plans Are Not Less Costly Than Traditional Medicare

The major goal of Medicare reform based on private plans is to use competition to control the growth in overall Medicare costs. The experience from M+C suggests that private plans do not save Medicare money and that, to the contrary, they can increase program costs (Table 4).[38]

The reasons why M+C private plans have not succeeded in reducing total Medicare costs include:

- Enrollees in M+C managed care plans have historically been healthier than those who remain in fee-for-service Medicare, and risk-adjusted Medicare payment does not fully compensate for this pattern.[40]
- To attract M+C plans in more rural and non-metropolitan areas, Medicare has increased payments for M+C plans above the level it pays in these areas for traditional Medicare. While this has not led to increased participation by Medicare HMOs, increased rural payments translate into higher Medicare costs for PFFS plan contracts.
- The newer private plans—PFFS plans and demonstration PPOs—contract in areas where M+C payment rates are higher than traditional Medicare rates.[41]
- Medicare administrative costs average approximately 2 percent, while administrative costs in private plans in employer groups generally exceed 10 percent. In particular, private plans have costs associated with marketing and, in the case of for-profit plans, a return for investors.[42]

New, less-structured PFFS and PPO plans, with broader provider networks and fewer cost containment features, may be even less able than are current M+C HMO plans to limit total costs through reductions in price, rates of hospitalization, and use of specialized services.[43]

The lesson from M+C suggests that it is difficult for private plans to reduce total costs of care from the level of the traditional Medicare program.[44] It is even more difficult for private plans to offer additional benefits, cover marketing and

administrative costs, and make a profit while pricing their products below the costs of the Medicare fee-for-service program.

Conclusion

In 1997, it was predicted that 34 percent of Medicare beneficiaries would be enrolled in M+C private plans by 2005.[45] Instead, 11 percent of the Medicare population is enrolled in M+C plans in 2003, down from 16 percent in 1998.[46] Policy experts also projected that M+C plans would expand to all parts of the country, educated beneficiaries would begin to make informed choices based on costs and quality, and competition among plans would reduce overall costs to the Medicare program and to beneficiaries alike.

None of these predictions has occurred. Instead, the M+C program has fostered broad dissatisfaction by private plans, providers, and elderly and disabled beneficiaries. Rather than steady growth, the program has undergone a period of persistent instability and a decline in enrollment.

The history of M+C is a cautionary tale. It offers important lessons for consideration in any new program to expand the use of private plans in Medicare.

Notes

[1] See "The Bush 'Triple Option' Medicare Plan," *Washington Healthbeat,* March 4, 2003; The Bush White House, *21st Century Medicare: More Choices—Better Benefits: A Framework to Modernize and Improve Medicare;* "Baucus-Grassley Plan May Be Breakthrough," *Washington Healthbeat,* June 5, 2003.

[2] In addition to Medicare HMOs, the legislation authorized other types of private plans—Preferred Provider Organizations, Provider Sponsored Organizations, Private Fee-For-Service Plans, and Medical Savings Account Plans—to enroll Medicare beneficiaries.

[3] Medicare Health Plan Compare at http://www.Medicare.gov. Studies have found that HMO members tend to be more satisfied with the cost of care than are FFS patients. Overall plan satisfaction ratings have been shown to be related to beneficiary age. See D. Cox, B. Lanyi, and A. Strabic, "Medicare Health Maintenance Organization Benefits Packages and Plan Performance Measures," *Health Care Financing Review* 24 (Fall 2002): 133–44.

[4] Studies have found that FFS beneficiaries are generally more satisfied with access measures than are those in M+C plans. Areas where M+C beneficiaries tend to be least satisfied include access to care and quality of care. See Cox, Lanyi, and Strabic, 2002.

[5] Henry J. Kaiser Family Foundation, *Medicare+Choice Fact Sheet* (Washington, D.C.: Kaiser Family Foundation, April 2003).

[6] Henry J. Kaiser Family Foundation, *Medicare+Choice Fact Sheet* (Menlo Park, Calif.: Kaiser Family Foundation, February 2003). Fifty-six percent of beneficiaries have the option of enrolling in a PFFS plan and 61 percent have the option of enrolling in any M+C product. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2003): 198.

[7] MedPAC, 2003.

[8] L. Achman and M. Gold, *Medicare+Choice and Medicare Beneficiaries: Monthly Tracking Report for May 2003* (Washington, D.C.: Mathematica Policy Research, Inc., 2003).

[9] M. Gold, L. Achman, and J. Verdier, *The Medicare Preferred Provider Organization Demonstration: Overview of Design, Characteristics, and Outstanding Issues of Interest* (Washington, D.C.: AARP Public Policy Institute, Publication #2003-07, June 2003).

[10] Gold, Achman, and Verdier, 2003.

[11] Achman and Gold, 2003.

[12] G. Dallek, A Dennington, and B Biles, *Geographic Inequity in Medicare+Choice Benefits: Findings from Seven Communities* (New York: The Commonwealth Fund, September 2002).

[13] Ibid.

[14] Gold, Achman, and Verdier, 2003.

[15] B. Biles, G. Dallek, and A. Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future* (New York: The Commonwealth Fund, September 2002): 3.

[16] M. Gluck, *Medicare Chart Book* (Menlo Park, Calif.: Kaiser Family Foundation, Fall 2001): 52, Second ed.

[17] For-profit and national plans and plans with small market share were more likely to quit the M+C market. T. Lake and R. Brown, *Medicare+Choice Withdrawals: Understanding the Key Factors* (Washington, D.C.: Kaiser Family Foundation, June 2002). See also, R. Hurley, J. Grossman, and B. Strunk, "Medicare Contracting Risk/Medicare Risk Contracting: A Life-Cycle View from Twelve Markets," *Health Service Research* 38 (February 2003, Pt. 2): 395–417; Biles, Dallek, and Dennington, 2002; and J. Stuber, G. Dallek, and B. Biles, *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (New York: The Commonwealth Fund, October 2001).

[18] The BBA effectively limited the annual increase in Medicare payments to 2 percent per year in most areas. Congressional efforts to encourage M+C plans to serve areas where no plans were being offered (Balanced Budget Refinement Act of 1999) and stem plan withdrawals and benefit reductions (Benefits Improvement and Protection Act of 2000) through increased funding had little effect on either benefits or plan availability. *General Accounting Office, Medicare+Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001* (Washington, D.C.: GAO, November 2001).

[19] C. Boccuti and M. Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs* (March/April 2003): 230–37.

[20] See generally, Biles, Dallek, and Dennington, 2002; Centers for Medicare and Medicaid Services, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002,* December 2002; L. Achman and M. Gold, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (New York: The Commonwealth Fund, January 2002).

[21] Achman and Gold, 2002.

[22] In 2001, 18 percent of M+C enrollees were in a PacifiCare plan, 7 percent in Humana, 7 percent in United HealthCare, 5 percent in Aetna plans, 4 percent in HealthNet, and 1 percent in CIGNA plans. D. Draper, M. Gold, and J. McCoy, *The Role of National Firms in Medicare+Choice* (Washington, D.C.: Kaiser Family Foundation, 2002).

[23] Researchers who studied M+C in 12 markets over a three-year period concluded that the use of private plans in Medicare involves an "inescapable measure of instability." Hurley, Grossman, and Strunk, 2003: 416; the Medicare Payment Advisory Commission has similarly determined that "instability for Medicare beneficiaries…is part of the reality of competition." MedPAC, 2003: 211.

[24] Ibid.

[25] Health Plan Compare at http://www.medicare.gov.

[26] G. Dallek and A. Dennington, *Physician Withdrawals: A Major Source of Instability in the Medicare+Choice Program* (New York: The Commonwealth Fund, January 2002).

[27] Biles, Dallek, and Dennington, 2002.

[28] T. Buchmueller, "The Health Plan Choices of Retirees Under Managed Competition," *Health Services Research* 35 (December 2000): 949-76; C. Young and J. Mittler, "Medicare+Choice: Views from the Field," *Operational Insights* (Washington, D.C.: Mathematica Policy Research, Inc., March 2002).

[29] See generally, G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, October 2001).

[30] General Accounting Office, *Medigap Insurance: Better Consumer Protection Should Result from 1990 Changes to Baucus Amendment* (Washington, D.C.: GAO/HRD-91-49, March 1991); P. D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* 20 (Spring 1995): 31–48; T. Rice, M. L. Graham, and P. Fox, "The Impact of Policy Standardization on the Medigap Market," *Inquiry* (Summer 1997): 106–16; Buchmueller, 2000.

[31] K. Davis, C. Schoen, M. Doty, and K. Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (October 9, 2002): W3-189–W3-198.

[32] Dallek and Edwards, 2001.

[33] General Accounting Office, *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (GAO/HEHS-00-161, August 2000).

[34] In interviews with private plan executives around the country, a number of plan executives admitted that the purpose of some benefit cuts and increased cost-sharing were to "decrease adverse selection."

[35] Biles, Dallek, and Dennington, 2002; L. Achman and M. Gold, *Medicare+Choice Plans Continue to Shift More Costs to Enrollees* (New York: The Commonwealth Fund, April 2003).

[36] M. Gold and L Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002* (New York: The Commonwealth Fund, November 2002); Achman and Gold, 2003.

[37] Dallek, Dennington, and Biles, 2002.

[38] Estimates of the Medicare costs associated with private plans vary widely. CMS estimates that PPOs will be able to offer all Medicare benefits at 98–99 percent of what the government pays in FFS Medicare, while the Congressional Budget Office estimates that they will cost 10–12 percent more than original Medicare. R. Pear, "Bush Will Accept Identical Benefits on Medicare Drugs," *New York Times,* June 10, 2003, pp. A1, A24.

[39] GAO, 2000.

[40] PPO demonstrations are paid the greater of 99 percent of the Medicare AAPCC payment rate or the current M+C rate. In 82 percent of the counties in which a PPO demonstration is located, the PPO is paid the current M+C rate. Gold, Achman, and Verdier, 2003.

[41] M. Merlis. *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform* (Washington, D.C.: Kaiser Family Foundation, 2003).

[42] The new PPO demonstration could further increase costs to Medicare. In addition to paying more for PPO enrollees than it would if beneficiaries had remained in traditional Medicare, Medicare shares risk with many of the PPO demonstrations. If PPO enrollees are more costly than expected, Medicare will share in those added costs.

[43] MedPAC, 2003: 210.

[44] R. Berenson, "Medicare+Choice: Doubling or Disappearing?" *Health Affairs* Web Exclusive (November 28, 2001): W65-W82.

[45] Henry J. Kaiser Family Foundation, *Medicare+Choice Fact Sheet* (Washington, D.C.: Kaiser Family Foundation, April 2003).

Table 1. Beneficiaries Affected by M+C Withdrawals, 1999–2002

	Jan. 1999	Jan. 2000	Jan. 2001	Jan. 2002	Jan. 2003
M+C plan terminations	45	41	65	22	33
M+C plan service area reductions	54	58	53	36	23
Beneficiaries affected	407,000	327,000	934,000	536,000	217,000
Percentage of M+C enrollees	6.3%	4.7%	13.6%	9.6%	3.9%

* Number of beneficiaries affected is number enrolled in a plan at the due date for plans to announce withdrawal. For example, the 1999 column refers to beneficiaries enrolled as of June 1999 in a plan that withdrew effective January 2000.

Source: CMS Fact Sheet "Protecting Medicare Beneficiaries after Medicare+Choice Organizations Withdraw," September 2002; CMS quarterly state/county market penetration reports, June 1998, June 1999, June 2000, September 2001, June 2002.

Table 2. M+C Plans in Cleveland: Selected Benefits, 1999–2003

	1999	2001	2003
Plans	10	5	5
Plan products	15	7	10[a]
Products with hospital cost-sharing	Not available	3	9
Average cost of 5-day hospital stay for products with cost-sharing	Not available	$558	$717
Range of costs for a 5-day stay	Not available	$0–$875	$0–$1,325
Products with any prescription drug/ any brand coverage	15/15	6/6	6/2[a]
Average monthly premium	$9.50	$24.70	$50.60
Premium range	$0–$38.50	$0–$95	$0–$120
Average monthly premium/ any prescription drug benefit	$9.50	$28.80	$65.70
Premiums range	$0–$38.50	$0–$95	$0–$120
Average monthly premium/ brand+generic ≥ $1,000 or unlimited generic & brand ≥ $500	$13	$41.30	$100
Premium range	$0–$38.50	$0–$95	$80–$120

[a] One plan offers five different products, including a $0 premium product with no prescription drug coverage and two premium products with an optional prescription drug rider, costing an additional $40/month for brand coverage of $500. A second plan offers two products.

Source: CMS, Medicare Health Plan Compare: 1999, 2001, 2003.

Table 3. States with Highest Primary Care Provider Turnover Rates, 2001

New Mexico: 33%	Michigan: 23%
Connecticut: 30%	Oklahoma: 22%
Illinois: 29%	Florida: 21%
Texas: 26%	Missouri: 20%
Arizona: 23%	

Source: Medicare Health Plan Compare at http://www.medicare.gov.

Table 4. 2003 Expected Costs of M+C Plans Compared with Traditional Medicare

M+C Plan	Percent of Average FFS Medicare Payment*
HMOs	104%
PPO Demonstrations	109%
PFFS Plans	102%

* These estimates include the following assumptions: 1) M+C risk adjusters are not improved; 2) enrollment in the PPO demonstrations is proportional to their availability across participating counties; and 3) PFFS enrollees are demographically similar to the average Medicare beneficiary. Average FFS spending includes area-specific adjustment in payment rates.

Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2003): 195–97.

2001 Premium and Selected Benefit Copayments: Tampa Medicare+Choice Plans

		Plan V_1	Plan V_2	Plan W	Plan X_1	Plan X_2	Plan Y	Plan Z_1	Plan Z_2
Enrollment limit		No	No	Yes	No	No	No	No	Yes
Premium		$63	$0	$63	$179	$0	$0	$0	$19
Doctor visits:	Primary care	$10	$15	$10	$10	$10	$15	$10	$5
	Specialist	$5–$200	$15–$400	$25	$15	$15	$20	$15	$10
Outpatient visits:	Ambulatory surgery	$200	$500	$0	$35	$50	$100	$25	$25
	Hospital visit	$200	$500	$50	$35	$50	$50	$25	$25
Durable medical equipment		$0	$0	$0	$0	$0	20%	$0	$0
Diagnostic tests:	Clinical lab	$0	$0	$0	$0	$0	$5	$0	$0
	X-rays/diagnostic lab	$40–$200	$40–$350	$0	$0	$0	$5 X-ray; $50 other radiation services	$0	$0
Radiation therapy		$40/visit	$40/visit	$0	$0	$0	$5–$50	$15/service	$10/service
Outpatient rehabilitation services		$40/visit	$40/visit	$25/visit	$10–$15/visit	$10–$15/visit	$25/visit	$15/visit	$10/visit
Inpatient hospital care		$500 per adm.; $200/day for days 7–30 at network hosp.	$500 per adm.; $200/day for days 7–30 at network hosp.	$150/day	$100/stay	$300/stay	$150/day	$200/stay	$0
Skilled nursing facility:	Days 1–20	$0/day	$0/day	$0	$0	$0	$75	$0	$0
	Days 21–100	$85/day	$90/day	$97	$0		$75	$0	$0
Home health care		$0	$0	$0	$0	$0	$0	$0	$0
Bone mass measurement		$10/physician's office, $40 non-physician clinic	$15/physician's office, $40/non-physician clinic	$0	$0	$0	$0	$0	$0
Prescription drugs		$10	No prescription drug coverage	$5	$5	$10	$8	(31-day)	(31-day)
Formulary drugs		$20 preferred		$20	$15	Not covered	$40	$7	$5
30–31-day supply		$20		$15	$15	$30	$24	$20	$15
Generic copay		$40 preferred		$60	$45	Not covered	$120	Not available	Not available
Brand copay		$150/3 months		Unlimited	Unlimited	Unlimited	$500/year	Unlimited	Unlimited
90-day mail order		generic and preferred		$250/6 month	$50/month	Not covered	Plan has	$125/3 months	$125/3 months
Generic copay		& non-preferred		formulary & non-	formulary & non-	Not covered	no formulary	non-formulary	non-formulary
Brand copay		brand		formulary brand	formulary brand			generic & all	generic & all
Cap		$10		$35	$30			brand drugs	brand drugs
Generic		$40		$35	$30			$30	$30
Brand		$10		$105	$90			$30	$30
Non-formulary		$80		$105	$90			Not available	Not available
30–31-day supply		See above		See above	See above			See above	See above
Generic copay									
Brand copay									
90-day mail order									
Generic copay									
Brand copay									
Cap									

[a] Plan Y has a $3,500 out-of-pocket limit protection for combined inpatient and outpatient services, not including certain office visit copays, prescription drugs, medical supplies, and selected other benefits.

[b] $40 specialist per visit copay, except $10/visit to Allergy physicians, $5/specimen to hospital pathologists, $5/interpretation to hospital radiologists, $50/visit to ER physician, $200 for cataract surgery, $50/each allergy skin testing, and 40% of charges for non-plan second medical opinion.

[c] $50 specialist per visit copay, except $15/visit to Allergy physicians, $15/specimen to all hospital pathologists, $15/interpretation to hospital radiologists, $50/ visit to ER physicians, $400 for cataract surgery, and 50% of charges for non-plan second medical opinion.

[d] $200 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copay for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.

[e] $350 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copayment for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.

[f] $1,000 per admission and $200/day for days 7–30 at non-participating hospitals.

[g] $1,000 per admission and $300/day for days 7–30 at non-participating hospitals.

[h] Glucose monitors, test strips, lancets, and self-management training.

Source: G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, October 2001).

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