MEDICARE+CHOICE IN 2000: WILL ENROLLEES SPEND MORE AND RECEIVE LESS?

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EXECUTIVE SUMMARY

This report provides a detailed look at changes in benefits offered under Medicare+Choice, Medicare's managed care program, during the period 1999–2000. The analysis is drawn from a database we created using publicly available data from Medicare Compare, the Health Care Financing Administration's consumer-oriented summary of information on Medicare+Choice plans, including benefits they offer, beneficiary cost-sharing requirements, and enrollment levels by county.

Our study yielded the following key findings:

- In 2000, fewer managed care organizations (MCOs) are offering a "zero premium" product as their basic Medicare+Choice plan, down a third from 62 percent of basic plans in 1999 to 42 percent in 2000. Copayments for physician and hospital services, meanwhile, are higher.

- Prescription drugs—a major reason Medicare beneficiaries are attracted to MCOs—are still covered in most packages. But there was a small decline in the share of basic contracts covering this benefit (from 73 percent to 68 percent), and evidence exists of either some decline in the generosity of the benefit or an increase in required cost-sharing. When looking at all the benefit packages offered in each year (not just the basic plan), the same downward trend is found with regard to generosity of benefits and growth in cost-sharing.

- Benefit levels vary widely across the country, and substantial disparities between urban and rural areas are evident. This means that access to additional benefits through Medicare+Choice enrollment is not the same in all regions or that these benefits are not equally attractive to beneficiaries across the country.

Medicare+Choice enrollment in 2000 still provides a vehicle for many beneficiaries to obtain broader coverage at low cost. In many areas of the country, however, beneficiaries will have to pay more for this coverage and will likely get fewer additional benefits. Benefit reductions since 1999 reflect the managed care industry's response to changes in payment rules made in the Balanced Budget Act of 1997 (BBA), though they also likely reflect the influence of other factors, such as increased difficulty in negotiating competitive rates from providers and the added administrative costs imposed by the BBA.

Policymakers seeking to use the Medicare+Choice option as a means of addressing limitations in Medicare's benefit package should be concerned. This analysis indicates that the generosity of these benefits may decline in the future, especially if capitation rate increases continue to be small. It also shows that the generosity of benefits varies substantially across the country. Policymakers interested in encouraging more equitable and complete access to comprehensive benefits would be well-advised to consider alternatives for reforming Medicare benefits and reducing the geographic disparity in options available to beneficiaries.

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I. INTRODUCTION AND OBJECTIVES

Many Medicare beneficiaries have long had the option of receiving their health care through the traditional, fee-for-service program or through a managed care organization (MCO). Under Medicare+Choice, Medicare's current managed care program, MCOs such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider-sponsored organizations offer all the services covered under traditional Medicare and do so with lower cost-sharing requirements (deductibles, coinsurance, and copayments). Medicare+Choice plans also often cover supplemental benefits not covered under traditional Medicare. All or a portion of the costs for these extra benefits is paid for through savings generated by these plans in providing traditional Medicare benefits.

The Health Care Financing Administration (HCFA), the federal agency that administers Medicare, oversees the Medicare+Choice program and annually contracts with MCOs to cover specific benefits with specific cost-sharing requirements. HCFA and the MCO agree on the counties in which the MCO will operate, called the contract's service area. HCFA then pays the MCO an amount for each beneficiary who enrolls in the MCO; Medicare+Choice rates vary by county and are determined by the county in which the beneficiary lives. The supplemental benefits covered and cost-sharing requirements are determined by the MCO, which can change covered benefits from year to year as well as the cost of enrolling in the MCO (the premium) and/or change the amount that beneficiaries have to pay to receive care (most often copayments). Each year, MCOs may decide to stop serving specific counties or may choose to withdraw from the Medicare+Choice program altogether.

Since its creation under the Balanced Budget Act of 1997 (BBA), the Medicare+Choice program has experienced much turmoil. Numerous health plans stopped participating in the Medicare+Choice program in both 1999 and 2000. Those plans that continued to participate, however, made few changes in their benefits or costs from 1998 to 1999 (Gold et al. 1999). This report provides a detailed look at the changes in Medicare+Choice supplemental benefits and cost-sharing requirements that occurred from 1999 to 2000. The analysis of benefit changes is based on a data file we constructed using publicly available data for each Medicare+Choice contract, including benefits as summarized in Medicare Compare, HCFA's consumer-oriented summary of

Medicare+Choice cost-sharing requirements and supplemental benefits.

While changes in supplemental benefits available in 2000 have been publicized (HCFA 1999a, MedPAC 2000), this report examines this topic in greater depth by answering the following four questions:

1. To what extent are Medicare+Choice organizations modifying the type and cost of benefits they offer?

2. For key supplemental benefits that continue to be covered, are the details of coverage changing? Do these changes reduce the generosity of the benefit?

3. How have beneficiaries been affected by the combination of benefit changes and plan withdrawals from Medicare+Choice? Are there more or fewer beneficiaries in 2000 than in 1999 who live in counties where the choices available cover specific benefits (e.g., prescription drugs) or have low costs (e.g., zero premium)? Are certain counties more affected than others by benefit changes (e.g., rural vs. urban counties)?

4. What are the general effects of BBA payment changes on benefit levels, and how are they affecting disparities in the availability of benefits across counties?

In the discussion that follows, we explain why these questions are important and how we went about answering them. We then review the findings and conclude by discussing what they mean for policymakers.

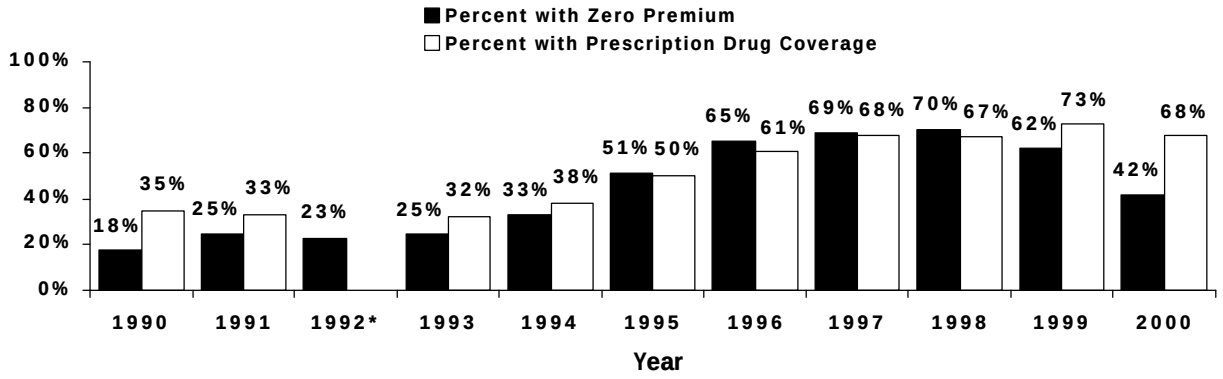
WHY THE INTEREST IN MEDICARE+CHOICE BENEFITS AND PREMIUMS IN 2000

Research consistently shows that the biggest factor drawing Medicare beneficiaries to a Medicare+Choice plan is the supplemental benefits, which are often offered at no additional cost (MedPAC 1999; PPRC 1997). Offering these benefits without charging an additional premium is possible because federal law requires that if an MCO estimates that its costs for providing services covered under traditional Medicare will be less than the Medicare+Choice rate HCFA pays the MCO, the MCO must return those savings to beneficiaries.[1] This is most commonly done by covering additional benefits or lowering out-of-pocket costs. In addition to covering Medicare's cost-sharing requirements, more

[1] Medicare beneficiaries enrolled in Medicare+Choice organizations must still pay the Medicare Part B premium, which is $45.50 per month in 2000. Medicare+Choice organizations may also charge an additional premium for their managed care product.

and more basic managed care plans have included outpatient drug coverage and routine preventive services, often without charging an additional premium (Figure I.1).

Figure I.1
Percentage of Basic Packages with Zero Premiums and Prescription Drug Coverage, 1990–2000



* An estimate of 1992 prescription drug coverage is not presented because the available data appears erroneous. According to the December 1992 HCFA Monthly Report, 97 percent of basic packages included a prescription drug benefit.

Source: Mathematica Policy Research compilation of HCFA Monthly Report data (1990–1998). Estimates for 1999 and 2000 are derived from Mathematica Policy Research's analysis of Medicare Compare data.

There is great concern, however, that such options will be less available in the future. Without a Medicare+Choice option, Medicare beneficiaries with moderate incomes may lose the most affordable way of gaining supplemental coverage. Research shows, for example, that beneficiaries living below the poverty level are much less likely than beneficiaries with higher incomes to have employer/retiree coverage or a Medicare supplemental plan known as Medigap (KFF 1999).

Research also demonstrates that the percentage of beneficiaries living in poverty with no source of additional coverage—Medigap, Medicaid, or employer-purchased coverage—is increasing (Copeland 2000).

The concern over future Medicare+Choice benefits stems from BBA changes to the Medicare managed care program. Through the BBA, Congress aimed to expand managed care choices available to Medicare beneficiaries as well as address long-standing flaws in the way Medicare MCOs are paid by HCFA. Historically, Medicare MCOs were paid 95 percent of the expected fee-for-service costs for demographically similar beneficiaries in the same county. In effect, this approach made managed care less feasible in rural counties, where fee-for-service costs are lower. It also led to inequities: Medicare paid lower rates to counties where patterns of health care provision resulted in lower fee-for-service costs. Beneficiaries in more highly paid counties benefited, since higher rates

allowed more generous supplemental benefits. Although Congress sought to reduce this payment disparity over time, it did not want to do so by spending more than it would otherwise spend. Consequently, changes had to be achieved by redistributing funds rather than by "adding to the pot."

When Congress established the Medicare+Choice program under the BBA, it authorized the phasing-in of changes to the original method of setting payment rates. The BBA, for example, changed the way in which county payment rates are updated each year. Under Medicare+Choice, MCOs receive the greatest of three possible increases over the payment rate from the previous year:

- a phased-in blend of a national payment rate and the county rate;
- a national "floor," or minimum, payment rate; or
- a minimum increase of 2 percent over the previous year's county rate.

However, no blending of rates occurred in 1998 or 1999 because of provisions designed to save the federal government money. Growth in payments has also been constrained by excluding from the payment rates certain graduate medical expenses. And starting in 2000, HCFA is phasing in risk-adjusted payments to MCOs, which will take into account enrollees' health status by paying more for sicker beneficiaries and less for healthy beneficiaries. HCFA estimates that risk adjustment will slightly decrease total payments to MCOs (HCFA 1999b).

By 1999, the impact of these changes was already being felt. Of those counties with at least one Medicare+Choice option available in 1998 or 1999, 87 percent received an increase in payment rates of 2 percent in 1999 (Kornfield and Gold 1999). Ninety-nine MCOs did not renew their Medicare+Choice contracts with HCFA or renewed them but also reduced the service area.[2] Plan withdrawals from the Medicare+Choice program or reductions in participation directly affected 407,000 enrollees.

In 2000, plans are receiving greater increases in payment rates, as blended rates are allowed. Seventy-three percent of counties with at least one Medicare+Choice contract received an increase of more than 2 percent. Yet, just as in 1999, MCOs are exiting the

[2] Each Medicare+Choice organization contracts with HCFA to serve specific counties or portions of counties. Those counties make up the contract's service area.

program or reducing their service area. These changes have involved 99 of the 310 contracts and have affected 327,000 of the 6.3 million people enrolled in a Medicare+Choice plan as of late 1999.

Although payment rates are clearly an important influence on plan withdrawals, they are not the only influence. MCO leaders, for example, say that HCFA's administrative requirements, as well as market conditions and providers' growing resistance to contracting terms, were important considerations in their decision to withdraw (Gold and Hurley 1999). In some cases, too, MCOs entered markets in which they could not effectively compete. Rather than incur losses—particularly when profits in other areas of the industry, such as commercial managed care products, were low—they chose to leave the Medicare+Choice program altogether.

As previously mentioned, earlier work shows little evidence of Medicare+Choice organizations reducing Medicare+Choice benefits in either 1998 or 1999 (Gold et al. 1999). The data available for 1998, though somewhat limited, indicated that MCOs offered a relatively consistent package of benefits across the two years. However, we, and others, speculated that such consistency could very easily be short-lived. Because of the requirement in 1998 that plans submit benefit changes to HCFA in May for the following year (rather than in November, the previous deadline), the impact of rate changes finalized in March 1998 may have been muted. We also speculated that firms might be hesitant to rush into benefit changes that could have long-term implications for their market position.

In sum, the evidence suggests that the managed care industry's response to Medicare+Choice is still evolving and that continuous monitoring of trends in Medicare managed care benefits is essential. This report provides information that policymakers should find useful for this purpose.

HOW WE DID THE STUDY

The study documented in this report is based on a database we created by merging information HCFA provides on Medicare+Choice contracts, services areas, county enrollments, and benefits. Though general benefit information has been available for some time, HCFA developed a new—and much more detailed—database with this information called Medicare Compare, starting in 1998. We used the final August 1999 release of Medicare Compare for 1999 benefit information and the October 1999 release of Medicare Compare for benefit information in 2000.[3]

[3] See "Trends in Medicare Managed Care Benefits and Premiums, 1998-2000: Technical Notes" for more detailed information on how the data file was constructed.

Under HCFA rules, Medicare+Choice organizations may offer more than one package of benefits, called "plans."[4] They may also vary the packages offered across portions, or "segments," of their service area, but they must offer the same benefits with the same costs to all counties within a segment. In our analysis, we focused on the benefits offered to each segment of the MCO's service area, called the "contract segment," because within the contract segment the premium, benefits, and cost-sharing requirements are constant. In 1999, there were 443 contract segments, compared with 468 in 2000. While withdrawals and service reductions reduced the number of contracts, more MCOs added segments to their service areas in 2000 to allow them to vary benefits and premiums across counties.

In each segment of an MCO's service area, we identified one plan as the basic benefit package offered to Medicare beneficiaries by the MCO. In most cases, this plan had the lowest additional premium; however, in some cases, when many plans were offered at the same low premium, we chose as the basic package the plan that included prescription drug coverage.[5] In approximately one-third of the contract segments, the MCO does offer as well an additional "high option" plan at a higher premium than the basic package. In 1999, 28 percent of enrollees in Medicare+Choice organizations had access to a high-option plan, and in 2000, 22 percent do so.

High-option plans were not included in this analysis for two reasons: (1) because they are available to a relatively small number of enrollees, and (2) because we focused on the benefits available at the lowest cost to beneficiaries, since Medicare+Choice plans are often seen as a means for low-income beneficiaries to obtain additional health care coverage. We do, however, report on analyses we conducted to test the sensitivity of our findings to this decision to concentrate on the basic plans. Those findings show that while including high-option plans in the analysis might affect the magnitude of the estimates, the conclusions drawn from the results would be the same.

Because of the interest in understanding how beneficiaries—especially those enrolled in Medicare+Choice plans—are affected by changes in benefits, we present our findings in two ways. First, unweighted estimates were developed to show benefit

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[4] Under the BBA, a "plan" is a group of benefits offered to a defined service area. An MCO may offer multiple plans under one contract if it offers a high-option package in addition to its basic package or if it divides its service area into multiple segments.

[5] Medicare Compare is designed for beneficiary education rather than as a research tool. To use the data for this analysis, we had to code and classify sentences that describe the benefit offerings. For information on the decision rules used in the coding process, please see "Trends in Medicare Managed Care Benefits and Premiums, 1998–2000: Technical Notes."

variation across the basic packages offered. Second, weighted estimates were developed to reflect the relative Medicare enrollment in that contract segment.

Readers should note that the available data do *not* tell us the specific plan in which an MCO member is enrolled when more than one plan is offered. This means we can estimate how many enrollees are members of MCOs that offer certain benefits in their basic plans, but we cannot provide a precise count of how many enrollees actually receive those benefits versus a more generous, but more costly, plan offered by the same MCO. By focusing on the basic plan offered to each contract segment, our findings reflect the minimum amount of coverage enrollees in the Medicare+Choice organizations are receiving. Furthermore, enrollment data are not yet available for the year 2000. Thus, we use September 1999 enrollment data for both the 1999 and 2000 estimates. *This means that the analysis does not show the full impact of MCO withdrawals and/or changes in benefits in 2000 once beneficiaries have had the opportunity to respond by switching or withdrawing from plans.*

In addition to looking at variation in benefits across contract segments, we also examined benefit availability in counties classified by degree of urbanization and by changes in counties' Medicare+Choice payment rate. Here, we focus on the benefits available in particular counties. Since the emphasis in this part of the analysis is the availability of benefits, the results are weighted by the number of beneficiaries living in the county who have access to certain benefits.

II. FINDINGS

OVERALL CHANGES IN BENEFITS AND PREMIUMS, 1999–2000

Fewer MCOs are offering a Medicare+Choice plan with no additional premium—a zero-premium plan—in 2000 than in 1999 (Table II.1). A basic plan that charges no premium is available in only 42 percent of contract segments in 2000, down by a third from 62 percent in 1999. On average, monthly premiums are nearly double, increasing from $13.31 to $25.73.

Table II.1
Monthly Premiums for Basic Plans, Medicare+Choice
Contract Segment 1999–2000

	Percentage of Basic Plans		Weighted by 1999 Enrollment	
	1999	2000	1999	2000
None	62.1	42.3	79.6	56.0
Less than $20	3.2	5.3	3.1	8.8
$20–$49.99	20.5	26.9	13.5	19.8
$50 or more	7.4	22.8	3.2	13.2
Unknown	5.9	2.6	0.6	2.2
Mean	$13.31	$25.73	$6.37	$16.17
Mean if premium	$39.08	$45.47	$32.11	$37.83

Source: Mathematica Policy Research analysis of Medicare Compare data.

Large monthly premiums are still relatively rare, but the premiums charged can be substantial. Monthly premiums of $50 or more, for example, are required in 23 percent of the basic plans in 2000, nearly three times as many as in 1999 (8 percent). Thirteen percent of Medicare+Choice enrollees in 1999 were in plans affected by these increases.

While premiums are increasing, a majority of MCOs continue to offer many additional benefits (Table II.2). There has been a decline, however, in the availability of some key benefits. Most notably, prescription drug coverage is included in only 68 percent of basic plans in 2000, compared with 73 percent in 1999. Coverage for preventive dental benefits, meanwhile, is included in 30 percent of basic plans in 2000, down from 40 percent in 1999. Chiropractic benefits, always relatively limited, are being offered in even fewer plans in 2000: only 9 percent of basic plans representing 6 percent of the enrollment, compared with 19 percent of basic plans representing 21 percent of enrollment in 1999.

Table II.2
Supplemental Benefits in Basic Plans, Medicare+Choice
Contract Segments 1999–2000

	Percentage of Basic Plans		Weighted by 1999 Enrollment	
	1999	2000	1999	2000
Prescription drugs	73.4	67.5	83.9	77.7
Preventive dental	40.2	30.1	61.9	38.2
Vision benefits	93.8	91.7	97.8	95.2
Hearing benefits	82.4	85.2	91.3	91.6
Physical exam	100.0	100.0	100.0	100.0
Podiatry benefits	27.8	28.1	26.9	27.4
Chiropractic benefits	19.0	8.8	20.9	6.3

Source: Mathematica Policy Research analysis of Medicare Compare data.

CHANGES IN THE STRUCTURE OF SPECIFIC BENEFITS, 1999-2000

In addition to raising premiums and reducing some benefits, MCOs are changing the way coverage is structured. In particular, increases in cost-sharing such as copays for physician visits or other services are being imposed, presumably as a means of holding down costs while continuing to offer a relatively attractive set of benefits.

Medicare+Choice plans continue to cover most Medicare cost-sharing, but copayments for physician visits and hospitalizations are higher (Table II.3). In 2000, only 34 percent of basic plans require a copayment of $5 or less for primary care physician visits, down from 43 percent in 1999. A greater portion of basic plans are requiring copayments of more than $10 for specialist services, and more are requiring some form of copayment on hospital admissions, though there are still few MCOs using this feature. Emergency room copayments of more than $40 also are becoming more common, but cost-sharing for laboratory and X-ray services remains rare.

Pharmacy benefits are a key attraction of Medicare+Choice benefit packages. Plans appear to be holding the line on the annual dollar limit of their pharmacy benefit, perhaps because this feature is the most visible to beneficiaries. However, not all have been able to do so. MCOs are also more likely to use copayments and/or formularies to steer enrollees to less expensive drugs (Table II.4).

Table II.3
Copayments for Medical and Hospital Services in Basic Plans, Medicare+Choice Contract Segments 1999–2000

	Percentage of Basic Plans		Weighted by 1999 Enrollment	
	1999	2000	1999	2000
Primary Care Physician				
None	7.7	6.1	18.0	8.9
$5 or less	43.1	33.6	44.5	33.8
$5.01–$10.00	41.8	49.6	32.1	48.2
$10.01–$15.00	6.9	9.2	5.1	8.2
$15.01 or more	0.5	1.5	0.3	0.9
Specialist				
None	7.2	5.3	15.9	7.1
$5 or less	38.1	25.4	39.6	27.6
$5.01–$10.00	36.1	34.0	26.8	35.3
$10.01–$15.00	11.4	18.9	9.9	20.9
$15.00 or more	2.2	9.2	1.2	6.3
Varies	5.0	7.2	6.6	2.8
Emergency Room				
None	3.7	2.0	6.5	2.7
$20 or less	12.1	6.6	24.5	13.5
$20.01–$40.00	31.2	28.1	30.5	34.3
$40.01–$50.00	52.7	63.4	38.2	49.5
Over $50	0.2	0.0	0.2	0.0
Any Copayment				
Hospital admission	9.4	20.0	4.3	13.2
Hospital outpatient	21.5	22.6	30.7	27.7
X-Ray	6.2	11.7	7.5	11.4
Lab	3.2	5.7	3.9	6.8

Source: Mathematica Policy Research analysis of Medicare Compare data.

As in 1999, prescription drug benefits without any dollar limit are being offered by MCOs in a small share of basic plans in 2000 (8 percent and 9 percent, respectively, in each year). These plans, however, tend to be offered to segments with larger-than-average enrollments, which means a higher proportion of enrollees has access to unlimited pharmacy benefits. While the distribution of drug limits across basic plans was relatively stable between years, more MCOs are capping prescription drug benefits at less than $750 in 2000 (42 percent, compared with 35 percent in 1999). The effect on enrollees, though, is greater: compared with 1999, nearly double the percentage of enrollees in 2000 are in plans whose basic package offers less than $500 in prescription drug coverage. (As noted earlier, however, the enrollment weights are based on 1999 figures and do not reflect changes in enrollment due to changes in benefits offered.) This finding is not driven by restriction of the analysis to the basic Medicare+Choice plans. Looking across all the plans offered, including both basic and high-option plans, the availability of prescription drugs benefits decreased slightly and there was a slight downward shift in the level of coverage

offered.

Table II.4
Prescription Drug Benefits in Basic Plans,
Medicare+Choice Contract Segments 1999–2000

	Percentage of Basic Plans		Weighted by 1999 Enrollment	
	1999	2000	1999	2000
Any Coverage	73.4	67.5	83.9	77.7
Annual Cap				
$500 or less	23.3	27.1	10.6	20.6
$501–$750	12.0	14.4	10.1	11.7
$751–$1,000	27.5	23.2	26.3	17.9
$1001–$1,500	12.0	13.4	9.4	12.8
$1,500–$2,000	13.0	9.8	17.8	20.5
$2,001 or more	4.5	3.3	4.1	3.0
No cap	7.8	8.8	21.7	13.5
Practices				
Formulary	81.6	91.6	80.3	92.9
Mail orders	89.3	88.6	95.7	95.9
Quarterly cap	14.9	23.1	12.2	13.3
Ratio of Copays				
Brand-name to generic[a]				
2.0 or less	45.1	38.3	55.7	43.4
2.01–3.0	32.3	32.1	24.9	32.9
3.01 or more	21.9	27.8	19.2	21.5
Copay				
Generic				
None	6.0	4.4	7.6	6.0
$10 or less	89.3	92.2	84.4	91.4
$10.01 or more	4.7	3.4	8.0	2.6
Brand-name				
None	5.2	2.9	6.3	4.3
$10 or less	24.7	8.7	35.9	19.2
$10.01–$20	51.7	56.7	43.8	55.7
$20.01 or more	18.4	31.8	14.0	20.8

[a] In 1999, two contract segments (0.7 percent of those with prescription drug coverage) had a brand-name but no generic copay. In 2000, 6 contract segment (1.8 percent) had a brand-name but no generic copay.

Source: Mathematica Policy Research analysis of Medicare Compare data.

In 2000, a larger share of basic plans is using a formulary (91 percent vs. 82 percent). Copayments, especially for brand-name drugs, have increased substantially as well. This is true both in terms of the level of brand-name copayments and in comparing brand-name copayments to copayments for generic drugs. Moreover, a higher share of basic plans impose a quarterly cap on benefits (24 percent in 2000 vs. 15 percent in 1999).

IMPACT OF CHANGES ON PACKAGES OFFERED TO BENEFICIARIES BY COUNTY OF RESIDENCE, 1999–2000

Withdrawals and service area reductions mean that fewer Medicare beneficiaries live in counties with a Medicare+Choice contract in 2000. Sixty-eight percent of beneficiaries are in counties with such a managed care option in 2000, compared with 72 percent in 1999. When they do have a Medicare+Choice option, beneficiaries are less likely to have the choice of at least one plan that includes a pharmacy benefit or a plan that is offered with a zero premium (Table II.5).

Table II.5
Medicare+Choice Choices Available to Beneficiaries, by County of Residence 1999–2000

	All Counties	Metropolitan		Non-Metropolitan	
		Center City	Other	MSA Adjacent	Other
Distribution Nationally					
Beneficiaries	100.0	40.8	35.2	13.3	10.8
Any Medicare+Choice Plan Offered	71.6	99.0	71.4	37.7	10.4
1999	68.4	97.1	67.4	32.4	7.7
2000					
Medicare+Choice Basic Plan with Prescription Drug Benefit Offered					
1999	61.5	92.1	56.9	24.4	5.5
2000	54.7	89.7	44.5	16.3	2.3
Medicare+Choice Basic Plan with Prescription Drug Benefit and >$1,000/Year Offered					
1999	35.8	58.3	26.8	10.6	1.5
2000	35.8	63.3	23.1	6.3	0.0
Zero Premium Basic Plan Offered					
1999	61.4	92.7	56.2	25.4	3.0
2000	52.7	90.0	39.0	14.5	1.9

Source: Mathematica Policy Research analysis of Medicare Compare data.

The analysis confirms a substantial disparity in benefits by county of residence. Beneficiaries in the most urban counties—those in the center cities of metropolitan statistical areas—continue to be more likely to have Medicare+Choice options available. And when they are available, the options are more likely to include a plan with a zero premium and/or drug coverage.

Nearly all (97 percent) beneficiaries living in center city counties will have a

Medicare+Choice option available to them in 2000, and this is only slightly less than in 1999 (99 percent). In contrast, such an option will exist for only 67 percent of beneficiaries in other metropolitan counties, 32 percent in rural counties adjacent to metropolitan areas, and 8 percent in all other counties. Twenty-four percent of Medicare beneficiaries live in those non-metropolitan counties, meaning that 7.4 million beneficiaries are in counties with no managed care option in 2000, up from 7 million in 1999.

Medicare+Choice benefits are available to fewer beneficiaries in 2000, and more beneficiaries are being asked to pay premiums for the Medicare+Choice plans that are available—regardless of whether they live in metropolitan or non-metropolitan areas. However, the extent of the decline in availability of Medicare+Choice benefits is much greater outside the center cities, and beneficiaries in the most urbanized areas even have access to more generous drug benefits in 2000. Two-thirds of beneficiaries in the metropolitan counties surrounding the center cities still have access to a Medicare+Choice option, but fewer than half of those basic plans contain prescription drug coverage and more than 60 percent require a premium.

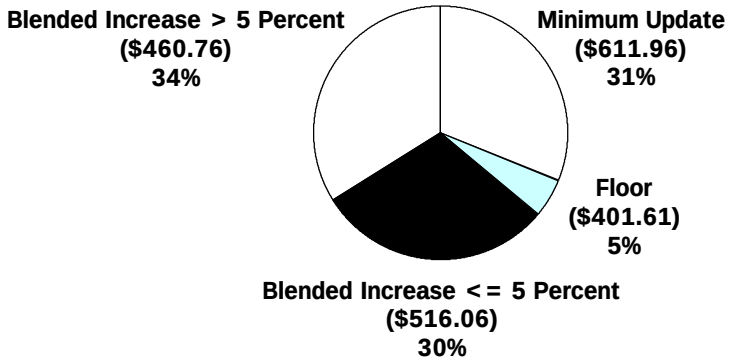
In 1999, beneficiaries in non-metropolitan counties had limited access to a Medicare+Choice plan—much less to one with no premium or generous drug coverage. These benefits are even rarer in 2000, and no beneficiaries in the most rural counties (non-metropolitan and not adjacent to a metropolitan area) are offered a basic plan with more than $1,000 in drug benefits.

HOW BENEFITS CHANGE WITH PAYMENT RATES

Our analysis of the effect of changes in Medicare+Choice payments on benefits in 2000 focuses on MCOs that offered a Medicare+Choice plan in 1999 and 2000 to the same counties. The analysis is based on changes in premiums and drug benefits, the two most costly and visible elements of MCO coverage. As we discuss below, we compared benefit changes associated with different rates of increase in the Medicare+Choice payment rate. It is important to recognize, however, that such changes in payment rates build on the original payment levels. Because of efforts to reduce disparities in payment rates among counties, counties with the highest average payment levels received the lowest payment increases (Figures II.2 and II.3). Though changes in benefits are influenced by the rate of increase in payments, they also are greatly influenced by the amount of the payment, regardless of the amount of increase over the previous year's payment rate.

Figure II.2

Distribution of Counties Served by the Same MCO in 1999 and 2000, by Type of Payment Rate Increase in 2000

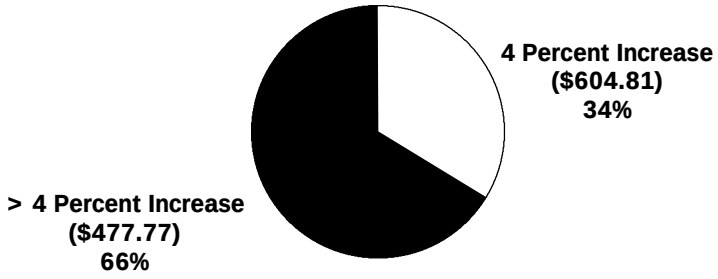


Note: The number in parentheses is the average M+C payment rate for 2000 in each category. For example, $516 is the average M+C payment rate in the 30 percent of counties served by the same MCO in 1999 and 2000 which received a blended payment rate increase of less than or equal to 5 percent in 2000.

Source: ?

Figure II.3

Distribution of Counties Served by the Same MCO in 1999 and 2000, by Payment Rate Increase from 1998 to 2000



Note: The number in parentheses is the average M+C payment rate for 2000 in each category. For example, $605 is the average M+C payment rate in the 34 percent of counties served by the same MCO in 1999 and 2000 which received a payment rate increase of 4 percent from 1998 to 2000.

Source: ?

As mentioned earlier, one of the most important elements of the BBA—and the Medicare+Choice program it created—is the new way HCFA calculates increases in payment rates each year. Because of the importance of this new system, we describe changes in the benefits offered to counties classified by the type of payment rate increase each county received. To recap our earlier discussion, this increase is the greatest of three

possible methods of calculating the new rate—increases to a minimum payment rate (the floor), a combination or blend of the county rate and a national payment rate, or a guaranteed minimum increase of at least 2 percent. Counties that received an increase to the minimum payment rate of $401.61 in 2000 are hereafter referred to as "floor counties." Counties that received the guaranteed increase of 2 percent are described as receiving the "minimum update."

In 2000, a majority of counties received a blended payment rate. Those increases ranged from just greater than 2 percent to as much as 16 percent. Counties receiving the "blend" in 2000 are further broken down into counties for which this resulted in an increase of less than 5 percent and those for which the increase was greater than 5 percent. Figure II.2 illustrates the distribution of counties included in the analysis by the type of payment increase received in 2000, while Figure II.3 shows the distribution by the rate of increase from 1998 and 2000.

Among MCOs serving the same counties in 1999 and 2000, 53 percent have made no change in the premium for their basic Medicare+Choice plan: 46 percent offer a zero-premium plan in both years and 7 percent charge the same premium. Nearly all the remaining MCOs require enrollees to pay more for their basic benefit package: 28 percent added a premium in 2000, and 16 percent increased their premium over the 1999 level (Table II.6). Medicare+Choice organizations in the highest-paid counties were much more likely to offer a zero premium plan in 1999 and are much more likely to continue to offer a plan without a premium in 2000, despite payment increases restricted to the minimum update of 2 percent. And although floor counties received greater payment increases under the BBA, MCOs in these counties are still less likely to offer a zero-premium plan in 2000, and many also have raised their premiums. Despite having received blended payments, even MCOs with the greatest payment increases in 2000 (more than 5 percent) are likely to add or raise a premium.

The pattern for changes in pharmaceutical benefits from 1999 to 2000 is similar to the pattern of changes in premiums (Table II.7). Among MCOs participating in both years, roughly a quarter (27 percent) had no drug benefit in either year, and another 29 percent made no change to their benefit. Ten percent made their benefit package more generous, either by adding a prescription drug benefit where there was none or by raising the annual dollar limit for prescription drug coverage. But 30 percent made their plan less generous by lowering the annual limit, and 4 percent instituted a mixed set of changes.[6]

[6] An MCO was considered to have made a "mixed change" if it lowered its maximum coverage limit in 2000 but began applying that limit to brand-name drugs only while both brand-name and generic drugs

Drug benefits are substantially less likely to be offered in floor counties in 2000, whereas only 12 percent of counties receiving a minimum 2 percent update were not offered a prescription drug benefit in either 1999 or 2000. Since Medicare+Choice organizations serving counties with the highest payment rates (those that received the minimum payment increase) were the most likely to offer prescription drug coverage, those MCOs are also the most likely to have changed those benefits.

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had been limited in 1999.

Table II.6
Changes in Medicare+Choice Premiums for Basic Plans,
Counties Served in Both 1999 and 2000 by Change in Payment Rate

		County Payment Rate Increase in 2000					
				Blend		Cumulative Increase from 1998 to 2000	
	All Contract/County Combinations[a]	Minimum	Floor	≤5%	>5%	4%	>4%
Changes in Premiums[b]							
Zero premium in both years	45.9	66.9	31.6	48.5	27.2	65.6	35.7
Added a premium in 2000 (none in 1999)	27.6	25.5	8.9	34.0	26.4	26.6	28.2
Increased premium (premium in both years)	16.1	3.4	34.2	10.6	29.5	3.7	22.5
Same premium in both years	7.1	3.2	19.0	4.6	11.2	3.0	9.2
Reduced premium (premium in both years)	3.3	1.1	6.3	2.3	5.7	1.2	4.4

[a] There are 1,869 contract/county combinations in our analysis. Contract/county combinations are counties served by the same contract in 1999 and 2000. These 1,869 combinations reflect 789 unduplicated counties and 260 unduplicated contracts.

[b] This distribution excludes 110 contract/county combinations for which premium information is missing in at least one year.

Source: Mathematica Policy Research analysis of Medicare Compare data.

Table II.7
Changes in Medicare+Choice Prescription Drug Benefits for Basic Plans,
Counties Served in Both 1999 and 2000 by Change in Payment Rate

		County Payment Rate Increase in 2000					
				Blend		Cumulative Increase from 1998 to 2000	
	All Contract/County Combinations[a]	Minimum	Floor	≤5%	>5%	4%	>4%
Changes in Prescription Drug Benefit[b]							
No drug benefit in 1999 or 2000	27.1	12.3	55.7	20.0	42.3	12.8	34.4
Added a drug benefit in 2000	1.2	0.7	0.0	1.7	1.3	1.0	1.3
No change in drug benefit	29.4	36.4	21.5	27.6	26.0	35.4	26.4
Increased benefit limit[c]	9.0	10.3	7.6	9.8	7.3	10.1	8.4
Mixed change[d]	3.5	3.0	0.0	5.7	2.6	3.4	3.6
Decreased limit in 2000							
>$500 change[e]	5.2	8.2	0.0	7.2	1.6	8.6	3.5
$500 change or less[f]	12.3	18.7	11.4	11.5	7.6	18.1	9.3
Dropped benefit in 2000	12.3	10.3	3.8	16.4	11.5	10.7	13.0

[a] There are 1,869 contract/county combinations in our analysis. Contract/county combinations are counties served by the same contract in 1999 and 2000. These 1,869 combinations reflect 789 unduplicated counties and 260 unduplicated contracts.

[b] This distribution excludes 106 contract/county combinations for which drug limit information is missing in at least one year.

[c] Includes contract/county combinations for which the value of the benefit limit did not change but the contract limited both generic and brand-name drugs in 1999 and brand-name drugs only in 2000.

[d] Mixed change is a decrease in benefit limit but a simultaneous shift from limiting both brand-name and generic drugs to limiting only brand-name drugs.

[e] Includes contract/county combinations for which the benefit limit did not change but contract limited only brand-name drugs in 1999 but both generic and brand-name drugs in 2000.

[f] Includes contracts which offered an unlimited drug benefit (no limit on either brand name or generic drugs) in 1999 and limited either brand-name and generic drugs or only brand-name drugs in 2000.

Source: Mathematica Policy Research analysis of Medicare Compare data.

III. CONCLUSIONS

Four major findings emerge from this study:

1. For MCOs that have stayed in the Medicare+Choice program, BBA-related changes have begun to affect the generosity of benefits and the premiums charged for them in 2000.

This finding stands in contrast to the relative stability of benefits in 1999. Further, the changes are not trivial—they involve substantial increases in premiums and/or out-of-pocket expenses in the form of copayments. The changes in 2000 Medicare+Choice benefits are a response to payment rate changes; however, payment rate changes are likely not the only reason for changes in benefits. The BBA and related regulations also increased the administrative requirements on MCOs in areas such as provider contracting and quality management. In addition, the managed care industry has faced other difficulties, including the "managed care backlash" against the industry from patients, physicians, and other health care providers. Negotiating competitive rates with providers is becoming harder for some plans. These forces also affect the ability of MCOs to offer Medicare+Choice plans and the benefits included in those plans.

2. Strategic considerations appear to be important influences on how MCOs structure Medicare+Choice products.

In adapting their benefit packages to the reduced growth in payments and increased administrative costs of the Medicare+Choice program, MCOs can raise premiums, lower benefits, or do both. Our results suggest that the managed care industry believes that it will be more likely to attract beneficiaries to Medicare+Choice plans by continuing to offer supplemental benefits even if a premium is charged for those benefits. But Medicare+Choice organizations also need to limit benefits to some extent to avoid the need to charge even higher premiums. This focus on preserving the availability of key benefits makes sense because the only alternative for many beneficiaries is a Medigap supplemental plan, which costs more and may have even less generous benefits.

We cannot say how MCO decisions about premiums and benefits will affect beneficiaries. The data do not reveal how likely beneficiaries are to pay a premium and therefore how changes in benefits will ultimately affect enrollment levels in Medicare+Choice organizations. Presumably, some beneficiaries could decide that they cannot afford the premium or do not believe the benefits are valuable enough to justify it. These beneficiaries could decide to remain covered only through traditional Medicare. If

they do, Medicare+Choice enrollment levels will decline, especially in two cases: (1) when beneficiaries reside in counties in which there is no more attractive plan to which they could transfer, and (2) when disenrollment from the Medicare+Choice organization is not offset by the enrollment of newly eligible beneficiaries or by beneficiaries no longer able to afford traditional Medigap plans.[7] National enrollment data suggest that this may be occurring (Cassidy and Gold 2000). In 1999, when there were numerous withdrawals from the Medicare+Choice program but limited benefit changes, Medicare+Choice enrollment fell at the start of the year but had returned to its December 1998 levels by the beginning of March. In 2000, however, after experiencing both withdrawals and changes in benefits, roughly 126,000 fewer beneficiaries were enrolled in Medicare+Choice plans as of March 1, 2000 than as of December 1, 1999.

3. Not only do benefits and premiums vary greatly across the country, there are also differences in benefits and premiums between urban and rural areas.

Because a Medicare+Choice option is often the most affordable way for individuals to supplement Medicare benefits—especially if they have no employer coverage—elderly residents in areas less attractive to Medicare+Choice organizations are less likely to have access to such coverage. This is true despite the fact that these individuals pay the same Part B premium for Medicare coverage as people who do have access to such coverage. As a result, not all beneficiaries under the same Medicare program have the same range of choices.

We believe that this situation reflects less on the Medicare+Choice organizations than it does on the contradictions in Medicare policy itself. That is, efforts to reform Medicare using competition among private sector organizations, such as the Medicare+Choice program, rely on the competitive forces of the market for their success. Under such a market-based approach, firms will only enter when it makes financial sense for them to do so—and financial incentives are greater in markets where payment rates are higher. Though the policymakers who designed the BBA aimed to reduce geographic differences in payment rates, the impact of this change for standardizing the Medicare+Choice plans offered in different parts of the country appears to be relatively limited thus far. If Congress wants to create uniformity in the benefits available to Medicare beneficiaries, it is more likely to succeed by creating legislation to govern

[7] Medigap premiums increased substantially between 1995 and 1996 and Medigap carriers predicted continued increases of more than 10 percent in the years following that rise. In addition, more carriers are age-rating their Medigap premiums, meaning premiums will increase as the beneficiary grow older (Alecxih

benefit cost and availability than by relying on the market to achieve those goals.

4. Reductions in prescription drug benefits, as well as MCO withdrawals from the Medicare+Choice program, accentuate the limitations in the traditional Medicare benefit package.

As others have shown (Davis et al. 1999), drug benefits in general tend to be limited unless they are offered through employment-based coverage based on work prior to retirement. Medicare managed care organizations offer drug coverage that is more comprehensive and lower cost than Medigap policies, but coverage is still limited.[8] Furthermore, drug coverage under MCOs, which probably served as a safety valve for the Medicare program by providing a low or no-cost option for supplementing traditional Medicare benefits, may be more costly in the future or even less available. Rising drug costs are increasing the pressure on this benefit even as Congress tries to hold down overall spending on the Medicare+Choice program.

Pressure to improve Medicare benefits is likely to grow, especially if current policies continue and Medicare+Choice payments to MCOs continue to fall short of increases in medical costs. HCFA recently announced that 69 percent of counties will receive the minimum two percent increase in 2001, in part because of an adjustment for overpayments in prior years. This suggests that it is important to continue to monitor trends in Medicare+Choice benefits. It also suggests that policymakers interested in encouraging more equitable and complete access to comprehensive benefits would be well-advised to consider alternatives for reforming Medicare benefits and for reducing the disparity among options available to beneficiaries who live in different parts of the country.

1997, Dallek 1996).

[8] Only Medigap plans H, I, and J contain prescription drug coverage. All three plans have a $250 deductible for drug costs and pay 50 percent of prescription drug costs up to the plan's limit. Plans H and I offer $1,250 in drug coverage while Plan J offers $3,000 in coverage (HCFA 1999c).

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