EARLY IMPLEMENTATION OF MEDICARE+CHOICE IN FOUR SITES: CLEVELAND, LOS ANGELES, NEW YORK, AND TAMPA–ST. PETERSBURG

Geraldine Dallek and Donald Jones
Institute for Health Care Research and Policy
Georgetown University

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) significantly changed the Medicare managed-care market. The legislation:

- authorized Medicare+Choice (M+C), a new Part C of Medicare, to expand beneficiaries' health care choices;
- authorized the Health Care Financing Administration (HCFA) to undertake a new Medicare education initiative that includes disseminating M+C plan comparison data and other information via a yearly mailing, a toll-free telephone hotline, and an Internet site;
- required M+C organizations to adhere to new, and stronger, managed-care consumer protections;
- altered the way HMOs and other new M+C plans are reimbursed; and
- changed the enrollment and disenrollment rules, phasing in a lock-in requirement beginning in 2002.

This paper assesses the effect of these changes on the general Medicare+Choice environment. The project's staff examined early implementation of the system in Cleveland, Los Angeles, New York City, and Tampa–St. Petersburg. Results reported here are based on visits to the study sites in early 1999, follow-up interviews, a survey of newspaper and other printed materials, and analysis of HCFA data and plan marketing materials and activities.

FINDINGS

1. Market conditions influenced the development of Medicare+Choice.

The market environments in which M+C was implemented vary by study site. HMO-provider relations are contentious in all four. In Los Angeles, the financial frailty of medical groups and Independent Practice Associations (IPAs) is of special concern to providers and regulators alike.

Beneficiaries in the study sites have a large number of Medicare HMOs from which to choose. Lower Medicare reimbursement rates in the Cleveland area and Tampa–

St. Petersburg (compared with those in Los Angeles and New York City) did not dramatically affect plans' willingness to market in these communities. M+C plans have grown rapidly except in New York City (table ES-1). There, HMO growth has been impeded by the state hospital rate-setting system (discontinued in 1997), the lack of employer interest in HMOs, the dominance of prestigious academic medical centers, high marketing costs, and a general distrust of HMOs.

Table ES-1
Payment Rate and Medicare+Choice in Four Study Sites

Site	Medicare Rate	Number of Plans	Medicare HMO Penetration	
			1993	1999 (Sept.)
Cleveland (5-county area)	$463–$564	5–9	4.4%	24.2%
Los Angeles County	$647	12	29.6%	37.6%
New York City (5-county area)	$686–$798	7–11	5.1%	18.7%
Tampa–St. Petersburg (2-county area)	$506–$520	8	14.1%	34.9%

Despite this growth in the number of plans, Medicare enrollment in each of the study sites is concentrated in two or three plans. In Los Angeles, PacifiCare and Kaiser Permanente have 69 percent of the Medicare HMO market. In New York City, Oxford, HIP, and Aetna have 80 percent, and in Tampa–St. Petersburg, Humana, Prudential, and Health Options (BC/BS) have 76 percent. In the Cleveland area, Aetna's purchase of Prudential will leave Kaiser Permanente and Aetna with 66 percent of the Medicare market.

2. It is difficult for beneficiaries to make informed decisions about plans using criteria based on prescription drug benefits and provider networks, which are subject to change.

Medicare HMOs compete on costs, benefit packages (especially prescription drugs), and provider networks. Project staff analyzed the 1999 prescription drug benefits that M+C plans offered in the study sites. The array of packages is bewildering. They vary by brand versus generic drugs, formulary structure, drug substitution policies, one-month versus mail order copayments, drug benefit caps, the basis upon which these caps are calculated, and which drugs are covered. In addition to these differences, the number of benefit packages offered—10 in Tampa–St. Petersburg, 22 in Manhattan, 18 in Cleveland, and 12 in Los Angeles—makes it difficult to collect and compare packages. Thus, it is virtually

impossible for Medicare beneficiaries to make an informed choice among plans based on the plans' drug benefits.

Examples of 1999 M+C Prescription Drug Benefit Packages in Cuyahoga County (Cleveland)

Which is the best value?: **Plan A's unlimited generic benefit and $700 maximum on brand drugs (with a $10 copay for generic formulary and $20 for brand formulary) *or* Plan B's $500 quarterly limit on generic and brand named drugs combined (with a $5 copay for generic formulary drugs and $15 for brand formulary drugs) *or* Plan C's $50 a month no-copay benefit for a 60 day supply of drugs (with a 50% rollover of unused monthly allowance) *or* Plan D's $250 per quarter benefit ($1000 yearly maximum) with a $250 rollover provision and copays of $8 for generic and $20 for brand name drugs, but no mail order benefit? None of these plans charged a premium in 1999.**

Beneficiaries choosing an HMO must also weigh factors that include whether their physicians contract with a particular plan and which hospitals are in which provider network. To the extent that physician and hospital membership in plan networks overlap, the decision to enroll in any particular plan is less consequential. Project staff used plans' provider directories to analyze the degree of overlap of primary care physicians, cardiologists and hospitals in New York, Cleveland, and St. Petersburg. The Los Angeles analysis looked at overlap of physician groups.[a]

The staff found significant overlap of provider networks, especially in St. Petersburg and Cleveland. The overlap of providers in New York is smaller, probably a consequence of fewer contracting physicians and lower Medicare HMO market penetration. In Los Angeles, the larger physician groups contract with all or most of the Medicare HMOs in the county, but many of the smaller hospital-based groups contract with only one or two. The division of the larger physician groups into subgroups based on geography further limits beneficiary choice. Enrollees of a particular medical group generally have several primary care physicians from which to choose, but only a limited number of specialists and hospitals.

Some L.A. Medical Groups/IPAs Offer Little Choice of Providers

Los Angeles medical groups/IPAs listed in Medicare HMO provider directories generally list a minimum of 10 primary care physicians, but far fewer specialists and hospitals. For example, one medical group located in the western part of Los Angeles County offers enrollees a choice of 80 primary care physicians (family practice and internal medicine physicians) from which to choose, but list only one allergist, one audiologist, two cardiovascular surgeons, two ophthalmologists, one oral maxillofacial surgeon, one orthopedic surgeon, one medicine and rehabilitation physician, one plastic surgeon, two podiatrists, one pulmonary disease specialist, and one vascular surgeon.

[a] Generally, HMOs in Los Angeles and California contract with physician groups, which in turn contract with individual physicians and hospitals.

Contract disputes in both Tampa–St. Petersburg and Cleveland, and medical group/IPA financial problems in Los Angeles have roiled the Medicare markets in these study sites and disrupted member-physician relationships.

3. Plan participation and premium/benefit changes differed by study site.
Ironically, M+C has contributed to less, not more, competition. One year after implementation, no new types of M+C plans had entered the market in any of the four study sites. Hospital and provider groups are hesitant about contracting directly with Medicare because of the financial risk. They also fear that if they compete directly with HMOs for Medicare beneficiaries, HMOs will no longer contract with them to provide care to commercial enrollees. In January 2000, a Florida Medicare HMO entered the Tampa–St. Petersburg market, replacing a small HMO that pulled out at the end of 1999. Also in early 2000, an existing New York City HMO began marketing in three additional NYC boroughs.

Nationally almost 200 plans pulled out of Medicare at the end of 1998 and 1999. Few M+C plans pulled out of the study sites during this time period, and those that did withdraw had small enrollments. However, plan pullouts had a greater impact in counties neighboring New York, Tampa–St. Petersburg, and Cuyahoga County (Cleveland). According to several plan representatives we interviewed, the pullouts stemmed as much from their plans' failure to obtain favorable contracts from local hospitals and physicians as from BBA reimbursement changes.

High Medicare reimbursement rates in New York and Los Angeles, along with competitive pressures, kept benefit packages generous in both communities, especially in Los Angeles. M+C plans in Cleveland and Tampa–St. Petersburg were more likely to have increased premiums and/or reduced benefit packages in 2000. Plan withdrawals, premium increases, and benefit cutbacks angered Medicare HMO enrollees who flooded local Medicare hotlines with complaints. Beneficiaries in the Cleveland area were also distressed by plan-provider contract terminations.

4. No major marketing problems were found in the study sites, although plans could improve their marketing activities and materials.
Volunteers and staff members of community organizations in the study areas attended a total of 29 plan marketing presentations. These were marked generally by sins of omission rather than commission in Cleveland, Tampa–St. Petersburg, and especially in New York and Los Angeles. For example, speakers explained the M+C appeals process in only 59 percent of presentations attended, gave the prudent-layperson definition of *emergency* in 38 percent, and described the BBA's direct-access to a woman's health care provider

provisions in 62 percent. A few presenters also made inappropriate remarks about original Medicare or other HMOs in their communities.

An analysis of plan marketing literature found critical information missing, including information about self-referrals to women's health care providers and for mammography. Perhaps of greatest concern was the lack of information about the appeals process in 20 percent of the materials reviewed. Marketing materials also included inaccurate, conflicting, or confusing information.

Plan provider directories were also problematic, often failing to supply information on languages spoken by physicians, board certification, physician-hospital affiliation, physicians with closed practices, the addresses of specialists, and listings of contracted nursing homes and home health agencies.

BBA marketing regulations make it explicit that plans must market to the under-65 disabled Medicare population as well as to minority and low-income beneficiaries. Plan executives interviewed for this study noted their under-65 Medicare membership reflected the proportion of the non-elderly in the general Medicare population. However, in only seven of 30 plans' marketing materials is it explicitly noted that beneficiaries under age 65 are eligible to join. Further, only six of the 30 (20 percent) marketing packages reviewed included a picture of a man or woman who appeared to be younger than 65 and disabled. Finally, the names by which Medicare HMOs are known imply that they restrict services to seniors (see box below).

Names of M+C Plans

The names of M+C plans imply that they only enroll elderly Medicare beneficiaries. For example, in Los Angeles, Medicare HMO products have the following names: Senior Secure, 65 Plus, Healthcare for Seniors, Seniority Plus, Services to Seniors, Senior Advantage, Max 65 Plus, Secure Horizons, and Health Care for Seniors.

Almost all plans under review included photographs of minorities in their marketing materials. Despite repeated attempts to obtain Spanish translations in the three sites with large Hispanic populations (Los Angeles, Tampa–St. Petersburg, and New York), only seven of 26 plans (27 percent) sent any Spanish language materials. Calls to the major minority newspapers in the four study sites found that few M+C plans advertise in these papers. Los Angeles HMOs did significantly better on this measure than HMOs in the other study sites.

Although most Medicare HMOs use trained staff to market their product, a few plans are beginning to use private insurance agents for marketing and referrals. This trend is likely to continue with the implementation of lock-in—plans will be less likely to employ and train marketing staff for use during the one-month open-enrollment period. A private for-profit organization that referred beneficiaries to HMOs for a commission operated for a time in the Tampa–St. Petersburg area. Although the organization promised to refer beneficiaries to area plans that best met their needs, several consumer and HMO representatives believed that the organization limited referrals to those HMOs that paid a commission.

5. Continuing high disenrollment rates for some plans will negatively affect the way the lock-in provision is received.

Currently, Medicare beneficiaries can quit their HMOs at any time. This will change when Medicare phases in an annual enrollment period and lock-in beginning in 2002. The impact of this change will depend in part on whether members are satisfied with their HMOs. In May 2000, HCFA presented on its website (www.Medicare.gov) M+C plans' voluntary disenrollment rates for 1998 and 1999.[b] Using HCFA data for 1998 and the first six months of 1999, project staff calculated plans' rapid disenrollment rates and the percentage of those 80 and older who disenrolled.[c] On average, there was more churning of enrollees in Tampa–St. Petersburg and less in Cleveland than in the other study sites. However, disenrollment rates varied dramatically among plans: six of seven reporting plans in Tampa–St. Petersburg, four of nine reporting plans in New York, three of 11 reporting plans in Los Angeles, and two of eight reporting plans in Cleveland had disenrollment rates of 20 percent or greater in 1999. In 1998, four plans, and in 1999, seven plans, in the study sites had both disenrollment rates of 20 percent or more *and* rapid disenrollment rates of at least 30 percent. Continuing high disenrollment rates for some plans and the large number of beneficiaries who change plans or return to original Medicare during the year have implications for M+C lock-in provisions. In New York, for example, over 108,000 Medicare HMO members voluntarily quit their plans in the last nine months of 1998.

Interviewees in the four study sites were of mixed opinion on the impact of lock-in. Some HMO executives felt that lock-in would lend stability to the market and allow plans to improve care. Others feared that lock-in would make beneficiaries "nervous" about joining an HMO and result in "dissatisfied" members who felt "trapped." Representatives of consumer groups in the four sites argued that continuous disenrollment

[b] Voluntary disenrollments include Medicare beneficiaries who leave an HMO during the year for reasons other than death, loss of Medicare eligibility, a move out of the area, or plan closure.

[c] Rapid disenrollment includes Medicare beneficiaries who (1) sign an application but cancel before enrollment becomes final, or (2) voluntarily leave a plan within 3 months of enrollment.

was "one of the most important HMO consumer protections," and a "safety valve" for beneficiaries who don't like their plan.

6. Initial M+C education efforts were positive, but there is room for improvement.

In its first educational M+C mailing in October 1998, HCFA sent a 55-plus page *Medicare & You* 1999 handbook to consumers in five states, including Florida and Ohio. Beneficiaries in other states were sent a shorter 8-page *Medicare & You* bulletin. There was little response to the first handbook in Tampa–St. Petersburg and Cleveland, although organizations working with Medicare beneficiaries were overwhelmed with calls about plan withdrawals. Generally, beneficiary groups and providers found the first year's handbook confusing. By contrast, the bulletin, which contained five simple pieces of information and prominently displayed the phone numbers of the State Health Insurance Assistance Programs (SHIPs), yielded an avalanche of calls to local SHIPs.

The 2000 *Medicare & You* handbook, mailed in October 1999, resulted in increased calls to SHIP programs in the four study sites. Again, however, calls about plan withdrawals and premium increases/benefit decreases in affected areas overshadowed any beneficiary response to the handbook. Those interviewed for this study felt that the 2000 handbook was greatly improved.

In November 1998, HCFA opened its 1-800-MEDICAR(E) telephone hotline to beneficiaries in five states, expanding the service to beneficiaries in other states in early 1999. Volunteers in the four study sites made a total of 91 hotline calls to assess the accuracy of hotline staff responses to test questions. Response accuracy varied by question. Overall, hotline staff responded correctly to 51 of the 91 calls made from the four study sites. Thus, callers received the correct information only 56 percent of the time.

7. Plan executives saw new consumer protections as generally positive, but some were difficult to implement.

Plan executives interviewed for this study viewed many of the new BBA consumer protections as positive, but felt that some rules, such as a shorter time to enroll new members, were difficult to implement. Further, although plans had no problem with most of the consumer protections taken separately, the totality of the changes were administratively costly to implement. Consumer groups were very supportive of the new protections, especially the shorter appeal time frames.

8. HEDIS and CAHPS show substantial differences in quality of care.

The BBA requires HCFA to collect and publish a range of performance and enrollee satisfaction measures. In March 1999, HCFA published its first set of M+C quality measures (the Health Plan Employer Data and Information Set, or HEDIS, and the Consumer Assessment of Health Plans Survey, or CAHPS) on its website (www.Medicare.gov). The agency published results of its second M+C enrollee satisfaction survey in August 1999, and in September, the results of its second HEDIS report. An analysis of the CAHPS and HEDIS data in the four study sites found that:

- The performance measures show substantial differences among plans.
- With some exceptions, plans' HEDIS scores improved between 1997 and 1998. In a few cases, scores improved dramatically.
- Most, but not all, plans that had low member satisfaction scores also had high disenrollment rates.

During the study period, consumer groups in the four study sites did not make extensive efforts to educate either their volunteers or Medicare consumers about HEDIS and CAHPS. However, these groups were looking at ways to use performance measures in the future. Medicare+Choice plans in the study sites also did not make any effort to educate beneficiaries about the report cards. When volunteers attending marketing presentations asked about HEDIS and CAHPS, no marketing agent provided accurate information about their plans' scores. Many did not know about HEDIS and CAHPS. Others simply referred beneficiaries to the Internet.

CONCLUSION

Case-study findings suggest that a full assessment of the effect of Medicare+Choice legislation needs more time. In the short term, the program has had both positive and negative results. On the positive side, the BBA initiated the beginning of what is likely to be a revolution in the education of Medicare beneficiaries. For the first time, consumers have available information on Medicare HMO quality. While efforts to educate Medicare beneficiaries are still in their infancy, HCFA's national educational campaign, hotline, and Internet site, and the agency's progress in making available quality-of-care information is likely to result in a more informed Medicare consumer. The BBA's strong consumer protections, although still new to both plans and enrollees, are also likely to result in improved enrollment decisions and better quality.

On the negative side, local market conditions, the financial vulnerability of some plans, and BBA-authorized reimbursement changes led to a large number of plan pullouts at the ends of 1998 and 1999. Moreover, the significant reductions in benefits and increases in premiums in both Cleveland and Tampa–St. Petersburg for 2000 compared with New York and Los Angeles are reflective of a system that provides more benefits to some Medicare beneficiaries than others. In the short term, plan withdrawals and premium increases and benefit cuts resulted in beneficiary anger and angst.

Both high voluntary disenrollment rates and high levels of member dissatisfaction in some plans portend poorly for the phase-in of lock-in beginning in 2002. While lock-in may make beneficiaries more accountable for their choices, it also puts vulnerable enrollees who are less able to make an informed decision about enrollment at risk. Finally, the lack of standardized benefit packages, some problems with plan marketing materials and presentations, and the instability of provider networks and drug formularies also undermines the ideal of informed choice.

Implementation of M+C occurred in a tumultuous health care environment. Antagonism between HMOs and physicians and hospitals is likely to continue to disrupt the Medicare market even without further program changes. Both beneficiaries and plans will need more time to digest fully BBA's changes to the Medicare program.

EARLY IMPLEMENTATION OF MEDICARE+CHOICE IN FOUR SITES: CLEVELAND, LOS ANGELES, NEW YORK, AND TAMPA–ST. PETERSBURG

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) changed the Medicare managed-care market significantly. The legislation:

- created Medicare+Choice (M+C), a new Part C of Medicare, to expand the health care choices available to beneficiaries;
- authorized the Health Care Financing Administration (HCFA) to undertake a new Medicare education initiative that includes the dissemination of M+C plan-comparison data and other information via an annual mailing, a toll-free telephone hotline, and an Internet site;
- required M+C organizations to adhere to new and stronger managed-care consumer protections;
- altered the way HMOs and other new M+C plans are reimbursed; and
- changed the enrollment and disenrollment rules, adding a lock-in requirement which will be phased in beginning in 2002.

To assess the effect of these changes and the current Medicare HMO market, project staff examined early implementation of Medicare+Choice in the Los Angeles, Tampa–St. Petersburg, New York City, and Cleveland metropolitan areas.[d] These case studies sought to assess:

- the education of beneficiaries about M+C;
- the marketing of Medicare HMOs to beneficiaries;
- market changes related to federal HMO reimbursement changes;

[d] The Commonwealth Fund funded the study of M+C in Tampa–St. Petersburg, Cleveland, and New York. The Los Angeles case study was funded by a grant from the California Wellness Foundation.

- plan, provider, and consumer perceptions of the impact of M+C consumer regulatory changes; and

- insurer interest in establishing new types of M+C plans.

The study sites were chosen based on variables that included minority representation in the Medicare population and the existence of Medicare HMOs in the market. Geographic diversity was also a consideration. A final important variable was the existence of a local community organization to help with the data collection and research.[e]

This report is based on information obtained during visits to the study sites in early 1999, follow-up phone interviews, a survey of newspaper and other printed materials, analysis of HCFA data, including enrollment/disenrollment data, and analysis of plan marketing materials and activities, provider networks, and benefit packages. During site visits and follow-up phone calls, project staff interviewed physicians and representatives of plans, hospitals, and consumers to get their impressions of the Medicare HMO market and implementation of Medicare+Choice.

MEDICARE+CHOICE MARKETS

Marketplace dynamics differed in each of the study sites, although all were in some state of transition.

Los Angeles

The Los Angeles market is in turmoil: The long history of managed care in the city has not resulted in a stable health care market. Los Angeles and the rest of California have developed a unique structure for the provision of managed care. For the most part, HMOs do not contract directly with physicians and hospitals; instead they contract with groups of physicians for a capitated rate. In turn, these groups contract with physicians and hospitals. Medical groups are put at direct financial risk.

Individual physicians and hospitals administrators in the Los Angeles market said they felt powerless. Most feel they cannot turn down managed-care contracts because of the oversupply of providers, the heavy reliance of employers on managed care to control costs, and the large number of Medicare beneficiaries in managed care. Therefore,

[e] In Tampa–St. Petersburg, project staff worked with the Florida State Department of Elder Affairs, Office of Volunteer and Community Services Serving the Health Insurance Needs of Elders (SHINE) and the Tampa Bay Regional Planning Council/Area Agency on Aging; Cleveland: the Coalition to Monitor Medicare Managed Care; New York: the Medicare Rights Center; Los Angeles: the Center for Health Care Rights.

physician groups contract with large numbers of HMOs, and individual physicians contract with a number of provider groups, as do hospitals. This practice leads to significant overlap and duplication of administrative functions and high administrative costs throughout the system. Physician, hospital, and medical group representatives all describe a health care system that is about to implode. The insolvency of two large medical groups in 1998 and 1999 and the precarious financial straits of many other groups may have a long-term impact on the way managed care is delivered in Los Angeles.[1]

Tampa–St. Petersburg

Contentious relations between providers and HMOs characterize this market. Medicare HMO enrollment has grown rapidly in the Tampa Bay area in the last few years despite modest Medicare reimbursement rates (table 1). However, this growth has occurred against a backdrop of HMO consolidations, payment disputes between plans and contracting providers, and HMO and hospital financial losses.[2] Here, Medicare HMOs generally contract with individual physicians instead of physician groups. Since 34 percent of the Medicare population is enrolled in M+C plans, Tampa–St. Petersburg physicians feel they have little choice but to contract with Medicare HMOs for rates below those of original Medicare. Efforts to band together to form physician–hospital organizations (PHOs) or the purchase of physician groups by practice management companies do not appear to have increased physicians' bargaining clout or proved a successful alternative to direct contracting with HMOs.

With the possible exception of the Columbia/HCA hospital system, hospitals also lack bargaining position in their negotiations with Medicare HMOs.[3] The Tampa–St. Petersburg area has an oversupply of acute-care hospital beds—70 percent above the national average.[4] Because Florida hospitals derive 46 percent of their admissions from Medicare, they cannot afford to terminate Medicare HMO contracts.[5] Like Tampa–St. Petersburg physicians, area hospitals prefer Medicare reimbursement to HMO Medicare payment rates. "Medicare is golden," remarked one Tampa Bay hospital executive.

One St. Petersburg insurance broker described this health care marketplace as a "war . . . between providers and managed-care companies, and they're always putting a gun to each other's head."[6]

Cleveland

Cleveland HMOs operate in a fairly complex health care environment dominated by two health systems—University Hospitals Health System and the Cleveland Clinic—that, together, have a virtual monopoly on hospital beds in Northeast Ohio.[7] University

Hospitals owns its own HMO and contracts with other HMOs in the community. Cleveland Clinic affiliates with a number of hospitals and their PHOs to form a "super PHO," which contracts with area HMOs. Member PHOs also contract separately with plans. The majority of Cleveland physicians are in group practice. HMOs contract with PHOs and large groups on a capitated rate. Discounted fee-for-service remains the dominant form of provider payment with the significant exception of Kaiser Permanente (the physician group affiliated with the Kaiser Foundation Health Plan), and the Cleveland Clinic, both of which pay physicians a salary.[8]

Physicians in Cleveland, as in other parts of the country, express dissatisfaction with HMOs, saying they increase the administrative burden and reduce their incomes.[9] Disputes over payment issues are increasing, as evidenced by the December 1999 termination of the contract between University Hospitals and its affiliated physicians and Prudential. This termination resulted in significant disruption in patient care.[10]

New York City

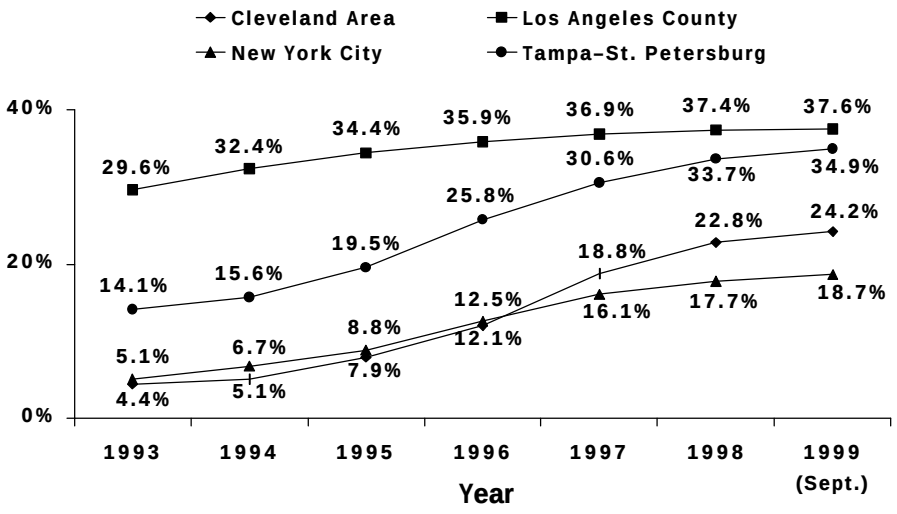
HMOs have been slow to grow in the five boroughs of New York City. New York State's hospital rate-setting system (discontinued in 1997), employers' lack of interest in HMOs, the dominance of prestigious academic medical centers, high marketing costs, and general distrust of HMOs have impeded their growth here. The dominance of New York City's academic medical centers and other teaching hospitals has resulted in a hospital-centered health care delivery system with a disproportionately large number of hospital beds and inpatient days per 1,000 population.[11] Hospitals prefer other payers to HMOs because of their higher reimbursement rates and administrative simplicity.[12] Although hospital-HMO relations are antagonistic, individual physicians seem less affected, primarily because HMO market penetration is relatively low. New York physicians tend to be in small group or solo practices, or are affiliated with New York's hospitals.[13] Most physicians contract with HMOs, although some "high-end physicians" won't accept managed-care contracts.

Nevertheless, there are conflicting views on the situation in New York: "I have never in my life seen a chorus of complaints like this by chief executive officers over the absolutely horrible practices of the HMO industry. If (HMOs) were considered bad actors before, it has gotten worse," says Kenneth Raske, president of the Greater New York Hospital Association. "It is easy for hospitals to sit back and say, 'It's not fair, and you're causing the problem,'" replied Dr. Osheroff , chief medical officer of Empire Blue Cross/Blue Shield. "It would be more helpful to acknowledge that hospitals could be more efficient."[14]

GROWTH OF MEDICARE+CHOICE PLANS

The growth of Medicare HMOs has been rapid in all of the study sites except for New York City (figure 1 and table 1).

Figure 1
Medicare Managed Care Market Penetration:
Four Study Sites, 1993–1999



Source: HCFA, Quarterly Managed Care Market Penetration Reports, 1993–1999.

Los Angeles's health care environment was particularly receptive—its long history of commercial managed care, coupled with a high Medicare payment rate ($647 per member per month in 1999) led to an influx of Medicare HMOs beginning in the mid-1980s. By September 1999, 37.6 percent of the Medicare population was enrolled in 12 Medicare+Choice plans, up from 29.6 percent in 1993.

In Florida, 34.9 percent of the Tampa–St. Petersburg area's Medicare population belonged to one of eight HMOs as of September 1999, up from 14.1 percent in December 1993. This growth is remarkable given the relatively late entrance of HMOs to the Medicare market in the area and modest reimbursement rates ($520 per member per month in 1999 in Pinellas County [St. Petersburg] and $506 in Hillsborough County [Tampa]). The first Medicare HMO in the region, International Medical Centers, began enrolling beneficiaries in 1985. It was later taken over by the state and sold to Humana in 1988 following a series of exposés about its Medicare program.[15] The area's second Medicare HMO did not enter the market until late 1993. Six additional HMOs began serving Medicare beneficiaries between 1994 and 1996; one entered the market in 1998, and one in 2000.

Table 1
1999 Medicare Reimbursement Rates, Number of Plans, and Market Penetration Rates: Four Study Sites

Site	Medicare Payment Rate	Number of Plans	Medicare HMO Market Penetration (9/99)
Los Angeles County	$647	12	37.6%
Tampa–St. Petersburg			34.9%
Hillsborough County (Tampa)	$506	8	35.0%
Pinellas County (St. Petersburg)	$520	8	34.8%
Cleveland Area			24.2%
Cuyahoga County (Cleveland)	$564	9	25.8%
Geauga County	$463	7	19.9%
Lake County	$493	6	28.8%
Lorain County	$505	5	13.8%
Medina County	$498	6	17.8%
New York City			18.7%
New York County (Manhattan)	$742	8	11.6%
Richmond County (Staten Island)	$798	7	31.8%
Queens County	$686	11	22.3%
Bronx County	$758	8	18.4%
Kings County (Brooklyn)	$734	8	17.9%

Source: HCFA, Quarterly Medicare Managed Care Market Penetration Reports, September 1999.

The Cleveland area has experienced an equally dramatic growth of M+C plans. With the exception of Kaiser Foundation Health Plan of Ohio, which began enrolling Medicare beneficiaries in December 1986, Medicare HMOs are also relatively new to the Cleveland area. Of the other eight Medicare HMOs in the area, three entered the market in 1994, two in 1996, two in 1997, and one in January 1998.[f] As of September 1999, 25.8 percent of the Medicare population in Cuyahoga County (Cleveland) was enrolled in nine M+C plans. M+C enrollments in the five-county Cleveland area increased from 4.4 percent in 1993 to 24.2 percent in September 1999.

Despite having some of the highest Medicare reimbursement rates in the country, the growth of Medicare HMOs in four of the five boroughs of New York City has been modest, especially in Manhattan. With the exception of HIP and Aetna U.S. Healthcare, Medicare managed care is relatively new to the New York market. Although Oxford began its Medicare program at the end of 1991, rapid increase in the number of Medicare HMOs did not occur until 1996. As of September 1999, 18.7 percent of Medicare beneficiaries in the five boroughs were in HMOs, up from 5.1 percent in 1993. Market

[f] Although HCFA records show SummaCare as beginning Medicare operations in 1996, the plan did not actually begin marketing until April 1, 1998.

penetration in the five boroughs ranges from 11.6 percent in Manhattan to 31.8 percent in Staten Island.

Because of turmoil in the Medicare HMO market, membership growth leveled off in the first nine months of 1999 in all four study sites.

COMPETITION

As table 1 shows, beneficiaries in the four study sites have a significant degree of choice among Medicare+Choice plans. Plan withdrawals (see discussion below) and consolidations affected beneficiary choice only minimally. "The market is flooded," noted one Tampa–St. Petersburg Medicare HMO executive in February 1999.

Medicare reimbursement changes, general market conditions, plans' financial troubles in all four study sites, and concerns over the implementation of risk adjustment dampened competition somewhat in 1999, especially in New York City and Cleveland.[16] Consumer groups in all study sites noticed a decline in plan advertisements and marketing presentations during the year. However, competition among plans remains intense, especially in Los Angeles, where most provider representatives interviewed for this study continue to rate the level of competition a 10 (on a scale of one to 10).

Despite the large number of Medicare HMOs in the study sites, enrollment is concentrated in two or three plans (figures 2a–2d). Kaiser Permanente and Prudential have 49 percent of the market in the Cleveland area; with Aetna's purchase of Prudential, the two plans will have 66 percent of that market. In Los Angeles, PacifiCare and Kaiser have 69 percent of the Medicare market; in New York, Oxford, HIP and Aetna have 80 percent, and in Tampa–St. Petersburg, Humana, Prudential, and Health Options (BC/BS) have 76 percent.

Figure 2
Medicare Managed Care Risk Market Share: Four Study Sites, September 1999

Figure 2a
Medicare Managed Care Risk Market Share: Cleveland, September 1999

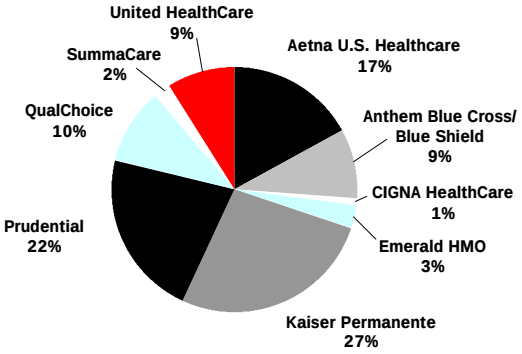


Figure 2b
Medicare Managed Care Risk Market Share: Los Angeles, September 1999

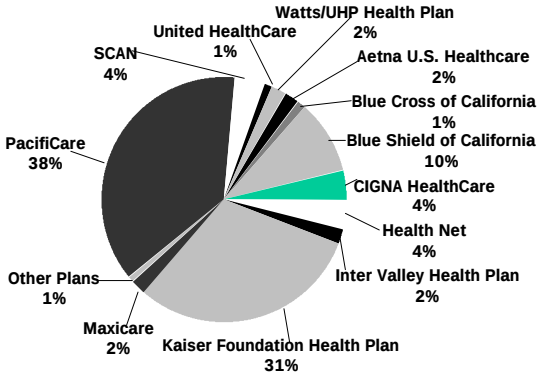


Figure 2c
Medicare Managed Care Risk Market Share: New York City (Five Boroughs), September 1999

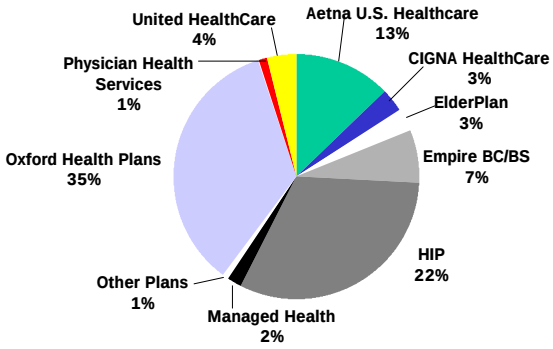
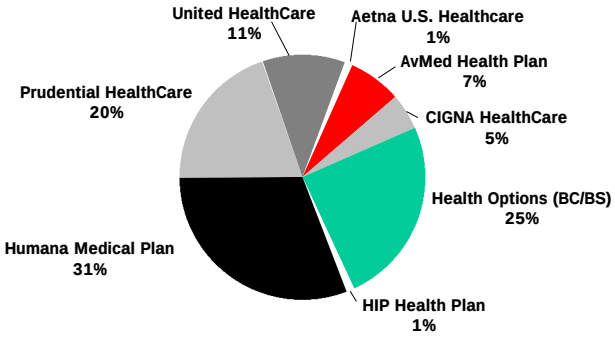


Figure 2d
Medicare Managed Care Risk Market Share: Tampa–St. Petersburg, September 1999



Source: HCFA, Quarterly Medicare Managed Care Market Penetration Reports, September 1999.

CHOICE

According to observers in all four study sites, many beneficiaries not only are able to handle this level of choice but also use it to their advantage. Plan and hospital representatives in Tampa–St. Petersburg commented on what one called "program surfers"—beneficiaries who switch plans when they reach their prescription drug benefit cap. In Cleveland, several HMO executives said that beneficiaries were "savvy" to the point that, according to one, they ask questions about whether a prescription drug benefit is based on the "average wholesale price."

At the same time, consumer and provider representatives in all the study locales felt that significant numbers of Medicare beneficiaries remain ill informed about HMOs and

how to pick a plan best suited to their needs.[17] "Which HMO is best?" or "which HMO do you belong to?" are questions Medicare consumers commonly ask of volunteers who work with Medicare counseling programs. In addition, high voluntary disenrollment rates within three months of enrollment for some Medicare HMOs (see below) indicate a continuing level of confusion about Medicare HMOs among some beneficiaries.

Some of this confusion may stem from the complexity of M+C plans' offerings. The availability of generous benefit packages, especially for prescription drugs, has fueled the growth of Medicare HMOs in the four study sites. A large and overlapping network of providers is also an incentive for beneficiary enrollment.

M+C Prescription Drug Benefit Packages

Many beneficiaries join Medicare HMOs because they can no longer afford the costs of Medicare supplemental policies and prescription drugs.[g, 18] However, despite their importance, the ways in which M+C plans structure their drug benefit packages are confusing.[19] "Medicare beneficiaries can't get a clear handle on the prescription drug benefit. They don't know how to figure it out," says a staff member of the Center for Health Care Rights in Los Angeles. "For example, they want to know how the prescription drug cap is calculated. They also have problems learning before they join a plan whether their prescriptions are on the plan's formulary."

The composition of drug benefits varies by brand versus generic drugs, formulary versus non-formulary drug policies, formulary structure, drug substitution policies, one-month versus three-month mail-order copayments, drug benefit caps, and the basis upon which these caps are calculated. In addition, the sheer number of benefit packages offered and the difficulty of collecting prescription drug information and presenting it in any kind of reasonable format takes significant effort. In Tampa–St. Petersburg, eight M+C plans offered 10 different Medicare benefit packages in 1999; in Manhattan, eight plans offered 22 different benefit packages; in Cleveland, nine plans offered 18 benefit packages; and in Los Angeles, 11 plans offered 12 benefit packages.

Even if beneficiaries could easily collect information on prescription drug benefits for all area plans, calculating the best benefit package for any individual is difficult, if not impossible.[h] Table 2 provides examples of how hard it is to compare prescription drug

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[g] They also join because their employer retirement plan contracts only with HMOs.

[h] HCFA's Medicare web site (www.Medicare.gov) provides a comparison of plans' costs, benefits, and quality indicators (see "Medicare Health Plan Compare"). However, the information on prescription drugs is limited. For example, the drug benefit information does not include plan policies on mail-order drugs, policies regarding mandatory substitution of generic for brand drugs, how prescription drug maximums are calculated, and, in some cases, whether plans have monthly or quarterly caps on their benefits. It also fails to provide clear information about plans' use of formularies.

benefit packages. None of the plans in the following examples charged a premium, but all might vary on other benefits (e.g., eyeglasses and hearing aids) or copayments (e.g., physician copayments).

Table 2
Examples of 1999 Prescription Drug Benefit Packages in the Four Study Sites: Which Prescription Drug Benefit Is Best?

Study Site	Examples of Prescription Drug Benefits Offered in 1999
Cuyahoga County (Cleveland)	*Which is the best value?:* CIGNA's unlimited generic benefit and $700 maximum on brand drugs (with a $10 copay for generic formulary and $20 for brand formulary) or SummaCare's $500 quarterly limit on generic and brand named drugs combined (with a $5 copay for generic formulary drugs and $15 for brand formulary drugs)? QualChoice's $50 a month no-copay benefit for a 60 day supply of drugs (with a 50% rollover of unused monthly allowance) or the plan's $250 per quarter benefit ($1000 yearly maximum) with a $250 rollover provision and copays of $8 for generic and $20 for brand name drugs, but no mail order benefit?
Tampa–St. Petersburg	*Which is the best value?:* BC/BS Health Options' unlimited generic (with a $3 copay) and $1000 brand maximum (with a $15 copay for brand formulary drugs and $30 copay for non-formulary drugs) or AvMed's $1500 cap for generic and brand drugs combined (with $7 copay for generic, $14 for brand formulary, and full price for 20 classes of brand drugs unless "medically necessary?")
Los Angeles	*Which is the best value?:* Aetna's unlimited generic (with a $6 copay) and $2000 brand maximum (with a $24 copay for formulary and $59 copay for non-formulary) or Health Net's drug benefit of $2000 generic and brand maximum with unlimited generic drugs after $2000 is reached and $5 copay for generic formulary drugs and $20 for brand formulary drugs?
New York County (Manhattan)	*Which is the best value?:* One of Aetna's Medicare products that offers an unlimited generic benefit and $1000 brand maximum with a $12 copay per prescription (and an undefined policy on formulary drugs) or Oxford's $1000 cap for generic and brand drugs combined with a maximum $500 carryover to the next calendar year and a $7 generic formulary copay and $25 brand copay?

Source: Medicare+Choice Plans' 1999 Summary of Benefits.

For example, some descriptions for Los Angeles M+C plans note that "If you do not use plan-approved drugs, your costs may be different." Does this statement mean that a formulary is used or not? Finally, in a few instances, information on "Medicare Compare" is at best misleading, and at worst inaccurate. For example, information on year 2000 benefits describes Aetna's Medicare 10 plan in New York City as providing the following: "Prescription drugs are covered with limits. You have an unlimited prescription drug benefit. There may be additional restrictions on your drug benefit. Contact plan for details." In fact, this plan provides no prescription drug benefit, although it does allow members to buy prescription drugs at a discount.

In part, the decision on which prescription drug benefit package is best depends on the particular drugs a Medicare consumer is taking. However, it is difficult to find out which prescription drugs are in which plans' formularies. Moreover, plans sometimes change formulary drugs during the year.[20]

Provider Networks

In addition to choosing an HMO based on plan benefits, beneficiaries must also weigh plan factors that include ascertaining whether or not their physicians contract with a particular plan and which hospitals are in which networks. To the extent that plan networks overlap, the decision to enroll in any particular plan is less consequential. Project staff analyzed the degree of overlap of primary care physicians, cardiologists, and hospitals in Manhattan, Cleveland, and St. Petersburg (table 3). The analysis was based on plans' provider directories and may not be accurate to the extent that these directories do not generally reflect recent network changes. Nevertheless, the analysis provides some sense of the overlap in provider networks. Because Los Angeles M+C provider directories list providers only by medical groups/IPAs, the Los Angeles analysis was at the medical group level.

Table 3
Provider Overlap in M+C Plans: Pinellas County (St. Petersburg), Cuyahoga County (Cleveland), and New York County (Manhattan)

Study Site	Directory Issue Dates	Number of Directories	Primary Care Physicians		Cardiologists		Acute Care Hospitals	
			Number [a]	% in plans	Number [a]	% in plans	Number [a]	% in plans
St. Petersburg	8/98-1/99	7 [b]	438	3+ plans: 52% 5+ plans:18%	86	3+ plans: 80% 5+ plans: 55%	13	3+ plans: 92% 5+ plans: 69%
Manhattan	8/98-2/99 (one plan 8/97)	8 pcp/hosp. 7 card.[c]	1433	3+ plans: 31% 5+ plans: 7%	443	3+ plans: 42% 5+ plans: 9%	22	3+ plans: 68% 5+ plans: 37%
Cleveland	9/98-5/99	8 pcp/card.[d] 9 hospitals	922	3+ plans: 59% 5+ plans: 29%	246	3+ plans: 72% 5+ plans: 49% [c]	13	3+ plans: 90% 5+ plans: 48%

[a] Number of contracting providers listed in analyzed provider directories.

[b] In Pinellas County, HIP was excluded from the analysis as it was not marketing to Medicare beneficiaries in 1999 because of a planned pullout from the market.

[c] One plan did not include a listing of specialists in its provider directory.

[d] Two Cuyahoga County plans do not include in their provider directories the addresses of their network specialists. For these plans, cardiologists were included in the data only if they were in the network of another Cuyahoga County Medicare HMO. Thus, this analysis may slightly overestimate the number of cardiologists in more than one HMO. Because Kaiser contracts with the closed panel Kaiser Permanente Medical group, it was excluded from the physician analysis.

As table 3 shows, there is significant overlap of provider networks, especially in St. Petersburg and Cleveland. The smaller overlap of providers in Manhattan is most likely a consequence of lower Medicare-HMO market penetration; Manhattan physicians can retain

much of their Medicare patient base without contracting with large numbers of HMOs. All of the HMOs in the three study sites had substantial network capacity, providing members with a broad choice of primary care physicians, specialists, and hospitals.

In Los Angeles, the perception that all medical groups/IPAs contract with all Medicare HMOs is not the case. Although the larger medical groups/IPAs contract with all or most of the Medicare HMOs in the county, many of the smaller, hospital-centered groups contract with fewer Medicare HMOs. Here, project staff analyzed the provider directories of seven HMOs. Of the 141 medical groups listed in seven Los Angeles County Medicare HMO provider directories, 50 percent contracted with only one plan, 35 percent contracted with three or more plans, and only 13 percent with five or more plans.

Los Angeles beneficiaries' choice of physicians and hospitals is limited more by their choice of medical group/IPA than their choice of HMO. Choice is further limited by the division of the larger medical groups/IPAs into subgroups based on geography. A single medical group/IPA might be divided into 15 subgroups, each formed around a single hospital, located throughout the county. For example, of the 96 medical groups and sub-groups listed by one Medicare HMO, only four include more than one "affiliated hospital." Although the vast majority of groups and sub-groups list more than 10 primary care physicians from which to choose, the choice of specialists is more restricted. Thus, while a medical group/IPA may be quite large and include hundreds of physicians and scores of hospitals located throughout Los Angeles County, its enrollees may have only one hospital and one or two specialists in several specialty areas from which to choose.

Some L.A. Medical Groups/IPAs Offer Little Choice of Providers

One sub-medical group located in western Los Angeles County offers enrollees a choice of 80 primary care physicians (family practice and internal medicine). However, it lists only one allergist, one audiologist, two cardiovascular surgeons, two ophthalmologists, one oral maxillofacial surgeon, one orthopedic surgeon, one medicine and rehabilitation physician, one plastic surgeon, two podiatrists, one pulmonary disease specialist, and one vascular surgeon.

Contract disputes in both Tampa–St. Petersburg and Cleveland, and medical group/IPA financial problems in Los Angeles have roiled the Medicare markets in these study sites and disrupted member–physician relationships.[21] Prudential's announcement in December 1999 that it would no longer contract with Cleveland's University Hospitals Health System and its associated 590-physician network significantly angered beneficiaries. In order to keep their providers, Prudential directed its 6,400 members to Aetna, its parent company. However, this option was unattractive to many of Prudential's members because Aetna had just raised its year 2000 premium to $91 a month for a plan offering

comparable prescription drug benefits. Cleveland's Emerald Medicare HMO announced a similar change, advising Medicare members that the Cleveland Clinic system would no longer participate in its plan.[22]

THE BBA's EFFECT ON PLAN PARTICIPATION AND BENEFIT PACKAGES

No new types of M+C plans entered the study markets in 1999. However, financial problems common to HMOs in general, local market conditions, and BBA-mandated reimbursement changes resulted in a large-scale defection of plans from Medicare and significant reductions in the benefits M+C plans offered. The impact of these changes varied by study site. The bankruptcy of several provider-sponsored organizations during 1999 and the lack of information systems infrastructure needed to contract directly with Medicare made large hospital systems, physician groups, and physician-hospital groups cautious about becoming Medicare provider-sponsored organizations. These groups also feared that Medicare HMOs would drop them from their commercial products if they competed for Medicare business.

Plan Withdrawals

Few M+C plans had pulled out of the study sites at the ends of December 1998 and 1999 (table 4). The ones that did withdraw had small enrollments and a limited share of the Medicare market. However, plan pullouts had a greater impact in counties neighboring New York City, Tampa–St. Petersburg, and Cuyahoga County. For example, all five M+C plans in the Tampa–St. Petersburg area withdrew from neighboring Polk County at the end of December 1998. Plans pulled out of other neighboring counties as well. Counties in the greater New York area also had several plan pullouts: three withdrew from Nassau County, four from Suffolk County, and six from Westchester County, affecting almost 50,000 Medicare beneficiaries in all.

Reasons for the pullouts varied. A number of New York City HMO executives interviewed for this study commented that, while medical costs in Nassau, Suffolk, and Westchester counties were equal to those of New York City, the Medicare payment rate was significantly lower. HMO representatives from the other study sites explained that they withdrew from some areas because they were unable to obtain favorable contracts from hospitals and physicians. Finally, the uncertainty associated with the phase-in of a risk-adjusted payment methodology made plans less willing to stay in counties where they were losing money.

"If a hospital has a monopoly," said a Tampa area HMO executive, "the AAPCC [Medicare payment rate] doesn't matter. The question was how much you lose and how long you want to lose it."

Table 4
1998–1999 Plan Withdrawals: Four Study Sites

SITE	Plan Withdrawals		Affected Beneficiaries	# of Plans: 1/2000
	12/98	12/99		
Los Angeles County	1	1	2,279	11
Tampa–St. Petersburg				
Hillsborough County (Tampa)	0	1	1,155 (total)	8[a]
Pinellas County (St. Petersburg)	0	1		8[a]
Cleveland Area				
Cuyahoga County (Cleveland)	0	1	6,077 (total)	8
Geauga County	0	2		5
Lake County	1	1		5
Lorain County	1	2		4
Medina County	0	0		6
New York City				
New York County (Manhattan)	2	0	4,619 (total)	8
Richmond County (Staten Island)	2	0		7
Queens County	2	1		10
Bronx County	2	0		8
Kings County (Brooklyn)	2	0		8

[a] Although HIP pulled out of Tampa–St. Petersburg at the end of 1999, a new M+C HMO began marketing at the beginning of 2000.

Changes in 1999–2000 Benefit Packages

Between 1999 and 2000, many M+C plans throughout the nation increased premiums, reduced prescription drug benefits, and generally cut benefit packages.[23]

Of the eight plans remaining in the Cleveland area in 2000, two increased premiums, seven increased physician copayments, four increased prescription drug copayments, and three decreased maximum coverage for prescription drugs. Aetna, the area's third-largest M+C plan, dropped prescription drugs from its $10-a-month plan and increased premiums to $91- and $107-a-month for its two other Medicare products.

Tampa–St. Petersburg M+C plans similarly increased premiums or reduced their benefit packages. Of the seven plans in the Tampa–St. Petersburg market in 1999 and 2000, five imposed or increased premiums, four increased physician copayments, and five increased enrollee cost-sharing for prescription drugs and/or reduced the maximum coverage for prescription drugs. In 2000, only three plans offered a zero-premium plan with a prescription drug benefit. Premiums in the other plans ranged from $10 to $118 a month.

High Medicare reimbursement rates in New York and Los Angeles, along with competitive pressures, kept benefit packages generous in both communities. In 2000, all Los Angeles plans continued to offer a zero-premium product with a generous prescription drug benefit. The two largest plans (Kaiser and PacifiCare) both increased physician and prescription drug copayments, but continued to offer an unlimited generic and brand formulary drug benefit. Similarly, in 2000, seven of eight Manhattan plans offered a zero-premium product with prescription drugs. Further, bucking the national trend, the two largest plans (HIP and Oxford) both increased their prescription drug benefit from 1999-2000 in their zero-premium products.

Effect on Beneficiaries

Plan withdrawals, premium increases, and benefit cutbacks distressed Medicare HMO enrollees. Beneficiaries who called the hotline of the Cleveland-area Coalition to Monitor Medicare Managed Care complained about having to switch plans, sometimes twice in two years, because of plan withdrawals and the loss of providers resulting from HMO-provider contract terminations. More than 300 beneficiaries turned up at a HCFA-sponsored information meeting held in January 2000 to discuss the contract termination between University Hospitals and Prudential.

"We are quite upset because we only have two weeks to find another insurer and my husband has a lot of medical problems," commented one Prudential enrollee after being notified that the HMO and University Hospitals and its clinic subsidiary could not agree on a contract. The *Cleveland Plain Dealer* reported the case of a husband and wife who lost their coverage in December 1998 when QualChoice scrapped its program in Lake County, Ohio. The couple signed on with CIGNA only to find out six months later that this HMO also was pulling out. "CIGNA made a big pitch about how they would take care of us. Now we find we are being abandoned. I don't know what we're going to do."[24]

Medicare HMO enrollees in Tampa–St. Petersburg flooded the help line for the Tampa Bay Regional Planning Council/Area Agency on Aging in December 1999 and early January 2000 with complaints about the increases in HMO costs and reductions in benefits.

MARKETING OF MEDICARE+CHOICE PLANS

Plan marketing presentations, which volunteers and staff members of local organizations attended in the study sites, were generally accurate, but some left out important information. Project staff also analyzed plan marketing activities and materials to assess the degree to which they supplied comprehensive and accurate information to prospective Medicare HMO enrollees

Marketing Presentations

Few HMOs held presentations in the early months of 1999 when the marketing visits were planned in Tampa–St. Petersburg, Cleveland, and New York. Volunteers and staff attended a total of 16 marketing presentations: Representatives of the Tampa Bay Area Agency on Aging attended four; members of the Coalition to Monitor Medicare Managed Care attended seven; and volunteers and staff from the Medicare Rights Center attended five. Volunteers from the Center for Health Care Rights attended 13 Los Angeles marketing presentations from October 1999 to January 2000.

Sins of omission rather than commission generally marked presentations in Cleveland, Tampa–St. Petersburg, and especially New York City and Los Angeles. With the exception of one Los Angeles presentation, marketing agents did not exert pressure on beneficiaries to enroll. (At the Los Angeles presentation, the presenter "aggressively urged immediate enrollment" in the HMO, telling attendees to "drop other HMOs quickly.") All presenters clearly explained the need to use network providers, but two failed to explain the role of the primary care physician as gatekeeper. Presenters left out other important information as well. For example, presenters described the M+C appeals process in only 59 percent of the presentations, gave the prudent layperson definition of *emergency* in 38 percent, and described the BBA's direct access to a woman's health care provider provisions in 62 percent of the presentations attended (table 5). In response to a question about plan withdrawals, a CIGNA representative in Cleveland promised that his plan would not withdraw from the area. Later in the year, CIGNA did exactly that.

In New York, two presenters included some questionable statements about the "government" and original Medicare.

"Because Medicare can't handle the funds, they had to let people in private industry handle them," said one New York marketing agent. "The government has been losing money on Medicare because doctors are ripping them off," said another. After attending a complex, rushed presentation in New York on prescription drug copayments and maximum drug benefits, a Medicare Rights Center attendee commented that she thought she was in a "calculus class."

Table 5
Summary of Analysis of Marketing Presentations:
Four Study Sites, Selected Indicators

Study Site	Tampa–St. Petersburg	Cleveland Area	New York City	Los Angeles County	All Four Sites
Number of Presentations Attended	4	7	5	13	29
	Percentage Providing Correct Information				
Enrollees Must Use Network Providers	100%	100%	100%	100%	100%
Role of PCP as Gatekeeper	100%	100%	100%	85%	93%
Direct Access to Woman's Health Care Provider	100%	100%	40%	39%	62%
Prudent Layperson Definition of Emergency Care	100%	71%	20%	8%	38%
No Prior Authorization Required for Emergency Care	75%	100%	20%	62%	66%
Premiums Could Increase/Benefits Could Decrease in 2000	50%	43%	80%	69%	62%
Process to Obtain Out-of-Area Urgent Care	100%	100%	40%	77%	79%
What to Do If Problem with HMO or Health Care (Appeals)	75%	86%	20%	54%	59%

Marketing Materials and Provider Directories

All M+C plan marketing materials must be approved by HCFA. Despite this requirement, an April 1999 General Accounting Office (GAO) report found that, of 16 plans studied, all supplied information to prospective enrollees and current members that contained inaccurate and incomplete benefit information. The GAO also reported that plans were distributing outdated information.[25] A February 2000 report by the Health and Human Services Office of the Inspector General found that Medicare HMO marketing packages often failed to meet federal requirements.[26] The analysis of plan marketing literature that M+C plans distribute in the four study localities showed a range of similar problems (table 6).

Onsite project partners collected plan marketing materials—member handbooks, marketing brochures, and benefit summaries—at marketing presentations, or made follow-up calls to request them. In addition, project staff called M+C plans from which materials had not been received. Even then, some plans failed to provide a marketing brochure or

member handbook. These HMOs were excluded from the following analysis of marketing materials from 30 plans. Table 6 provides a summary of key pieces of information that were (or were not) included in these packages.

Table 6
Analysis of M+C Member Handbooks/Summary of Benefits:
Four Study Sites, 30 Plans

	Number of Plans Where Indicator Was Present	Percent of Total Plans
Eligibility: explicitly states the under-65 disabled included	7	23%
Eligibility: explicitly states may not exclude for preexisting condition	21	70%
Enrollment first of following month	10	33%
States specifically you do not lose Medicare	12	40%
Care through network providers	30	100%
Primary care physician as gatekeeper	30	100%
Right to change primary care physician	28	93%
Direct access to ob/gyn	26	87%
Emergency care: no prior authorization required	29	97%
Emergency care: gives prudent layperson definition	26	87%
Out-of-area care "urgent" care definition	26	87%
May be out of area for year and remain enrolled	26	87%
Prescription drugs: copays and caps	30	100%
Describes prescription drug plan (formulary and non-formulary)	30	100%
Bone mass measurements	9	30%
Diabetes monitoring	9	30%
Self referral for mammography	22	73%
Colorectal cancer screening	12	40%
How to disenroll	28	93%
Disenrollment effective the first day of following month	22	73%
Medigap: (1) keep until enrolled or (2) keep for 3 months to make sure satisfied	21	70%
Medigap: explains state or federal rules for Medigap purchase after disenrollment	4	13%
Appeals process	24	80%

Source: Georgetown University Institute for Health Care Research and Policy analysis of Los Angeles, California's, Cleveland, Ohio's, New York, New York's, and Tampa–St. Petersburg, Florida's M+C Plans Marketing Materials collected January–August 1999.

Several plans omitted critical information from their marketing literature. Often missing was information about self-referrals to a woman's health care provider and for mammography. Few plans explicitly stated that disabled Medicare beneficiaries under age

65 were eligible to enroll, and few explained that beneficiaries do not lose Medicare when they join an HMO. Plans also did a poor job when describing the new BBA preventive care benefits.[i] Of greatest concern was the lack of information about the appeals process in 20 percent of the materials reviewed.

The manner in which written information was presented varied dramatically. Some plans did an excellent job; others failed to provide information in a clear, easy-to-read format. Furthermore, some plan packets include materials that are clearly outdated. In several instances, the information in individual pieces sent in the same packet conflicted because of differences in the dates when materials were revised.

Examples of Inaccurate, Conflicting, or Confusing Information in Plan Marketing Materials

One HMO gave conflicting definitions of *emergency*: its "Member's Handbook" contained the "prudent layperson" definition, but the plan's "Evidence of Coverage" presented an older (and incorrect) definition.

Several plans failed to use HCFA's definition of *out-of-area urgent care*. One plan's materials incorrectly stated that "urgently needed care resulting from an unforeseen illness *may* also be covered outside of your home area." [emphasis added].

A national plan advised beneficiaries to "hold on to your federal Medicare ID card for senior discounts at restaurants, movies and transportation and for general identification purposes." Although not technically incorrect, this sentence undermines the important point that the beneficiary remains in the Medicare program even though he or she has joined a Medicare+Choice plan.

One plan's marketing brochure noted that the member was "covered by prescriptions prescribed by your … [plan] physician." However, the summary of benefits explained that "you are covered for prescriptions dispensed according to either the … preferred drug list or brand-name drugs not on the preferred prescription drug list (unless excluded in your member policy/certificate of coverage)."

One plan incorrectly implied that original Medicare requires beneficiaries to pay something for home health care (currently there are no copayments for home health benefits), and that the plan would provide full coverage for home health care. In a table that compares original Medicare benefits with the HMOs, a box is checked off indicating that the plan, but not original Medicare, provides "Full coverage of home health care … at no cost to you." "Full coverage" implies far more home health services than either Medicare or M+C plans provide.

Provider directories were also problematic. As table 7 shows, a number of plans failed to provide critical information about contracting physicians, including languages

[i] Plans may not have had the opportunity to redo their marketing materials to reflect BBA changes by the first six months of 1999 when the materials were collected. However, plans had from 1997, when the BBA was passed, to learn about BBA changes and benefits and include them in their 1999 marketing materials.

spoken, hospital affiliation, and board certification. Less than 50 percent of the packages reviewed listed contracting nursing homes and home health agencies.

Table 7
Analysis of M+C Provider Directories, 34 Plans

	Indicator Present	Percent of Total Plans
Primary Care Physician Director Listings		
Board Certified	15	44.1%
Physicians with Closed Practices	25	73.5%
Languages Spoken	18	52.9%
Hospital Affiliation	23	67.7%
Specialist Directory Listings		
Board Certified	13	38.2%
Physicians with Closed Practices	14	41.2%
Languages Spoken	11	32.4%
Hospital Affiliation	16	47.1%
Hospital Listings	34	100.0%
Nursing Home (SNF) Listings	14	41.2%
Home Health Agency Listings	14	41.2%

Marketing to Low-Income, Minority, and Disabled Beneficiaries Under Age 65

BBA marketing regulations explicitly state that plans must market to the under-65 disabled Medicare population as well as to minority beneficiaries. Specifically, M+C plans must demonstrate that marketing resources are allocated to the disabled Medicare population, and that they do not engage in discriminatory marketing activity, and they must translate materials in communities with a "significant non-English speaking population." It was not possible to assess the degree to which M+C plans in the study sites market to the disabled Medicare population. Plan executives interviewed for this study noted that it was difficult to market to the under-65 group, but that their under-65 Medicare membership reflected the proportion of those younger than 65 in the Medicare population.

Nonetheless, plans' marketing materials, as well as the names chosen for their Medicare products, suggest they need to make additional efforts to reach out to the under-65 population. Only 7 of the reviewed packages of marketing materials state explicitly that beneficiaries under age 65 are eligible to join; other plans simply note that all Medicare beneficiaries with Parts A and B are eligible without specifically referencing those under 65 (see table 6). Only six of the 30 plans' marketing packages (20%) included a picture of a man or woman in a wheelchair who appeared younger than 65. Moreover, many plans market under names that imply they are open only to seniors. Plans reported that they

were beginning to modify their marketing materials to include pictures of disabled beneficiaries younger than 65.

Names of M+C Plans

New York City: Choice Senior Plan, Golden Medicare Plan, Healthcare Seniors, Senior Health, 65 Plus, and Select 65.

Los Angeles: Senior Secure, 65 Plus, Healthcare for Seniors, Seniority Plus, Services to Seniors, Senior Advantage, Max 65 Plus, Secure Horizons, and Health Care for Seniors.

The project was also unable to assess the extent to which Medicare HMOs market to minority Medicare populations. Most plans in the four study sites included photographs of minorities in their marketing materials. Moreover, plan representatives in study localities with large numbers of Hispanic elderly people—Tampa–St. Petersburg, New York, and Los Angeles—said they were translating materials into Spanish and using bilingual staff at call centers. However, calls to request translated marketing materials were not fruitful. Despite repeated attempts to obtain it, only seven of 26 plans (27%) in the three study sites sent any Spanish language material. Four of 11 Los Angeles plans sent translated matter; one of six that were contacted in Tampa–St. Petersburg sent translated marketing information; and two of nine New York plans responded to request calls made in Spanish by sending Spanish language information. In several instances, it was impossible to get through to a representative who even knew whether translated publications were available. In other cases, materials were promised but never sent.

Calls to the major minority newspapers in the four study sites revealed that few M+C plans advertise in these papers. For example representatives of New York's *Amsterdam News,* the city's major African-American newspaper, and *El Diario,* the major Puerto Rican newspaper, each recalled only one Medicare HMO that had advertised in their papers. According to representatives from both the *Sentinel* and *La Gaceta* (African-American and Hispanic newspapers in Hillsborough County, Florida), no Medicare HMO had ever placed advertisements in their papers. Nor has any Medicare HMO ever advertised in the *Call and Post,* northern Ohio's oldest and most respected African-American newspaper. By contrast, a number of plans had advertised in several of the Los Angeles County's minority newspapers.

Although most plans continue to use trained staff to market their product, a few are beginning to use private insurance agents for referrals. In Tampa–St. Petersburg, for example, one HMO relies on individual, insurance company–trained agents; the HMO itself has no marketing staff in the community. Another Medicare HMO pays a $100- to $200-per-enrollee referral fee to private independent insurance agents when their referral

leads to an enrollment. In New York, at least two HMOs pay a commission for referrals from private insurance agents. One of these plans pays a $300 commission for each referred beneficiary who enrolls and remains in the plan for 90 days. (One insurance agent described this fee as "one hell of a commission.") A few Los Angeles plans pay individual insurance agents for each enrollment (not just a referral) and tie compensation to a retention requirement.

During the study period, a private for-profit organization expanded its operations from Boca Raton, Florida, to the Tampa–St. Petersburg area, offering beneficiaries free help with choosing a Medicare plan. Some, but not all, area plans paid the organization for each referral. Consumer advocacy groups and several HMOs questioned the process the organization used to advise callers, and also whether it restricted referrals to plans that paid the referral fee. Plans that did not contract with the entity did not get referrals.[27] The organization closed its Tampa Bay office in April 1999, but continues to operate in Boca Raton under a different name.

DISENROLLMENT AND LOCK-IN

Currently, Medicare beneficiaries can quit their HMOs at any time. This will change when Medicare phases in an annual one-month enrollment period and lock-in beginning in 2002. The way in which beneficiaries receive this change will depend in part on how satisfied they are with the HMOs they are enrolled in at the time.

Voluntary Disenrollment Rates

One way to measure enrollee satisfaction and the adequacy of marketing campaigns is by an analysis of voluntary disenrollment rates. In April 2000, HCFA provided 1998 and 1999 voluntary disenrollment information on its website (www.Medicare.gov).[j] Project staff, meanwhile, used data provided by HCFA separately to calculate rapid-disenrollment rates and the percentage of those 80 and older who disenrolled for 1998 and the first six months of 1999 (table 8 and figures 3a–3d).[k] High rates of voluntary disenrollment may stem from market conditions, marketing inadequacies, or quality-of-care issues. A high rapid-disenrollment rate is often an indication that newly enrolled beneficiaries did not understand the implications of enrollment or that marketing agents provided inadequate information about enrollment or about the plan. A high percentage of disenrollment for those 80 years and older might indicate either problems with providing adequate care to beneficiaries with high medical needs or encouragement of high-need patients to quit the HMO.

[j] Voluntary disenrollments include Medicare beneficiaries who leave an HMO during the year for reasons other than death, loss of Medicare eligibility, a move out of the area, or plan closure.

[k] Rapid disenrollment includes Medicare beneficiaries who (1) sign an application but cancel before enrollment becomes final, or (2) voluntarily leave a plan within 3 months of enrollment.

Table 8
Disenrollment Rates in the Four Study Sites: 1998 and 1999 [a]

Study Site	Voluntary Disenrollments[b]		Rapid Disenrollments[c]		Percentage Disenrollees 80+	
	State Average	Range	Average	Range	Average	Range
Tampa–St. Petersburg						
1998	14%	11%–18%	17.3%	13.4%–32.3%	20.8%	14.8%–23.3%
1999	24%	10%–62%	26.6%[d]	9.2%–64.3%[d]	22.8%[d]	13.2%–28.5%[d]
Cleveland Area						
1998	12%	5%–22%	14.0%	9.5%–48.8%	17.0%	15.5%–21.9%
1999	13%	4%–37%	21.8%[d]	9.6%–42.9%[d]	17.2%[d]	14.5%–23.0%[d]
New York City						
1998	13%	6%–27%	8.4%	1.6%–54.5%	14.0%	11.8%–29.6%
1999	10%	6%–26%	26.7%[d]	2.2%–72.3%[d]	17.8%[d]	16.3%–33.5%[d]
Los Angeles						
1998	9%	2%–23%	21.4%	7.3%–49.2%	24.6%	16.6%–35.2%
1999	9%	2%–27%	21.1%[d]	4.3%–63.6%[d]	24.7%[d]	14.7%–31.8%[d]

[a] Disenrollment rates data are for the geographic area covered by plans' contracts and are often geographically larger than the study site areas. For example, in Los Angeles, some M+C plan contracts cover a number of Southern California counties.

[b] The percentage of a plan's average yearly membership who voluntarily leave the plan during the year. It does not include people who were disenrolled because of ineligibility, death, plan withdrawals, or a move out of the area.

[c] Medicare beneficiaries who sign an application but cancel before enrollment becomes final or voluntarily leave within three months of enrollment.

[d] January 1999–June 1999.

Source: Voluntary disenrollment rates were obtained from "Medicare Health Care Compare" at www.Medicare.gov. Rapid disenrollment rates and percentage of disenrollees 80 years and older are from HCFA, Monthly Disenrollment Patterns Report, 1998, and January–June 1999.

Disenrollment data may indicate a problem if:

- plans have high disenrollment rates for more than one year;
- a plan's disenrollment rate or percentage of those 80 years and older who disenroll is significantly higher than that of other plans in a community; or
- a plan has both a high disenrollment rate and a high rapid-disenrollment rate.

Disenrollment rates are often influenced by market conditions, i.e., when plans change premiums, benefits, or provider networks. Plan features also influence these rates. For example, New York's ElderPlan and Los Angeles's SCAN are both Social HMOs

Figure 3
1999 Average Voluntary Disenrollment Rates: Four Study Sites

Figure 3a
Cleveland, Ohio

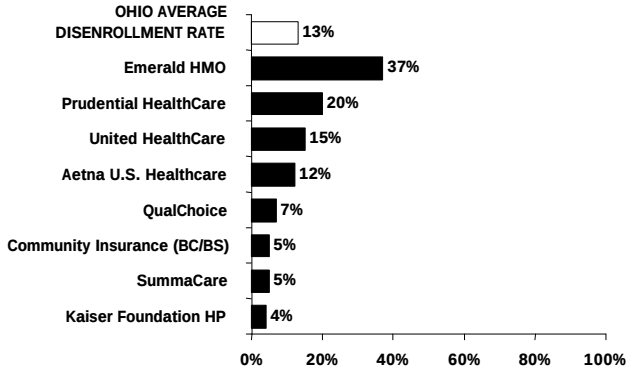


Figure 3b
Los Angeles, California

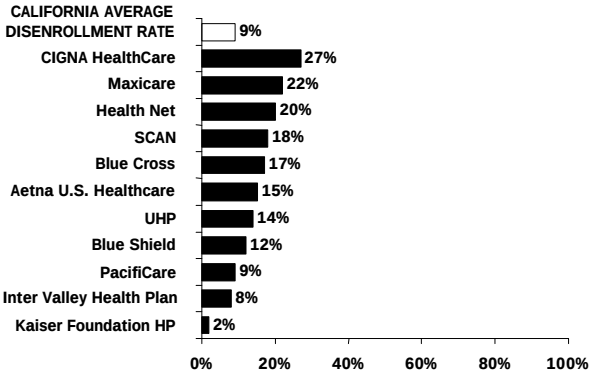


Figure 3c
New York, New York

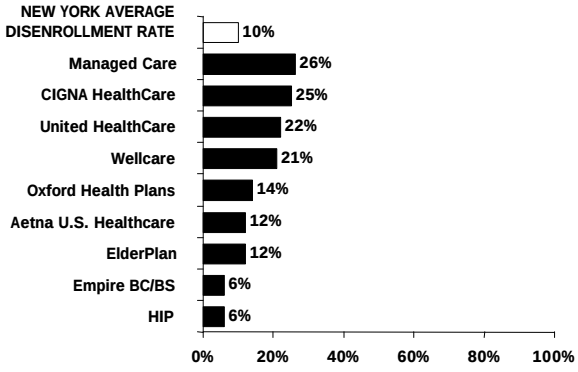
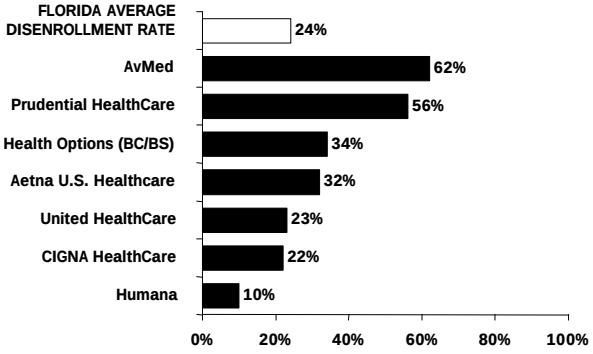


Figure 3d
Tampa–St. Petersburg, Florida



Source: HCFA, "Medicare Health Plan Compare People Leaving Medicare Results," <http://www.Medicare.gov/mphCompare/Search/PeopleLeaving.asp>, accessed May 2000.

that offer added long-term care benefits and do not enroll beneficiaries younger than 65. Thus, it would be expected that their members and those who disenroll would be older than those of other plans. The HCFA-imposed enrollment freeze on Oxford for the second half of 1998 influenced that plan's disenrollment and rapid-disenrollment rates.

With the exception of 1999 rates for Tampa–St. Petersburg, disenrollment rates do not indicate any major marketing problem in the four sites, even though a few plans in Cleveland, New York, and Los Angeles continue to have disenrollment rates of more than 20 percent. On average, there was significantly more churning of enrollees in Tampa–St. Petersburg than in the other study sites. Analysis of the rates in each study site found:

Tampa–St. Petersburg area: Disenrollment rates increased in Tampa–St. Petersburg from 1998 to 1999 for all but one M+C plan. In some cases, the

increase was dramatic: Aetna's disenrollment rate increased from 11 percent to 32 percent, AvMed's from 14 percent to 62 percent, and CIGNA's from 13 percent to 22 percent. Of the eight reporting plans, four had disenrollment rates of more than 30 percent in 1999 and six had disenrollment rates of more than 20 percent. High disenrollment rates may be the result of the significant benefit reductions announced by some plans in late 1999. No plans had both high voluntary and high rapid-disenrollment rates in 1998 and the first half of 1999. The higher percentage of older members who quit their plans may be explained by Pinellas County's (St. Petersburg) high proportion of older beneficiaries.

Cleveland area: In 1999, Cleveland-area plans had the lowest disenrollment rates among the four study sites. In 1998, no plans and in 1999 only one small plan had a disenrollment rate of more than 30 percent. SummaCare, Kaiser, and QualChoice had the lowest disenrollment rates during both years.

New York area: No plans had voluntary disenrollment rates of more than 30 percent in 1998 and 1999. However, in 1999, seven of nine reporting plans had disenrollment rates above the state average of 10 percent, and four plans had rates over 20 percent. In 1999 Empire Blue Cross and Blue Shield and HIP Health Plan had the lowest disenrollment rates. There was greater variance among plans in the age of New Yorkers who disenrolled than those who disenrolled in the other study sites. In 1998, more than 27 percent of those who disenrolled from three plans were 80 and older compared with less than 16 percent in three other plans.

Los Angeles area: In 1998 and 1999, no plan had a voluntary disenrollment rate of more than 30 percent, although three plans had a rate of 20 percent or greater in both years. Of the 11 reporting plans in 1999, eight had disenrollment rates above the state average of 9 percent. In 1998 and 1999, Kaiser Permanente and PacifiCare—the two largest plans—along with Inter Valley Health Plan had the lowest disenrollment rates. Kaiser Permanente's disenrollment rate of 2 percent in both 1998 and 1999 was the lowest among the four study sites. The higher percentage of elderly people who disenrolled in Southern California (compared with the other study sites) most likely reflects an older Medicare HMO population.

Implications for Lock-In

Beginning in 2002, most beneficiaries will be locked into the plan of their choice for the last nine months of the year. Continuing high disenrollment rates for some plans and the large number of beneficiaries who change plans or who return to original Medicare during

the year has implications for the way M+C lock-in provisions will be received. For example, more than 108,000 Medicare HMO members in New York City quit their plan in the last nine months of 1998.

Interviewees in the four study sites were of mixed opinion on the impact of lock-in. Some HMO executives felt that it would lend stability to the market, allow plans to improve care for members, and make beneficiaries more accountable for their plan selection and use of health services. Other HMO representatives were less sanguine, fearing that lock-in would make beneficiaries "nervous" about joining an HMO and result in "dissatisfied members" who felt "trapped." Continuous open enrollment, they felt, keeps HMOs "on their toes." Consumer group representatives in the four study localities argued that continuous disenrollment was "one of the most important HMO consumer protections," a "safety valve" for beneficiaries who don't like their plan. They also felt that lock-in puts the least sophisticated beneficiaries at a disadvantage because they might join a plan without fully understanding the new disenrollment rules.

EDUCATING MEDICARE BENEFICIARIES ABOUT M+C

HCFA's M+C educational initiative can only be assessed over the long term. In the short term, the agency's initial efforts had mixed results.

Medicare & You Mailings

The first HCFA mailing of M+C educational material took place in October 1998, when the agency sent a 55-plus page *Medicare & You* handbook to consumers in five states—Arizona, Florida, Ohio, Oregon, and Washington. Medicare beneficiaries in the other states, including New York and California, were sent an 8-page *Medicare & You* bulletin.

There was little response to the first *Medicare & You* handbook in either Tampa–St. Petersburg or Cleveland. According to one Cleveland area HMO executive, HMOs were "underwhelmed by calls." Physicians also noted little patient interest in the handbook. One industry interviewee described it as "long and cumbersome," and several others said it was "confusing." Organizations working with Medicare beneficiaries received few calls about the handbook, although they were overwhelmed with calls about plan withdrawals. By contrast, the bulletin, which contained five simple pieces of information and prominently displayed the phone numbers of the State Health Insurance Assistance

Programs (SHIPs), resulted in an avalanche of calls to New York's Medicare Rights Center and Los Angeles's Center for Health Care Rights.[l]

Medicare beneficiaries generally found the second *Medicare and You* handbook, mailed in October 1999, easy-to-read and informative.[28] The year 2000 handbook prominently displayed each state's assistance (SHIP) phone line, which increased calls to SHIP programs in the four study sites. Again, however, calls about plan withdrawals and premium increases/benefit decreases overshadowed any beneficiary response to the handbook.

HCFA's Toll-Free Medicare+Choice Hotline

HCFA made its 1-800-MEDICAR(E) hotline available to beneficiaries in five states in November 1998, expanding access to beneficiaries in other states in early 1999. Volunteers from the Tampa–St. Petersburg and Cleveland study sites called to the hotline between November 1998 and March 1999 to assess the accuracy of hotline staff responses to seven test questions. New York calls were made between April and June 1999, Los Angeles calls between June and August 1999. New York and Los Angeles callers asked five test questions that were slightly different from those used in Cleveland and Tampa.

A total of 91 hotline calls were made in the four areas. Response accuracy varied by question. For example, 100 percent of callers who asked why they received the *Medicare & You* handbook and what response was necessary were correctly told that "if you are happy with your current coverage, you do not have to do anything." However, hotline staff provided less accurate responses to a number of other questions. They responded correctly to questions about new guaranteed-issue Medigap protections only 40 percent of the time, and to questions about denials of service, 64.3 percent. Overall, hotline staff responded correctly to 51 of the 91 calls made from the four study sites. Thus, callers received the correct information only 56 percent of the time.

IMPLEMENTATION OF M+C CONSUMER PROTECTIONS

The BBA includes a number of new and important M+C consumer protections. Plan executives interviewed for this study saw many of these new consumer protections as

[l] Representatives of the elderly in Asian communities in both Los Angeles and New York City noted that many of their agency's clients couldn't read the brochure and simply ignored it. This was not the case for some low-income Hispanic elderly in New York. Beneficiaries, whose families had been affected by the welfare-to-work legislation and changes in immigration law, worried that they had to respond to the government mailing in some fashion. A New York organization that works with the Hispanic elderly had to reassure its clients that they did not have to mail something to the government in order to keep their Medicare.

positive. For example, one executive felt that changes in the appeals timelines were "one of the best parts of the Act," and "in the interests of the members." Plan representatives also noted that they had already implemented some BBA provisions, such as direct access to obstetricians–gynecologists and health assessments of new members.

However, the provisions did not meet with uniform praise. Said a Los Angeles HMO executive: "Meeting the M+C regulatory requirements has been a significant undertaking, involving a tremendous amount of work and high administrative costs." Specifically, plan representatives complained that requiring enrollment by the first day of the month after signing an enrollment form was very difficult to implement[m] and that providing continuity of care for enrollees who are out of the area for up to a year was problematic. Also, although plan representatives had no problem with most of the consumer protections taken separately, they felt that the totality of the changes were administratively costly to implement.

Some of the new regulations had not been put into effect because of lack of direction from HCFA. For example, the agency is requiring plans to submit a quality-assurance action plan that includes a discussion of how they will meet cultural competency and other quality-of-care requirements. At the time of the site visits, plans were awaiting guidance on what it means to provide services in a "culturally competent manner."

A BBA mandate that needs additional plan attention relates to disclosure of plan information. As noted, it proved difficult to obtain member-marketing materials and impossible to determine whether these materials had been translated into Spanish.

QUALITY OF CARE

Plans and their contracting providers differ on their perception of whether M+C plans improve care for Medicare beneficiaries. Plan executives believe that their disease-management programs, quality-improvement activities, and ability to weed out poor-quality physicians lead to better care for beneficiaries compared with fee-for-service Medicare. They also argue that they improve quality by providing bonuses when contracting providers perform above a certain level.

[m] The Balanced Budget Refinement Act of 1999 modified this requirement. Beginning January 2000, beneficiaries who sign up for an HMO on or before the 10th of the month will be enrolled in the HMO beginning the next month. Enrollments received after the 10th of the month will be delayed by a month. Thus, if a beneficiary enrolls on January 9, enrollment will be effective February 1; if a beneficiary enrolls on January 11, enrollment will be effective March 1.

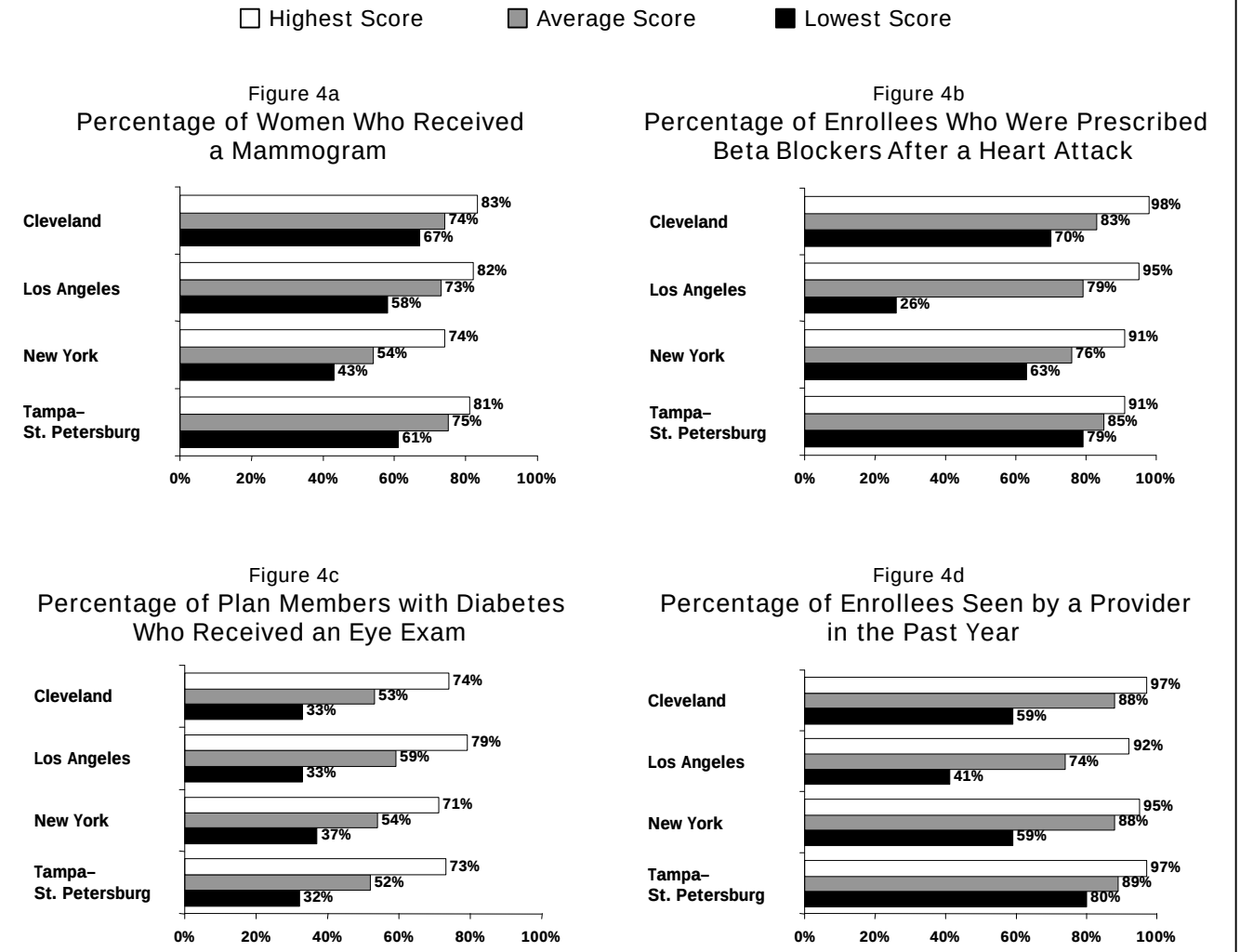
Contracting providers in all the study sites questioned this assumption. One Tampa area physician felt there was no difference in quality of care among the Medicare HMOs with which he contracts and that HMOs aren't selective in contracting decisions. HMOs new to the area, for example, will send a contract to all area physicians and, he added, if HMOs are educating physicians on best practices, "they don't tell us." A Cleveland doctor echoed these sentiments, arguing that plans can't "recognize poor-quality providers," and don't appear to turn down physicians because of poor quality. A Los Angeles physician noted that "primary care physicians do things the way they want to do things," and that it is difficult to impose programs on doctors who are not in your direct employ. Physicians in New York and Los Angeles noted that some HMOs send them practice profiles and some don't, and that because the profiles often cover such a small number of patients, doctors can't tell anything from them. Hospital administrators in the study sites also felt that HMOs contract based on costs, not quality.

One Los Angeles doctor felt that managed care has reduced time spent with patients. "Overly hassled PCPs refer to hassled specialists, who refer back to hassled PCPs," he complained.

Quality Indicators

The BBA requires HCFA to collect and publish a range of performance and enrollee satisfaction measures. HCFA published its first set of these M+C quality measures (the Health Plan Employer Data and Information Set, or HEDIS, and the Consumer Assessment of Health Plans Survey, or CAHPS) on its web site (www.Medicare.gov) in March 1999. In August of that year, the agency published results of its second M+C enrollee satisfaction survey and, in September, the results of its second HEDIS report. The performance measures show some substantial differences among plans and among study sites (figures 4a–4d and 5a–5d). For example, in the Cleveland area, only 33 percent of Emerald HMO enrollees with diabetes received regular eye exams compared with 74 percent of Kaiser enrollees. Similarly, only 37 percent of CIGNA HealthCare of New York enrollees with diabetes received an eye exam compared with 71 percent of Healthfirst 65 Plus enrollees.

Figure 4
1998 HEDIS Data: High–Low Ranges and Average Scores, Four Study Sites



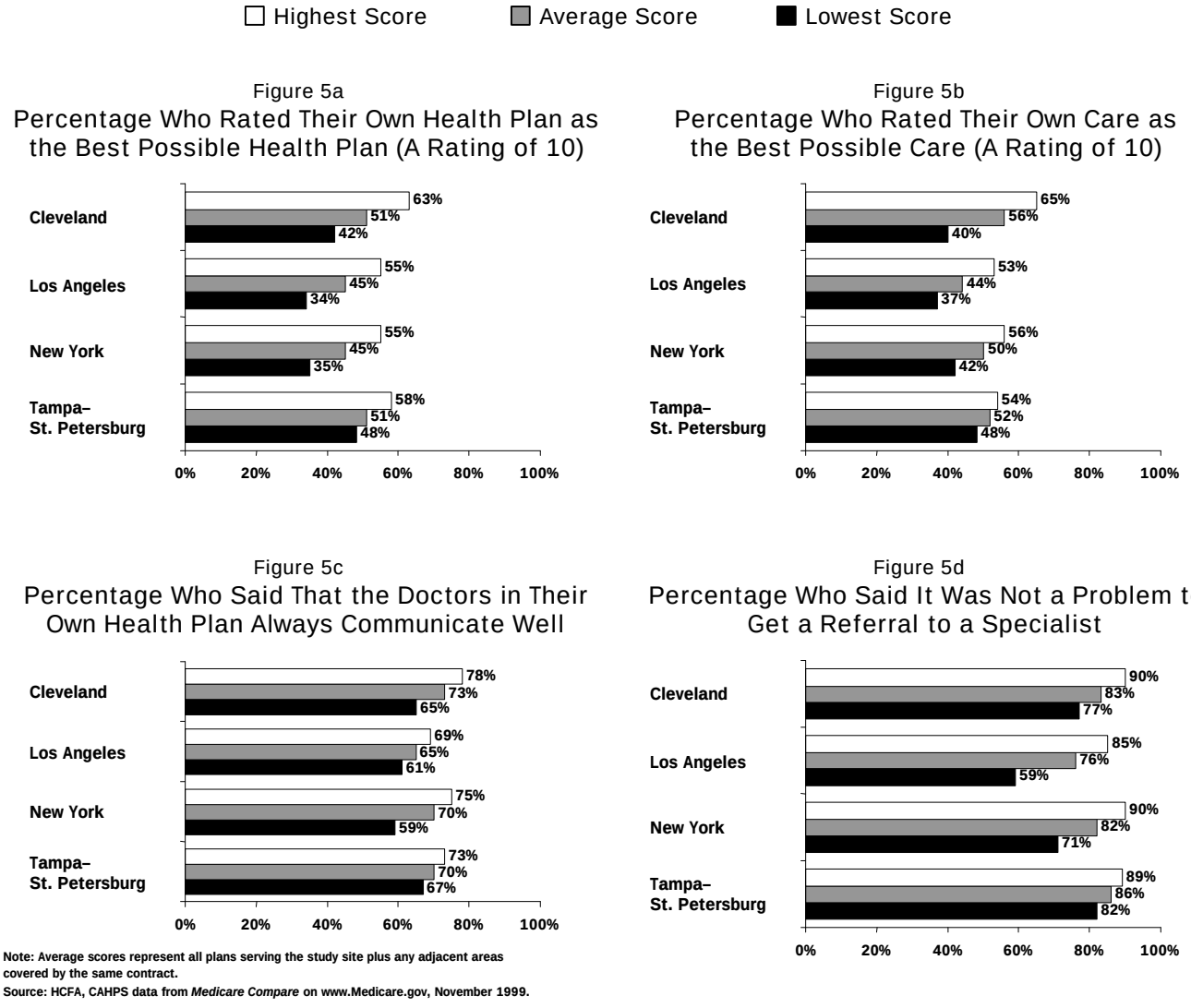
Note: Average scores represent all plans serving the study site plus any adjacent areas covered by the same contract.

Source: HCFA, HEDIS data from *Medicare Compare* on www.Medicare.gov, November 1999.

The high HEDIS scores of some plans undermine providers' arguments that plans do not affect quality, at least in the areas HEDIS measures. While high scores might be expected in plans like Kaiser that have a closed network of providers (and indeed the Kaiser plans in Los Angeles and Cleveland had the highest HEDIS scores on the measures shown), a number of plans with much looser networks also did well on HEDIS. Moreover, all but a few plans in the study sites did better than fee-for-service Medicare on the two measures for which comparison information was provided—the percentage of women who received a mammogram and the percentage of enrollees a provider saw within the past year.

There were fewer, but still substantial, differences among plans in the Consumer Assessment of Health Plans (CAHPS). In general, Cleveland M+C enrollees were more satisfied with their plans and the care they received than enrollees in the other study sites (figures 5a–5d). Project staff obtained plan information for all CAHPS measures, including those that do not appear on the Medicare Compare Internet site. These data include information about whether plans' scores are statistically above or below the average for all plans in the HCFA region. Table 9 provides CAHPS data for the largest M+C plans in the four study sites. Kaiser Permanente in Los Angeles and Prudential in Tampa–St. Petersburg had particularly good CAHPS scores, while Kaiser Permanente and Prudential in Cleveland, and HIP in New York, did poorly.

Figure 5
1998 CAHPS Data: High–Low Ranges and Average Scores, Four Study Sites



Note: Average scores represent all plans serving the study site plus any adjacent areas covered by the same contract.
Source: HCFA, CAHPS data from *Medicare Compare* on www.Medicare.gov, November 1999.

Table 9

CAHPS 1998 Data: Selected Performance Measures for Plans with Market Penetration Above 20 Percent in Four Study Sites*

	Cleveland Area			Los Angeles County			New York City			Tampa–St. Petersburg			
Plan (market share)	*HCFA Regional Average*	Kaiser Permanente *H3607* (27%)	Prudential *H3654* (22%)	*HCFA Regional Average*	PacifiCare *H0543A* (38%)	Kaiser Permanente *H0524A* (31%)	*HCFA Regional Average*	Oxford *H3307* (35%)	HIP *H3330* (32%)	*HCFA Regional Average*	Humana *H1036B* (31%)	Health Options *H1082* (25%)	Prudential *H1074* (20%)
Composite—Always Receive Care Quickly	*64%*	55%(-)	60%(-)	*58%*	61%	51%	*62%*	62%	47%(-)	*61%*	62%	65%	66%(+)
Composite—Not a Problem Getting Needed Care	*87%*	83%(-)	85%	*80%*	82%	86%(+)	*87%*	87%	84%	*85%*	84%	88%	88%(+)
Composite—Doctors Who Always Communicate Well	*72%*	65%(-)	71%	*66%*	68%	65%	*72%*	72%	63%(-)	*71%*	67%	73%	70%
Composite—Excellent Customer Service	*70%*	71%	60%(-)	*69%*	77%	70%	*67%*	70%	58%(-)	*70%*	68%	70%	68%
Best Possible Rating of Personal Doctor or Nurse (10 out of 10)	*53%*	45%(-)	55%	*46%*	55%	47%(+)	*52%*	56%	44%(-)	*52%*	43%(-)	57%(+)	52%
Best Possible Rating of Specialist (10 out of 10)	*54%*	42%	57%	*47%*	49%	44%	*52%*	49%	42%(-)	*53%*	50%	51%	45%
Best Overall Rating of Own Health Care (10 out of 10)	*54%*	41%(-)	56%	*45%*	49%	45%(+)	*52%*	51%	43%	*52%*	48%	53%	52%
Best Overall Rating of Plan (10 out of 10)	*51%*	44%	50%	*43%*	46%	49%(+)	*46%*	46%	39%	*50%*	48%	50%	49%(+)
No Problem Getting a Referral in the Last Six Months	*86%*	77%(-)	77%(-)	*78%*	80%	81%	*86%*	87%	81%	*83%*	82%	86%	89%(+)

* Note: Numerical values shown are performance measures without adjustment for case mix. Case-mix adjustment estimates the CAHPS score that a plan would obtain if all plans cared for comparable groups of beneficiaries. Positive and negative indicators of statistical significance refer to scores adjusted for case mix (case-mix adjusted values are not shown). %(+)=Case-mix adjusted results statistically better than HCFA Regional Average, %(-)= Case-mix adjusted results statistically worse than HCFA Regional Average.

Source: HCFA. 1998 Medicare CAHPS Report, July 1999.

As would be expected, the higher the satisfaction, the lower the disenrollment rates. For example, Kaiser Foundation Health Plan and Inter Valley Health Plan in Los Angeles had the two lowest voluntary disenrollment rates in 1998 and the two highest satisfaction rates as measured by CAHPS. Concomitantly, and with some exceptions,[n] plans that did poorly on CAHPS had high voluntary disenrollment rates. For example, Blue Shield of California had the highest 1998 voluntary disenrollment rate in Southern California and the lowest member satisfaction scores.

Also, with some exceptions, HEDIS scores generally improved between 1997 and 1998. For example, the average percentage of Tampa–St. Petersburg Medicare enrollees with diabetes who received regular eye exams increased by almost three percentage points between 1997 and 1998. Three of the five Cleveland area plans reporting this diabetes measure in both years bettered their scores by 16 to 29 percentage points. All Tampa–St. Petersburg, New York, and Los Angeles M+C plans reporting in both 1997 and 1998 improved the treatment of heart attack patients by prescribing beta blockers, although New York plans did not consistently improve on the other HEDIS measures.

The Effect of HEDIS and CAHPS Scores on Beneficiaries

The publication of quality report cards has two purposes: (1) to encourage M+C plans to improve quality; and (2) to give beneficiaries information on quality that will help them choose a plan. Plan representatives in all study sites said that they would use both HEDIS and CAHPS scores to improve the quality of care they provide to members. However, progress has been slower on the goal of helping beneficiaries understand the quality measures and take them into consideration when choosing a plan. At the time of this study, consumer groups working with the Medicare population in the four sites had not made extensive efforts to educate either volunteers or Medicare consumers about HEDIS and CAHPS, but they were looking to use performance measures in the future. Also, M+C plans in the study sites did not make any effort to educate beneficiaries about the report cards. When volunteers attending marketing presentations asked about HEDIS and CAHPS, no marketing agent provided information about their plans' scores. Many did not know about HEDIS and CAHPS; others simply referred beneficiaries to the Internet.

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[n] In Cleveland, Kaiser's high dissatisfaction rates are not reflected in high disenrollment rates. This may be because many of Kaiser's Medicare members are covered through their retirement policies and would lose their benefits if they quit the plan. Similarly, in New York, where HIP's high dissatisfaction scores are not reflected in high disenrollment rates, plan members are often enrolled through a retirement plan. ElderPlan in New York and SCAN in Los Angeles—Social HMOs that provide added long-term care benefits—have average disenrollment rates for their communities but high dissatisfaction rates. Some plan members, although dissatisfied, may not disenroll because they are dependent on the home care services offered by these plans.

DISCUSSION AND POLICY IMPLICATIONS

Case-study findings suggest that it will take more time to fully assess the impact of M+C legislation. The program has had both positive and negative results in the short term.

On the positive side, the BBA has initiated the beginning of what is likely to be a revolution in the education of Medicare beneficiaries. For the first time, Medicare HMOs are supplying consumers with information on quality. Efforts to educate beneficiaries about the uses of quality data in the four study sites and in the rest of the country are still in their infancy. Yet HCFA's national educational campaign and its progress in making quality-of-care information available to beneficiaries is likely to result in more informed Medicare consumers. The BBA's strong consumer protections, although still new to both plans and enrollees, are also likely to result in improved enrollment decisions and better quality.

On a negative note, financial problems of HMOs generally and BBA-authorized reimbursement changes coupled with local market conditions led to a large exodus of plans from the Medicare program at the ends of 1998 and 1999. Although plan withdrawals did not greatly affect Medicare beneficiaries in the four study locales, communities surrounding New York City, Cleveland, and Tampa–St. Petersburg were significantly affected. Moreover, M+C reimbursement changes that were made to reduce the large differences in Medicare HMO reimbursement rates across the country did not prevent plans in lower-reimbursement areas from increasing premiums and reducing benefits. The significant reductions in benefits and increases in premiums in both Cleveland and Tampa–St. Petersburg for 2000 compared with New York and Los Angeles reflect a system that favors some beneficiaries over others depending on where they live. In the short term at least, plan responses to market conditions and changes in Medicare reimbursement policies resulted in beneficiary anger and angst.

Some of the most far-reaching M+C changes are those that affect enrollment and disenrollment. Both high voluntary disenrollment rates and high levels of member dissatisfaction in some plans do not portend well for the phase-in of lock-in beginning in 2002. While lock-in may make beneficiaries more accountable for their choices, it also puts at risk vulnerable Medicare beneficiaries who are less able to make an informed decision about enrollment. The failure to standardize benefit packages and the instability of provider networks and drug formularies also undermines the ideal of informed choice. Problems associated with confusing benefit packages, network changes after enrollment, and alterations in drug formularies should be addressed before lock-in is implemented.

The implementation of M+C occurred in a tumultuous health care environment. Increased consolidation and antagonism among HMOs, physicians, and hospitals will probably continue to disrupt the Medicare market even without further program changes. The financial health of plans and medical groups also affects M+C decisions. Prudential's recent termination of its contract with Cleveland's University Hospitals, the financial failure of large medical groups in Los Angeles, and the continuing contentious relations between HMOs and providers in all study sites may be omens of future upheavals in the Medicare market.

Early implementation of Medicare+Choice offers a lesson in caution. Before we embark on additional, even more radical changes in the program, we should learn more from M+C about how to educate beneficiaries, how to address geographic inequities in Medicare funding, and how to protect vulnerable beneficiaries from making poor choices.

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#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#371 *An Assessment of the President's Proposal to Modernize and Strengthen Medicare* (June 2000). Marilyn Moon, The Urban Institute. This paper discusses four elements of the President's proposal for Medicare reforms: improving the benefit package, enhancing the management tools available for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

#380 *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

#366 *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#398 *Managed Care and Low-Income Populations in Texas: 1996–98 Update* (December 1999). Hilary Frazer, Marsha Gold, and Barbara Lyons. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#397 *Managed Care and Low-Income Populations in Florida: 1996–98 Update* (December 1999). Anna Aizer, Marsha Gold, and Catherine DesRoches. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#396 *Managed Care and Low-Income Populations: A Case Study of Managed Care in California* (December 1999). Debbie Draper, Marsha Gold, and Julie Hudman. Update of May 1996 report. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to the President. It also examines possible reform opportunities following the November 2000 elections.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#403 *Managed Care and Low-Income Populations: Four Years' Experience with Tennessee* (May 1999). Anna Aizer, Marsha Gold, and Cathy Schoen. Update of July 1995 report. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

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#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#308 *Medicare Beneficiaries: A Population at Risk—Findings from the* Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries (December 1998). Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland. This survey report, based on beneficiaries' own accounts of their incomes and health status, points to serious challenges in insuring an aging, vulnerable population.

ENDNOTES

[1] See generally, California Health Policy Roundtable, "A Risky Proposition? Risk-Bearing and Solvency in California's Medical Groups," *Policy Brief*, February 2000.

[2] Susan Lundine, "Doctors Battle United Over Claims," *Orlando Business Journal*, March 12, 1999, p. 1; Julie A. Jacob, "Controversy Greets Humana's Claims Review Program," *American Medical News*, August 23/30, 1999, pp. 1, 34; "Health Agency, Insurance Department Launch HMO Audits in Wake of Complaints," *Bureau of National Affairs*, Vol. 7, No. 18, April 3, 1999, p. 738.

"Managed Care Monitor-Florida: HMO Earnings Slide, Providers Say 'Pay Up!'" *American HealthLine*, August 19, 1999; "30% Drop in Hospital Profits Blamed on HMOs," *Health Line*, March 3, 1999.

[3] John Murawski, "Deal with Columbia to Force Humana to Raise Premiums as Much as 15%," *Palm Beach Post*, May 1, 1999. p. 8B

[4] Anna Aizer and Marsha Gold, *Medicare Beneficiaries and HMOs: A Case Study of the Tampa–St. Petersburg Market* (prepared for the Henry J. Kaiser Family Foundation, Washington, D.C.), July 1998, p. 10.

[5] "In the Eye of the Hurricane," *Florida Business Network*, Feb. 12, 1999.

[6] Robert Neil, "New United HealthCare Will Reign Over Florida," *Medical Industry Today,* June 5, 1998.

[7] Drown, *Akron Beacon Journal*, as cited in "Hospitals & Health Systems—Columbia/HCA: Moves Out of Northeast Ohio, Taking Losses," *American HealthLine*, March 3, 1999; Raquel Santiago, "As UHHS Grows, So Does Debt," *Crain's Cleveland Business*, May 17, 1999, p. 3; Center for Studying Health System Change, "Columbia/HCA Retreats: Cleveland, Ohio," *1998: A Year in the Life of the Health Care System (1998 Annual Report)*, December 30, 1998, pp. 24–25.

[8] Center for Studying Health System Change, *Health System Change in Cleveland, Ohio*, 1999, p. 14.

[9] The Academy of Medicine Cleveland, *Physician Ratings of Managed Care Organizations*, 1998.

[10] Susan Jaffe, "Many Elderly Must Find New Health Care Providers," *Cleveland Plain Dealer,* December 8, 1999, p. 4B; Susan Jaffe, "HMO Shuffle Irks Congressmen; Plan Changes Face Thousands of Senior Citizens," *Cleveland Plain Dealer*, December 15, 1999, p. 3B.

[11] Center for Studying Health System Change, *Health System Change in Cleveland, Ohio*, 1999, p. 14.

[12] Susan Rubinowitz, "Pay-Slow HMOs Stir Hospital Woe$," *The New York Post*, June 20, 1999, p. 23.

[13] Anna Aizer, Marsha Gold, and Randall Brown, *Medicare Beneficiaries and HMOs: A Case Study of the New York City Market* (Mathematica, Washington, D.C.), January 1998.

[14] Barbara Benson, "Hospitals Seeking a Cure for Payment Denial Ills: HMOs Reject More Hospitals Claims; Some Institutions Are Fighting Back," *Crain's New York Business,* August 30, 1999, p. 3.

[15] Anna Aizer and Marsha Gold, *Medicare Beneficiaries and HMOs: A Case Study of the Tampa–St. Petersburg Market* (prepared for the Henry J. Kaiser Family Foundation, Washington, D.C.), July 1998.

[16] Because of financial problems, HCFA prohibited Oxford, New York City's largest Medicare HMO, from marketing in the last six months of 1998.

[17] A March–April 1999 poll found that 37 percent of California seniors said they had "difficulty understanding all the different health care coverages available under Medicare," and 39 percent felt "overwhelmed by all the different kinds of information I get about Medicare." California HealthCare Foundation, "A Survey of California Seniors Covered Under Medicare," March–April 1999.

[18] A 1999 survey of California seniors found that 62 percent said they worry a lot about how they would pay for prescription drugs if they needed some of the more expensive medications and 80 percent worry a lot that they won't be able to continue paying the monthly premium for their current health care coverage. California HealthCare Foundation, *A Survey of California Seniors Covered Under Medicare,* March–April 1999.

[19] U.S. General Accounting Office, *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature*, GAO/HEHS-99-92, April 1999. General Accounting Office, *Prescription Drug Benefits: Implications for Beneficiaries of Medicare HMO Use of Formularies*, GAO/HEHS-99-166, July 1999.

[20] General Accounting Office, *Prescription Drug Benefits: Implications for Beneficiaries of Medicare HMO Use of Formularies*, GAO/HEHS-99-166, July 1999. See also, Phil Galewitz, "HMOs Profit by Just Saying No to Drugs," *Cleveland Plain Dealer*, June 1, 1999, pp. 1-A, 5-A; "California: 6 HMOs Ordered to Restore Drugs to Formulary," *American HealthLine,* July 23, 1999.

[21] Gary Sheperd, "Pinellas PHO Group Cancels Third Contract; Medicare Patients Affected by Change," *The Tampa Bay Business Journal*, April 26, 1999, p.1.

[22] Susan Jaffe, "Many Elderly Must Find New Health Care Providers, *Cleveland Plain Dealer,* December 8, 1999, p. 4B; Susan Jaffe, "HMO Shuffle Irks Congressmen; Plan Changes Face Thousands of Senior Citizens," *Cleveland Plain Dealer*, December 15, 1999, p. 3B. See also Troy Flint, "Aetna Still Recovering from Last Acquisition," *Cleveland Plain Dealer*, March, 1998, p. 2C.

[23] Health Care Financing Administration, *Medicare+Choice: Changes for the Year 2000; An Analysis of the Medicare+Choice Program and How Beneficiaries Will Be Affected by Changes*, September 1999.

[24] Regina McEnery, "When HMOs Dump Medicare Patients; QualChoice Prime, Other Providers Anger, Panic Many Older Ohioans," *Cleveland Plain Dealer,* August 6, 1999, p. 1A; Susan Jaffe, "Insurer Agrees to Let Subscribers Keep Their Doctors," *Cleveland Plain Dealer,* December 10, 1999.

[25] General Accounting Office, *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature,* GAO/HEHS-99-92, April 1999.

[26] Department of Health and Human Services, Office of Inspector General, *Medicare Managed Care: 1998 Marketing Materials*, February 2000, OEI-03-98-00271.

[27] Bob Lamendola, "Commissions Paid to HMO Service Raise Questions About Objectivity," *Orlando Sun Sentinel,* December 26, 1998.

[28] Presentation, Mary Agnes Laureno, Director, Education and Health Promotion Group, Center for Beneficiary Services (CBS) at National Medicare Education Program Coordinating Committee Meeting, February 28, 1999, Washington, D.C.