TRENDS IN MEDICARE+CHOICE BENEFITS AND PREMIUMS, 1999–2002

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EXECUTIVE SUMMARY

The Medicare+Choice (M+C) program, created by the Balanced Budget Act of 1997 (BBA), was a congressional effort to provide a wide choice of private health plans to Medicare beneficiaries. But five years later the number of plans available has in fact declined, and those remaining have made significant changes to their benefit packages. The BBA and federal budget constraints limit M+C payment rates, while health care costs are increasing and providers are more aggressive in their contract and price negotiations with plans. As a result, beneficiaries looking to Medicare HMOs as an affordable supplemental insurance option are being asked to pay more for fewer benefits.

This report continues the joint effort of Mathematica Policy Research, Inc., and The Commonwealth Fund to provide policymakers with critical information on M+C program trends to support policy development. We examine broad trends in benefits and premiums since 1999 and analyze 2002 benefit packages, focusing on changes that are likely to affect chronically ill beneficiaries who require more services. Finally, we analyze the patterns in plan benefit and premium changes since 1999 and speculate about what these might reveal about health plan strategies.

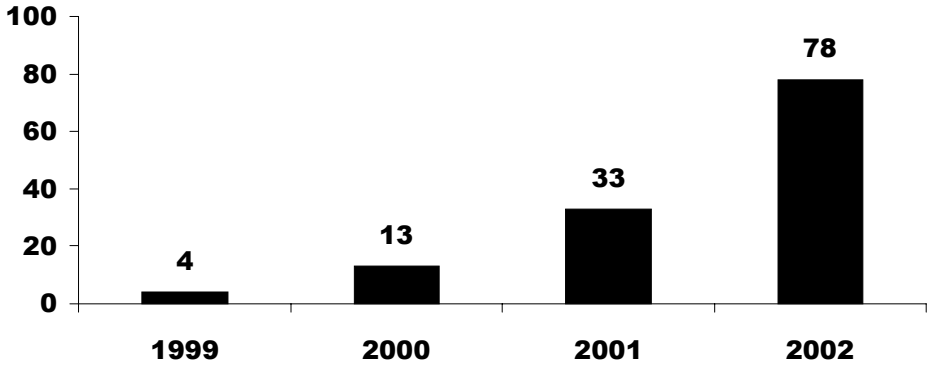
The data used in this report are from Medicare Compare, the Centers for Medicare and Medicaid Services' (CMS) consumer-oriented summary of information on M+C plans. Medicare Compare shows benefits, beneficiary cost-sharing requirements, and service areas.

Key findings of the report include the following:

1. **M+C plans continued to increase premiums and cost-sharing while reducing the benefits they offer.**

   - In 2002, the average monthly premiums, while still well below those of most Medigap plans, increased by nearly 40 percent—from $25 in 2001 to $32 in 2002. Cost-sharing also increased dramatically; the percentage of enrollees in an M+C plan requiring hospital cost-sharing more than doubled, from 33 percent in 2001 to 78 percent in 2002 (Figure ES-1). Copayments for physician office visits also increased.

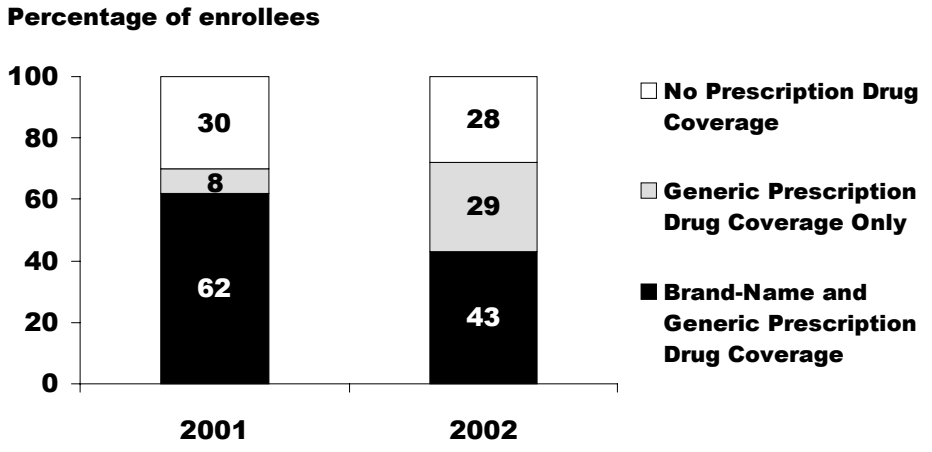
Figure ES-1. Percentage of Medicare+Choice Enrollees with Any Cost-Sharing for Inpatient Hospital Admissions, 1999–2002



Source: Mathematica Policy Research analysis of Medicare Compare data.

- Particularly notable were cuts in pharmacy benefits. Plans reduced or eliminated coverage for brand-name prescription drugs or coverage for off-formulary (the plan-approved list) prescriptions or both. In 2001, 62 percent of M+C enrollees had at least some coverage for brand-name prescriptions drugs; in 2002, only 43 percent have this coverage (Figure ES-2).

Figure ES-2. Prescription Drug Coverage in Medicare+Choice, 2001–2002



Note: Figures are based on March enrollment files for each year. In 2001, our estimates account for 396 contract segments and 5,577,787 total enrollees. In 2002, our estimates account for 344 contract segments and 4,964,007 total enrollees.
Source: Mathematica Policy Research analysis of Medicare Compare data.

2. **Some chronically ill enrollees face substantial out-of-pocket costs because of increases in cost-sharing for hospital and other services.**

   - The mean Medicare enrollee cost for a 12-day hospital stay is $419, but M+C beneficiaries in some plans could actually pay more for such a stay than they would under traditional Medicare. Cost-sharing also could be substantial if specialized services are needed. For example, while 57 percent of M+C enrollees are in a plan with no cost-sharing for radiation treatment, 17 percent are in plans that require copayments between $100 and $250 per treatment. (This analysis does not reflect the recent elimination of such copayments by Secure Horizons).

3. **As a first response to limited rate increases, many health plans added or increased premiums. Since 2001, however, health plans have focused more on reducing benefits to hold down costs.**

   - In 1999, 55 percent of plans offered an M+C product with no additional premium but that nevertheless featured benefits we classified as "high." By 2002, only 13 percent of plans are in this category, and 16 percent of the plans have monthly premiums of $50 or more and benefit packages we classified as "low." While many plans have used a combination of premium increases and benefit reductions to adjust to changing market conditions, some plans continue to offer "zero-premium" products—though often with limited benefits.

M+C plans appear to be responding to financial strains by making adjustments to minimize losses. For example, plans unwilling to raise premiums, which may discourage continued enrollment by healthy beneficiaries, choose instead to reduce benefits and increase the amount of cost-sharing required for services. Further research on how plans target particular groups for their M+C product and the implications for coverage and risk selection would be valuable.

Clearly, M+C plans' ability to offset limitations in the traditional Medicare benefit package is eroding. Beneficiaries who originally enrolled in a plan with nominal cost-sharing may now incur substantial out-of-pocket expenses in the event of a major illness. Most enrollees can no longer count on adequate pharmacy benefits as well. Given these changes, it is important for potential enrollees to assume the responsibility of checking a plan carefully to be sure it can meet their particular health care needs. Congress must also deal more directly with the limitations in the basic Medicare benefit package.

TRENDS IN MEDICARE+CHOICE BENEFITS AND PREMIUMS, 1999–2002

INTRODUCTION

For the fourth consecutive year, Medicare+Choice (M+C), Medicare's managed care plan, experienced significant plan withdrawals. In 2002, an estimated 536,000 M+C enrollees were affected when their Medicare HMO left the program or stopped serving their county. In response to increasingly difficult financial conditions, many health plans that continued to participate in the program made significant changes in their benefit packages, shifting more costs to enrollees. M+C payment rates are limited by the Balanced Budget Act (BBA) of 1997 and federal budget constraints, while health care costs are increasing and providers are more aggressive in their contract and price negotiations with plans (Young and Mittler 2002; Draper et al. 2002).

Medicare beneficiaries who look to Medicare HMOs as an affordable supplemental insurance option are being asked to pay more while receiving fewer benefits. In 2002, monthly premiums have again increased. At the same time, limits have been placed on prescription drug coverage and other supplemental benefits, and new cost-sharing requirements have been added to certain benefits, such as inpatient hospital care. The 2002 changes in benefit packages can be difficult to understand, complicating beneficiaries' decisions about HMOs. Overall, M+C enrollees in 2002 will face higher out-of-pocket costs as they adjust to the slimmer benefit packages health plans are offering (Gold and Achman 2002).

This report is part of a series of reports from The Commonwealth Fund concerning benefit and premium trends in M+C health plans (Achman and Gold 2002a; Achman and Gold 2002b, Achman and Gold 2002c, Achman and Gold 2002d, Gold and Achman 2002, Gold and Achman 2001). We begin with a discussion of data and methods, and follow with an overview of premium and benefit trends from 1999 to 2002. We continue with an examination of benefit changes in 2002 that affect chronically ill populations in particular, including changes to inpatient hospital care, mental health care, radiation therapy, and diabetic supplies. We then discuss strategies that plans are using to attract specific segments of the Medicare population. The conclusion examines the implications of the report's findings for policymakers addressing the problems of Medicare's limitations.

METHODS

We based this analysis on data from the Medicare Compare database of the Centers for Medicare and Medicaid Services (CMS). For enrollment data, we used the Quarterly

State/County/Plan Market Penetration File, which tracks enrollment in each county by contract. The 2002 numbers reflect enrollment as of March 2002 and track beneficiaries' movement across plans following the 2002 plan withdrawals and the implementation of changes in benefit packages.[1] The public has access to both databases through the Medicare and CMS websites.

Medicare Compare is targeted to the consumer. It is a summary of M+C health plan packages and includes information on benefits, beneficiary cost-sharing requirements, and service areas. Medicare Compare provides this information at the plan level, defined as a unit within a managed care organization's contract that offers the same benefit and cost-sharing structures to all members in a specified service area. This report uses the December 2001 release of Medicare Compare for the 2002 benefit period.

CMS allows managed care organizations to offer more than one plan, or benefit package, within a contract service area as well as across portions of the contract service area. The authors used contract segments for this analysis. These are geographical units within a contract service area in which the same plans are available to all enrollees in the contract segment. However, a managed care organization's service area may include more than one contract segment, and each contract segment may include more than one plan benefit package. Within a contract segment there is a basic plan, with the lowest monthly premium, and one or more additional plans, typically with a higher premium that covers a richer set of benefits. CMS data do not distinguish enrollment in basic versus other benefit packages. For this analysis, we assigned all enrollees to the basic plan in each contract segment. In cases in which more than one plan has the same monthly premium, we used the plan with the most generous prescription drug coverage. Focusing this analysis on basic plans offers a picture of the enrollees' minimum coverage.[2]

The report presents results of our analysis in two ways, as unweighted plan estimates and weighted enrollment estimates. Through unweighted plan estimates, it is possible to see how benefits vary across contract segments, regardless of enrollment. The weighted enrollment estimates, however, provide a more accurate picture of what

[1] The statistics supersede our analysis of 2002 benefits that was based on September 2001 enrollment numbers, the most recent enrollment data then available (Achman and Gold 2002a).

[2] This year Medicare HMOs were also allowed to offer supplemental benefits at an additional cost to their enrollees. These often included prescription drug coverage, dental, hearing and/or vision benefits. For instance, in one health plan enrollees could purchase dental coverage for an additional $11.95 per month. A scan of the Medicare Compare website found that a number of Medicare HMOs were offering supplemental benefit packages to their plans. However, we were unable to provide any estimate of the extent to which HMOs used this option, or the types of benefits available, because these data were not included in the Medicare Compare database available for this research.

beneficiaries actually experience, because they take into account plan size. Enrollment weights reflect total enrollment in each contract segment for all benefit packages. In 2002, fewer contract segments offered more than one benefit package (17 percent versus 42 percent in 2001). The reduction may be the result of new flexibility plans have in 2002 to offer supplemental benefits. For instance, a plan may offer a supplemental prescription drug benefit for an additional cost per year. Having this option eliminates the need to offer an entirely separate plan.

AN OVERVIEW OF PREMIUM AND BENEFIT TRENDS

In 2002, most M+C beneficiaries face substantial premium increases. While M+C premiums continued on average to remain below those charged for Medigap (Chollet 2001), the average M+C monthly premium rose by nearly 40 percent, from $22.94 in 2001 to $32.08 in 2002 (Table 1). The number of enrollees in plans with monthly premiums of $50 or greater jumped from 19 to 32 percent. Furthermore, the number of enrollees in plans with no premiums dropped from 46 percent to 41 percent.

The benefit erosion that started in 2000 continued into 2002. Limits on prescription drug coverage have become very common. The percentage of M+C enrollees with any prescription drug coverage remains stable in 2002; 72 percent have coverage in 2002 compared with 70 percent in 2001 (Table 2). But this stability is offset by the fact that, in 2002, only about 2 percent of M+C enrollees who are in plans with drug benefits have unlimited coverage, compared with 22 percent in 1999 and 10 percent a year ago. In addition, plans have increased beneficiaries' copays for prescription drugs. Of those M+C enrollees with prescription drug coverage, the percentage with a copayment of $10 or more for generic drugs increased from 8 percent in 1999 to nearly 20 percent in 2002. Copayments for brand-name drugs have increased even more dramatically: beneficiaries with a copay of $20 or more for brand-name drugs increased from 14 percent in 1999 to nearly 81 percent in 2002.

Not only did the percentage of enrollees with copayments for brand-name drugs rise in 2002, but far fewer had any brand-name prescription drug coverage at all; 43 percent have such coverage in 2002, compared with 62 percent a year ago (Figure 1). This exclusion of brand-name prescription drugs drastically reduces the value of prescription drug benefits. According to one report, of the 50 drugs the elderly most commonly use, 40 are brand-name drugs, and only eight of these are available in a generic version.[3]

[3] Families USA report based on claims from Pennsylvania's prescription drug assistance program, Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) (Families USA 2001).

Table 1. Monthly Premiums for Basic Packages in Medicare+Choice Contract Segments, 1999–2002

	Percentage of Basic Plans				Percentage of Enrollees			
	1999	2000	2001	2002	1999	2000	2001	2002
None	62.1	42.3	45.5	38.1	79.6	59.0	46.0	40.7
Less than $20.00	3.2	5.3	5.1	2.9	3.1	8.7	8.2	4.8
$20.00–$49.99	20.5	26.9	21.5	20.6	13.5	19.3	27.1	22.8
$50.00 or More	7.4	22.9	27.5	38.4	3.2	11.1	18.6	31.8
Unknown	5.9	2.6	0.5	0.0	0.6	1.8	0.1	0.0
Mean	$13.31	$25.73	$28.65	$37.98	$6.37	$14.43	$22.94	$32.08
Mean if Premium Does Not Equal $0.00	$39.08	$45.47	$52.75	$61.34	$32.11	$36.19	$42.52	$54.05
Number of Contract Segments/ Number of Enrollees	443	468	396	344	6,254,616	6,094,767	5,577,787	4,964,007

Note: Enrollment is from March of each year.

Source: Mathematica Policy Research analysis of Medicare Compare data.

Table 2. Prescription Drug Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999–2002

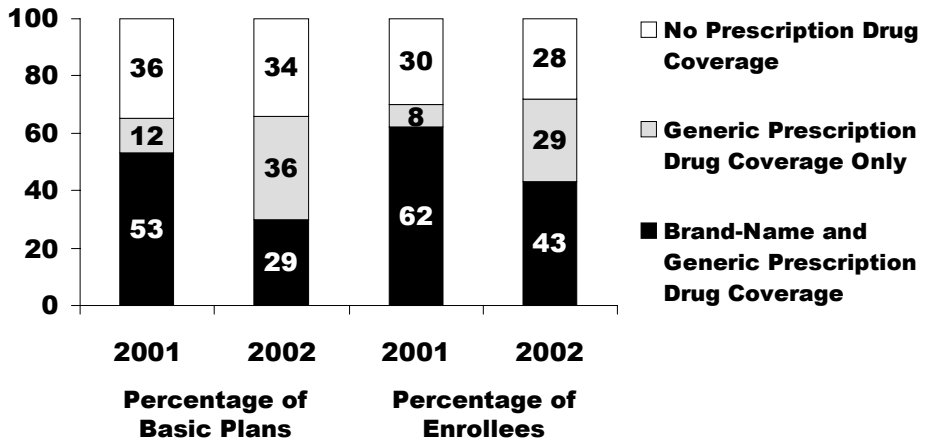
	Percentage of Basic Plans				Percentage of Enrollees			
	1999	2000	2001	2002	1999	2000	2001	2002
Any Drug Coverage	73.4	67.5	64.5	65.7	83.9	78.0	70.2	71.7
Annual Drug Cap								
$500 or Less*	23.3	37.1	37.5	68.8	10.6	20.8	28.2	50.1
$501–$750	12.0	14.4	12.1	7.6	10.1	10.6	10.8	7.28
$751–$1,000	27.5	23.2	19.0	11.6	26.3	17.4	10.7	19.1
$1,001–$1,500	12.0	13.4	11.3	2.2	9.4	12.6	12.8	2.9
$1,501–$2,000	13.0	9.8	9.7	4.5	17.8	20.3	22.0	15.6
$2,001 or More	4.5	3.3	6.1	2.7	4.1	3.4	5.2	2.9
No Cap	7.8	8.8	4.4	2.7	21.7	14.9	10.4	2.2
Practices								
Formulary	81.6	91.6	89.4	83.2	80.3	92.0	90.6	89.4
Mail Orders	89.3	88.6	85.0	86.7	95.7	95.5	93.5	93.8
Quarterly Cap	14.9	23.1	20.9	18.1	12.2	13.1	15.1	11.1
Copay								
Generic								
None	6.0	4.4	6.5	7.8	7.6	7.1	7.8	7.1
$10.00 or Less	29.3	92.2	82.5	71.2	84.4	90.4	83.4	73.1
$10.01 or More	4.7	3.4	11.0	21.0	8.0	2.5	8.8	19.8
Brand Name								
None	5.2	2.9	2.0	0.0	6.3	5.5	2.4	0.0
$10.00 or Less	24.7	8.7	8.6	6.5	35.9	19.8	21.7	4.6
$10.01–$20.00	51.7	56.7	41.4	26.9	43.8	54.3	43.6	14.8
$20.01 or More	18.4	31.8	47.8	66.7	14.0	20.4	32.3	80.6
Ratio of Copays Brand Name to Generic								
2.0 or Less	45.1	38.3	22.9	20.4	55.7	44.8	30.5	12.2
2.01–3.0	32.3	32.1	32.8	28.0	24.9	32.3	35.2	52.6
3.01 or More	21.9	27.8	36.3	38.7	19.2	20.7	25.6	25.5
Positive Brand Name, No Generic	0.7	1.8	8.0	12.9	0.2	2.2	8.7	9.8

Note: Enrollment is from March of each year. Only plans that cover brand-name drugs are included in the "Ratio of Copays" section.

* In all years, plans with generic-only benefits are classified as having a benefit limit less than $500 per year, regardless of the benefit limit on generic drugs. In 2002, the number of plans offering generic drug coverage only increased dramatically, from 17.8 percent of plans with prescription drug coverage in 2001 to 55.3 percent in 2002. This accounts for some of the large increase in the percentage of plans with an annual limit below $500.

Source: Mathematica Policy Research analysis of Medicare Compare data.

Figure 1. Prescription Drug Coverage in Medicare+Choice, 2001–2002



Note: Figures are based on March enrollment files for each year. In 2001, our estimates account for 396 contract segments and 5,577,787 total enrollees. In 2002, our estimates account for 344 contract segments and 4,964,007 total enrollees.
Source: Mathematica Policy Research analysis of Medicare Compare data.

Some plans that do include coverage of brand-name prescription drugs place strict limits on the amount of the benefit (Table 3). Sixteen percent of enrollees who have generic and brand-name coverage have an annual limit of $500 or less; some plans set annual limits as low as $200 or $300. Annual costs of prescription drugs for beneficiaries ran from $329 to $1,567, well above the limitations some plans impose.[4]

Another important change in prescription drug benefit packages in 2002 is the decreased coverage for prescription drugs not on the formulary, or plan-approved list. In some cases, there may not be an appropriate alternative to a drug not on the formulary. In contrast to M+C plans, most commercial plans allow some exceptions to the plan-approved list of drugs. About 37 percent of M+C enrollees with prescription drug coverage have no coverage for off-formulary drugs in 2002.

[4] This estimate takes into account recent data on drug prices and prescription use. In 2000, the average retail price was $65.29 for brand-name prescriptions and $19.33 for generic drugs (Kaiser Family Foundation 2001). In 1998, Medicare beneficiaries who had prescription drug coverage filled on average 24 prescriptions per year and those without coverage filled 17 prescriptions per year (Poisal and Murray 2001).

Prescription Drug Benefit Descriptions from Medicare Compare

The prescription drug benefits described on Medicare Compare for M+C plans vary significantly in terms of amount and type of coverage. Beneficiaries choosing a health plan should consider the amount and type of prescription drugs they may be taking in order to determine which plan offers the best coverage for their situation. Following are some examples of drug benefits for different M+C plans as they are described on the Medicare Compare website:

- For prescription drugs on the plan-approved list (formulary), you pay for each prescription or refill $10 to $15 for formulary generic drugs up to a 30-day supply, and $35 to $45 for formulary brand drugs up to a 30-day supply. There is no individual limit on formulary generic drugs. There is a $1,000 limit annually for formulary brand drugs. You may be covered for non-formulary drugs when medically necessary.

- For prescription drugs on the plan approved list (formulary), you pay for each prescription or refill $8 for formulary generic drugs up to a 30-day supply; $15 for formulary-preferred brand-name drugs up to a 30-day supply; $60 for formulary brand-name drugs up to a 30-day supply. You are NOT covered for prescription drugs that are not on a plan-approved list (formulary). There is a $1,000 limit annually for combined formulary generic, formulary-preferred brand-name and formulary brand prescription drugs. There is no limit on formulary generic drugs after the combined limit on formulary generic, formulary-preferred brand-name, and formulary brand is reached.

- For prescription drugs on the plan-approved list (formulary), you pay for each prescription or refill $9 for formulary generic drugs up to a 30-day supply. There is no individual limit on Formulary Generic drugs. You are NOT covered for prescription drugs that are not on a plan-approved list (formulary).

- For prescription drugs on a plan-approved list (formulary), you pay for each prescription or refill $10 for formulary generic drugs up to a 30-day supply; $25 for formulary brand-name drugs up to a 30-day supply. There is no individual limit on formulary generic drugs. For prescription drugs that are NOT on a plan-approved list (formulary), you pay for each prescription or refill $10 for non-formulary generic drugs up to a 30-day supply; $50 for non-formulary brand-name drugs up to a 30-day supply. There is no individual limit on non-formulary generic drugs. There is a $1,000 limit annually for combined formulary brand and non-formulary brand prescription drugs.

- For prescription drugs on a plan-approved list (formulary), you pay for each prescription or refill $7 for formulary generic drugs up to a 30-day supply; $25 for formulary-preferred brand-name drugs up to a 30-day supply; $35 for formulary brand-name drugs up to a 30-day supply. You are NOT covered for prescription drugs that are not on a plan-approved list (formulary). There is a $200 limit annually for combined formulary-generic, formulary-preferred brand-name, and formulary-brand prescription drugs.

Note: Information common to all benefit descriptions and information on mail order options are not shown here. All other information is the exact language that appears on Medicare Compare.

Source: Medicare Compare (www.medicare.gov).

Table 3. Limits on Prescription Drug Coverage by Type of Coverage Offered, 2001–2002

	Percentage of Basic Plans		Percentage of Enrollees	
	2001	2002	2001	2002
Of Plans with Some Prescription Drug Coverage:				
Percentage Covering Generic Only[1]	18.5	55.3	11.4	40.3
Percentage Covering Generic and Brand-Name Drugs	81.5	44.7	88.6	59.7
Annual Drug Cap				
For Plans Covering Both Generic and Brand-Name Prescription Drugs[2]				
$500 or Less	25.6	29.3	19.7	16.1
$501–$750	14.5	17.2	12.1	12.2
$751–$1,000	22.7	26.3	11.9	32.1
$1,001–$1,500	13.5	5.1	14.3	4.9
$1,501–$2,000	11.6	10.1	24.6	26.2
$2,001 or More	7.3	6.1	5.8	4.9
No Cap	4.8	6.1	11.6	3.6

Note: Enrollment is from March of each year.

[1] Approximately 90 percent of enrollees (85% of basic plans) in plans with generic-only coverage have an unlimited generic benefit; the remaining have an annual cap of $500 or less.

[2] The basic plan limit that applies to brand-name drugs was used for this analysis. Some plans that cover both brand-name and generic drugs have differing limits for each class of drug.

Source: Mathematica Policy Research analysis of Medicare Compare data.

In 2002, many plans participating in M+C reduced their coverage of supplemental benefits, including preventive dental, vision, and hearing care (Table 4). Twenty-nine percent of enrollees had some type of preventive dental coverage in 2001 while only 16 percent have preventive dental coverage in 2002. Vision benefits declined from 95 percent of enrollees having coverage in 2001 to 87 percent in 2002, and hearing benefits declined from 78 percent of enrollees having coverage in 2001 to 54 percent in 2002.

Also in 2002, M+C plans began to reduce coverage of the cost-sharing expenses for medical and hospital services under traditional Medicare (Table 5). In 1999, M+C plans typically provided benefits to offset all of Medicare's hospital cost-sharing and benefit limitations, and beneficiary copayments for physician services were nominal. In 2002, the percent of M+C enrollees with copayments of $15 or more has increased slightly for primary care physicians (from 3 percent in 2001 to 4 percent in 2002), but it almost doubled for specialist visits, from 22 percent to 41 percent.

Table 4. Supplemental Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999–2002

	Percentage of Basic Plans				Percentage of Enrollees			
	1999	2000	2001	2002	1999	2000	2001	2002
Prescription Drugs	73.4	67.5	64.5	65.7	83.9	78.0	70.2	71.7
Preventive Dental	40.2	30.1	27.2	18.8	69.9	39.0	28.6	15.5
Vision Benefits	93.8	91.7	89.3	83.6	97.8	96.2	94.7	86.7
Hearing Benefits	82.4	85.2	75.5	61.0	91.3	92.0	77.7	54.3
Physical Exam	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Podiatry Benefits	27.8	28.1	37.7	34.0	26.9	28.2	29.4	26.2
Chiropractic Benefits	19.0	8.8	10.7	6.7	20.9	6.8	6.0	3.7
Number of Contract Segments/ Number of Enrollees	443	468	396	344	6,254,616	6,094,767	5,577,787	4,964,007

Note: Enrollment is from March of each year.

Source: Mathematica Policy Research analysis of Medicare Compare data.

Table 5. Copayments for Medical and Hospital Services for Basic Plans in Medicare+Choice Contract Segments, 1999–2002

	Percentage of Basic Plans				Percentage of Enrollees			
	1999	2000	2001	2002	1999	2000	2001	2002
Primary Care Physician								
None	7.7	6.1	4.6	5.3	18.0	10.0	5.3	5.7
$5.00 or Less	43.1	33.6	25.6	16.1	44.5	34.1	21.7	12.4
$5.01–$10.00	41.8	49.6	45.5	52.2	32.1	47.8	43.6	57.0
$10.01–$15.00	6.9	9.2	20.0	19.1	5.1	7.2	26.7	21.1
$15.01 or More	0.5	1.5	4.4	7.3	0.3	0.8	2.8	3.8
Specialist								
None	7.2	5.3	5.4	4.4	15.9	8.0	5.7	3.4
$5.00 or Less	38.1	25.4	17.6	6.7	39.6	28.0	16.4	6.4
$5.01–$10.00	36.1	34.0	33.2	28.2	26.8	35.8	37.1	34.6
$10.01–$15.00	11.4	18.9	24.5	18.5	9.9	19.3	19.3	14.5
$15.01 or More	2.2	9.2	19.4	42.2	1.2	6.5	21.5	41.1
Varies	5.0	7.2	0.0	0.0	6.6	2.3	0.0	0.0
Emergency Room								
None	3.7	2.0	4.6	3.9	6.5	3.4	3.4	2.6
$20.00 or Less	12.1	6.6	7.2	1.2	24.5	14.0	11.9	0.5
$20.01–$40.00	31.2	28.1	20.8	10.7	30.5	33.9	30.9	12.6
$40.01–$50.00	52.7	63.4	67.4	84.3	38.2	48.7	53.8	84.3
$50.01 or More	0.2	0.0	0.0	0.0	0.2	0.0	0.0	0.0
Any Copayment								
Hospital Admission	9.4	20.0	45.5	73.4★	4.3	12.8	32.7	78.4★
Hospital Outpatient	21.5	22.6	36.9	55.5	30.7	28.6	43.7	69.9
X-Ray	6.2	11.7	17.1	18.6	7.5	11.3	17.2	17.0
Lab	3.2	5.7	15.3	14.5	3.9	6.4	16.4	12.3

Note: Enrollment is from March of each year.

★ Thirteen contract segments, representing 96,976 enrollees, were excluded from this analysis because the plans were missing information on Medicare Compare about inpatient hospital benefits. Together, these basic plans represent 3.8 percent of all contract segments (344 in total) and 2.0 percent of all enrollees (4,964,007).

Source: Mathematica Policy Research analysis of Medicare Compare data.

The percentage of enrollees with hospital cost-sharing requirements increased substantially. In 2001, 33 percent of M+C enrollees had a copayment for an inpatient hospital admission. In 2002, this number has more than doubled, to 78 percent. The proportion of enrollees having to make copayments for hospital outpatient procedures also has increased, from 44 percent in 2001 to 70 percent in 2002. A small percentage of

enrollees are in plans with cost-sharing for laboratory and X-ray services; this percentage increased from 1999 to 2001 but has not increased in 2002.

In spite of benefit changes, only a negligible number of M+C enrollees switched to another M+C plan at the beginning of the 2002 benefit year. By comparing September 2001 enrollment with March 2002 enrollment, we found that the only benefit affected at all by enrollee movement was inpatient hospital cost-sharing. September 2001 enrollment predicted that 80 percent of beneficiaries would be in a plan with inpatient cost-sharing in 2002. However, March 2002 enrollment shows that 78 percent of M+C enrollees are in a plan with some inpatient hospital cost-sharing (Achman and Gold 2002a). The fact that so few enrollees appeared to change health plans indicates that they were generally not able to offset benefit reductions or premium increases by switching to another plan.

COST-SHARING FOR SERVICES USED DISPROPORTIONATELY BY THE CHRONICALLY ILL

One of the most publicized changes in M+C benefit packages in 2002 was the increase in cost-sharing for services used disproportionately by the chronically ill. Our analysis found a substantial increase in cost-sharing for inpatient hospital care from 2001 levels; the cost-sharing burden on M+C beneficiaries sometimes exceeds the cost of inpatient hospital care under traditional Medicare. This situation is the result of a CMS requirement that M+C plans provide benefits equal to the actuarial value of Medicare's fee-for-service package, but allows plans to have flexibility on specific cost-sharing for individual benefits. (The actuarial value is the estimated dollar value of the coverage provided by the benefit package, after excluding patient cost-sharing.)

Although the majority (78%) of 2002 M+C enrollees are in plans that require cost-sharing for inpatient hospital services, the nature of the cost-sharing varies considerably among plans (Table 6).[5] Twenty percent of enrollees are in a plan with a copayment per day, and another 51 percent have a copayment per stay or benefit period.[6] Approximately 36 percent of M+C enrollees with cost-sharing for inpatient hospital services have an out-of-pocket limit (7 percent have a limit per hospital stay or benefit period, and 29 percent have an annual limit). Some managed care organizations have an overall out-of-pocket limit on the entire M+C benefit package, excluding prescription drugs. Because the 2002 Medicare Compare data do not indicate which plans use these limits, it is not possible to

[5] The traditional Medicare Part A benefit package has a deductible of $812 for an inpatient hospital stay up to 60 days per benefit period. Per-day copayments are required for stays longer than 60 days.

[6] As defined by Medicare, a benefit period begins at the time of admission and ends when an individual has not received hospital or skilled nursing facility care for 60 consecutive days.

estimate the number of enrollees in such plans. Clearly, however, M+C enrollees must consider the financial implications of a plan's deductibles, copays per day, copays per stay, and the combination of these factors in order to make informed decisions about supplemental plans.

Table 6. Inpatient Cost-Sharing in Medicare+Choice Basic Benefit Packages, 2002

	Percentage of Basic Plans	Percentage of Enrollees
No Cost-Sharing	26.6	21.6
Cost-Sharing		
Deductible Only	6.3	5.7
Copay		
Per Day Only	28.1	19.6
Per Stay Only	35.3	51.4
Both	3.3	1.4
Deductible and Copay/Day	0.3	0.4
Of Those with Cost-Sharing, Percentage with an Out-of-Pocket Maximum[1]		
Per Stay	10.6	6.8
Per Year	20.5	29.3
Percentage with No Out-of-Pocket Maximum	68.9	63.9
Number of Contract Segments/Enrollees[2]	331	4,867,031

[1] Some Medicare HMO plans instituted out-of-pocket limits that place a limit on an enrollee's out-of-pocket expenses for all services. Medicare Compare does not provide information on plan-level out-of-pocket limits, so it is not possible to estimate the number of plans with such a provision.

[2] Thirteen contract segments, representing 96,976 enrollees, were not included because the plans were missing information on Medicare Compare about inpatient hospital benefits. Together, these basic plans represent 3.8 percent of all contract segments (344 in total) and 2.0 percent of all enrollees (4,964,007).

Source: Mathematica Policy Research analysis of Medicare Compare data.

To demonstrate the financial impact of these cost-sharing increases, we estimated enrollee costs in various M+C plans under different inpatient hospital scenarios (Table 7). Our analysis shows that, even with the cost-sharing increases, most M+C plans still provide enrollees greater financial protection than is provided by the Part A benefit package in traditional Medicare. For example, the mean estimated M+C enrollee cost for a 12-day hospital stay in 2002 is $419, compared with $812 for an enrollee in traditional Medicare. For the 2 percent of all M+C enrollees in the plans with the highest cost-sharing, out-of-pocket requirement would be $3,540 for a 12-day hospital stay.

Table 7. Inpatient Hospital Care Cost Estimates for Enrollees in Medicare+Choice Basic Plans, 2002

	Percentage of Basic Plans	Percentage of Enrollees
One 3-Day Stay		
$0	27.1%	22.9%
$1–$200	20.7%	33.4%
$201–$450	33.1%	23.3%
$451–$750	11.9%	15.8%
$751 or More	7.3%	4.6%
Mean	$270.86	$264.24
Median	$225.00	$200.00
Maximum	$1,000.00	$1,000.00
One 6-Day Stay		
$0	27.1%	22.9%
$1–$200	17.9%	31.7%
$201–$450	20.4%	16.9%
$451–$750	24.0%	19.8%
$751–$1,000	5.2%	4.3%
$1,001 or More	5.5%	4.4%
Mean	$370.24	$336.48
Median	$250.00	$200.00
Maximum	$1,770.00	$1,770.00
One 12-Day Stay		
$0	27.1%	22.9%
$1–$250	27.4%	38.1%
$251–500	16.7%	14.9%
$501–1,000	21.9%	19.0%
$1,001–1,500	2.1%	1.1%
$1,501 or More	4.9%	4.1%
Mean	$477.81	$418.82
Median	$250.00	$200.00
Maximum	$3,540.00	$3,540.00
Two 6-Day Stays and One 3-Day Stay		
$0	27.1%	22.9%
$1–$750	32.8%	43.5%
$751–$1,250	12.5%	11.1%
$1,251–$2,000	19.8%	16.6%
$2,001–$3,000	2.7%	1.6%
$3,001+	5.2%	4.4%
Mean	$900.43	$830.24
Mean	$650.00	$600.00
Maximum	$4,425.00	$4,425.00
Two 6-Day Stays and One 12-Day Stay		
$0	27.1%	22.9%
$1–$750	32.2%	43.2%
$751–$1,250	10.3%	8.7%
$1,251–$2,000	18.6%	17.1%
$2,001–$3,000	6.4%	3.4%
$3,001 or More	5.5%	4.4%
Mean	$984.13	$896.01
Median	$750.00	$600.00
Maximum	$4,800.00	$4,800.00
Number of Contract Segments/Enrollees	329	4,768,142

Note: This analysis excludes 15 plans, representing 195,865 enrollees. Thirteen of these plans (96,976 enrollees) were excluded because they were missing inpatient hospital benefit information on Medicare Compare. Two additional plans were excluded because they used coinsurance rather than copays and were therefore not directly comparable.

Source: Mathematica Policy Research analysis of Medicare Compare data.

Inpatient Hospital Benefit Descriptions from Medicare Compare

M+C organizations have constructed their inpatient hospital benefits in a number of different ways. In order to understand which plan would provide the most financial protection, enrollees should have a good idea of what their future hospital use will be in terms of number and length of stays. Following are examples of inpatient hospital benefits as they are described on the Medicare Compare website:

- There is no copayment for inpatient hospital services in a network hospital.
- You pay $150 for each Medicare-covered stay in a network hospital.
- You pay $75 each day for day(s) 1–90 for a Medicare-covered stay in a network hospital. There is a $2,000 maximum out-of-pocket limit every year.
- You pay a deductible of $200. There is no copayment for inpatient hospital services in a network hospital.
- You pay $100 each day for day(s) 1–5 and $0 each day for day(s) 6–90 for a Medicare-covered stay in a network hospital. There is a $500 maximum out-of-pocket limit every stay.
- You pay $200 for each Medicare-covered stay in a network hospital. There is an $800 maximum out-of-pocket limit every year.
- You pay $295 each day for day(s) 1–90 for a Medicare-covered stay in a network hospital. You pay $295 each day for additional day(s) 91 and beyond in a network hospital. There is a $4,800 maximum out-of-pocket limit every year.

Note: Information common to all benefit descriptions is not shown here. All other information is the exact language that appears on Medicare Compare.
Source: Medicare Compare (www.medicare.gov).

Beneficiaries deciding between M+C and Medigap should pay particular attention to the wide range of cost-sharing requirements for inpatient hospitalization under M+C plans. Although Medigap monthly premiums are higher than premiums for M+C plans, Medigap's standardized Policies B through J cover all of Medicare's Part A deductible and coinsurance. This means that a Medigap enrollee pays nothing for a 12-day hospital stay at the time of service.

We also analyzed cost-sharing levels for other types of care, aside from hospitalization, often used by the chronically ill. This analysis examined inpatient and outpatient mental health care, radiation treatments, and diabetes supplies. The Medicare basic benefit for inpatient mental health care is the same as the benefit for inpatient medical hospital stays, with the exception of a 190-day lifetime limit on care in psychiatric hospitals.[7] Approximately 74 percent of M+C enrollees are in plans that require cost-

[7] For inpatient hospital stays, Medicare beneficiaries pay an $812 deductible for days 1–60 and $203 per day for days 61–90 per benefit period. There is no limit on the number of benefit periods per beneficiaries. For hospital stays beyond 90 days, beneficiaries also are entitled to 60 lifetime reserve days for a copayment of $406 per day. Individuals who have exhausted their lifetime reserve days and have a hospital stay longer than 90 days are responsible for 100 percent of costs.

sharing for inpatient mental health stays (Table 8). As with inpatient hospital medical stays, cost-sharing for inpatient mental health stays may entail a deductible, copay per stay, or copay per day. Among plans requiring a per-stay copay, amounts vary from $25 to $1,000 per stay, with about 60 percent of enrollees in these plans paying $250 or less.

Table 8. Mental Health Cost-Sharing, 2002

	Percentage of Basic Plans	Percentage of Enrollees
Inpatient Mental Health[1]		
No Cost-Sharing	35.1	26.1
Deductible Only	5.5	5.5
Copayments		
Per Stay Only	28.7	41.8
Per Day Only	20.4	16.8
Per Stay and Per Day	7.9	7.9
Deductible and Copay per Day	2.4	1.8
Outpatient Mental Health		
No Cost-Sharing	2.9	2.8
Cost-sharing for First Visit		
$0	3.2	2.8
$1–$10	23.5	32.5
$11–20	39.5	34.9
$21–30	21.5	19.8
$31–40	8.1	4.7
$41 or More	0.3	0.2
Coinsurance	3.8	5.0
Copayments for 52 Visits[2]		
$0	3.1	3.0
$1–$600	22.3	32.7
$601–$1,000	11.6	10.8
$1,001–$1,300	47.1	40.7
$1,301–$2,000	14.4	12.4
$2,001 or More	1.5	0.5

[1] 16 contract segments with 121,030 enrollees are missing information on inpatient mental health cost-sharing. These plans are excluded from this analysis.

[2] Only basic plans using copayments were included in this analysis. Seventeen basic plans, with 352,400 enrollees, were excluded because they use coinsurance rather than copayments. Coinsurance in these plans is usually 50 percent.

Source: Mathematica Policy Research analysis of Medicare Compare data.

Under traditional Medicare, beneficiaries pay 50 percent of Medicare's allowed fee for outpatient mental health therapy. Most M+C plans also require some cost-sharing for

these services (Table 8). A few plans increase copayments for more frequent use. For instance, one plan has a $10 copayment for one to six individual or group therapy visits and increases it to $25 per visit for further sessions. Even though these plans are in the minority, they are consistent with the general trend toward higher M+C copayments, especially for frequent users. That makes the difference between out-of-pocket cost-sharing under traditional Medicare and under M+C less than it has been in the past—a trend of particular relevance to high users of services who are at greater risk for incurring out-of-pocket expenses.

The number of all Medicare beneficiaries who reported a mental disorder in the 1997 Medicare Current Beneficiary Survey is low, under 10 percent. However, 41 percent of disabled Medicare beneficiaries under 65 reported a mental disorder (Sharma 2001). The authors calculated the amount an M+C enrollee would spend out-of-pocket on mental health care for one visit per week for a full year. In 2002, more than half of M+C enrollees would pay in excess of $1,000 for outpatient mental health care services. An individual without supplemental insurance would pay $2,392.[8]

Much attention has been paid to the 2002 increases in M+C plan copayments for cancer treatments, specifically for radiation and chemotherapy (Appleby 2002a). We were not able to examine chemotherapy copayments because the Medicare Compare database does not include this information. However, the database does include information about copayments for radiation therapy, although it was difficult to determine the precise copayment level in many M+C plans because of the broad range of copayments listed (e.g., $0–$100, $0–$250, or $10–$150 per radiation therapy session). Overall, the majority of all M+C enrollees, about 57 percent, are in a plan with no cost-sharing for radiation therapy. Seventeen percent are in a plan with a substantial copayment, which could be as high as $100 to $250 per treatment.[9]

Cost-sharing for diabetes supplies also varies across different M+C plans; as with radiation therapy, there are either no cost-sharing requirements or the costs are relatively high. About 46 percent of enrollees are in a plan that does not require a copayment for items used to self-monitor diabetes, while another 39 percent are in a plan that has a copayment of up to 20 percent. As with figures for radiation therapy, Medicare Compare

[8] This estimate is based on a 50 percent copayment, as required for most outpatient mental health visits under Medicare, and the Medicare-reimbursable relative value fee for psychoanalysis of $92 per session.

[9] The estimates are based on the benefit packages released on Medicare Compare in December 2002. In April, Secure Horizons announced that it was eliminating its copayment on radiation therapy following "widespread complaints" from cancer patients (Appleby 2002b). A more up-to-date version of Medicare Compare was unavailable at the time this report was written.

provides this information in general terms (e.g., an enrollee pays 0% to 20% of the cost for each Medicare-covered diabetes supply item, or $0 to $150 for each Medicare-covered diabetes supply item.) The value of such descriptions to beneficiaries is questionable, and the broad range of the figures provided makes a precise analysis impossible.

DYNAMICS OF CHANGES IN PREMIUMS AND BENEFITS, 1999–2002

It has been five years since that the BBA introduced the payment policies that applied to plans entering the new M+C program (Gold 2001).[10] In this section, we examine the ways in which plans have changed their M+C basic benefits in response to the limits the BBA put on their payments and speculate about what the trends may imply about the plans' strategies and their positioning of the M+C product in the marketplace. For example, we look at how plans weigh premiums, which apply to all beneficiaries regardless of health status, against increases in out-of-pocket costs at the point of service, which vary with an enrollee's health status.

This analysis examines cross-sectional trends in the benefits provided in the basic benefit packages offered by plans and changes in premiums from 1999 through 2002.[11] The analysis includes plans withdrawing from the program in this period.[12] There was little difference at the beginning of the period in benefits and premiums of plans that left than plans that stayed, however (Table A-1).

To create an overall score for a plan's benefits, we weighed pharmacy benefits by one-third and other benefits and cost-sharing by two-thirds (Table 9). A plan received the highest score for the pharmacy component if it covered pharmacy benefits, including brand-name prescription drugs, and had an annual limit in pharmacy coverage of $750 or more. The rest of a plan's score was based on the level of cost-sharing for physician services and hospital care and on the number of selected supplemental benefits the plan covers. The overall benefit summary score was calculated with the following formula:

.33[Pharmacy Coverage Score] + .67[(.5 x MD Cost-Sharing Score) + (.4 x Hospital Cost-Sharing Score) + (.1 x Supplemental Benefit Score)].

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[10] M+C payment policies took effect in 1998. The M+C program itself and most other changes were not effective until 1999.

[11] Though payment changes under M+C began to be introduced in 1998, detailed benefit data are not available before 1998. The data available for 1998 are limited and more useful to support comparisons with the year 1999 than for later years. Data for 1999 are more complete and detailed. Earlier analysis of change prior to 1999 suggests that there is little lost through initiating our analysis in that year. Between 1998 and 1999, there is little evidence of major changes either in the benefits M+C plans offered or in the premiums they charge (Gold, Smith, Cook, and Defillipes 1999).

[12] Plans started to withdraw in 1999, with 407,000 M+C enrollees (6.7 percent of M+C enrollment) affected. Withdrawals continued in 2000 (327,000 affected), spiked in 2001 (934,000 affected), and continued in 2002 (536,000 affected).

Theoretical scores range from 0.0 to 2.0. Those less than 0.4 are considered to have low benefits, those between 0.5 and 1.0 to have medium benefits, and 1.0 or more high benefits.

Table 9. Overview of Trends in Medicare+Choice Benefit Generosity, 1999–2002 (selected measures, unweighted by enrollment)

Measure (Score)	1999	2000	2001	2002
Premium Level				
None (Low)	65%	40%	45%	38%
Under $50 (Medium)	26	34	23	24
$50 or More (High)	9	25	32	38
Pharmacy Coverage				
None (0)	28	34	33	32
Generic Only or ≤ $750 Annually (1)	30	32	36	54
Brand-Name Coverage + > $750 Annually (2)	42	34	31	14
Cost-Sharing for MD Services				
Copay $15 More, Primary and/or Specialty Care (0)	15	29	47	62
In Between (1)	40	38	32	27
$5 or Less, Primary and Specialty (2)	46	32	22	11
Hospital Cost-Sharing				
Yes (0)	10	20	47	73
No (2)	90	80	53	27
Number of Selected Supplemental Benefits[1]				
0 (0)	6	5	6	16
1 (.5)	15	9	14	23
2 (1)	34	46	34	29
3 (1.5)	35	34	38	27
4 (2)	10	6	7	5
Benefit Summary Score[2]				
Low	3	8	22	42
Medium	18	24	29	33
High	79	68	49	25

[1] Measures how many of the following four supplemental benefits are covered: vision, hearing, preventive dental, and podiatry. We did not include physical exams because virtually all plans cover them. We excluded chiropractic benefits because coverage may be influenced by general state insurance mandates.

[2] This is calculated by the following formula: 0.33 [Pharmacy Coverage Score] + 0.67 [(0.5 x MD cost-sharing score) + (0.4 x hospital cost-sharing score) + (0.1 x supplemental benefit score)]. Theoretical scores range from 0 to 2. Those less than 0.4 are considered low, between 0.5 and 1.0 medium and 1.0 or more high.

Source: Mathematica Policy Research analysis of Medicare Compare data. Basic benefits in contract segments.

Year-to-Year Changes over the Period

After the BBA limited rate increases, the plans participating in M+C initially responded by adding a premium to the M+C product or by increasing those already in effect. Between 1999 and 2000, the share of plans offering products with no premiums declined from 65 to 40 percent, meaning that 25 percent of plans introduced a premium in response to the new restrictions on payment rates. Plans that had already had premiums raised them on average from $13 to $26 per month between 1999 and 2000. In 2000, 25 percent of plans charged at least $50 per month, while only 9 percent had charged that much in the previous year. In 2000, plans also reduced M+C benefit levels somewhat, but the extent of change was considerably less dramatic than it would be in later years.

Average premiums continued to rise; by 2002, 38 percent of plans charged at least $50 per month—a 13 percent increase since 2000. The share of plans offering a zero-premium product diminished only slightly from 2000 to 2002 (40% versus 38%). However, during these years there were significant benefit reductions, at least for the basic M+C product.[13] Particularly notable were the increases in hospital cost-sharing in 2001 and 2002 and the reduction of pharmacy benefits, especially in 2002. Required physician copayments increased in both years, and plans also covered fewer supplemental benefits.

The cumulative effect of decreased benefits is apparent in the overall plan scores on benefit generosity. In 1999, only 3 percent of plans received a low rating for benefits. In 2000, 8 percent of plans received a low rating. In 2001, the number of low-rated plans jumped to 22 percent; in 2002, the percent almost doubled, to 42 percent.

Trends in Benefit Generosity and Premiums

In 1999, more than half of all plans (55%) offered an M+C basic product with no monthly premium that included what this analysis classified as high benefits (Table 10). By 2002, just 13 percent of plans remained in this category. At the other end of the spectrum, only 1 percent of basic plans in 1999 had monthly premiums of $50 or more and low benefit packages; in 2002, the number of plans in this category rose to 16 percent.

Plans generally use both premium increases and benefit reductions as a strategy to respond to limited rate increases; nevertheless, some plans retained a zero-premium product while reducing benefits. The share of plans with a zero-premium product fell by

[13] Plans are able to offer additional benefit packages. Thirty percent did so in 2000 and 42 percent did so in 2001. In 2002, the proportion dropped to 17 percent, probably because plans were allowed to offer riders for specific supplemental benefits in that year. The data available to us do not indicate how many plans did so and what they covered.

70 percent between 1999 and 2002, compared with a fourfold drop in plans with high benefit levels. In other words, though plans used premium increases to respond to limits on rate increases, over time they increasingly turned to benefit reductions.

Table 10. Relationship Between Medicare+Choice Premium Levels and Benefits, 1999–2002

	1999	2000	2001	2002
Premium Low (none)	65%	40%	45%	38%
Benefit Low	1	3	10	15
Benefit Medium	9	6	13	10
Benefit High	55	31	22	13
Premium Medium (<$50)	26	35	23	24
Benefit Low	1	2	3	11
Benefit Medium	7	10	6	9
Benefit High	19	22	14	3
Premium High (≥$50)	9	25	32	38
Benefit Low	1	3	9	16
Benefit Medium	2	7	10	13
Benefit High	6	14	14	8

Note: Benefit levels are based on a benefit summary score. The score is based one-third on the generosity of pharmacy benefits and two-thirds on a composite of levels of physician cost-sharing, use of hospital cost-sharing, and coverage of supplemental benefits.

Source: Mathematica Policy Research analysis of Medicare Compare data. Basic benefits are in contract segments.

Thoughts on Medicare+Choice Plans' Strategies and Implications for Future Research

With so many forces affecting M+C health plan premium and benefit changes, it is virtually impossible to identify how plans weigh changes to benefits and premiums in response to limited growth in capitation payments over time. Nevertheless, some hypotheses can be developed and questions for further research identified.

Do plans structure their benefit packages knowing that most beneficiaries review only the basics on plan design?

Those advising beneficiaries about their plan choices report that most beneficiaries, including most Medicare beneficiaries, focus on a few aspects of their plan choices—the premium; the general benefits covered, and pharmacy coverage in particular; and whether their doctor is in the plan (Young and Mittler 2002; Gold et al. 2001). The pattern of benefit changes M+C plans made between 1999 and 2001 suggests that plans believe consumers pay more attention to price and the scope of benefits than to specific details of coverage. This is most apparent in coverage of pharmacy benefits. Although many M+C plans narrowed their pharmacy benefit, few eliminated it entirely. The result of this

general approach means that beneficiaries need to read the "fine print" to understand thoroughly their coverage.

Is there a "target premium or premium range" against which plans determine their benefit package? This analysis suggests that plans may attempt to hold their M+C premium within a competitive range to attract the desired number and mix of enrollees. The decision between "zero and something" may be the most critical one. Before the payment limits the BBA imposed, some plans marketed their product by stressing that a beneficiary could enroll without incurring a premium. Faced with payment restrictions, many plans instituted a premium as a first step, yet some plans chose instead to reduce the breadth or depth of their benefits. Other plans appear reluctant to continue raising the premium. This is particularly evident in 2002, when most plans have chosen to curtail benefits substantially (often increasing hospital cost-sharing and reducing pharmacy benefits) rather than raise premiums additionally. Between 2001 and 2002, the share of plans with low benefits almost doubled (from 22% to 42%), while the share with high benefits was halved (from 49% to 25%). These facts suggest that plans have in mind a "target" for the premium that they believe will work best to attract the mix and number of enrollees they need to make the M+C product viable.

Is there variation in the target enrollment group for M+C that varies by type of plan and market? Firms participating in M+C that operate in many states have noted that adverse selection, or having a disproportionate number of chronically ill beneficiaries enrolled in a plan, has an impact on how they determine the benefit package (Draper, Gold, and McCoy 2002). M+C beneficiaries in relatively good health use less care and may make their purchasing decisions based more on the cost of the premium than they do on cost-sharing requirements, given that monthly premiums are likely to comprise most of their expenses (Achman and Gold 2002c; see Table A-2 and Figure A-1 for out-of-pocket spending by health status). On the other hand, beneficiaries in poor health, who are frequent users of services, tend to focus on benefits and point-of-service cost-sharing. Consequently, plans can assume that they will attract a healthier enrollment mix by reducing benefits rather than by raising premiums.

Potential enrollees are not all in the same situation in deciding which plan to join. Table 11 presents estimated out-of-pocket costs for enrollees in the individual market according to their health status and whether they choose an M+C plan, Medigap options, or coverage from Medicare alone. Compared with Medigap, the M+C products tend to be less costly, largely because Medigap premiums are so high. Compared with Medicare

Table 11. Comparison of Projected "Average" Annual Out-of-Pocket Spending for Selected Supplemental Plans, 2002 (standardized to Medicare+Choice use assumptions and health status mix)

	Traditional Medicare Only	Medicare+Choice Coordinated Care Plan	Medicare+Choice Sterling Plan (Private Fee-for-Service)	Medigap Product[1]		
				C	F	J
Total	$2,582	$1,787	$2,717	$2,861	$2,930	$3,058
Part B Premium	648	648	648	648	648	648
Annual Supplemental Premium	0	378	936	1,318[2,3]	1,387[2,3]	1,810[2,3]
Out-of-Pocket Prescription Drugs	670	461	670	670	670	475
Other Cost-Sharing	1,264 [3,4]	300	463	225	225	125

Note: Estimates assume that 79 percent of HMO enrollees are in good health, 15 percent in fair health, and 6 percent in poor health, which corresponds to the distribution of self-reported health status among M+C enrollees in the 1998 Medicare Current Beneficiary Survey. Comparisons for supplemental products hold the health status mix constant across options and apply the same assumptions used for M+C coordinated care plans.

[1] All three plans cover the Parts A and B deductible and cost-sharing. Out-of-pocket costs for "other cost-sharing" are for preventive services not included in Medicare (e.g., eye examination, hearing examination, annual physical examination). Plans C and F do not cover these services or prescription drugs. Plan J covers up to $120 each year in preventive care services, including an annual physical examination and hearing test. Plan J also has a prescription drug benefit that covers 50 percent of prescription drug costs up to $1,500 once a $250 deductible is met.

[2] Premiums are based on Chollet (2001) estimates, which are 1999 averages weighted by plan enrollment. The 1999 averages were then inflated to 2002 estimates using the increases in Consumer Price Index for medical care for 2000–2002 (4.1% for 2000, 4.6% for 2001, and 4.4% for 2002). Actual prices paid vary substantially by location, policy, age, and underwriting factors. In New York City (zip code 10036), for example, a 65-year-old person would pay $1,929 for Plan C and $1,938 for Plan F offered by AARP (Plan J is not available). In Orange County, California (zip code 92646), a 65-year-old person would pay $1,838, $1,862, and $2,621, respectively, for Plans C, F, and J. For Washington, D.C., the prices would be $1,145, $1,159, and $1,735, respectively.

[3] The estimates for Medigap premiums and traditional Medicare's "other cost-sharing" are national estimates and are not adjusted to the primarily urban locations of Medicare HMOs.

[4] Annualized projections based on CMS actuary estimates of the monthly actuarial value of Medicare deductible and coinsurance for Part A and Part B benefits in out-of-pocket costs for 2002. The estimate overstates the differential against M+C because it includes some components of out-of-pocket cost (e.g., mental health, rehabilitative care) that are not considered in calculating other options, but understates it to the extent M+C enrollees are located disproportionately in high-cost counties.

Source: Based on estimates developed with HealthMetrix Research's Medicare HMO Cost Share Methodology, which is outlined in the Appendix.

alone, the M+C product offers more financial protection for Medicare beneficiaries, but requires a greater fixed contribution up front. Some beneficiaries may not be able to afford this and therefore their only option is Medicare alone. Enrollees in better health are likely to be much more sensitive to the premium, particularly if they are not risk averse. This suggests that the risk high premiums pose to selection is less a concern when beneficiaries are actively choosing between Medigap and M+C than when their choice is between M+C and Medicare alone (either because Medigap is too expensive or they are ineligible). Plans that depend on lower-income or more price-sensitive beneficiaries may be particularly concerned with restraining the growth in premiums.

Are some plans making their basic packages less attractive as an alternative to leaving the M+C program?

The trends in benefits suggest that plans initially attempted to absorb payment limits with some increases in premiums. By 2001, as revenue growth remained limited and costs of care were increasing, plans began to reduce benefits (Gold 2001; Gold 2002). If a health plan believed that either the premium increase or benefit change would be unattractive to beneficiaries, it departed the program, leading to a record number of non-renewal of contracts in 2001. In 2002, non-renewals were lower than in 2001, but benefits again declined as some plans appear to have decided on a major reduction in benefits, regardless of the impact on enrollment growth. This may reflect a judgment that the politics of withdrawal are less attractive than the politics of reduced benefits. Alternatively, it may be that plans, uncertain of the future and needing a less abrupt exit strategy, stayed "in the game" with a product that positioned them on the edge, meaning a product that exposed the health plan to limited financial loss and reduced enrollment (Draper, Gold and McCoy 2002).

Further research is necessary to determine how the changes plans are making concerning risk selection are affecting the M+C program. In particular, further study is needed to distinguish between what plans are doing to compete for beneficiaries considering Medigap and what plans are doing to compete for those who see M+C as an alternative to Medicare alone. It also would be useful to consider M+C plans' dependence on employer groups, or "age-ins," for enrollment. Age-ins are arguably less sensitive to premium costs because they want to retain their provider relationships. Consequently, plans with distinctive provider networks that rely heavily on age-ins may be able to charge higher premiums without losing beneficiaries. This is also true of plans with heavy enrollment from employer groups, who typically subsidize beneficiaries' premiums. Some employers buy a minimal package and purchase a separate rider to supplement it, while others buy the standard packages. The latter circumstance may give plans more flexibility to raise premiums as an alternative to cutting benefits.

CONCLUSION

This report documents the continued erosion of M+C plans' ability to address the benefit limitations of Medicare. What began as nominal cost-sharing at the start of the M+C program has now become sufficiently extensive under M+C that the program cannot necessarily protect beneficiaries from high out-of-pocket costs for major illnesses. Pharmacy benefits also are more limited than ever. Together, these trends are increasing the pressure on Congress to address directly the limitations in the Medicare benefit package.

This analysis offers a foundation for understanding how M+C plans position their product in the marketplace and handle increasing financial constraints. Some plans appear unwilling to raise premiums further and instead will reduce benefits to encourage a less financially risky mix of enrollees. For beneficiaries priced out of the supplementary market, going bare with only Medicare coverage may prove more attractive. Should this happen, M+C enrollment will slow, further undermining M+C by causing yet more plans to withdraw from the program. Further research is needed to assess these trends, especially to examine how different plans are targeting the M+C product and what this implies both for beneficiary coverage and for risk segmentation within the Medicare market.

APPENDIX

Out-of-Pocket Cost Estimate Methodology

We estimated out-of-pocket spending for M+C enrollees using the HealthMetrix methodology. The methodology is based on utilization profiles for Medicare managed care enrollees in good, fair, and poor health. The estimates are divided into three types of health care expenditures: premiums, out-of-pocket spending for prescription drugs, and other out-of-pocket spending (largely acute care costs for physician visits, medical care, and some preventive services). In addition to the three categories of costs, MPR added a fourth, the Medicare Part B premium.

To support the estimates for out-of-pocket spending for prescription drugs and other medical services, assumptions are made about the costs of prescription drugs, how M+C plans calculate their drug benefit limits, and the cost of preventive services. For example, in 2002, brand-name prescription drugs are assumed to cost both the health plan and an enrollee without coverage $66 for a month's supply. Similarly, generic drugs are assumed to cost $39 for a one-month supply. Detailed information on the cost assumptions and utilization profiles used in the HealthMetrix HMO CostShare Reports is available on the HealthMetrix Research CostShare Report website at www.hmos4seniors.com, or by contacting the authors. The model assumes no change in utilization patterns from 1999–2002. The only prices assumed to have changed during the time period are those for prescription drugs.

This estimate for "all enrollees" was created by weighting out-of-pocket cost estimates for those in good, fair, and poor health according to the reported health status of Medicare beneficiaries enrolled in risk HMOs in the 1998 Medicare Current Beneficiary Survey (MCBS).

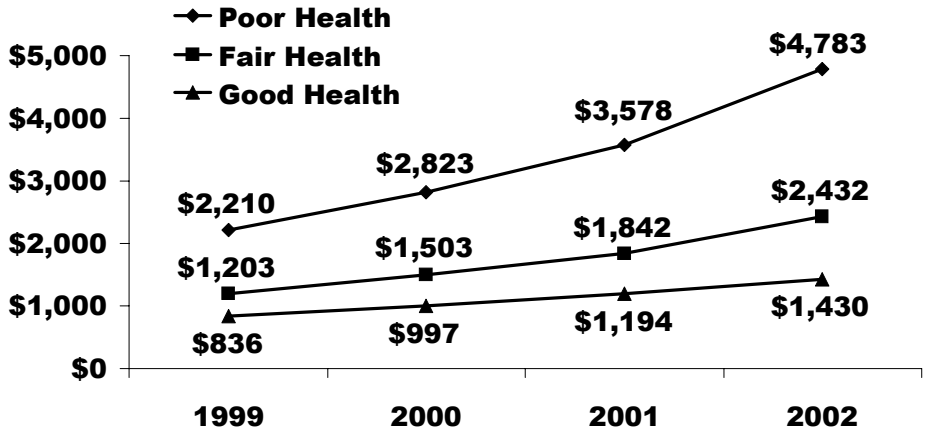
Table A-1. Comparison of Premium and Benefit Levels—Plans Staying In and Leaving the Medicare+Choice Program, 1999–2002

	Plans Staying (n=184)		Plans Leaving (n=226)
	1999	2002	1999
Premium Low (None)	65%	24%	65%
Benefit Low	1	13	1
Benefit Medium	11	9	8
Benefit High	52	12	57
Premium Medium (<$50)	29	24	24
Benefit Low	1	12	0
Benefit Medium	10	8	4
Benefit High	18	4	19
Premium High (≥$50)	7	41	11
Benefit Low	1	18	2
Benefit Medium	1	14	3
Benefit High	5	9	6

Note: Contract numbers are used to define those who stayed throughout the period.

Source: Mathematica Policy Research analysis of Medicare Compare data. Basic benefit packages in contract segments.

Figure A-1. Estimated Total Annual Out-of-Pocket Spending for Medicare+Choice Enrollees by Health Status, 1999–2002



Source: Mathematica Policy Research analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

Table A-2. Average Annual Enrollee Out-of-Pocket Costs in Medicare+Choice Plans, 1999–2002

	1999	2000	2001	2002	Absolute Change 2001–2002	Absolute Change 1999–2002	Percent Change 2001–2002	Percent Change 1999–2002
Annual Part B Premium	$ 546.00	$ 546.00	$ 600.00	$ 648.00	$ 48.00	$ 102.00	8%	19%
Annual M+C Premium	63.37	173.16	275.24	377.58	102.34	314.21	37	496
Prescription Drug Cost-Sharing								
All[1]	234.19	291.75	344.02	460.72	116.70	226.53	34	98
Good Health	109.74	135.09	157.71	213.79	56.08	104.05	36	95
Fair Health	434.61	539.69	610.88	824.69	213.81	390.08	35	90
Poor Health	1,343.62	1,699.25	2,088.98	2,747.28	658.30	1,403.66	32	104
Hospital and Physician Cost-Sharing								
All[1]	132.08	174.42	218.74	299.89	81.15	167.81	37	127
Good Health	117.08	142.99	161.57	190.19	28.62	73.11	18	62
Fair Health	159.41	244.49	356.02	582.15	226.13	422.74	64	265
Poor Health	257.81	405.23	613.84	1,010.29	396.45	752.48	65	292
Total Annual Cost-Sharing								
All[1]	975.64	1,185.33	1,438.00	1,786.19	348.19	810.55	24	83
Good Health	836.19	997.24	1,194.52	1,429.56	235.04	593.37	20	71
Fair Health	1,203.39	1,503.34	1,842.14	2,432.41	590.27	1,229.02	32	102
Poor Health	2,210.80	2,823.64	3,578.06	4,783.15	1,205.09	2,572.35	34	116
Total Cost Ratio for Poor to Good Health	2.64	2.83	3.00	3.35				

Note: Results are weighted by plan enrollment.

[1] Assumes 79 percent of enrollees are in good health, 15 percent in fair health, and 6 percent in poor health. This corresponds to the distribution of self-reported health status among Medicare+Choice enrollees in the 1998 Medicare Current Beneficiary Survey.

Source: Mathematica Policy Research analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

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premiums, plan payments, and satisfaction and quality in Medicare+Choice. Available online only at www.cmwf.org.

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#496 *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (January 2002). Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles. This executive summary of an unpublished report (available on the Fund's website only) examines recent changes in seven Medicare+Choice markets and the effects of these changes on Medicare beneficiaries.

#495 *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (January 2002). Geraldine Dallek and Andrew Dennington, George Washington University. The authors find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher.

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#491 *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (October 2001). Jennifer Stuber, Geraldine Dallek, and Brian Biles, George Washington University. The authors of this field report found a substantial decline in the number of Medicare+Choice plans in five of seven large markets around the country.

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#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

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#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

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#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

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A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#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.

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#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

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#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.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#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 might happen since the National Bipartisan Commission on the Future of Medicare finished its work without issuing recommendations to President Clinton. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs,* vol. 18, no. 4. 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 article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#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.

#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.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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