



GEOGRAPHIC INEQUITY IN MEDICARE+CHOICE BENEFITS
FINDINGS FROM SEVEN COMMUNITIES

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FIELD REPORT

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EXECUTIVE SUMMARY

As a national social insurance program, Medicare was built on the premise that all beneficiaries would receive the same health care benefits no matter where they lived. The Medicare+Choice program is eroding this promise of equitable benefits because many beneficiaries have no Medicare+Choice options; in communities that do have Medicare+Choice plans, benefit offerings and cost-sharing requirements vary substantially. This report compares the 2002 benefit packages of Medicare+Choice plans in Los Angeles and New York City with the benefits of plans in five other areas—Cleveland, Houston, Long Island, N.Y., Seattle, and Tucson—in order to assess geographic inequality in benefit packages.

The analysis shows that Medicare+Choice plans in Los Angeles and New York City provide far more generous benefits at lower costs to beneficiaries than plans in the other five sites. We found large differences in enrollment-weighted premiums, coverage of prescription drugs, and cost-sharing for specialty and hospital care. Added together, these differences result in wide variations in out-of-pocket costs depending on where beneficiaries live. The causes are threefold: differences in Medicare payment rates that are not always reflective of the cost of care; the inability of Medicare+Choice plans in some communities to control costs and utilization; and in some instances, plans' fear of adverse risk selection.

Policymakers' options for addressing these geographic disparities in benefits are limited. Increasing reimbursements in low-payment counties only or in all Medicare+Choice markets would not address the problem. However, addressing the underlying reasons for payment differentials—differences in fee-for-service practice patterns—by rewarding areas that provide high-quality care would likely lead to cost-efficient, higher quality care.

The existence of “have” and “have not” Medicare+Choice communities runs counter to Medicare's tradition of providing a uniform benefit package to all beneficiaries. These differences undermine both the Medicare+Choice program and Medicare generally. The current geographic disparities of the Medicare+Choice program will be difficult to avoid in any capitated private plan-based approach to Medicare's future.

GEOGRAPHIC INEQUITY IN MEDICARE+CHOICE BENEFITS

FINDINGS FROM SEVEN COMMUNITIES

Intended as a national insurance plan, Medicare was built on the premise that all would receive the same health care benefits no matter where they lived. The Medicare+Choice program, which enables private insurers to offer Medicare beneficiaries health insurance options, especially HMOs, is eroding this promise of equal benefits. Many Medicare beneficiaries live in communities that have no Medicare+Choice options—in 2002, only 12.8 percent of beneficiaries in rural (non-MSA) counties had access to a Medicare+Choice HMO. Nationally, only 60.5 percent of the Medicare population had access to at least one Medicare+Choice HMO, down from 74 percent in 1998.¹ The inequity goes beyond disparities in access: benefit offerings and cost-sharing requirements vary substantially among communities that do have Medicare+Choice options. Consequently, beneficiaries in one area may experience an entirely different Medicare program than those in other locations.

This issue brief examines the benefit packages of plans in seven areas—Cleveland, Houston, Long Island, N.Y., Los Angeles, New York City, Seattle, and Tucson—to find disparities in benefits and to assess the effect these differences have on beneficiaries' costs.² It concludes with an analysis of the causes of these disparities and the implications for policymakers who would address this fundamental flaw in Medicare+Choice.

MEDICARE+CHOICE BENEFIT REQUIREMENTS

Medicare+Choice plans are required to provide at least the same benefits as fee-for-service Medicare. However, the plans may impose cost-sharing requirements on benefits in amounts up to the average amount beneficiaries would pay out-of-pocket for benefits in the fee-for-service program (assuming they had no Medigap insurance coverage). This was \$105 per month in 2002. Plans may also offer supplemental benefits, e.g., outpatient prescription drugs, with caps and cost-sharing requirements that vary widely.

Unlike Medigap plans, Medicare+Choice plans are not required to offer standardized benefit packages. Therefore, intra- and inter-market variations in benefit offerings and cost-sharing requirements are common. Within markets, these differences make it difficult and confusing to compare benefit packages.³ Among markets, differences in premiums, benefits, and cost-sharing requirements leave some beneficiaries better off than others, depending on where they live. For example, Medicare+Choice plans continue to offer generous prescription drug benefits for low or no premiums in a few

large urban counties; in other markets, plans charge high premiums while limiting coverage to generic drugs or offer no prescription drug benefits at all. Moreover, deductibles, copayments, and coinsurance requirements for Medicare-covered benefits that all Medicare+Choice organizations must provide vary widely and can make the cost of these benefits dramatically different, depending on the plan's market.

DISPARITIES IN BENEFIT PACKAGES—THE HAVE AND HAVE-NOT COMMUNITIES

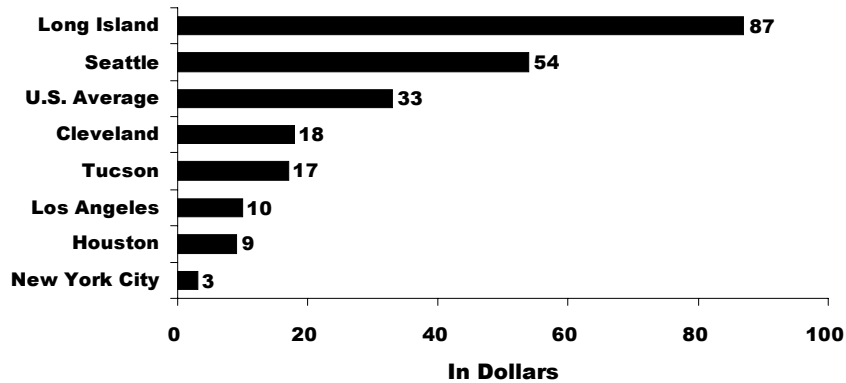
We compared the 2002 benefit packages of Medicare+Choice plans in two communities—Los Angeles and New York City—with packages in five other areas—Cleveland, Houston, Long Island, N.Y., Seattle, and Tucson. For reasons discussed below, Medicare+Choice plans in Los Angeles and New York City can offer far more generous benefits at lower costs to beneficiaries than plans in the other five sites. We analyzed the benefits of the “have” and “have-not” communities for differences in: (1) plan premiums, (2) prescription drug caps, and (3) cost-sharing for specialty physician care and hospital services.

Premiums

Medicare+Choice premiums have risen steeply since 1999, when 61 percent of the Medicare population had access to a zero-premium plan.⁴ In 2002, almost a third (32 %) of Medicare+Choice enrollees will pay premiums of more than \$50 a month and seven percent will pay premiums of more than \$80 a month.⁵

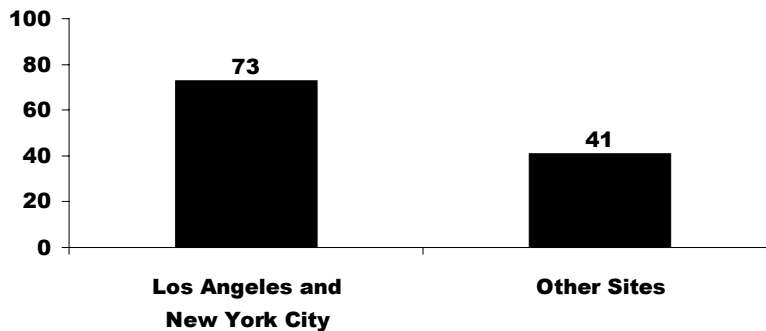
Figure 1 shows the 2002 enrollment-weighted average monthly premium for the Medicare+Choice basic plan in the seven study communities.⁶ These premiums range from \$3 in the five boroughs of New York City, where only one of 10 plans charges a premium, to \$87 in Long Island, where premiums range from \$89 to \$160 (with the exception of one small plan in Nassau and Suffolk Counties that has 10 percent of the Medicare+Choice enrollment). In New York City and Los Angeles, 73 percent of enrollees are in plans that offer zero-premium products, compared with 41 percent in the other five sites (Figure 2).

**Figure 1. Average Monthly Premium, Medicare+Choice Plans, 2002
Weighted by Plan Enrollment**



Source: George Washington University analysis of Medicare Health Plan Compare and CMS State/County/Plan Market Penetration Report, March 2002. U.S. Average from CMS, *Medicare+ Choice Changes in Access, Benefits, and Premiums, 2001 to 2002*, December 2001. Each Medicare+Choice plan's "basic plan" is considered. CMS defines a "basic plan" as "the lowest cost, most generous (in benefits) plan offered by a Medicare+Choice organization in a particular county."

Figure 2. Percentage of Medicare+Choice Enrollees in Plans Offering a Zero-Premium Product, 2002

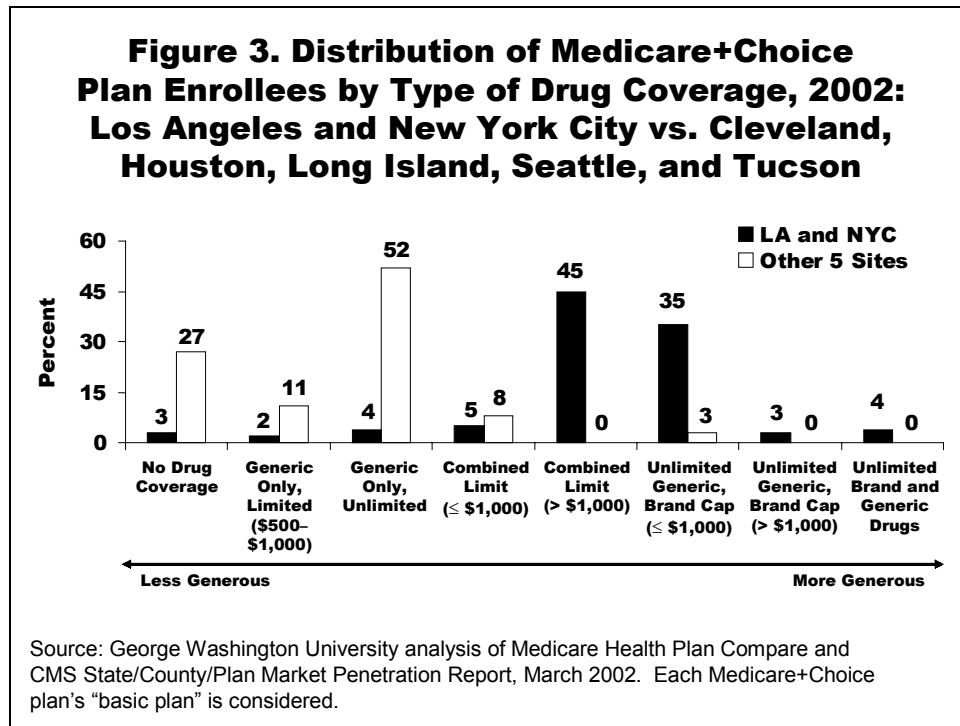


Source: George Washington University analysis of Medicare Health Plan Compare and CMS State/County/Plan Market Penetration Report, March 2002. U.S. Average from CMS, *Medicare+ Choice Changes in Access, Benefits, and Premiums, 2001 to 2002*, December 2001. Each Medicare+Choice plan's "basic plan" is considered. CMS defines a "basic plan" as "the lowest cost, most generous (in benefits) plan offered by a Medicare+Choice organization in a particular county."

Prescription Drug Benefits

The availability of prescription drug coverage is the primary reason Medicare beneficiaries join Medicare+Choice plans. However, both the availability and cost of these benefits eroded significantly from 1999 to 2002.⁷ Fifteen percent of enrollees are now in plans that

do not offer any drug coverage. Among plans that continue to offer the benefit in 2002, the value of coverage has diminished, especially in coverage for brand-name medications. In 2002, 63 percent of plans offered some brand coverage, down from 87 percent in 2001.⁸



Despite this across-the-board decline in coverage, plans in select markets continue to offer generous prescription drug benefits. Although some plans in Los Angeles and New York City followed the national trend by reducing prescription drug benefits from 1999 to 2002,⁹ the difference between prescription drug benefits offered in these two markets and those offered in the other five markets is still dramatic. Figure 3 shows that Los Angeles and New York City beneficiaries have access to far more generous prescription drug benefits than do their counterparts in the other five sites. For example, 92 percent of enrollees in Los Angeles and New York City are in plans that provide some brand coverage compared with 11 percent of enrollees in the other five communities. In Seattle, none of the three Medicare+Choice plans offers any prescription drug coverage;¹⁰ in Houston and Tucson, no plan offers brand coverage; in Long Island, only one small plan with a limited network offers any brand coverage and the other four plans offer generic coverage only. In Cleveland, two of five plans do not cover drugs, one offers generic-only coverage, and two offer some limited brand coverage.

Cost-Sharing

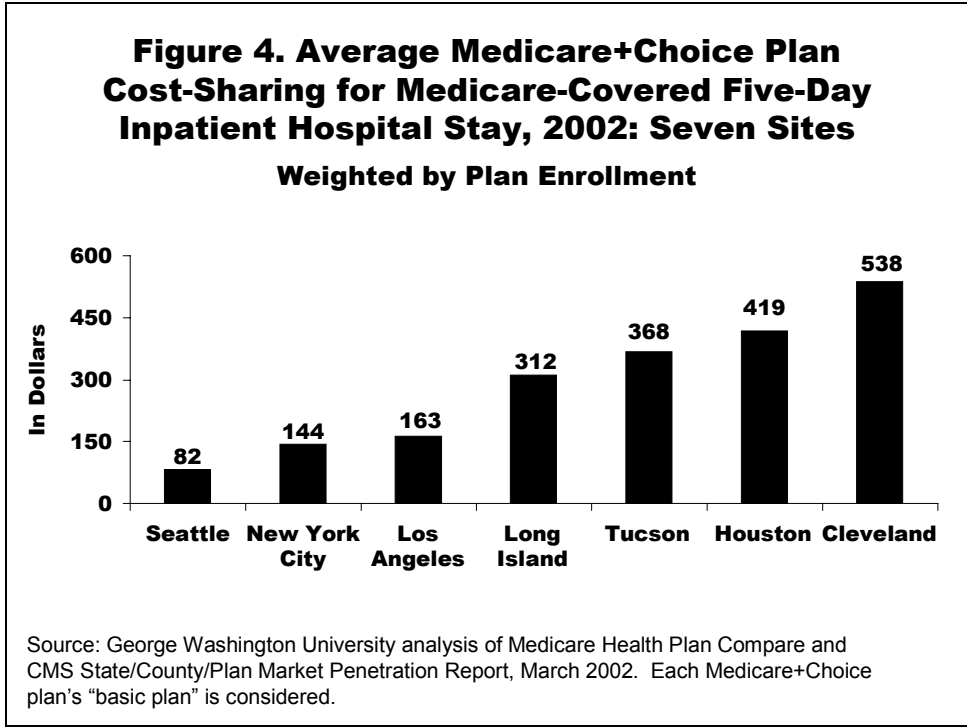
Cost-sharing (out-of-pocket costs for covered benefits) also varies dramatically by market. Increasingly, Medicare+Choice plans are imposing higher deductibles, copayments, and coinsurance for Medicare-covered services as a way to transfer costs to members and reduce utilization.¹¹ Over the past three years, enrollees have experienced significant increases in copayments for primary care, and especially for specialty physician visits.

As with premiums and drug coverage, copayments for a visit to a specialist physician vary among markets. On average, these copayments are significantly lower in Los Angeles and New York City than they are in the other five communities (Table 1). None of the Los Angeles plans and only four of 10 New York City plans charged \$20 for a specialist visit compared with 10 plans (63 %) in the other five communities, where enrollees paid \$20 or more for a specialty visit. Enrollees in Cleveland, Houston, and Tucson can pay as much as \$30 for a visit to a specialist.

Table 1. Medicare+Choice Plan Copayments for Office Visit to Specialist Physicians, 2002: New York City and Los Angeles vs. Cleveland, Houston, Long Island, Seattle, and Tucson

Specialist Copayments	New York City and Los Angeles (19 Plans)		Other Five Sites (16 Plans)	
	No. of Plans	Percent of Plans	No. of Plans	Percent of Plans
Under \$20	15	78.9%	6	37.5%
\$20 and Over	4	21.1%	10	62.5%
\$30	—	—	3	18.8%

Out-of-pocket costs for hospital care also vary significantly depending on where enrollees live. Enrollment-weighted average copayments for one five-day Medicare-covered inpatient hospital stay ranged from \$82 in Seattle to \$538 in Cleveland. New York City and Los Angeles have the second- and third-lowest enrollment-adjusted hospital costs, \$144 and \$163 respectively (Figure 4). Enrollment-weighted average costs are lower in Seattle because of the large enrollment in Group Health of Puget Sound, a staff-model HMO that charges no hospital deductible or copayment.

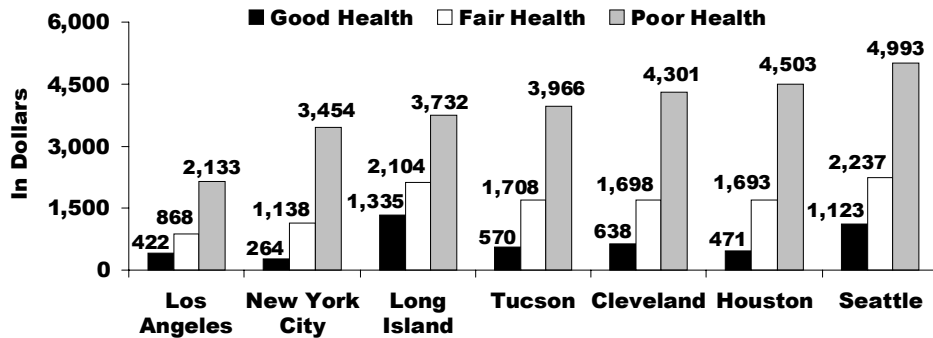


Cost-sharing for other benefits and services, e.g., ambulance, occupational therapy visits, durable medical equipment and diabetes monitoring supplies, also varies, but there is a less discernable pattern across markets.

MEDICARE+CHOICE OUT-OF-POCKET COSTS

Added together, the differences in premiums, benefit caps (especially for prescription drugs), and cost-sharing result in wide geographical variations in out-of-pocket costs. To compare these costs, we used a methodology developed by Mathematica Policy Research using HealthMetrix Research, Inc.'s HMO cost-share report.¹² Figure 5 shows enrollment-weighted average estimated out-of-pocket expenses for Medicare+Choice enrollees in good, fair, and poor health in the seven communities.¹³ In this example, Seattle enrollees in good health pay 2.7 times as much in out-of-pocket costs as enrollees in Los Angeles; enrollees in fair health, 2.6 times; and in poor health, 2.3 times as much. On average, Long Island enrollees in good health pay out-of-pocket expenses that are more than five times what their neighbors in New York City pay; those in fair health pay 1.8 times the New York City amount.

Figure 5. Average Estimated Out-of-Pocket Health Care Expenses in Medicare+Choice Plans, 2002: Seven Sites



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

Combining out-of-pocket costs for premiums and cost-sharing produces a fuller picture of the wide variations in enrollee expenses because some plans trade off high premiums with low cost-sharing.¹⁴ Thus, although more than 90 percent of Houston enrollees pay no premiums, limited prescription drug benefits and high cost-sharing make average out-of-pocket costs for enrollees in poor health the second highest among the seven sites. Long Island enrollees in good health have the highest out-of-pocket expenses among the seven sites, primarily because of the high premiums. From the enrollee perspective, high premiums coupled with no prescription drug coverage make Seattle the most expensive market in the study.

On average, enrollees still pay significantly less in out-of-pocket costs than they would in original fee-for-service Medicare.¹⁵ However, because of high copayments imposed for some services, such as injectable drugs, beneficiaries with life-threatening diseases may pay more in a Medicare+Choice plan than in original fee-for-service Medicare, depending on their health plan.¹⁶

CAUSES OF DISPARITIES IN BENEFITS

The causes of benefit disparities are threefold: (1) Medicare payment rate differences; (2) the ability of Medicare+Choice plans in different markets to control costs and manage care; and (3) fear of adverse risk selection.

Medicare Payment Rates

The differential in Medicare payment rates across the country is both dramatic and not always reflective of the cost of care. Nowhere is the contrast in reimbursement rates more pronounced than in Long Island and New York City. Medicare+Choice observers in both communities were unanimous in their assessment that the cost of providing care is as great or even higher in Nassau County, Long Island, than it is in parts of New York City. Nonetheless, the monthly Medicare payment rate in Nassau County is from 12 to 31 percent less than in the five NYC boroughs.

Table 2. Monthly Medicare Payment Rates (AAPCC): Seven Sites

Site	2002
Cleveland, OH	
Cuyahoga County	\$605
Houston, TX	
Harris County	\$664
Los Angeles, CA	
Los Angeles County	\$694
Long Island, NY	
Nassau County	\$654
Suffolk County	\$622
New York City, NY	
Bronx County	\$812
Kings County	\$786
New York County	\$795
Queens County	\$735
Richmond County	\$856
Seattle, WA	
King County	\$553
Tucson, AZ	
Pima County	\$553
Minimum AAPCC	\$500
Maximum AAPCC	\$856
Average AAPCC	\$608

The Cost of Care

Higher prescription drug costs, provider demands, and increasing utilization increase the costs of providing care. Even in the two lowest payment sites—Seattle and Tucson—where payments increased by 14.5 percent and 10.8 percent respectively from 1999 to 2002, added Medicare payments were not enough to offset escalating costs. Increases in

prescription drug costs of 17 percent in 2001 made it impossible for Medicare+Choice plans to hold the line on prescription drug benefits.¹⁷

A provider backlash against managed care as well as the consolidation of hospitals in several of the study sites also made it more difficult for Medicare+Choice plans to wring efficiencies and price discounts from contracting providers. This was especially the case in Houston, where Medicare payment rates are well above the national average. Houston plans were unable to control costs because of high hospital costs and utilization rates well above the national norm. This resulted in a mass exodus of plans at the end of 2000 and higher cost-sharing in the remaining plans.¹⁸

Fear of Adverse Risk Selection

Some increases in cost-sharing seem to be directly related to plans' fear of adverse risk selection. Across the nation, plans increased costs on services that were more likely to be used by members with life-threatening illnesses and chronic conditions (e.g., hospital and nursing home care, oxygen and other durable medical equipment, mental health services, and injectable drugs). In addition, in communities like Tucson, where only two Medicare+Choice plans remain, the fear of adverse selection makes plans play follow-the-leader. Only a year after one plan dropped all brand-name drug coverage, the second plan followed suit.¹⁹

POLICY OPTIONS

Many beneficiaries are aware of geographic disparities in Medicare+Choice benefits. For example, participants in a December 2001 Long Island focus group reacted strongly to Medicare+Choice plan announcements of their withdrawals, premium hikes, and benefit reductions for 2002. They couldn't understand why their neighbors in Queens had access to zero-premium plans with generous prescription drug benefits while they did not. Focus group participants in Seattle were similarly aware that Medicare+Choice plans in Los Angeles and Miami provided generous prescription drug packages, while they had no such options.²⁰ In response to these concerns, the State of Washington announced in 2000 that it was considering legal action against the Federal government for Medicare plan payment differentials that result in benefit disparities.²¹

Such disparities cannot be easily fixed. Many of the payment options under consideration (see below) either do not address the problem at all or raise other concerns. Because payment differences in Medicare+Choice are linked to payments in the traditional fee-for-service program, the answer to inequity in Medicare+Choice may lie

outside of the program itself and in the nature of the nation's health care delivery system itself.

- **Increasing reimbursements to low-payment counties.** A payment system that continues disproportionate increases in Medicare payments to low-payment counties like Seattle and Tucson necessarily creates winners and losers. Under this scenario, Medicare+Choice enrollees in Los Angeles and New York would lose benefits, while those in Seattle and Tucson would see enhanced benefit packages. The effectiveness of such a policy is doubtful. For example, payment increases under the Benefits Improvement and Performance Act in 2001 had little effect in stopping either plan withdrawals or benefit reductions.
- **Increasing payments in all markets.** Significantly raising Medicare payments equally across all markets also would not address the problem of benefit disparities, although it might allow plans in low-payment areas to enhance benefits. In addition, this option would increase Medicare costs in some areas to a level above that of original fee-for-service Medicare and reward inefficient, as well as efficient, health plans.
- **Implementation of a risk-adjusted payment methodology.** A risk-adjusted payment methodology should result in higher payments to plans that enroll disproportionate numbers of high-cost beneficiaries. However, plans that have healthier enrollees compared with original Medicare will see their Medicare payments decline, leading them to reduce benefits or even withdraw from the program. Thus, while risk adjustment would result in fairer payments to plans based on the health status of their members, it is unlikely that it would reduce geographic disparities in plan benefits.
- **Addressing the underlying reasons for payment differentials in the Medicare+Choice program.** Medicare+Choice payments are tied to local per capita costs in fee-for-service Medicare. In large part, these differences in payment rates are due to differences in practice patterns that have little or no relationship to the quality of care provided. Policy analysts and researchers have proposed changing Medicare payment policy to better reward areas of the country and health care systems that practice high-quality efficient medical care.²² In the long term, fixing the underlying structural flaws in Medicare fee-for-service payments would improve quality, reduce costs, and address many of the payment inequities in Medicare+Choice markets.

Other options to address the problems caused by geographic disparities in Medicare+Choice benefit packages go beyond changes in the payment methodology:

- **Standardization of Medicare+Choice benefit packages.** Requiring plans to offer one of a set of benefit packages across the country would, at a minimum, make similar benefits available to all enrollees. For example, plans could be required to offer three benefit packages—one with no prescription drug benefits, one with generic benefits only, and one with generic and brand benefits. Cost-sharing could also be standardized. Although premiums would vary significantly, beneficiaries in all areas would at least have some prescription drug options and be able to better compare their choices.²³
- **Providing a prescription drug benefit in Medicare.** A Medicare prescription drug benefit would provide beneficiaries with some prescription drug coverage. Thus, Medicare+Choice plan benefit differentials would be less of a concern for enrollees who joined the program for the added drug benefit.

SUMMARY

The generosity of Medicare+Choice plan benefit packages, as measured by premiums, drug coverage, and overall cost-sharing, varies extensively across metropolitan areas. An even wider gap exists between the Medicare+Choice plan benefits offered to beneficiaries in urban and rural areas, since there are few rural areas where Medicare+Choice plans operate.

The existence of “have” and “have not” Medicare+Choice communities runs counter to Medicare’s tradition of providing a uniform benefit package to all beneficiaries nationwide. These differences undermine both Medicare+Choice and Medicare generally. The geographic disparities currently seen in the Medicare+Choice program will be difficult to avoid in any capitated private plan–based approach to Medicare’s future.

NOTES

¹ In addition to Medicare coordinated care plans, 16 percent of the Medicare population had access to Sterling Option I, a private fee-for-service plan, as the only available Medicare+Choice plan. See Center for Medicare and Medicaid Services, *Medicare+Choice Changes in Access, Benefits, and Premiums, 2001 to 2002* (Washington, D.C.: CMS, December 2001. Available at <http://cms.hhs.gov/healthplans/>).

² The analysis is part of an ongoing effort by The Commonwealth Fund to monitor the implementation of Medicare+Choice in these seven communities. See Jennifer Stuber et al., *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (New York: The Commonwealth Fund, January 2002).

³ Geraldine Dallek and Claire Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, October 2001).

⁴ Lori Achman and Marsha Gold, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (New York: The Commonwealth Fund, February 2002).

⁵ CMS, *Medicare+Choice Changes in Access*, December 2001.

⁶ Ibid. CMS defines a “basic plan” as “the lowest cost, most generous (in benefits) plan offered by a Medicare+Choice organization in a particular county.”

⁷ Ibid.

⁸ Ibid.

⁹ In Los Angeles in 2002, for example, Aetna U.S. Healthcare began charging a \$25/month premium and reduced brand coverage from \$2,000 to \$1,000 a year; Blue Shield reduced brand coverage from \$2,500 to \$1,000 a year; and Kaiser Permanente went from an unlimited drug benefit to a \$2,000 combined cap for generic and brand drugs.

¹⁰ Group Health’s high-option plan has a prescription drug benefit for a \$189 a month premium, but has been closed to new enrollees since 1994.

¹¹ Stuber et al., *Instability and Inequity*, January 2002; Achman and Gold, *Medicare+Choice 1999–2001*, February 2002.

¹² See Lori Achman and Marsha Gold, *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (New York: The Commonwealth Fund, February 2002); detailed discussion of methodology at HealthMetrix Research Inc., <http://www.hmos4seniors.com>.

¹³ Methodology for this analysis was developed by HealthMetrix Research Inc. Good health status assumes low annual utilization (4 in-network doctor office visits; 1 out-of-area urgent care visit; no inpatient admissions); 6 prescriptions (3 generic and 3 brand prescriptions); 1 physical (vision, hearing exam); and 1 dental prevention visit. Fair health status assumes moderate annual utilization (12 in-network doctor office visits; 1 emergency room visit; 1 three-day inpatient admission); 24 prescriptions (2 generic and 2 brand per month); 1 physical (vision, hearing exam); and 1 dental prevention visit. Poor health status assumes high annual utilization (24 in-network doctor office visits; 2 emergency room visits; 2 three-day inpatient admissions); 72 prescriptions (3 generic and 3 brand per month); 1 physical (vision, hearing exam); and 1 dental prevention visit. See www.hmos4seniors.com.

¹⁴ CMS, *Medicare+Choice Changes in Access*, December 2001.

¹⁵ Ibid.

¹⁶ Brian Biles, Geraldine Dallek, and Andrew Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future* (New York: The Commonwealth Fund, September 2002).

¹⁷ Ceci Connolly, "Pharmaceutical Spending Continues Steady Increase; A Few Heavily Advertised and High-Priced 'Blockbuster' Medications Drive 17 Percent Increase," *Washington Post*, March 29, 2002: A09.

¹⁸ Biles, Dallek, and Dennington, *Medicare+Choice After Five Years*, September 2002.

¹⁹ *Ibid.*

²⁰ *Ibid.*

²¹ S. Smokey, "State May Go to Court Over Medicare," *Seattle Times*, July 8, 2000. A federal appeals court recently rejected a similar lawsuit by beneficiaries in Minnesota. C. DeFiebre, "Appeals Court Rejects Medicare Payment Suit," *Minneapolis Star Tribune*, December 14, 2001.

²² John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs* (February 13, 2002, web exclusive): W96–W114; Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2002).

²³ Dallek and Edwards, *Restoring Choice to Medicare+Choice*, October 2001.

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#562 *Medicare+Choice After Five Years: Lessons for Medicare's Future—Findings from Seven Major Cities* (September 2002). Brian Biles, Geraldine Dallek, and Andrew Dennington. This field report argues that, five years later, Medicare+Choice has not become what program proponents had envisioned. While it was originally forecast that program enrollment would rise to 34 percent of total Medicare enrollment by 2005, the enrollment has now fallen from its 1997 level of 14 percent to just 13 percent.

#548 *Medicare+Choice in New York City: So Far, So Good?* (September 2002). Jennifer Stuber, Andrew Dennington, and Brian Biles. In this field report, the authors suggest that New York City's more than 200,000 elderly and disabled enrollees in Medicare+Choice plans—representing about 20 percent of all New York City Medicare beneficiaries—may soon begin to experience large-scale health plan withdrawals, premium increases, benefit reductions, and provider network instability, as have beneficiaries in most other markets.

#544 *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (August 2002). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this policy brief, the authors suggest that a modest Medicare prescription drug benefit could be crafted that provides some coverage to all beneficiaries while protecting those with low-incomes and high out-of-pocket expenses.

#530 *State Pharmaceutical Assistance Programs: Approaches to Program Design* (May 2002). Kimberley Fox, Thomas Trail, and Stephen Crystal, Rutgers Center for State Health Policy. State pharmacy assistance programs for Medicare beneficiaries help only a small proportion of the Medicare population—just 3 percent, or 1.2 million beneficiaries out of 39 million nationwide. According to the authors, a federal program is needed to fill this gap in coverage, and it should coordinate with the 28 state programs currently in place.

#538 *A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the significant policy challenge of designing an effective and politically viable Medicare prescription drug benefit. Available online only at www.cmwf.org.

#537 *Medicare Managed Care: Medicare+Choice at Five Years* (April 2002). Colleen L. Barry and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, examines trends in enrollment, benefits and premiums, plan payments, and satisfaction and quality in Medicare+Choice. Available online only at www.cmwf.org.

#533 *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (March 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. In this report (available on the

Fund's website only), the authors note that while increases in monthly premiums will affect all enrollees in 2002, sicker beneficiaries will bear the brunt of changes in the structure of prescription drug benefits and cost-sharing requirements as more plans restrict drug coverage to generics only and raise cost-sharing requirements for services such as inpatient and outpatient hospital care.

#497 *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. The authors report that mean premium and cost-sharing levels in Medicare+Choice plans continued to increase in 2001 while coverage of prescription drugs was reduced. This trend continued despite congressional action that increased the payment rate MCOs received.

#494 *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. Analysis by the authors of Medicare Compare found that out-of-pocket spending for Medicare+Choice enrollees can be substantial and varies significantly with health status. In 2001, the average enrollee in good health spent \$1,195 annually out-of-pocket on health care, while an enrollee in poor health spent \$3,578, or about three times as much.

#505 *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy* (January 2002). Becky Briesacher, Bruce Stuart, and Dennis Shea. In this issue brief, the authors evaluate trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project their future coverage, costs, and needs. Based on data from 1993 to 1998, the projections indicate that beneficiary drug coverage likely peaked in 1998 or shortly thereafter, and has been in decline ever since.

#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.

#510 *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?* (December 2001). Geraldine Dallek, Brian Biles, and Andrew Dennington, George Washington University. This issue brief points to large-scale health plan withdrawals and provider turnover in the Medicare+Choice market among reasons to delay or repeal the Medicare+Choice policy to lock beneficiaries into their plans for a specified period.

#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.

#490 *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (October 2001). Geraldine Dallek and Claire Edwards, George Washington University. In this field report, the authors discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans,

poring over data, and making complicated calculations in order to make any kind of reasonable comparison of plans.

#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. The authors argue that any major change to the Medicare program—such as requiring coinsurance for home health care—must take into account the steep costs seriously ill beneficiaries already pay for health services.

#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.cmrwf.org/programs/medfutur/gold_bipa_467.pdf

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund’s president cautioned that any effort to reform Medicare’s benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare’s Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

#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.

Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review*, vol. 2, no. 1. Reprinted from *New Jersey Medicine*, March 2000. Available online at <http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html>.

#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.

#430 *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries* (January 2001). Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

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.

#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 President Clinton'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.

#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.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs*, vol. 19, 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.

#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 may happen now that the National Bipartisan Commission on the Future of Medicare has 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.

The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *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.