MEDICARE+CHOICE PLANS CONTINUE TO SHIFT MORE COSTS TO ENROLLEES

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April 2003

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

This report (**#628**) is available online only from The Commonwealth Fund's website at **www.cmwf.org.**

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Mathematica Policy Research, with funding from The Commonwealth Fund, has analyzed trends in benefits and premiums in the Medicare+Choice—Medicare's managed care option—since 1999. The tables that follow provide a first look at benefit trends in 2003. Much like in previous years, Medicare+Choice plans have continued to raise premiums and beneficiaries' cost-sharing, while at the same time limiting coverage of supplemental benefits such as prescription drug coverage. Key findings from 2003 include:

- In 2003, monthly enrollee premiums have increased again, to an average $37, from $32 in 2002 (Table 1). Thirty-eight percent of beneficiaries are enrolled in basic plans with a zero premium, including those plans offering a rebate for the Part B premium (which covers ambulatory care and related services).

- The Benefits Improvement and Protection Act of 2000 (BIPA) amended the Social Security Act to allow Medicare+Choice managed care organizations to offer a reduction in an enrollee's Part B premium as an additional benefit, effective in 2003. Only 1 percent of plans, accounting for just 0.2 percent of enrollees, took advantage of the option to offer a Medicare Part B rebate (Table 1). Enrollees in these plans, which are in Florida and New York, see their Medicare Part B premium reduced by 80 percent of the amount the managed care organization has elected to reduce its monthly capitation rate. For example, a plan offering a full Medicare Part B rebate in 2003, $59 in 2003, must take a $74 reduction in its monthly capitation rate from the Centers for Medicare and Medicaid Services (CMS). Managed care organizations are not allowed to offer a reduction that exceeds the standard Part B premium.

- The percentage of enrollees with prescription drug coverage dropped slightly in 2003 to 69 percent, from 72 percent in 2002 (Tables 2 and 5).

- Health plans continue to limit their prescription drug coverage to generic medications only. In 2003, 60 percent of basic plans will only cover generics, compared with 55 percent in 2002 and 19 percent in 2001 (Table 3). Plans that do cover both brand-name and generic drugs have tightened the annual limits on that drug coverage: those imposing an annual limit of $500 or less increased to 20.5 percent in 2003 from 16 percent in 2002. In 2003, only three plans offer "unlimited" drug coverage for generic and brand-name drugs. Two of those plans, however, require 70 percent coinsurance, while the third plan has a prescription drug deductible of $6,250.

- In 2002, a substantial number of Medicare+Choice plans added inpatient hospital copayments. This trend has continued in 2003. This year, 82 percent of enrollees will have some type of cost-sharing for inpatient hospital admissions (Table 4). Nonetheless,

the proportion of enrollees with cost-sharing for hospital outpatient procedures has decreased, from 70 percent in 2002 to 54 percent in 2003.

- Copayments for physician visits, both primary care doctors and specialists, rose in 2003. This year, 24 percent of enrollees have a primary care physician copayment greater than $15, compared with just 4 percent last year. Similarly, 63 percent of enrollees have a specialist copayment greater than $15, compared with 41 percent last year.

- In 2003, Medicare Compare—CMS's online tool that allows beneficiaries to compare Medicare+Choice plans' benefits, cost-sharing, and service areas—included information on overall annual out-of-pocket maximums for the first time. Approximately 28 percent of basic plans, accounting for 35 percent of enrollees, reported having an out-of-pocket plan maximum for "certain plan services"[1] (Table 6). Basic plans that reported an out-of-pocket maximum were all at or below $5,000 per year. Those plans that did not report an overall out-of-pocket maximum may have individual out-of-pocket maximums for specific benefits, such as inpatient hospital services.

Methods

The analysis presented here is based on a database created from publicly available information from Medicare Compare. Enrollment numbers from CMS's Geographic Service Area report have been merged with the file in order to provide enrollment-weighted estimates. Medicare+Choice plans may offer more than one benefit package to beneficiaries in an area; however, enrollment numbers are available only at the plan level. Therefore, this analysis is based on the "basic" benefit package under a contract—defined generally as the benefit package with the lowest monthly premium and, in cases where the premium is the same, the package with the most extensive prescription drug benefit. Plans that reduce benefits, however, may offer alternative packages or riders to provide additional options to enrollees. Future analysis of 2003 benefits will examine choice in the context of the full range of packages offered to beneficiaries. Plan-weighted estimates are based on contract segments, which represent geographic areas serviced under a contract where the choice of benefit packages is uniform.

[1] Medicare Compare does not note which services are included in the phrase "certain plan services."

Table 1. Monthly Premiums for Basic Packages in Medicare+Choice Contract Segments, 1999–2003

	Percentage of Basic Plans					Weighted by Enrollment				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Reduced Part B Premium	na	na	na	na	1.2	na	na	na	na	0.2
None	62.1	42.3	45.5	38.1	39.3	79.6	59.0	46.0	40.7	38.1
Less than $20.00	3.2	5.3	5.1	2.9	1.2	3.1	8.7	8.2	4.8	1.3
$20.00–$49.99	20.5	26.9	21.5	20.6	19.2	13.5	19.3	27.1	22.8	25.2
$50.00 or more	7.4	22.9	27.5	38.4	39.0	3.2	11.1	18.6	31.8	35.2
Unknown	5.9	2.6	0.5	0.0	0.0	0.6	1.8	0.1	0.0	0.0
Mean	$13.31	$25.73	$28.65	$37.98	$39.36	$6.37	$14.43	$22.94	$32.08	$37.43
Mean if premium does not equal $0	$39.08	$45.47	$52.75	$61.34	$66.40	$32.11	$36.19	$42.52	$54.05	$60.50
Number of Contract Segments/ Number of Enrollees	443	468	396	344	333	6,254,616	6,094,767	5,577,787	4,964,007	4,564,252

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

Note: Enrollment is for 1999–2002 is from March of each year. Enrollment for 2003 is from February 2003.
na: not applicable; authorized only beginning in 2003

Table 2. Prescription Drug Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999–2003

	Percentage of Basic Plans					Weighted by Enrollment				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Any Drug Coverage	73.4	67.5	64.5	65.7	66.1	83.9	78.0	70.2	71.7	68.9
Annual Drug Cap										
$500 or less*	23.3	37.1	37.5	68.8	70.0	10.6	20.8	28.2	50.1	53.4
$501–$750	12.0	14.4	12.1	7.6	10.0	10.1	10.6	10.8	7.28	7.6
$751–$1,000	27.5	23.2	19.0	11.6	6.4	26.3	17.4	10.7	19.1	17.6
$1,001–$1,500	12.0	13.4	11.3	2.2	3.6	9.4	12.6	12.8	2.9	5.8
$1,501–$2,000	13.0	9.8	9.7	4.5	5.5	17.8	20.3	22.0	15.6	10.9
$2,001 or more	4.5	3.3	6.1	2.7	3.2	4.1	3.4	5.2	2.9	3.4
No Cap	7.8	8.8	4.4	2.7	1.4	21.7	14.9	10.4	2.2	1.4
Practices										
Formulary	81.6	91.6	89.4	83.2	80.9	80.3	92.0	90.6	89.4	85.7
Mail Orders	89.3	88.6	85.0	86.7	85.9	95.7	95.5	93.5	93.8	93.1
Quarterly Cap	14.9	23.1	20.9	18.1	13.2	12.2	13.1	15.1	11.1	8.8
Copay										
Generic										
None	6.0	4.4	6.5	7.8	4.3	7.6	7.1	7.8	7.1	5.1
$10.00 or less	29.3	92.2	82.5	71.2	62.1	84.4	90.4	83.4	73.1	71.9
$10.01 or more	4.7	3.4	11.0	21.0	33.7	8.0	2.5	8.8	19.8	23.0
Brand-name										
None	5.2	2.9	2.0	0.0	2.5	6.3	5.5	2.4	0.0	0.7
$10.00 or less	24.7	8.7	8.6	6.5	8.6	35.9	19.8	21.7	4.6	5.7
$10.01–$20.00	51.7	56.7	41.4	26.9	7.4	43.8	54.3	43.6	14.8	20.1
$20.01 or more	18.4	31.8	47.8	66.7	81.5	14.0	20.4	32.3	80.6	73.5
Ratio of Copays										
Brand Name to Generic										
2.0 or less	45.1	38.3	22.9	20.4	29.1	55.7	44.8	30.5	12.2	17.4
2.01–3.0	32.3	32.1	32.8	28.0	41.8	24.9	32.3	35.2	52.6	59.0
3.01 or more	21.9	27.8	36.3	38.7	17.7	19.2	20.7	25.6	25.5	14.0
Positive Brand, No Generic	0.7	1.8	8.0	12.9	8.9	0.2	2.2	8.7	9.8	8.7

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

Note: Enrollment for 1999–2002 is from March of each year. Enrollment for 2003 is from February 2003. Only plans that cover brand-name drugs are included in the "Brand-name Copays" and "Ratio of Copays" sections.

* 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. From 2001–2003, the number of plans just offering generic drug coverage increased dramatically, from 18.5 percent of plans with prescription drug coverage in 2001 to 60.0 percent in 2003, which accounts for some of the large increase in the percent of plans with an annual limit below $500.

Table 3. Limits on Prescription Drug Coverage by Type of Coverage Offered, 2001–2003

	Percentage of Basic Plans			Weighted by Enrollment		
	2001	2002	2003	2001	2002	2003
Of those plans with some prescription drug coverage:						
Percent covering generic-only[1]	18.5	55.3	60.0	11.4	40.3	41.4
Percent covering generic and brand name drugs	81.5	44.7	40.0	88.6	59.7	58.6
Annual Drug Cap						
For Plans Covering Both Generic and Brand-Name Prescription Drugs[2]						
$500 or less	25.6	29.3	25.0	19.7	16.1	20.5
$501–$750	14.5	17.2	25.0	12.1	12.2	13.0
$751–$1,000	22.7	26.3	15.9	11.9	32.1	30.0
$1,001–$1,500	13.5	5.1	9.1	14.3	4.9	10.0
$1,501–$2,000	11.6	10.1	13.6	24.6	26.2	18.6
$2,001 or more	7.3	6.1	8.0	5.8	4.9	5.7
No Cap[3]	4.8	6.1	3.4	11.6	3.6	2.4

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

Note: Enrollment for 2001–2002 is from March of each year. Enrollment for 2003 is from February 2003.

[1] In 2002, approximately 90 percent of enrollees in plans (85 percent of plans) with generic-only coverage had an unlimited generic benefit. The remaining had an annual cap of $500 or less. In 2003, about 74 percent of enrollees in plans with generic-only coverage (61 percent of plans) have an unlimited generic benefit, the remaining had 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.

[3] There are three plans that are counted as having an unlimited drug benefit. Two of these plans have 70 percent enrollee coinsurance. The third plan has a prescription drug deductible of $6,250.

Table 4. Copayments for Medical and Hospital Services for Basic Plans in Medicare+Choice Contract Segments, 1999–2003

	Percentage of Basic Plans					Weighted by Enrollment				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Primary Care Physician										
None	7.7	6.1	4.6	5.3	8.5	18.0	10.0	5.3	5.7	7.1
$5.00 or less	43.1	33.6	25.6	16.1	9.1	44.5	34.1	21.7	12.4	5.5
$5.01–$10.00	41.8	49.6	45.5	52.2	45.3	32.1	47.8	43.6	57.0	45.7
$10.01–$15.00	6.9	9.2	20.0	19.1	21.6	5.1	7.2	26.7	21.1	17.9
$15.01 or more	0.5	1.5	4.4	7.3	15.5	0.3	0.8	2.8	3.8	24.2
Specialist										
None	7.2	5.3	5.4	4.4	6.1	15.9	8.0	5.7	3.4	4.1
$5.00 or less	38.1	25.4	17.6	6.7	2.4	39.6	28.0	16.4	6.4	1.7
$ 5.01–$10.00	36.1	34.0	33.2	28.2	15.2	26.8	35.8	37.1	34.6	12.0
$10.01–$15.00	11.4	18.9	24.5	18.5	16.8	9.9	19.3	19.3	14.5	18.9
$15.01 or more	2.2	9.2	19.4	42.2	59.5	1.2	6.5	21.5	41.1	63.3
Varies	5.0	7.2	0.0	0.0	0.0	6.6	2.3	0.0	0.0	0.0
Emergency Room										
None	3.7	2.0	4.6	3.9	4.0	6.5	3.4	3.4	2.6	3.1
$20.00 or less	12.1	6.6	7.2	1.2	0.3	24.5	14.0	11.9	0.5	0.0
$20.01–$40.00	31.2	28.1	20.8	10.7	6.7	30.5	33.9	30.9	12.6	5.9
$40.01–$50.00	52.7	63.4	67.4	84.3	88.7	38.2	48.7	53.8	84.3	91.0
$50.01 or more	0.2	0.0	0.0	0.0	0.3	0.2	0.0	0.0	0.0	0.0
Any Copayment										
Hospital Admission	9.4	20.0	45.5	73.4*	79.9	4.3	12.8	32.7	78.4*	81.9
Hospital Outpatient	21.5	22.6	36.9	55.5	53.9	30.7	28.6	43.7	69.9	54.1
X-Ray	6.2	11.7	17.1	18.6	18.5	7.5	11.3	17.2	17.0	16.2
Lab	3.2	5.7	15.3	14.5	15.1	3.9	6.4	16.4	12.3	12.9

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

* 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).

Note: Enrollment for 1999–2002 is from March of each year. Enrollment for 2003 is from February 2003.

Table 5. Supplemental Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999–2003

	Percentage of Basic Plans					Weighted by Enrollment				
	1999	2000	2001	2002	2003	1999	2000	2001	2002	2003
Prescription Drugs	73.4	67.5	64.5	65.7	66.1	83.9	78.0	70.2	71.7	68.9
Preventive Dental	40.2	30.1	27.2	18.8	27.3	69.9	39.0	28.6	15.5	19.4
Vision Benefits	93.8	91.7	89.3	83.6	85.9	97.8	96.2	94.7	86.7	88.1
Hearing Benefits	82.4	85.2	75.5	61.0	67.9	91.3	92.0	77.7	54.3	57.1
Physical Exam	100.0	100.0	100.0	100.0	99.7	100.0	100.00	100.0	100.0	99.6
Podiatry Benefits	27.8	28.1	37.7	34.0	35.1	26.9	28.20	29.4	26.2	26.9
Chiropractic Benefits	19.0	8.8	10.7	6.7	5.7	20.9	6.8	6.0	3.7	4.8
Number of Contract Segments/ Number of Enrollees	443	468	396	344	333	6,254,616	6,094,767	5,577,787	4,964,007	4,564,252

Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

Note: Enrollment for 1999–2002 is from March of each year. Enrollment for 2003 is from February 2002.

Table 6. Annual Enrollee Out-of-Pocket Maximums in Medicare+Choice Basic Plans, 2003

	Percentage of Basic Plans	Percentage of Enrollees
No Maximum	72.5	64.9
$0–$1,000	2.4	2.9
$1,001–$2,000	2.7	1.3
$2,001–$3,000	13.8	25.4
$3,001–$4,000	1.8	1.5
$4,001–$5,000	6.9	4.1

Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

Note: This is the first year Medicare Compare has provided information on global annual out-of-pocket limits. As worded in Medicare Compare, the annual limits summarized above apply to "certain plan services." Generally, they would not apply to some of the supplemental benefits, such as prescription drug cost-sharing. Some plans may also have out-of-pocket maximums for specific benefits, such as inpatient hospital services. Historically, annual limits on spending were not an issue in many M+C plans because point of service cost sharing was low. Limits have become more relevant as cost sharing has increased. Enrollees in some plans with no maximum on out-of-pocket spending could be protected if they are in a plan with limited cost-sharing.

Other Commonwealth Fund Publications on Medicare Managed Care

#580 *Trends in Medicare+Choice Benefits and Premiums, 1999–2002* (November 2002). Lori Achman and Marsha Gold, Mathematica Policy Research.

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