



**PHYSICIAN WITHDRAWALS: A MAJOR SOURCE
OF INSTABILITY IN THE MEDICARE+CHOICE PROGRAM**

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FIELD REPORT

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EXECUTIVE SUMMARY

Public attention has recently focused on the withdrawal of Medicare+Choice plans from the Medicare program between 1998 and 2001 as a source of instability in the program. This report looks at a second major, if less visible, cause of program instability—physician withdrawals from Medicare+Choice plans. When providers leave plans, patient care is often disrupted.

This report examines Medicare data on primary care provider turnover rates in the 38 states (and the District of Columbia (D.C.)) for which data were available and in seven Medicare+Choice study sites—Cleveland, Houston, Los Angeles, Minneapolis-St. Paul, New York City, Tampa-St. Petersburg, and Tucson. It also analyzes the turnover rates for primary care physicians, cardiologists, and hospitals in Cleveland and St. Petersburg over a two-year period.

Provider turnover rates vary dramatically by state. Of the 38 states and D.C. with reported data, six states and D.C. had turnover rates of 20 percent or higher. Data also show substantial variability in provider turnover rates among plans within the same Medicare+Choice market.

Our analysis of data from 1999 and 2001 plan provider directories found that primary care physician turnover rates during the two-year period ranged from 23 percent to 61 percent among plans in St. Petersburg and from 17 percent to 25 percent among plans in the Cleveland area. Cardiology turnover rates in Medicare+Choice plans were also high in St. Petersburg and in one Cleveland plan. In contrast to the turnover rates among primary care physicians and cardiologists, however, turnover rates among hospitals were generally low. Moreover, high turnover rates generally did not affect the ratio of providers to enrollees. Most of the Medicare+Choice health maintenance organizations (HMOs) in Cleveland and St. Petersburg added as many or more providers to their networks as left the plans.

This report discusses two major causes of plan network instability—payment of providers and financial problems within networks. Plan payment rates that providers consider insufficient to cover the cost of care, as well as claims denials and payment delays, resulted in contentious relationships between plans and their provider networks at all the study sites. The financial problems of large provider organizations in three of the study sites—Houston, Los Angeles, and Tucson—also contributed to provider instability.

Policymakers should consider the following options until they adequately resolve the causes of recent Medicare+Choice program instability:

- Delay by one to two years the requirement that beneficiaries be “locked in” to a Medicare+Choice plan for a specified time even if their doctors leave the plan.
- Allow beneficiaries in the middle of treatment to continue receiving care for a specified time period from a physician or hospital that is withdrawing from a Medicare+Choice plan.
- Once lock-in is implemented, allow beneficiaries to change plans or return to fee-for-service Medicare and Medigap if their primary care physician or principal specialist leaves the plan during the lock-in period.

Continuity of care is of critical importance to Medicare beneficiaries. Medicare+Choice will remain a viable option for senior and disabled beneficiaries only if they feel secure in their health care relationships.

PHYSICIAN WITHDRAWALS: A MAJOR SOURCE OF INSTABILITY IN THE MEDICARE+CHOICE PROGRAM

INTRODUCTION

Public attention has recently focused on the withdrawal of Medicare+Choice plans from the Medicare program between 1998 and 2001. The withdrawal of 364 plans from all or part of their service areas over this four-year period disrupted care to some 2.2 million Medicare beneficiaries—more than one in four of the 6 million enrollees in Medicare managed care plans.

Plan withdrawals are not the only cause of instability in the Medicare+Choice program.¹ Physician withdrawals from plans are a major, if less visible, source of program instability. When physicians leave their Medicare+Choice plans, beneficiaries either have to find new doctors within a plan or follow their doctors by changing health plans or returning to fee-for-service Medicare.² Whichever course they choose, patient care is disrupted. Evidence suggests, meanwhile, that long-standing physician relationships help raise patient satisfaction,³ lower health care costs, and minimize the likelihood of hospitalization.⁴

To understand the full dimensions of physician withdrawals, this paper:

- Examines Medicare data on primary care provider turnover rates in the 38 states (and the District of Columbia (D.C.)) for which data are available and in seven Medicare+Choice study sites.
- Analyzes the turnover rates for primary care physicians, cardiologists, and hospitals in two metropolitan areas—Cuyahoga County (Cleveland, Ohio) and Pinellas County (St. Petersburg, Florida) over a two-year period, from 1999 to 2001.
- Examines some of the reasons for Medicare+Choice plan network changes.
- Concludes with a discussion of the implications of high provider turnover rates and possible short-term solutions.

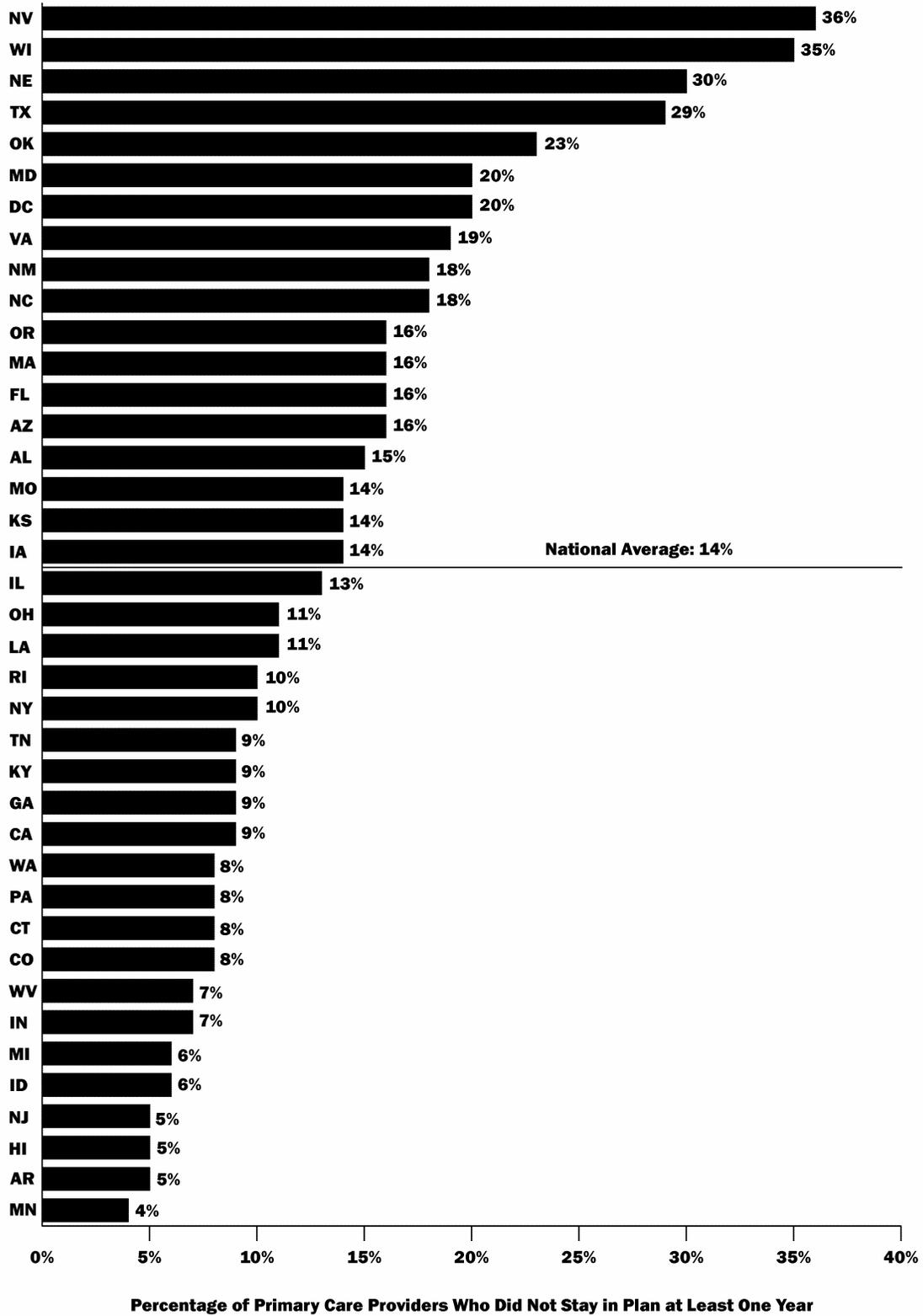
This report is based in part on information from an ongoing study of Medicare+Choice in seven cities—Cleveland, Houston, Los Angeles, Minneapolis–St. Paul, New York City, Tampa–St. Petersburg, and Tucson.⁵

PRIMARY CARE PROVIDER TURNOVER RATES BY STATE

Since 1997, Medicare has been reporting the percentage of primary care providers who stay in their Medicare+Choice plan during the entire year.⁶ Statewide provider turnover rates for 1999, the most recent year for which data were available, can be found at <http://www.medicare.gov>. The data presented in this issue brief include the rates for all Medicare+Choice HMOs continuing in the program in 2001 and the state averages across these plans.

Figure 1 shows the percentage of primary care physicians who left their plan during the year.⁷ The turnover rates vary dramatically by state, ranging from 4 to 36 percent in 1999. Although several states had Medicare+Choice plans with very low turnover rates, of the 38 states and D.C. with reported data, six states and D.C. had turnover rates of 20 percent or higher. This compares with a national turnover rate of 14 percent.

Figure 1. Primary Care Provider Turnover Rates by State



Source: Medicare Health Plan Compare database, 1999 data (see www.Medicare.gov).

In some instances, the statewide turnover rate reflects the turnover rates of only one or two plans that remained in the state as of 2001. In other states, such as Texas, the data show that a large number of Medicare+Choice HMOs had problems retaining their primary care providers (Table 1).

Table 1. States with Lowest and Highest Primary Care Provider Turnover Rates, 1999

Lowest Primary Care Provider Turnover Rates				Highest Primary Care Provider Turnover Rates			
State	Turnover Rate* (percent)	Number of Plans	Range in Turnover Rates (percent)	State	Turnover Rate* (percent)	Number of Plans	Range in Turnover Rates (percent)
Minnesota	4	3	3–6	Nevada	36	4	7–65
Arkansas	5	1	—	Wisconsin	35	3	5–48
Hawaii	5	2	3–6	Nebraska	30	1	—
New Jersey	5	5	2–17	Texas	29	11	10–41
Idaho	6	2	4–7	Oklahoma	23	4	14–76
Michigan	6	8	4–11	Maryland	20	1	—
				Washington, D.C.	20	1	—

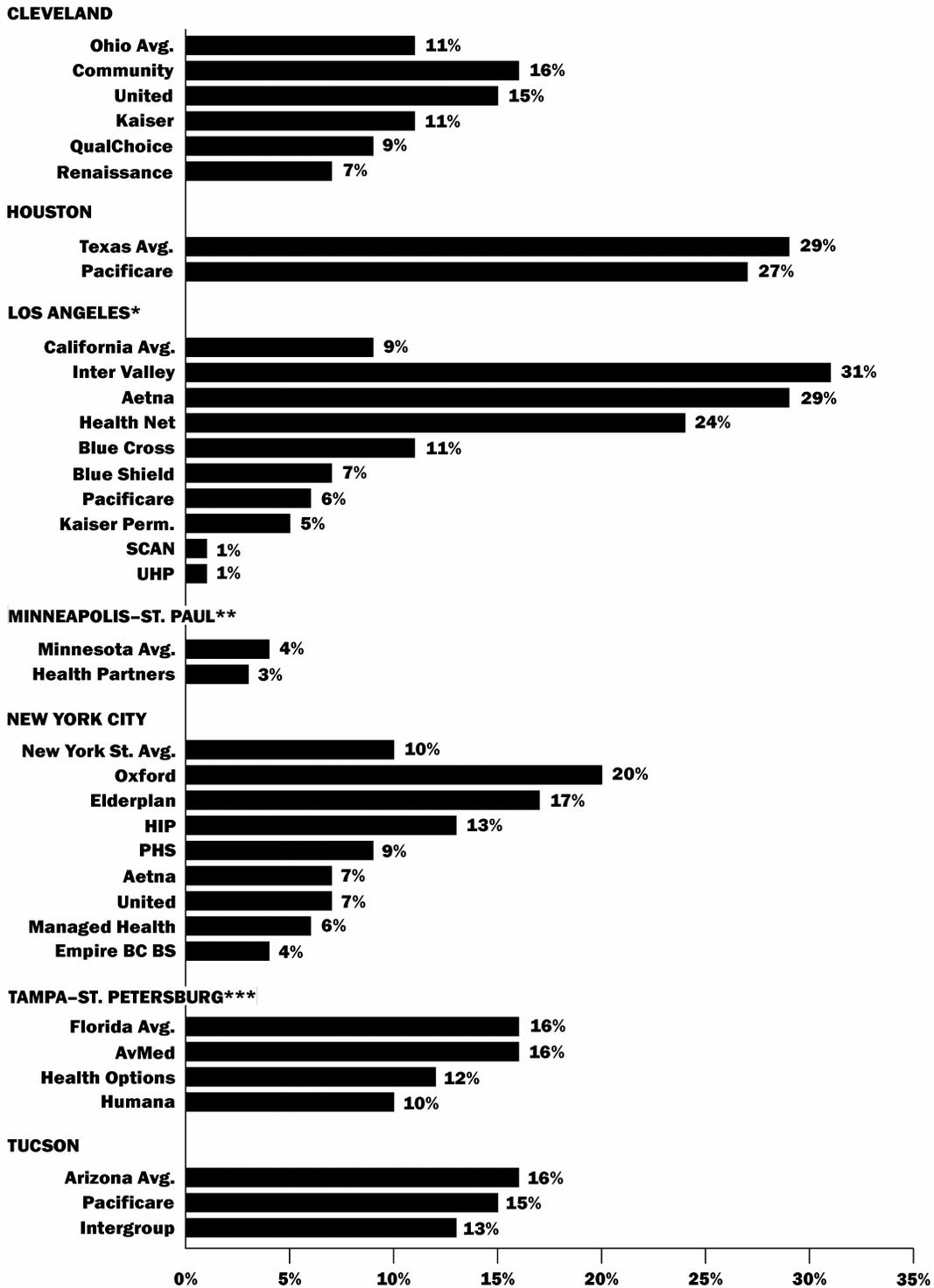
* Based on the turnover rate of plans that remained in the Medicare+Choice program in 2001.

Source: Medicare Health Plan Compare database, 1999 data (see www.Medicare.gov).

PRIMARY CARE PROVIDER TURNOVER RATES IN SEVEN CITIES

Provider turnover rates also varied dramatically within cities or metropolitan areas, as shown in Figure 2. There was substantial variability in provider turnover rates among plans within the same Medicare+Choice market, including Cleveland, Los Angeles, and New York City. In these communities, some Medicare HMOs had greater difficulty with provider relations than other plans. The overall turnover rates in New York City, for example, understate the degree of disruption for beneficiaries because the city’s two largest Medicare HMOs—Oxford Health Plans with a 35 percent market share and HIP with a 22 percent market share—had the highest primary care provider turnover rates.

Figure 2. Primary Care Provider Turnover Rates for Medicare HMOs with Recorded Data in 2001, Seven Sites



* Provider turnover rates were not available for Maxicare.

** Provider turnover rates were not available for UCare.

*** Provider turnover rates were not available for United or WellCare.

Source: Medicare Health Plan Compare database, 1999 data (see www.Medicare.gov).

PRIMARY CARE PHYSICIAN, CARDIOLOGIST, AND HOSPITAL TURNOVER RATES IN TWO CITIES, 1999–2001

To examine provider turnover rates in detail, we reviewed the provider directories of Medicare+Choice plans in Cleveland and St. Petersburg in both 1999 and 2001.⁸ Directories for plans in the market for both years were analyzed to assess which providers—primary care physicians (family practice physicians, general practitioners, and internists), cardiologists, and hospitals—listed in the 1999 directories were also listed in the 2001 directories (Table 2).

It should be noted that this analysis may not have captured all the instability in physician participation in individual Medicare+Choice plans. The plan provider directories only allow for a comparison of plan network providers at two points in time. Because plan networks can change dramatically during a year, the directories may not provide an up-to-date picture of them. In fact, one plan representative told researchers that, as of August 2001, the plan would issue its fourth provider directory for the year. In addition, with only one exception, the project staff accepted the accuracy of the information in the directories provided by the plans without further review.⁹

Physician Turnover Rates

As Table 2 shows, substantial numbers of primary care physicians in both cities left a Medicare+Choice plan between 1999 and 2001. This was also true of cardiologists in St. Petersburg (Pinellas County), Florida.

Primary care physician turnover rates during the study period ranged from 23 to 61 percent among plans in St. Petersburg and from 17 to 25 percent among plans in the Cleveland area. Thus, over a two-year period, enrollees who were patients of 61 percent of the primary care physicians in one large St. Petersburg Medicare HMO had to find new doctors, follow their physicians to another HMO, or return to fee-for-service Medicare.

Cardiology turnover rates in Medicare+Choice plans were also high in St. Petersburg. Turnover rates among Medicare+Choice plan network cardiologists in St. Petersburg ranged from a high of 54 percent to a low of 13 percent. With the exception of one Cleveland plan in which 29 percent of the 1999 cardiologists left, the average cardiologist turnover rates in the Cleveland area were significantly lower, ranging from 10 to 12 percent.

Table 2. Provider Turnover Rates in Two Cities, 1999–2001

	St. Petersburg (Pinellas County)				Cleveland (Cuyahoga County) ^a				
	Plan A	Plan B	Plan C	Plan D	Plan V	Plan W	Plan X	Plan Y	Plan Z
Primary Care Physicians (Family Practice, General Practice, and Internists)									
1999 providers	85	263	157	246	586	372	417	66	N/A
2001 providers	84	307	289	137	590	424	491	109	N/A
# new providers	20	104	171	42	106	139	178	59	N/A
# providers left plan	21	60	39	151	102	87	104	16	N/A
% providers who left plan: 1999–2001	24.7	22.8	24.8	61.4	17.4	23.4	24.9	24.2	N/A
Cardiologists									
1999 providers	48	55	68	68	191	124	94	21	N/A
2001 providers	28	64	74	65	199	166	130	20	N/A
# new providers	6	20	15	16	28	57	45	6	N/A
# providers left plan	26	11	9	19	20	15	9	5	N/A
% providers who left plan: 1999–2001	54.2	20.0	13.2	27.9	10.5	12.1	9.6	23.8	N/A
Hospitals									
1999 Providers	9	8	13	20	20	11	8	4	17
2001 providers	4	11	12	19	19	11	12	3	14
# new providers	0	3	0	0	0	0	5	0	0
# providers left plan	5	0	1 ^b	1 ^c	1 ^d	0	1	1	3
% providers who left plan: 1999–2001	55.5	0	7.7	5.0	5.0	0	12.5	25.0	17.6

^a One Cleveland plan did not list physician addresses in its 1999 directory (which covered several counties).

^b One Plan C contracting hospital closed in 1999.

^c One Plan D contracting hospital closed in 1999. Plan D's 2001 provider directory (dated January 2001) stated that the contract with four of its network hospitals would expire as of March 31, 2001, but the contracts were renewed and the hospitals remained in the network.

^d One Plan V contracting hospital closed in 2000.

Source: 1999 and 2001 Medicare+Choice provider directories in Cuyahoga County, Ohio, and Pinellas County, Florida.

Hospital Turnover Rates

In contrast to the turnover rates among primary care physicians and cardiologists, turnover rates among hospitals were generally low. With only three exceptions, Medicare HMOs in St. Petersburg and Cleveland retained or even expanded their hospital networks. Of the three HMOs with significant changes in hospital participation, a St. Petersburg Medicare+Choice HMO lost four of nine contracting hospitals between 1999 and 2001; one Cleveland plan lost one of its four network hospitals; and a second Cleveland plan lost three of 17 hospitals.

Provider/Enrollee Ratios

In only a few instances does it appear that plan turnover rates affected the ratio of providers to enrollees. Most of the Medicare+Choice HMOs in the two cities added as

many or more providers to their networks as left the plans. For example, between 1999 and 2001, St. Petersburg’s Plan C increased its primary care physician network by 84 percent and Cleveland’s Plan X increased by 18 percent. By contrast, Plan D in St. Petersburg experienced a 44 percent decline in its primary care physician network and Plan A had a 42 percent decline in the number of listed network cardiologists.¹⁰

CAUSES OF PROVIDER NETWORK INSTABILITY

Beginning in the late 1990s, contentious plan–provider relations over payment levels, risk-sharing arrangements, and payment delays, plus the financial problems and bankruptcies of several large medical groups, resulted in substantial provider turnover in a number of Medicare+Choice markets.¹¹

Contentious Plan–Provider Relations

Plan payment rates that providers considered insufficient to cover the cost of care, as well as claims denials and payment delays, resulted in contentious relationships between plans and their provider networks at all the study sites. Tucson is a good example of a Medicare+Choice market plagued by plan–provider contract disputes and terminations. In July 1999, the University of Arizona Medical Center

and its faculty independent practice association (IPA), University Physicians, severed ties with Intergroup HMO, affecting 2,800 elderly and disabled patients.¹² In April 1999, Carondelet Health Network, the oldest and largest health care system in Tucson, dropped its contract with PacifiCare, claiming that it could “no longer afford to provide quality health care under the HMO’s reimbursement schedule.”¹³ The hospital network re-contracted with the HMO later in the year. In 2000, UnitedHealthcare lost its contract with Arizona Community Physicians, which may have contributed to the plan’s decision to withdraw from Medicare+Choice at the end of the year. Finally, what many consider the premier hospital (and only academic medical center) in Tucson—the University Medical Center—terminated all its Medicare HMO contracts in 2000 because of payment issues.

Provider Turnover in Tucson: First-Hand Observations

- When a Tucson hospital system dropped its contract with PacifiCare, “enrollees were angry—they felt tricked and deceived, and had to travel all the way across town for care,” noted one provider group executive.
- Seniors were left “high and dry,” complained a Tucson community representative when, in 2000, UnitedHealthcare lost its contracts with Arizona Community Physicians.
- Another community representative described as “heart-wrenching” University Medical Center’s decision to terminate all contracts with Tucson Medicare+Choice plans.

Source: Authors’ interviews with Tucson, Arizona, site visit respondents, October 2000.

Provider–HMO contract terminations and disputes also occurred in Cleveland and Tampa–St. Petersburg. In December 1999, Prudential (which pulled out of the Cleveland market at the end of 2000) and University Hospitals Health System and its associated 590–physician network failed to renew their contracts, affecting over 6,000 Medicare members. Renaissance (formerly Emerald) HMO also dropped its contract with the Cleveland Clinic.¹⁴ In 1999, the University Hospitals of Cleveland terminated all contracts with the city’s Medicare+Choice plans, except for QualChoice, which it owns. Because QualChoice does not offer a prescription drug benefit, beneficiaries who join competing HMOs for needed drug coverage have no access to one of the two premier hospitals in the metropolitan area.

In Tampa Bay, one large physician–hospital organization dropped its contracts with three Medicare+Choice plans in April 1999.¹⁵ At the end of 2000, last minute negotiations between Blue Cross/Blue Shield of Florida and two hospital chains—Bay Care Health System and HCA—barely averted contract terminations.¹⁶ One St. Petersburg insurance broker described the local health care marketplace as a war “between providers and managed care companies and they’re always putting a gun to each other’s head.”¹⁷

Provider Group Financial Problems

In many communities, plans contract not with individual providers but with large provider organizations—physician hospital organizations (PHOs), physician practice management companies (PPMCs), and IPAs. The financial problems of these provider groups have also contributed to plan instability in three study cities—Houston, Los Angeles, and, especially, Tucson.

Historically, Medicare HMOs in Tucson paid providers a percentage of the Medicare capitated rate after taking a percentage of Medicare reimbursement off the top for administration. HMOs then passed the capitated payment, along with the risk, down to contracting provider groups. This enabled the HMOs (who were not at risk) to hold down costs; however, according to several respondents, capitation was a financial disaster for provider groups, several of which went bankrupt, including the largest medical groups in Tucson, Thomas Davis Group and Group Health Medical Associates (see box).

The financial plight and bankruptcy of several large physician groups has also exacerbated the general turmoil in the Houston market that followed multiple plan withdrawals. In July 1998, for example, FPA, a physician practice management group,

declared bankruptcy, owing thousands of dollars to between 600 and 1,000 Houston doctors on its payroll.¹⁸ Then, in 1999, MedPartners sold off its physician practices and PhyCor, which manages multi-specialty practices, restructured to address problems, including the exit of dissatisfied physicians.¹⁹ In September 2000, North American Medical Management (NAMM)—a company that managed 19 Houston IPAs and processed HMO payments to these groups—announced it was facing bankruptcy.²⁰

Provider organization financial problems are occurring not only at sites roiled by HMO withdrawals. Recently, physician group solvency problems have disrupted the Los Angeles Medicare market, which had experienced few withdrawals in the past three years.²¹

Chronology of Provider Group Financial Problems in Tucson

1920	Thomas Davis Clinic starts in downtown Tucson, eventually becomes a large clinic chain.
Mid-1970s	Pima Health Care, first managed care plan organized by local doctors, established.
1981	Thomas Davis and Tucson Clinic create Intergroup.
1994	Intergroup sells to Foundation Health.
1994	Tucson Medical Center, owner of the Partners Health Plan HMO, buys Group Health Medical Associates (GHMA), formerly Pima Health Care. Resulting partnership becomes HealthPartners of Southern Arizona in July 1995.
1996	Foundation sells management of Thomas Davis Medical Centers to FPA.
1998	Tucson Medical Center closes GHMA and sells its HMO (HealthPartners) to UnitedHealthcare.
1998	FPA files for bankruptcy and pulls out of Arizona; Thomas Davis Medical Centers, a Tucson institution for 78 years, closes its doors.
1998	GHMA goes out of business.
1998	Talbert Medical Group, spin-off of PacifiCare, goes out of business.

Source: Interviews with Tucson plan, provider, and beneficiary representatives during October 2000 site visit and various *Arizona Daily Star* articles.

IMPLICATIONS OF PROVIDER TURNOVER AND RECOMMENDATIONS

Since the late 1990s, large numbers of Medicare+Choice enrollees have contended with losing access to a trusted physician or hospital because of plan withdrawals and instability in provider networks. The loss of their primary care physician, specialist, or hospital is often traumatic for Medicare beneficiaries, especially those with chronic conditions or those in

the middle of treatment. Moreover, as in Tucson, provider contract terminations can leave enrollees without access to the only academic medical center in a metropolitan area.

Even when plans and providers finally do agree to contract terms, negotiations are sometimes accompanied by a game of “brinkmanship,” often played out in the local media. Showdowns between plans and providers cause anxiety among plan members and may lead to precipitous changes in coverage.²² For example, one St. Petersburg plan’s January 2001 provider directory stated that its contract with four Columbia-owned area hospitals was due to expire at the end of May. Although the contract was ultimately renegotiated, it is likely that some enrollees changed plans because of the publicized contract termination. In any dispute between Medicare+Choice plans and network providers, plan members are always caught in the middle.

Faced with the loss of a provider and disruption in their care, Medicare beneficiaries have been able to follow their provider back to fee-for-service Medicare or, if a provider contracts with another Medicare+Choice plan, switch to that plan; however, this option becomes more limited beginning in 2002, when members will be locked in to their plan for a period of time. In 2002, beneficiaries can change plans once during the first six months of the year. Beginning in 2003, beneficiaries will be able to change plans on January 1 and once more during the first three months of each year—in effect locking them in their Medicare+Choice plan for at least nine months of the year. Plan members thus may no longer have the choice of maintaining their physician or hospital relationship following a plan-provider contract termination.

In the short term, contentious Medicare+Choice plan-provider relations may have stabilized because of changing reimbursement systems and payment increases to contracting Medicare+Choice providers. Across the seven study sites, provider groups and hospitals were moving away from capitation and risk-based contracting and back to physician fee-for-service and hospital per diem or diagnosis-related group payments. “The days of providers accepting the risk for patient care are numbered,” concluded one Cleveland HMO executive. “Risk-sharing is almost a dinosaur,” agreed a consulting firm executive.²³ The change in provider payment methods may help to improve the fiscal health of provider groups and to stabilize plan provider networks. Further, by contracting individually with physicians and hospitals, plans may be less likely to lose large numbers of providers at any one time.²⁴

A number of Medicare+Choice plans have recently increased provider payment rates. The December 2000 Benefits Improvement and Protection Act (BIPA) provided \$11 billion in extra funding over the next five years to Medicare+Choice plans. Nationwide, the majority of plans used BIPA funds to help stabilize their provider networks.²⁵

In the longer term, however, the pressures leading to provider discontent and high network turnover rates are likely to remain. Escalating prescription drug costs and the desire to minimize premiums and cost-sharing increases will likely keep pressure on Medicare+Choice plans to hold the line on provider payment levels.

Recommendations

Policymakers need to find ways to counter the negative effects of high provider turnover rates on beneficiaries. Until policymakers address these and other causes of recent instability within Medicare+Choice, they might want to consider the following options:

- To preserve access to and continuity of care, implementation of Medicare+Choice lock-in should be delayed by one to two years.
- Medicare+Choice plans could be required to allow beneficiaries in the middle of treatment to continue to receive care from a physician or hospital for a specified time period when the provider is withdrawing from a plan.
- Once lock-in is implemented, enrollees could be allowed to change plans or return to fee-for-service Medicare and Medigap if their primary care physician or principal specialist leaves the plan during the lock-in period.

Buffeted by plan withdrawals, premium increases, and benefit reductions, the Medicare+Choice program has been noticeably unstable in recent years, as the data in this issue brief have highlighted. Medicare+Choice will remain a viable option for senior and disabled beneficiaries only if they feel more secure in their health care relationships, and that depends on restoring stability to the program.

NOTES

¹ See Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles, *Instability and Inequity in Medicare+Choice: The Impact on Medicare Beneficiaries—Findings from Seven Case Studies* (executive summary), The Commonwealth Fund, January 2002.

² One study found that 60 percent of Medicare+Choice enrollees elected to stay with their provider when forced to choose between their provider and staying with the health plan. S. Sofaer and M. Hurwicz, “When Medical Group and HMO Part Company: Disenrollment Decisions in Medicare HMO,” *Medical Care* 31 (1993): 808–821.

³ See J. H. Wasson, et al., “Continuity of Outpatient Medical Care in Elderly Men: A Randomized Trial,” *Journal of the American Medical Association* 252 (1984): 2413–17; A. J. Dietrich and K. L. Marton, “Does Continuous Care From a Physician Make a Difference?” *Journal of Family Practice* 15 (1982): 929–37; P. Hjortdahl and E. Laerum, “Continuity of Care in General Practice: Effect on Patient Satisfaction,” *British Medical Journal* 304 (1992): 1287–90.

⁴ Linda J. Weiss and Jan Blustein, “Faithful Patients: The Effect of Long-Term Physician–Patient Relationships on the Costs and Use of Health Care by Older Americans,” *American Journal of Public Health* 86 (1996): 1742–47.

⁵ See Geraldine Dallek and Donald Jones, *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa-St. Petersburg*, The Commonwealth Fund, August 2000; Stuber et al., 2002.

⁶ The Centers for Medicare and Medicaid Services (CMS) defines a primary care provider as “someone a plan member can choose to serve as a first contact for all health care needed.” See <http://www.medicare.gov>.

⁷ Although CMS presents data in terms of providers who remain in their plans, this paper presents data in terms of providers who leave their plans.

⁸ These sites were chosen because 1999 plan provider directories in Cleveland and St. Petersburg had been collected previously for an earlier study. See Dallek and Jones, 2000.

⁹ One St. Petersburg plan’s 2001 provider directory (dated January 2001) noted that its contract with four network hospitals would expire as of March 31, 2001; however, according to a plan representative, the contract was renewed with the hospitals.

¹⁰ Data do not allow for any assessment of the impact of provider turnover on access to care. Some plan provider directories note whether individual practices are closed to new patients while other plan directories fail to include this information. Further, there is no way of determining from plan directories how many full-time equivalent providers are available to serve plan enrollees. Without information on full-time equivalent providers, comparisons among plans are not meaningful. For example, it appears that one plan in Cleveland has far fewer primary care physicians and cardiologists per member than other Cleveland plans; however, most of the physicians in this particular Medicare+Choice plan belong to a medical group that is exclusive to the HMO. Thus, access in this plan may be equal to or greater than that of another plan with far more contracting physicians, most of whom may see only a few plan patients each.

¹¹ See Ashley C. Short, Glen P. Mays, and Timothy K. Lake, *Provider Network Instability: Implications for Choice, Costs and Continuity of Care*, Issue Brief 39, Center for Studying Health System Change, June 2001; Bradlye C. Strunk, Kelly Devers, and Robert E. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief 40, Center for Studying Health System Change, June 2001.

¹² Jane Erikson, "UA Doctors Sever Ties with Senior Care HMO," *Arizona Daily Star*, May 13, 1999, p. 1A.

¹³ Jane Erikson, "Carondelet Dropping PacifiCare to Check Financial Bleeding," *Arizona Daily Star*, April 1, 1999, p. 1A.

¹⁴ Susan Jaffe, "Many Elderly Must Find New Health Care Providers," *Cleveland Plain Dealer*, December 8, 1999, p. 4B; Susan Jaffe, "HMO Shuffle Irks Congressmen: Plan Changes Face Thousands of Senior Citizens," *Cleveland Plain Dealer*, December 15, 1999, p. 3B.

¹⁵ Gary Sheperd, "Pinellas PHO Group Cancels Third Contract: Medicare Patients Affected by Change," *Tampa Bay Business Journal*, April 26, 1999, p. 1.

¹⁶ Rafael Gerena-Morales, "Tampa, Fla.—Area Hospital Network, Blue Cross/Blue Shield End Dispute," *Knight-Ridder Tribune Business News*, October 1, 2000; Michele Chandler, "Florida Blue Cross/Blue Shield Approves Deal with Hospital Company," *Knight-Ridder Tribune Business News*, December 2, 2000.

¹⁷ Robert Neil, "New UnitedHealthcare Will Reign over Florida," *Medical Industry Today*, June 5, 1998.

¹⁸ Mary Sit-DuVall, "The Business Side of the Operation: Physicians Linking with Managers, But Problems Prompt Call for Restructuring," *Houston Chronicle*, August 6, 1998, Business p. 1.

¹⁹ Mary Sit-DuVall, "Practice Makes Profits: A Medical Manager's Different Approach May Help It Succeed in a Tough Specialty," *Houston Chronicle*, August 15, 1999, Business p. 1.

²⁰ Mary Sit-DuVall, "Houston Practice-Management Firm Struggles, May Leave Doctors Holding the Bag," *Houston Chronicle*, November 4, 2000, Business p. 1.

²¹ In 1999, MedPartners went bankrupt. Most recently, KPC Medical Management Group announced it was filing for bankruptcy following a turbulent five years of acquisitions and mergers in the physician management industry. KPC's bankruptcy resulted in the closure of 42 clinics across southern California, affecting 300,000 patients. Recently enacted California legislation sets minimum financial standards for provider groups, and CMS and the new California Department of Managed Care are focusing attention on provider group financial problems. Jerry Hirsch, "KPC Files for Chapter 11 Bankruptcy," *Los Angeles Times*, November 28, 2000, Orange County Edition, p. 3; California Health Policy Roundtable, "A Risky Proposition? Risk-Bearing and Solvency in California's Medical Groups," February 2000.

²² Strunk, Devers et al., 2001.

²³ "Medicare+Choice Plans Tap Experience to Prove Their Viability, Endurance," *Managed Medicare & Medicaid* 7 (February 19, 2001): 3. See also Cara S. Lesser and Paul B. Ginsburg, "Back to the Future? New Cost and Access Challenges Emerge," Issue Brief 35, Center for Studying Health System Change, February 2001; Jon B. Christianson et al., *Increased Consolidation Raises Concerns: Cleveland, Ohio, Community Report #2*, Center for Studying Health System Change, Fall 2000.

²⁴ Short, Mays et al., 2001.

²⁵ *HCFA Analysis of How Medicare+Choice Organizations Used BIPA Payment Increases*; see <http://www.hcfa.gov/medicare/bipahome.htm>.

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#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.

#497 *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (January 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* (January 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.

#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, pouring 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. In this report, the authors argue that policymakers contemplating changes to the entitlement program for the elderly and disabled must take steps to protect the most vulnerable beneficiaries—those with chronic or acute physical or cognitive ailments—from incurring out-of-pocket expenses that are even higher than what they currently bear.

#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.

#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.

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>.

#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.

#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.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70*, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn’t cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn’t cover.

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

#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 the President. 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.

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

#294 *Improving Coverage for Low-Income Medicare Beneficiaries* (December 1998). Marilyn Moon, Niall Brennan, and Misha Segal, The Urban Institute. The authors examine ways in which the Qualified Medicare Beneficiary and related programs could be modified to increase participation and protect more sick and low-income Medicare beneficiaries.

#302 *The Future of Medicare* (November 1998). Brian Biles, Susan Raetzman, Susan Joseph, and Karen Davis. This issue brief discusses the two ways in which the National Bipartisan Commission on the Future of Medicare is examining the Medicare program and making recommendations to keep it fiscally healthy into the twenty-first century: through the development of incremental reforms and the analysis of major restructuring. The authors also discuss projections of the future costs of care and sources of revenues to finance care for the elderly and disabled.

#272 *Shaping the Future of Medicare* (April 1998). Karen Davis. Presented as invited testimony before the National Bipartisan Commission on the Future of Medicare's hearing on "Medicare and the Baby Boomers" on April 21, 1998, this report suggests ways to prepare the Medicare program for the challenge of coping with unprecedented numbers of elderly and disabled Americans. The author identifies several principles to guide the debate.