MEDICARE+CHOICE 1999–2001: AN ANALYSIS OF MANAGED CARE PLAN WITHDRAWALS AND TRENDS IN BENEFITS AND PREMIUMS

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EXECUTIVE SUMMARY

Enrollment in Medicare managed care plans grew during the 1990s, driven by the availability of benefits designed to complement Medicare's exclusions and limits at relatively little additional cost. These plans are especially attractive to those with low to moderate incomes who have no access to employer-subsidized group-based retirement benefits and whose only other option is Medigap coverage. In the wake of the Balanced Budget Act of 1997 (BBA) and Medicare+Choice, however, many plans have exited the program, while others have substantially reduced the generosity of the benefits they offer. At the same time, premiums have increased.

This report continues our joint effort with the Commonwealth Fund to provide policymakers with critical information on program trends to support policy development. It addresses two areas. First, we seek a better understanding of program withdrawals by comparing historical trends in benefits and premiums for plans that left the Medicare+Choice program in 2001 compared with those that stayed. Second, we update our continuing analysis of trends in Medicare+Choice benefits and premiums to take into account both the response in March 2001 to payment increases authorized by the Benefits Improvement and Performance Act of 2000 (BIPA) and the shifts in enrollment through March 2001 that occurred as a reaction to plan withdrawals and benefit changes in 2001.

The analyses are based on a database we created from publicly available data from Medicare Compare, the Centers for Medicare and Medicaid Services' (CMS) consumer-oriented summary of information on Medicare+Choice plans. The data reflect benefits, beneficiary cost-sharing requirements, and enrollment levels by county.

Our study yielded the following key findings:

- Managed care organizations (MCOs) that withdrew from the Medicare+Choice program in 2001 had lower enrollments, higher premiums, and less-generous benefit packages than those that remained in the program. This combination of circumstances may indicate competition problems for MCOs that withdrew.

- 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 in 2001. Average (mean) monthly premiums went from $14.43 in 2000

to $22.94 in 2001. The proportion of Medicare+Choice enrollees with prescription drug coverage fell from 78 percent in 2000 to 70 percent in 2001.

- Viable coverage options for Medicare beneficiaries in rural, generally low-payment counties continue to be absent. Medicare+Choice enrollees in these areas continue to pay higher premiums for less coverage than their counterparts in high-payment counties.

Plan withdrawals, increased premiums, and decreased benefits all contributed to significant instability in the Medicare+Choice market following enactment of the BBA. Consequently, enrollment began to decline at the end of 2000 for the first time in the program's history, and it continues to do so. Many beneficiaries who saw Medicare HMOs as an affordable way to obtain supplemental coverage now see their coverage eroding even as their costs increase. Worse, the option of a Medicare HMO has disappeared entirely for some. With more health plan withdrawals and shrinking benefit packages on the horizon, Congress passed BIPA in December 2000. The act increased payments to health plans and rolled back some of the provisions of the BBA. Nonetheless, MCOs generally did not return to the program, and few of these givebacks were translated into lowered premiums or increased benefits.

The year 2001 brought little positive change for enrollees. Many had fewer options, somewhat higher costs, and less coverage. Despite payment increases in low-payment areas, benefit generosity continued to vary substantially. Rural beneficiaries continued to have fewer options and less-generous coverage. Given these trends, it becomes clearer that Medicare MCOs cannot provide a long-term solution to the fundamental deficiencies in Medicare's basic benefit package. Policymakers seeking to provide affordable and equitable access to additional benefits cannot count on Medicare+Choice to do this. They must focus on reforming the entire benefit package.

MEDICARE+CHOICE 1999–2001: AN ANALYSIS OF MANAGED CARE PLAN WITHDRAWALS AND TRENDS IN BENEFITS AND PREMIUMS

I. INTRODUCTION

Congress continues to debate Medicare reform and the potential expansion of benefits to include prescription drugs. If these deliberations are to bear fruit, policymakers need good information about current coverage options for Medicare beneficiaries. Particularly relevant is good information on benefits under Medicare managed care plans, because this option provides the most affordable supplemental coverage for those who do not qualify for subsidized coverage through employer-sponsored benefits or through Medicaid supplemental plans (Gold and Mittler 2001).

Even though enrollment in Medicare managed care grew rapidly in the mid-1990s, it slowed and then reversed after 1999 (Figure 1). Plans began to withdraw from the Medicare+Choice program that year and had continued to do so throughout 2001, which saw the withdrawals of HMOs that enrolled almost a million beneficiaries (Table 1). Congress's response to this exodus was the enactment of a number of measures aimed at stemming departures by raising payment rates, particularly for plans with the lowest rates; however, these changes, part of the Benefits Improvement and Protection Act of 2000 (BIPA), did little to change the program's direction. In 2002, an estimated 536,000 Medicare+Choice enrollees will lose coverage as a result of yet another round of health plan withdrawals (CMS 2001).

For the past three years, the Commonwealth Fund has commissioned Mathematica Policy Research, Inc. (MPR) to monitor the benefits and premiums of managed care plans that participate in Medicare+Choice. Earlier work documented trends in benefit levels, which remained stable from 1998 to 1999 (Gold et al. 1999), but declined in 2000 (Cassidy and Gold 2000), and again in 2001—at least until BIPA went into effect (Gold and Achman 2001a). Over the past decade, we saw an increase in offers for zero-premium policies that provided some prescription drug coverage, followed by a reduction in benefits that began in 2000 (Figure 2).

This report extends our exploration of these trends through 2001 with analyses that address two important questions:

1. Are managed care organizations (MCOs) that left the Medicare+Choice market in 2001 different from those that stayed? Information about similarities and

differences is important to policymakers who want to know how to better interpret and address concerns about departures.

2. Did BIPA lead MCOs to expand benefits in 2001, and what were the overall trends in benefits from 1999 through 2001?

This paper discusses our data and methods, and our findings on the preceding two questions. We conclude with a general discussion of the implications of the findings for policymakers interested in addressing beneficiary concerns about stable coverage and adequate protection against financial risk.

II. DATA AND METHODS

Our analysis is based on a merged file we created from data in the Centers for Medicare and Medicaid Services' (CMS) Medicare Compare database and in its State/County/Plan Quarterly Market Penetration File.[1] Both databases are available to the public on the CMS and Medicare websites. The merged file includes information on Medicare+Choice contracts, service areas, county enrollments, and benefits.

The Medicare Compare database provides detailed benefit information at the plan level, with "plan" being defined as a unit within a contract that offers the same benefit and cost-sharing structure to all members in a specified service area. We used the October 2000 release of Medicare Compare for pre-BIPA 2001 benefit information (effective January-February) and, new to this analysis, the February 2001 release of Medicare Compare for the post-BIPA period (effective March-December).

Enrollment data are based on CMS's State/County/Plan Quarterly Market Penetration File, which tracks enrollment in each county by contract. We used the March 2001 State/County/Plan file for 2001 enrollment information in both the pre- and post-BIPA periods, because no enrollment data were available for January 2001. Our previous analysis of 2001 benefits was based on 2000 enrollment because of the lag between the collection and the release of data. The March enrollment data allowed us to capture beneficiary movement across plans after the 2001 withdrawals, but because we lacked January data, we could not track any enrollment changes before and after BIPA.

CMS allows MCOs to offer more than one plan, or benefit package, within a contract service area. MCOs may also offer differing plans across portions of the contract

[1] CMS was formerly the Health Care Financing Administration (HCFA).

service area, called segments, but must offer the same benefits with the same costs to all enrollees within a particular plan. We used contract segments as the basic unit of analysis because the plan options for all beneficiaries are the same within a contract segment. There were 468 contract segments in 2000. In 2001, there were 380 contract segments for January–February and 396 for March–December.

MCOs may offer more than one plan to enrollees in a contract segment; unfortunately, enrollment information is available only at the contract level. We have no way of knowing how many enrollees chose each option when more than one was available. More than one plan was offered under a single contract in about 40 percent of the contract segments in 2001. We included only basic plans in our analysis because that provides a picture of the most basic level of coverage available to Medicare+Choice enrollees. A basic plan is the plan within a contract segment with the lowest premium. When the premiums for more than one plan within a contract segment were the same, we chose the plan with prescription drug coverage.[2]

Our analysis is presented in two ways. Unweighted plan estimates show how benefits varied across plans, regardless of enrollment. The weighted enrollment estimates provide a more accurate picture of where beneficiaries were actually enrolled.

III. FINDINGS

A. Comparison of Withdrawn Plans with Remaining Plans

We compared MCOs that announced withdrawals from Medicare+Choice in 2001 with those that chose to stay. We did not complete a market analysis of MCOs that compared exiting MCOs with their direct competitors in a specific market; however, our more general investigation of withdrawals supports the idea that MCOs that withdrew or reduced their service areas in 2001 had been at a competitive disadvantage in 2000 in terms of enrollment, generosity of benefits offered, and stability of benefits offered (compared with plans that remained in the program). This competitive situation appears to hold true even when controlling for the degree of urbanization and the payment rate for the area from which the MCO withdrew.

1. Withdrawn Plans Had Lower Enrollments

MCOs that withdrew from the Medicare+Choice program in 2001 had much smaller average enrollments than did MCOs that remained. Average contract enrollment for all

[2] Because traditional Medicare does not cover prescription drugs, Medicare+Choice HMO enrollees often cite the availability of prescription drug coverage as a reason for enrolling in a plan.

MCOs was 23,441 in 2000; however, there was a significant difference between MCOs that renewed at least some part of their Medicare+Choice contract for 2001 and those that withdrew. Average total contract enrollment in 2000 was 26,357 for MCOs that stayed in 2001, compared with only 8,057 for MCOs that decided to leave the program entirely.

These differences do not appear to be the result of the departure of a disproportionate number of MCOs from small, rural counties. When we looked at the withdrawals by county urban/rural characteristics, we found that the MCOs that reduced their service areas or completely withdrew from a county had lower average county enrollments than the remaining organizations (Figure 3). Looking at metropolitan center-city counties, for instance, we found that the average MCO that stayed in 2001 had a county enrollment of 7,594 in 2000 compared with 2,134 enrollees for organizations that withdrew from a similar county.

Lower enrollments among exiting MCOs lend support to the General Accounting Office's (GAO) previous analyses of earlier withdrawal patterns. In a study of 1999 market withdrawals, the GAO (1999) reported that plans frequently withdrew from counties that they had entered recently, counties that had fewer enrollees, and/or counties where they faced larger competitors. In a follow-up study, the GAO (2000) found that MCOs that pulled out of the Medicare+Choice market in 2000 tended to withdraw from areas where they had failed to attract enough enrollees or from the counties they had entered most recently. Our analysis supports similar reasons for the 2001 withdrawals.

2. Withdrawn Plans Offered Less-Generous Benefit Packages

In addition to enrollment differences between exiting and staying MCOs, we found differences—specifically in premiums and prescription drug coverage—in the generosity of their 2000 basic benefit packages. In general, we found that MCOs that withdrew had offered less-generous benefit packages than those that remained in the market, again supporting the idea that competition was a factor in the decision to withdraw.

Medicare HMOs are attractive to potential enrollees because of the promise of coverage—including prescription drug coverage—that is more comprehensive than that available from traditional fee-for-service Medicare and cheaper than policies in the Medigap supplemental market. Low monthly premiums are especially important to the low-income Medicare beneficiaries the Medicare+Choice program could potentially help the most. Overall, exiting MCOs had higher average premiums than those that stayed in the market ($24.54 monthly compared with $12.64) and were less likely to have offered a zero-premium package, when weighted by enrollment. The difference in premiums

between exiting and staying MCOs was most significant in higher-payment areas (Figure 4).[3]

We also found that exiting MCOs had less-generous basic plan prescription drug benefits and were less likely than MCOs that remained in the market to cover prescription drugs. About 80 percent of enrollees in basic plans that continued into 2001 had some drug coverage in 2000, compared with about 69 percent of enrollees in withdrawing plans (Figure 5). Unlike the difference in premiums, differences in prescription drug coverage were most significant in low-payment areas. Of the basic plans that offered prescription drug coverage, those that left the market generally set lower annual limits than plans that remained. Basic plans of MCOs that left the market—either through a total withdrawal or a service area reduction—were more likely to have an annual prescription drug limit of $500 or less and less likely to offer an unlimited benefit.

The GAO (2000) similarly found that MCOs that terminated their Medicare+Choice contracts or reduced their service areas in 2000 or 2001 spent less on benefits not covered by traditional Medicare than MCOs that remained. According to the GAO's study of the 2000 Adjusted Community Rate Proposals submitted by Medicare+Choice plans, MCOs that continued into 2001 spent about 25 percent of their 2000 Medicare payments on additional benefits, compared with 22 percent for MCOs that completely withdrew in 2001 and 18 percent for MCOs that reduced their service areas in 2001. The GAO's 1999 Adjusted Community Rate Proposals reported similar results for plans that withdrew or reduced their service areas in 2000.

3. Benefits of Withdrawn Plans Were Less Stable from 1999 to 2000

We also evaluated the relative stability of benefit packages in the 1999–2000 period. This comparison was intended to ascertain whether MCOs that withdrew in 2001 were signaling competitive difficulties when they made changes to benefit packages in 2000 that made them less attractive to beneficiaries. We found that benefit instability does appear to be associated with the decision to withdraw.

In 2000, MCOs that subsequently withdrew in 2001 were more likely to have increased the 1999 premium for the basic package in a given county, either by adding a premium where none had existed or by raising an established premium. Fifty percent of withdrawn MCOs—as opposed to 40 percent of remaining MCOs—increased the basic

[3] MCOs are reimbursed a fixed dollar amount per enrollee month. The dollar amount varies by the county in which the enrollee resides. Historically, the county reimbursement rates have been tied to medical costs in the fee-for-service program, which meant rural areas typically received much less than urban areas.

plan premium in a county served in both 1999 and 2000 (Table 2). Prescription drug benefits of MCOs that withdrew were also less stable, again making the plans less attractive to enrollees (Table 2). Just over 42 percent of withdrawn MCOs that served the same county in both 1999 and 2000 reduced prescription drug coverage in 2000, either by dropping the benefit entirely (18%) or by decreasing the annual limit on coverage (24%). In contrast, of the MCOs continuing into 2001, only 23 percent reduced drug coverage in 2000 (9 percent dropped the benefit entirely and 14 percent reduced the annual cap).

4. Withdrawn Plans Faced Competition Problems

Our findings support the idea that MCOs that withdrew from the Medicare+Choice market in 2001 (either completely or through a reduction in their service area) were not as strong competitively as their counterparts that remained in the program, irrespective of the payment rate received. Specifically, MCOs that left the market may have had trouble attracting enrollees to their plans both on the county and on the contract level. The lower and less-stable benefit levels of plans that withdrew probably made them less attractive to enrollees, although it is unclear whether lower levels of coverage led to lower enrollment or whether lower enrollment led to lower levels of coverage. The withdrawals of smaller MCOs reveal two important issues. First, MCOs with small enrollments may be led to withdraw because their small market shares make them unable to obtain favorable contracts with local hospitals and physicians (Dallek and Jones 2000). Second, some communities are not large enough to support multiple MCOs, or possibly even one; in such cases, the withdrawals are simply an indicator of the market's evolution and necessary consolidation.

The lesson policymakers might take away from this analysis of 2001 withdrawals is that the future Medicare+Choice market will depend on the stability of a few large MCOs rather than on competition between many smaller plans. For beneficiaries, the positive aspect of this development is that MCOs that cover the most enrollees and offer the most comprehensive coverage appear to be the least likely to withdraw.

B. BIPA's Impact on Trends in Premiums and Benefits Through March 2001

The Medicare+Choice program continued to lose ground as it headed into 2001. Total enrollment in December 2000 was down nearly 87,000 from the same time the year before, the first decrease in the program's history. With the 2001 withdrawals set to take effect in January, enrollment would decline even further. The organizations that remained were reducing benefits while slightly increasing premiums and cost-sharing requirements. Further, there continued to be a wide disparity between the benefits offered to residents of high-payment counties and those of low-payment counties. Congress passed BIPA in

response to these conditions and amid continuing pressure from health insurance plans to roll back some of the provisions of the Balanced Budget Act of 1997 (BBA).[4] Generally, BIPA had relatively little impact on the Medicare+Choice marketplace; recent trends in benefits and premiums continued.

1. BIPA's Payment Increases Went Primarily to Low-Payment Areas

BIPA had three purposes: (1) to create geographical equity in payment across counties, reducing the disparity in benefits between low- and high-payment counties; (2) to encourage plans that had announced withdrawals to reenter the program; and (3) to roll back the reductions in benefits planned for the 2001 benefit year.

Among its provisions, BIPA:

- Raised the 2001 floor payment rate (the minimum amount an MCO can receive per enrollee month) from $415 to $475;

- Created a new floor payment of $525 for counties in urban areas with populations of 250,000 or more;

- Increased the minimum payment update for 2001 from 2 to 3 percent over the 2000 level (for 2001 only);[5] and

- Extended the bonus payments to MCOs entering a county where no other plan had been offered since 1997 or where coverage was terminated in January 2001.

It is estimated that these payment rate changes will result in an $11 billion increase in Medicare+Choice payments over the next five years, including an extra $1 billion in 2001 (HCFA 2001a).

BIPA restricted the payment increases to the following uses:

- To reduce beneficiary premiums and/or cost-sharing;

- To enhance benefits;

[4] The BBA attempted to limit the growth of Medicare+Choice payment rates and close the gap between high- and low-payment counties.

[5] In 2001, any county not qualifying for a floor payment rate received the minimum increase over the previous year's payment rate. These counties receive higher payments than floor rate counties.

- To deposit the revenue in a stabilization fund intended to even out benefits and premiums over time; and

- To improve the health care provider network available to enrollees.

Of the 118 Medicare+Choice organizations that had planned withdrawals or service area reductions in 2001, only four decided to reenter the program as a result of BIPA. These organizations covered 11 counties in three states and enrolled about 13,000 people in 2000 (HCFA 2001a). BIPA increased the county payment rate in six of these counties by more than 20 percent (HCFA 2001a).

A HCFA[6] analysis (2001b) showed that the largest payment increases—averaging 9.7 percent—went to counties that qualified for the newly established $525 monthly floor rate (counties in urban areas with populations of 250,000 or more) (Table 3). Counties receiving the $475 floor rate got an average payment increase of 8.3 percent over pre-BIPA 2001 rates. All other counties received an increase of only 1 percent (a 3% versus a 2% increase over the 2000 rate), but these counties had received higher payments all along.

HCFA (2001b) also reported that most MCOs used the extra funds to enhance provider networks. Sixty-five percent of Medicare+Choice enrollees were in plans that used the payment increase only to enhance provider networks; another 11 percent were in plans that deposited the entire increase in a benefit stabilization fund, an option rarely used in the past (Table 4). Relatively few enrollees saw benefit package changes as a result of BIPA. Only 6 percent of enrollees were in MCOs that used the funds only to reduce premiums and/or cost-sharing. Another 1 percent of enrollees were in plans that used the increase only to enhance plan benefits. MCOs in floor rate counties (both $475 and $525) were more likely to have used multiple options and to have reduced premiums or cost-sharing.

BIPA's tight implementation schedule probably influenced many plans' decisions not to use the payment increase to restructure premiums or benefits. The legislation was signed December 21, 2000, and the associated rate increases, announced on January 4, 2001, took effect in March. Medicare+Choice organizations were required to submit revised Adjusted Community Rate Proposals and benefit packages to the Health Care

[6] At the time of the analysis, CMS was known as the Health Care Financing Administration (HCFA).

Financing Administration (HCFA) within two weeks of the rate announcement.[7] MCOs also had to notify enrollees about any changes. The costs required to make benefit and premium adjustments probably made the changes impractical for plans that received only a small increase (Gold and Achman 2001b). Eighty-seven percent of plans that received the 1 percent increase enhanced provider payment only or used the stabilization fund only (HCFA 2001b). Consequently, the real effects of BIPA may be hidden in the future, when some plans may decide to access money deposited in the stabilization fund to prevent further erosion in benefit generosity or to actually enhance benefits and reduce cost-sharing. Some plans had little discretion in how to use the BIPA increases because they were contractually required to pass a proportion of the funds on to providers (Gold and Achman 2001b).

2. Premiums and Benefits Continued to Decline in 2001

Enrollees saw little change in premiums and benefits as a result of BIPA. Although there was a slight lowering of premiums and some increase in the generosity of benefits under the new payment rates, the changes were generally targeted and limited; enrollees in floor rate counties were the most likely to have gained from the benefit increases. On the other hand, the changes did not erase the disparity in benefit levels and premiums between floor and non-floor rate areas, nor did they bring 2001 benefit and premium levels back to where they had been in 2000.

Average (mean) monthly premiums went down slightly following BIPA, from $25.26 to $22.94 (Table 5). The percentage of enrollees in plans with a zero premium also increased slightly, from 44 percent to 46 percent. Despite these improvements, BIPA did little to reverse the trend of increasing premiums. The mean post-BIPA premium ($22.94) was still 59 percent higher than the mean premium in 2000 ($14.43).

Decreases in monthly premiums were the most significant in counties that qualified for the new $525 floor payment rate (Figure 6). Mean premiums in these counties went from $38.78 pre-BIPA to $31.81 post-BIPA—an 18 percent decrease; however, the post-BIPA premium was still 15 percent higher than the mean 2000 premium for these counties ($27.57). Premiums for plans in $475 floor rate counties went down by about 4 percent following BIPA, from $59.29 to $56.73, but these rates were still much higher than their mean 2000 premium of $38.55. Despite the larger payment

[7] Adjusted Community Rate Proposals are actuarial cost estimates that tell HCFA how an MCO will use its premiums and what the benefit package will be for a plan.

increases in floor rate counties, premiums for plans in these areas were still higher than the mean post-BIPA premium of $20.09 in non-floor rate counties.

A comparison of the post-BIPA 2001 benefit packages and the 2000 benefit packages shows that MCOs rarely made changes that reduced enrollee expense. Of all MCOs serving the same county in both periods, 49 percent raised the premium of the basic package in 2001, either by adding a premium when none had existed or by increasing the established premium level (Table 6). MCOs in non-floor rate counties were the most likely to have increased premiums—a quarter of these organizations charged premiums for the first time; however, far fewer MCOs in floor rate counties had a zero-premium plan in 2000 and the mean premium was still higher in floor rate counties. Only about 13 percent of MCOs reduced premiums in 2001, compared with 49 percent that raised them. MCOs in floor rate counties were more likely to have reduced premiums, probably because they received larger payment increases under BIPA.

Prescription drug coverage remained relatively stable following BIPA. Overall, 70 percent of enrollees had coverage in March 2001, compared with 69 percent in January 2001 (Table 7). Like the changes in premiums, this post-BIPA increase in coverage was still down from the 2000 level, when 78 percent of enrollees were covered. Improvements in prescription drug coverage were again most apparent in $525 floor rate counties (Figure 7). Coverage in these counties increased from 37 percent pre-BIPA to 43 percent post-BIPA—a 16 percent increase; however, the 43 percent coverage rate compares with 55 percent coverage in 2000, meaning that there was still a 22 percent decline in prescription coverage in 2001. Prescription drug coverage in $475 floor rate counties increased slightly following BIPA, from 31 percent to 33 percent. Coverage in non-floor rate counties remained stable at 78 percent, still much higher than the rate of coverage in counties with either of the floor payment rates.

MCOs were unlikely to have enhanced prescription drug benefits in 2001 (Table 8). Fifty-nine percent of MCOs serving the same county in both 2000 and 2001 kept their prescription drug benefit as it was in 2000, either by continuing to offer no benefit or by not changing the annual limit. About 30 percent of all MCOs serving the same county in both 2000 and 2001 reduced the benefit, either by dropping coverage altogether or by reducing the annual cap. Again, MCOs in non-floor rate counties were the most likely to have reduced their prescription drug benefit, but these plans have also traditionally been the most generous with their coverage. Only about 6 percent of MCOs improved coverage over the 2000 level, either by adding the benefit or raising the annual limit.

In addition to prescription drug coverage, Medicare+Choice plans may offer other benefits not covered under fee-for-service Medicare, e.g., vision, hearing, and preventive dental coverage. Like prescription drug coverage, MCOs can fund these supplemental benefits with savings generated. Medicare-covered hearing services, such as routine hearing exams and hearing aids, also declined in 2001 (Table 9). Ninety-two percent of enrollees had hearing coverage in 2000, compared with 78 percent in 2001, a 15 percent decline. Coverage for preventive dental benefits also declined in 2001, from 39 percent of enrollees to just 29 percent.

In conjunction with the decline in coverage, many Medicare+Choice enrollees also saw increased copayments in 2001 (Table 10). The percentage of enrollees with no copayment for a visit to either a primary care physician or a specialist decreased. The biggest increases were in copayments for hospital admissions and outpatient hospital visits. In 2000, 13 percent of enrollees were charged a copayment for a hospital admission compared to 33 percent in 2001—a 155 percent increase. The percentage of enrollees charged a copayment for an outpatient visit also increased substantially, from 29 percent of enrollees in 2000 to 44 percent in 2001.

3. The Rural/Urban Divide Continues

BIPA was also intended to reduce the variation in the availability of Medicare+Choice plans and in the generosity of that coverage between urban and rural areas. Historically, Medicare beneficiaries in low-payment, generally rural, counties have not benefited from the advantages Medicare+Choice plans might offer. MCOs have been reluctant to enter these areas, citing low payments, a dispersed population of beneficiaries, and the more difficult task of creating a network of health care providers (U.S. Senate Finance Committee 2001). Furthermore, plans that have entered lower-paying areas generally offer less comprehensive benefits than those in areas receiving higher payments. BIPA did little to change these disparities. Because only four plans reentered the program as a result of BIPA, the availability of Medicare+Choice plans in rural areas did not change significantly. There continues to be a disparity in the choices available to rural and to urban beneficiaries. Post-BIPA, 97 percent of Medicare beneficiaries living in counties in a center-city metropolitan area had at least one Medicare+Choice plan available to them, compared with only 22 percent of beneficiaries in a rural county adjacent to a metropolitan statistical area (MSA) (Table 11).

This large divide between rural and urban beneficiaries continues with respect to the availability of supplemental benefits and out-of-pocket costs. Seventy-one percent of Medicare beneficiaries in a center-city metropolitan county had at least one zero-premium

Medicare+Choice plan available in 2001, compared with only 7 percent of beneficiaries in non-metropolitan, MSA-adjacent counties. Similarly, 78 percent of beneficiaries in center-city counties could enroll in a plan with prescription drug coverage, compared with just 9 percent of beneficiaries in non-metropolitan, MSA-adjacent counties.

The geographical disparity in premiums may actually increase in coming years because one of BIPA's provisions will allow MCOs to offer a rebate on an enrollee's Part B premiums in the future. Up until now, all Medicare+Choice enrollees were required to pay the full Part B premium in addition to any monthly premium instituted by an MCO. If MCOs that currently require no premium begin offering Part B rebates, the geographical differences will probably increase even more.

Overall, choice in Medicare+Choice declined in all types of counties in 2001. For instance, 90 percent of Medicare beneficiaries in a center-city metropolitan county could enroll in a zero-premium plan in 2000; only 71 percent had such an opportunity in 2001. Similarly, the percentage of beneficiaries in non-metropolitan, MSA-adjacent areas who had access to a zero-premium plan declined from 15 percent in 2000 to 7 percent in 2001.

4. Implications

Despite congressional action, the basic concerns related to the Medicare+Choice program continued in 2001. BIPA's payment increases did little to lower premiums or improve benefits for enrollees because so many MCOs used the extra money to enhance provider networks. BIPA did not significantly reduce the number of health plan withdrawals from the program. As a result, the 2001 benefit period was destined to be marked by continuing erosion in benefit packages and an enduring disparity between the choices available to urban and rural Medicare beneficiaries.

Despite its failures, BIPA may ultimately be successful in counties receiving the upgraded urban $525 monthly floor rate payment. These areas have historically been able to maintain the provider networks and enrollments critical to managed care, but they were not attracting organizations to the area because of low reimbursement rates. BIPA's increase was most substantial in these areas and the effect on benefits and premiums was most significant in these areas as well. In the coming years, it will be interesting to see whether the increase in payment is enough to attract new organizations and expand the program in these areas.

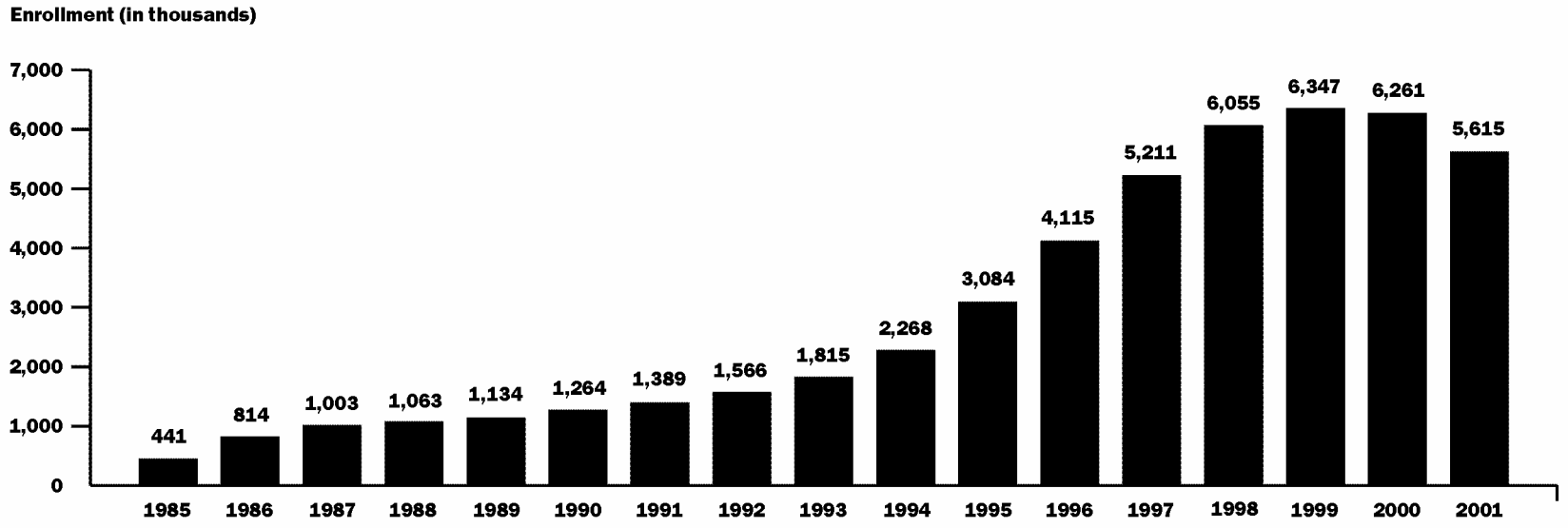
IV. CONCLUSION

The Medicare+Choice program has been in constant flux since June 2000, when announced withdrawals affected the largest number of enrollees yet. Following those announcements, the planned 2001 benefit packages released in September 2000 showed an overall increase in premiums and enrollee cost-sharing along with a commensurate decrease in benefit generosity (Gold and Achman 2001a). Three months later, and after much debate, Congress passed BIPA, which increased the payment MCOs would receive for each enrollee and gave MCOs that had withdrawn the opportunity to reenter the program. BIPA's impact was minimal. Although the short time frame used in assessing BIPA's effects may understate longer-term impacts, more dramatic long-term effects are unlikely. The majority of Medicare+Choice enrollees are in plans receiving only minimal and short-term increases through BIPA (an additional 1 percent for March–December 2001 only). Increases were substantial in floor rate counties, but evidence suggests that increases alone are unlikely to make managed care more viable in these more-rural areas. For the future, the most important effect to monitor will be to see if BIPA helped stabilize plan participation in urban counties receiving $525 monthly floor rate payments.

Experience to date suggests that increasing payments to health plans alone is not enough to solve the problems that plague Medicare managed care. The initial Medicare+Choice goals—to save money and to supplement benefits—have competed from the start. As the government attempted to reap the savings it initially hoped for by implementing the BBA and more closely aligning reimbursement with costs, it should have expected premiums would increase and/or the generous supplemental benefits offered early on would diminish. The trend suggests that policymakers should focus reform on Medicare's basic benefit package in order to provide the generous supplemental benefits common among managed care plans pre-BBA, instead of relying on more limited reform of the Medicare+Choice program.

The lack of managed care penetration in rural markets also remains a problem. A wide urban/rural divide in Medicare+Choice persists—beneficiaries in urban areas have more choice and better coverage options than their counterparts in rural areas. Establishing Medicare managed care in these markets may be impossible considering that commercial MCOs have experienced the same problems as health plans in Medicare+Choice, namely, an inability to establish comprehensive provider networks. The most recent attempts at Medicare+Choice reform, including BIPA, have been aimed at reducing the disparity in payment rates between urban and rural areas. Instead, policymakers may want to shift their focus to shoring up the Medicare+Choice program in areas where the program has already established some track record.

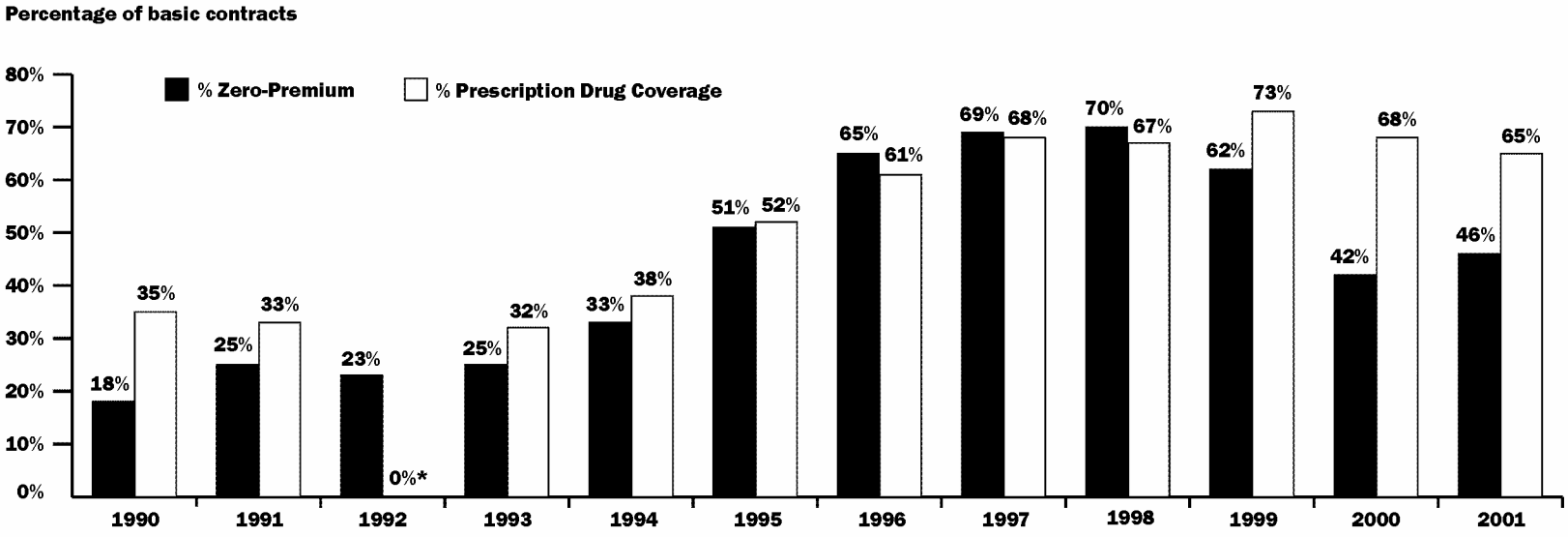
Figure 1. Medicare Risk/Medicare+Choice Enrollment, 1985–2001



Note: All data are from December except 2001, which is from May. Data for 1999–2001 are for enrollees in Medicare+Choice Coordinated Care Plans (CCPs). Data for prior years are for enrollees in Medicare risk contracts.

Source: Mathematica Policy Research (MPR) analysis of CMS's Medicare Managed Care Contract Plans Monthly Summary Report.

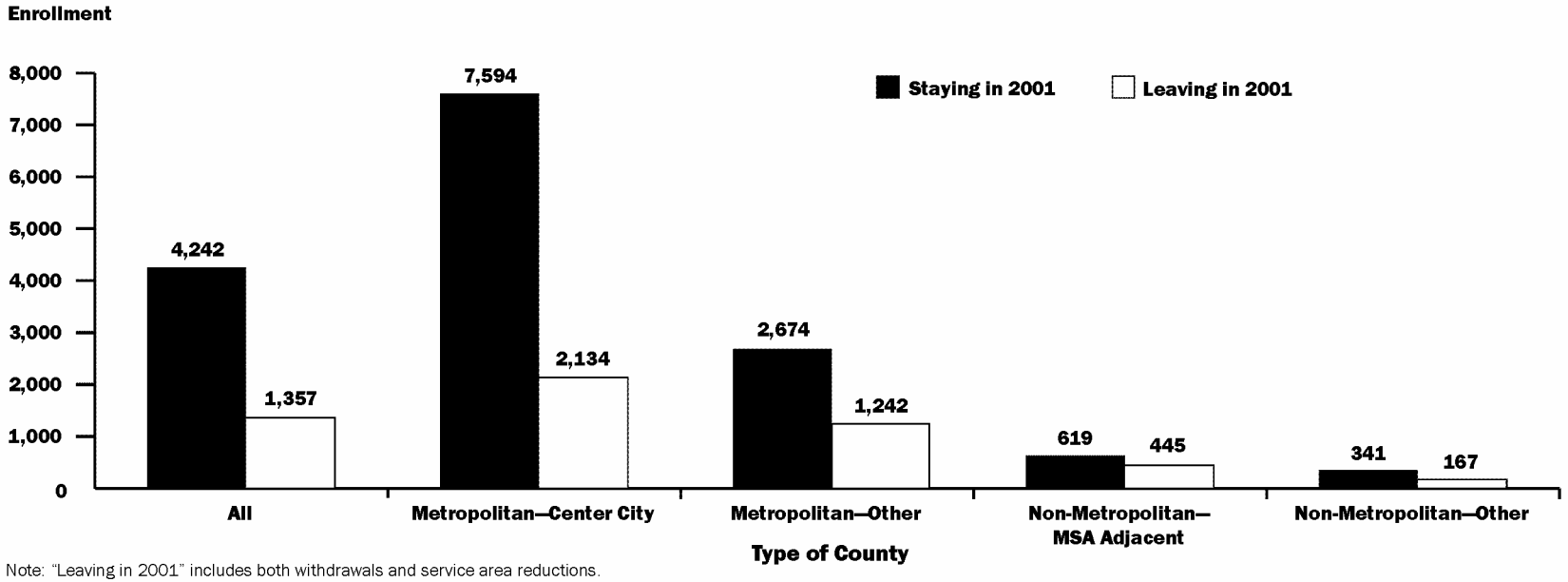
Figure 2. Pharmacy Benefits and Zero-Premium Products in Medicare Risk/M+C Contracts, 1990–2001



* Not presented (data problematic).

Source: MPR compilation of HCFA Monthly Report data (1990–1998) and Medicare Compare (1999–2001), for The Commonwealth Fund. Data for 2001 is post-BIPA.

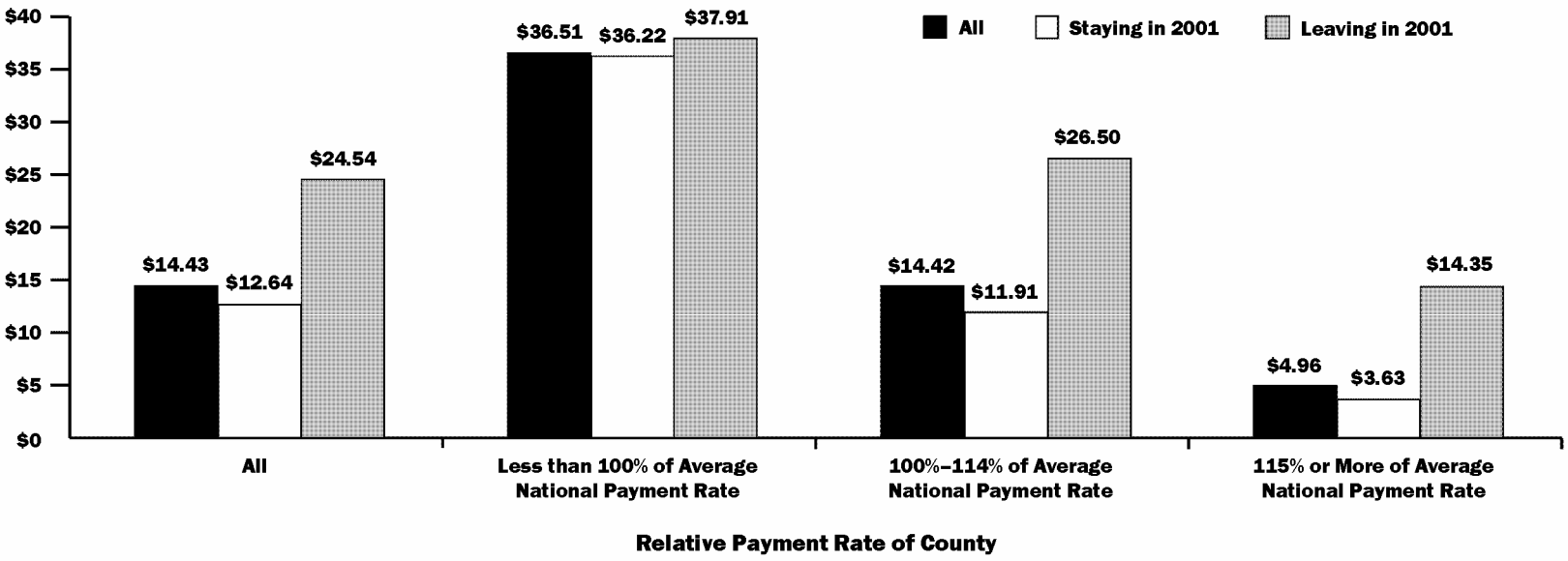
Figure 3. Average 2000 County Enrollment in MCOs Staying in and Leaving M+C Program in 2001, by County Urbanicity



Note: "Leaving in 2001" includes both withdrawals and service area reductions.

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

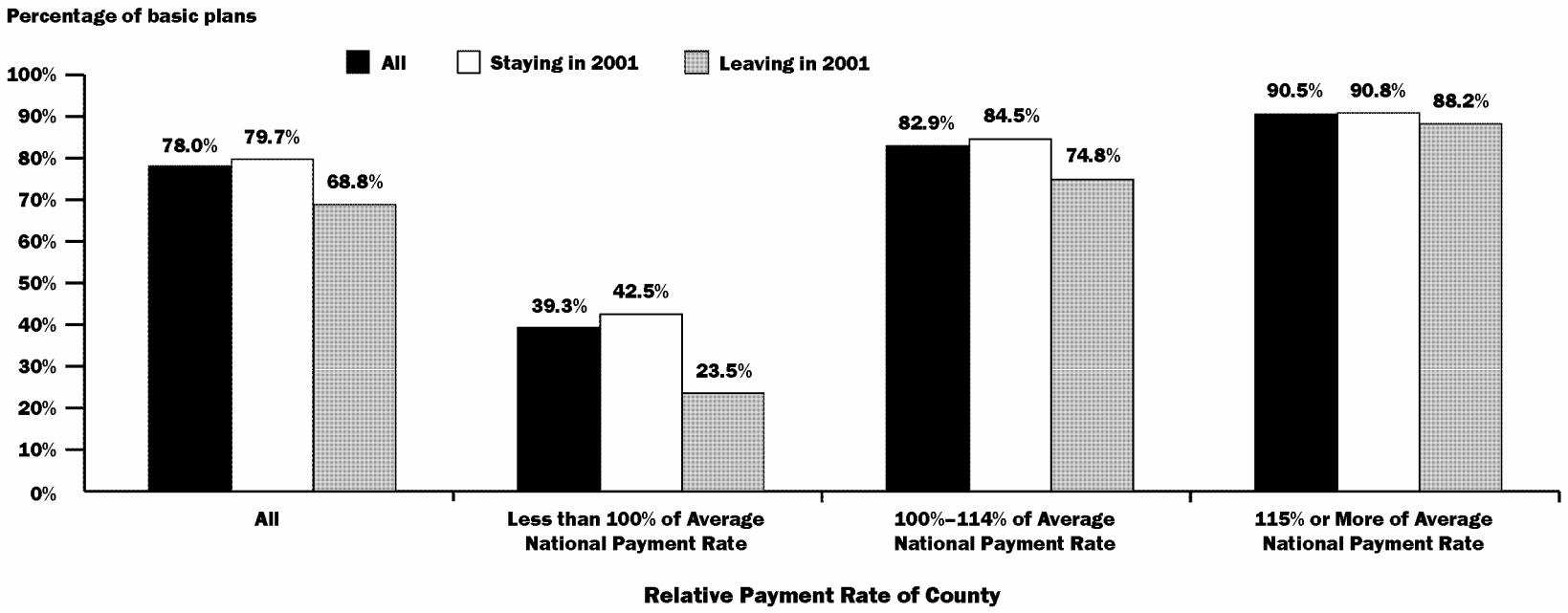
Figure 4. Mean 2000 Premiums of MCOs Staying in and Leaving M+C Program in 2001, by Relative County Payment Rate in 2001



Note: Contract segment payment rate defined by the payment rate in the county with the largest enrollment before BIPA. Data is weighted by enrollment. "Leaving in 2001" includes both withdrawals and service area reductions.

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

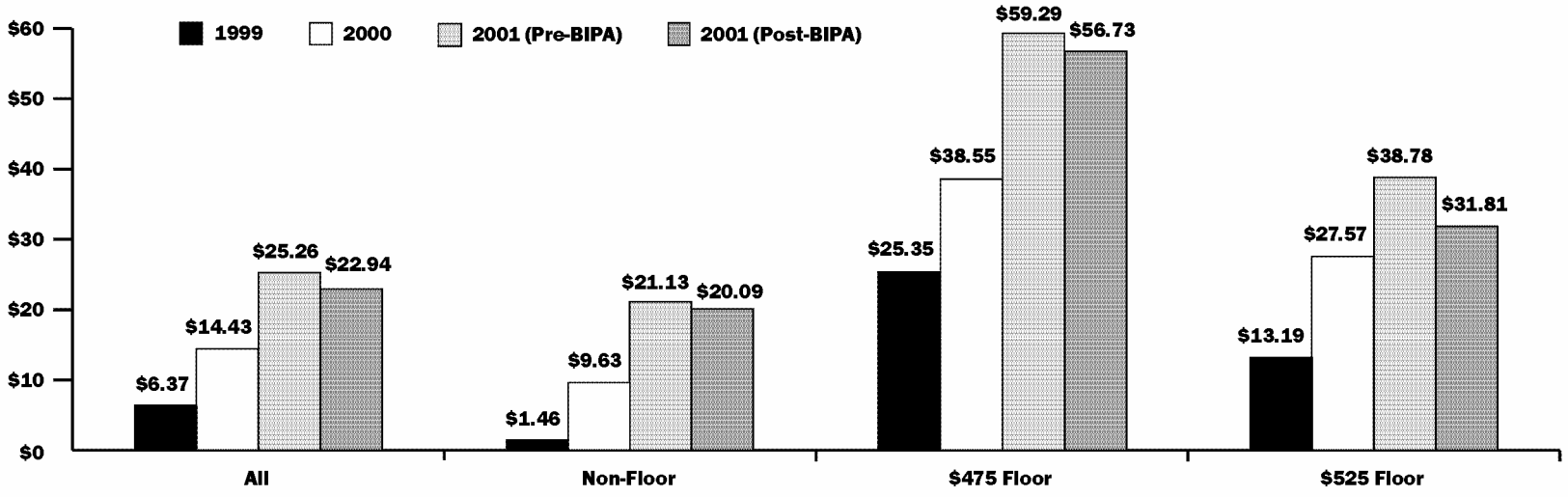
Figure 5. 2000 Prescription Drug Coverage for Renewing and Nonrenewing Plans, by Relative County Payment Rate in 2001



Note: Contract segment payment rate defined by the payment rate in the county with the largest enrollment before BIPA. Data is weighted by enrollment. "Leaving in 2001" includes both withdrawals and service area reductions.

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

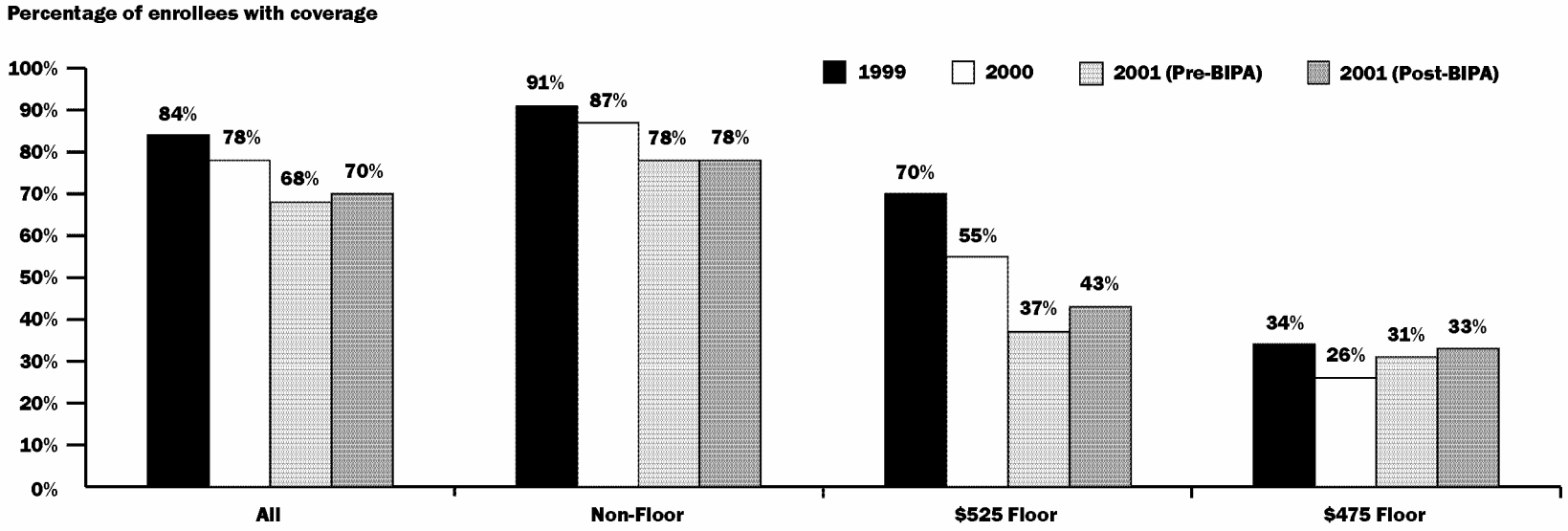
Figure 6. Mean Premiums for M+C Basic Packages 1999–2001, by Payment Rate in 2001 (data are enrollment weighted)



Note: Contract segment payment rate defined by the payment rate in the county with the largest enrollment.

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

Figure 7. Prescription Drug Coverage in M+C Basic Packages 1999–2001, by Payment Rate in 2001 (data are enrollment weighted)



Note: Contract segment payment rate defined by the payment rate in the county with the largest enrollment.

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

Table 1. Medicare+Choice Enrollees Affected by Withdrawals and Service Area Reductions, 1999–2001

	1999	2000	2001
Number of M+C Enrollees	6,055,546	6,347,434	6,260,549
Number of M+C Enrollees Affected by Withdrawal or Service Area Reduction	407,000	328,000	934,000
Percent of M+C Enrollees Affected by Withdrawal or Service Area Reduction	6.72%	5.17%	14.92%

Note: Number of Enrollees is the number of Coordinated Care Plan M+C enrollees in December of the previous year. The 2001 number for affected enrollees includes those enrollees in the four plans that re-entered following BIPA, about 13,000.

Source: MPR analysis of HCFA's Monthly Medicare Managed Care Contract Report and information on contract withdrawals and service area reductions.

Table 2. Trends in Basic Packages 1999–2000 and the Participation Decision for 2001

1999–2000	All	Stay	Leave*
Percentage of Basic Packages with Changes in Premium			
No Change	53.0	55.5	48.4
None Either Year	45.9	46.2	45.2
No Change in 2000	7.1	9.3	3.2
Increase	43.7	40.3	50.0
Added Premium in 2000	27.6	22.2	37.5
Raised Premium in 2000	16.1	18.1	12.5
Reduced Premium in 2000	3.3	4.2	1.6
Percentage of Basic Packages with Changes in Prescription Drug Benefit			
No Change	56.5	63.5	44.0
None Either Year	27.1	29.5	22.8
No Change in 2000	29.4	34.0	21.2
Reduced Benefit	29.8	22.7	42.4
Eliminated Benefit in 2000	12.3	9.0	18.0
Decreased Limit in 2000			
$500 or less	12.3	8.4	19.3
>$500 change	5.2	5.3	5.1
Increased Benefit in 2000	10.2	10.2	10.3
Added Benefit	1.2	1.9	0.0
Increased Limit	9.0	8.2	10.3
Mixed Change	3.5	3.6	3.3

* Includes both withdrawals and service area reductions.

Note: All data are for contracts which served the same county in 1999 and 2000. Mixed change indicates the MCO dropped coverage of brand name prescription drugs but increased the annual limit on generics.

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

Table 3. 2001 Payment Changes Under BIPA

	Non-Floor	$525 Floor	$475 Floor
Share of Medicare Beneficiaries	44.0%	32.0%	24.0%
Share of M+C Enrollees	75.3%	23.0%	1.8%
Average Payment Increase from BIPA	1.0%	9.7%	8.3%

Note: Statistics are enrollment weighted.

Source: "HCFA Analysis of How Medicare+Choice Organizations Used BIPA Payment Increases" (www.hcfa.gov/medicare/bipafact.htm).

Table 4. M+C Organizations' Use of Increased Payments from BIPA, 2001

	All	Non-Floor	$525 Floor	$475 Floor
Enhanced Provider Access Only	65.0%	72.3%	43.5%	48.6%
Stabilization Fund Only	11.0%	14.2%	2.8%	0.0%
Reduced Premium or Cost-Sharing Only	6.0%	5.3%	8.7%	8.4%
Added or Enhanced Benefits Only	1.0%	0.9%	0.0%	0.9%
Used Multiple Options	17.0%	7.3%	45.0%	42.1%

Note: Statistics are enrollment weighted.

Source: "HCFA Analysis of How Medicare+Choice Organizations Used BIPA Payment Increases" (www.hcfa.gov/medicare/bipafact.htm).

Table 5. Monthly Premiums for Basic Packages in Medicare+Choice Contract Segments, 1999–2001

	Percentage of Basic Plans				Weighted by Enrollment*			
	1999	2000	2001 Jan–Feb	2001 Mar–Dec	1999	2000	2001 Jan–Feb	2001 Mar–Dec
None	62.1	42.3	43.4	45.5	79.6	59.0	44.1	46.0
Less than $20.00	3.2	5.3	5.3	5.1	3.1	8.7	9.0	8.2
$20.00–$49.99	20.5	26.9	18.2	21.5	13.5	19.3	22.9	27.1
$50.00 or More	7.4	22.9	32.4	27.5	3.2	11.1	24.0	18.6
Unknown	5.9	2.6	0.8	0.5	0.6	1.8	0.1	0.1
Mean	$13.31	$25.73	$30.83	$28.65	$6.37	$14.43	$25.26	$22.94
Mean if Premium Does Not Equal $0.00	$39.08	$45.47	$54.83	$52.75	$32.11	$36.19	$45.18	$42.52
Number of Contract Segments/ Number of Enrollees	443	468	380	396	6,254,616	6,094,767	5,563,588	5,577,787

* Enrollment is from March of each year.

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

Table 6. Changes in M+C Basic Package Premiums for MCOs Serving the Same County in 2000 and 2001

		Type of County MCO Serves		
	All	Non-Floor	$475 Floor	$525 Floor
Percent of Basic Packages with:				
No Change in Premium	38.6	44.6	39.0	27.6
Kept the Same	6.6	5.1	19.5	4.6
Kept No Premium	32.0	39.5	19.5	23.0
Increase in Premium	48.6	49.8	43.2	38.5
Added a Premium	18.2	25.0	7.6	9.8
Increased Premium Level	30.4	24.8	35.6	38.7
Reduction in Premium	12.8	5.6	17.8	23.9

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

Table 7. Prescription Drug Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999–2001

	Percentage of Basic Plans				Weighted by Enrollment*			
	1999	2000	2001 Jan–Feb	2001 Mar–Dec	1999	2000	2001 Jan–Feb	2001 Mar–Dec
Any Drug Coverage	73.4	67.5	64.2	64.5	83.9	78.0	68.5	70.2
Annual Drug Cap								
$500 or Less	23.3	37.1	37.8	37.5	10.6	20.8	27.6	28.2
$501–$750	12.0	14.4	12.5	12.1	10.1	10.6	11.2	10.8
$751–$1,000	27.5	23.2	18.7	19.0	26.3	17.4	10.7	10.7
$1,001–$1,500	12.0	13.4	10.8	11.3	9.4	12.6	12.8	12.8
$1,501–$2,000	13.0	9.8	10.4	9.7	17.8	20.3	22.4	22.0
$2,001 or More	4.5	3.3	5.8	6.1	4.1	3.4	5.3	5.2
No Cap	7.8	8.8	4.2	4.4	21.7	14.9	10.1	10.4
Practices								
Formulary	81.6	91.6	89.7	89.4	80.3	92.0	90.3	90.6
Mail Orders	89.3	88.6	85.1	85.0	95.7	95.5	93.3	93.5
Quarterly Cap	14.9	23.1	21.5	20.9	12.2	13.1	15.4	15.1
Ratio of Copays Brand-Name to Generic								
2.0 or Less	45.1	38.3	22.6	22.9	55.7	44.8	30.6	30.5
2.01–3.0	32.3	32.1	32.2	32.8	24.9	32.3	35.1	35.2
3.01 or More	21.9	27.8	36.7	36.3	19.2	20.7	25.4	25.6
Copay								
Generic								
None	6.0	4.4	7.2	6.5	7.6	7.1	8.0	7.8
$10.00 or Less	29.3	92.2	82.7	82.5	84.4	90.4	83.5	83.4
$10.01 or More	4.7	3.4	10.1	11.0	8.0	2.5	8.5	8.8
Brand-Name								
None	5.2	2.9	2.0	2.0	6.3	5.5	2.4	2.4
$10.00 or Less	24.7	8.7	9.0	8.6	35.9	19.8	21.8	21.7
$10.01–$20.00	51.7	56.7	42.7	41.4	43.8	54.3	44.0	43.6
$20.01 or More	18.4	31.8	46.2	47.8	14.0	20.4	31.8	32.3

* Enrollment is from March of each year. All quarterly, monthly and 6-month caps have been annualized.

In 1999, 2 contract segments (0.7 percent of those with prescription drug coverage) had a brand-name but no generic copay.

In 2000, 6 contract segments (1.8 percent) had a brand-name but no generic copay.

In 2001 (January–February), 25 contract segments (6.53 percent) had a brand-name but no generic copay.

In 2001 (March–December), 25 contract segments (5.97 percent) had a brand-name but no generic copay.

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

Table 8. Changes in M+C Basic Package Prescription Drug Benefits Among MCOs Serving the Same County in 2000 and 2001

		Type of County MCO Serves		
	All	Non-Floor	$475 Floor	$525 Floor
Percent of Plans with No Change	59.2	50.6	72.3	70.3
No Change in Benefit	23.0	26.3	12.5	20.9
No Benefit Either Year	36.2	24.3	59.8	49.4
Percent of Plans with an Increased Benefit	6.2	6.9	4.5	5.4
Added Benefit	1.8	2.4	2.7	0.3
Increased Yearly Limit	4.4	4.5	1.8	5.1
Percent of Plans with a Decreased Benefit	30.1	35.6	22.4	22.5
Dropped Benefit	8.6	6.1	15.2	10.8
Decreased Annual Limit				
$500 or less	14.8	19.1	9.8	6.3
>$500	6.7	10.4	0.9	1.9
Mixed Change	4.6	6.8	0.9	1.9

Note: Mixed change indicates the MCO increased the annual limit for generic drugs but stopped covering brand-name drugs.
Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

Table 9. Supplemental Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999–2001

	Percentage of Basic Plans				Weighted by Enrollment*			
	1999	2000	2001 Jan–Feb	2001 Mar–Dec	1999	2000	2001 Jan–Feb	2001 Mar–Dec
Prescription Drugs	73.4	67.5	64.2	64.5	83.9	78.0	68.5	70.2
Preventive Dental	40.2	30.1	25.8	27.2	69.9	39.0	27.5	28.6
Vision Benefits	93.8	91.7	90.2	89.3	97.8	96.2	94.7	94.7
Hearing Benefits	82.4	85.2	76.3	75.5	91.3	92.0	77.5	77.7
Physical Exam	100.0	100.0	99.5	100.0	100.0	100.00	99.8	100.0
Podiatry Benefits	27.8	28.1	37.5	37.7	26.9	28.20	29.3	29.4
Chiropractic Benefits	19.0	8.8	10.1	10.7	20.9	6.8	5.9	6.0
Number of Contract Segments/ Number of Enrollees	443	468	380	396	6,254,616	6,094,767	5,563,588	5,577,787

* Enrollment is from March of each year.

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

Table 10. Copayments for Medical and Hospital Services for Basic Plans in Medicare+Choice Contract Segments, 1999–2001

	Percentage of Basic Plans				Weighted by Enrollment*			
	1999	2000	2001 Jan–Feb	2001 Mar–Dec	1999	2000	2001 Jan–Feb	2001 Mar–Dec
Primary Care Physician								
None	7.7	6.1	4.8	4.6	18.0	10.0	5.3	5.3
$5.00 or Less	43.1	33.6	26.3	25.6	44.5	34.1	21.7	21.7
$5.01–$10.00	41.8	49.6	44.0	45.5	32.1	47.8	42.6	43.6
$10.01–$15.00	6.9	9.2	20.7	20.0	5.1	7.2	27.7	26.7
$15.01 or More	0.5	1.5	4.2	4.4	0.3	0.8	2.7	2.8
Specialist								
None	7.2	5.3	5.6	5.4	15.9	8.0	5.7	5.7
$5.00 or Less	38.1	25.4	18.0	17.6	39.6	28.0	16.5	16.4
$5.01–$10.00	36.1	34.0	32.6	33.2	26.8	35.8	35.8	37.1
$10.01–$15.00	11.4	18.9	23.3	24.5	9.9	19.3	19.8	19.3
$15.01 or More	2.2	9.2	20.4	19.4	1.2	6.5	22.3	21.5
Varies	5.0	7.2	0.0	0.0	6.6	2.3	0.0	0.0
Emergency Room								
None	3.7	2.0	4.8	4.6	6.5	3.4	3.4	3.4
$20.00 or Less	12.1	6.6	7.4	7.2	24.5	14.0	12.0	11.9
$20.01–$40.00	31.2	28.1	21.3	20.8	30.5	33.9	30.9	30.9
$40.01–$50.00	52.7	63.4	66.5	67.4	38.2	48.7	53.8	53.8
$50.01 or More	0.2	0.0	0.0	0.0	0.2	0.0	0.0	0.0
Any Copayment								
Hospital Admission	9.4	20.0	46.4	45.5	4.3	12.8	33.4	32.7
Hospital Outpatient	21.5	22.6	38.8	36.9	30.7	28.6	44.2	43.7
X-Ray	6.2	11.7	18.4	17.1	7.5	11.3	17.3	17.2
Lab	3.2	5.7	16.9	15.3	3.9	6.4	17.0	16.4

* Enrollment is from March of each year.

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

Table 11. Availability of Medicare+Choice Plans to Medicare Beneficiaries by County of Residence, 1999–2001

	All Counties	Metropolitan		Non-Metropolitan	
		Center City	Other	MSA-Adjacent	Other
Distribution of Medicare Beneficiaries Nationally	100.0	40.7	35.3	13.3	10.8
Percent of Beneficiaries Offered at Least One M+C Plan					
1999	71.6	99.0	71.4	37.7	10.4
2000	68.5	97.1	67.4	32.4	7.8
Pre-BIPA 2001	63.5	96.4	58.5	22.2	6.6
Post-BIPA 2001	63.9	96.5	59.4	22.4	6.6
Percent of Beneficiaries Offered a M+C Plan with Prescription Drug Coverage					
1999	61.5	92.1	56.9	24.4	5.5
2000	54.7	89.7	44.5	16.3	2.3
Pre-BIPA 2001	46.5	78.3	38.0	7.7	1.4
Post-BIPA 2001	46.9	78.3	39.0	8.6	1.4
Percent of Beneficiaries Offered a M+C Plan with a Prescription Drug Limit Greater than $1,000/Year					
1999	35.8	58.3	26.8	10.6	1.5
2000	35.9	63.3	23.2	6.3	0.0
Pre-BIPA 2001	21.5	42.1	12.4	2.5	0.0
Post-BIPA 2001	22.0	42.2	13.5	2.5	1.0
Percent of Beneficiaries Offered a Zero-Premium M+C Plan					
1999	61.4	92.7	56.2	25.4	3.0
2000	52.6	90.0	39.1	14.5	1.9
Pre-BIPA 2001	37.2	64.9	28.1	6.3	0.3
Post-BIPA 2001	40.2	70.7	29.9	6.5	0.3

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

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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.

#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.

#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.