EXECUTIVE SUMMARY

INSTABILITY AND INEQUITY IN MEDICARE+CHOICE: THE IMPACT ON MEDICARE BENEFICIARIES

FINDINGS FROM SEVEN CASE STUDIES

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INSTABILITY AND INEQUITY IN MEDICARE+CHOICE: THE IMPACT ON MEDICARE BENEFICIARIES

Findings from Seven Case Studies

This report examines recent changes in seven Medicare+Choice markets (Cleveland, Houston, Los Angeles, Minneapolis–St. Paul, New York City, Tampa–St. Petersburg, and Tucson) and the effects of these changes on Medicare beneficiaries.[1] The analysis is based on data collected during site visits and follow-up interviews in 1999 and 2000, as well as a survey of newspaper articles and other relevant documents and analysis of data from several sources, including the Centers for Medicare and Medicaid Services (CMS). Project staff interviewed Medicare+Choice plan representatives, community leaders and advocacy groups, provider and provider organization executives, and CMS regional staff. Project staff also conducted eight focus groups with Medicare beneficiaries in Houston, Minneapolis, and Tucson.

FINDINGS

Medicare+Choice market changes have resulted in increasing program instability and inequity.[2] The specific findings of the study were:

1. In 2000, Medicare HMO withdrawals affected over 144,000 beneficiaries in the seven study sites. Plan withdrawals in 1998, 1999, and especially 2000, as well as benefits reductions and disruptions in provider networks, contributed to noticeable disruptions in five sites. Medicare+Choice withdrawals caused the most significant disruption in Houston, where seven of eight plans withdrew, affecting 85 percent of enrollees. In Cleveland, Minneapolis–St. Paul, Tampa–St. Petersburg, and Tucson, from 11 percent to 35 percent of Medicare+Choice enrollees were affected.

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[1] See Marsha Gold and Lori Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (New York: The Commonwealth Fund, April 2001); and Geraldine Dallek and Donald Jones, *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (New York: The Commonwealth Fund, August 2000) for additional background on the Medicare+Choice program and a discussion of recent national trends.

[2] Instability refers to a decrease in the reliability and dependability of health care coverage while inequity refers to unequal access to Medicare+Choice plans and benefits among and within Medicare managed care markets.

Table ES-1. Percentage of Beneficiaries Affected by HMO Withdrawals, 1998, 1999, 2000

Site	1998		1999		2000	
	Beneficiaries Affected	Percentage of M+C Enrolled Population	Beneficiaries Affected	Percentage of M+C Enrolled Population	Beneficiaries Affected	Percentage of M+C Enrolled Population
Cleveland	0	0.0%	308	0.5%	20,935	33.0%
Houston	6,874	10.0%	54	0.1%	66,135	85.1%
Los Angeles	36,316	9.2%	0	0.0%	11,432	2.8%
Minneapolis–St. Paul	1,298	3.0%	0	0.0%	13,347	35.4%
New York City	3,776	1.8%	919	0.4%	3,614	1.6%
Tampa–St. Petersburg	3,389	3.0%	1,105	0.9%	13,268	11.2%
Tucson	0	0.0%	5,341	8.8%	15,799	25.9%

Source: Centers for Medicare and Medicaid Services data. Percentage of affected beneficiaries based on June enrollment figures.

2. Both national factors and local market dynamics explain plans' decisions to withdraw from the Medicare program. National factors contributing to plan pull-outs included low Medicare payment rates, the timing of CMS's annual notification requirement, regulatory burdens, and national plan strategy. Local factors that influenced plans' decisions to withdraw from Medicare included: growing unwillingness of provider groups to contract with Medicare HMOs and to accept capitated payment rates, the monopolistic position of some providers in both urban and rural areas, increasing utilization and cost of services, concerns about plan adverse selection,[3] and low market share.

3. Recent trends in plan benefits packages included increased costs to beneficiaries, reduced prescription drug benefits, and increased complexity.[4] To varying degrees across the study sites, Medicare HMOs are tightening the upper limits on prescription drug coverage and imposing higher copays on drugs; increasing premiums; and requiring new or increased cost-sharing for non-drug benefits, including physician visits and hospital stays. In five study sites, plans increased premiums and/or significantly reduced benefits. For example, in Tampa, one Humana group increased premiums from $19 to $179, while reducing coverage for brand drugs from $1,000 a year to $50 a month.

[3] The Center for Health Services Research and Policy's analysis of CMS enrollment data shows that, with the exception of Minneapolis–St. Paul, managed care enrollees tended to be somewhat younger than fee-for-service enrollees in the study sites.

[4] See Marsha Gold and Lori Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (New York: The Commonwealth Fund, April 2001).

Plans also are increasing or imposing cost-sharing for benefits that had previously been free to beneficiaries, such as hospital care, durable medical equipment, lab and X-ray services, and nursing home days. As plan benefits become increasingly complex, the failure to simplify and standardize benefits packages makes cost/benefit comparisons among plans difficult, if not impossible.

One Cleveland plan's cost-sharing for selected nonprescription drug benefits

Primary care physician visit: $5
Specialist visit: $20
Outpatient mental health visit: 20%
Outpatient surgery: $50
Durable medical equipment: 20%
Radiation therapy: $5–$20 or 20% of costs
Diagnostic tests, X-rays, and lab services: $5–$20 or 20% of costs
Outpatient rehabilitation services: $20 or 20% of costs
Inpatient hospital care: $50/day

4. Plan-provider disputes relating to payment rates and payment delays have resulted in significant disruptions in provider networks. Financial troubles of some large provider groups have added to plan network disruptions. Hospitals and physicians are less willing to accept plan-imposed contracts and in some cases are refusing altogether to contract with Medicare managed care plans. Across study sites, there is a discernible movement by provider groups away from capitation and risk-based contracting and back toward hospital per diem or diagnosis-related group (DRG) and physician fee-for-service payments. Plan-provider contract disputes have affected plan members in Cleveland, Tampa–St. Petersburg, and Tucson.

Percentage of primary care physicians leaving a plan's network after one year

Cleveland: 7% to 16%
Houston: 27%
Los Angeles: 1% to 31%
Minneapolis–St. Paul: 3%
New York City: 4% to 20%
Tampa–St. Petersburg: 10% to 16%
Tucson: 13% to 15%

Provider group financial problems have contributed to network disruptions in Houston, Los Angeles, and Tucson. Several respondents attributed such financial problems to sub-capitation, by which Medicare+Choice plans passed the financial risk of care down to contracting providers.

5. Inequity in the Medicare+Choice program—geographical variation in plan availability—undermines Medicare's tradition of providing uniform benefits. Across study sites, the number of plan choices varied dramatically. In Minneapolis–St Paul and Tucson, beneficiaries had only two Medicare HMOs from which to choose in 2001, compared with 10 plans in parts of Los Angeles and New York City. Limits on

enrollment further decreased the availability of plans to new members in Cleveland, Houston, and Tampa–St. Petersburg.

Benefits offered by Medicare HMOs also varied dramatically across sites. In Minneapolis–St. Paul, no Medicare HMO offered substantial prescription drug coverage for less than $300 per month. In contrast, many seniors living in Los Angeles in 2001 continued to pay no premiums for plans with generous prescription drug coverage. Even within markets with Medicare+Choice plans available, accessibility and availability and the generosity of Medicare HMO plan benefits varied. For example, Anthem HMO offered more generous brand-name prescription coverage in Cuyahoga County (Cleveland) than in neighboring counties. For seniors living in rural areas surrounding Tucson, access to care was reduced for HMO enrollees because they had to travel long distances to see network providers.

6. Medicare beneficiaries affected by HMO withdrawals and benefits reductions have few alternative sources from which to obtain prescription drugs. Beneficiaries participating in focus groups for this project were especially upset over reduced or eliminated prescription drug benefits. Few viable options exist for beneficiaries unable to obtain generous prescription drug benefits through a Medicare+Choice plan. Only the lowest-income Medicare beneficiaries qualify for prescription coverage through Medicaid. State pharmaceutical assistance programs are an option for lower-income seniors in Minneapolis–St. Paul, New York City, and Tampa–St. Petersburg; however, these programs have very restrictive eligibility requirements, with the exception of New York.[5] Some seniors in Minneapolis–St. Paul and, especially, Tucson have resorted to traveling outside the United States to purchase prescription drugs, while other seniors rely on samples from providers and/or are stockpiling their medications by taking less than the prescribed daily dose.

The "seniors' drug run"

The Tucson physicians and community informants we spoke with do not discourage seniors from traveling to Mexico to fill prescriptions, which typically cost one-third of the U.S. price. Many Mexican pharmacies sell brand-name drugs that are manufactured by large, international pharmaceutical companies; often the packaging of these drugs is the same as in the United States. The Tucson seniors we spoke with all knew of seniors who were making the trip to Nogales, Mexico. One senior commented, "Half the seniors in Tucson are going to Mexico for their prescriptions. They get a carload full of people together and make the hour-long trip." Another Tucson senior described trips to Nogales as "seniors' version of a drug run."

[5] As of February 2001, 26 states had authorized some type of pharmaceutical assistance program. Five additional states, including California, have recently created programs that offer a discount only.

7. Seniors are surprised, confused, worried, and angry about Medicare+Choice instability and inequity. Beneficiaries and counselors working with the elderly reported that members of plans that have left the Medicare program are angry and frustrated, anxious and worried, confused and panicked, and in some cases, immobilized—unable to make a decision about what to do next. The intensity of the response varied by city with the greatest concerns expressed in Houston and Tucson.

The beneficiaries affected by withdrawals and benefits cuts were confused about their remaining choices, about plan benefits packages, and by changes in provider networks. Some beneficiaries also were confused by the rules regarding the purchase of a Medigap policy.

Seniors' reactions to instability and inequity in Medicare+Choice seemed to affect their trust in the Medicare program. Some beneficiaries could not understand why a perceived "entitlement" to prescription drug benefits was being reduced or taken away. Still others said they thought Medicare discriminated against them because Medicare+Choice is not available in rural areas.

DISCUSSION AND POLICY IMPLICATIONS

Project staff analysis of local market dynamics in seven sites suggests that raising payment rates is not the only policy remedy needed to address instability and inequity in the Medicare+Choice market.

Many factors other than payment rates influence plans' decisions about withdrawals and benefits, including medical cost inflation, escalating prescription drug costs, greater provider (especially hospital) negotiating clout, and a move away from risk-based contracting and restrictive provider networks. There is little evidence that the extra funding[6] recently provided to Medicare+Choice plans was enough of an incentive for withdrawing plans to return to the program or for existing plans to increase their benefits packages.[7]

Similarly, there is no easy fix to program inequity. Additional funding as a result of the Benefits Improvement and Protection Act of 2000 (BIPA) did not result in new Medicare+Choice plans in rural or sparsely populated counties or reduce access problems

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[6] In an effort to deal with plan withdrawals and benefits reductions, Congress enacted the Benefits Improvement and Protection Act (BIPA) in 2000, which authorized $11 billion in extra funding over the next five years to Medicare+Choice plans. BIPA increased minimum Medicare+Choice payment rates and provided a new entry bonus in counties without plans as of October 2000.

[7] *HCFA Analysis of How Medicare+Choice Organizations Used BIPA Payment Increases,* available at www.hcfa.gov/medicare/bipahome.htm; and Marsha Gold and Lori Achman, *Raising Payment Rates: Initial Effects of BIPA 2000* (Washington, D.C.: Mathematica Policy Research, Inc., June 2001).

for rural enrollees. Nor did it reduce the variability in benefits offered by plans or address the unfairness of a system that offers prescription drugs and other benefits for some beneficiaries but not others. Inequities in the Medicare+Choice program undermine the traditional goals of Medicare.

Findings suggest that the cost to Medicare HMOs of providing a prescription drug benefit has driven a lot of the recent market volatility. The need for prescription drugs also accounts for much of the adverse impact of program instability and inequity on beneficiaries. The experience of beneficiaries in the seven study sites suggests that the basic problems underlying recent Medicare+Choice program turmoil may be difficult to address if a Medicare prescription drug benefit is not added.

In addition to adding a prescription drug benefit to the Medicare entitlement, options to address the most serious problems of the Medicare+Choice program include:

- Standardizing Medicare HMO plan benefits, thus allowing beneficiaries to compare Medicare+Choice plans based on costs and quality.

- Requiring all plan-provider contracts to last for a calendar year, from January to December, and to be finalized prior to the open-enrollment period in November of the preceding year.

- Allowing enrollees to change plans or return to fee-for-service Medicare and Medigap if either their primary care provider or their specialist leaves the plan during the year.

- Increasing support for beneficiary education initiatives at the national and local levels.

- Delaying implementation of beneficiary lock-in until plan and provider participation in the Medicare+Choice program is more stable.

- Requiring plans that wish to participate in Medicare+Choice to commit for a minimum of three years.

The instability and inequity of Medicare+Choice described in this report contrast with the stability and fairness of the original Medicare program. Although BIPA may have stabilized Medicare+Choice markets in the short term, the decline in enrollment from

June 2000 to March 2001 in six of the seven study sites provides some evidence that the program is losing beneficiary support. Nevertheless, in five of seven study sites Medicare+Choice plans continue to attract from 22 percent to 43 percent of the Medicare population, and despite recent market turmoil and benefits cuts, beneficiaries continue to turn to Medicare+Choice to fill in gaps in Medicare. Future changes in Medicare+Choice should respond to the need for greater stability and equity to allay confusion and anxiety among affected beneficiaries and to prevent further erosion of beneficiary support.