



**MEDICARE+CHOICE IN NEW YORK CITY:
SO FAR, SO GOOD?**

Jennifer Stuber, Andrew Dennington, and Brian Biles

FIELD REPORT

September 2002

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

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering publication number **548**. The report can also be found on the Fund's website at **www.cmf.org**.

CONTENTS

About the Authors.....	iv
Executive Summary.....	v
Introduction	1
National Instability in Medicare+Choice	1
Medicare+Choice in New York City: More Choice, Better Benefits.....	2
Medicare+Choice in New York City: Elements of Future Instability.....	6
Conclusion	15
Notes.....	16

LIST OF FIGURES

Figure 1 Declining Medicare+Choice Penetration in Seven Markets, 1999–2002: But Less So in New York and Los Angeles	3
Figure 2 Percent of M+C Enrolled Population Affected by Plan Withdrawals, 1999–2002.....	3
Figure 3 Number of Medicare+Choice HMOs in Seven Markets, 1993–2002.....	4
Figure 4 Average M+C Plan Monthly Premium, 2002.....	5
Figure 5 Distribution of M+C Enrollees by Type of Drug Coverage, 2002	5
Figure 6 Average Annual Estimated Out-of-Pocket Health Care Expenses in M+C Plans, 2001	6
Figure 7 Medicare+Choice Monthly Payment (AAPCC) Rates per Beneficiary, 2002.....	7
Figure 8 M+C Plans' Market Share: New York City, March 2002.....	8
Figure 9 Medicare+Choice Health Plan Withdrawals in Connecticut, New Jersey, and New York by Counties, 1999–2002	9
Figure 10 Primary Care Provider Turnover Rates in NYC M+C Plans.....	11
Figure 11 Hospital Utilization: United States and New York City, 1990–99.....	13
Figure 12 New York State's EPIC Program: Eligibility Criteria and Benefits Provided	14
Figure 13 EPIC Enrollment by County, 1999–2001.....	15

ABOUT THE AUTHORS

Jennifer Stuber, Ph.D., recently earned a doctorate in health care policy from Yale University. She is currently a research associate at The New York Academy of Medicine. Prior to moving to New York City, she was a research associate at the George Washington University's Center for Health Services Research and Policy.

Andrew Dennington is a recent graduate of Columbia College. He served as research assistant at George Washington University's Center for Health Services Research and Policy before joining the staff of Congresswoman Zoe Lofgren in the U.S. House of Representatives.

Brian Biles, M.D., M.P.H., is professor in the Department of Health Services Management and Policy at George Washington University. He has previously served as staff director of the Subcommittee on Health of the U.S. House Committee on Ways and Means, deputy assistant secretary for health in the U.S. Department of Health and Human Services, deputy secretary of the Maryland Department of Health and Mental Hygiene, and senior vice president at The Commonwealth Fund. He earned his M.D. from the University of Kansas and M.P.H. from John Hopkins University.

EXECUTIVE SUMMARY

The Medicare+Choice (M+C) program was created by the Balanced Budget Act of 1997 to expand Medicare beneficiaries' choice of private health plans and offer them additional benefits such as prescription drug coverage. While the program is faltering across the country because of large-scale withdrawals by health plans, premium increases, and benefit reductions, the M+C program remains fairly stable in New York City.

New York City's Medicare beneficiaries enjoy greater choice of M+C plans, lower plan premiums, and more generous plan benefits than their counterparts in other major metropolitan areas and in suburban counties outside of New York City. For example, in New York City, the average M+C plan monthly premium is \$3 versus \$33 across the United States. While 10 plans offer M+C products in New York City, only two offer these products in Seattle. And while only one small M+C plan on Long Island covers brand-name prescription drugs, eight of 10 New York City plans offer such coverage.

The relatively successful five-year track record of the M+C program in New York City is due to payment rates to health plans that are among the highest in the nation. Furthermore, because of the city's large supply of competing physicians and hospitals that continue to contract with HMOs, plans are able to negotiate favorable rates. Four factors, however, indicate that these conditions are likely to change, suggesting future instability in New York City's M+C market:

- Annual Medicare payment increases to M+C plans have run only 2 to 3 percent over the past five years, while health care inflation has increased at more than twice that rate.
- Three of New York City's five largest M+C plans, which together account for 43 percent of M+C enrollment in the city, are large national for-profit insurers that have a record of withdrawing from M+C in suburban New York and other major metropolitan areas.
- Physicians and hospitals in New York City are beginning to demonstrate less willingness to accept reduced rates from, or even contract with, Medicare HMOs.
- Recent M+C benefit reductions and eligibility expansion of New York State's popular Elderly Pharmaceutical Insurance Program have decreased the incentives for beneficiaries to join an M+C plan.

These factors suggest that New York City's more than 200,000 elderly and disabled enrollees in M+C plans, representing about 20 percent of all New York City Medicare beneficiaries, may soon begin to experience large-scale health plan withdrawals, premium increases, benefit reductions, and provider network instability, as have beneficiaries in most other markets.

MEDICARE+CHOICE IN NEW YORK CITY: SO FAR, SO GOOD?

INTRODUCTION

New York City is one of only a few urban areas that have been spared recent instability in the Medicare+Choice (M+C) program. Across the country, most enrollees in M+C HMOs have experienced either withdrawals of health plans, reductions in benefits, high rates of provider turnover within plans, or some combination of these events. This instability has led experts to call into question the future viability of the program on the national level. In contrast, New York City's more than 200,000 M+C enrollees, representing about 20 percent of all New York City Medicare beneficiaries, continue to enjoy more choice among M+C plans than beneficiaries in most other cities, have better benefits and lower premiums, and are less affected by contract disputes between M+C plans and their contracting providers.

This disparity has prompted discussion about how much longer the M+C program in New York City can avoid the ills that afflict the program nationally. This report assesses the current state of the M+C program in New York City, discusses recent trends in the city's M+C marketplace, and concludes with a discussion of the direction this program might take in New York City in the near future.

In addition to data gathered and analyzed by the authors, this report draws on interviews with New York City health plan executives, provider and hospital organization representatives, community leaders and advocacy groups, and relevant New York State government staff. For perspectives on the national status of the M+C program, interviews were also conducted with similar representatives in seven municipalities around the country: Cleveland, Ohio; Houston, Texas; Nassau and Suffolk counties (Long Island), New York; Los Angeles, California; Seattle, Washington; and Tucson, Arizona.¹

NATIONAL INSTABILITY IN MEDICARE+CHOICE

The M+C program was created by the Balanced Budget Act of 1997 (BBA). BBA aimed to expand beneficiaries' health care choices, including access to HMOs, and to provide additional benefits such as prescription drugs. The goal was also to use market competition among health plans to restrain the growth of Medicare expenditures. By almost all accounts, BBA has failed to deliver more choices and to expand benefits to Medicare beneficiaries nationally.² In fact, the number of beneficiaries enrolled in Medicare HMOs across the country is actually lower now than it was before BBA was enacted.

While BBA has kept cost increases relatively low by limiting payment increases to most Medicare HMOs in large urban counties to 2 percent per year, this has caused large-scale plan withdrawals from the program, affecting over 2.2 million beneficiaries nationwide since 1998.³ The overall increase in payments to plans from 1997 to 2001 for high-cost areas such as New York City, 11 percent, is well below the increase in spending in the fee-for-service Medicare program over the same period, 21 percent.⁴ Congress gave M+C plans in most large urban areas an additional one-time 1 percent payment increase for 2001, but large-scale withdrawals continued the following year.⁵

Among the health plans still participating in M+C, benefit reductions⁶ and premium increases have made them less attractive to beneficiaries. Contentious plan-provider relationships leading to disruptive contract terminations have further destabilized the program.⁷

MEDICARE+CHOICE IN NEW YORK CITY: MORE CHOICE, BETTER BENEFITS

Judging from a variety of measures—beneficiary enrollment, access to M+C plans, and plan premiums and benefits—the M+C program is strikingly more stable and attractive to beneficiaries in New York City than it is in most other cities across the country.

Beneficiary Enrollment

While the percentage of Medicare beneficiaries who choose to enroll in an M+C plan is declining both nationally and within major metropolitan markets across the country, M+C enrollment remains fairly stable in New York City. National enrollment has declined 24 percent from its peak in 1999, and some markets have seen an even greater drop, yet enrollment in New York City is down only 7.4 percent from its peak (see Figure 1). In March 2002, M+C market penetration rates of 20.1 percent in New York City remained well above the national average of 13 percent in four of the city's five boroughs, ranging from 32.7 percent in Staten Island to 12.2 percent in Manhattan.

Figure 1. Declining Medicare+Choice Penetration in Seven Markets, 1999–2002: But Less So in New York and Los Angeles

	Peak		March 2002		Percent Decline in Penetration Rate
	Market Penetration Rate	Number of M+C Enrollees	Market Penetration Rate	Number of M+C Enrollees	
New York City	21.7% ^a	214,190	20.1%	206,913	7.4%
Cleveland	26.4% ^b	64,279	21.0%	50,220	20.5%
Houston	27.0% ^a	77,715	10.7%	31,825	60.4%
Long Island	23.7% ^b	100,226	13.6%	59,050	42.6%
Los Angeles	39.9% ^a	388,038	35.7%	372,360	10.5%
Seattle	32.4% ^b	65,834	23.6%	48,479	27.2%
Tucson	48.3% ^b	61,001	36.1%	48,626	25.3%
United States	17.5% ^b	6,964,667	13.3%	5,047,329	24.0%

^a Reached peak in June 2000.

^b Reached peak in June 1999.

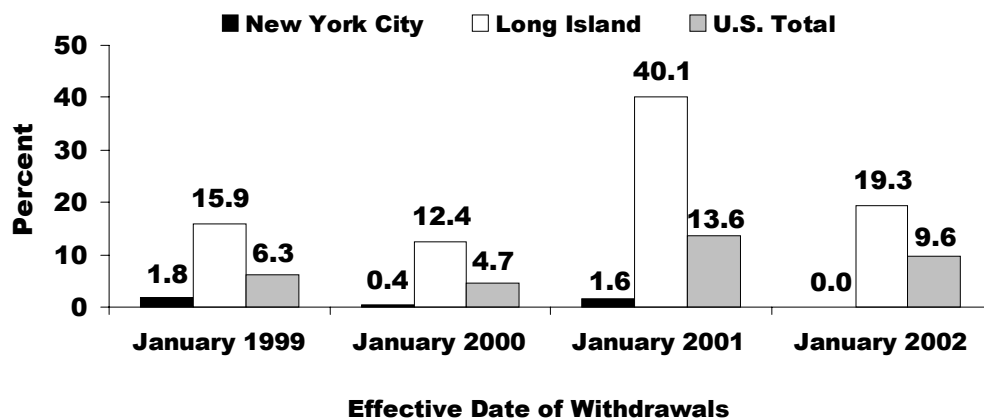
Note: Long Island includes Nassau and Suffolk Counties.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services quarterly state/county and state/county/health plan data files. The table shows the percentage decline from peak until 2002.

Access to Medicare+Choice Plans

New York City has been spared the recent wave of large-scale withdrawals that have forced millions of M+C enrollees across the country to choose a new M+C plan, if available, or return to fee-for-service Medicare (see Figure 2).

Figure 2. Percent of M+C Enrolled Population Affected by Plan Withdrawals, 1999–2002



Note: Long Island includes Nassau and Suffolk Counties.

Source: George Washington University (GWU) analysis of Centers for Medicare and Medicaid Services data on withdrawals.

Whereas the number of M+C plans has dropped nationally by more than half in only four years, there has been no comparable decline in New York City (see Figure 3). When plans have withdrawn from all or part of New York City, the impact has been relatively minimal since those plans all had small enrollments, none of them amounting to a market share of over 2 percent.

Figure 3. Number of Medicare+Choice HMOs in Seven Markets, 1998–2002

Market	Number of Plans				
	12/98	12/99	12/00	12/01	4/02
New York City	13	12	11	10	10
Cleveland	9	9	8	5	5
Houston	11	9	8	3	3
Los Angeles	14	11	11	10	10
Long Island	11	9	8	4	3
Seattle	5	6	6	2	2
Tucson	8	7	4	2	2
Total in Seven Markets	71	63	56	36	35

Notes: Long Island includes Nassau and Suffolk Counties. In Cleveland, one plan left and one new plan entered in 2002. In Houston, although all but one plan left at the end of 2000, two new plans, AmCare and SelectCare, entered the market. For Los Angeles, figures reflect the MaxiCare bankruptcy in 2001 and Blue Shield's partial service area reduction in 2002. For Seattle and Tucson, figures do not include Sterling Option I, a private fee-for-service plan that entered Seattle and Tucson in 2001. As of March 2002, this plan had less than 200 enrollees in each of these markets.

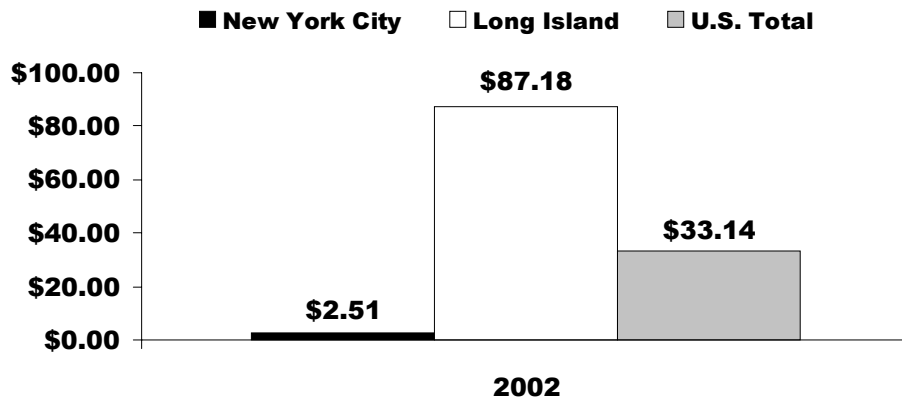
Sources: Centers for Medicare and Medicaid Services (CMS), state/county/health plan market penetration reports; CMS data on health plan withdrawals, 1998–2002. U.S. total includes only M+C HMOs; it does not include private fee-for-service plans.

New York City beneficiaries still have access to 10 M+C plans, in stark contrast with beneficiaries on Long Island and in other metropolitan areas like Seattle, Tucson, and Houston. For example, the number of Medicare HMOs operating on Long Island dropped from 11 to three after four consecutive years of large health plan withdrawals. Los Angeles is among the few cities that, like New York, have not experienced significant plan withdrawals.

Premiums and Benefits

Premiums have remained low in New York City's M+C plans (see Figure 4). Every M+C plan in the city except Aetna still offers a basic, zero-premium option with drug coverage. While the national enrollment-weighted average M+C premium increased 53 percent from 2001 to 2002, to \$33.14, the average premium in New York City was only \$2.51 in 2002.⁸

Figure 4. Average M+C Plan Monthly Premium, 2002

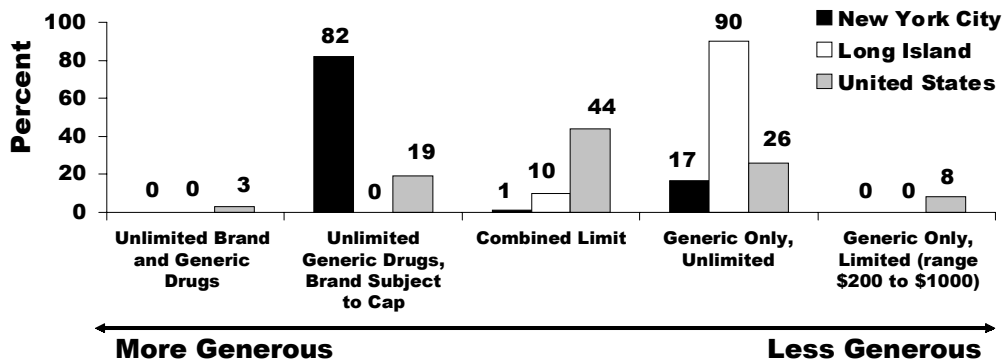


Note: Enrollment-weighted averages calculated using March 2002 CMS enrollment data. Figures computed using “basic plan” options. Source: CMS, Trends in Benefits (2001) and GWU analysis of Medicare Health Plan Compare.

Medicare HMOs in New York City also have comparatively generous drug coverage. While a common trend across the country has been for many M+C plans to drop all coverage for brand-name prescription drugs, 82 percent of New York City M+C enrollees are in plans with unlimited generic drug coverage plus brand-name drug coverage of \$500 to \$2,000 annually (see Figure 5).

Figure 5. Distribution of M+C Enrollees by Type of Drug Coverage, 2002

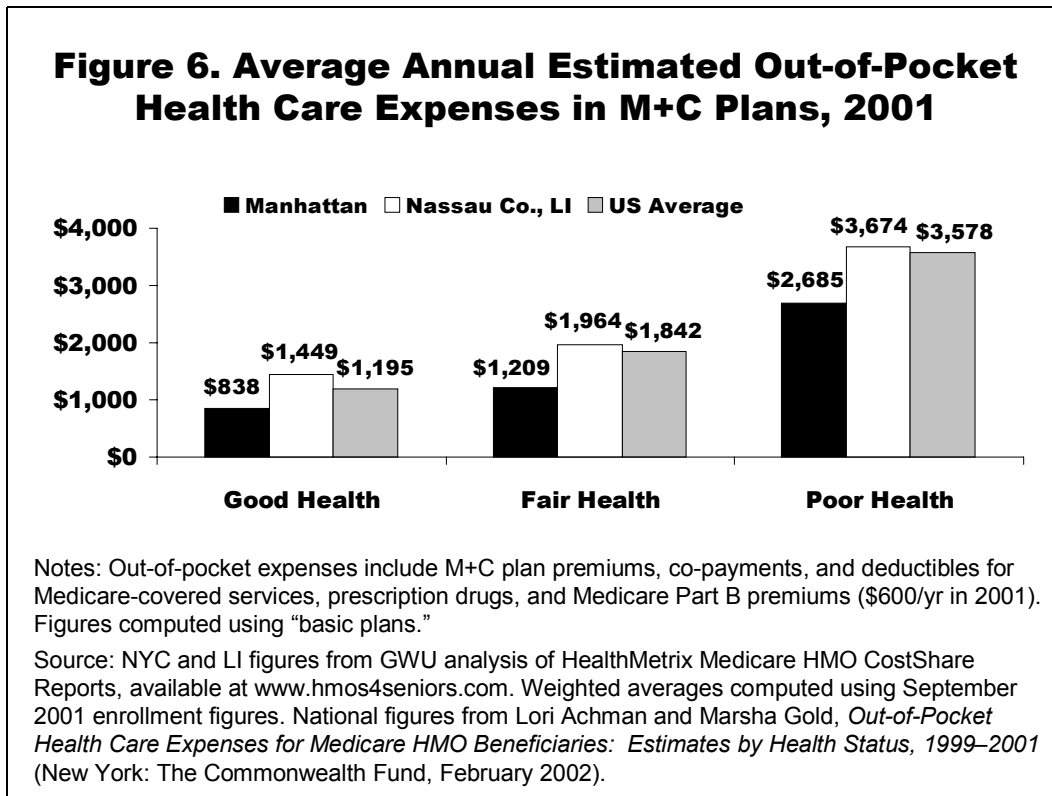
Distribution of Beneficiaries by Type of Drug Coverage, 2002
Enrollees Unaffected by Withdrawals



Notes: Figures computed using “basic plans.” Data presented in this figure only reflect beneficiaries who have not been affected by M+C health plan withdrawals.

Source: NYC and LI figures from GWU analysis of Medicare Health Plan Compare and March 2002 enrollment figures. National figures from CMS, M+C Changes in Access, Benefits, and Premiums, 2001 to 2002, December 2001.

Overall estimated cost sharing is also far lower in New York City M+C plans than it is nationally or on Long Island (see Figure 6). Most plans across the country have added substantial new co-payments and deductibles for services such as inpatient hospital care, prescription drugs, and durable medical equipment, but plans in New York City have so far largely avoided this trend.



MEDICARE+CHOICE IN NEW YORK CITY: ELEMENTS OF FUTURE INSTABILITY

New York City's Medicare+Choice marketplace has proven stable since BBA because, according to HMO representatives, M+C remains a profitable line of business for health plans operating in the five boroughs. This is due both to the high level of Medicare payments in New York City (see Figure 7) and the nature of the local health care marketplace, in which HMOs can negotiate favorable rates from among a large number of competing health care providers.

**Figure 7. Medicare+Choice Monthly Payment
(AAPCC)* Rates per Beneficiary, 2002**

New York City	
Richmond County	\$856
Bronx County	\$812
New York County	\$795
Kings County	\$786
Queens County	\$735
Suburban New York	
Nassau County	\$654
Westchester County	\$639
Suffolk County	\$622
Other Metropolitan Areas	
Philadelphia County, PA	\$785
Boston (Suffolk County), MA	\$711
Los Angeles County, CA	\$694
Washington, D.C.	\$651
Chicago (Cook County), IL	\$624
San Francisco County, CA	\$601
National Average	\$601

* AAPCC is the adjusted average per capita cost.

Note: The 2002 national average was computed assuming a 2 percent increase in the December 2001 enrollment-weighted average AAPCC rate.

This stability in the New York City M+C market may not last much longer, however. Four factors could cause serious problems in the near future: 1) tight limits on annual Medicare payment increases to M+C plans; 2) the potential for the withdrawal of New York City's five largest M+C plans; 3) growing resistance to managed care by New York City's physicians and hospitals; and 4) recent M+C benefit reductions that decrease the "value added" that beneficiaries can realize from enrolling in an M+C plan.

1. Limited Medicare Payment Increases to Health Plans

New York City's M+C plan executives are acutely aware of the national factors that have caused M+C plans to withdraw from the program elsewhere in the New York metropolitan area and across the country.⁹ The most visible of these is Medicare's current health plan payment policy, which has effectively limited annual payment increases to plans operating in most urban areas to 2 percent.¹⁰ This policy is a product of the BBA, which was, at its heart, intended to curb the growth of Medicare expenditures in an effort to balance the federal budget.

HMO representatives predict that their plans' profit margins will decline and benefits will be reduced without changes to the current payment policy. M+C plans in New York City have received annual payment increases of only 2 to 3 percent since BBA while medical costs are now increasing by 8 to 10 percent each year.

Executives report that it is only a matter of time before this differential entirely consumes their profit margins. As one plan representative describes, “Without changes to reimbursement rates, the future of the M+C program looks bleak.” In response to these concerns, the Bush administration has proposed a 6.5 percent increase in payments to M+C plans operating in counties that have received only the minimum payment update for the past four years, effective January 2003.¹¹

2. Potential for Withdrawal Among New York City Medicare+Choice Plans

Confronted with these challenging market conditions, plans have withdrawn from M+C in large numbers, especially large, national, for-profit, independent provider association (IPA) plans.¹² For example, in the last two years, Aetna withdrew from M+C in 118 counties in 13 states.¹³ The withdrawals by this one firm alone affected over 460,000 beneficiaries.

Three of New York City’s five largest M+C plans—Aetna, Oxford Health Plans, and United Healthcare—are large publicly traded firms under pressure from Wall Street analysts to shut down unprofitable M+C operations (see Figure 8).¹⁴ They also have a prior history of withdrawals in the tri-state area. Since 1998, withdrawals by these plans affected 172,324 beneficiaries in New York, New Jersey, and Connecticut (see Figure 9). If, for example, Oxford withdrew from the five boroughs, 31 percent of the city’s M+C enrollees would be affected.

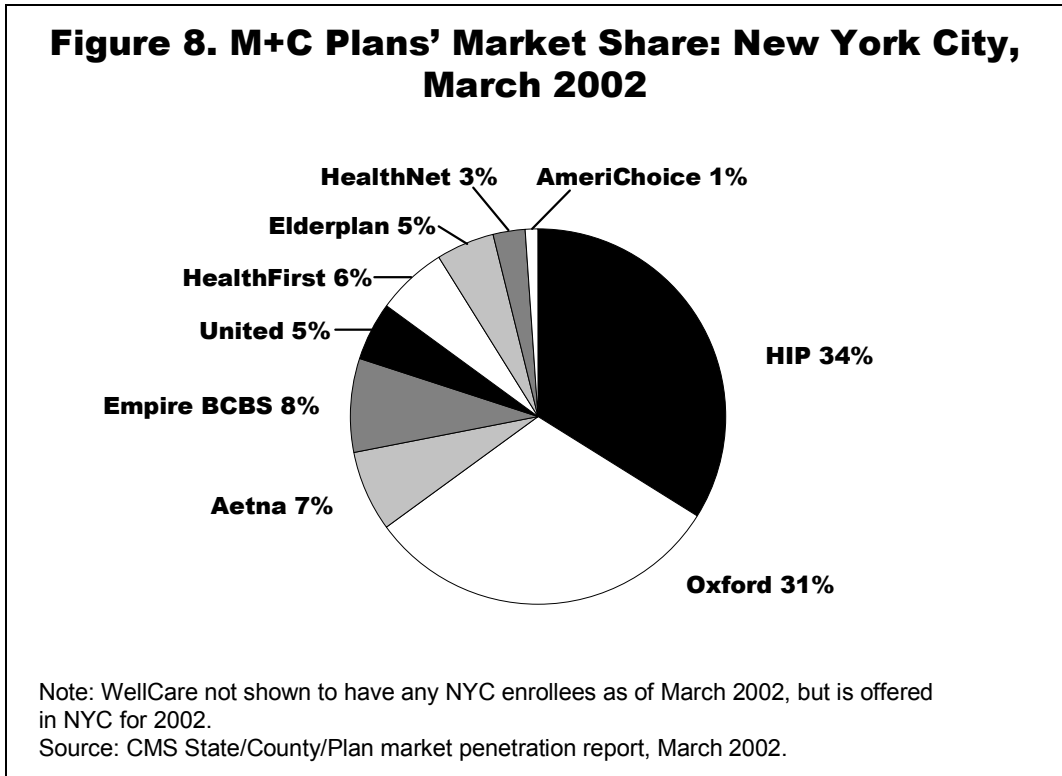


Figure 9. Medicare+Choice Health Plan Withdrawals in Connecticut, New Jersey, and New York by Counties, 1999–2002

Firm		Effective Date of Withdrawals				TOTAL
		1999	2000	2001	2002	
Aetna	Location of Withdrawals	2 CT counties	—	All of CT 5 NY counties	All of NJ	88,710
	Beneficiaries Affected	901	0	49,426	38,383	
HIP	Location of Withdrawals	—	—	Suffolk, NY*	Orange, NY Rockland, NY	1,281
	Beneficiaries Affected	0	0	0	1,281	
Oxford Health Plans	Location of Withdrawals	6 CT counties 4 NY counties 8 NJ counties	Suffolk, NY	8 NJ counties	4 NJ counties Nassau, NY	61,469
	Beneficiaries Affected	28,487	9,123	7,048	16,811	
United Healthcare	Location of Withdrawals	5 NY counties 7 NJ counties	4 NJ counties Nassau, NY Suffolk, NY	—	—	9,570
	Beneficiaries Affected	3,990	5,580	0	0	
TOTAL	Beneficiaries Affected	33,378	14,703	67,768	56,475	172,324

Source: George Washington University analysis of Centers for Medicare and Medicaid Services data on M+C health plan withdrawals. Figures for affected beneficiaries in 1999 were calculated using June 1998 enrollment figures.

Health Insurance Plan (HIP) of New York is the largest M+C plan in New York City. Most local observers believe that HIP, a nonprofit insurer that has been based in New York for more than 50 years, has a social commitment to the M+C program in the city. Many of its members, particularly retired state and city employees, have aged into their M+C plan after years of HIP membership through their employer-based health coverage. The plan has particularly high market shares in Staten Island (with 41 percent of the borough's M+C enrollees and 14 percent of its Medicare enrollees) and Queens (with 32 percent of the borough's M+C enrollees and 8 percent of its Medicare enrollees).

Nonetheless, HIP also has a record of reacting to M+C financial challenges by withdrawing from the program. The plan withdrew from Rockland and Orange Counties, effective in 2002, and shut down its Florida M+C operation, which served many New York City retirees, in 2000. Also in 2000, HIP announced its intention to withdraw from Suffolk County on Long Island, but was eventually persuaded to stay under political pressure from New York's congressional delegation.¹⁵

The strategies of New York City's five largest Medicare HMOs, which together account for 85 percent of M+C enrollment, combined with current Medicare payment policies, suggest that the city's M+C plans may not stay in this market indefinitely.

3. New York City Physicians and Hospitals Increasingly Resist Managed Care

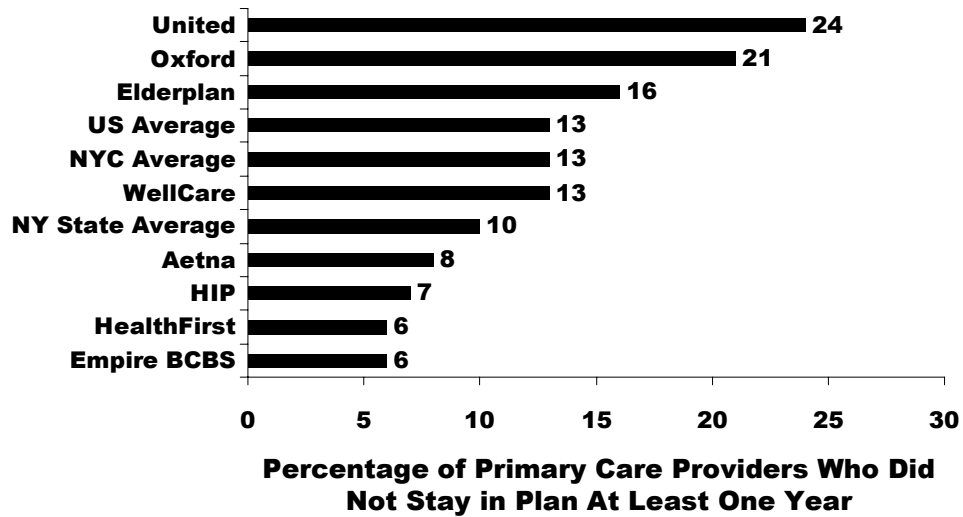
Initially after BBA, M+C health plans across the country were largely able to negotiate payments to physicians and hospitals well within the monthly rates they received from Medicare. But as newly consolidated large hospital systems and financially unstable medical groups have begun to demand large payment increases, these negotiations have become increasingly contentious. So far, New York City M+C plans have been able to avoid much of this "provider pushback" against managed care plans' payment policies.

On the physician side of the market, M+C plans benefit from New York City's high ratio of physicians to its population, which generally encourages competition. In addition, many of the city's primary care physicians are in private practice, contracting with Medicare HMOs on an individual basis. One local observer reports that, to remain competitive, many of New York City's primary care physicians feel as if they have to contract with M+C plans, which therefore gives HMOs leverage in contract negotiations. Generally, M+C plans have been able to pay primary care physicians on a capitated basis instead of discounted fee-for-service rates, although generally they do not assume risk for specialty care services.¹⁶

In the near future, however, M+C plans in New York City may face a less favorable environment for contract negotiations with physicians. HMO-physician relations have recently deteriorated, emboldening many New York City primary care physicians to consider dropping contracts with Medicare HMOs. In particular, the New York Medical Society, which represents 27,000 physicians, filed suit in August 2001 against six HMOs, including four M+C plans operating in Manhattan, for denying necessary care, reducing reimbursements, and "faulty business practices."¹⁷

Recent data from the Centers for Medicare and Medicaid Services provide evidence that provider dissatisfaction with managed care is now beginning to translate into "provider pushback" in New York City. As Figure 10 illustrates, primary care provider turnover rates in some New York City M+C plans were above the national average in 2000, the latest year for which data are available, and are similar to rates in some unstable markets.¹⁸ Oxford's 21 percent primary care provider turnover rate is particularly significant because that plan holds 31 percent of the M+C market in New York City.

Figure 10. Primary Care Provider Turnover Rates in NYC M+C Plans



Source: CMS, Medicare Health Plan Compare, 2000 data.

On the hospital side of the market, New York City’s M+C plans again benefit from a large number of competing providers, which allows plans to negotiate lower payment rates to hospitals. The city has been far less affected by hospital consolidation than other markets such as Seattle, Houston, and Long Island. For example, one plan representative with knowledge of the M+C market both in New York City and on Long Island notes that hospitals in New York City, especially those in Brooklyn and Queens, are willing to accept lower payment rates than hospitals in Nassau County. This is the result of large-scale hospital consolidation on Long Island, he said, where the 14-facility North Shore–Long Island Jewish Health System and the 11-facility Long Island Health Network now control a combined 81 percent of the staffed beds in Nassau and Suffolk Counties.¹⁹ The bargaining power of these systems has enabled them to “push back,” thus negotiating higher rates with M+C health plans. While hospital mergers have occurred throughout New York, there is no such phenomenon of market control in the city.

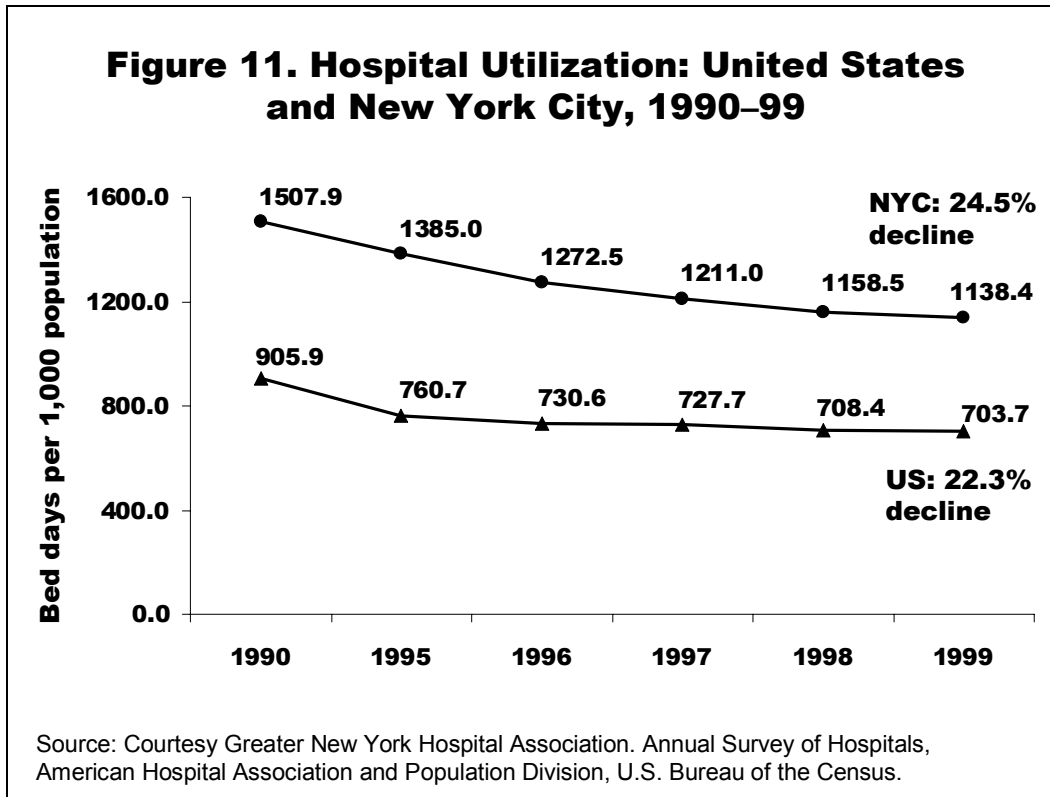
Unlike consolidated hospital markets such as Cleveland, where large hospital systems have become aggressive and dropped their contracts with low-paying M+C plans, all of New York City’s hospitals still contract with M+C plans, with the exception of Memorial Sloan–Kettering Cancer Center. While M+C plans generally cannot get

New York City hospitals to accept capitation arrangements, they still are able to negotiate discounted fee-for-service rates or favorable per diem and diagnosis-related group (DRG) payments.

Nonetheless, there is reason to believe that plans' advantageous contracting arrangements with hospitals, which have been a key factor in this market's stability, may have begun to erode. Behind the scenes, New York City hospital executives are dissatisfied with many HMO practices. For example, one hospital executive complained that Medicare HMOs frequently deny payment for needed post-acute care services on the grounds that such care is not medically necessary, without promptly informing the patient. This results in patients spending unnecessary days in the hospital without receiving the rehabilitation services they need. In the end, the hospital is forced to foot the bill for patients' extra days' stay.

In response, New York City hospitals are now "learning how to play hardball with the HMOs," according to one local expert. Many are aggressively renegotiating health plan reimbursement arrangements back to the more generous Medicare DRG payments. In some recent cases, hospitals have been aggressive enough to terminate a contract, only to have the health plan come back to the negotiating table at the eleventh hour, before the dispute is made public.

Another indication of provider resistance to managed care in this market is New York City's consistently high hospital utilization rates. While the influence of managed care has pushed down these rates in New York City and across the country, HMOs have not been able to change local practice patterns enough to close the gap between hospital utilization in New York City and the national average (see Figure 11). Explanations for this gap include the city's high proportion of academic medical centers, which tend to have longer lengths of stay compared to other hospitals, and New York's patient population, which local observers describe as highly resistant to managed care practices. Unless Medicare HMOs can reduce utilization by wringing "waste" out of New York City's health care delivery system, especially its hospitals, M+C plans will be increasingly unable to make a profit in the face of limited payment increases from Medicare.



4. Benefit Changes Make Medicare+Choice a Less Attractive Alternative

While advocates for the elderly note that Medicare beneficiaries in the five boroughs have not experienced anything approaching the level of benefit reductions as their counterparts on Long Island—where, for example, Empire Blue Cross Blue Shield charges its Nassau County M+C members a \$160 monthly premium for a product that does not cover brand-name prescription drugs and has a \$250 deductible for inpatient hospital care—New York City M+C plans are beginning to follow national trends in benefit reductions.

For example, HIP increased its inpatient hospital deductible from \$50 to \$100 and added a new 20 percent co-payment for customized durable medical equipment. Oxford’s comparable benefit package in 2002 increased its inpatient hospital deductible from \$250 to \$500. In addition, several M+C plans increased co-payments for doctor’s office visits and diagnostic tests as well as for diabetes monitoring supplies and for skilled nursing facilities.

Plans have also begun reducing prescription drug coverage in New York City. For 2002, HIP dropped coverage of brand-name prescription drugs for its members in Queens, the county in which M+C plans receive the lowest payments in New York City. Furthermore, advocates complain that New York City’s Medicare HMOs now have very restrictive formularies, some of which do not cover commonly prescribed cholesterol-

lowering and hypertension drugs. Such benefit changes may begin to reduce the incentive for beneficiaries to join M+C plans. Senior advocates describe that, so far, benefit reductions have not affected beneficiaries' decisions about M+C HMOs in New York City because many are not yet aware of the changes and also because plan benefits are still relatively generous. Further reductions, however, could change this calculation for beneficiaries in the future.

A final factor influencing how consumers view M+C plans is New York State's popular Elderly Pharmaceutical Insurance Program (EPIC). After expanding its eligibility criteria in 2000 and 2001, EPIC now has an enrollment of over 250,000 members, which cost the state over \$300 million in 2001. The program is arguably the most generous state prescription drug assistance program in the country, offering coverage for couples earning up to \$50,000 per year (see Figure 12 for eligibility criteria and benefits offered). For many beneficiaries, EPIC reduces their drug expenses by half.²⁰

Figure 12. New York State's EPIC Program: Eligibility Criteria and Benefits Provided

Program	Eligibility Criteria	Benefit Provided
Fee Program	Individuals 65 years or older with incomes \$20,000 Couples with incomes \$26,000	After paying an annual fee of \$8–\$230 (single) or \$8–\$300 (married), calculated on a sliding scale based on income, members pay a co-payment at the pharmacy of \$3–\$20, depending on the cost of the drug.
Deductible Program	Individuals 65 years or older with incomes between \$20,000 and \$35,000 Couples with incomes between \$26,000 and \$50,000	After meeting an annual deductible of \$530–\$1,230 (single) or \$650–\$1,715 (married), calculated on a sliding scale based on income, members pay a co-payment at the pharmacy of \$3–\$20, depending on the cost of the drug.

The program is particularly popular in New York City (see Figure 13). Each borough saw its EPIC enrollment approximately double after eligibility criteria were significantly expanded, despite the relatively generous drug benefits that were still available from Medicare HMOs. Large enrollment increases in Suffolk County on Long Island also suggest that the elderly are increasingly turning to the state program for drug coverage in the wake of M+C plan withdrawals.

Figure 13. EPIC Enrollment by County, 1999–2001

County	9/1999	9/2000	9/2001	Percent Change, 1999–2000	Percent Change, 2000–01
Bronx	3,244	3,406	6,388	5	88
Kings	9,391	9,819	17,232	5	76
New York	4,711	4,993	9,838	6	97
Queens	8,891	9,363	18,863	5	102
Richmond	1,542	1,729	3,743	12	117
Nassau	5,683	6,723	15,672	18	133
Suffolk	6,207	7,546	18,649	22	147

Source: EPIC Annual Report, 2000; communication with EPIC representatives.

The upshot for Medicare+Choice in New York State is that many middle- and low-income Medicare beneficiaries may no longer need M+C plans to cover their prescription drug costs because the state has created an attractive entitlement program that serves the same purpose. It is an open question how New York City’s M+C plans will react to EPIC’s success. Some plans may follow Oxford’s lead and restructure their benefit packages to wrap around EPIC. In an unusual 2001 mid-year filing, the firm created a new zero-premium product that offers no coverage for prescription drugs, but instead focuses on significantly lowering cost-sharing for Medicare-covered services. As one Oxford representative states, “By pulling drugs out of the equation, plans have the flexibility to do more for beneficiaries.” Alternatively, EPIC may simply create disincentives for Medicare beneficiaries to participate in the program in the future.

CONCLUSION

During the past five years, New York City’s Medicare+Choice marketplace has quietly avoided the highly publicized plan withdrawals and benefit cuts that have disrupted M+C both in suburban New York and in other major metropolitan areas. Enrollment has held fairly steady in the city at slightly more than 200,000 members, and plans continue to offer fairly generous benefits. It has become an important part of the city’s health care financing structure.

Looking ahead to the near future, several key elements of instability—limits on payment increases to M+C plans, pressure from Wall Street analysts on for-profit insurers to withdraw from M+C, growing provider pushback against managed care, and the beginning of significant cuts in M+C benefits—indicate that there may be trouble on the horizon for the program in New York City. Representatives from plans, provider groups, and beneficiary organizations have all noted that these factors may lead to future plan withdrawals from New York City, particularly among the three large, national, for-profit firms that control 43 percent of the city’s M+C market. This should be a cause of concern for national policymakers weighing the future shape of Medicare+Choice.

NOTES

¹ See Brian Biles, Geraldine Dallek, and Andrew Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future—Findings from Seven Cities*. New York: The Commonwealth Fund, forthcoming. See also Jennifer Stuber et al., *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries*. New York: The Commonwealth Fund, October 2001.

² See Marsha Gold, "Medicare+Choice: An Interim Report Card." *20 Health Affairs* (July/August 2001): 120–38.

³ The Bush administration's fiscal year 2003 budget states that "the most important reason that private plans are withdrawing from Medicare ... is that federal payments to Medicare+Choice have not kept pace with rising health care costs in many areas of the country." Office of Management and Budget, *Budget of the United States Government Fiscal Year 2003*. Washington, D.C. February 2001, p. 153.

⁴ White House press release, *Fact Sheet: Strengthening Medicare*, January 28, 2002.

⁵ For a discussion of the effects of the Benefits Improvement and Protection Act of 2000, see General Accounting Office, Report No. GAO-02-202, *Medicare+Choice: Recent Payment Increases Had Little Effect on Benefits or Plan Availability in 2001*. Washington, D.C., November 2001.

⁶ For example, from 2001 to 2002, 855,695 M+C beneficiaries nationwide lost coverage of brand-name prescription drugs, while 50,189 lost coverage for all drugs. Centers for Medicare and Medicaid Services, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002*, December 2001. Available at <http://cms.hhs.gov/healthplans/>.

⁷ Primary care provider turnover rates regularly run over 25 percent in some cities' M+C plans. Geraldine Dallek and Andrew Dennington, *Physician Withdrawals: A Major Source of Instability in the Medicare+Choice Program*. New York: The Commonwealth Fund, January 2002.

⁸ CMS provides enrollment data at the managed care organization (MCO) level (e.g., Oxford, HIP, Aetna), but not at the "plan" (e.g., "low option" plan v. "high option" plan with additional benefits) level. Following CMS methodology, this analysis assumes that each MCO's member is enrolled in that MCO's "basic plan." CMS defines a basic plan as "the lowest-cost, most generous (in benefits) plan offered by an M+C organization in a particular county." Thus, this data on average premiums is "enrollment weighted" toward a health plan's basic offering.

⁹ For a discussion of reasons for health plan withdrawals nationally, see Jennifer Stuber, Geraldine Dallek, and Brian Biles, *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice—Analyses of Seven Medicare+Choice Markets*, New York: The Commonwealth Fund, October 2001.

¹⁰ Prior to BBA, Medicare HMOs were paid 95 percent of the average cost of providing care to each beneficiary under the fee-for-service program (adjusted average per capita cost [AAPCC] rate). BBA replaced this with a more stringent M+C formula under which plans receive the highest of three amounts: a minimum 2 percent increase over the prior year's AAPCC rate, a minimum dollar amount called a "floor," or an amount derived from blending the local rate with a national rate based on historic spending under the fee-for-service program. Because BBA has been so successful at restraining spending in the fee-for-service program, most plans in non-floor counties have never received an increase from the blended rate, and thus are effectively limited to 2 percent annual payment increases.

¹¹ White House press release, *Fact Sheet: Strengthening Medicare*, January 28, 2002.

¹² Brian Biles, Geraldine Dallek, and Andrew Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future—Findings from Seven Cities*, New York: The Commonwealth Fund, forthcoming.

¹³ In the last two years, Aetna withdrew from 118 counties in Arizona, California, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, New York, New Jersey, Ohio, Pennsylvania, and Washington.

¹⁴ Centers for Medicare and Medicaid Services, "Wall Street's View of Managed Care," *Health Care Industry Market Update*, November 28, 2001. Available at <http://www.cms.hhs.gov/reports/hcimu/>.

¹⁵ Roni Rabin, "A HIP Deal for Suffolk: HMO to Stay in County, Boost Premiums for Seniors," *Newsday*, December 3, 2000, sec. A p. 6.

¹⁶ A few IPAs such as Montifiore Medical Center prefer risk contracts with Medicare HMOs because they have found them to be financially beneficial. Reasons suggested for how these IPAs are successfully able to manage risk include having well-integrated delivery systems, defined provider networks, and established infrastructures that have experience handling risk.

¹⁷ "New York: Physician Group Sues Six HMOs," *American HealthLine*, August 16, 2001.

¹⁸ Dallek and Dennington, January 2002.

¹⁹ Communications with Nassau-Suffolk Hospital Council.

²⁰ EPIC website, <http://www.health.state.ny.us/nysdoh/epic/faq.htm>.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org**. Other items are available from the authors and/or publishers.

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

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

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

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

#533 *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (March 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. In this report (available on the Fund's website only), the authors note that while increases in monthly premiums will affect all enrollees in 2002, sicker beneficiaries will bear the brunt of changes in the structure of prescription drug benefits and cost-sharing requirements as more plans restrict drug coverage to generics only and raise cost-sharing requirements for services such as inpatient and outpatient hospital care.

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

#494 *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. Analysis by the authors of Medicare Compare found that out-of-pocket spending for Medicare+

Choice enrollees can be substantial and varies significantly with health status. In 2001, the average enrollee in good health spent \$1,195 annually out-of-pocket on health care, while an enrollee in poor health spent \$3,578, or about three times as much.

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

#496 *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (January 2002). Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles. This executive summary of an unpublished report (available on the Fund's website only) examines recent changes in seven Medicare+Choice markets and the effects of these changes on Medicare beneficiaries.

#495 *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (January 2002). Geraldine Dallek and Andrew Dennington, George Washington University. The authors find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher.

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

#491 *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (October 2001). Jennifer Stuber, Geraldine Dallek, and Brian Biles, George Washington University. The authors of this field report found a substantial decline in the number of Medicare+Choice plans in five of seven large markets around the country.

#490 *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (October 2001). Geraldine Dallek and Claire Edwards, George Washington University. In this field report, the authors discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans, 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. The authors argue that any major change to the Medicare program—such as requiring coinsurance for home health care—must take into account the steep costs seriously ill beneficiaries already pay for health services.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs*, vol. 20, no. 4. The author gives Medicare+Choice (M+C) a “barely passing grade,” noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to

date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf or www.cmrwf.org/programs/medfutur/gold_bipa_467.pdf.

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

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

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

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

#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs*, vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine*, vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

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

A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry*, vol. 37, no. 4. Copies are available from *Inquiry*, P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs*, vol. 19, no. 5. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

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

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs*, vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs*, vol. 19, no. 1. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that

health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy*, vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to President Clinton. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs*, vol. 18, no. 4. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs*, vol. 18, no. 1. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs*, vol. 18, no. 1. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *Health Affairs*, vol. 18, no. 1. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

