THE 2002 MEDICARE+CHOICE PLAN LOCK-IN: SHOULD IT BE DELAYED?

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The Balanced Budget Act of 1997 (BBA) revamped Medicare managed care policies when it created the Medicare+Choice program. Presently, Medicare beneficiaries can, with few exceptions, enroll in or withdraw from a Medicare+Choice plan at any time.[1] Beginning 2002, however, a new system modeled after the open-enrollment practices of employer-based health insurance policies will, for the first time, lock Medicare+Choice enrollees into their health plan for a specified period. The BBA also expanded the ability of Medicare enrollees to purchase a Medigap policy after leaving a Medicare+Choice plan under certain circumstances.

Recent problems in the Medicare+Choice market, including large-scale health plan withdrawals and provider turnover, have raised serious questions about implementation of a beneficiary lock-in in 2002. The following discussion examines the BBA lock-in provision and its rationale. It then discusses some of the policy implications of lock-in and the options available for delaying its implementation or repealing the provision altogether.

MEDICARE+CHOICE'S PLAN LOCK-IN POLICY

Beginning in 2002, the BBA limits the ability of Medicare beneficiaries to withdraw, or "disenroll," from a Medicare+Choice plan. Beneficiaries will be able to switch Medicare+ Choice plans or reenroll in traditional fee-for-service Medicare only once during the first six months of the year, and will be locked into their plan after July 1. They can elect to change plans or return to traditional Medicare in November 2002, with the change effective the following January.

Beginning in 2003, beneficiaries who enroll in a Medicare+Choice plan will be locked in after April 1 for nine months. Beneficiaries can switch plans or reenroll in original Medicare only once during the first three months of the year and in November, with the change effective the following January.

The BBA provides for a number of exceptions to the lock-in rule. Beneficiaries can change Medicare+Choice plans or reenroll in fee-for-service Medicare if their plan is terminated, if they move outside the plan's service area, or if the plan fails to meet contract provisions. Beneficiaries who enroll in a Medicare+Choice plan when they first purchase Part B of Medicare (which covers physician services and outpatient care), and those who are trying a Medicare+Choice plan for the first time, can opt to disenroll at any time

within one year of enrollment. Other selected Medicare beneficiaries, including nursing home residents and those dually eligible for Medicare and Medicaid,[2] can also change their health plan or return to original Medicare at any time during the year. The BBA also requires Medicare supplemental insurers to offer all or some of their Medigap products to many of these beneficiaries.[3]

To help beneficiaries make a well-informed choice among their health care options, the BBA requires the Centers for Medicare and Medicaid Services (CMS) to provide them with a range of comparative information about plan options as well as assistance with Medicare and Medicare+Choice questions.[4]

The lock-in policy was adopted in 1997 when the Medicare+Choice program was first created. Congress's intention was to improve continuity and quality of care, make beneficiaries more accountable for their plan selection and use of health services, and lend stability to the Medicare+Choice market. With lock-in, plans would have a greater incentive to provide preventive services and keep beneficiaries healthy, knowing that enrollees would remain in the plan for a minimum period.

Policymakers also believed lock-in would prevent beneficiaries and plans from "gaming" the Medicare+Choice system over a year's time. For example, beneficiaries would no longer be able to switch plans once they exhausted their Medicare+Choice plan's annual prescription drug benefit. Lock-in would also prevent plans from encouraging enrollees with an acute medical problem that requires expensive treatment to switch back to traditional Medicare.

Finally, Medicare+Choice lock-in provisions would also afford plan enrollees more protections than those available to employees enrolled in managed care plans. Unlike managed care enrollees with employment-based insurance coverage, Medicare beneficiaries would be able to change plans twice during the year. Moreover, Medicare+Choice policies would provide some specific exceptions to the lock-in rule.

CURRENT STATUS OF MEDICARE+CHOICE AND THE 2002 LOCK-IN

A number of Medicare+Choice's goals envisioned in 1997 have not been achieved. Plan and beneficiary representatives now say that plan lock-in, if implemented in 2002, could add to the difficulties of an already unstable program.[5] They cite three primary reasons:

1. Implementing beneficiary lock-in at a time of instability in the Medicare+Choice program will only add to beneficiaries' distrust of the program.
2. Protections are inadequate to ensure that lock-in does not tie beneficiaries—especially those who are oldest and those with chronic illnesses—into plans that do not meet their needs.
3. Beneficiaries lack the information on plan withdrawals, benefits, and providers needed to make an educated choice of plans for 2002.

Instability in the Medicare+Choice Market

Over the past four years, the Medicare+Choice program has experienced significant plan withdrawals while enrollees have faced increasing insurance premiums and reduced benefits. High provider turnover rates in Medicare+Choice plans have also added to program instability. Proponents of a delay in the lock-in provision maintain that lock-in would make beneficiaries less likely to choose a Medicare+Choice option and further increase instability.[6]

Medicare+Choice Plan Withdrawals

The new Medicare+Choice program was expected to lead to well-functioning Medicare managed care markets and an increase in plan membership from 14 percent of Medicare beneficiaries in 1997 to 31 percent in 2009.[7] These expectations have not been met. Instead of steadily increasing, the number of Medicare+Choice plans participating in the program has declined from 346 in December 1998 to an anticipated 149 in 2002. Overall enrollment in Medicare+Choice plans has declined from a peak of 6.3 million in 1999 to 5.6 million in 2001.[8]

The complete withdrawal of 173 plans from the Medicare+Choice market from 1998 to 2002, and the withdrawal of 201 plans from part of their service areas during this period, disrupted care for some 2.2 million Medicare beneficiaries. More than a third of the 6 million enrollees in Medicare managed care plans have been affected (see Table 1). Furthermore, there is no reason to think that the Medicare+Choice program is becoming more stable. Without substantial federal funding increases, program disruptions are likely to continue into the future.

Table 1. Impact of Medicare+Choice Withdrawals, 1999–2002

	January 1999	January 2000	January 2001	January 2002
Medicare+Choice Plan Terminations	45	41	65	22
Medicare+Choice Plan Service Area Reductions	54	58	53	36
Beneficiaries Affected*	407,000	327,000	934,000	536,000
Percentage of Medicare+ Choice Enrollees	6.3%	4.7%	13.6%	9.6%
Percentage of Medicare Population	1.0%	0.8%	2.3%	1.3%

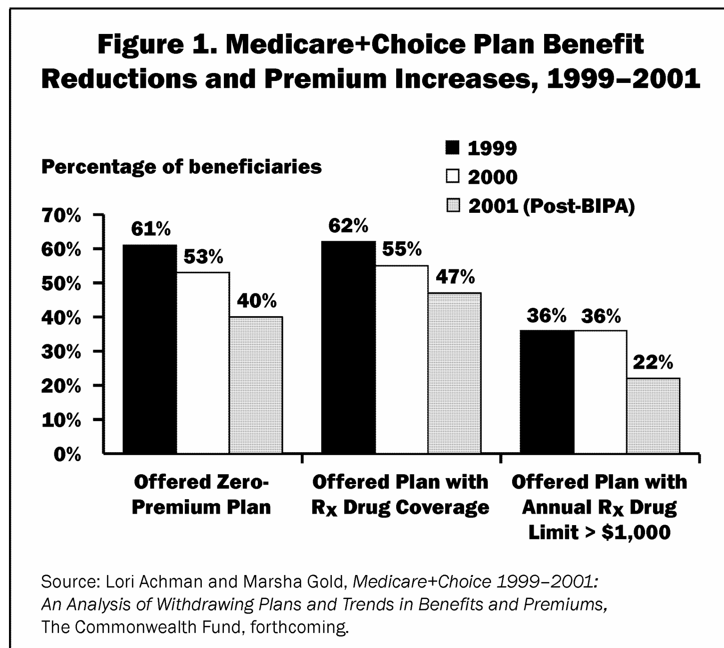
* "Beneficiaries Affected" is the number enrolled in a plan at the deadline for plans to announce withdrawal. For example, the 1999 column refers to beneficiaries enrolled as of June 1999 in a plan that withdrew effective January 2000.

Source: Centers for Medicare and Medicaid Services, *Protecting Medicare Beneficiaries After Medicare+Choice Organizations Withdraw* (fact sheet), September 2001; analysis of CMS quarterly state/county market penetration reports for June 1998, June 1999, June 2000, and September 2001.

Premium Increases and Benefit Reductions

Medicare beneficiaries often join Medicare+Choice plans in order to obtain supplemental benefits, including prescription drug coverage, at lower costs than Medigap policies. Almost all plans that have remained in Medicare+Choice have reduced benefits and increased premiums for 2002. In some cases, the reductions in benefits and increases in cost-sharing have been dramatic.[9] Prescription benefits—one of the primary reasons that beneficiaries join Medicare+ Choice plans[10]—have been particularly hard hit, with many plans severely limiting, or eliminating, brand-name drug benefits.[11] (Figure 1)

Figure 1. Medicare+Choice Plan Benefit Reductions and Premium Increases, 1999–2001



Source: Lori Achman and Marsha Gold, *Medicare+Choice 1999–2001: An Analysis of Withdrawing Plans and Trends in Benefits and Premiums,* The Commonwealth Fund, forthcoming.

Some plans are also charging large copayments for other services, such as hospital and nursing home care, lab and X-ray services, rehabilitation services, and durable medical equipment.[12] In 2002, of four Medicare+Choice plans in Cleveland, one will require a

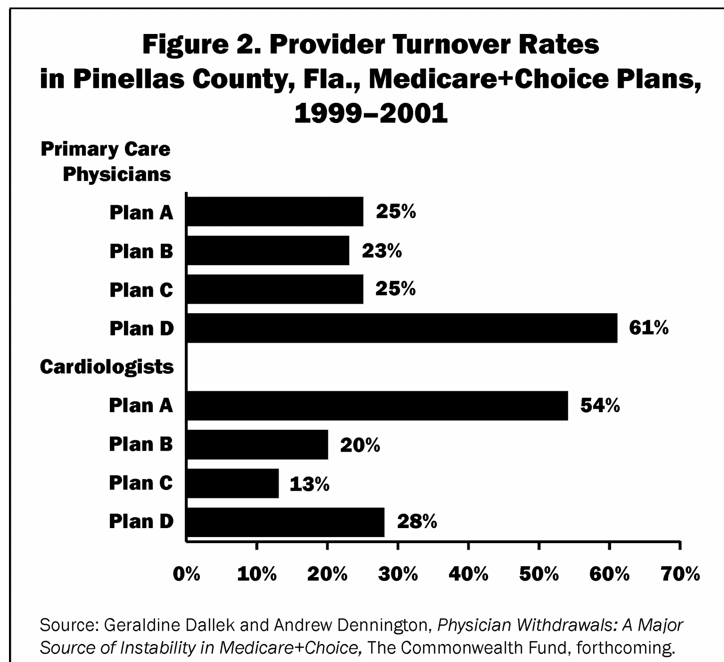
$375-per-day copayment for hospitalization, while a second plan will require a $792 deductible for the first day of a hospital stay.

Physician and Provider Turnover

When physicians withdraw from their Medicare+Choice plans, beneficiaries must either find new doctors within a plan or follow their physicians by changing health plans or returning to fee-for-service Medicare. One study found that 60 percent of Medicare+ Choice enrollees chose to move with their provider when forced to choose between their provider and staying with their health plan.[13] Continuity of care is especially important to the elderly and disabled with chronic conditions.

High turnover rates of plan network physicians have caused disruptions in care to Medicare+Choice enrollees. Nationally, primary care physician turnover rates have averaged 14 percent. Figure 2, which shows provider turnover rates for plans in one Florida county, illustrates the difficulty that Medicare+Choice enrollees encounter in trying to maintain long-term relationships with their providers.[14]

Figure 2. Provider Turnover Rates in Pinellas County, Fla., Medicare+Choice Plans, 1999–2001



Source: Geraldine Dallek and Andrew Dennington, *Physician Withdrawals: A Major Source of Instability in Medicare+Choice,* The Commonwealth Fund, forthcoming.

Beneficiary Protections

Those who represent Medicare beneficiaries argue there are three reasons why the protections built into the lock-in provision are inadequate to protect vulnerable Medicare+Choice enrollees. First, no exception is made for enrollees whose physician or hospital leaves a plan during the lock-in period, even though Medicare beneficiaries are sicker and more dependent on their physicians and hospitals than younger managed care enrollees. Beneficiaries will be locked-in, but their providers will not.

Second, unlike the health plan choices offered by many large employers, Medicare does not require Medicare+Choice plans to offer comparable benefits. The lack of standardized Medicare+Choice benefit packages and the confusing nature of plan benefits undermines beneficiaries' ability to make an informed choice. Benefit packages differ from

plan to plan and from year to year even within the same plan. These differences make it difficult, if not impossible, for a beneficiary to calculate which plan provides the most benefits for the costs.[15] Moreover, many beneficiaries do not understand plan benefit limits, especially for prescription drugs. Given the confusing nature of plan benefit packages, some beneficiaries will not learn the true costs associated with their medical care until they need services—which may be during the lock-in period.

Third, many beneficiaries are unlikely to be able to make complicated health plan choices in their own best interests under any circumstances. One-third of Medicare beneficiaries have a serious physical or mental impairment; 26 percent have less than a high school education; and 11 percent are age 85 or older.[16] The task of educating millions of elderly and disabled individuals about such complex topics is a daunting one indeed.[17] Unable to understand their options, some beneficiaries may enroll in plans that will not meet their health care needs. The ability to change plans or return to traditional Medicare is one way to ensure these beneficiaries are able to secure the coverage they require.

Limited Education of Beneficiaries About Medicare+Choice Plans

Substantial progress has been made since 1997 to provide beneficiaries with easily accessible information about Medicare+Choice plans and benefits.[18] CMS's yearly handbook, *Medicare & You* (mailed to all Medicare beneficiaries), Medicare's toll-free telephone hotline, and Medicare's website all provide beneficiaries with valuable help in understanding their health care options. But these tools alone are not enough. As long as plan benefit packages remain complicated, change continues in the Medicare+Choice plans available, and funding for community organizations responsible for working directly with Medicare beneficiaries remains inadequate, beneficiaries will achieve only a limited understanding of their plan choices for 2002.[19]

Further complicating matters was the delay, from July to September 2001, in required reporting of 2002 plan withdrawals and benefit changes. Because of the delay, beneficiaries did not receive a mailing from Medicare describing plan benefits until late October. That has left much less time—only a few weeks before the beginning of the November enrollment period—to inform beneficiaries about 2002 changes, leaving them with little time to make carefully considered decisions regarding plan benefits and membership. In addition, plan benefit descriptions for 2002 did not include any information on whether benefits included brand-name drugs and on the level of cost-sharing for a range of critical medical services, such as hospital care and durable medical equipment.

Finally, it is likely that a large number of beneficiaries who select Medicare+ Choice plans for 2002 will be unaware of the new lock-in provision.[20]

LOCK-IN OPTIONS FOR 2002

Confusing benefit packages, inadequate protections for beneficiaries, and the lack of time and resources to educate beneficiaries adequately for the November 2001 enrollment period suggest that 2002 may not be the best time to implement what amounts to a sea change in Medicare+Choice enrollment and disenrollment rules.

Congress has a number of options for revising the Medicare+Choice lock-in policies for 2002. These include:

- Delaying the lock-in schedule for one year.
- Delaying lock-in implementation until the Medicare+Choice market has stabilized, as indicated by increased Medicare+Choice plan enrollment or the easing of plan withdrawals and benefit reductions.
- Delaying lock-in until a streamlined waiver policy is implemented for beneficiaries who want leave their plan for medical care reasons, especially the termination of their provider from their plan's network.
- Repealing the lock-in policy.

Any one of these options could be coupled with a review by the Centers for Medicare and Medicaid Services, the General Accounting Office, or other agency of the Medicare+Choice program's current status and its implications for beneficiary lock-in.

It should be noted that proponents of lock-in suggest that any delay in implementation could become permanent. At this time, there is no way to project the future development of Medicare managed care. The Medicare+Choice program could, at some point after the current period of difficulty has passed, return to a pattern of rapid growth in membership. On the other hand, continuing decline in Medicare+Choice enrollment or a beneficiary backlash against lock-in could lead to a reconsideration of the policy at any time—with or without a delay in implementation.

NOTES

[1] Medicare beneficiaries with End Stage Renal Disease and those lacking Part A or Part B coverage may not join a Medicare+Choice plan.

[2] Centers for Medicare and Medicaid Services, "Election Period Changes in 2002 (Lock-In)," National Medicare Education Program Coordinating Committee Meeting (Washington, D.C.), October 24, 2001.

[3] Medigap insurers must offer beneficiaries affected by a plan withdrawal or move outside of a plan's area Medigap plans A, B, C, or F (to the extent they market these options). Medigap insurers must give beneficiaries who enroll in a Medicare+Choice plan when they turn 65 or when they first purchase Part B and subsequently quit the plan within a year, a six month window to purchase any of the 10 Medigap standardized policies offered by the insurer. Insurers must also offer beneficiaries who try a Medicare+Choice plan for the first time and quit within a year the same Medigap policy they dropped when they joined the plan if it is still available. If not, they must offer them plans A, C, D, and F (to the extent they market these options).

[4] The BBA requires CMS (formerly known as the Health Care Financing Administration) to send all beneficiaries a broad range of information on plans prior to the November annual election period; to establish a toll-free hot line (1-800-Medicare) to answer questions about Medicare and Medicare+Choice; and to establish an Internet site (www.medicare.gov) where users can get cost and quality information comparing plans.

[5] American Association of Health Plans, *Enrollment Lock-In Is Destabilizing to Both Beneficiaries and Medicare+Choice Plans* (Washington, D.C.: AAHP, June 2001).

[6] Ibid.

[7] Henry J. Kaiser Family Foundation, *Medicare Managed Care Factsheet* (Menlo Park, Calif.: Kaiser Family Foundation, September 1999).

[8] CMS Medicare Managed Care Contract Report (www.hcfa.gov/stats/mmcc.htm). CMS Medicare+Choice Program Briefing, October 24, 2001.

[9] See J. Stuber et al., *Instability and Inequity in Medicare+Choice: The Impact on Medicare Beneficiaries—Findings from Seven Case Studies* (New York: The Commonwealth Fund, forthcoming).

[10] B. Stuart, D. Shea, and B. Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (New York: The Commonwealth Fund, August 2000).

[11] In 2001, 46 percent of plans that continued to provided coverage for brand drugs charged copays of $20 or more; brand copays of $30–$40 are not unusual. See L. Achman and M. Gold, *Medicare+Choice 1999–2001: An Analysis of Withdrawing Plans and Trends in Benefits and Premiums* (New York: The Commonwealth Fund, forthcoming); and G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, October 2001).

[12] Dallek and Edwards, 2001.

[13] S. Sofaer and M. Hurwicz, "When Medical Group and HMO Part Company: Disenrollment Decisions in Medicare HMO," *Medical Care* 31 (1993): 808–821.

[14] See G. Dallek and A. Dennington, *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (New York: The Commonwealth Fund, forthcoming).

[15] Dallek and Edwards, 2001.

[16] Gold and Stevens, 2001; M. Moon and M. Storeygard, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (New York: The Commonwealth Fund, September 2001).

[17] M. Gold and B. Stevens, "Informed Health Plan Choice for Vulnerable Subgroups of Medicare Beneficiaries, *Operational Insights Number 5* (Washington, D.C.: Mathematica Policy Research, Inc., September 2001); J. Hibbard et al., "Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?" *Health Affairs* 20 (May/June 2001): 199–203.

[18] CMS provides information about Medicare+Choice through the Medicare hotline (1-800-MEDICARE), the Medicare website (www.Medicare.gov) and a yearly *Medicare & You* handbook mailed to all program beneficiaries.

[19] B. Stevens and J. Mittler, *Understanding and Meeting the Information Needs of Beneficiaries at the Local Level* (Washington, D.C.: Mathematica Policy Research, Inc., November 2000).

[20] In a preliminary Medicare Rights Center survey of 20 Medicare+Choice plans (a total of 40 calls), customer service representatives answered incorrectly 60 percent of the time the question of whether a beneficiary could leave the Medicare+Choice plan at any time during the year in 2002 and switch back to original Medicare.