



The **FAILURE** of
Medicare + Choice

*Erosion of Benefits
Plans Withdrawing
Increase in Medicare Costs
Beneficiary Distrust*

A Case for National Health Care

*A Report by the
Alliance for
Retired
Americans
November 2002*

About the Alliance for Retired Americans

The Alliance for Retired Americans is a senior advocacy organization that was created in January 2001 by national and local affiliates of the AFL-CIO, together with community-based organizations, to provide a voice for the rapidly growing numbers of union retirees and older Americans.

The mission of the Alliance for Retired Americans is to ensure social and economic justice and full civil rights for all citizens so they may enjoy lives of dignity, personal and family fulfillment and security. The Alliance believes that all older and retired persons have a responsibility to strive to create a society that incorporates these goals and rights; and that retirement provides them with opportunities to pursue new and expanded activities with their unions, civic organizations and their communities. The Alliance's public policy and legislative goals will be achieved through mobilization of members in an extensive grassroots network in every region, state and district in the country.

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Summary

The Medicare+Choice (M+C) managed care program, mandated by the Balanced Budget Act of 1997, was intended to provide Medicare beneficiaries access to greater benefits than the traditional Medicare program and, at the same time, reduce Medicare spending. Medicare+Choice, however, is a failed experiment. Over 2.2 million beneficiaries have been involuntarily disenrolled since 1999, 327,000 of whom had no other M+C plan available to them. Nearly 200,000 are expected to be dropped by their M+C plan in 2003. During the same time, program costs have increased substantially and benefits have eroded.

M+C organizations, primarily health maintenance organizations (HMOs), contend that the current payment rate is not sufficient to match inflation rates for medical costs and they predict that plans will continue to withdraw from the program. If payment rates are not increased significantly, plan administrators forecast the demise of the program within two to five years.

Another major factor influencing withdrawal of plans from the program is a growing inability on the part of HMOs to maintain an adequate provider network both in M+C and managed care generally. Providers such as doctors and hospitals are increasingly unwilling to accept HMO payments they consider

inadequate to cover the costs of care, and they have less toleration for claim denials and payment delays.

There is evidence that increased payments to Medicare HMOs do not substantially increase access or benefits for enrollees. One billion dollars was added to the program in 2001 yet over half a million beneficiaries lost coverage that year. In only 29 percent of M+C plans did managed care organizations use some or all of their additional money to improve benefits.

Quality of services provided by M+C HMOs is mixed. Older cancer patients are more likely to be diagnosed at an earlier stage than those in fee-for-service. On the other hand, HMO enrollees with chronic illnesses have disparate access to specialists and other critical services, have poorer health outcomes and less satisfaction than those in fee-for-service.

Information about M+C is not user friendly for beneficiaries. One study examined the benefit packages of five M+C plans and determined that beneficiaries would have to spend many hours calling plans, examining data and doing calculations in order to make an adequate comparison.

The M+C program has not resulted in cost savings to Medicare. In fact, the average spending on beneficiaries in the M+C program in 2001 was 4 percent

higher than spending for demographically similar beneficiaries in the traditional Medicare program.

Some proposals for perpetuating the M+C program would introduce competitive bidding among plans to determine M+C payment rates. Even though there are a number of unknowns about the value of competitive bidding, two of the prescription drug proposals in the 107th Congress would introduce competitive bidding and a heavy reliance on HMOs into the Medicare program. These are changes that move Medicare away from a defined benefit program with set benefits and co-payments to a defined contribution health plan where only the amount of the government contribution is set and benefits and co-payments vary. The proposals can only be interpreted as an attempt to privatize the Medicare program.

The lesson to be learned from the Medicare+Choice experiment is that HMOs or any private plans should not be used as the vehicle nor the model for other Medicare changes, such as for providing prescription drugs.

The best way to help persons affected by plan withdrawals is to add a universal drug benefit to Medicare and to improve preventive benefits. These are the reasons that Medicare beneficiaries went into the M+C plans in the first place.

Ultimately, seniors and all Americans would be best served in the goal to achieve access to affordable health care if policy makers were to implement a national health care system in the United States.

Introduction

The Medicare+Choice (M+C) managed care program, mandated by the Balanced Budget Act of 1997, was intended to provide Medicare beneficiaries access to greater benefits than the traditional Medicare program and at the same time reduce Medicare spending. Despite an upsurge initially in the number of plans and enrolled beneficiaries, the program has since seen significant annual plan withdrawals leaving hundreds of thousands of Medicare beneficiaries each year to either find another plan or revert to the Medicare fee-for-service (FFS) program. Over 2.2 million Medicare beneficiaries have been dropped from the program between 1998–2002. This report attempts to examine why the program floundered so quickly and the implications for current policy proposals based on a similar structure. The focus of this report is on the Medicare+Choice program only and will not look at other managed care arrangements such as those provided in the Medicaid program or through employers.

Background

The Medicare program was created in 1965 and, since then, has provided hospital and outpatient medical services coverage for persons over age 65 and for those with disabilities. At the time of creation, the two-part scheme of the program reflected the structure of private insurance that generally had sepa-

rate insurance for hospital and physician care. Medicare Part A covers certain costs of in-patient hospital and limited post-acute care services and is primarily financed by a 1.45 percent payroll tax from both employees and employers. Medicare Part B helps cover the cost of doctor services, outpatient care, and other post-acute services and is financed through a combination of beneficiary premiums and federal general revenues. From the beginning until 1997, most Medicare beneficiaries were enrolled in the fee-for-service program meaning that their providers charge the program for the covered services that they provide.

In the Balanced Budget Act of 1997 (BBA, P.L. 105–33), Congress created a new Medicare+Choice program (M+C) as Part C, in an attempt to bring the rising costs of the Medicare program under control. Under Medicare Part C, managed care plans contract with Medicare to provide both Part A and Part B services and are paid from the trust funds of both parts on a capitated (see glossary), rather than fee-for-service basis. It was anticipated that the expansion would provide additional services and cost-savings at the same time. Medicare beneficiaries could be offered additional services such as preventive care and prescription drug coverage. A number of protections were written in, such as guaranteed access to emergency care, quality assurance, informational requirements on the part



Multiple Tries, Multiple Losses in Connecticut

Medicare beneficiaries in Connecticut have had a great deal of experience with Medicare HMOs. Many of them have been enrolled and involuntarily disenrolled not once, not twice, not even three times. In the span of just four years, a number of Connecticut beneficiaries have been enrolled in four M+C HMOs—ConnectiCare, Cigna, Anthem Blue Cross and Blue Shield, and MedSpan. Despite assurances from the HMOs at new enrollee orientation meetings that they were going to stay the course, each of the plans withdrew from the M+C program within a year. The only HMO remaining is not accepting new members.

of participating health maintenance organizations (HMOs), and external review, grievance, and appeal requirements. Although other types of plans may participate in M+C, almost all plans are HMOs.¹

For managed care plans, M+C was an enticing opportunity, as the program would expand their market base, pro-

viding an opportunity for increased profits. They are paid a flat rate to care for the Medicare beneficiaries they enroll. The less expensive the care, the more they make in profits.

The M+C program is not the first experience the Medicare program has had with managed care. In the 1970s, private health plans were allowed to contract with the Medicare program, administered by the Health Care Financing Administration (HCFA), on a cost-reimbursement basis. Because of a number of restrictions, however, few HMOs opted to participate.² In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (P.L. 97-248) that created the risk contract program allowing HCFA to contract with private entities, primarily HMOs. Under the 1982 law, HMOs were to provide all Medicare-covered items and services as are provided under Parts A and B in exchange for a preset monthly per capita or capitated payment.³ They could also cover Parts A and B co-payments and deductibles and additional services not covered under traditional Medicare such as prescription drugs, hearing aids and eyeglasses. The HMOs were allowed to charge those enrolled a monthly premium and cost-sharing for services not covered under Medicare but the majority did not.⁴

In 1997, the BBA replaced the risk contract program with Medicare+Choice and instituted a new payment system.

But First, The Numbers

Decline in plans and enrollments

During the years before and immediately after passage of BBA, the number of HMO plans increased steadily from 96 in 1990 to a peak of 346 in 1998. The number of enrollees also increased from 1.3 million in 1990 to 6.3 million in 1999 and 2000.⁵ As the M+C program began to take effect, however, plans and enrollees declined. In 2002, there are just 180 M+C plans and 5 million enrollees, accounting for 12 percent of Medicare beneficiaries, down from 14 percent in 2001 and 16 percent in 2000.⁶ Over 2.2 million have been involuntarily disenrolled (see glossary) since 1999, 327,000 of whom had no other M+C

plan available to them. Another 198,000 are expected to be involuntarily disenrolled in 2003.

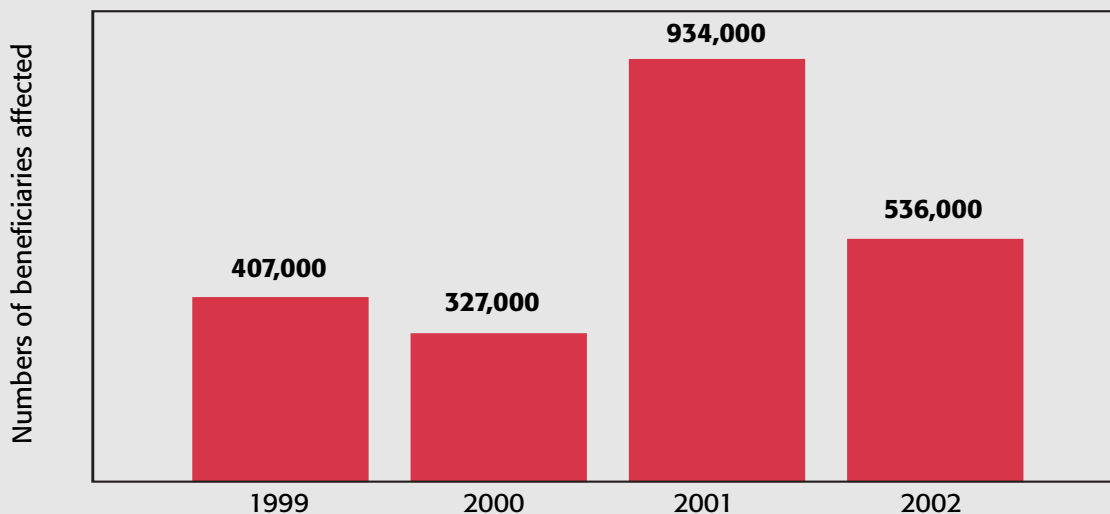
Figures 1 and 2 show the number of beneficiaries affected by HMO withdrawals from 1999–2002 and the percentage of those who lost HMO coverage during those years and had no other M+C plan available to them.

Access to M+C largely depends on one's geographic location. Figure 3 shows the percent of Medicare beneficiaries in each state with access to M+C plans. Over half (56 percent) of enrollees are in four states alone: California, New York, Florida, and Pennsylvania. In 80 percent of counties in the United States, there is

Figure 1

Number of Beneficiaries Affected by HMO Withdrawals

January 1999– January 2002



Source: Congressional Research Service. *Medicare + Choice: Plans Leaving the Program*. (December 20, 2001)

no M+C HMO available. In urban areas, 75 percent of Medicare beneficiaries have access to M+C but only 13 percent have access in rural areas.⁷ This occurs because the Medicare population, as with the general population, is not distributed equally across counties but concentrated in metropolitan areas where M+C plans predominate.

Benefits and Costs

In recent years, many M+C enrollees have experienced not only a decrease in available plans but also increased premiums and cost-sharing. The percent of enrollees with a plan that provides prescription drug coverage remains approximately the same between 2001 and 2002—70/71 percent—but the benefit has been changed for most. In 2002,

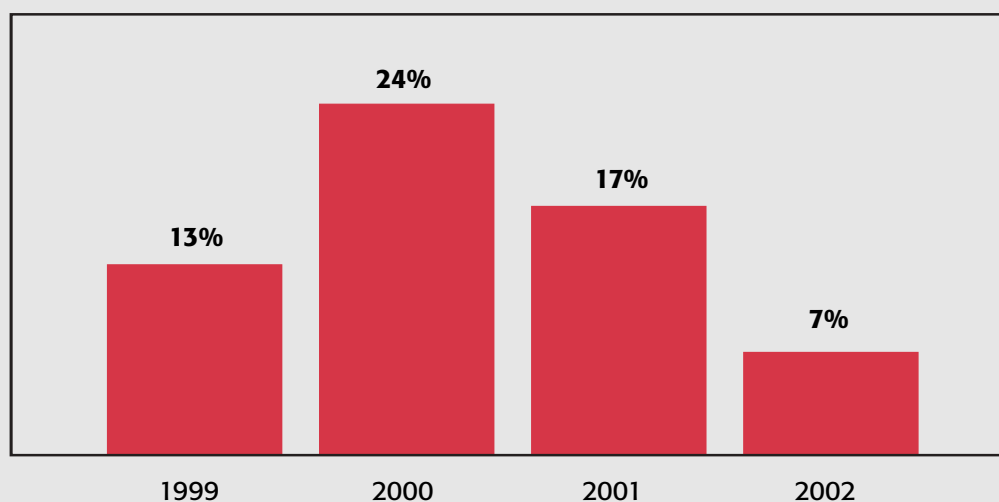
39.4 percent of plans with prescription drug coverage cover generic drugs only compared to 11.5 percent of plans in 2001.⁸

Plans are also imposing limits on the dollar amount of prescription drugs covered. In 2002, 58.9 percent of plans covering both generic and brand name drugs have annual limits of \$1,000 or less compared to 44.1 percent of plans in 2001.⁹

Other benefits are also eroding: in 2002, preventive dental care is offered in only 14.3 percent of basic plans, a decline from 28.6 percent in 2001; hearing aids and other benefits are offered in 53.2 percent of basic plans, down from 77.7 percent in 2001.¹⁰

Figure 2

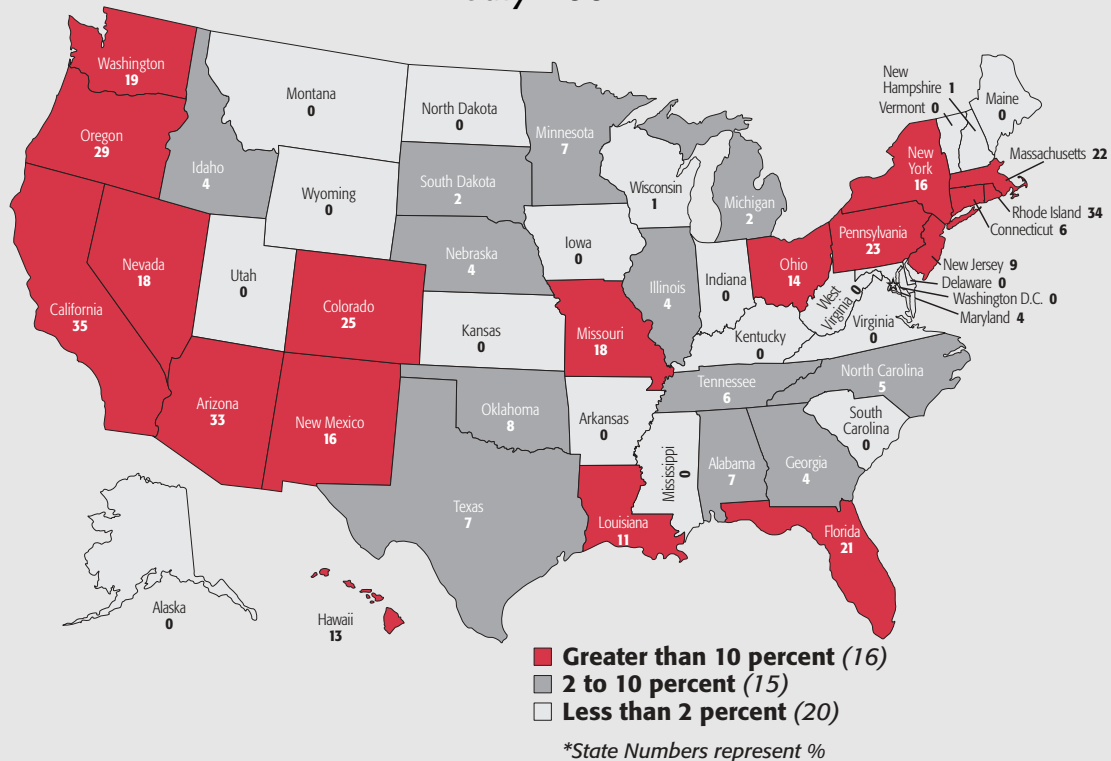
Percent of Disenrolled Beneficiaries With No Other M+C Plan Available *January 1999– January 2002*



Source: Congressional Research Service. *Medicare + Choice: Plans Leaving the Program*. (December 20, 2001)

Figure 3

Percent of Medicare Beneficiaries Enrolled in Medicare + Choice*, by State* July 2002



Source: Prepared by the Alliance for Retired Americans, August 2002. Data from CMS. Medicare Managed Care Contract Report, July 2002.

Figure 4 shows the proportion of Medicare beneficiaries with access to M+C HMOs with zero premiums is 32 percent in 2002, down from 39 percent in 2001, 53 percent in 2000, and 61 percent in 1999.

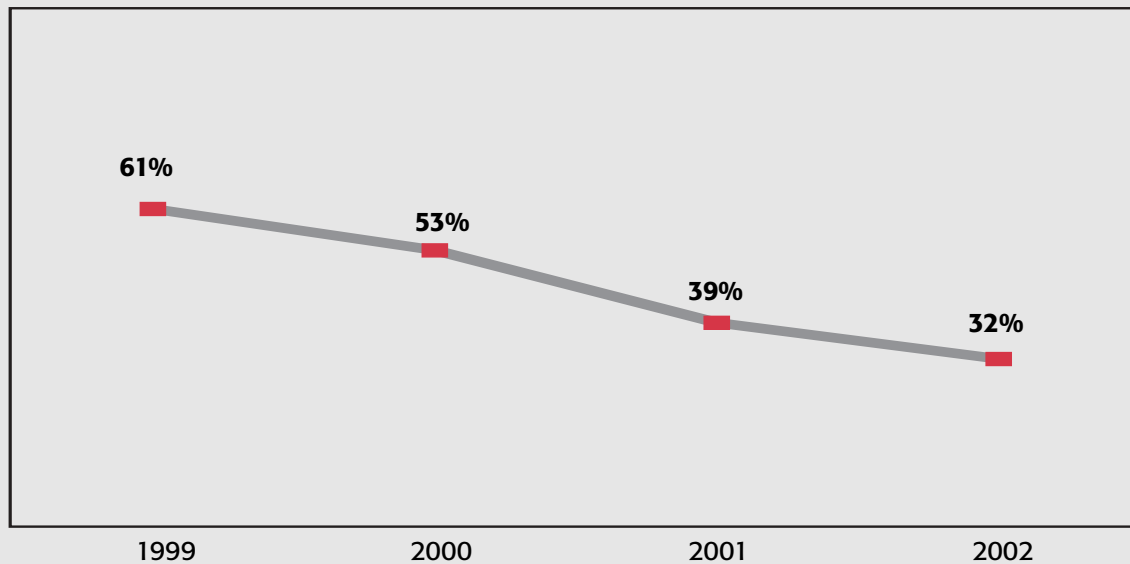
However, even for those fortunate enough to have a zero premium plan,¹¹ there are tradeoffs—cost sharing is significantly higher in such plans than those plans with premiums. In 2002, the difference in cost sharing charges between zero premium and premium plans as an average monthly out-of-pocket expenditure is approximately

\$16, significantly higher than the \$4 difference in 2001. Monthly premiums overall for M+C enrollees are increasing from an average of \$21.64 in 2001 to \$33.14 in 2002 with nearly one third of enrollees (32 percent) having basic premiums over \$50 compared to 14 percent in 2001.¹²

Additionally, some plans have started charging higher co-payments for some services—such as hospital, home health, and skilled nursing home care—than are charged in the fee-for-service program.

Figure 4

**Percent of Overall Medicare Population in US with
Access to Zero Premium M+C HMO Plans
1999-2002**



Source: Centers for Medicare & Medicaid, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002* (December, 2001)

Effects on Enrollees

Consequently, this creates a dilemma for beneficiaries. If the M+C plan increases the premiums and cost-sharing, then the enrollee faces greater out-of-pocket costs. For example, they would have to pay more for their prescription drugs, if there is a drug benefit, and pay more to see doctors. The instability in the market place has also affected continuity of care. If the plan withdraws from Medicare, then the individual experiences a disruption in treatment. Options are to try to find another M+C plan or go back to traditional Medicare.

The BBA guarantees beneficiaries—who have been involuntarily disenrolled

because of a plan withdrawal—available Medigap coverage but Medigap plans have high premiums and costs and many beneficiaries cannot afford this option. The Medigap guarantee applies only to plans without prescription drug coverage, not those with drug coverage.

Additionally, many providers, including doctors, have pulled out of plans, forcing beneficiaries to also leave plans in order to stay with their doctors.

All of this obviously adversely affects the Medicare beneficiaries, leaving them feeling stranded, betrayed and wary of managed care.

What Went Wrong?

The Payment System

Prior to enactment of BBA, payments to Medicare HMOs were based on the adjusted average per capita costs (AAPCCs). It was calculated according to a complex formula founded on the cost of providing Medicare benefits to beneficiaries in the fee-for-service Medicare program. The per capita payment was set at 95 percent of the AAPCC and adjusted for certain demographic characteristics of HMO enrollees. It was assumed that HMOs could operate more efficiently than the Medicare fee-for-service program, thus the 5 percent reduction. However, the risk adjusters in the AAPCC proved to be insufficient in predicting a beneficiary's expected health care use, resulting in the Medicare program overcompensating HMOs between 7 percent to 37 percent.¹⁵

Following BBA and beginning in 1998, health plans participating in the M+C program received monthly payments in advance for each enrolled beneficiary in a payment area, typically a county. The payments were the highest of three annual per capita rates:

- A minimum or **floor** rate
- A rate reflecting a **minimum percent increase** from the previous year's rate, or
- A **blend** of national and local rates

The BBA was intended to increase beneficiary benefit options, particularly in areas previously under- or unserved by reducing the geographic differences in payment levels. These rates were to decrease variation in local payment rates nationwide, by increasing payments in areas with traditionally low payments, and slowing the rate of growth in areas with higher payments.¹⁴

The **floor payment rate** grew 3.5 percent in 1998–99 (\$367–\$380 per month), 5.8 percent from 1999–2000 (\$380–\$402), but the rate of increase declined to 3.2 percent from 2000–01 (\$402–\$415). The 2001 floor rate was later raised and divided into two different rates for rural and urban counties. In 2002, the floor is \$500 for rural and \$553 for urban counties but both floors will be lowered to \$495 and \$548 respectively in 2003.

The **minimum percent increase** rule is intended to protect counties that would otherwise receive only a small, if any, increase. It is applied to the 1997 AAPCC rate as the starting point. In 1998, 1999, and 2000, the minimum rate was 102 percent of the AAPCC; in other words a 2 percent increase. In 2001, the increase was 3 percent but returned to 2 percent for subsequent years.

The **blended rate** is designed to gradually shift county rates away from solely local rates, which reflect wide variations in fee-for-service costs, toward a national average rate. The percentage in the blend assigned to the area-specific-rate is

reduced incrementally over 6 years from 90 percent in 1998 to 50 percent in 2003 while the corresponding percentage for the national component is increased from 10 percent to 50 percent in the same period. Thus, in 2003, the blended rate will be based on 50 percent of the area-specific-rate and 50 percent of the national rate.

M+C payments are also risk adjusted to control for variations in the cost of providing health care to all enrollees. Risk adjustment is designed to compensate a plan for above average health expenses if there is a high enrollment of very ill patients. The risk adjustment mechanism is currently based on inpatient data known as principal inpatient diagnostic cost groups (PIP-DCGs). Beginning in 2004, risk adjustment will also be based on data from ambulatory settings as well as inpatient hospitals.

Another factor in the calculation is the national growth percentage which affects which of the rate rules is used in payments to counties through 2002.

Results

Because of the national growth percentage, no county in 2002 is being paid using the blended-rate rule. About 79 percent of all counties have their payment set at the floor with the remainder of payments set at the minimum update of 2 percent. For 2003, all but six counties will have their payments set at the minimum update of 2 percent.¹⁵

The floor payment in rural areas did not work but this was not entirely due to the payment rate. Another factor contributing to the failure to increase access in rural areas includes difficulties with developing adequate provider networks.¹⁶

M+C organizations contend that the 2 percent rate is not sufficient to match medical costs' inflation rates, which have increased at 9-10 percent annually over the last few years, and they predict that plans will continue to withdraw from the program. If there are no payment increases beyond two percent, the current minimum, plans forecast the demise of the program in two to five years.¹⁷

One study looked at the possible effect of increasing payments to M+C plans and how that would alter the number of enrollees. As Table 1 shows, the best case scenario for stabilizing the enrollment in the program would be to increase reimbursements by an average annual rate of 4.6 percent through 2005 but that would only maintain the current 5 million enrollment. Under current law and a continuing 2 percent minimum percentage increase, nearly a million enrollees would be lost resulting in 4.1 million enrollees. A 2.5 percent annual increase would result in 4.3 million enrollees. Setting M+C payments at 100 percent of FFS spending per capita would be the worst case scenario, decreasing enrollment to 3.3 million by 2005.¹⁸

Table 1**Projected Effect of Payment Increases on Number of M+C Enrollees**

Payment Rate Increase	Result in number of enrollees-2005
Current law-2% minimum rate increase	4.1 million
4.6% annual increase	5 million
2.5% annual increase	4.3 million
Align M+C to Medicare FFS	3.3 million

Source: Thorpe, Kenneth, Atherly, Adam. Medicare+Choice: Current Role and Near-Term Prospects. Health Affairs. (July 17, 2002)

The Medicare Payment Advisory Commission (MedPAC), the independent federal body established to advise Congress on issues affecting the Medicare program, reports that the M+C program has not resulted in cost savings to Medicare. In fact, the average spending on beneficiaries in the M+C program in 2001 was 4 percent higher than spending for demographically similar beneficiaries in the traditional Medicare program.¹⁹

How Important is Medicare+Choice?

Beneficiaries

Quality of Services

Research on the quality of care provided in M+C shows that opinions and results vary. A study of older cancer patients in M+C HMOs found they are more likely to be diagnosed at an earlier stage than those in fee-for-service.

Although the majority of M+C enrollees are satisfied with their care, other studies show that HMO enrollees with chronic illnesses have disparate access to specialists, home health and rehabilitation services and poorer health outcomes and less satisfaction than those in FFS.²⁰

One study indicates that blacks receive poorer quality care than whites in M+C plans in at least four health services: follow-up exams after hospitalizations for mental illness, eye exams for diabetics, prescription of beta blockers after heart attacks, and breast cancer screenings for women.²¹ Yet, another study shows that the HMOs staying in the M+C program provide higher quality care than those that withdraw.²² This latter finding may be due partially to the fact that most plans withdrawing in the first year after the BBA were smaller and less able to offer the benefits of larger plans.²⁵



Employer Renounces Promise To Retirees

There is more than one way to lose Medicare+Choice coverage as Pat Salamone, a former president of his IUE local in Wisconsin, found out. In 1991, his employer, Magna Tech, told those retiring in that year that they were the last to have health insurance coverage paid by the company for the balance of their and their spouses' lives, a long-standing promise. In 1993, the company told retirees that they would have to pay for the wrap-around as well as co-payments. For the Salamones, this was considerable—rising over the years to \$192 per month by 2002. Health care was provided through a M+C HMO, United Health Care. In August, 2002, Magna Tech notified retirees that it will completely cease to provide a health benefits plan for them. This is a major set-back for the Salamones and an example of the need for national health care.

Choices

A key beneficiary concern with M+C is the need for understandable information to help with comparing benefits, particularly prescription drug benefits, among the various health plans. The Department of Health and Human Services (DHHS) Inspector General's Office found that the information that many HMOs provide to beneficiaries about certain elements of the drug benefit is inconsistent, incomplete and confusing. Comparing the dollar limits on drug benefits in particular can be a daunting undertaking, it concluded.²⁴ The Commonwealth Fund examined the benefit packages of five M+C plans and determined that beneficiaries would have to spend many hours calling plans, examining data and doing calculations in order to make an adequate comparison.²⁵ M+C plans, for their part, are resistant to efforts by the Centers for Medicare & Medicaid Services (CMS) to standardize M+C forms and marketing materials. They maintain it is too costly and precludes a plan from accurately describing its benefits.²⁶

Lock-In

One beneficiary problem with M+C has been temporarily addressed. The BBA of 1997 placed a limit on the number of enrollment changes a beneficiary can make in a year; a similar practice is applied in open-enrollment periods of employer-based health insurance. Beginning in 2002, the BBA limited or "locked-in" enrollees so that they could enroll or disenroll only once during the

open enrollment period from January to June and they were not allowed to make any further changes until November, the annual enrollment period. Beginning in 2003 and every year thereafter, beneficiaries were to be locked-in after 3 months of open enrollment. This undermined the ability of many Medicare beneficiaries to receive the stable and consistent health care they require. In June, 2002, President Bush signed into law an antiterrorism measure that includes M+C provisions, effective immediately, suspending until 2005 the lock-in requirement and changing the annual election period to November 15–December 31 for 2002, 2003 and 2004.

As access to M+C is almost nonexistent in rural areas in the United States, the future of the program is not as important to rural residents as it is to beneficiaries residing in urban areas. Low-income and minority beneficiaries represent a high proportion of M+C enrollees in urban areas and are more likely to be affected by shrinking coverage, higher cost-sharing, and plan withdrawals. Nationally, 40 percent of older African Americans and 51.6 percent of older Hispanics are enrolled in M+C.²⁷

HMOs and Providers

The program is important to HMO firms only if there are profits to be made from participation. If that does not happen, they cut their losses and withdraw. Eighty-eight percent of with-

drawal contracts in 2001 of M+C HMOs were for-profit. Non-profit M+C HMOs, on the other hand, are more likely to have a sense of local community obligation.²⁸

Foremost among the reasons given by M+C health plans for withdrawal from the Medicare +Choice program are the insufficient payments they receive which, except for one year, have been limited to two percent annual rate increases.

Additional reasons cited for withdrawal or reduction in areas served are related to other market conditions: low M+C enrollment levels; small share of the M+C market; and fear of adverse risk selection. Some national plans also leave local Medicare markets in favor of more profitable employer-based enrollment.²⁹

Also contributing to withdrawals is a growing inability on the part of HMOs to maintain an adequate provider network both in M+C and managed care generally. Providers such as doctors and hospitals are increasingly unwilling to accept HMO payments they consider inadequate to cover the costs of care and they have less toleration for claim denials and payment delays.³⁰ Providers have had more negotiating leverage in recent years with consolidation of hospitals and practices and are now refusing to contract on a risk basis, preferring to return to fee-for-service payments instead.³¹

M+C plan executives themselves are pessimistic about the future of the program. In a study of eight national managed care firms accounting for over 70 percent of M+C enrollment, most believed M+C product strategies are terminal and, even with reform, some expect total withdrawal from the M+C program within two to five years.³²

Policy Makers

The Medicare+Choice program leaves policy makers split into three camps. First, despite the problems with Medicare+Choice, the program looms as the model upon which other efforts to reform Medicare may be based. Consequently, those policy makers who seek to inject private markets into the Medicare program want to keep the program alive. The House of Representatives passed a bill (H.R. 4954) that includes a number of changes to the Medicare program including increasing the minimum percentage payment under M+C to 3 percent for 2003 and 2004. This bill also provides a major role for HMOs in providing prescription drugs.

President Bush's budget for fiscal year 2003 and a Senate proposal would go farther. A so-called "provider giveback" bill (S. 3018) would increase the minimum percentage rate to 4 percent in 2003 and 3 percent in 2004. Under the President's proposal, payments for M+C plans would be increased by an average annual rate of 6.5 percent and M+C HMOs given more flexibility in designing their coverage.

Other policy makers, however, would argue that a program based on a private market approach is destined for instability and would eradicate it or at least let it pass away. Positioned in between are those who represent districts and States with a heavy concentration of M+C enrollees dependent on the program. These policy makers believe they have a responsibility to maintain the program for the welfare of their constituents.

Proposed Solutions: Continue or Eliminate?

Medicare+Choice was a gamble and the future of the program represents the classic horns of a dilemma for policy makers. How might participating plans be encouraged to stay in the program, if that is a clear-cut objective? At the same time, how may program costs be brought under control?

Alternatively, should the M+C program be eliminated? If so, what would happen to the beneficiaries? If M+C were abolished, one study estimates that 30 percent of all enrollees would move into the Medicare fee-for-service program; 52 percent would purchase a Medigap plan; and 18 percent would enroll in Medicaid.³³ The consequences would likely be different for members of minority groups, however. It is estimated that without the M+C program, 42.3 percent of current African American enrollees and 39 percent of Hispanic enrollees would return to the



Medicare fee-for-service program. Supplemental coverage, such as Medigap plans, would not be an option for many in these groups if they were to lose access to M+C.⁵⁴

Short Term

Many M+C plan representatives assert that the situation would be improved by: increasing the payment levels; changing the regulatory framework i.e. less paperwork and oversight; and making more beneficiary education materials available.⁵⁵

There is evidence, however, that increased payments to Medicare HMOs do not substantially increase access or benefits for enrollees. The Benefits Improvement and Protection Act (BIPA, P.L. 106-554) of 2000 increased M+C payments on March 1, 2001. One billion dollars was added to the program in 2001 yet over half a million beneficiaries lost coverage at the end of that year. In only 29 percent of M+C plans did managed care organizations use some or all of their additional money to improve benefits. These improvements, which affected about a quarter of all M+C enrollees, primarily consisted of reduced premiums or lowered cost-sharing requirements. Added or enhanced coverage of pharmaceuticals and other services affected only about 3 percent of all M+C enrollees. After BIPA, four HMOs reentered counties they had dropped, and four expanded into counties they had not previously served. This expanded plan availability affected

The Alliance for Retired Americans opposes any premium support, voucher plan or undermining federal administration of Medicare by turning it or any part thereof, over to insurance companies and other private plans.

only 15 counties. The HMOs that expanded service areas acknowledged they would have done so without increased payments.⁵⁶

At the same time, increasing payment levels increases the costs of the program so the end result is that the program has not only not decreased Medicare spending but has led to a decrease in the number of enrollees.

Nevertheless, the Administration and some policy makers in Congress remain committed to supporting private plans. They not only want to encourage Medicare HMOs, they want private plans to be a significant part of a “reformed” Medicare program including providing prescription drugs. These policies are evident in the Medicare bill passed by the House in June (H.R. 4954) and the so-



The Alliance for Retired Americans supports a comprehensive, high quality, fair and equitable national health care system covering all Americans.

called “tripartisan” bill that was rejected by a close vote in the Senate (S. 2729).

In the meantime, there are some short term proposals that would protect beneficiaries by:

- extending the M+C contract periods from one year to two or three year periods (H.R. 279, H.R. 2127) making enrollees less vulnerable to yearly plan terminations;
- extending the existing Medigap guarantee protections that apply to people whose M+C plan withdraws from the program to anyone whose M+C plan changes benefits, increases cost-sharing, or whose doctor or hospital leaves the plan (H.R. 3267);
- prohibiting M+C plans from charging higher cost-sharing for a service than Medicare charges in the FFS program (H.R. 3267); and
- creating uniform benefits in a service area (H.R. 2127).

Competitive Bidding

Some proposals for perpetuating the M+C program would introduce competitive bidding among plans to determine M+C payment rates (S.358, S. 2729, H.R. 803, H.R. 4954). None of these bills delineate a role for the Medicare FFS program in a competitive bidding payment system. The goal of competitive bidding is to allow market forces to determine the amount plans receive. It has some resemblance to employer-provided health benefit programs where the employer sets the amount it is willing to contribute towards a health insurance plan and accepts bids from competing plans that want to offer benefits. Enrollees are responsible for any premiums charged above the employer’s contribution, paying more if they choose a plan with higher cost-sharing.

In the M+C context, the government would set the maximum amount or benchmark that it is willing to pay M+C plans in an area and participating plans would bid against each other. If the bid were above the government’s contribution, the plan would charge enrollees an additional premium to cover the difference. If the bid were below the government’s contribution, part of the difference would be shared with enrollees in the form of lower premiums, reduced cost-sharing, or increased benefits. The benchmark is basically a subsidy that encourages the purchase of more insurance for a given out-of-pocket price resulting in an increase in the unsubsidized price i.e. the bid.

A major problem with competitive bidding, however, is that competition is conducive to adverse selection as has been found in studies of employer-sponsored plans. Additionally, three attempts by the Department of Health and Human Services (DHHS) in the late 1990s to conduct competitive bidding demonstrations never materialized due to opposition by local plans and policy makers, largely because Medicare FFS was not required to participate in the project.³⁷ Even though there are a number of unknowns, two of the prescription drug proposals in Congress would introduce competitive bidding (H.R. 4954, S. 2729) as well as a heavy reliance on HMOs into the Medicare program.

These are changes that move Medicare away from a defined benefit program with set benefits and co-payments to a defined contribution health plan where only the amount of the government contribution is set and benefits and co-payments vary. The proposed changes can only be interpreted as attempts to privatize the Medicare program.

In the end, the best way to help persons affected by plan withdrawals is to add a universal drug benefit to Medicare and to improve preventive benefits. These are the reasons that Medicare beneficiaries went into the Medicare+Choice program in the first place.



Conclusion

The Medicare+Choice program was an attempt to bring the private sector into the Medicare program for the twin objectives of increasing benefits for enrollees while controlling rising Medicare costs. The program has not been a success—only 12 percent of Medicare beneficiaries are enrolled in M+C and costs are still rising; and the added benefits have been reduced as profit margins decreased.

While Medicare is a uniform, guaranteed benefit program available all over the United States, the M+C program is available only in limited areas and benefits vary greatly. Expanding M+C through payment increases won't help to expand the program and is not fiscally prudent. Such an approach will only prolong the problems for beneficiaries.

The lesson to be learned from this failed experiment is that HMOs or any private plans should not be used as the vehicle nor model for other Medicare changes, such as for providing prescription drugs. From this privatization experience, we have learned that:

- It adds instability to health care as plans and provider networks come and go;
- Costs are passed on to beneficiaries thereby increasing, not decreasing, their burden;

- Beneficiaries have problems making informed choices with inconsistent materials, and incomplete information;
- Private plans are not interested in certain markets; and
- There is no cost savings to the Medicare program.

If private plans are used for delivering prescription drugs, the difficulties that seniors and those with disabilities experience with accessing affordable medicines will worsen. Introducing private plans into Medicare exacerbates rather than alleviates the problem and may even destroy Medicare as an entitlement program.

Ultimately, seniors and all Americans would be best served in the goal to achieve access to comprehensive and affordable health care if policy makers were to implement a national health care system in the United States.

The Alliance for Retired Americans supports the passage of a universal health care system based on a sound financing model similar to Medicare. The Alliance is firmly convinced that Medicare costs will never truly be brought under control until all health care costs are reined in.

To that end, the Alliance supports comprehensive reform of the nation's health care system that incorporates these principles:

- **universal coverage financed through mandated contributions by all employers, fair share contributions by individuals, and tax revenues;**
- **comprehensive and high quality benefits package that includes children's health services, preventive services, home and community-based long-term care, pharmaceutical benefits, and acute and other services now included in mainstream health plans;**
- **strong cost restraints, including controls on drug prices; and**
- **full choice of physicians, other health providers and health plans with strong consumer controls in the operation of the health system.**

Until the United States has a national health care system, all attempts to resolve health access problems affecting Medicare beneficiaries as well as the uninsured and others in this country will continue to create a spiral of additional complications that in turn must be addressed but never fully resolved.

Glossary of Key Managed Care Terms

ADJUSTED AVERAGE PER CAPITA COST (AAPCC).

The payment formula for pre-BBA (Balanced Budget Act of 1997) Medicare HMOs based on 95 percent of the average county-level fee-for-service costs.

ADVERSE SELECTION. When a health plan attracts members who are sicker than the general population.

CAPITATION. A payment method in which a health care provider is paid a fixed amount per person and per time period to supply covered health services to beneficiaries.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS). The federal agency that administers the Medicare and Medicaid programs; formerly called the Health Care Financing Administration.

COORDINATED CARE/MANAGED CARE PLAN. Plan that acts as both insurer and provider of health care services to enrollees. Includes health maintenance organizations (HMOs), provider sponsored organizations (PSOs) and preferred provider organizations (PPOs)

DISENROLLMENT. Enrollees in a M+C plan leave the plan and go to fee-for-service or another plan. Disenrollment may be involuntary if enrollees are dropped when their plan withdraws from the M+C program or reduces the area it serves.

FEE-FOR-SERVICE. Method of billing for health services under which a provider charges separately for each patient encounter or service rendered.

HEALTH CARE FINANCING ADMINISTRATION (HCFA). Until 2001, the name of the federal agency responsible for administering the Medicare and Medicaid programs. Renamed as the Centers for Medicare & Medicaid Services (CMS).

HEALTH MAINTENANCE ORGANIZATION (HMO).

Managed care plan primarily owned and operated by insurers that acts as both the insurer and the provider of health care services to an enrolled population.

INDEPENDENT PRACTICE ASSOCIATION (IPA).

Managed care organization that contracts with physicians in solo practice or with an association of physicians that, in turn, contracts with their member physicians to provide health care services.

MANAGED CARE PLAN/ORGANIZATION. A plan/organization that provides a range of services in exchange for a per capita payment.

MANAGED CARE ORGANIZATION, GROUP MODEL. Plan model whereby MCO contracts with one or more group practices of physicians to provide health care services, and each group primarily treats the plan's members.

MANAGED CARE ORGANIZATION, STAFF MODEL. MCO employs health care providers, such as physicians and nurses, directly who are employees of the plan and deal exclusively with their enrollees.

MEDICAL SAVINGS ACCOUNT (MSA). A combination of a high deductible insurance policy and tax-advantaged personal savings account for medical expenses.

MEDICARE+CHOICE (M+C). Part C in the Medicare program allows private companies to offer a health plan to Medicare eligible beneficiaries. Typically offers benefits not covered by the traditional Medicare program.

MEDIGAP PLANS. Private supplemental insurance plans designed to cover gaps in the Medicare program. There are 10 standardized policies labeled Plan A through Plan J. Only Plans H-J offer a prescription drug benefit.

NATIONAL GROWTH PERCENTAGE. The projected per capita increase in total Medicare expenditures minus a specific reduction set in law. For example, the reduction was 0.5 percentage points from 1999 through 2001; in 2002, it is 0.3 percentage points. There is no reduction after 2002.

PREFERRED PROVIDER ORGANIZATION (PPO).

A group of physicians and hospitals that contract with an insurer to offer their services on a fee-for-service basis at negotiated rates that are lower than those charged to non-enrollees in return for expedited claims payment. Unlike other managed care plans, they generally do not have gate keepers.

PRIVATE FEE-FOR-SERVICE (PFFS). Plan that covers enrollees through a private indemnity health insurance policy. Providers, such as doctors, hospitals and others, are reimbursed for services provided at a pre-determined rate. There is only one PFFS plan in Medicare+Choice.

PROSPECTIVE PAYMENT SYSTEM (PPS). Method of paying health care providers in which the payments are set by predetermined rates and are not affected by providers' actual costs or posted charges.

PROVIDER SPONSORED ORGANIZATION (PSO).

Managed care plan owned and operated by providers. There is only one PSO in Medicare+Choice.

RISK ADJUSTMENT. The way that payments to health plans are changed to take into account an enrollee's health status or demographic characteristics. Intended to minimize incentives, plans may have to select healthier than average enrollees.

Endnotes

- ¹ The Medicare+Choice program also allows for private fee-for-service (PFFS) plans and, on a demonstration basis, a medical savings account (MSA) plan. Additionally, it allows for other coordinated care plans in addition to HMOs to participate such as provider-sponsored organizations (PSOs) as well as preferred provider organizations (PPOs). To date no private plan has established an M+C MSA and there is only one PFFS plan offered by Sterling Life Insurance Co., which began in mid-2000. A demonstration PPO program will begin in January 2003. Thus, almost all current M+C plans are HMOs and they are the subject of this report. See Glossary for description of the different types of private plans.
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Acknowledgments

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