



HEALTH CARE FINANCING ADMINISTRATION

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Responses to AAHP Letter

- We have heard all these points before, and responded in detail through letters, public notices, the report to Congress, public meetings, etc.
 - ◆ There is considerable evidence that, on average, Medicare has overpaid managed care plans and that it continues to overpay many plans, in part because payments are not adjusted accurately for relative health risk.
- The arguments about inadequacy of payments basically reiterate the fairness gap arguments to which we responded in detail some months ago. (There is a memo from HCFA to Kevin Thurm which we prepared for a HCFA issues meeting at which we discussed AAHP's fairness gap argument.)
- The current CBO position that it had assumed that M+C risk-adjustment would be budget neutral is a reconstruction of history. There is no legislative history that supports this current view, and in CBO's analysis of the BBA in 1997 stated that risk-adjustment might reduce payments to plans. We believe CBO did not score savings because it did not believe HCFA could actually implement risk-adjustment.
- Any serious Medicare restructuring – whether the President's or Breaux-Thomas—requires risk-adjustment. We need to get started but have committed to working with AAHP to fine-tune the current model. Nevertheless, we have agreed that the in-patient model needs fine-tuning.
- We agree that the inpatient-only model has limitations relative to a comprehensive model. For that reason, we have always emphasized the importance of moving toward the implementation of the comprehensive model in 2004--the most ambitious feasible schedule.
- We have also adopted a transition policy, under which the inpatient-only model accounts for only 10 percent of payment in the first year (2000), in order to shield plans from abrupt changes in payment.
- In the meantime, the inpatient model is a clear improvement over the existing system (e.g., it explains two to three times the variation in health costs compared to the current system) and we do not think that we should allow the "best" (a comprehensive model) be the undoing of the "better" (inpatient-only model).
 - ◆ As mandated by Congress, HCFA subjected the PIP-DCG based payment system (i.e. inpatient model) to an independent actuarial review. The American Academy of Actuaries convened an expert panel to conduct this review, including actuaries from a number of major health plans. They concluded that the system is actuarially sound, an improvement over the current demographic-only model, and

an appropriate step in the direction of improving Medicare managed care payments.

- ◆ While also recognizing its shortcomings, MedPAC has endorsed our approach as "a substantial improvement over the current method."
- Generally, we want to focus our resources on moving from the inpatient only model to a more comprehensive model, rather than trying to work on the shortcomings of the inpatient model. To that end, we are holding a public meeting with the industry next month to discuss requirements for submission of the physician and hospital outpatient data that will be necessary to run the comprehensive model.
- We have agreed to look into the disease management issue, focusing on congestive heart failure (CHF). The treatment of CHF seems to be a particularly appropriate vehicle for recognizing effective outpatient treatment by M+C organizations. A panel of five expert congestive heart failure physicians will meet next week to discuss the issue. AAHP is working with HCFA to sponsor this meeting and review disease - management incentives.
- Exclusion of one-day stays was a policy judgment call to deal with one possible form of gaming under the inpatient-only system (medically unnecessary brief hospitalizations to generate a risk score). We have explained the reasons for this decision, in detail, in the January 15, 1999 risk adjustment announcement and in the report to Congress. The financial impact is small. Comprehensive risk adjustment will put this issue in a new context, where exclusion of one-day stays may no longer be necessary.
- Where AAHP points out payment increases are low under BBA relative to other payers, this fails to recognize that the prior trend in private sector payment was lower than Medicare for many years. That is, Medicare payments to plans exceeded their own costs by a substantial amount.
- We are concerned about withdrawal of M+C plans from the program, especially from rural areas. However, we do not believe that recent plan withdrawals can be attributed primarily to the payment changes mandated by the BBA, in general, or to risk adjustment in particular. Plans make business decisions each year about whether they will participate in the M+C program.
- ◆ Many factors affect plan participation decisions, but withdrawals are neither occurring in the lowest payment rate counties nor in the counties where payments are increasing only by the minimum update. Instead, M+C organizations are predominately leaving counties with payments in the middle of the distribution of payment rates, between \$451 and \$500.
- ◆ The U.S. General Accounting Office found factors other than payment largely

explain withdrawals. These include establishing adequate provider networks, enrolling sufficient beneficiaries, and difficulties competing with other M+C plans.

- One important financial problem that health plans are facing is the absence of a Medicare drug benefit. Health plan payments do not recognize coverage for prescription drugs, even though it is the fastest growing cost that plans are facing today. This is among the reasons that we need a Medicare drug benefit -- drug coverage would offset this cost experience.



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American Association of
HEALTH PLANS

Karen Ignagni
President and Chief Executive Officer

• Rick Smith
• technical
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October 15, 1999

Mr. Chris Jennings
Deputy Assistant to the President
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Washington, DC 20500

*Rick
Risk
adjustment
as close as possible
for*

Dear Chris:

The American Association of Health Plans (AAHP) appreciates the opportunity to provide you with information to assess the effect of the Balanced Budget Act of 1997 (BBA) on the Medicare managed care program. The more than 1,000 member organizations of AAHP have long been committed to expanding the health plan choices available to our nation's Medicare beneficiaries. With the passage of the bipartisan BBA and the creation of the Medicare+Choice program, our nation's Medicare beneficiaries, health plans, and lawmakers endorsed the principle of expanding choices and pledged to work together to modernize and strengthen the program. However, the legislation and its implementation have created unanticipated consequences. Rather than having new coverage options, beneficiaries are facing higher premiums, reduced benefits, and in many parts of the country, reductions in the number of plans available.

Given the trends in the Medicare+Choice program, we are encouraged by the Administration's desire to assess the program based on the most up-to-date information available. Moreover, in making forward-looking assessments, it is vital to consider the effects of policy changes that the Administration proposes to implement in 2000 and beyond. By way of example, the 30 percent implementation of the Administration's risk adjuster in plan year 2001 means that nearly all Medicare+Choice beneficiaries live in counties where plans will receive *no* increase in payment over the previous year. The consequences of this approach—more exits, premium increases, and benefit reductions—could be devastating for beneficiaries and I know that you will want to factor them into the Administration's analysis.

I. Current State of the Medicare+Choice Program

A. Enrollment Trends in Medicare+Choice and Private Sector Managed Care

OMB: What about growth in private sector?

You have requested information on private sector managed care enrollment growth compared to Medicare+Choice enrollment growth. As you know, managed care emerged as a major form of health coverage first in the private sector and later in government programs. In fact, before the effects of BBA took hold, beneficiary enrollment hit a high of 100,000 new members per month. Now the average monthly growth is approximately 28,000. Seventeen percent of beneficiaries, compared to about 83 percent of participants in employer-sponsored coverage enrolled in managed care plans.

What about private sector profit margins?

Comparing managed care enrollment growth rates in Medicare+Choice to the private sector should be treated cautiously, since this actually is a comparison of growth from a low base in a previously emerging market (i.e., Medicare) to growth from a high base in a more mature market (i.e., the private sector). Enrollment growth in Medicare+Choice has slowed dramatically over the last two years. Between January and September 1997, Medicare managed care enrollment grew by 17.4 percent. During January and September 1998, growth declined to 11.1 percent. Between January and September 1999, this decline has continued, with year-to-date growth of only 6.8 percent. The September 1999 enrollment report released by HCFA shows that enrollment increased by only 23,000 new enrollees, down from the already low average monthly growth earlier in 1999 and from the nearly 100,000 new enrollees per month in 1997.

In addition to the low level of growth in the HMO and POS products in Medicare+Choice, the expectation that other plan options would enter the program and expand consumers' choices has not been met. To date, not one PPO has entered Medicare+Choice. Florida Hospital Healthcare System, a provider-owned plan that had the highest enrollment among participants in the Administration's Medicare Choices demonstration, exited the demonstration last year. In addition, nearly two hundred health plans have been forced to reduce or end their participation in the Medicare+Choice program since the BBA's enactment. Of the more than 725,000 beneficiaries affected by these decisions, an estimated 110,000 have had to return to the fee-for-service program because there is no other Medicare+Choice health plan option in their area.

In July, AAHP reported that many beneficiaries who will be able to keep their Medicare+Choice plan likely will face higher premiums and reduced benefits next year. The Administration's recently released analysis coincides with our findings. These grave events clearly indicate that the Medicare+Choice program is in crisis.

B. Health Plans' Financial Status

You have requested information about recent trends and projections in bond ratings, stock prices, and net worth. Publicly available information shows that many publicly traded companies providing services to Medicare+Choice beneficiaries are near or at 52-week lows. Other publicly available information indicates that health plans are operating on very narrow margins:

- A February 1999 study of profit margins conducted by Standard and Poor's DRI for AAHP found that managed care ranked 29th out of 39 industries in average profit margin (1993-1997), with the industry ranked first having the highest margin and the industry ranked 39th having the lowest.

AAHP has profit margin built into it —
Why haven't you considered it?

Examples of other industries with significantly higher average margins than managed care include, but are not limited to: the biotechnology industry; pharmaceutical companies; telephone companies; publishing; retail department stores; and lodging/hotels. Even within the health care sector, the managed care industry's profit margin is small compared to other industries, ranking 9th out of 12 industries examined. *SOWTAT*

- A.M. Best reports that HMO profit margins were -0.7 percent in 1997. HCIA found that HMO profit margins were 2.64 percent in 1994 declining to -2.95 percent in 1997.¹

Numerous recent reports prepared by financial analysts carry the consistent theme that Medicare is a very difficult sector in which to operate, primarily due to the unintended consequences of enactment and implementation of the BBA. Several top analysts have expressed significant concerns about the Medicare managed care line of business. In summary, reports suggest that continued participation in Medicare will be challenging for managed care companies, and that companies planning to enter the Medicare+Choice program have a particularly difficult road ahead.

In addition, the Hospital and Healthsystem Association of Pennsylvania reported last month that all but four of the State's thirteen Medicare+Choice plans reported losses on their Medicare product last year. Six of these Medicare+Choice plans experienced Medicare losses in excess of \$4.8 million.

C. Inaccuracies of HCFA's Risk Adjustment Model

You have requested documentation of the contention that Medicare enrollees are sicker than is assumed under HCFA's risk adjustment model. This documentation comes in two forms. First, there is widespread recognition that the current risk adjustment model penalizes plans that promote effective management of care. This model often will result in an inappropriately low "score" for an individual in a Medicare+Choice plan, making the individual appear healthier than the identical individual in fee-for-service Medicare due to differences in patterns of care. Second, AAHP, in conjunction with PricewaterhouseCoopers, has prepared extensive analyses of the relationship between Medicare+Choice and Medicare fee-for-service payments. These analyses show that in many areas Medicare+Choice payment relative to fee-for-service payment will fall far below prior estimates of favorable selection, yet the Administration's risk adjuster operates to reduce payment in these areas. These items are further discussed below.

1. **Risk Adjustment.** HCFA has chosen to implement its new risk-adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated *additional* \$11.2 billion over a five-year period beginning in 2000. This is an administratively imposed increase in the \$22.5 billion savings Congress expected from the payment methodology as enacted in the BBA. Neither key Members of Congress nor the Congressional Budget Office (CBO) expected the risk-adjuster to reduce Medicare+Choice payments further, and there is no statutory requirement whatsoever that the Administration do so. In fact, CBO stated that it had "previously assumed" that the Medicare+Choice risk-adjustment methodology would be budget neutral.²

¹ Best's Aggregates and Averages, HMO, United States, 1998 Edition; A.M. Best Company, 1998; and The Guide to the Managed Care Industry, HCIA, 1998.

² An Analysis of the President's Budgetary Proposals for Fiscal Year 2000, April 1999

working
to move to
as all
sites of care
as soon
as we can.

a. Disease Management

AAHP repeatedly has noted the fundamental design flaws in HCFA's PIP-DCG risk-adjustment methodology. Rather than measuring health status, HCFA's method measures inpatient hospital utilization for certain illnesses. This design ignores the fact that for many serious illnesses, such as congestive heart failure (CHF), diabetes, and cancer, numerous plans have developed and successfully implemented disease and case management programs that reduce hospitalizations for members who otherwise would have been treated in inpatient settings. Despite having the same illness or "risk" as a fee-for-service enrollee who has had a hospitalization related to CHF or cancer, the HCFA model categorizes Medicare+Choice beneficiaries in such disease or case management programs who do not have a hospitalization as healthier, resulting in substantial underpayments for Medicare+Choice beneficiaries with the same chronic diseases.

In his testimony before the Senate Finance Committee last June, Peter Smith, Chief Executive Officer of Ralin Medical, a leading disease management company that partners with many health plans, stated that HCFA's risk-adjuster negatively affects advances achieved through disease management programs. Specifically, Mr. Smith stated that:

"[P]lans that have been leaders and innovators in the development of health promotion programs for the Medicare+Choice population would be penalized during the initial risk adjustment process. They would exhibit a low number of hospitalizations relative to the health status of their patient populations. These plans have invested in focused patient education and behavioral modification programs to improve clinical status and quality of life for their members while at the same time reducing hospitalizations. [T]he unintended consequence of the risk adjustment methodology would be to stifle the development of programs and initiatives which have been shown to be beneficial to patients and to contain medical costs through health promotion, disease prevention, and reduction in hospitalizations."

b. Inclusion of Ambulatory Care-Sensitive and Geographically Variable Admissions

Some researchers, including scholars at the Institute of Medicine (IOM), have identified certain diagnoses for which a higher rate of inpatient admissions indicates low-quality ambulatory care. Four of these diagnoses (chronic obstructive pulmonary disease, congestive heart failure, bacterial pneumonia, and urinary tract infection), which the IOM researchers identified as "ambulatory care-sensitive diagnoses," are included in HCFA's risk-adjustment methodology. Based on the IOM research, then, HCFA's model will grant higher payment for inpatient admissions that indicate a failure of ambulatory care, rather than for accurate measurement of health status. In light of health plan initiatives to improve ambulatory care, HCFA's inclusion of ambulatory care sensitive diagnoses is likely to portray our members as healthier than they actually are.³

Likewise, an AAHP analysis of 1999 Dartmouth Atlas of Health Care data shows dramatic regional variation in inpatient admissions for certain diagnoses included in the PIP-DCG risk-adjuster chosen by HCFA. This finding indicates that HCFA's risk-adjuster includes a substantial number of discretionary admissions. Since Medicare+Choice plans undertake substantial efforts to avoid unnecessary hospitalizations, and HCFA's risk-adjuster measures inpatient hospitalizations, rather than health status,

³ Access to Health Care In America, "Using Indicators to Monitor National Objective," Institute of Medicine, 1993.

the risk-adjuster produces results indicating that Medicare+Choice members are healthier than they actually are.

As you know, HCFA engaged the American Academy of Actuaries to fulfill the Congressional mandate for an independent evaluation of its risk-adjuster. In its report, the Academy expressed concern about several aspects of the HCFA design and the strong possibility that the design would result in an incorrect determination that health plan members were healthier.⁴

c. Exclusion of One-Day Stays

HCFA's decision not to count diagnoses related to one-day hospital stays in the risk adjustment formula also inappropriately reduces payment for Medicare+Choice members. Patients covered by health plans may be treated in the hospital for one day and then in an alternate setting such as a Skilled Nursing Facility. Higher payment is not received on behalf of such members, although the risk adjuster does increase payments for an individual with identical health status who is treated through an inpatient stay of two days or more.

In its January 14, 1999 report, the American Academy of Actuaries expressed misgivings regarding the exclusion of one-day stays. Specifically, the Academy stated that as a result of HCFA's design, "a plan which manages care may be paid less than a plan which does not manage care for exactly the same type of patients." The Actuaries also reported that the average proportion of one-day stays may be greater among managed care plans, which tend to reduce lengths of stay. In expressing concern for the Medicare program as a whole, the Academy further stated that "there is substantial risk for the Medicare system if the risk adjustment methodology does not work as intended. The negative consequences could include withdrawal of Medicare+Choice health plans from the market, financial problems or insolvency for health plans and the potential for a reduction in benefits provided to beneficiaries." As you know, the Academy's concerns have become a reality.

In sum, while HCFA's risk adjuster measures use of inpatient hospital services for selected illnesses, it does not measure health status. In light of the different utilization patterns between managed care plans and fee-for-service Medicare, including management of chronic illness to avoid acute episodes that result in hospitalization and substitution of non-inpatient hospital settings for some inpatient hospital services, HCFA's risk adjuster understates the disease health status of the Medicare+Choice population.

2. Risk Adjuster's Interaction with Payment Formula. AAHP has long believed in the goal of ensuring that Medicare payments to health plans are accurate and that they fairly reflect the health care service needs of the Medicare beneficiaries who enroll. We do, however, take issue with prior studies on selection bias, which conclude that plans enroll healthier Medicare beneficiaries. These studies suffer from numerous flaws. Even if one accepts the results of these flawed studies solely for purposes of analysis, the Administration has designed its risk adjuster in a manner that actually reduces payment even in counties where non-risk adjusted payments will fall far below the level needed to offset prior estimates of selection bias. For instance, even in the many counties where per capita Medicare+Choice payment falls to 90 percent or less of per capita fee-for-service payments, the Administration's risk-adjuster often reduces payment by an additional 3 to 16 percent.

The analysis that we shared with the Administration earlier this year on the Fairness Gap between payments to health plans on behalf of enrollees and fee-for-service payments illustrates this point. As you may recall, the analysis shows that government payments to health plans on behalf of beneficiaries will be 85 percent or less of fee-for-service Medicare payments in 2004 for nearly half of Medicare+Choice

⁴ Actuarial Review of the Health Status Risk-Adjuster Methodology, American Academy of Actuaries Risk Adjustor Work Group, January 14, 1999.

enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment. This percentage difference significantly exceeds any estimates of so-called "overpayment" due to favorable selection. In these 100 counties, the annual dollar difference in per capita government payments to health plans on behalf of beneficiaries and payments for beneficiaries in the fee-for-service program will be at least \$1,000 for two-thirds of Medicare+Choice enrollees. When AAHP examined the top 101 to 200 counties as ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be \$1,000 or more in 2004. Overall, HCFA's risk-adjuster is responsible for about one-half of the total difference between per capita fee-for-service and per capita Medicare+Choice payments.

AAHP conducted this analysis using Medicare+Choice payment projections prepared by PricewaterhouseCoopers. In projecting 2004 Medicare+Choice county payments, the PricewaterhouseCoopers payment model incorporates BBA rules including the carve-out of graduate medical education payments; the two percent minimum update, payment floor, and blending of national and local rates; and the budget neutrality requirement. The impact of HCFA's risk-adjustment methodology was estimated using county-specific information released by HCFA on March 1. PricewaterhouseCoopers derived the 2004 county-level fee-for-service estimates by trending forward the 1997 county fee-for-service per capita expenditures. CBO projections of Medicare spending growth were used. Although county-level Medicare+Choice payments were actually lower than fee-for-service per capita payments in 1997, *to be conservative* AAHP's analysis assumes that county-level Medicare+Choice and fee-for-service payments were equal. This assumption understates the estimates of the gap in per capita payment between Medicare+Choice and fee-for-service.

D. Payment and Costs by Payer

You ask about how Medicare has changed compared to other payers. Since the BBA, payment increases have been well below private sector cost trends, particularly those for prescription drugs. For instance, in 1999 the effective rate of increase in government payment for a majority of Medicare+Choice plans was two percent, less the user fee, while Medicare fee-for-service spending increased by 4 percent and government increases for FEHBP averaged 9.5 percent. In 2000, the government's effective rate of increase for almost 70 percent of Medicare+Choice enrollees will be 4 percent or less. In contrast, Medicare fee-for-service spending will grow by 5.76 percent in 2000 and the government's payments in FEHBP will increase by 9 percent. Likewise, in the CalPERS program, payment will increase an average 9.7 percent next year. *MC spending is going down.*

The lower growth rate in Medicare+Choice payments compared to Medicare fee-for-service payments, as documented in the AAHP analyses previously shared with you, has challenged plans' ability to develop and maintain their provider networks. In an increasing number of cases, providers around the country simply have told health plans that given the likelihood of lower Medicare+Choice payments and increased regulatory requirements, it is more advantageous to serve beneficiaries under the fee-for-service program. Without adequate provider networks, health plans cannot meet HCFA's Medicare+Choice participation requirements, leaving them with few other options but to exit the program.

Medicare+Choice payments are becoming more comparable to payments under many state Medicaid managed care programs, where health plans, providers, and consumer groups have voiced serious concerns about payment inadequacy.

E. Sources of Medicare+Choice Program Instability

The health plans that have announced their decisions to leave the Medicare+Choice program or to reduce benefits have done so with great reluctance. Many of these plans worked right up to the deadlines to

devise strategies that would enable them to maintain their current service areas, to stay in the program next year, or to minimize benefit reductions and premium increases. But for many of these plans, current problems with Medicare+Choice payments and increased regulatory burdens were too overwhelming, and they were forced to reduce their participation, to withdraw from the program, or to scale-back benefits.

Medicare+Choice Payments

As you know, AAHP supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund. In 1998 and 1999, because of the low national growth percentage and the inability to achieve budget neutrality, no counties received blended payment rates. While blended payments will be received by some plans during 2000, in many instances these blended payments yield rates of increase that are far below the average for traditional Medicare. In fact, even in some counties receiving blended payments, the average update plans will receive in 2000 will be below two percent, due to the effects of the Administration's implementation of the risk adjuster.

Regulatory Environment

The challenges facing the Medicare+Choice program go beyond payment to encompass the program's regulatory structure. HCFA's regulatory approach to overseeing the program is contributing to the current volatility. Beneficiaries should have confidence that all options, including both Medicare+Choice plans and the Medicare fee-for-service program, meet standards of accountability that ensure that they will have access to all Medicare benefits and rights regardless of the coverage choice they make. All Medicare+Choice options offered to Medicare beneficiaries should be required to meet comparable standards in such areas as quality of care, access, grievance procedures, and solvency.

These standards should be implemented through regulatory requirements that make efficient use of plans' resources to ensure that beneficiaries receive the maximum value from the program. This means that when requirements are established, their benefits must outweigh their costs. While we appreciate HCFA's efforts to address concerns about certain aspects of the Medicare+Choice regulation over the past several months, the fact remains that health plans are having to devote substantial human and financial resources toward compliance activities, which in turn means fewer resources devoted to benefits.

Solving the Problems that Undermine the Success of the Medicare+Choice Program

Since the BBA's approval, AAHP and its member plans have worked diligently with Congress and the Administration to identify and address issues that serve to undermine the success of the Medicare+Choice program. In achieving this goal, AAHP believes that Medicare+Choice payments must be adequate and predictable to promote expanded coverage choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established.

For over a decade, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these coverage choices are at risk. Congress and the Administration should act immediately to create a more level playing field between the payments under the Medicare+Choice program and the Medicare fee-for-service program, and a regulatory environment based on the principles of ensuring that the value to beneficiaries justifies the resources required for compliance and equal accountability under the Medicare+Choice and Medicare fee-for-service programs.

Our concern last year that without action, more beneficiaries would lose access to their plan and that others would face reductions in benefits has become a dismal reality. Further delay could render the Medicare+Choice program beyond repair or salvage. As noted above, due to the Administration's policy choices concerning risk adjustment, many plans can expect a zero percent update for 2001, on the heels of a one to two percent update in 2000, and two percent updates in 1998 and 1999. This outcome would be a loss not only for the beneficiaries who have chosen a Medicare+Choice plan, but also for future beneficiaries who would be denied the opportunity to do so.

Again, thank you the opportunity to provide you with information on the Medicare+Choice program. Please do not hesitate to call if you have any questions.

Sincerely,



Karen Ignagni



American Association of
HEALTH PLANS

Karen Ignagni
President and Chief Executive Officer

October 15, 1999

Mr. Chris Jennings
Deputy Assistant to the President
for Health Policy
Old Executive Office Building
17th And Pennsylvania Ave NW
Room 216
Washington, DC 20500

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I. Current State of the Medicare+Choice Program

A. Enrollment Trends in Medicare+Choice and Private Sector Managed Care

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Comparing managed care enrollment growth rates in Medicare+Choice to the private sector should be treated cautiously, since this actually is a comparison of growth from a low base in a previously emerging market (i.e., Medicare) to growth from a high base in a more mature market (i.e., the private sector). Enrollment growth in Medicare+Choice has slowed dramatically over the last two years. Between January and September 1997, Medicare managed care enrollment grew by 17.4 percent. During January and September 1998, growth declined to 11.1 percent. Between January and September 1999, this decline has continued, with year-to-date growth of only 6.8 percent. The September 1999 enrollment report released by HCFA shows that enrollment increased by only 23,000 new enrollees, down from the already low average monthly growth earlier in 1999 and from the nearly 100,000 new enrollees per month in 1997.

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B. Health Plans' Financial Status

You have requested information about recent trends and projections in bond ratings, stock prices, and net worth. Publicly available information shows that many publicly traded companies providing services to Medicare+Choice beneficiaries are near or at 52-week lows. Other publicly available information indicates that health plans are operating on very narrow margins:

- A February 1999 study of profit margins conducted by Standard and Poor's DRI for AAHP found that managed care ranked 29th out of 39 industries in average profit margin (1993-1997), with the industry ranked first having the highest margin and the industry ranked 39th having the lowest.

Examples of other industries with significantly higher average margins than managed care include, but are not limited to: the biotechnology industry; pharmaceutical companies; telephone companies; publishing; retail department stores; and lodging/hotels. Even within the health care sector, the managed care industry's profit margin is small compared to other industries, ranking 9th out of 12 industries examined.

- A.M. Best reports that HMO profit margins were -0.7 percent in 1997. HCIA found that HMO profit margins were 2.64 percent in 1994 declining to -2.95 percent in 1997.¹

Numerous recent reports prepared by financial analysts carry the consistent theme that Medicare is a very difficult sector in which to operate, primarily due to the unintended consequences of enactment and implementation of the BBA. Several top analysts have expressed significant concerns about the Medicare managed care line of business. In summary, reports suggest that continued participation in Medicare will be challenging for managed care companies, and that companies planning to enter the Medicare+Choice program have a particularly difficult road ahead.

In addition, the Hospital and Healthsystem Association of Pennsylvania reported last month that all but four of the State's thirteen Medicare+Choice plans reported losses on their Medicare product last year. Six of these Medicare+Choice plans experienced Medicare losses in excess of \$4.8 million.

C. Inaccuracies of HCFA's Risk Adjustment Model

You have requested documentation of the contention that Medicare enrollees are sicker than is assumed under HCFA's risk adjustment model. This documentation comes in two forms. First, there is widespread recognition that the current risk adjustment model penalizes plans that promote effective management of care. This model often will result in an inappropriately low "score" for an individual in a Medicare+Choice plan, making the individual appear healthier than the identical individual in fee-for-service Medicare due to differences in patterns of care. Second, AAHP, in conjunction with PricewaterhouseCoopers, has prepared extensive analyses of the relationship between Medicare+Choice and Medicare fee-for-service payments. These analyses show that in many areas Medicare+Choice payment relative to fee-for-service payment will fall far below prior estimates of favorable selection, yet the Administration's risk adjuster operates to reduce payment in these areas. These items are further discussed below.

1. **Risk Adjustment.** HCFA has chosen to implement its new risk-adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated *additional* \$11.2 billion over a five-year period beginning in 2000. This is an administratively imposed increase in the \$22.5 billion savings Congress expected from the payment methodology as enacted in the BBA. Neither key Members of Congress nor the Congressional Budget Office (CBO) expected the risk-adjuster to reduce Medicare+Choice payments further, and there is no statutory requirement whatsoever that the Administration do so. In fact, CBO stated that it had "previously assumed" that the Medicare+Choice risk-adjustment methodology would be budget neutral.²

¹ Best's Aggregates and Averages, HMO, United States, 1998 Edition; A.M. Best Company, 1998; and The Guide to the Managed Care Industry, HCIA, 1998.

² An Analysis of the President's Budgetary Proposals for Fiscal Year 2000, April 1999

a. Disease Management

AAHP repeatedly has noted the fundamental design flaws in HCFA's PIP-DCG risk-adjustment methodology. Rather than measuring health status, HCFA's method measures inpatient hospital utilization for certain illnesses. This design ignores the fact that for many serious illnesses, such as congestive heart failure (CHF), diabetes, and cancer, numerous plans have developed and successfully implemented disease and case management programs that reduce hospitalizations for members who otherwise would have been treated in inpatient settings. Despite having the same illness or "risk" as a fee-for-service enrollee who has had a hospitalization related to CHF or cancer, the HCFA model categorizes Medicare+Choice beneficiaries in such disease or case management programs who do not have a hospitalization as healthier, resulting in substantial underpayments for Medicare+Choice beneficiaries with the *same* chronic diseases.

In his testimony before the Senate Finance Committee last June, Peter Smith, Chief Executive Officer of Ralin Medical, a leading disease management company that partners with many health plans, stated that HCFA's risk-adjuster negatively affects advances achieved through disease management programs. Specifically, Mr. Smith stated that:

"[P]lans that have been leaders and innovators in the development of health promotion programs for the Medicare+Choice population would be penalized during the initial risk adjustment process. They would exhibit a low number of hospitalizations relative to the health status of their patient populations. These plans have invested in focused patient education and behavioral modification programs to improve clinical status and quality of life for their members while at the same time reducing hospitalizations. [T]he unintended consequence of the risk adjustment methodology would be to stifle the development of programs and initiatives which have been shown to be beneficial to patients and to contain medical costs through health promotion, disease prevention, and reduction in hospitalizations."

b. Inclusion of Ambulatory Care-Sensitive and Geographically Variable Admissions

Some researchers, including scholars at the Institute of Medicine (IOM), have identified certain diagnoses for which a higher rate of inpatient admissions indicates low-quality ambulatory care. Four of these diagnoses (chronic obstructive pulmonary disease, congestive heart failure, bacterial pneumonia, and urinary tract infection), which the IOM researchers identified as "ambulatory care-sensitive diagnoses," are included in HCFA's risk-adjustment methodology. Based on the IOM research, then, HCFA's model will grant higher payment for inpatient admissions that indicate a failure of ambulatory care, rather than for accurate measurement of health status. In light of health plan initiatives to improve ambulatory care, HCFA's inclusion of ambulatory care sensitive diagnoses is likely to portray our members as healthier than they actually are.³

Likewise, an AAHP analysis of 1999 Dartmouth Atlas of Health Care data shows dramatic regional variation in inpatient admissions for certain diagnoses included in the PIP-DCG risk-adjuster chosen by HCFA. This finding indicates that HCFA's risk-adjuster includes a substantial number of discretionary admissions. Since Medicare+Choice plans undertake substantial efforts to avoid unnecessary hospitalizations, and HCFA's risk-adjuster measures inpatient hospitalizations, rather than health status,

³ Access to Health Care In America, "Using Indicators to Monitor National Objective," Institute of Medicine, 1993.

the risk-adjuster produces results indicating that Medicare+Choice members are healthier than they actually are.

As you know, HCFA engaged the American Academy of Actuaries to fulfill the Congressional mandate for an independent evaluation of its risk-adjuster. In its report, the Academy expressed concern about several aspects of the HCFA design and the strong possibility that the design would result an incorrect determination that health plan members were healthier.⁴

c. Exclusion of One-Day Stays

HCFA's decision not to count diagnoses related to one-day hospital stays in the risk adjustment formula also inappropriately reduces payment for Medicare+Choice members. Patients covered by health plans may be treated in the hospital for one day and then in an alternate setting such as a Skilled Nursing Facility. Higher payment is not received on behalf of such members, although the risk adjuster does increase payments for an individual with identical health status who is treated through an inpatient stay of two days or more.

In its January 14, 1999 report, the American Academy of Actuaries expressed misgivings regarding the exclusion of one-day stays. Specifically, the Academy stated that as a result of HCFA's design, "a plan which manages care may be paid less than a plan which does not manage care for exactly the same type of patients." The Actuaries also reported that the average proportion of one-day stays may be greater among managed care plans, which tend to reduce lengths of stay. In expressing concern for the Medicare program as a whole, the Academy further stated that "there is substantial risk for the Medicare system if the risk adjustment methodology does not work as intended. The negative consequences could include withdrawal of Medicare+Choice health plans from the market, financial problems or insolvency for health plans and the potential for a reduction in benefits provided to beneficiaries." As you know, the Academy's concerns have become a reality.

In sum, while HCFA's risk adjuster measures use of inpatient hospital services for selected illnesses, it does not measure health status. In light of the different utilization patterns between managed care plans and fee-for-service Medicare, including management of chronic illness to avoid acute episodes that result in hospitalization and substitution of non-inpatient hospital settings for some inpatient hospital services, HCFA's risk adjuster understates the disease health status of the Medicare+Choice population.

2. Risk Adjuster's Interaction with Payment Formula. AAHP has long believed in the goal of ensuring that Medicare payments to health plans are accurate and that they fairly reflect the health care service needs of the Medicare beneficiaries who enroll. We do, however, take issue with prior studies on selection bias, which conclude that plans enroll healthier Medicare beneficiaries. These studies suffer from numerous flaws. Even if one accepts the results of these flawed studies solely for purposes of analysis, the Administration has designed its risk adjuster in a manner that actually reduces payment even in counties where non-risk adjusted payments will fall far below the level needed to offset prior estimates of selection bias. For instance, even in the many counties where per capita Medicare+Choice payment falls to 90 percent or less of per capita fee-for-service payments, the Administration's risk-adjuster often reduces payment by an additional 3 to 16 percent.

The analysis that we shared with the Administration earlier this year on the Fairness Gap between payments to health plans on behalf of enrollees and fee-for-service payments illustrates this point. As you may recall, the analysis shows that government payments to health plans on behalf of beneficiaries will be 85 percent or less of fee-for-service Medicare payments in 2004 for nearly half of Medicare+Choice

⁴ Actuarial Review of the Health Status Risk-Adjuster Methodology, American Academy of Actuaries Risk Adjuster Work Group, January 14, 1999.

enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment. This percentage difference significantly exceeds any estimates of so-called "overpayment" due to favorable selection. In these 100 counties, the annual dollar difference in per capita government payments to health plans on behalf of beneficiaries and payments for beneficiaries in the fee-for-service program will be at least \$1,000 for two-thirds of Medicare+Choice enrollees. When AAHP examined the top 101 to 200 counties as ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be \$1,000 or more in 2004. Overall, HCFA's risk-adjuster is responsible for about one-half of the total difference between per capita fee-for-service and per capita Medicare+Choice payments.

AAHP conducted this analysis using Medicare+Choice payment projections prepared by PricewaterhouseCoopers. In projecting 2004 Medicare+Choice county payments, the PricewaterhouseCoopers payment model incorporates BBA rules including the carve-out of graduate medical education payments; the two percent minimum update, payment floor, and blending of national and local rates; and the budget neutrality requirement. The impact of HCFA's risk-adjustment methodology was estimated using county-specific information released by HCFA on March 1. PricewaterhouseCoopers derived the 2004 county-level fee-for-service estimates by trending forward the 1997 county fee-for-service per capita expenditures. CBO projections of Medicare spending growth were used. Although county-level Medicare+Choice payments were actually lower than fee-for-service per capita payments in 1997, *to be conservative* AAHP's analysis assumes that county-level Medicare+Choice and fee-for-service payments were equal. This assumption understates the estimates of the gap in per capita payment between Medicare+Choice and fee-for-service.

D. Payment and Costs by Payer

You ask about how Medicare has changed compared to other payers. Since the BBA, payment increases have been well below private sector cost trends, particularly those for prescription drugs. For instance, in 1999 the effective rate of increase in government payment for a majority of Medicare+Choice plans was two percent, less the user fee, while Medicare fee-for-service spending increased by 4 percent and government increases for FEHBP averaged 9.5 percent. In 2000, the government's effective rate of increase for almost 70 percent of Medicare+Choice enrollees will be 4 percent or less. In contrast, Medicare fee-for-service spending will grow by 5.76 percent in 2000 and the government's payments in FEHBP will increase by 9 percent. Likewise, in the CalPERS program, payment will increase an average 9.7 percent next year.

The lower growth rate in Medicare+Choice payments compared to Medicare fee-for-service payments, as documented in the AAHP analyses previously shared with you, has challenged plans' ability to develop and maintain their provider networks. In an increasing number of cases, providers around the country simply have told health plans that given the likelihood of lower Medicare+Choice payments and increased regulatory requirements, it is more advantageous to serve beneficiaries under the fee-for-service program. Without adequate provider networks, health plans cannot meet HCFA's Medicare+Choice participation requirements, leaving them with few other options but to exit the program.

Medicare+Choice payments are becoming more comparable to payments under many state Medicaid managed care programs, where health plans, providers, and consumer groups have voiced serious concerns about payment inadequacy.

E. Sources of Medicare+Choice Program Instability

The health plans that have announced their decisions to leave the Medicare+Choice program or to reduce benefits have done so with great reluctance. Many of these plans worked right up to the deadlines to

devise strategies that would enable them to maintain their current service areas, to stay in the program next year, or to minimize benefit reductions and premium increases. But for many of these plans, current problems with Medicare+Choice payments and increased regulatory burdens were too overwhelming, and they were forced to reduce their participation, to withdraw from the program, or to scale-back benefits.

Medicare+Choice Payments

As you know, AAHP supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund. In 1998 and 1999, because of the low national growth percentage and the inability to achieve budget neutrality, no counties received blended payment rates. While blended payments will be received by some plans during 2000, in many instances these blended payments yield rates of increase that are far below the average for traditional Medicare. In fact, even in some counties receiving blended payments, the average update plans will receive in 2000 will be below two percent, due to the effects of the Administration's implementation of the risk adjuster.

Regulatory Environment

The challenges facing the Medicare+Choice program go beyond payment to encompass the program's regulatory structure. HCFA's regulatory approach to overseeing the program is contributing to the current volatility. Beneficiaries should have confidence that all options, including both Medicare+Choice plans and the Medicare fee-for-service program, meet standards of accountability that ensure that they will have access to all Medicare benefits and rights regardless of the coverage choice they make. All Medicare+Choice options offered to Medicare beneficiaries should be required to meet comparable standards in such areas as quality of care, access, grievance procedures, and solvency.

These standards should be implemented through regulatory requirements that make efficient use of plans' resources to ensure that beneficiaries receive the maximum value from the program. This means that when requirements are established, their benefits must outweigh their costs. While we appreciate HCFA's efforts to address concerns about certain aspects of the Medicare+Choice regulation over the past several months, the fact remains that health plans are having to devote substantial human and financial resources toward compliance activities, which in turn means fewer resources devoted to benefits.

Solving the Problems that Undermine the Success of the Medicare+Choice Program

Since the BBA's approval, AAHP and its member plans have worked diligently with Congress and the Administration to identify and address issues that serve to undermine the success of the Medicare+Choice program. In achieving this goal, AAHP believes that Medicare+Choice payments must be adequate and predictable to promote expanded coverage choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established.

For over a decade, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these coverage choices are at risk. Congress and the Administration should act immediately to create a more level playing field between the payments under the Medicare+Choice program and the Medicare fee-for-service program, and a regulatory environment based on the principles of ensuring that the value to beneficiaries justifies the resources required for compliance and equal accountability under the Medicare+Choice and Medicare fee-for-service programs.

Our concern last year that without action, more beneficiaries would lose access to their plan and that others would face reductions in benefits has become a dismal reality. Further delay could render the Medicare+Choice program beyond repair or salvage. As noted above, due to the Administration's policy choices concerning risk adjustment, many plans can expect a zero percent update for 2001, on the heels of a one to two percent update in 2000, and two percent updates in 1998 and 1999. This outcome would be a loss not only for the beneficiaries who have chosen a Medicare+Choice plan, but also for future beneficiaries who would be denied the opportunity to do so.

Again, thank you the opportunity to provide you with information on the Medicare+Choice program. Please do not hesitate to call if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Karen', with a long, sweeping horizontal line extending to the right.

Karen Ignagni

**MEDICARE+CHOICE:
CHANGES FOR THE YEAR 2000**
*An Analysis of the Medicare+Choice Program and
the How Beneficiaries Will Be Affected by Changes*

**A Report
by the
Health Care Financing Administration**

September 1999

MEDICARE+CHOICE: CHANGES FOR THE YEAR 2000

EXECUTIVE SUMMARY

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and —most importantly-- Medicare beneficiaries and their advocates to understand how M+C is evolving.

BENEFICIARY ENROLLMENT AND MANAGED CARE ORGANIZATION PARTICIPATION

- *Beneficiary Enrollment* -- Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. Approximately 33 million beneficiaries are in traditional fee-for-service Medicare.
- *Plan Participation* -- Plan participation has been somewhat volatile over time. In fact, the highest rate of increase in participating organizations (almost 40 percent) since 1986 occurred in 1994. The largest rate of decrease occurred in 1990 (almost 30 percent.) In both 1999 and again in 2000, approximately 13 percent of the contracts were not renewed.

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN EXTRA BENEFITS OFFERED

Although beneficiary access to prescription drugs and other non-Medicare benefits offered by M+C plans will remain relatively constant, many plans will restructure drug benefits in ways that increase enrollee out-of-pocket costs and limit drug coverage.

- *Drug Caps* -- In 2000, 86 percent of plans will have annual dollar limits (caps) on brand and/or generic drugs. About 82 percent of plans will cap their per enrollee prescription drug spending below \$2000 in 2000. The annual caps are becoming more restrictive. In 1999, only 21 percent of plans had a cap on drugs of \$500 or less; in 2000, 32 percent of plans will have a \$500 per enrollee benefit spending cap on either brand or generic drugs. Although enrollees will be more likely to have access to unlimited generic drug coverage, they will also be more likely to have even tighter caps imposed on brand-name drugs.
- *Copayments* -- There will be increased use of copays for prescription drugs. In fact, for the first time, all beneficiaries will live in areas where M+C organizations charge copays for prescription drugs. In 1999, over one million beneficiaries live in areas where plans have no copayments for generic and brand name drugs. In 2000, all plans will have copays on both types of drugs. On an enrollment-weighted basis that assumes M+C

enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees, average copays for brand-name drugs would increase by 21 percent, with average copayments for generic drugs increasing by 8 percent.¹

- *Access to Extra Benefits Varies by State* — Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year. However, there will be state variation. Several states will have a substantial decrease in the number of beneficiaries who have access to a drug benefit through an M+C plan. These states include Iowa, North Carolina, and Delaware. At the same time, a few states will have increased availability of drugs as part of the basic package in 2000, including Michigan, New Hampshire, and Washington

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN PREMIUMS

- *Increase in Premiums* -- For the M+C program overall, there will be an increase in the level of monthly premiums. For example, in 1999 on an enrollment-weighted basis, the average monthly premium for basic plans was \$5.35. For 2000, this amount would almost triple to \$15.84. Moreover, in 2000, the number of beneficiaries for whom the lowest available premium will be in the \$20 to \$60 range will increase by approximately 50 percent over 1999. Of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over \$80, 94 percent (over 195,000) live in areas with only one plan available.
- *Decline in Plans with Extra Benefits for No Premium* -- In 2000, there will be a decline of about 3 million in the number of Medicare beneficiaries with access to a plan that does not charge for a premium for enrollment. This represents a slight decrease in the percentage of beneficiaries with access to any plan who will have a zero premium plan, from 85 percent in 1999 to 77 percent in 2000.

MEDICARE+CHOICE IN THE YEAR 2000 -- WITHDRAWALS AT THE END OF 1999

- *Plans Withdrawing From the Program* —Over the past two years, a small percentage of beneficiaries have been affected by M+C withdrawals. In 1999, 407,000 enrollees (6.5 percent of M+C enrollees at the time in 1998) were affected in some way, with approximately 51,000 (less than one percent of the total) being left without the option of enrolling in another M+C plan. Approximately half of beneficiaries affected by the withdrawals who still had an M+C option choose original fee-for-service Medicare and the other half chose to enroll in another organization.

¹ As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur.

For 2000, there were 327,000 enrollees affected (5 percent of M+C enrollees) and 79,000 (1.3 percent of enrollees) left with no M+C option. These beneficiaries were enrolled in 99 separate organizations that either withdrew entirely from the program or reduced their service area.

- *New Plan Approvals Will Help Improve Access --* Despite volatility in the overall managed care marketplace, new organizations continue to come into the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program affecting 400,000 beneficiaries in 87 counties. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. As of August 1999, there are 13 pending applications from organizations seeking new M+C contracts and nine requests for service areas expansions. Over 50 percent of the counties included in these pending applications currently have no M+C plans.
- *Access to Plans Reduced Slightly --* As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, as it did in 1999. The trend of the decline in beneficiaries who had access to one or more M+C organizations has been slightly negative --in 1998, 72 percent of had such access; in 1999, the percentage declined to 71 percent; and for 2000 the percentage declined to 69 percent.²
- *Revenue and the Relation to Non-Renewal Decisions --* Withdrawals of organizations from M+C are not primarily occurring in the lowest payment areas. They are disproportionately withdrawing from counties where payment rates are in a payment mid-range of \$451 and \$500 for the year 2000. If payment were the primary factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level (\$401) were affected. Yet, 12 percent of enrollees in counties with payments in the higher range of \$451 to \$500 were affected. Similarly, withdrawals do not appear to be correlated with low payment growth rates. Plan withdrawals will affect 7.2 percent of enrollees in counties where rates are rising by 10 percent or more, but such withdrawals will only affect 2.4 percent of enrollees where M+C payment rates are rising by the 2 percent minimum.

MEDICARE+CHOICE IN THE YEAR 2000 -- PARALLELS TO PRIVATE SECTOR

- *The M+C Experience Corresponds to the Private Sector Experience --* Program withdrawals, reduced benefits, and premium increases are not unique to Medicare. They reflect the

² The year 2000 figure is based on currently approved plans. The percentage will increase as new plan applicants enter the program.

industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels.

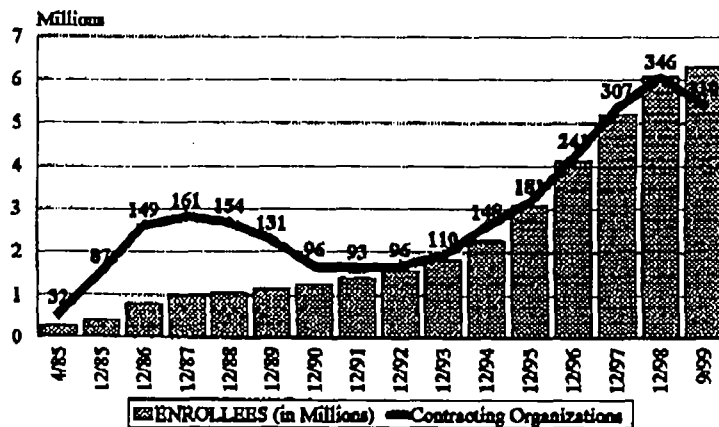
- *Factors Other than Payment Leading to Non-Renewal Decisions* — Overall, the facts suggest that the General Accounting Office's findings about withdrawals for the 1999 contract year still hold true: causes other than payment rates appear to play a large role in business decisions to participate in M+C in 2000. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and --most importantly-- Medicare beneficiaries and their advocates to understand how M+C is evolving.

Beneficiary Enrollment and Managed Care Organization Participation

Despite recent volatility in the managed care market, an ever-increasing percentage of Medicare beneficiaries choose to enroll in M+C organizations.¹ Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. About one in every six beneficiaries is now enrolled in an M+C organization, and the enrollment rate among those Medicare beneficiaries who live in an area served by one or more M+C

Medicare Risk HMO/M+C Enrollment and HMO Participation, 1985-1999

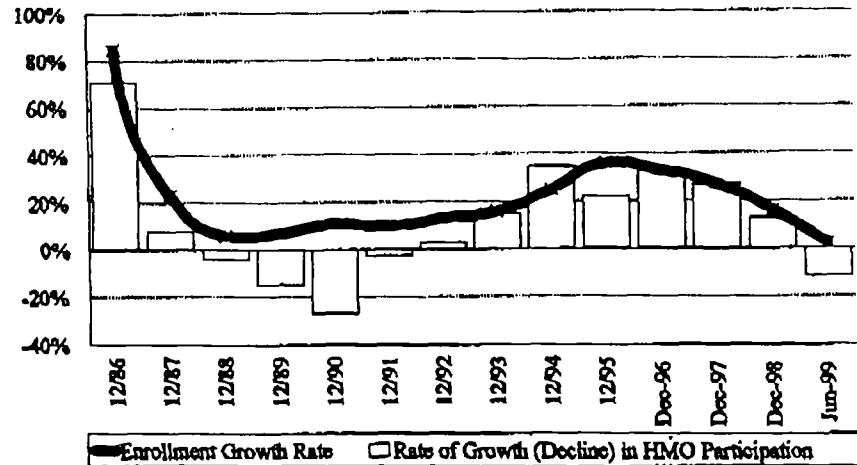


¹ As a result of provisions of the Balanced Budget Act of 1997 (BBA), the terms *organization* and *plan* have specific meanings in the context of the M+C program. The methodology section of the paper explains the difference in these definitions and the relevance to our analysis. Please see the methodology section for an explanation of several other key issues related to the development of this report.

organizations is about 23 percent (nearly one in four Medicare beneficiaries chooses an M+C plan where one is available).

We anticipate that program growth will continue in the long-term despite decisions by some organizations to discontinue participation in the M+C program for the 2000 contract year. Despite the fact that health maintenance organization (HMO) participation in the program has been volatile—and has even declined during certain

Yearly Medicare Risk Enrollment Growth Rates and Rates of Change in HMO Participation Levels, 1986-1999



periods—beneficiary enrollment has increased consistently. Enrollment losses resulting from reductions in organization participation in the 1999 contract year were recouped within just two months. Enrollment in Medicare risk organizations (today's M+C organizations) has grown every year since the inception of the program in 1985.

Even though the level of access to M+C plans has remained relatively stable in the last few years, the absolute number of beneficiaries enrolling in M+C each month has dropped. During 1997, the size of the M+C program increased by 91,000 beneficiaries each month on a net average basis. Thus far, in 1999, the corresponding increase has slowed to 28,000 beneficiaries each month.²

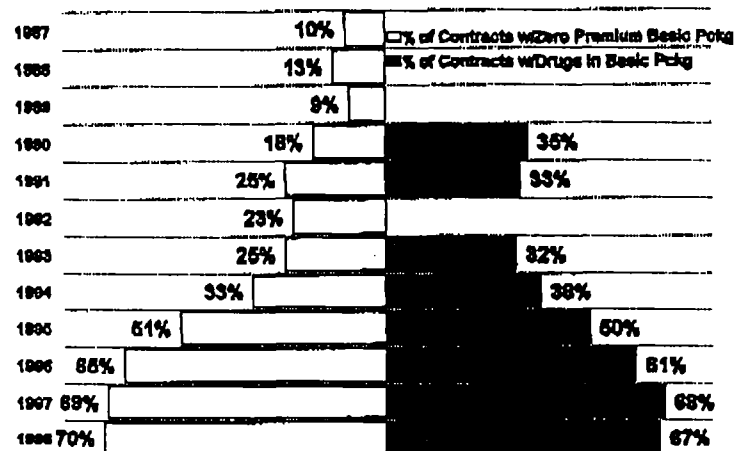
² In 1999, the net average monthly enrollment increase has been about 28,000 beneficiaries. This includes the large drop in enrollment due to the decisions made by M+C organizations in 1998 to withdrawal for the 1999 contract year. Subsequent to that drop, M+C enrollment has increased on a net average basis by over 40,000 beneficiaries per month during 1999.

Furthermore, the *rate of increase* in enrollment has declined recently. After 1986, the highest rate of increase in enrollment from one year to the next (36 percent) occurred between 1994 and 1995. Both prior to and after this period, enrollment growth has been more modest. However, the rate of enrollment growth for M+C in the late 1990s still exceeds the rate of growth in the number of beneficiaries entering the Medicare program overall.

The Medicare+Choice Program in the Year 2000

Although the majority of M+C organizations will remain in the program in the year 2000, many of these organizations will increase premiums, as well as reduce and restructure benefits. As a result, enrollee out-of-pocket costs will likely increase. A major factor behind this increase is the rising cost of offering prescription drug coverage—one of most attractive features of M+C for Medicare beneficiaries.

Historical Prevalence of Zero Premiums and Drug Coverage in Medicare Risk/M+C Contracts, 1987-1998



For missing years, data unavailable. Sources: HCFA monthly managed care reports for 1990-1998; adjusted community rate proposals for 1987-1989 data.

Changes in Premiums and

Benefits. Since the beginning of the Medicare risk/M+C program, the general trend has been towards an increase in zero premium³ plans and the inclusion of drug coverage in the basic plan option regardless of any extra benefits (the basic option is generally the lowest-cost option available from an organization.)⁴ In fact, since 1994, most plans have offered zero premium plans that include

³ Please see the methodological note for a definition of zero premium.

⁴ The paper later explains the difference in basic and optional supplemental benefits coverage.

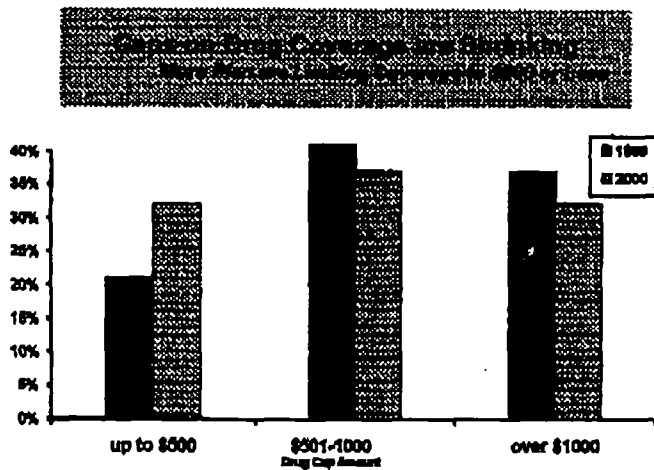
drug coverage.⁵ While access to a drug benefit has been relatively steady, there has been a decrease in the value of that extra benefit.

Prescription Drug Coverage. Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year -- dropping only from 25.4 million beneficiaries (65 percent of the total) in 1999 to 25.2 million (63 percent of the total) in 2000. However, there is significant state-by-state variation. For example, the percent of beneficiaries who will have access to an M+C plan that offers any prescription drug coverage in 2000 will decrease significantly in a number of states, including Louisiana, North Carolina, and Delaware. Also, all available M+C plans will drop drug coverage *entirely* in four states (Arkansas, Iowa, Nebraska, and West Virginia.) At the same time, in a few states (such as Hawaii, Michigan, New Hampshire, and Washington) beneficiaries will have increased availability of drugs. (Please see Attachment A for a full state-by-state analysis.)

Access to Prescription Drug Coverage in Rural Areas is Stable. As mentioned above, there will only be a slight decrease in access to prescription drug coverage nationally. This is also true of rural areas. Among beneficiaries residing in rural counties, the number of beneficiaries whose M+C options do not include *any* level of drug coverage is roughly the same—433,000 in 1999 and 438,000 in 2000. This is an indication that the organizations withdrawing from rural areas generally did not offer drug coverage. While there is no change, the large disparity in access to prescription drug coverage in M+C in rural areas will continue. Only 4 percent of beneficiaries in rural areas will have access to prescription drug coverage through an M+C plan in 2000.

Decreasing Value of Drug Coverage. The *value* of the prescription drug benefit offered by plans will generally decline in 2000. This decline will be due to a number of factors, including decreases in the amount of drug spending covered (particularly for brand-name drugs) and increases in out-of-pocket costs for beneficiaries.

⁵ With regard to the above chart, "Historical Prevalence of Zero Premiums and Drug Coverage," data for 1999 and 2000 are not available due to changes in the definition of M+C plans and organizations under the BBA.



Greater Use of Drug Caps by Plans Overall. Although a few additional plans will offer unlimited prescription drug benefits for both generic and brand-name drugs in 2000 relative to 1999, the vast majority of plans (86 percent) will continue limiting drug benefits next year. For organizations that do impose limits, the annual limits are more restrictive for 2000. For example, the percentage of plans

with annual benefit limits of \$500 or less will increase from 21 percent in 1999 to 32 percent in 2000. Furthermore, 82 percent of plans in 2000 will cap drug coverage below the \$2000 level. On an enrollee level, there will be greater availability of unlimited generic drug coverage. At the same time, the caps on brand-name drugs will become more restrictive.

Basic Versus Optional Supplemental Drug Coverage. Although most Medicare beneficiaries will have drug coverage as a feature of their basic M+C plan, more beneficiaries in 2000 will have drug coverage available *only* as optional supplemental. If a covered item is in the basic package, only the plan's standard monthly premium (if any) applies. However, items that are covered as optional supplements require an additional monthly premium to be paid in addition to any premium already being charged for the basic plan. Benefits that are only available as optional supplemental are, by definition, are more expensive to obtain than benefits offered as basic coverage.

As a result of program changes, there is a greater likelihood that more generous drug coverage is only available with the payment of the additional premium needed to purchase the optional supplemental benefit. More beneficiaries will have to pay an additional premium for their drug coverage.

Copays for the Drug Benefit – Plans Are Increasing Levels. Organizations are increasing copays for both brand name and generic drugs.

For the first time, all organizations will require copays for drugs. In 1999, over one million beneficiaries live in areas with zero copayments for generic and brand name drugs. In 2000, all beneficiaries will live in areas with copays on both types of drugs.

In 1999, 20 percent of beneficiaries are offered plans with copayments averaging \$5 or less for generic drugs. The comparable percentage in 2000 will be three percent. Furthermore, the percentage of all beneficiaries faced with average copayments for generic drugs in the \$10 to \$15 range will triple. Finally, in 1999, only 274,000 of all beneficiaries live in an area with copayments on brand-name drugs averaging \$25 or more. In 2000, there will be one million beneficiaries facing that level of copayment.

Copays and the Drug Benefit – Beneficiaries Charges are Increasing on Average. Overall, M+C enrollees would, on average, be subject to higher copay levels. Assuming M+C enrollment levels remain constant from 1999 to 2000 and that different M+C organizations maintain their same proportion of enrollees, the average copayment for brand name drugs would increase by 21 percent between 1999 and 2000 on an enrollment-weighted basis. Using the same type of analysis, the data show that copays on generic drugs would increase by an average of 8 percent between 1999 and 2000.⁶

⁶ As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that “would” (as opposed to will) occur. Please see the methodological note for further detail.

Copayment Levels in M+C Plans and Averages Weighted by Enrollment 1999 and 2000 ⁷		
	Brand-Name Copay: Enrollment Wtd. Avg.	Generic Copay: Enrollment Wtd. Avg.
1999	\$14.34	\$6.88
2000	\$17.30	\$7.42
Percent Increase 1999 to 2000	21%	8%

Other Benefits. The coverage for other, extra benefits not covered by Medicare fee-for-service (such as dental, vision, and hearing aid benefits) will remain substantially unchanged from 1999 to 2000 in M+C plans. For example, the percentage of the total Medicare beneficiary population living in an area with M+C plans that offer dental benefits will only drop from 83 percent in 1999 to 80 percent in 2000. Similarly, access to vision coverage remains unchanged at 99 percent for both 1999 and 2000.

Changes in Premiums. For 2000, despite some state by state variation, there is a clear trend toward increasing premiums for M+C plans—especially in rural areas. There has been a corresponding decline in the number of zero premium plans. Furthermore, though relatively small numbers of beneficiaries are involved, there will be a significant increase in the number of beneficiaries who will have to pay relatively high premiums to enroll in an M+C plan.

Decline in Zero Premium Plans. The table below shows that, in 2000, there will be a decline of more than 3 million in the *number* of Medicare beneficiaries with access to at least one zero premium plan. This represents a slight decrease in the *percentage* of beneficiaries with access to any plan who will have a zero premium plan, from 85 percent in 1999 to 77 percent in 2000.

⁷ This chart includes data from plans with any level of drug coverage in the basic plan.

The corresponding drop in rural areas is greater. One-half million fewer rural beneficiaries will have access to a zero premium plan. In 1999, 1.3 million rural beneficiaries (63 percent of those with any plan available) live in an area with at least one zero premium plan; in 2000, only 784,000 rural beneficiaries (40 percent of those with any plan available) will have such an option.

Some states will see significant changes (positive and negative) in the number of zero premium plans that are available. In the table below, a negative change is an indication that access to zero premium plans is being reduced.

Zero Premium Plan Availability, Changes Over 5% 1999-2000^b				
State	Beneficiaries with Access to Plans	Beneficiaries with Access to a Zero Premium Plan		
		1999	2000	Change
NEW HAMPSHIRE	170,050	100%	0%	-100%
KANSAS	398,171	92%	45%	-47%
ARKANSAS	447,359	72%	35%	-37%
MISSOURI	876,481	88%	56%	-32%
CONNECTICUT	522,372	90%	63%	-27%
PENNSYLVANIA	2,133,804	78%	57%	-21%
WASHINGTON	742,235	82%	61%	-21%
WISCONSIN	797,476	87%	66%	-21%
LOUISIANA	618,618	100%	84%	-16%
NEW JERSEY	1,220,622	100%	86%	-14%
FLORIDA	2,835,297	92%	80%	-12%
MASSACHUSETTS	979,167	100%	94%	-6%
CALIFORNIA	3,937,181	97%	91%	-5%
OHIO	1,735,412	79%	84%	5%
TEXAS	2,273,849	92%	98%	6%
VIRGINIA	885,285	32%	44%	12%
MARYLAND	647,249	83%	96%	13%
WEST VIRGINIA	344,377	0%	32%	32%
TENNESSEE	838,289	50%	83%	33%
OKLAHOMA	516,047	3%	96%	94%

^b The percentage of beneficiaries with access to a zero premium plan may increase or decrease solely because the number of beneficiaries with access to any M+C plan has increased or decreased.

Increases in Premiums. Data shows that there will be an increase in the level of those premiums in M+C. For example, in 1999, the enrollment-weighted average premium for a basic plan was \$5.35. For 2000, this amount would almost triple to \$15.84.⁹ Measured in terms of access to plans across the entire Medicare population, the number of beneficiaries living in areas where M+C premiums are in the \$20 to \$60 range will increase by approximately 50 percent in 2000 over 1999 representing a shift from lower groups. Finally, for 1999, only 50,000 Medicare beneficiaries live in an area where the minimum premium is in the \$80 to \$100 range; however, in 2000, the number will rise to 207,000. The majority of such individuals (60 percent) are residents of rural counties.

Premiums in Areas with Only One Plan. Medicare beneficiaries who live in areas with a choice of only one plan will be particularly affected by premium increases. Approximately 8 percent of M+C beneficiaries (just over three million) live in areas with a choice of only one plan. However, of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over \$80, 94 percent (over 195,000) live in areas with only one plan available. There will be a nearly six-fold increase—from 1.6 percent to 9.3 percent—in the percentage of beneficiaries who live in an area where the sole M+C plan available has a monthly premium in the \$80 to \$100 range for 2000.

Minimum Premium	Medicare Beneficiary Population (Total), Access to Only One Plan			
	Year 1999		Year 2000	
	Beneficiaries	%	Beneficiaries	%
Zero	803,162	31.6%	599,553	28.4%
\$0.01 - \$19.99	17,614	0.7%	-	0.0%
\$20.00 - \$39.99	467,284	18.4%	410,662	19.5%
\$40.00 - \$59.99	716,862	28.2%	683,029	32.4%
\$60.00 - \$79.99	499,095	19.6%	220,237	10.4%
\$80.00 - \$99.99	39,742	1.6%	195,432	9.3%
Totals	2,543,559	100%	2,108,913	100%

⁹ Again, please see the methodological note to learn that the enrollment-weighted analysis assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. This average does not include premiums that beneficiaries pay for supplemental plans.

Premium increases in areas with only one plan will have the most pronounced impact in rural areas. From 1999 to 2000, roughly the same percentage of beneficiaries who live in rural areas will have only one plan available –28.4 percent and 29.6 percent in each year respectively. However, the table below shows that zero premium plans are becoming less widely available in rural areas. It also shows that there will be a significant increase in the number of rural Medicare beneficiaries whose only M+C option is a relatively high cost plan.

Minimum Premium	Medicare Beneficiary Population (Rural Only)			
	Access to Only One Plan			
	Year 1999		Year 2000	
	Beneficiaries	%	Beneficiaries	%
Zero	271,833	37.7%	174,956	28.1%
\$0.01 - \$19.99	17,614	2.4%	-	0.0%
\$20.00 - \$39.99	96,131	13.3%	104,796	16.8%
\$40.00 - \$59.99	135,440	18.8%	146,425	23.5%
\$60.00 - \$79.99	160,647	22.3%	81,774	13.1%
\$80.00 - \$99.99	39,742	5.5%	115,689	18.5%
Totals	721,407	100%	623,620	100%

Other Cost Sharing. As with drug coverage, copayments and coinsurance for office visits are increasing. The enrollment-weighted average copayment across all plans for a primary care office visit would increase by 20 percent, from \$6.90 in 1999 to \$8.33 in 2000. The enrollment-weighted average copayment across all plans for a specialty visit would increase by 37 percent, from \$7.67 in 1999 to \$10.52 in 2000.¹⁰

¹⁰ Please see methodological note for information on enrollment-weighted averages.

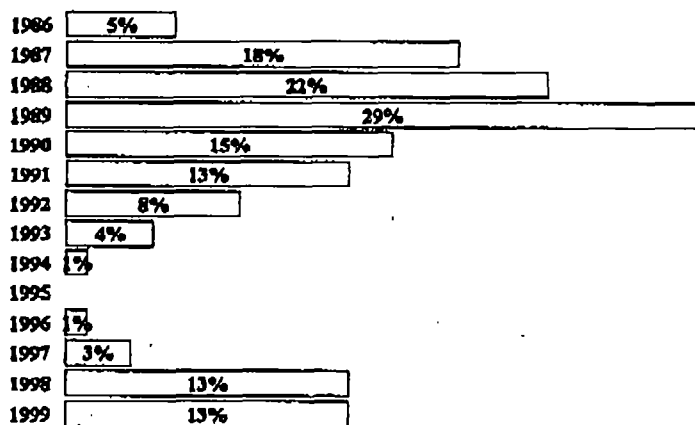
Access to Medicare+Choice Plans at the End of 1999

This year and last, a number of organizations decided to end or reduce their participation in the M+C program. For 2000, 99 M+C organizations will reduce or drop participation in the program. This includes 41 contractors that completely terminated their M+C contract and another 58 contractors that reduced the size of the service area. These changes will affect 327,000 M+C enrollees (5 percent of total) across 329 counties within 33 states. Of the 327,000 affected, 79,000 M+C enrollees (1.3 percent of total) will have to return to traditional Medicare because they will not have an M+C plan available in their county. This is in contrast to the 407,000 M+C enrollees (6.5 percent of total) affected by contract nonrenewals and service area reductions in 1999. Of the 407,000, 51,000 M+C enrollees (less than one percent of total) were left without access to another M+C plan.

Terminations of contracts by managed care organizations still remain well below the rates experienced a decade

ago. In 1988, 22 percent of Medicare managed care organizations withdrew from the program entirely. This affected 8.2 percent of enrollees.¹¹ Similarly, in 1989, 29 percent of organizations terminated their contracts, affecting 6.6 percent of enrollees. The high percentage of withdrawals in the late 1980s and then the withdrawals in the late 1990s (13 percent in 1998 and again in 1999) are a stark contrast to the stability experienced from 1993 to 1997.¹²

**Risk Contract Non-Renewals by Percent of Plans, 1986-1999
(Excludes Service Area Reductions)**



Refers only to risk non-renewals (including conversion to cost plans), not service area reductions. The 1989 figure includes 29 plans that had no enrollees. The percent for 1995 was less than one. 1999 data are based on the number of plans as of August 1999.

¹¹ The data in this paragraph pertain only to contract terminations, not to service area reductions because HCFA does not have complete historical data on the number of beneficiaries affected by service area reductions.

¹² The term withdrawal is generally used to include both organizations that reduced their service areas or completely terminated their contracts for 2000. In 1998 and 1999, 13 percent of organizations terminated their contracts, with 3.7 percent and 2.7 percent of beneficiaries affected each year (exclusive of service area reductions). With reference to the chart "Risk Contract Non-Renewals," the number of plans in 1999 are for the 2000 contract year.

New Plan Approvals Will Increase Availability. Despite volatility in the overall marketplace, new organizations continue to enter the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program. As of August 1999, there were 13 pending applications from organizations seeking new M+C contracts, and nine pending requests for service area expansions.¹³ Over 50 percent of the counties included in these pending applications currently have no M+C plans. If approved, these applications would bring M+C access to an additional 1.5 percent of total Medicare beneficiaries.

For 2000, 262 organizations will continue their M+C contracts with Medicare. With the additional 13 new applications, the number of contractors operating in 2000 would be at least 275. As a result, the net percentage decrease in contracting organizations from 1999 to 2000 would be 10 percent -- a slightly lower percentage decrease than was experienced in 1998 and 1999 (13 percent in each individual year as shown on the previous page).

New Plan Approvals Will Especially Help Rural Areas. For counties where there were no M+C plans in March of 1999, applications have already been approved that will result in 400,000 additional beneficiaries (living in 87 counties) gaining access to M+C plans for 2000. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. It is also interesting to note that the 400,000 beneficiaries gaining new M+C plans represent only one percent of the total number of beneficiaries; but, the 200,000 rural beneficiaries who will have an M+C plan represent 2.2 percent of rural beneficiaries. For all pending applications from organizations to begin or to expand participation in M+C, 51 percent of the applications are for rural counties. Plans are not simply expanding into high payment areas; only three of the 87 counties being added will have an M+C payment over \$450 in the year 2000 (with 2,200 enrollees in the three counties).¹⁴

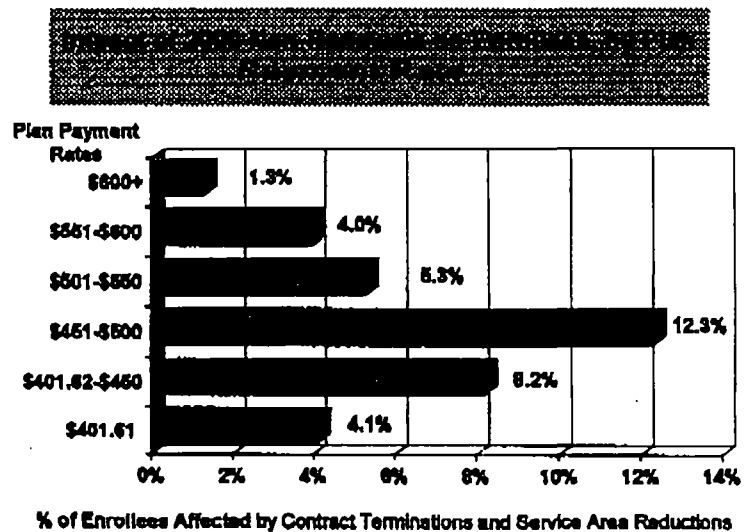
¹³ This does not include the pending application for the private fee-for-service plan.

¹⁴ The average M+C base county payment for 2000 for aged beneficiaries, weighted by county beneficiary populations in all US counties, exclusive of US territories, is \$513 (\$491 in 1999). The simple average of county payment rates for 2000 is \$452 (\$427 in 1999), with the minimum in the US counties (exclusive of territories) set at

Access to M+C Organizations. As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, just as it did in 1999. The percentage of all beneficiaries with access to one or more M+C organizations has declined steadily in recent years --from 72 percent in 1998, to 71 percent in 1999, and to 69 percent for 2000.¹⁵ (Please see Attachment B for a state-by-state analysis of beneficiary access to M+C organizations.)

Access Differences in Rural Areas. Beneficiaries in rural areas will be disproportionately affected by the withdrawal decisions made by M+C organizations for 2000. While access to an M+C plan in urban areas will decline by about 4 percent, access to M+C plans will decline in rural areas by about 10 percent.¹⁶

Medicare Revenue and Its Relation to Non-Renewal Decisions. Contrary to assertions by some industry sources, the level of payments to organizations does not appear to explain the decisions by M+C organizations to withdrawal from --reduce or discontinue participation-- the program. Organizations are primarily withdrawing from counties where payment rates are in a payment mid-range of \$451 and \$500 for the year 2000. If payment were the primary



\$401.61 (\$379.84 in 1999), the maximum \$814 (\$798 in 1999), and the median \$435 (\$401 in 1999).

¹⁵ The year 2000 figure is based on currently approved organizations. The percentage will increase as new applicants enter the program.

¹⁶ Although 83 percent of urban beneficiaries will have access to M+C plans in 2000 (down slightly from 86 percent of urban beneficiaries in 1999), only 21 percent of rural beneficiaries will have access to an M+C plan in 2000 (down from 23 percent in 1999.) The drop from 21 percent to 23 percent represents a 10 percent shift.

factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level (\$401) were affected. Yet, 12 percent of enrollees in counties with payments in the higher range of \$451 to \$500 were affected. Fully, 96 percent of M+C enrollees who are currently in M+C organizations operating in "floor" counties can retain their current M+C plan in the year 2000. Enrollees in counties with the highest payment rates were less likely to be affected by non-renewals. In fact, only 1.3 percent of affected beneficiaries are enrollees in counties where payments are \$600 or higher.

Payment will increase in all counties this coming year by an average of 5 percent.¹⁷ The range of payment increases vary from 2 percent to 18 percent.¹⁸ These increases are the result of the Balanced Budget Act (BBA) reforms designed to bring more plan choices to beneficiaries and level the playing field across geographic areas by increasing payment in counties that had the lowest rates. Yet, counties receiving some of the largest increases under the BBA payment system will experience the most disruption. Organization withdrawals will affect 7.2 percent of enrollees in counties where rates will rise by 10 percent or more, but will affect only 2.4 percent of enrollees in counties where rates will rise by the minimum increase—2 percent.

In addition to M+C payments from HCFA, another source of revenue for M+C organizations is the collection of premiums and other cost sharing from Medicare enrollees. The relation between the availability of a zero premium plan and the level of payment in a given county remains virtually unchanged between 1999 and 2000. If Medicare payments were insufficient for the revenue needs of organizations, one would expect to find zero premium options being limited to the highest payment areas. The data do not show that to be the case.

¹⁷ Calculation based on the average weighted by county Medicare beneficiary populations.

¹⁸ Please note that the 18 percent increase was in an Alaskan county that does not have an M+C option available. The highest percentage payment level increase for a county with an M+C option is 12 percent.

Average HCFA M+C Payment for Counties with at Least One \$0 Premium P						
	1999			2000		
	Urban	Rural	Total	Urban	Rural	Total
Simple Average	\$500.36	\$450.49	\$483.88	\$499.08	\$445.02	\$483.39
Weighted Average	\$539.47	\$455.72	\$534.41	\$535.05	\$449.86	\$531.57

Comparison of Benefits of Dropped Contracts and Counties to the Overall M+C Program.

Organizations withdrawing from M+C are not significantly different than organizations remaining in M+C for the 2000 contract year. There is a similarity between the level of benefits offered, and premiums required, by organizations that are withdrawing from M+C and all organizations that participate in M+C during 1999. Among all M+C enrollees, 84 percent are enrolled in an organization where the basic plan offers some level of drug coverage, and 85 percent are enrolled in an organization offering the individual a zero premium plan. The percentages are similar for enrollees affected by withdrawals; 79 percent are enrolled in an organization where the basic plan offers some level of drug coverage, and a like percentage have access to a zero premium plan (in the two-thirds range.)

Other Factors Affecting Non-Renewal Decisions. In its analysis of the M+C terminations and service area reductions occurring for the 1999 contract year, the General Accounting Office concluded that a variety of factors other than payment rates played a role in organizations' decisions regarding participation in the M+C program. Given that payment cannot be directly correlated with such decisions regarding M+C contracts for the year 2000, it appears that other factors continue to play a large role in determining the level of organizations' participation in M+C. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

Different organizations have made different business decisions regarding their participation in the M+C program. Cigna Corporation has substantially reduced its participation through withdrawals

and service area reductions affecting at least a quarter of all the corporations M+C enrollment. Cigna will have about 125,000 remaining M+C enrollees as a result of these changes. By contrast, there will be a minimal effect among enrollees of the largest M+C contractor, PacifiCare, which has over one million M+C enrollees. Fewer than one percent of PacifiCare's M+C enrollees were affected by terminations or service area reductions. The PacifiCare termination involved a contract that included only one county in Oregon, where PacifiCare had a 24 percent M+C market share, but the county is a floor payment county (\$401.61 payment in 2000). PacifiCare's service area reductions involved counties where the organization had an average market share of 23 percent, including Eastern Washington, where PacifiCare is leaving both Medicare and commercial markets. However, small numbers were involved. The average number of enrollees in the affected counties is under 1,500 (and the average payment level is \$494).

As another illustration, Kaiser is withdrawing from markets in eastern and southern states for both M+C and other lines of business. The organization is terminating the M+C contract of its Capital Area Community Health Plan in upstate New York. A comparison between that contract and Kaiser's M+C contract in Oregon, where the M+C contract will remain in place in 2000, shows that the M+C characteristics are very similar: each has small enrollment, relatively low payment rates, modest benefit packages, and substantial market share (particularly Capital Area), yet Kaiser has chosen to terminate only one of the contracts. Therefore, it seems that other factors have led to a decision not to renew one of the contracts even though the HMOs' revenues and benefit structure are similar in each location.

	Enrollment (mid-1999)	M+C Market Share	1999 Weighted Monthly Average M+C Payment	Weighted Monthly Plan Premium in Service Area	Nature of Drug Benefit Limit
Kaiser of the Northwest	35,000	26%	\$394	\$75	Unlimited, but 70% coinsurance
Capital Area	17,000	73%	\$419	\$25	Annual limit of \$500, \$1000 varying by county

A number of organizations have made reference to their inability to maintain viable networks in their public statements regarding termination decisions. For example, the Group Health Cooperative in Washington State announced that it was discontinuing operations (for all lines of business, Medicare and others) in eleven rural counties in the State—the first time in the 52-year history of the organization that it has taken such an action. The organization's press release cited its inability to maintain a viable provider network as a contributing factor.

In another example, despite a generous payment rate of \$592, Oxford left 9,100 enrollees in Suffolk County, New York because of provider network difficulties.

Parallels of the Medicare+Choice Experience to the Private Sector

Volatility in the marketplace is not confined to Medicare. Program withdrawals, reduced benefits and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels. These challenges facing managed care organizations have been widely reported in the financial and trade press and are related to the business decisions that organizations are making.

There are many examples of health plans withdrawing from markets other than Medicare. As discussed in the earlier section, PacifiCare is withdrawing from both Medicare and commercial markets in several Washington State counties. Also, Group Health Cooperative is pulling out of both Medicare and non-Medicare markets in 14 counties in eastern Washington and northern Idaho, citing a variety of reasons for its decision. And in several north-eastern markets, Kaiser Permanente is withdrawing from Medicare, Medicaid, and its commercial business, affecting about 500,000 enrollees. Kaiser has specifically said that its withdrawal from these markets cannot be attributed to changes in Medicare payments.

Over the last two years, the Federal Employees Health Benefits Program (FEHBP, with 9 million enrollees) has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20 percent of participating HMOs withdrew from the FEHBP program. At the end

of 1999, it is expected that about 13 percent of plans will withdraw from FEHBP. Premiums in FEHBP increased by 7.2 percent for 1998 and slightly over 9.5 percent for 1999. Increases for 2000 will average 9.3 percent.

There also are many examples of health plans raising premiums and reducing benefits in other markets. The California Public Employees Retirement System (CalPERS), which covers over 1 million people, agreed to an average premium increases of 7.3 percent for 1999 and more than 9.7 percent for 2000—the largest premium increase in CalPERS since 1991.

HCFA actuaries are predicting increases of nine percent in private health plan premiums for the year 2000 on average. According to Towers-Perrin, large employers experienced a 7 percent increase in average health insurance premiums for active workers in 1999. One finding in the survey was that rate increases for HMO products in 1999 equaled or exceeded the increases for traditional indemnity plans.

It is essential to note that the large increases now common in the private sector follow several years when private sector increases were quite small—the so-called "underwriting" cycle. In those same years, Medicare increases were two to three times higher than private sector increases, and in fact some financial analysts have pointed out that Medicare revenues subsidized premiums of other payers. Those years of excessive Medicare payment increases greatly contributed to the ability of organizations to provide generous benefit packages. As the cycle continues, plans are finding that they cannot use Medicare revenues to subsidize other lines of business despite statements made by the General Accounting Office and others that M+C pays plans more than adequately for the provision of the Medicare benefits package.

Conclusions

Managed care organizations are now experiencing programmatic and financial challenges. Although public and private markets are structured somewhat differently, managed care's difficulties are producing important changes that affect all their products, including their participation in M+C.

Organizations are increasing premiums for private and public sector purchasers alike. Enrollees (in both private and public products) are finding that many plans are restructuring benefits to increase cost sharing or reduce the level of coverage available (particularly for drug coverage). In M+C, there has been clear movement towards rethinking market strategies--including corporate decisions to exit particular markets; and a movement towards increasing out-of-pocket costs for enrollees and reducing the level of benefits provided. At the same time, the M+C program continues to receive new applications that will increase access to managed care for beneficiaries, especially in lower paid areas.

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METHODOLOGICAL NOTE

Definitions

- **Plans and Organizations** – In a context other than Medicare+Choice (M+C), the term *plan* (or *health plan*) is generally understood to mean a health benefit offering of a particular insurance company or health maintenance organization (HMO.) In Medicare, the term has a special meaning as a result of provisions of the Balanced Budget Act of 1997 (BBA). Prior to the BBA changes, a Medicare-contracting HMO was commonly referred to as a “plan,” and the plan could offer a variety of benefit packages—for example, one plan could offer several optional supplemental benefit packages available to Medicare enrollees for an additional premium; or a plan could vary its Medicare benefit offerings in different counties, under certain circumstances. The BBA changes give a specific meaning to the term *plan* that is different from prior usage of the term. Under the BBA, the various offerings of a contracting HMO or other organization are referred to as “plans.” The “plans” may vary by the level of benefits provided (“plans” that offer extra benefits for enrollees choosing to pay an additional premium); or they may vary by the structure of the “plan” (one organization may offer a “plan” structured as a PPO under its M+C contract while, at the same time, offering, in the same service area, a “plan” structured as a closed-panel HMO). The term *plan*, under the BBA, continues to include what were referred to in pre-BBA terminology as “high option” plans or supplemental offerings available for an additional premium (please see below for a definition of optional supplemental coverage.)

Under the BBA provisions, “plans” offered by an *organization* may have different service areas under a single contract. However, each “plan” offered by a contracting organization must have a uniform benefit and premium structure throughout the approved service area of the “plan”; that is, once a “plan” is offered in multiple counties under one contract, all residents of all the counties where the “plan” is offered must receive the same level of benefits if they choose that plan. Another way in which an M+C organization may offer more than one plan under one contract is through “segmented service areas.” The segmented service area provision is the successor to the pre-BBA “flexible benefits” policy under which an

organization could vary premiums and benefits under one contract on a county-by-county basis. The segmented service area policy allows organizations to essentially set up multiple service areas under a single contract in such a way that each sub-service area has a different “plan” (enabling the organization to comply with the BBA requirement of uniform premiums and benefits within a service area—a requirement that applies at the plan level, not at the organization level).

- **Zero Premium** -- If there is not a monthly charge beyond the regular Part B Medicare premium to enroll in a risk/M+C organization, then the organization is said to have a “zero premium.” All M+C enrollees must continue to pay their Part B premium (or have it paid on their behalf). Organizations that charge the beneficiary a monthly amount in addition to the Part B premium to enroll are not considered zero premium organizations.
- **Beneficiaries and Enrollees** -- For reasons described in the Methodology Section of this Note, beneficiary and enrollee are used in specific ways for purposes of this paper. “Beneficiary” is used to refer to all Medicare beneficiaries—those both enrolled in original fee-for-service Medicare and those enrolled in M+C. “Enrollee” is used to refer to those persons actually participating in a managed care plan --whether that plan is part of M+C or a private program.

Methodology

The analyses in this paper present data from a variety of sources. Data are arrayed and presented along different dimensions, but generally fall into one of three categories:

- Plan-level data,
- Population-level data, based on the level of the total Medicare beneficiary population in a county, a state, a sub-area (e.g., rural areas), or in the nation as a whole, and
- Enrollment-level data, based on enrollment in M+C organizations in 1999.

Plan-Level Data. BBA policy changes related to the designation of “plans” applied to M+C contracts for 1999. In 1999, although there are about 300 contracting organizations, 622 “plans” are offered to beneficiaries by M+C contractors. In the year 2000, although there will be about 260 contractors, they will offer 793 different plans to beneficiaries. These 793 plans include both the “high option” supplements available for an additional premium, as well as “plans” that represent inter-county variation in premiums and benefits. The growth in segmented service areas has contributed to the growth in the number of plans.

The plan-level analyses in the paper are analyses across all “plans” under the BBA definition of the term. For example, in the data, an average premium among all plans would be computed across all 793 plans in 2000, or across all 622 plans in 1999. Because the set of “plans” includes optional supplemental packages, and HCFA does not collect data on the number of M+C enrollees who elect optional supplements offered by their M+C organization, the plan-level analysis only provides a rough indicator of what is happening at the beneficiary level. However, the plan-level analysis can provide an indication of the general trends and changes from year to year in plan offerings that beneficiaries will see. In addition, the plan level analysis does not account for the fact that each plan contains a different number of enrollees. By failing to appropriately weight the policies of a given plan by the number of enrollees in that plan, this type of analysis may not provide an accurate picture of how the enrollee population is affected by a given policy.

Population-Level Data. Another way in which data are presented in this paper is at the level of the overall Medicare beneficiary population. Plan benefits and premiums are analyzed in terms of the number of Medicare beneficiaries residing in the counties in which the M+C organizations are offering their plans. That is, the data provide a means of showing what beneficiaries across the Nation—including beneficiaries enrolled currently in an M+C plan, as well as those not enrolled currently—can expect in the way of benefit offerings from M+C organizations operating in the counties where they live. Overall access figures (e.g., data on whether or not any M+C plan is available to beneficiaries) are also presented using beneficiary population numbers that include both beneficiaries enrolled in M+C plans and non-enrollees. The population-level data in almost cases are

combined with plan-level data. For example, a statement to the effect that a certain number of beneficiaries will have access to plans in which the average premium level is a certain dollar figure includes an averaging across all "plans." For 2000, the analysis assumes the beneficiary population by county as February 1, 1999.

Enrollment-Level Data. Until beneficiaries decide, for the year 2000, whether to continue their M+C enrollment, change to another M+C organization, or newly enroll into or disenroll from an M+C organization, enrollment levels for 2000 will not be known. However, in order to provide more information about what kinds of changes in their premiums and benefit packages beneficiaries may see in the year 2000, this paper provides an analysis of the differences between 1999 and the year 2000 in *basic benefit packages* offered by M+C organizations that were operating in February of 1999 and will continue to operate in the year 2000. To offer an indication of the possible impact of benefit changes on the current M+C enrolled population, the analysis uses the actual distribution of enrollment in 1999 to assign enrollment numbers to organizations for the year 2000 for purposes of analyzing the data on benefits and premiums and to examine how beneficiaries may be affected by changes made by the organizations in which they are currently enrolled. That is, the analysis presents the changes in the M+C program using the assumption that (a) enrollment levels will remain the same, and (b) different organizations will have the same proportion of M+C enrollment, as a share of overall M+C enrollment, that they had in 1999.

An element of the enrollment-level analysis is the identification of a basic benefit package (or basic "plan") in 1999 and 2000 to establish the minimum level of benefits available to an M+C enrollee in a particular organization. The basic package is also used as the unit of analysis because, as noted above, HCFA does not have enrollment information regarding optional supplemental packages.¹⁹ The basic package is identified at the county level to account for segmented service areas (which would have different benefit packages). It is generally assumed that a plan that has a zero premium is the

¹⁹ Beneficiaries enrolled in M+C plans as employer-sponsored retirees may have additional benefits beyond those offered to individual Medicare beneficiaries; however, HCFA does not collect data on the nature of such benefits.

basic package. Where two plans in the same county offered by the same organization have a zero premium, the plan with the more generous benefit package is assumed to be the basic plan (particularly if one plan provides some level of drug coverage and another zero premium plan offered in the same county by the same organization does not). Co-existing zero premium plans may be offered by one organization in the same county for a number of reasons. One of the organization's zero premium plans may have extra benefits covered because the competing zero premium plan is a point-of-service option allowing greater use of non-network providers. In certain states, organizations may also offer zero premium plans that do not include drug coverage (but have, for example, lower copayments for physician visits) along with a zero premium plan that does cover drugs. This is done in order to offer a "plan" that is attractive to Medicare beneficiaries who obtain their drug coverage from sources such as state pharmacy assistance programs. In such a case, the analysis treats the plan with a zero premium *and* drug coverage as the "basic package" offered to any Medicare beneficiary residing in the county where the organization offers various plans. Where multiple options are offered by the same organization and all require the payment of a premium (beyond Medicare's Part B premium), the lowest-cost plan is assumed to be the basic plan.

The enrollment-level data therefore:

- Impute enrollment levels for 2000, based on a methodology that assumes, essentially, that enrollment levels, and the enrollment distribution among plans, remain static between 1999 and 2000;
- Refer only to what the analysis treats as a "basic benefit" in each county for each organization (i.e., one "plan" is chosen to be the basic benefit package for each organization operating in a county); and
- Present data aggregated at the imputed enrollment level. For example, an enrollment-weighted premium for this group would be the actual average premium across all unique basic plans in 1999. The imputed year 2000 average enrollment-weighted premium for the unique basic plan average across the 1999 enrollees of the organizations in the individual counties that the organization continues to include in its service area.

ATTACHMENT A

Changes in Access to Any Drug Coverage for Beneficiaries with Access to at Least One M+C Plan 1999-2000 <i>Negative change indicates drop in coverage.</i>			
State	1999	2000	Change
AK	100%	100%	0%
AL	0%	0%	0%
AR	37%	0%	-37%
AZ	100%	100%	0%
CA	99%	98%	-1%
CO	100%	100%	0%
CT	100%	100%	0%
DC	100%	100%	0%
DE	100%	58%	-42%
FL	97%	98%	0%
GA	100%	100%	0%
HI	0%	100%	100%
IA	100%	0%	-100%
ID	100%	100%	0%
IL	92%	92%	0%
IN	100%	100%	0%
KS	100%	100%	0%
KY	100%	100%	0%
LA	93%	84%	-10%
MA	100%	100%	0%
MD	100%	100%	0%
ME	100%	100%	0%
MI	89%	100%	11%
MN	100%	100%	0%
MO	100%	100%	0%
MS	100%	100%	0%
MT	100%	100%	0%
NC	72%	18%	-55%
ND	0%	0%	0%
NE	100%	0%	-100%
NH	72%	100%	28%
NJ	100%	100%	0%
NM	100%	80%	-20%
NV	100%	100%	0%
NY	88%	88%	-1%
OH	88%	96%	-2%

Changes in Access to Any Drug Coverage for Beneficiaries with Access to at Least One M+C Plan 1999-2000 <i>Negative change indicates drop in coverage.</i>			
State	1999	2000	Change
OK	100%	100%	0%
OR	65%	66%	1%
PA	97%	93%	-4%
RI	100%	100%	0%
SC	0%	0%	0%
SD	0%	0%	0%
TN	81%	82%	1%
TX	96%	95%	0%
UT	0%	0%	0%
VA	63%	100%	37%
VT	0%	0%	0%
WA	10%	88%	78%
WI	100%	100%	0%
WV	62%	0%	-62%
WY	0%	0%	0%

ATTACHMENT B

Beneficiaries with Access to M+C Plan, Percent Changes 1999 to 2000 <i>Negative change indicates drop in coverage.</i>			
State	1999	2000	Change
AK	0.0%	0.0%	0.0%
AL	28.6%	28.6%	0.0%
AR	31.0%	31.1%	0.1%
AZ	100.0%	94.3%	-5.7%
CA	95.1%	95.0%	-0.1%
CO	81.2%	81.7%	0.4%
CT	100.0%	97.1%	-2.9%
DC	100.0%	100.0%	0.0%
DE	58.0%	100.6%	42.6%
FL	84.1%	82.6%	-1.5%
GA	38.8%	34.8%	-1.8%
HI	95.0%	100.5%	5.5%
IA	2.9%	2.9%	0.0%
ID	28.4%	28.6%	0.2%
IL	68.5%	68.5%	0.0%
IN	34.6%	34.7%	0.1%
KS	35.2%	35.3%	0.1%
KY	25.8%	25.8%	0.0%
LA	87.1%	59.6%	-27.5%
MA	98.9%	97.1%	0.2%
MD	100.0%	82.0%	-18.0%
ME	62.8%	63.1%	0.3%
MI	62.6%	62.7%	0.1%
MN	48.4%	48.6%	0.2%
MO	58.5%	58.6%	0.2%
MS	0.0%	0.0%	0.0%
MT	0.0%	0.0%	0.0%
NC	48.8%	47.0%	0.2%
ND	0.0%	0.0%	0.0%
NE	26.0%	23.4%	-2.7%
NH	64.5%	46.7%	-17.8%
NJ	100.0%	100.2%	0.2%
NM	65.5%	65.9%	0.4%
NV	88.7%	89.6%	0.9%
NY	91.0%	90.6%	-0.4%
OH	84.9%	87.0%	2.1%

Beneficiaries with Access to an M+C Plan, Percent Changes 1999 to 2000 <i>Negative change indicates drop in coverage.</i>			
State	1999	2000	Change
OK	80.7%	77.4%	-3.3%
OR	81.6%	81.1%	-0.4%
PA	86.2%	86.3%	0.1%
RI	100.0%	100.1%	0.1%
SC	11.6%	0.0%	-11.6%
SD	0.0%	0.0%	0.0%
TN	73.5%	60.1%	-13.3%
TX	73.3%	71.5%	-1.8%
UT	0.0%	0.0%	0.0%
VA	53.1%	33.5%	-19.6%
VT	0.0%	0.0%	0.0%
WA	84.7%	82.6%	-2.1%
WI	42.8%	50.6%	7.8%
WV	36.2%	20.5%	-15.7%
WY	0.0%	0.0%	0.0%

MEDICARE+CHOICE: POLICY CONCERNS, IMPLICATIONS, AND PRESCRIPTION FOR CHANGE

Medicare+Choice: An Important Part of Medicare. Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. The Medicare+Choice (M+C) program continues to grow despite challenges that parallel those in the larger managed care market in the United States. As of August 1999, there were 6.3 million M+C enrollees representing about 16 percent of the more than 39 million seniors and disabled Americans in Medicare. Total Medicare managed care enrollment has more than doubled in the past four years from 3.1 million enrollees at the end of 1995 to 6.3 million enrollees today. Although the enrollment growth rate has been lower in 1999 than in previous years, growth in M+C still exceeds the rate of growth in the number of beneficiaries entering the Medicare program.

General Changes in Managed Care Affect M+C. Managed care organizations are now experiencing programmatic and financial challenges. Although public and private markets are structured somewhat differently, these challenges are influencing plan decisions and are affecting all their products, including those offered to Medicare beneficiaries.

In the early to mid 1990s, health plans successfully controlled health care costs, and, accordingly were attractive to private and public purchasers, including Medicare and its beneficiaries. Managed care organizations experienced substantial growth in enrollment across multiple product lines. For the most part, their profitability increased even as annual premium increases in the private sector were reduced. This environment made market entry attractive for new organizations and encouraged the existing organizations to attract ever larger numbers of enrollees.

As the decade progressed, however, health plans experienced a downturn in the market. Because of fierce competition for enrollees, private sector premiums flattened. At the same time, health plans began to experience new inflationary pressures on their health care costs. As a result, profits began to decline. Indeed, by 1996, only 35 percent of publicly traded health maintenance organizations (HMOs) were profitable. By the latter part of the decade, health plans began to experience additional problems on a number of fronts. Their health care costs, particularly for prescription drugs, started rising well beyond recent levels; plans began to experience difficulties maintaining provider networks as hospitals, physicians, and other service providers started to successfully resist additional reductions in the payment rates from plans. The strategy of some HMOs to pass on financial risk to providers in the form of capitation payments has proved problematic because many "at-risk" providers have proved incapable of successfully managing the risk they had assumed.

In an attempt to respond to these and other strategic and operational problems, managed care organizations are increasing premiums for private and public sector purchasers alike. For example,

in calendar years 1998-2000, health plans have increased premiums charged in the Federal Employees Health Benefit Program an average of about 9 percent. In addition, enrollees are finding that many plans are also restructuring benefits to increase cost sharing and to reduce the levels of coverage, particularly for prescription drugs.

Changes in Medicare+Choice in the Year 2000. The report released today by the Health Care Financing Administration (HCFA) highlights emerging trends in M+C, based on proposed premium and benefit structures as reported by M+C organizations for the year 2000. The trends generally fall within three broad categories: (1) reductions in benefits; (2) premium increases; and, (3) plan withdrawals.

- *Managed Care Reductions in Extra Benefits.* In general, plans will restructure benefits in ways that increase enrollee out-of-pocket costs and limit coverage, particularly in relation to prescription drugs. In 2000, 86 percent of plans will have annual dollar caps on brand and/or generic drugs. The annual caps are becoming more restrictive: while in 1999 only 21 percent of plans had a per enrollee limit of \$500 or less; in 2000, 32 percent of plans will have a \$500 cap on either brand or generic drugs.

There will be increased use of copays for prescription drugs. In fact, for the first time, all M+C organizations will charge copays for prescription drugs. In 1999, over one million beneficiaries live in areas with zero copayments for generic and brand name drugs. In 2000, all beneficiaries will live in areas with copays on both types of drugs. On an enrollment-weighted basis that assumes M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees, average copays for brand-name drugs would increase by 21 percent, with average copayments for generic drugs increasing by 8 percent.¹

- *Premium Increases for Extra Benefits.* Preliminary data indicate a decline of about 3 million beneficiaries who live in areas with access to a plan that does not charge a premium for enrollment. Though a relatively small number of beneficiaries are involved, there will be a significant increase in the number of beneficiaries who will have to pay over \$80 per month to enroll in an M+C plan. In 1999, only 50,000 Medicare beneficiaries live in an area where the minimum premium is above \$80 for 1999; but in 2000, the number will rise to 207,000.
- *M+C Withdrawals Reduce Access.* Over the past two years, a small percentage of beneficiaries have been affected by M+C withdrawals. In 1999, 407,000 enrollees (6.5 percent of M+C enrollees at the time in 1998) were affected, with approximately 51,000 (less than one percent of the total) being left without the option of enrolling in another M+C plan. Approximately half

¹ As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur.

of beneficiaries affected by the withdrawals who still had an M+C option chose original fee-for-service Medicare and the other half chose to enroll in another M+C organization.

For 2000, there were 327,000 enrollees affected (5 percent of M+C enrollees) and 79,000 (1.3 percent of enrollees) left with no M+C option. These beneficiaries were enrolled in 99 separate organizations that either withdrew entirely from the program or reduced their service area.

Some of the effects of the withdrawals will be offset as new organizations enter the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program. As of August 1999, there were 13 pending applications from organizations seeking new M+C contracts, and nine requests for service area expansions. Over 50 percent of the counties included in these pending applications currently have no M+C plans. If approved, these applications would bring M+C access to an additional 1.5 percent of total Medicare beneficiaries.

Withdrawals of organizations from M+C are not primarily occurring in the lowest payment areas. Only 4 percent of enrollees in counties with the minimum payment level (\$401) were affected. Yet, 12 percent of enrollees in counties with payments in the higher range of \$451 to \$500 were affected. Similarly, withdrawals do not appear to be correlated with low payment growth rates. Plan withdrawals will affect 7.2 percent of enrollees in counties where M+C payment rates are rising by 10 percent or more, but only affect 2.4 percent of enrollees where rates are rising by the 2 percent minimum.

These facts suggest that the General Accounting Office findings about withdrawals for the 1999 contract year still holds true: causes other than payment rates appear to play a large role in business decisions to participate in M+C in 2000. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

Changes in Medicare+Choice Vary by State. Changes in access to M+C and changes in the coverage and premiums for the year 2000 vary significantly by state and between urban and rural areas. In some areas, there was little change in benefits or premiums. However, in other areas, there were significant changes.

- *Access to Extra Benefits:* In 2000, several states will have a substantial decrease in the number of beneficiaries with access to at least one M+C plan who have access to a drug benefit. These states include Iowa, North Carolina, and Delaware. At the same time, a few states will have increased availability of drugs as part of the basic package in 2000, including Virginia, New Hampshire, and Washington State.
- *Premium Increase for Additional Benefits:* In some cases, the availability of a basic drug benefit will come at the cost of a significant premium increase. For example, in Washington State the

population-weighted monthly average plan premium will rise from \$28 to \$48. New Hampshire's beneficiaries will experience a similar increase, from \$11 to \$40 per month.

- **Withdrawals and Access to M+C Plans:** A total of 19 states experienced a change in the level of access to M+C affecting more than one percent of that states beneficiary population. The number of beneficiaries with access to at least one M+C plan has dropped by more than 10 percent in several states, including Louisiana, Virginia, New Hampshire, Maryland, and Tennessee. Conversely, for four states experienced an increase availability of M+C options for beneficiaries --Ohio, Hawaii, Wisconsin, and Delaware.

Access to Medicare+Choice and Extra Benefits in Rural America. Partly because of the challenges in setting up provider networks, there has never been widespread access to Medicare managed care in rural areas. Although the Balanced Budget Act of 1997 provided for significant payment increases in rural counties, access to managed care in rural areas will decline in 2000.

In addition, there are significant disparities between urban and rural M+C plans in the extra benefits provided and their costs. Drug coverage is less common in rural areas than urban areas for M+C enrollees: of the beneficiaries who have access to a plan, only 23 in rural areas percent have access to a plan that offers drug coverage. The corresponding percentage for urban beneficiaries is to 86 percent. Only 4 percent of beneficiaries in rural areas will have access to prescription drug coverage through an M+C plan in 2000.

There are new M+C applicants entering rural areas: about 200,000 additional beneficiaries, or 2.2 percent of the total number of rural beneficiaries, have already gained access to an M+C through contracts already approved this year. These new plans will offset the effect of the M+C organization withdrawals for the 2000 contract year that had affected approximately 160,000 beneficiaries in rural areas.

Implications of the Medicare+Choice Report. As in 1998, the current changes in M+C parallel the changes occurring in the private sector. Increasing numbers of organizations are exiting markets, rethinking corporate strategies, and modifying benefit offerings. Volatility in the marketplace is not confined to Medicare. There are many examples of health plans withdrawing from markets other than Medicare. PacifiCare is withdrawing both Medicare and commercial service in several Washington state counties. Over the last two years, the Federal Employees Health Benefits Program (FEHBP), which covers 9 million people, has seen the same kinds of changes that the M+C program has experienced. For example, premiums in FEHBP increased by 7.2 percent for 1998, slightly over 9.5 percent for 1999, and 9.3 percent for 2000. Furthermore, at the end of 1999, about 13 percent of plans are expected to withdraw from FEHBP. And, in 1999, about 20 percent of managed care plans withdrew from FEHBP.

While volatility is inherent in competitive systems, it has serious consequences for Medicare beneficiaries who choose managed care. Private plans' use of supplemental benefits to attract beneficiaries has led to an expectation that plans will continue to offer prescription drug coverage,

reduced cost sharing and other extra benefits that by law cannot be covered by fee-for-service Medicare. In fact, these services are often essential to beneficiaries' health and otherwise unaffordable. However, there is neither a Medicare requirement to offer extra benefits—specifically prescription drugs—nor explicit payment to managed care to cover them. As a result, private plans' business decisions to alter these benefits in the face of cost pressures take on greater meaning since beneficiaries are not now guaranteed alternatives in traditional Medicare or Medigap.

Organizing and maintaining managed care networks in rural areas is a challenge both in Medicare and the private sector. Although these issues probably cannot be avoided, the consequences are more severe for Medicare beneficiaries. Overall, half of Medicare beneficiaries living in rural areas have no prescription drug insurance coverage, compared to about one-third nationwide. The limited access to managed care contributes to this, although even those plans that do operate in rural areas rarely offer prescription benefits at all. As such, rural beneficiaries who pay the same Part B premium for Medicare do not have the same choices and the same options for extra benefits as do most urban beneficiaries.

There is some evidence that the decisions that organizations have made to discontinue their participation in the M+C program may have influenced beneficiaries' perceptions of whether to choose the M+C option. Among beneficiaries affected by contract terminations or service area reductions in 1998, half of those who could have chosen another managed care plan instead chose to return to the original fee-for-service Medicare program, presumably because of the uncertainty that M+C plans will continue to be there in specific locations or that provider networks will be stable. These perceptions may also be contributing to the slower recent enrollment growth in M+C.

President's Plan will Improve Medicare+Choice. Volatility in the M+C market underscores the importance of enacting the President's Medicare reform plan. It would ensure that plans receive full payment of market-based rates; guarantee that all beneficiaries have access to affordable prescription drug coverage whether or not they live in areas where M+C plans have chosen to provide care; and increase protections for beneficiaries when plans withdraw from the program.

The President's plan would modernize the way Medicare pays managed care plans. Rates would be set through competition among plans rather than through a complicated statutory formula, as they are today. All plans would be paid their full price through a combination of government and beneficiary payments. The lower the price, the less beneficiaries will pay since the beneficiary contribution rate declines relative to the price of the plan, as in the Federal Employees' Health Benefits Program. Beneficiaries choosing plans that cost as low as approximately 80 percent of traditional fee-for-service will pay no Part B premium. This more rational system replaces the complicated, statutory payment system and should provide more appropriate payments to plans.

The President's plan also ends the current inequity of subsidizing prescription drug coverage only through managed care. It would add to the basic Medicare benefit package an affordable, voluntary prescription drug benefit for all beneficiaries. The President's Medicare reform proposal gives all beneficiaries the option to pay a modest premium for a benefit that covers half of all prescription costs

up to \$5,000 annually when fully phased-in by 2008, with no deductible and for less than half the premiums of the average Medigap policy with drug benefits. The plan would explicitly pay managed care plans for offering prescription drugs to enrollees, easing the current constraints that they have in covering this basic service. The plan also eliminates preventive services cost sharing in Medicare.

Market volatility also makes clear that stronger protections are needed for beneficiaries affected by health plan corporate business decisions. The President's proposal will give enrollees in departing plans access to all Medigap policies, including those with drug coverage, regardless of health status; expand Medigap open enrollment to newly disabled beneficiaries and those with end stage renal disease, and allow those with end stage renal disease to enroll in another M+C plan; mandate a special Medigap open enrollment period for beneficiaries affected by a plan termination in January 1999; and increase penalties for violation of the Medigap open enrollment requirements. These provisions contribute to making M+C more stable and benefits more accessible—keys to continuing and expanding the important role of private plans in Medicare in the future.

Finally, the President's plan also dedicates 15 percent over \$300 billion of the on-budget surplus to Medicare for the next 15 years. This will assure the financial health of the Medicare Trust Fund through at least 2027, and help ensure that M+C plan payment rates will be adequate well into the future.

MEDICARE+CHOICE: CHANGES FOR THE YEAR 2000

EXECUTIVE SUMMARY

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and —most importantly— Medicare beneficiaries and their advocates to understand how M+C is evolving.

BENEFICIARY ENROLLMENT AND MANAGED CARE ORGANIZATION PARTICIPATION

- *Beneficiary Enrollment* — Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. Approximately 33 million beneficiaries are in traditional fee-for-service Medicare.
- *Plan Participation* — Plan participation has been somewhat volatile over time. In fact, the highest rate of increase in participating organizations (almost 40 percent) since 1986 occurred in 1994. The largest rate of decrease occurred in 1990 (almost 30 percent.) In both 1999 and again in 2000, approximately 13 percent of the contracts were not renewed.

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN EXTRA BENEFITS OFFERED

Although beneficiary access to prescription drugs and other non-Medicare benefits offered by M+C plans will remain relatively constant, many plans will restructure drug benefits in ways that increase enrollee out-of-pocket costs and limit drug coverage.

- *Drug Caps* — In 2000, 86 percent of plans will have annual dollar limits (caps) on brand and/or generic drugs. The annual caps are becoming more restrictive. In 1999, only 21 percent of plans had a cap on drugs of \$500 or less; in 2000, 32 percent of plans will have a \$500 per enrollee benefit spending cap on either brand or generic drugs. Although enrollees will be more likely to have access to unlimited generic drug coverage, they will also be more likely to have even tighter caps imposed on brand-name drugs.
- *Copayments* -- There will be increased use of copays for prescription drugs. In fact, for the first time, all M+C organizations will charge copays for prescription drugs. In 1999, over one million beneficiaries live in areas with zero copayments for generic and brand name drugs. In 2000, all beneficiaries will live in areas with copays on both types of drugs. On an enrollment-weighted basis that assumes M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same

proportion of enrollees, average copays for brand-name drugs would increase by 21 percent, with average copayments for generic drugs increasing by 8 percent.¹

- *Access to Extra Benefits Varies by State* — Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year. However, there will be state variation. Several states will have a substantial decrease in the number of beneficiaries with access to at least one M+C plan who have access to a drug benefit. These states include Iowa, North Carolina, and Delaware. At the same time, a few states will have increased availability of drugs in 2000, including Virginia, New Hampshire, and Washington

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN PREMIUMS

- *Increase in Premiums* -- For the M+C program overall, there will be an increase in the level of monthly premiums. For example, in 1999 on an enrollment-weighted basis, the average monthly premium for basic plans was \$5.35. For 2000, this amount would almost triple to \$15.84. Moreover, in 2000, the number of beneficiaries for whom the lowest available premium will be in the \$20 to \$60 range will increase by approximately 50 percent over 1999. Of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over \$80, 94 percent (over 195,000) live in areas with only one plan available.
- *Decline in Plans with Extra Benefits for No Premium* -- In 2000, there will be a decline of about 3 million in the *number* of Medicare beneficiaries with access to a plan that does not charge for a premium for enrollment. This represents a slight decrease in the *percentage* of beneficiaries with access to any plan that does not charge a premium, from 85 percent in 1999 to 77 percent in 2000.

MEDICARE+CHOICE IN THE YEAR 2000 -- WITHDRAWALS AT THE END OF 1999

- *Plans Withdrawing From the Program* — Over the past two years, a small percentage of beneficiaries have been affected by M+C withdrawals. In 1999, 407,000 enrollees (6.5 percent of M+C enrollees at the time in 1998) were affected, with approximately 51,000 (less than one percent of enrollees) being left without the option of enrolling in another M+C plan. Approximately half of beneficiaries affected by the withdrawals who still had an M+C option chose original fee-for-service Medicare and the other half chose to enroll in another organization.

¹ As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur.

For 2000, there were 327,000 enrollees affected (5 percent of M+C enrollees) and 79,000 (1.3 percent of enrollees) left with no M+C option. These beneficiaries were enrolled in 99 separate organizations that either withdrew entirely from the program or reduced their service area.

- *New Plan Approvals Will Help Improve Access* – Despite volatility in the overall managed care marketplace, new organizations continue to come into the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program affecting 400,000 beneficiaries in 87 counties. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. As of August 1999, there are 13 pending applications from organizations seeking new M+C contracts and nine requests for service areas expansions. Over 50 percent of the counties included in these pending applications currently have no M+C plans.
- *Access to Plans Reduced Slightly* – As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, as it did in 1999. The trend of the decline in beneficiaries who had access to one or more M+C organizations has been slightly negative --in 1998, 72 percent of had such access; in 1999, the percentage declined to 71 percent; and for 2000 the percentage declined to 69 percent.²
- *Revenue and the Relation to Non-Renewal Decisions* -- Withdrawals of organizations from M+C are not primarily occurring in the lowest payment areas. They are disproportionately withdrawing from counties where payment rates are in a payment mid-range of \$451 and \$500 for the year 2000. If payment were the primary factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level (\$401) were affected. Yet, 12 percent of enrollees in counties with payments in the higher range of \$451 to \$500 were affected. Similarly, withdrawals do not appear to be correlated with low payment growth rates. Plan withdrawals will affect 7.2 percent of enrollees in counties where M+C payment rates are rising by 10 percent or more, but only affect 2.4 percent of enrollees where rates are rising by the 2 percent minimum.

MEDICARE+CHOICE IN THE YEAR 2000 – PARALLELS TO PRIVATE SECTOR

- *The M+C Experience Corresponds to the Private Sector Experience* – Program withdrawals, reduced benefits, and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels.

² The year 2000 figure is based on currently approved plans. The percentage will increase as new plan applicants enter the program.

- *Factors Other than Payment Leading to Non-Renewal Decisions* -- Overall, the facts suggest that the General Accounting Office's findings about withdrawals for the 1999 contract year still hold true: causes other than payment rates appear to play a large role in business decisions to participate in M+C in 2000. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

To: Jeanne Lambrew, 456-5557
Fr: Peter Harbage

→ Fax 1 of 2

Per your request. I did

try to limit the # of charts,
there are a lot of charts +

I don't think they are relevant.

We continue to double check the #'s

+ do more analysis. Some of this you may
have seen before.

P/S. Let me know as soon as you
can what you will ~~you~~ want state-by-
state beyond what is here.

Thx
Pete

Medicare Choice
Premium and Benefit Analyses, By # of Medicare Eligibles (All)

	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		PERCENTAGE CHANGE
1) M+C Plan Premiums													
(Average Premium Range)													
\$0	3,855,164	15%	365,824	17%	4,220,988	15%	1,781,725	7%	232,194	12%	2,013,919	7%	-8%
\$0.01 - \$19.99	14,491,477	57%	586,159	28%	15,077,636	54%	6,610,159	27%	266,383	14%	6,876,542	26%	-29%
\$20.00 - \$39.99	4,998,372	20%	586,657	28%	5,585,029	20%	7,841,536	31%	456,881	24%	8,298,417	31%	11%
\$40.00 - \$59.99	1,375,156	5%	334,047	16%	1,709,203	6%	4,363,633	18%	394,506	20%	4,758,139	18%	12%
\$60.00 - \$79.99	567,109	2%	194,663	9%	761,772	3%	2,312,236	9%	368,354	19%	2,680,590	10%	7%
\$80.00 - \$99.99	0	0%	39,742	2%	39,742	0%	1,417,499	6%	203,160	10%	1,620,659	6%	6%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	603,775	2%	19,962	1%	623,737	2%	1%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	
2) M+C Plan Premiums													
(Minimum Premium Range)													
\$0	20,341,768	79%	1,331,493	63%	21,673,261	78%	19,422,463	78%	784,702	40%	20,207,165	75%	-3%
\$0.01 - \$19.99	377,001	1%	46,752	2%	423,753	2%	836,321	3%	213,475	11%	1,049,796	4%	2%
\$20.00 - \$39.99	1,192,150	5%	296,954	14%	1,489,104	5%	2,122,571	9%	352,954	18%	2,475,525	9%	4%
\$40.00 - \$59.99	1,071,638	4%	224,769	11%	1,296,407	5%	1,377,563	6%	333,463	17%	1,711,026	6%	2%
\$60.00 - \$79.99	338,448	1%	160,647	8%	499,095	2%	364,369	1%	133,437	7%	497,806	2%	0%
\$80.00 - \$99.99	3,393	0%	46,733	2%	50,126	0%	83,156	0%	123,409	6%	206,565	1%	1%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Not available	2,271,697	9%	11,355	1%	2,283,252	8%	724,120	3%	0	0%	724,120	3%	-6%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	
3) M+C Plan Premiums (plans w/ Rx)													
\$0	3,409,485	14%	295,266	18%	3,704,751	14%	1,363,961	6%	206,778	14%	1,570,739	6%	-8%
\$0.01 - \$19.99	14,391,871	60%	545,303	32%	14,937,174	58%	6,563,141	28%	204,096	14%	6,767,237	27%	-31%
\$20.00 - \$39.99	4,669,979	20%	455,926	27%	5,125,905	20%	7,386,503	32%	363,731	25%	7,750,234	31%	11%
\$40.00 - \$59.99	792,055	3%	233,783	14%	1,025,838	4%	3,726,218	16%	177,569	12%	3,903,787	16%	12%
\$60.00 - \$79.99	347,421	1%	122,525	7%	469,946	2%	2,233,458	10%	318,855	22%	2,552,313	10%	9%
\$80.00 - \$99.99	0	0%	19,174	1%	19,174	0%	1,397,924	6%	148,379	10%	1,546,303	6%	6%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	529,049	2%	15,342	1%	544,391	2%	1%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Missing	0	0%	0	0%	0	0%	0	0%	25,561	2%	25,561	0%	0%
	23,919,828	100%	1,683,588	100%		100%	23,200,254	100%	1,460,311	100%		100%	
4) M+C Plan Rx Annual Limits													
(Avg. Maximum Range)													
\$0 - \$500	2,189,979	9%	396,007	24%	2,585,986	10%	1,576,383	7%	318,388	22%	1,894,771	8%	-2%
\$501 - \$799	6,813,371	28%	331,004	20%	7,144,375	28%	2,432,937	10%	438,739	30%	2,871,676	12%	-16%
\$800 - \$999	4,553,891	19%	40,350	2%	4,594,241	18%	5,657,587	24%	194,280	13%	5,851,867	24%	6%
\$1,000	712,150	3%	286,437	17%	998,587	4%	671,224	3%	147,885	10%	819,109	3%	-1%
\$1001 - \$2000	5,091,696	21%	188,815	11%	5,280,511	21%	7,562,155	33%	346,995	24%	7,909,150	32%	11%
\$2001 - \$2500	0	0%	14,066	1%	14,066	0%	507,738	2%	2,889	0%	510,627	2%	2%
\$2500 +	0	0%	0	0%	0	0%	514,660	2%	11,135	1%	525,795	2%	2%
Missing	4,558,741	19%	426,909	25%	4,985,650	19%	4,277,570	18%	0	0%	4,277,570	17%	
	23,919,828	100%	1,683,588	100%		100%	23,200,254	100%	1,460,311	100%		100%	

show
No
if enrolled in 1999
with drugs
in basic
at
of premium

how does unlimited
american fit here?

Medicare Choice Premium and Benefit Analyses, By # of Medicare Eligibles (All)

A) Rx Copayments (per script) (Average By County)

Generic

Copayments

\$0	1,209,300	5%	34,631	2%	1,243,931	5%	0	0%	0	0%	0	0%	-5%
\$0.01-\$4.99	3,458,347	14%	225,475	13%	3,683,822	14%	798,350	3%	11,738	1%	810,088	3%	-11%
\$5.00-\$9.99	15,948,449	68%	848,389	49%	17,796,838	66%	16,408,831	68%	638,304	43%	17,047,135	67%	0%
\$10.00-\$14.99	1,567,607	6%	461,919	27%	2,029,526	8%	5,482,219	23%	703,565	48%	6,185,784	24%	17%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	28,627	0%	0	0%	28,627	0%	-1%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,395,096	93%	1,608,806	93%	25,003,902	93%	22,718,027	94%	1,353,607	92%	24,071,634	94%	

Coinsurance

15% - 24.99%	619,822	2%	24,163	1%	643,985	2%	528,476	2%	32,524	2%	561,000	2%	0%
25% and up	1,027,860	4%	92,289	5%	1,120,149	4%	876,489	4%	92,289	6%	968,778	4%	0%
	1,647,682	7%	116,452	7%	1,764,134	7%	1,404,965	6%	124,813	8%	1,529,778	6%	

Missing

Total Generic	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	25,042,778	100%	1,725,258	100%		100%	24,122,992	100%	1,478,420	100%		100%	

Brand

Copayments

\$0	1,214,074	5%	56,879	4%	1,270,953	5%	0	0%	0	0%	0	0%	-5%
\$0.01-\$4.99	0	0%	9,357	1%	9,357	0%	0	0%	0	0%	0	0%	0%
\$5.00-\$9.99	2,104,366	8%	182,913	11%	2,287,279	9%	871,992	3%	86,399	6%	958,391	3%	-5%
\$10.00-\$14.99	10,052,829	40%	610,663	38%	10,663,492	40%	4,267,243	15%	263,225	18%	4,530,468	15%	-25%
\$15.00-\$24.99	9,779,832	39%	519,720	32%	10,299,552	38%	16,496,878	58%	871,358	61%	17,368,236	58%	19%
\$25 and up	170,224	1%	103,694	6%	273,918	1%	944,382	3%	87,919	6%	1,032,301	3%	2%
	23,321,325	93%	1,483,216	93%	24,804,551	93%	22,580,495	79%	1,308,901	91%	23,889,396	80%	

Coinsurance

15% - 24.99%	736,137	3%	24,163	2%	760,300	3%	528,476	2%	32,524	2%	561,000	2%	-1%
25% and up	1,138,131	5%	92,289	6%	1,230,420	5%	5,493,101	19%	92,289	6%	5,585,390	19%	14%
	1,874,268	7%	116,452	7%	1,990,720	7%	6,021,577	21%	124,813	9%	6,146,390	20%	

Missing

Total Brand	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	25,195,593	100%	1,599,678	100%		100%	28,602,072	100%	1,433,714	100%		100%	

B) Rx Copayments (per script) (Minimum By County)

Generic

Copayments

\$0	4,592,990	18%	116,133	7%	4,709,123	18%	3,793,298	16%	11,738	1%	3,805,036	15%	-3%
\$0.01-\$4.99	3,040,592	12%	200,049	12%	3,240,641	12%	942,726	4%	0	0%	942,726	4%	-8%
\$5.00-\$9.99	14,474,089	58%	832,198	48%	15,306,287	57%	13,669,116	57%	660,949	45%	14,330,065	56%	-1%
\$10.00-\$14.99	1,076,032	4%	422,034	24%	1,498,066	6%	4,299,031	18%	680,920	46%	4,979,951	19%	14%

Medicare IChoice
Premium and Benefit Analyses, By # of Medicare Eligibles (All)

P.04/14

202 690 6262

HCFA 10A

SEP-13-1999 13:06

	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	13,856	0%	0	0%	13,856	0%	-1%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,395,096	93%	1,608,806	93%	25,003,902	93%	22,718,027	94%	1,353,607	92%	24,071,634	94%	
Coinurance													
15% - 24.99%	619,822	2%	24,163	1%	643,985	2%	528,476	2%	32,524	2%	561,000	2%	0%
25% and up	1,027,860	4%	92,289	5%	1,120,149	4%	976,489	4%	92,289	6%	968,778	4%	0%
	1,647,682	7%	116,452	7%	1,764,134	7%	1,404,965	6%	124,813	8%	1,529,778	6%	
Missing	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
Total Generic	25,042,778	100%	1,725,258	100%		100%	24,122,992	100%	1,478,420	100%		100%	
Brand													
Copayments													
\$0	3,305,144	13%	116,133	7%	3,421,277	13%	1,993,732	7%	11,738	1%	2,005,470	7%	-6%
\$0.01-\$4.99	0	0%	0	0%	0	0%	239,524	1%	0	0%	239,524	1%	1%
\$5.00-\$9.99	6,847,514	27%	194,173	12%	7,041,687	26%	1,851,344	6%	96,701	7%	1,948,045	6%	-20%
\$10.00-\$14.99	8,187,894	32%	566,502	35%	8,754,396	33%	6,322,988	22%	285,099	20%	6,608,087	22%	-11%
\$15.00-\$24.99	4,810,549	19%	502,724	31%	5,313,273	20%	11,726,996	41%	827,444	58%	12,554,440	42%	22%
\$25 and up	170,224	1%	103,694	6%	273,918	1%	445,911	2%	87,919	6%	533,830	2%	1%
	23,321,325	93%	1,483,226	93%	24,804,551	93%	22,580,495	79%	1,308,901	91%	23,889,396	80%	
Coinurance													
15% - 24.99%	736,137	3%	24,163	2%	760,300	3%	528,476	2%	32,524	2%	561,000	2%	-1%
25% and up	1,138,131	5%	92,289	6%	1,230,420	5%	5,493,101	19%	92,289	6%	5,585,390	19%	14%
	1,874,268	7%	116,452	7%	1,990,720	7%	6,021,577	21%	124,813	9%	6,146,390	20%	
Missing	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
Total Brand	25,195,593	100%	1,599,678	100%		100%	28,602,072	100%	1,433,714	100%		100%	
5) Dental Benefit													
Yes	21,721,135	85%	1,073,724	51%	22,794,859	82%	20,786,990	83%	780,070	40%	21,567,060	80%	-2%
No	3,875,160	15%	1,044,979	49%	4,920,139	18%	4,143,573	17%	1,161,370	60%	5,304,943	20%	2%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	
7) Vision Benefit													
Medicare Coverage Only	133,654	1%	88,301	4%	221,955	1%	207,586	1%	98,765	5%	306,351	1%	0%
Additional Benefit	25,462,641	99%	2,030,402	96%	27,493,043	99%	24,722,977	99%	1,842,675	95%	26,565,652	99%	0%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	

Note: Rx Copays + coinsurance will not equal the number of eligibles with Rx; due to assigning averages/minimum, some will be double-counted

UNKN	RUZL	TOTAL	UNKN	RUZL	TOTAL	% CHGR
1	2	3	4	5	6	7

CHPP/HPPAD/PFE

Medicare - Choice
Premium and Benefit Analyses, By Number of Counties (SARs only)

(Average By County)

Generic

Copayments

\$0
\$0.01-\$4.99
\$5.00-\$9.99
\$10.00-\$14.99
\$15.00-\$24.99
\$25 and up

UR	UR	UR	UR	TOTAL	UR	UR	UR	UR	UR	UR	UR	UR	% Change
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
12	52%	30	60%	42	58%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	17%	11	22%	15	21%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	17%	9	18%	13	18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	91%	50	100%	71	97%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Coinsurance

15% - 24.99%
25% and up

1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Missing

Total Generic

1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	100%	50	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Brand

Copayments

\$0
\$0.01-\$4.99
\$5.00-\$9.99
\$10.00-\$14.99
\$15.00-\$24.99
\$25 and up

0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	9%	7	14%	9	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10	43%	14	28%	24	33%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	22%	20	40%	25	34%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	74%	41	82%	58	79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Coinsurance

15% - 24.99%
25% and up

1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Missing

Total Brand

5	22%	9	18%	14	19%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	100%	50	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

48) Rx Copayments (per script)
(Minimum By County)

Generic

Copayments

\$0
\$0.01-\$4.99
\$5.00-\$9.99
\$10.00-\$14.99
\$15.00-\$24.99
\$25 and up

1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
12	52%	30	60%	42	58%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	13%	11	22%	14	19%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	17%	9	18%	13	18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	91%	50	100%	71	97%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Coinsurance

15% - 24.99%

1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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Medicare Choice
Premium and Benefit Analyses, By Number of Counties (SARs only)

	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25% and up	1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Generic	23	100%	50	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Brand													
Copayments													
\$0	1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$0.01-\$4.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$5.00-\$9.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$10.00-\$14.99	3	13%	7	14%	10	14%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$15.00-\$24.99	8	35%	14	28%	22	30%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$25 and up	5	22%	20	40%	25	34%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	17	74%	41	82%	58	79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance													
15% - 24.99%	1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25% and up	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	1	4%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	5	22%	2	18%	14	19%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Brand	23	100%	50	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5) Dental Benefit													
Yes	26	57%	21	32%	47	42%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
No	20	43%	44	68%	64	58%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	46	100%	65	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6) Vision Benefit													
Medicare Coverage Only	3	7%	10	15%	13	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Additional Benefit	43	93%	55	85%	98	88%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	46	100%	65	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Premium and Benefit Analyses, By Number of Counties (Withdrawals only)

	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
1A) Distribution of M+C Plan Premiums (Avg. Premium Range)													
\$0	68	55%	4	25%	72	51%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	11	9%	1	6%	12	9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	10	8%	6	38%	16	11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	23	19%	3	19%	26	18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	6	5%	2	13%	8	6%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	6	5%	1	1%	7	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	124	100%	16	101%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1B) M+C Plan Premiums (Min. Premium Range)													
\$0	88	71%	4	25%	92	65%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	0	0%	1	6%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	6	5%	6	38%	12	9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	22	18%	3	19%	25	18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	2	2%	2	13%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	6	5%	1	6%	7	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	124	100%	17	106%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2) M+C Plan Premiums (plans w/ Rx) (Avg. Premium Range)													
\$0	66	65%	4	25%	70	60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	11	11%	1	6%	12	10%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	10	10%	6	38%	16	14%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	6	6%	3	19%	9	8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	6	6%	2	13%	8	7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	2	2%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	101	100%	16	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3) M+C Plan Rx Annual Limits (Avg. Maximum Range)													
\$0 - \$500	11	11%	2	13%	13	11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$501 - \$799	21	21%	0	0%	21	18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$800 - \$999	15	15%	0	0%	15	13%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1,000	28	28%	10	63%	38	32%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1001 - \$2000	16	16%	0	0%	16	14%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$2001 - \$2500	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$2500 +	2	2%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	8	8%	4	25%	12	10%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	101	100%	16	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4A) Rx Cost-sharing (per script)													

Medicare - Choice
Premium and Benefit Analyses, By Number of Counties (Withdrawals only)

(Average By County)

Generic

Copayments

\$0

\$0.01-\$4.99

\$5.00-\$9.99

\$10.00-\$14.99

\$15.00-\$24.99

\$25 and up

Coinsurance

15% - 24.99%

25% and up

Missing

Total Generic

Brand

Copayments

\$0

\$0.01-\$4.99

\$5.00-\$9.99

\$10.00-\$14.99

\$15.00-\$24.99

\$25 and up

Coinsurance

15% - 24.99%

25% and up

Missing

Total Brand

4B) Rx Copayments (per script)
(Minimum By County)

Generic

Copayments

\$0

\$0.01-\$4.99

\$5.00-\$9.99

\$10.00-\$14.99

\$15.00-\$24.99

\$25 and up

Coinsurance

15% - 24.99%

URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
2	2%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	4%	0	0%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	60%	7	44%	68	58%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28	28%	5	31%	33	28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	94%	12	75%	107	91%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	1%	3	19%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	1%	3	19%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	5%	1	6%	6	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
101	100%	16	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	2%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	6%	1	6%	7	6%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
37	37%	0	0%	37	32%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
36	36%	8	50%	44	38%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	14%	3	19%	17	15%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	94%	12	75%	107	91%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	1%	3	19%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	1%	3	19%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	5%	1	6%	6	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
101	100%	16	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	2%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	4%	0	0%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	60%	7	44%	68	58%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28	28%	5	31%	33	28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	94%	12	75%	107	91%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Medicare - Omaha
Premium and Benefit Analyses, By Number of Counties (Withdrawals only)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
25% and up	1 1	1% 1%	3 3	19% 19%	4 4	3% 3%	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Missing	5	5%	1	6%	6	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Generic	101	100%	10	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Brand														
Copayments														
\$0	2	2%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$0.01-\$4.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$5.00-\$9.99	6	6%	1	6%	7	6%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$10.00-\$14.99	37	37%	0	0%	37	32%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$15.00-\$24.99	36	36%	8	50%	44	38%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$25 and up	14	14%	3	19%	17	15%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	95	94%	12	75%	107	91%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance														
15% - 24.99%	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25% and up	1	1%	3	19%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	1	1%	3	19%	4	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	5	5%	1	6%	6	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Brand	101	100%	10	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5) Dental Benefit														
Yes	74	60%	10	59%	84	60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
No	50	40%	7	41%	57	40%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	124	100%	17	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6) Vision Benefit														
Medicare Coverage Only	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Additional Benefit	124	100%	17	100%	141	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	124	100%	17	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Medicare - Choice
Premium and Benefit Analyses, By Number of Counties (SARs only)

	ALL	ALL	ALL	ALL	ALL	ALL	ALL	ALL	ALL	ALL	ALL	ALL	% CHNG
1A) Distribution of M+C Plan Premiums (Avg. Premium Range)													
\$0	31	42%	30	36%	61	39%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	9	12%	10	12%	19	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	9	12%	6	7%	15	9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	9	12%	8	10%	17	11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	10	14%	15	18%	25	16%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	1	1%	4	5%	5	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	1	1%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	4	5%	11	15%	15	9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	74	100%	84	102%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1B) M+C Plan Premiums (Min. Premium Range)													
\$0	45	61%	45	54%	90	57%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	2	3%	0	0%	2	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	7	9%	6	7%	13	8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	7	9%	5	6%	12	8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	9	12%	14	17%	23	15%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	3	4%	3	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	4	5%	11	13%	15	9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	74	100%	84	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2) M+C Plan Premiums (plans w/ Rx) (Avg. Premium Range)													
\$0	29	45%	25	39%	54	42%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	8	12%	10	16%	18	14%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	8	12%	6	9%	14	11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	9	14%	7	11%	16	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	10	15%	14	22%	24	19%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	2	3%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	1	2%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	65	100%	64	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3) M+C Plan Rx Annual Limits (Avg. Maximum Range)													
\$0 - \$500	9	14%	5	8%	14	11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$501 - \$799	11	17%	14	22%	25	19%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$800 - \$999	8	12%	5	8%	13	10%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1,000	22	34%	13	20%	35	27%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1001 - \$2000	9	14%	27	42%	36	28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$2001 - \$2500	1	2%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$2500 +	3	5%	0	0%	3	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	65	100%	64	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4A) Rx Cost-sharing (per script)													

Medicare - Choice
Premium and Benefit Analyses, By Number of Counties (SARs only)

(Average By County)

Generic

Copayments

\$0
\$0.01-\$4.99
\$5.00-\$9.99
\$10.00-\$14.99
\$15.00-\$24.99
\$25 and up

0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
42	65%	37	58%	79	61%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
12	18%	18	28%	30	23%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	11%	9	14%	16	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	97%	64	100%	127	98%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Coinsurance

15% - 24.99%
25% and up

2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Missing

Total Generic

0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	100%	64	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Brand

Copayments

\$0
\$0.01-\$4.99
\$5.00-\$9.99
\$10.00-\$14.99
\$15.00-\$24.99
\$25 and up

0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	2%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
13	20%	8	13%	21	16%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	45%	21	33%	50	39%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	14%	26	41%	35	27%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
52	80%	55	86%	107	83%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Coinsurance

15% - 24.99%
25% and up

2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Missing

Total Brand

11	17%	9	14%	20	16%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	100%	64	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

4B) Rx Copayments (per script)

(Minimum By County)

Generic

Copayments

\$0
\$0.01-\$4.99
\$5.00-\$9.99
\$10.00-\$14.99
\$15.00-\$24.99
\$25 and up

0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
43	66%	27	42%	70	54%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	17%	18	28%	29	22%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	11%	9	14%	16	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	97%	54	84%	117	91%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Coinsurance

15% - 24.99%

2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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Medicare Choice
Premium and Benefit Analyses, By Number of Counties (SARs only)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
25% and up	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	0	0%	10	16%	10	8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Generic	65	100%	64	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Brand														
Copayments														
\$0	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$0.01-\$4.99	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$5.00-\$9.99	1	2%	0	0%	1	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$10.00-\$14.99	15	23%	8	13%	23	18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$15.00-\$24.99	27	42%	21	33%	48	37%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$25 and up	9	14%	26	41%	35	27%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	52	80%	55	86%	107	83%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance														
15% - 24.99%	2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25% and up	0	0%	0	0%	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	2	3%	0	0%	2	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	11	17%	9	14%	20	16%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Brand	65	100%	64	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5) Dental Benefit														
Yes	43	58%	32	38%	75	47%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
No	31	42%	52	62%	83	53%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	74	100%	84	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6) Vision Benefit														
Medicare Coverage Only	4	5%	11	13%	15	9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Additional Benefit	70	95%	73	87%	143	91%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	74	100%	84	100%		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Medicare - Choice
Premium and Benefit Analyses, By # of Medicare Eligibles (Withdrawals & SARs)

	PLAN	PERCENT			TOTAL					TOTAL				
1) M+C Plan Premiums (Average Premium Range)														
\$0	1,730,084	56%	0	####	1,730,084	56%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	738,364	24%	0	####	738,364	24%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	212,255	7%	0	####	212,255	7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	358,288	12%	0	####	358,288	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	75,178	2%	0	####	75,178	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	3,114,169	100%	0	####		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1) M+C Plan Premiums (Minimum Premium Range)														
\$0	2,872,100	92%	0	####	2,872,100	92%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	40,882	1%	0	####	40,882	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	96,196	3%	0	####	96,196	3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	29,813	1%	0	####	29,813	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	75,178	2%	0	####	75,178	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	3,114,169	100%	0	####		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2) M+C Plan Premiums (plans w/ Rx)														
\$0	1,730,084	57%	0	####	1,730,084	57%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$ 0.01 - \$19.99	738,364	24%	0	####	738,364	24%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$20.00 - \$39.99	152,224	5%	0	####	152,224	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$40.00 - \$59.99	358,288	12%	0	####	358,288	12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$60.00 - \$79.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$80.00 - \$99.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$100 - \$149.99	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
above \$150	0	0%	0	####	0	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	75,178	2%	0	####	75,178	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	3,054,138	100%	0	####		100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3) M+C Plan Rx Annual Limits (Avg. Maximum Range)														
\$0 - \$500	152,224	5%	0	####	152,224	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$501 - \$799	203,772	7%	0	####	203,772	7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$800 - \$999	412,855	14%	0	####	412,855	14%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1,000	125,993	4%	0	####	125,993	4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1001 - \$2000	451,728	15%	0	####	451,728	15%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$2001 - \$2500	151,092	5%	0	####	151,092	5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$2500 +	1,528,049	50%	0	####	1,528,049	50%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Missing	28,425	1%	0	####	28,425	1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A